

# INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL



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**THE ART AND SCIENCE OF SOMATIC PRAXIS  
INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY  
JOURNAL**

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## Student Supplement: From the Guest Editor

Hello,

I'd like to take a moment to introduce myself. I am Dawn Bhat, the guest editor for the IBPJ's special student supplement. What an honor to have been nominated by Jacquie Carleton, Ph.D. to be guest editor for this special supplement of IBPJ, the same journal she single-handedly shaped into a distinguished publication and marvelous platform for body psychotherapists to be seen world-wide. As a new editorial team formed in 2015, I joined them in carrying forward Jacquie's vision to create a special edition of IBPJ devoted to student theses.

For many years, I worked on various writing projects with Jacquie, going to her Manhattan office and delving into her library of everything I wanted to read. Jacquie and I were productive together - publishing several papers, presenting workshops nationally and internationally, co-authoring a book chapter in the English translation of *The Handbook of Body Psychotherapy and Somatic Psychology*, co-editing a resource column of the latest and greatest book reviews impacting body psychotherapy today. I also worked toward the Somatic Experiencing © Practitioner certification studying and doing my personal and consultation sessions in SE © with Jacquie. It was a special kind of relationship, something more than what you might expect from the relationship between mentor and mentee or supervisor and supervisee. So, I knew first-hand Jacquie's commitment to the field and in nurturing fresh minds to contribute to something she put her heart into.

As a first-time editor, I must say, the experience was in some ways more challenging for me than writing. For five years, I was a writer for *Somatic Psychotherapy Today*, edited by Nancy Eichhorn, Ph.D. I gave Nancy good enough write-ups but received more from her editing. My writing blossomed over and over from Nancy's encouraging feedback. I hoped to do the same with these student authors. Being able to sit down to read/edit someone else's writing involved an entirely new process for me. Editing was getting into the minds of several other authors and hoping that they didn't mind my comments.

As a long-time student myself, I identified with the student writers but I saw something extraordinary in the authors I communicated with. As a group they were enthusiastic, appreciative, attentive, responsive, persistent and professional; yet, they each had their own unique presence in the articles. I learned from them what you might expect from an expert in the field with years of experience. These student authors did not hesitate to draw back to early theories and trace them forward contemporaneously while making meaningful connections among varying complexities to support and ground their own research. All of which made me as guest editor want to preserve the spirit of the student in this issue.

I would like to get you acquainted with the authors and papers in the IBPJ student supplement. But first, I want to mention that these papers were all reviewed by leading experts in body psychotherapy, and some were recommended to go straight into the main IBPJ but space was limited, of course. This student supplement includes five articles that cover various perspectives on body psychotherapy.

In *Equine Facilitated Psychotherapy in the Body Psychotherapy Session: Horse as Surrogate for Therapeutic Touch*, Kate Beauchene will take you through the literature on equine therapy but it was the section on touch that held me.

Rebecca Snell's paper, *Therapist Qualities, Interventions, and Perceived Outcomes: Bringing Developmental Movement into Body Psychotherapy*, brings more physical, sensory-motor development into the issue.

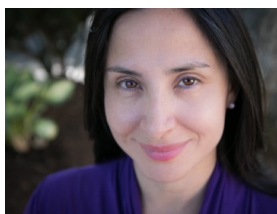
*Body Psychotherapy for Couples: Exploring the Somatic Components of Mutual Regulation* was Jennifer Buczko's contribution. This paper goes into the attachment research, neuroscience, and self-regulatory theories to share a somatic perspective on couples therapy.

*Clinician Experience with Addiction Treatment: Implications for Body Psychotherapy in Relapse Prevention* by Elizabeth Powers offers important insights that can be woven into different models of addiction treatment.

In *Body Psychotherapy and Social and Emotional Learning: An Integrative Model*, Nicole Calvano focuses on mindfulness in schools, social and emotional learning, and working with children and adolescents.

This IBPJ student supplement is intended to give a voice to somatic psychology and body psychotherapy students today. While students may be future leaders, writers, clinicians, theoreticians, they are the ones cultivating the field of somatic psychotherapy. As I read through these five papers, as a psychotherapist in private practice, I was reminded of how easy it is to slip away from the literature. Students and professionals alike will find this special issue a worthwhile read. I hope that in years to come these papers will continue to be resourceful.

As this issue is about to be available, I am settled as I moved from New York to Washington State taking this project from the East coast to the West coast of the US. Now we get to expand our work and give it to other body psychotherapists worldwide.



Dawn Bhat  
MA, MS, LMHC, LPC, SEP  
Camas, Washington

## Student Supplement-Editorial

### Peer Review: An Initiation to Academic Writing

Writing is part of our formal learning experience from kindergarten forward. We're trained to "tell" stories, to write our lives, to communicate with others using our words. Yet nothing prepares us for academic writing except immersion (reading and learning how to critique) and direct instruction. As potential therapists, our graduate program professors teach the format and structure of the academic paper, and many also require students to submit papers to peer review journals, which is not necessarily an easy thing.

It can be difficult enough to scribe one's thoughts in this structured format: write a 500 word abstract that tells a complete story; write a clear introduction that leads to a current review of the literature to support the content be it a theoretical premise, a pilot study, a potentially new application of an established method or an entirely new approach; and accurately offer data, analysis, results, conclusions and next steps. It can be just as daunting to reach out to an unknown editor at a formal peer reviewed journal, to know that professionals in your field will read and critique your paper for the soundness of the arguments presented, the validity of the research conducted and its conclusions, the format and writing style itself, and the references.

Yet, when we read articles in peer reviewed Journals, we know the content underwent rigorous study, that the authors most likely worked on several revisions and that, according to their peers, they are making a significant contribution to the "literature."

We are pleased to share this special student supplement knowing those who made it through peer review and revision upheld our focus on quality and rigorous study. They offered a particularly interesting perspective or project with enlightening outcomes and opinions. With this publication, they have joined the ranks of professionally published psychotherapists. We offer our thanks to Dawn Bhat for her dedication as Guest Editor for this supplement. She spent countless hours working with student writers, reading and offering detailed remarks for revision, copyediting, all the while supporting these young professionals entering a challenging writing environment.

Sincerely,

The IBPJ Editorial Team  
Asaf Rolef Ben-Shahar, PhD  
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## Equine Facilitated Psychotherapy in the Body Psychotherapy Session: Horse as Surrogate for Therapeutic Touch

Kate Beauchen

### Abstract

This theoretical paper explores the ways in which body psychotherapy and equine-facilitated psychotherapy approaches to treatment may be synthesized and applied to various populations. The primary focus is on the equine co-therapist's ability to provide touch interventions to the client while the human therapist supports processing and maintains the therapeutic container. The ability of the equine co-therapist to provide effective touch interventions in place of the human therapist rests on the equine's ability to serve as an attachment figure for the client.

**Keywords:** Body psychotherapy, equine-facilitated psychotherapy, touch, attachment theory

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The tendency for humans to carry on close relationships with certain animals has been well documented throughout history. More recently, the therapeutic possibility of these relationships is being explored in greater depth. In the 1960s, Boris Levinson unintentionally discovered the rapport-building boost his dog provided in sessions with a young, non-verbal client. Levinson coined the term "pet therapy" and his work is considered the beginning of animal-assisted therapy (AAT) (Levinson, 1962). Pet Partners (2012), an organization focused on improving the lives and health of humans through positive interactions with therapy, service, and companion animals, defines AAT as "a goal-directed intervention in which an animal [...] is an integral part of the treatment process." It is performed by a health or human service professional in a variety of settings "to promote improvement in human physical, social, emotional, and/or cognitive functioning.

This paper focuses on one specific branch of AAT, equine-facilitated psychotherapy (EFP). Equine-facilitated psychotherapy and equine-facilitated learning (EFL) are experiential forms of psychotherapy, and growth- and learning-directed activities that involve equines. The equine is an important co-



therapist or partner in the work of both EFP and EFL. Equines' sensitivity to subtle changes in the environment makes them ideal partners for professionals who act as counselors, teachers and guides. There are several different names for the various practices that fit under the umbrella of equine-facilitated or equine-assisted therapies. For the purpose of this paper, the term primarily employed will be equine-facilitated psychotherapy, EFP.

Unlike cats and dogs, the horse is a prey animal. As such, horses are biologically programmed to be hyper-vigilant, constantly assessing their environments to gauge the level of safety and fleeing from perceived threat or danger (Frewin & Gardiner, 2005; Dorotik, 2011; Hamilton, 2001; Irwin, 1998; McCormick & McCormick, 1997; Vidrine, 2002). As Kohanov (2003) stated, "Horses have a highly refined ability to sense the feelings of predators and other herd members *at a distance*." (p. xii, italics original). It is this ability that serves as the foundation for several of the therapeutic skills horses possess (Maujean, Kendall, Lillan, Sharp, & Pringle, 2013).

Due to their hyper-vigilant nature and well-developed intuition, horses can sense the feelings and intentions of human beings with whom they interact. Typically, horses respond swiftly to the inner world of humans. This innate ability of the horse to tune into a person's experience and respond to it with immediacy is believed to be the driving force behind EFP (Bachi, 2013; Burgon, 2011; Chardonens, 2009; Dorotik, 2011; Hamilton, 2011; Irwin, 1998; Klontz, Bivens, Leinart, & Klontz, 2007; Kohanov, 2003; Ford, 2013; Frewin & Gardiner, 2005; McCormick & McCormick, 1997).

Because of the biological need for horses to track predators and determine their intentions, they are considered "sentient" beings (Kohanov, 2003; Notgrass and Pettinelli, 2015). Sentient is defined as "responsive to or conscious of sense impressions, aware, and finely sensitive in perception or feeling" (Merriam Webster, 2012). This sentience allows horses to assess clients for mood/affect congruence. For instance, if a client externally presents an affect that is out of sync with their authentic internal experience, the horse will sense the individual's true inner feeling and reflect it back through their behavior (Bachi, 2013; Burgon, 2011; Chardonens, 2009; Frewin & Gardiner, 2005; Ford, 2013; Kohanov, 2003; McCormick & McCormick, 1997; Trotter, 2012).

By having a horse mirror their moods or behaviors, clients are afforded the opportunity to recognize personal patterns and coping mechanisms. "A horse walking away, ignoring, being distracted by other horses, sleeping, wanting to eat at the wrong time, biting, urinating, and neighing are common horse behaviors to which clients respond." (Klontz et al., 2007, p. 259). Clients typically experience thoughts, feelings, and sensations in response to these or other horse behaviors. Clients' responses to equine co-therapists in session are often relevant to their lives outside of therapy and can lead to rich psychotherapeutic work. It can be argued that EFP allows clients and therapists to delve deeper into emotional processing more quickly than traditional talk therapy (Trotter, 2012). The same has been said of somatic or body psychotherapy work. Equine-facilitated psychotherapy pairs well with many body-centered therapies because equines model present-centered awareness and also elicit it from the people with whom they're paired. Horses

communicate primarily nonverbally, also an essential part of body psychotherapy.

Body psychotherapy (BP) is a distinct branch of therapy that consists of an explicit theory of mind-body functioning, which takes into account the complexity of the intersections and interactions between body and mind (United States Association of Body Psychotherapy, 2009, Definition of Body Psychotherapy section, para. 1). BP assumes that no hierarchical relationship between mind and body exists, but that they are both functioning and interactive aspects of the whole human being. As such, BP utilizes the body (in addition to the psyche and intellect) as a vehicle for healing and change. This generally involves increasing somatic awareness and using breath, posture, movement, and touch (when appropriate). Somatic awareness, or body awareness, refers to the five sense perceptions available to human beings; the traditional five senses (hearing, sight, touch, taste, smell) constitute one sense perception area, and the others are kinesthetic, proprioceptive, vestibular, and visceral (Gopisetty, Daubenmier, Price, Hecht, & Stewart, 2009).

Another reason that the BP framework is appropriate for synthesis with EFP is that many of BP's principle elements are crucial to working with and developing relationships with horses. For instance, awareness of one's own body, the surrounding environment, and the interaction between the two is critical for maintaining safety around such large animals. A therapist may prompt a client to pay attention to where the individual is placing their feet when near a horse, or run their hand along the horse's flanks as they walk around its backside. Attention to such details helps clients focus on the present and can serve to strengthen somatic awareness.

A common EFP session activity involves clients leading horses around an arena or on a trail. To help manage a client's anxiety, a somatically oriented therapist may remind the client to breathe or match the length of each breath to a certain number of the horse's steps. This promotes increased present-centered awareness. In BP, breath is viewed as an essential resource that supports emotion regulation and distress tolerance (Aposhyan, 2004). Conscious incorporation of the client's body into the therapeutic work is what changes a pure EFP session into a combined BP/EFP session. In an EFP session facilitated by a therapist without somatic training, their ability to support the client in processing therapeutic material on all three levels (emotional, cognitive and somatic) and the complex interplay between them may be somewhat limited. Through the use of simple leading exercises, people can gain significant insight into internal states and external expression. With the guidance of a therapist, clients are able to slow down and receive continued support with tuning in to their inner experiences. Thus allowing them to identify both the sensations and emotions that they are feeling. Engaging in a relationship with the equine co-therapist creates a mutual pattern of reactions and responses between horse and client that the therapist can mine for psychotherapeutic material. While leading a horse, it is important to adopt an assertive posture — straight back, strong engaged legs, and upright head. A client may be taught or reminded how to adopt this posture in a combined BP and EFP session. This is due to the widely held belief in the field of BP that an

individual's body — their posture, movement, cognition, and speech — reflects their state of mind (Aposhyan, 2004). Furthermore, the state of one's body can serve to either anchor them in a particular state of mind or help bring about change and increased creativity.

Lastly, and possibly most importantly, a combined BP and EFP session would include touch. Nonverbal communication is an essential part of BP and it is also horses' primary mode of communication (Aposhyan, 2004; Caldwell, 1997; Hamilton, 2011; Irwin, 2001; Smith, Clance, & Imes, 1998). There has been much discussion regarding the significance of nonverbal communication in human interaction. Early estimates put the influence as high as 93%, but more recent studies suggest that nonverbal cues generally contribute about 65% of meaning, whereas verbal cues contribute about 35% (Burgon et al., 1996; Guerrero & Farinelli, 2009).

Clients who engage in EFP often receive clear and immediate nonverbal feedback from the horse, in response to their affect, general energy, or communication style. Much of the therapeutic relationship between horses and humans happens via nonverbal cues and physical touch. Horses' initial method of getting acquainted with others is through the use of smell. Touch and other nonverbal gestures can be employed by humans to bond with horses, reassure them, or reinforce positive behaviors (Hamilton, 2011; McCormick & McCormick, 1997). Touch between humans and horses can also be used in negative and abusive ways, but this paper focuses on the positive and therapeutic potential of touch.

## Review of the Literature

### Equine Facilitated Psychotherapy

Over the past two decades, a moderate amount of qualitative research has been done on the effects of EFP (Bachi, 2013; Burgon, 2011; Chardonnens, 2009; Ford, 2013; Frewin & Gardiner, 2005; Froeschle, 2009; Klontz et al., 2007; MacDonald, 2004; Maujean et al., 2013; Schultz, 2007; Sexauer, 2011; Trotter, Chandler, Goodwin-Bond, and Casey, 2008; McCullough, 2012; Meinersmann, Bradberry, and Roberts, 2008; Vidrine, 2002). A limited number of quantitative studies also exist. The results show that humans do seem to benefit from working with horses in a therapeutic setting. While there are many theories regarding causality, more scientific support is needed. Most of the studies have worked with small sample sizes and research participants recruited by convenience; both are common limitations in EFP research.

Research has shown that EFP can result in increased self-esteem for clients. MacDonald's (2004) evaluation of multiple EFP and therapeutic riding programs found that participants reported significant increases in self-esteem. This finding is echoed in a study comparing equine-assisted counseling (EAC) to classroom-based counseling (Trotter et al., 2008). Results indicated that EAC made "statistically significant improvements in seventeen behavior areas", whereas the classroom-based counseling group showed statistically significant improvement in only five areas.

Increases in self-efficacy, feelings of empowerment, and personal independence have also been shown to result from participation in EFP (Burgon, 2011; Klontz, 2007; Maujean et al., 2013; Meinersmann et al., 2009). A pilot study on a therapeutic horseback riding program in Norway that investigated the effects of EFP with children ages 10-11 with ADHD indicated an improvement in social role behavior, quality of life, and motor performance (Cuypers, De Ridder, & Strandheim, 2011). In addition to the proven therapeutic benefits of EFP, the involvement of horses in therapeutic sessions also contributes to client motivation to attend and participate actively in therapy (Trotter et al., 2008; Shultz, 2005; Waite & Bourke, 2013).

Though many of the studies have found some benefit from the involvement of horses in therapeutic work, this is not always the case. MacDonald's (2004) evaluation of a day school for at-risk youth that involved horses resulted in no statistically significant results. However, evidence suggests that poor or inconsistent program design may have played a role in this outcome. The program moved several times during the period of study and eventually became an educational enhancer as opposed to a strictly therapeutic program.

### **Equine Facilitated Psychotherapy and Body Psychotherapy**

Peer-reviewed literature on EFP and BP in combination is virtually nonexistent. Of the few works that do exist, a very small number have been published. Ford (2013) wrote about the combination of dance/movement therapy (DMT) and EFP. Ford's qualitative research explored the ways in which these two modalities might be combined to create an effective psychotherapeutic approach. Ford's research indicated that the use of DMT and EFP together "increased therapeutic possibilities, including levels of client and therapist embodiment and creative expression" and most notably for the purpose of this paper, "opportunities for contact and touch and the depth and breadth of the therapeutic relationship" (p. 11). Panetta's (2007) unpublished thesis discusses important individuals in the body psychotherapy world including Jung, Perls, Levine, and Rosenberg and Rand, their respective work, and the ways in which theoretical frameworks created by those individuals lend themselves to combination with EFP. In 2009, Hawkes explored the synergy of biofeedback and EFP as a hypothetical therapeutic model to teach clients how to regulate cognitive, emotional, and somatosensory experiences.

### **Touch**

Many important studies involving touch exist outside of the body psychotherapy literature. In an effort to acknowledge both seminal works and those related to the topics addressed in this paper, studies that fall outside of the realm of body psychotherapy in its strictest sense are also included. The following works serve to elucidate the complex relationship between touch, attachment theory, developmental trauma and the holding environment.

D.W. Winnicott's (1960) early work on parent-infant relationships made major contributions to object relations theory and also provided the foundation for attachment theory. For the purpose of this paper, the most important

concept is the “holding environment”, described by Winnicott as both the literal holding of the infant by the primary caregiver and the environmental factors put in place by that caregiver. Winnicott believed that it was only through the adequate holding environment that the infant could achieve maximum inherited potential.

In Harlow's (1966) now famous “cloth mother experiment” with rhesus monkeys, it was determined that the infant monkeys preferred a terrycloth doll that they could climb on and cuddle to a wire representation of a mother. The monkeys that had terrycloth “mother” forms tended to use them as a means of comfort when frightened, but the monkeys with wire “mother” forms instead hid in the corner rocking themselves. The monkeys with terrycloth “mothers” achieved greater social competency later in life. Spitz's (1945) study further illustrated the adverse affects that touch deprivation can have on human development. After researching infants of imprisoned mothers who had been placed in institutionalized care, Spitz concluded that the unusually high number of infant deaths occurring in this specific population were a result of psychological trauma associated with lack of touch.

Haworth and Sclare (1986) conducted a study that offers insight into how developmental trauma, sometimes called attachment wounding, might be treated. They researched the effects of holding therapy on nine children who presented emotional or behavioral difficulties within their adoptive families several years after placement. Holding therapy involves a caretaker gently holding a child while lying on the floor in a manner that limits the child's mobility. Six months after treatment, seven of the nine families reported positive changes in their children, including increased eye contact, proximity seeking, and accepting parent guidelines. Holding therapy was also described as a safe vehicle for the children to express strong emotions (as cited in Aquino & Lee, 2000, p. 22).

Other research has uncovered the detrimental effects of touch deprivation. The Bucharest Early Intervention Project (Almas et al., 2012) found that children who are deprived of nurturing and touch in early life develop deficits in cognitive (i.e., IQ) and socio-emotional behaviors (i.e., attachment). These children also experience an elevated incidence of psychiatric disorders, impairment, and differences in electrical activity in the brain. Montagu (1995), a seminal figure in the field of touch research, provides examples of the negative impact of touch deprivation on humanity. He states that without touch there may be growth deprivation, failures in communication, aggression, and even war.

**Touch in therapy.** Strozier, Krizek, and Sale's 2003 study of the use of touch by clinical social workers with clients determined that the touches most frequently used were handshakes and touches to the arm, shoulder, or back. Hugging was employed more than half of the time by the therapists in the study, and handholding about a third of the time. Holding/cradling, stroking and patting were the types of touch employed least by the therapists in the study.

In Strozier et al.'s same study (2003), participants listed the following as the most common reasons for using touch: to express empathy, be healing,

communicate acceptance, model healthy touch, express symbolic parenting focus on the client, help release repressed emotions, communicate affection, and remove barriers to work. The participants listed the following primary reasons for *not* employing the use of touch in sessions: it may be threatening to the client, the client may not know how to interpret the touch, it may feel coercive to the client, it may induce sexual feelings in the client, it may lead to legal issues, the therapist's own need to establish strong personal boundaries, fear that it would create an intensity in the therapeutic relationship, and the belief that it is unprofessional to employ touch. As evidenced by Strozier et al.'s (2003) research, bringing touch into work with a client has great potential to change the landscape of the therapeutic relationship, whether for better or worse. There are many points to consider, and this is another reason why touch in the combined BP and EFP session may be safer for some clients than in a pure BP session.

Furthermore, research has shown that touch can help with PTSD. In a randomized, controlled trial exploring the use of Healing Touch and Guided Imagery in combination to treat PTSD, nurses certified in the modality applied Healing Touch to veterans (Jain et al., 2012). Healing Touch is a biofield therapy that consists of gentle, non-invasive touch focused on working with the body's energy system to promote healing. The results of the study showed that those who received the Healing Touch intervention had a significant reduction in PTSD symptoms, depression, and cynicism, as well as an overall improvement in mental quality of life. It is clear that when used as a therapeutic modality touch can be beneficial for clients. An essential consideration, then, is when to use it.

**Touch in other settings.** When used appropriately, touch has been shown to provide a number of benefits to the receiver. In Field's (2001) series of studies on how massage therapy may help to reduce the aggression caused by physical contact deprivation, research showed that adolescents who received massage therapy treatment were less depressed and anxious, had lower levels of cortisol, and experienced an increase in nighttime sleep when compared to adolescents in the same inpatient facility who did not receive massage therapy. Additionally the teens were rated as less aggressive and more cooperative and empathetic by both mental health staff and their own parents. A tangentially related study on the effect touch has on medication compliance had medical practitioners touch their patients on the forearm for one to two seconds during an appointment (Guéguen, Meineri, & Charles-Sire, 2010). At the end of that same appointment practitioners solicited the patients for a verbal promise that they would take their antibiotics as prescribed. The research found that touch increased medication adherence across genders. A 2011 study on the effects of massage on weight gain in preterm infants found that massage contributed to weight gain in the infants in two different ways: the first was increased insulin release via the celiac branch of the vagus, and the second was increased gastric activity via the gastric branch of the vagus (Field, Diego, & Hernandez-Reif, 2011).

While much of the literature available on touch in clinical settings is positive, it does have the potential to be traumatic for clients. Dunleavy and Slowik's

(2012) paper presents a case study of a sixty-year-old woman with PTSD and chronic back pain. While in physical therapy for the back pain, the woman began to experience PTSD symptoms linked to being sexually assaulted at age nineteen. The physical therapists treating the woman “monitored somatic responses and body language closely and modified and planned treatment techniques to avoid PTSD triggers and limit hyper arousal” (Dunleavy & Slowik, 2012, p. 339). The physical therapists worked in concert with the client’s psychotherapists and used cognitive behavioral strategies to accomplish therapeutic goals. The aforementioned study illustrates the way that touch can evoke powerful, and sometimes disturbing memories.

### **Horse as Surrogate for Therapeutic Touch**

It is widely believed in the field of psychology that positive and nurturing early experiences help support individuals’ healthy growth in the realms of cognitive, physical, and emotional development (Ainsworth, 1989; Bachi, 2013; Bosanquet, 2011; Bowlby, 1977; Caldwell, 1997; Field, 2002; Harlow, Haworth, & Sclare, 1966, 1986; McCormick & McCormick, 1997; Schore, 2003; Spitz, 1945; St. Clair, 1994; Totton, 2011; Wallin, 2007; Westland, 2011; Winnicott, 1960; Zur, 2007). While this nurturance may be referred to as affection, positive regard, or even love, these positive early experiences are largely comprised of nonverbal communication (Heller, 1997; Field, 2001; Montagu, 1986).

On the most basic level, touch in the context of the psychotherapeutic session is used to accomplish specific goals and is never to be erotic in nature (Aquino, 2000; Smith et al., 1998; Strozier et al., 2003; Willisson & Masson, 1986; Zur, 2007). It can be used to reinforce or deepen the therapeutic relationship, provide support, encourage regression, support client’s increased somatic awareness, help access core affect, and allow for expression (Caldwell, 1997; Hunter & Struve, 1998; Smith et al., 1998; Totton, 2011; Willisson & Masson, 1986). Definitions of therapeutic touch range from simple hand contact to a full embrace. Individuals practicing as body psychotherapists should receive specific training on the ethics of touch in therapy, the types of touch that may be employed for the purpose of psychotherapeutic work, and when and how to apply types of touch in sessions (Caldwell, 1997; Hunter & Struve, 1998; Smith et al., 1998; Totton, 2011).

Situations might arise in which touch could be therapeutically beneficial but may be complicated when administered by the therapist. Some such examples are with individuals who have histories of abuse, PTSD, or severe psychosis. In cases like these, the equine co-therapist can serve as a surrogate for therapeutic touch, allowing the client to reap the benefits of physical contact without the risk of retraumatization, transference, or other dynamics that might confuse the boundaries of the human-to-human therapeutic relationship.

One noteworthy difference in the relationship between the client and human therapist and the client and horse co-therapist is that the client has implicit permission to touch the horse, whereas touching the human therapist would likely require explicit permission. It is possible that because the power differential between client and horse is not the same as it is between client and therapist, touching and being touched by the horse is emotionally safer for the client. Sometimes clients agree to touch interventions suggested by their

therapist out of a their desire to comply even though they would prefer to refuse touch. A client's need to please, and concurrent fear of rejection may feature less in their relationship with the horse than with the human therapist.

Additionally, with the horse as the primary provider of touch interventions, the therapist is free to aid in processing what comes up for the client, while also observing whatever transference the client directs toward the horse (Klontz et al., 2007). The human therapist can gather rich data from the way that the client receives and offers touch to the horse, or avoids it, and from clients' interpretations of what transpires in the session.

From an attachment theory perspective, the goal of therapeutic work is to allow the client to heal relational wounds from early childhood and ultimately attain a secure attachment style (Ainsworth, 1989; Bachi, 2013; Bowlby, 1977; Wallin, 2007; Winnicott, 1960), meaning an ability to form close bonds with other human beings (or animals) and achieve intimacy with them without experiencing high levels of anxiety, ambivalence, or avoidance. Winnicott (1960) believed that touch, play and the "holding environment" were all essential to the healthy development of the psyche. Ideally an infant is able to form a secure attachment to its primary caregiver. However, this is not always the case; sometimes children will form a secure attachment to another important figure in their lives, such as a grandparent, teacher, or coach. In the event that an individual has no opportunity to form a secure attachment while growing up, a therapist can hopefully provide a corrective experience by acting as an attachment figure for that client.

For those who have difficulty bonding with other humans, horses may be able to fill the role of attachment figure, or at least provide safe opportunities to practice relating (Bachi, 2013; Hallberg, 2008; McCormick & McCormick, 1997). There are several reasons that may contribute to this. Katcher (2001) argued "the ratio between body weight of a horse and a person is not unlike the ratio between body weight of mother and infant" (as cited in Vidrine, 2002, p. 591). Based on the average weight of North American adults and infants, 16.2% is the ratio of infant to parent, and 13.6% is the ratio of adult human to horse. The large size of horses is often spoken about as something that clients may find intimidating (Burgon, 2011; Trotter et al., 2008; Waite & Bourke, 2013). However, the fact that this size difference bears similarities to that of the "holding environment" is discussed less often (Bachi, 2013; McCormick & McCormick, 1997). Schultz (1999) outlines four basic ways in which the mounted equine experience can support the development of self-identity (as cited in Vidrine, 2002). Schultz reminds the reader the important role rhythm plays in the developing child's life, describes ways in which the "holding environment" is recreated (or created for the first time) in the horse-human dyad, and draws parallels between the "preverbal movement dialogue between mother and child" and the one between horse and rider (as cited in Vidrine, 2002, p. 590). If mounted work is happening in sessions, it provides great opportunity for the horse to hold the client – both literally, and metaphorically (Bachi, 2013).

Domesticated horses communicate largely on a nonverbal level, and with humans much of this communication manifests as horses both touching the human and allowing the human to touch them. Because of the equine anatomy



(four legs and no arms) a lot of the touch interactions involve their faces, necks, backs, and flanks. A client touching their therapist in any of these places would be unusual.

When a horse allows a client to touch its face, neck or flanks, the effect is a deepening of the relationship. Touch interactions between the horse and the client can evoke feelings in the client to be processed with the human therapist facilitating the session.

In a population of individuals that have commonly suffered both touch violation and deprivation at the hands of their fellow humans, horses can serve as surrogate providers of touch for their human co-therapists. The horse's contribution to the therapeutic process has the potential to enhance client well being and promote positive therapeutic outcomes. Previous sections of this paper sought to illustrate why a synthesized EFP and BP approach may be effective. The following section begins to examine how this framework may be applied to specific populations.

### **Applications**

Both body psychotherapy and equine-facilitated psychotherapy have been shown to be effective with a number of populations. The following model illustrates the ways in which a combined BP and EFP approach may affect positive change for three distinct client populations. Each client population illustrates one level of the tri-level framework proposed for utilizing a synthesized BP and EFP approach: 1. Physical interaction as event; 2. Social/relational; and 3. In-depth emotional processing. The examples provided are proposed as hypothetical sessions and are an amalgamation of personal experience.

#### **Physical Interaction as Event**

Clients who are afflicted with chronic mental illness, such as schizophrenia, bipolar disorder, or severe depression or anxiety, can often become increasingly isolated over time (Cathro & Devine, 2012). Family members may become distraught by their relative's symptoms or burnt out by caring for him/her (Weimand, Hall-Lord, Sällström, & Hedelin, 2013). The symptoms of these clients' illnesses - delusional thinking, talking to oneself aloud, etc. may make forming new relationships challenging, as might the stigma associated with certain diagnoses. As a result it is common for those struggling with chronic mental illness to be touch-deprived.

Opportunities to leave their home or treatment center are important for the chronically mentally ill, as their world can become quite small due to their symptoms (Murray & Devine, 2012). Regular individual or group therapy sessions involving equine work may offer clients an incentive to attend to activities of daily living (brushing teeth, showering, getting dressed), which is sometimes a challenge for the aforementioned population. Attending therapy also provides opportunities for human contact, both with therapists and, if in a group setting, others with similar diagnoses. The group therapy setting can also offer a culture of understanding, a place where individuals are able to speak about their personal struggles and receive validation and support from peers. Interaction with horses offers additional affordances for the chronically ill client — a chance for physical connection, nervous system regulation (Mistral, 2005),

and to connect with another living being without judgment. The following paragraphs offer options for conducting a combined body psychotherapy and equine-facilitated psychotherapy session in a group setting.

A therapist might lead clients through a somatically oriented check-in that includes a movement component along with verbalization of their current emotional states and any body sensations they are experiencing. For example, one particular treatment group begins by forming a circle. One by one the group members share the emotion each is experiencing in that moment while executing a movement to express that emotion physically. After the check-in, group members perform a few barn-related duties, and then move into the EFP component of the session.

As clients groom their horses, the therapist might direct their attention to the quality of various touches they employ in order to perform this task as well as the nonverbal and verbal feedback that the horses are giving them. The therapist can ask clients to interpret the feedback they are receiving from the horse, using questions like, "What do you think it means when the horse puts its ears back like that?" or "What do you think that horse's long exhale is trying to communicate?" Additionally, therapists can support clients in tracking their own experiences on cognitive, emotional, and somatic levels. The therapist could do this by directing clients to notice what they are thinking, feeling, and sensing as they progress through the session. In this way the therapist helps clients make connections between their inner experiences, their communication with the horses, and the responses that they are receiving.

Next the therapist can facilitate a herd observation, haltering horses and taking them for a walk or leading them through exercises in an arena. The activity chosen should be appropriate for the physical and cognitive abilities of the group members. At the conclusion of the group the therapist could ask clients to compare their cognitive, emotional, and somatic states *after* working with the horses to how they were feeling in these three categories during the initial check-in. At the end of a session like this, clients might report experiencing a decrease in their level of distress and negative emotions, as well as an increase in positive emotions, cognitions, and sensations (McCormick & McCormick, 1997).

### **Social/Relational**

Clients participating in the social/relational level of therapeutic work are higher functioning than the populations that would engage in interaction as social event. The clients' potential to make discoveries and gain insight about their own relational styles is greater. An example of work at this level is an individual in inpatient treatment for substance abuse. A potential scenario for this client is that they are paired with a horse that begins to lick their hand. The licking increases in intensity over the course of several minutes, and culminates in the horse nipping the client's finger, breaking the skin and causing slight bleeding. An incident like this could be viewed as a violation of a major ethical tenet of counseling, "do no harm". While the ethical implications are important, whether the potential therapeutic gains outweigh the damage done is also a question for the therapist to consider. This could be an important therapeutic moment. If the client continues to interact with the horse in the same way, this

indicates a lack of boundaries. The client could protect themselves by nonverbally requesting more space from the horse.

What is noteworthy in this particular session is the delivery of a negative touch interaction by the equine co-therapist. While it may bring up material that fosters discovery and self-growth on the part of the client, this type of touch intervention would be unethical if delivered by a human therapist. Some might argue that it is unethical even when delivered by a horse. However, this particular example illustrates the power and immediacy of EFP. When used in strictly somatic work, touch interventions can help clients to deepen their own emotions or sensations, to sequence movement that might relate to previous trauma or other psychological material, or to simply feel connected to and supported by their therapists. In the aforementioned example, the touch interaction between the horse and the client, if addressed consciously, could be the catalyst for this type of work between therapist and client.

In addition to serving as a possible illustration of the client's relationship to touch, interaction with the horse could inspire some interesting questions about the client's relationship dynamics outside of the therapeutic session. Are there ways that this individual has let others violate their boundaries? Have they placed themselves in situations that are unsafe without realizing the potential dangers? And if the client continues to let the horse lick their hand after the bite: historically, has this individual quickly forgiven others for transgressions, and if so, why?

If the client does allow the horse to lick their hand after being bitten the first time, the therapist must intervene. Imagine that the therapist moves closer to the client-horse dyad and says to the client, "I'm surprised to see you letting this horse lick your hand again after what just happened. Could you tell me more about your choice to allow it?" At this point, the client has the opportunity to recognize areas of choice. The client might respond to the therapist, "I really wanted this horse to like me. I figured it did when it was licking my hand and I think that the bite was accidental. If I don't let the horse lick my hand it won't like me anymore." Having succeeded in getting the client to delve more deeply into the relationship dynamic between themselves and the horse, the therapist might now ask, "Does that remind you of any other relationships you have?" The client would likely answer that it does, possibly adding something like, "Actually, yes, my father consistently violates my boundaries, but I forgive him quickly because I am afraid that if I don't he will stop loving me."

Having gotten to the root of the problem behavior, the therapist can now craft an intervention specifically meant to address this issue. An appropriate intervention would be teaching the client how to set a physical boundary with the horse. The therapist might demonstrate for the client how to gently, yet firmly push the horse's head away from them when the animal begins to invade their space. For clients who struggle with boundary setting, it could be difficult to determine what constitutes an invasion of space and the therapist may help determine a physical distance to work with for the purpose of this exercise. The therapist could verbally cue the client to check in with any sensation, emotion, or cognitions that arise while they repeatedly push the horse's head away.

At the social/relational level of work, clients receive all of the benefits of the physical interaction as event level, with the addition of increased opportunity

to identify their own problem behaviors and begin thinking about changing them. Such opportunities arise mainly from physical contact between the horse and client. As those touch interactions evoke thoughts and feelings for the client that they can then process with the human therapist.

### **In-Depth Emotional Processing**

At the in-depth emotional processing level, clients should have good ego-strength and be fairly high functioning. Though the experiences or activities might be similar to those used at the social/relational level of work, in a session where in-depth emotional processing occurs, the difference is the client's increased ability to engage in the process, make meaning of what is happening, relate it to his/her life outside of therapy, gain insight, and effect positive change.

What follows is an outline of a hypothetical session that demonstrates the possibilities for in-depth emotional processing when working through a synthesized BP and EFP approach. While casually interacting with the herd and their therapist in a pasture, a client touches upon something that triggers a traumatic memory, which they might name a "flashback". The client recalls a time that they witnessed a gunfight as a child and was told by their parent to stop crying about it. The client then becomes dysregulated. The body loses tone in the abdomen, adopts a hollow posture with shoulders hunched forward, and the client begins to cry. They might also report feeling numb and disconnected. At this point, the therapist invites the client to mount a large, strong horse standing in close proximity to them with an interested look. It is common for horses to voluntarily interact with a client, and therapists often interpret that as a horse's interest in working with that particular client.

Once on the horse, the therapist can guide the client through a modified body scan, directing them to feel the strength and support of the horse underneath them, feel the warmth of its skin, and notice all of the places that their two bodies are making contact. To strengthen this intervention, the therapist may invite the client to lie down on the horse's back and be guided through an internalization of this resource. This process can calm the client's nervous system in the present moment and create an embodied, sensation-based memory that the client can conjure in the future to self-soothe.

The aforementioned session is a prime example of the therapeutic value that touch interventions delivered by an equine co-therapist have. There are several important elements present in the session, one of which is the holding environment that is created for the client on both a metaphorical and actual level by the human therapist. The horse further reinforces this holding environment by *literally* holding the client on its back. The result is the client's experience of being supported and held close while expressing strong emotion, something that in their family of origin was not allowed. Thus, what transpired was likely a reparative experience for the client, as it reinforced on multiple levels that it is acceptable to feel a strong emotion and express it, and that one will not necessarily be shunned for doing so.

Though the human therapist can be involved in touch interventions, in this particular session the therapist was mostly free to track the client's interaction with the horse. This allows the therapist some distance from which to examine their own countertransference, both cognitive and somatic. By having such

space, the therapist may be able to observe and work with the client from a more objective standpoint, without their own experience hindering the therapeutic possibilities.

### **Limitations**

While the combination of BP and EFP work is believed to have provided positive outcomes for some individuals, there are certain limitations and ethical concerns to consider. Therapists working in concert with equine co-therapists should know the horses they are utilizing in sessions very well. This allows them to anticipate the horse's reactions and ideally means that the therapist and equine co-therapist have a positive and trusting relationship with one another. When the conditions listed above are met, safety for all participants is increased. It is important to remember also that the equine co-therapist is still an animal, and as such is driven largely by instinct. The potential for physical harm to occur when working with horses is a valid concern. The ethical therapist takes all steps necessary to keep the client safe, and still it is possible that injury may occur. In conversations questioning the safety of EFP the focus is generally on humans, research on what impact this work has on the horses is virtually nonexistent.

The framework presented in this paper assumes that clients are physically able to do this work with horses, and while equine-facilitated psychotherapy may be more challenging for those with physical disabilities, it is possible. In mounted work for the physically disabled it is common for at least three staff members to work with each individual. Similar accommodations could be made in the realm of combined BP and EFP work, but it would require the therapist to bring in additional human helpers, thus allowing them to witness the client's session and possibly complicating the therapist's ability to maintain proper client-patient confidentiality. Even when working with able-bodied clients, EFP therapists often employ the use of horse handlers to help maintain safety, which again, may adversely impact the confidentiality of the sessions.

Within the wide range of clinical populations seeking treatment, some may be more or less appropriate for BP/EFP treatment. High-functioning adults who are interested in personal growth are very appropriate for BP/EFP work. Those with severe mental illness, such as schizophrenia or severe depression or anxiety can also reap benefits from BP/EFP work, though certain symptoms of these diagnoses may complicate the therapy or endanger participants. There is some evidence to support diminished sensorimotor function in those with severe substance abuse issues and, as such, safety precautions when working with this client population are of the utmost importance (Hanlon, Wesly, Stapleton, Laurienti, & Porrino, 2011). Given these factors, it is important for therapists working in a combined BP and EFP setting to assess clients' appropriateness for the method upon intake. Another factor that might inhibit clients' ability to engage in work involving horses is the high cost and limited accessibility of services.

### **Conclusion**

It is relatively well documented that body psychotherapy is an effective treatment approach, and a wealth of articles extolling the virtues of equine facilitated therapy also exist. However, in both fields the bulk of this work is

anecdotal or theoretical in nature. Furthermore, the synthesis of BP and EFP as a treatment model has been addressed only minimally in the existing literature or scientific research. On a fundamental level, the pairing of BP and EFP seems very natural. Working with horses requires a certain level of presence and embodiment, and somatic therapy is focused on teaching skills that specifically support increased presence of mind, awareness of one's body, and ability to reside comfortably within it (Aposhyan, 2004; Caldwell, 1996; Irwin, 1998). On a deeper level, there exists the ancient and archetypal relationship between the two; the physical realities of the relationship and the way that they mimic attachment dynamics; opportunities for touch and emotional intimacy; and the physiological components of such touch, for example nervous system regulation. It could be argued that equine-facilitated psychotherapy is in fact already a body-centered modality, however, this paper sought only to lay the foundation for future work by illustrating that a synthesized approach would in fact be a viable form of treatment. This was accomplished through the examination of the efficacy of both EFP and BP as separate modalities, the exploration of touch and its therapeutic benefits in general, and the combination of all three as a treatment approach based largely on attachment theory and dynamics.

In order to prove the efficacy of a combined body psychotherapy and equine-facilitated psychotherapy approach to treatment reliably, more research must be done. Although theoretical papers have been written, almost no formal research, either qualitative or quantitative, has been done on these two modalities in combination. The next steps should be more research of a qualitative or quantitative nature, and potentially research on work that is similar to that proposed in this model/framework. No matter the direction that is taken in research, the author is confident that bringing conscious body awareness and touch into a session with horses creates the potential for transformative experiences to unfold.

## BIOGRAPHY

Kate Beauchene was born and raised in Santa Monica, California. She currently resides in Boulder, Colorado where she received her master's degree in somatic counseling psychology at Naropa University. Kate has had the good fortune to be mentored by equine-facilitated psychotherapists Jackie Ashley and Jean-Jacques Joris, as well as therapeutic riding instructor Sonny Mone. Research support for this paper was provided by Naropa University Somatic Counseling Program founder Christine Caldwell; reader, Wendy Allen; and editors, Dyana Reisen and Emily Taylor-Mortorff  
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## **Therapist Qualities, Interventions, and Perceived Outcomes: Bringing Developmental Movement into Body Psychotherapy**

**Rebecca L. Snell**

### **Abstract**

The past decade has seen an increasing awareness of the connection between mind and body in psychotherapy. Working directly with the body, and utilizing developmental movement in particular, has shown promise in children, those of normal functioning as well as some developmentally challenged, in the areas of reading, balance, and coordination (Goddard Blythe, 2005). However, research on utilizing developmental movement with adult clients is lacking. In response, this pilot study involving qualitative studies was conducted to assess how developmental movement can be used with adult clients in individual psychotherapy. Five therapists who utilize developmental movement in individual therapy sessions with adult clients were interviewed. Results of this study indicate that there are themes consistent among the interviewees regarding the qualities that a therapist needs to have to facilitate a session utilizing developmental movement, the types of interventions used, and the perceived outcomes of utilizing developmental movement with adult clients.

**Keywords:** developmental movement, body psychotherapy, adult clients

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### **INTRODUCTION**

The past two decades have seen an increasing awareness of the connection between mind and body in psychotherapy. The field of body psychotherapy in particular has contributed to this with insights into mindfulness, breathing, awareness, emotional processing and regulation techniques (Ogden, Minton, & Pain, 2006; Kurtz, 1997; Caldwell & Victoria, 2011). However, developmental movement in particular has not been the subject of much published research. In the words of an interviewee from this study, "Working with developmental movements is a psychotherapeutical child which is by far not well enough cared for." Therefore, the intention of this paper is to consider the perceived benefits of this modality and how it can be further brought to light in the field of body psychotherapy.

Developmental movement (DM) can be defined as the “series of early motor patterns that each person goes through from conception to walking” (Foster, 2007, p. 101). Included in the developmental movement patterns are five fundamental actions (yield, push, reach, grasp, pull) and the reflexes that underlie the patterns (Bainbridge Cohen, 2008). The developmental movement patterns were originally articulated in the 1940’s by a neurosurgeon, Dr. Temple Fay, and continue to be refined and developed over the decades (Warshaw, 2007). The therapeutic use of these movements is based on the idea that “each basic developmental movement pattern is coordinated by a specific area of the brain” (Hartley, 1995, p. 93) and that “it is possible to facilitate the performance of an inhibited movement pattern through restimulation of dysfunctioning areas of the brain” (Hartley, 1995, p. 93). Such restimulation is thought to support “automatic coordination of movement and bodily processes by the lower brain areas” (Hartley, 1995, p. 94), which is thought to free the higher cortical centers for creative, intellectual, and social potential (Hartley, 1995; Brook, 2001).

The objective of the pilot study is to examine the following questions: Among therapists who utilize developmental movement as a part of their treatment model, what are the perceived benefits? How do these therapists use developmental movement in sessions? Using convenience sampling, potential interviewees were contacted based on the criteria that they work with adult clients, that they utilize developmental movement in session with clients, and that they be practicing licensed psychotherapists.

Interviews were conducted with five participants, the interviews were transcribed, and the data was analyzed using a multi-phase coding process. Grounded theory, “a qualitative research method that seeks to develop theory that is grounded in data systematically gathered and analysed” (Urquhart, Lehmann, & Myers, 2010, p. 357), was chosen as the basis for interviewing and data analysis because it is widely used in the social sciences.

Obtaining information that would point to the effects of developmental movement with adult clients is beyond the scope of this research. Nonetheless, it is this researcher’s assertion that studying the perceived effects of developmental movement and how it is utilized in session will contribute to the field of body psychotherapy.

### **A Review of Literature**

This section of the paper will cover the topic of developmental movement as it has been researched and cited in texts. Developmental movement can be defined as “a universal set of movements through which infants generally, though individualistically, proceed during the first year or so of life” (Aposhyan, 1999, p. 62). This--- process of movement development, according to Bonnie Bainbridge Cohen, is “both ontogenetic (human infant development) and phylogenetic (the evolutionary progression through the animal kingdom)” (2008, p. 4). In addition, Bainbridge Cohen posits that “the developmental material includes primitive reflexes, righting reactions, equilibrium responses, and the Basic Neurological Patterns” (p. 5).

A brief history of developmental movement is presented here. Following that, the different methods that employ developmental movement, such as Body-Mind Centering, the Kestenberg Movement Profile, and Neurological

Reorganization Therapy, are briefly discussed. Finally, research on developmental movement is considered.

### **A Brief History of Developmental Movement**

The idea that “ontogeny recapitulates phylogeny” was first posited by Ernest Haeckel in 1866 (Swan, 1990), who theorized that “the embryonic stages in the development of an individual (its onto-geny) repeat the evolutionary history of its ancestors (its phylogeny)” (Hanken, 1998, p. 56). It is worth noting that Haeckel was quite a controversial figure, and indeed, his theory of recapitulation has not been embraced by many biologists (Blackwell, 2007).

Applying this concept of recapitulation to the development of movement, in the 1940's Dr. Temple Fay advanced his idea that there are neurodevelopmental movement patterns, or “locomotive movement strategies used across vertebrate species, generally representative of progressive levels of complexity of an animal's neural organization” (Warshaw, 2010, p. 48). These patterns are the Homologous pattern, the Homolateral pattern, and the Crossed Diagonal pattern, and they illustrate the “transition from amphibian, via reptilian, to the mammalian eras” (Stillman, 1968, p. 88). Homologous movement involves “simultaneous flexion or extension of both upper limbs and/or both lowers” (Warshaw, 2010, p. 49). In Homolateral movement, “same-side limbs, upper and lower, flex or extend together” (Warshaw, 2010, p. 50), and each side of the body is clearly differentiated. Finally, Contralateral movement “links the upper limb on one side of the body with the opposite lower limb” (Warshaw, 2010, p. 50).

Dr. Fay used these patterns to treat cerebral palsy, based on the assumption that brain damage in such cases affects a child such that the child “must function more from the mid-brain than from the cortex and that treatment, to be effective, must develop the movements which arise at this level” (Pollock, 1956, p. 14). His thought was that working with movement developmentally activates a lower part of the brain.

As the theories around these patterns developed, more patterns, such as Spinal movement, which connects the head and tail, were added (Brook, 2001). This idea of individual movement development following a phylogenetic pattern paved the way for future therapies which utilize developmental movement, such as Body-Mind Centering, Bartenieff Fundamentals, Neurological Reorganization Therapy, and the Kestenberg Movement Profile, to name a few.

While the idea for re-patterning movement from a developmental perspective was evolving, the concept of studying movement from a functional perspective was looked at by Rudolph Laban, who developed Laban Movement Analysis (LMA) in the first half of the twentieth century (Fortin & Siedentop, 1995) as a “theoretical framework for observing qualitative and quantitative changes in movement, ranging from conversational hand gestures to complex actions” (Adrian, 2002, p. 73). Laban thought that the way people move is affected by environmental factors, including interactions with others, and that this movement affects people physically and emotionally (Adrian, 2002). Laban sought to get people out of habitual movement patterns and back to the “natural” way to move.

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A contemporary of Laban, Veronica Sherborne, who trained in physiotherapy, and studied under Laban and Ullman at the Art Movement Studio in Manchester, UK, added to the knowledge of the way people move. She applied Laban's "theory of analysis and human movement to the needs of children with special needs" (Loots & Malschaert, 1999, p. 221). Along with Sherborne's approach to developmental movement, other modalities incorporating developmental movement evolved from people who studied with Laban or were influenced by his work. Some of the modalities that incorporate developmental movement will be discussed below.

### Methods Using Developmental Movement

Dr. Judith Kestenberg developed the Kestenberg Movement Profile (KMP) as a way to notate movement. She claimed that people's emotional experiences have an effect on the way they move and because of this, "the study of movement opens a door to the study of patterns of early development, coping strategies, and personality configurations" (Kestenberg Amighi, Lowen, Lewis, & Sossin, 1999, p. 2). Referencing the KMP, Loman and Foley (1996) claimed that "movement observation and interaction encourages empathy and relational embodiedness, both of self and other" (p. 349). The KMP uses ten developmental, rhythmic categories for children from birth to age six, consisting of the following: Sucking, Snapping/Biting, Twisting, Strain/Release, Running/Drifting, Starting/Stopping, Swaying, Surging/Birthing, Jumping, and Spurting/Ramming (Starnes, n.d.; Kestenberg, et. al., 1999). Loman and colleagues (1999) emphasize that the KMP and Body-Mind Centering (discussed below) can "support and enrich each other as systems of developmental movement" (p. ix). Indeed, similarities between the developmental movement patterns in the KMP and Body-Mind Centering can be observed. For example, the Strain/Release rhythms correspond with the Homologous and Homolateral patterns in the BMC, and Twisting, Running/Drifting, and Starting/Stopping patterns correspond with the Cross Diagonal pattern (Kestenberg, et. al., 1999).

Body-Mind Centering (BMC) was developed in the 1970's by Bonnie Bainbridge Cohen. BMC can be described as "an approach to movement reeducation and repatterning" (Aposhyan, 2004, p. 17). In developing BMC, Bainbridge Cohen "drew material from the world of physical therapy, modern dance, and Japanese body-mind approaches, including the martial arts" (Aposhyan, 2004, p. 17). In addition, Bainbridge Cohen, who started out as an occupational therapist and has an extensive background in movement, studied with both Kestenberg and Bartenieff (Bainbridge Cohen, 2008).

In BMC, the developmental material "includes primitive reflexes, righting reactions, equilibrium responses, and the Basic Neurological Patterns" (Bainbridge Cohen, 2008, p. 5). The reflexes are the automatic movement responses that underlie our volitional movement and thus play a role in developmental movement (Bainbridge Cohen, 2008). The righting reactions have more advanced patterns, and include patterns that "bring the head into vertical orientation in space in relationship to gravity, and those that bring the head and torso into mutual alignment in relationship to each other (Bainbridge Cohen, 2008, p. 124). Both Brook (2001) and Hackney (2002) cite that the basic reflexes and righting reactions play a role in how patterns be-

come automatic in the body during development. The actual developmental movement patterns in BMC consist of Naval Radiation, Breathing, Spinal movement, Homologous movement, Homolateral movement, and Contralateral movement (Bainbridge Cohen, 2008; Brook, 2001; Brook, 2000).

Other methods that utilize developmental movement include BrainDance, developed by Anne Green Gilbert, located in Seattle, WA. BrainDance is a “series of movements based on infant movement that represent the development of the central nervous system through the body’s experience of the physical world” (O’Shei, 2006, p. 46). Other researchers who use BrainDance label the series of movements as developmental movement (Patterson, 2010), and Anne Green Gilbert herself says that she has been working with developmental movement patterns since the 1970s (Seven, 2008).

Also located in Seattle, Bette Lamont uses Neurological Reorganization Therapy with both children and adults to retrace missed developmental stages so that psychotherapy can proceed more rapidly and successfully (Lamont, n.d.). Neurological Reorganization Therapy, which Lamont claims has a fifty-year history of success, is based on the concept of neurological organization (Lamont, n.d.). The idea behind neurological organization, similar to developmental movement, is that “the nervous system of each new human being must go through a definite series of developmental stages” (Bird, 1967, p. 29), and that each pattern needs to be developed for the brain to operate at its full potential (Bird, 1967). Doman and Delacato used the idea of neurological organization to form a large part of their therapy, which was highly influenced from their studies with Dr. Temple Fay (Bird, 1967).

Finally, Ruella Frank has made an extraordinary contribution to psychotherapy with her conception of a “somatic and developmental frame of reference” (Frank, 2001, p. 20). In a work done in collaboration with a colleague, Frances La Barre, Frank and La Barre present a theory called Foundational Movement Analysis, which looks at “the functional adaptations of movement patterns that emerge within the earliest relationships” (Frank & La Barre, 2011, p. 2), which they believe are basic to all relationships between adults. This theory looks at the developmental movement patterns in the first year of life, and goes on to elaborate how these patterns of nonverbal interaction continue to inform a person’s “expressive interactive repertoire throughout life” (Frank & La Barre, 2011, p. 1).

Methods such as BMC and others utilizing repatterning techniques assume that there is a neurological basis for movement development, that neurological pathways are expressed physically, and can be stimulated through movement (Bainbridge Cohen, 2008). As a person develops, habitual movement patterns form as “unconscious responses to our inner and outer environment initiate or obstruct the movement of energy through the body in a particular way” (Hartley, 1995, p. 102). These unconscious, subtle patterns can contribute to a healthy functioning person or to a state of imbalance (Hartley, 1995), which can lead to a wide variety of problems, from psychological issues to learning difficulties/disabilities to physical ailments. Therapies that utilize repatterning seek to treat these conditions on a physical level based on the conception that creating an alternative physical pattern creates new neural connections.

### Research on Developmental Movement

Much of the research done on developmental movement has been conducted with children. One research project conducted in England used a developmental movement program developed by the Institute for Neuro-Physiological Psychology, or INPP (Goddard Blythe, 2005). This study, implemented in schools with children with special needs, found that children in the experimental groups, which used developmental movement, showed “significantly greater improvement in reflex scores and tests for balance and coordination than the control or comparison groups” (Goddard Blythe, 2005, p. 429). The study also implies that improvement on reflex scores and coordination improves a child’s ability to learn.

Other research conducted at the University of Colorado at Boulder found that practicing developmental movement patterns decreased undesirable behaviors related to Attention Deficit Hyperactivity Disorder (Patterson, 2010). The children also experienced increased social ability. After completion of the program, a third of the participants returned to normal functioning, while two-thirds of the children retained some benefits (Patterson, 2010).

Although there is some research with developmental patterning work with autistic children and children with other learning disabilities, there is a paucity of research pertaining to the use of developmental movement in a psychotherapeutic setting with adult clients.

### Method

#### Participants

Using convenience sampling, this researcher contacted potential interviewees based on the criteria that they work with adult clients, utilize developmental movement in psychotherapy sessions with adult clients, and are practicing licensed psychotherapists. Interviewees were then chosen based on a willingness to participate in an interview via email, phone, or Skype.

The interviewees are all female, middle-aged and white, and each has been working in the field of psychotherapy for fifteen to thirty years or more. Three interviewees are from the United States and the other two from Europe. The three interviewees from the United States cited Body-Mind Centering as a foundation for their developmental movement work, while the two from Europe have some training in Body-Mind Centering as well as experience in other modalities that include developmental movement, such as the Kestenberg Movement Profile and the Feldenkrais Method. Some participants have published books in the field of psychotherapy, and some have contributed to the literature on Body-Mind Centering. The following pseudonyms are used throughout this paper to refer to the interviewees: Jan, Sue, Gertrud, Ida, and Sarah.

#### Instrumentation

To further understand the question of how to utilize developmental movement in sessions with adult clients, and the perceived benefits, if any, of utilizing developmental movement, semi-structured interviews were conducted. Two of the interviews were conducted via Skype. In addition, two more



interviews were collected via email using the same set of questions used during the live interviews, one of which was succeeded by a live follow-up interview via Skype. The last interviewee responded to the email interview but it should be noted that the interviewee's response was only a page and a half long. In total, five therapists were interviewed, with four having provided in-depth answers to each question, and three having participated in a live interview.

The live interviews were transcribed, and the email interviews were put into a word document format for the coding process. This process began with Open coding, in which pieces of text were taken from the interviews. These were analyzed and checked against codes created and notated on the original transcripts, which contained In Vivo (exact words or phrases used by interviewees) and Descriptive (a type of code used to describe, or summarize, what is in the data) coding (Taylor & Gibbs, 2010). The pieces of text were organized into categories and labeled according to themes that emerged from the groups of text. These were checked again with the transcripts for context, and for consistency from one round of coding to the next. The larger categories discussed below that emerged from this process were created from the processes: grouping text, checking the original transcript, and re-grouping the pieces of text.

## Results

Opening this section is a segment regarding the definition of developmental movement. Results are then presented along the three major categories that arose from the interviewees' answers: therapist qualities, interventions used by the interviewees, and perceived outcomes. This is followed by a passage regarding the risks and cautions of utilizing developmental movement with adult clients. Finally, this section concludes with a few examples of using developmental movement in a therapy session with adult clients.

### Definition of Developmental Movement

Literature on this topic suggests a broad definition for developmental movement or sometimes fails to clearly define it at all. Therefore, the first question posed to the interviewees regarded their definition of developmental movement.

All interviewees stated something similar to Jan's assertion that developmental movement is "a set of movement patterns that we develop in utero, in birth, and in the first year or so of life", and that they are the basic movement patterns that support or are present in movement throughout life. This definition is consistent with how DM is defined in the literature.

However, both of the two interviewees who reside in Europe also expanded on this definition. For example, Ida included the "interaction between mother and child and their phase-specific conflicts and growth processes" into her definition of developmental movement. Adding to her definition of DM, Gertrud stated that movement and development are synonymous, that "movements may serve the development into a more functional/healthy human and movement may lead the development into a less functional/healthy human". Thus, she summarized, "movements of any kind are an elemental way in which development of beings takes place". These definitions take a developmental

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look at all movement, in particular examining the developmental stages of early mother/child interaction, and may be worth considering as part of a framework for bringing developmental movement into session with an adult client.

### **Therapist Qualities**

As in psychotherapy in general, the qualities, knowledge, and skills a therapist brings to session provide the foundation for treatment utilizing developmental movement. The first requisite that participants agreed on is for a therapist to have both theoretical and experiential knowledge of the patterns. Regarding the importance of experiential knowledge, four out of the five therapists emphasized that a therapist would need to, as Jan pointed out, have a “very good sense of those patterns within herself”. There was an element of caution here as well; if someone were to try interventions with only a basic understanding of the patterns, she or he could potentially do harm to the client, as explicated in Sue’s interview.

#### *Therapist adaptability*

Another emerging theme speaks to the importance of a therapist’s adaptability. For example, Sue mentioned that a therapist should not be rigid, and that she or he needs to adjust the tone/pacing of interventions according to the client. Ida claimed that a therapist should have the ability to change roles according to what is needed in the moment and to “go with the flow”.

#### *Body-level relating*

Relating to a client on a body level was a notable theme. Two therapists, both with an extensive background in Body-Mind Centering, mentioned that it is important to, in Jan’s words, “be in touch with the embodied experience of relating in the moment”. Sue made a very similar statement, and also talked about how she uses “cellular presence to make contact”. In BMC, cellular presence is a type of awareness in which a person practices cellular breathing (the first DM pattern) to become aware of the body at a cellular level. Jan also called this an “animal knowing” level of relating.

#### *Embodiment, attention, and setting boundaries*

Other themes had to do with basic body psychotherapy skills such as embodiment, in which two therapists specifically mentioned that it is important to “be embodied” and to “work from an embodied state”. Attention is another category, which includes paying “high quality attention”, “tracking activation” and using one’s attention to assess if or when to use DM interventions. Only Gertrud directly named attunement as an important quality for a therapist to possess. Empathy was mentioned three times by Sue, making it worth mentioning here. Finally, setting boundaries was mentioned twice by Sue and once by Ida.

#### *Connection/making contact with the client*

Sue and Jan both named the ability to “connect with the client” as being important for therapists, while Sue and Ida both stated that they like to meet a client “where they are” (contact). Similarly, Jan noted that it is important to “meet the person’s frame of reference”.

#### *Attending to the relationship with the client*

Four of the interviewees had responses that fell into this relational category. For example, Sue stated that you have to “make sure everything is safe”, while

Jan stressed the importance of dealing with a mistake. Gertrud stated that “the relationship between client and therapist has to be clear and trustful”. Similarly, Ida states that there must be trust and to “have a relationship going”. Clearly, the relational aspect of therapy is important to most of the interviewees.

#### *Awareness of movement and client process*

The last categories that emerged focus on various aspects of awareness. One category on awareness of movement, about which both Sue and Jan suggested that a therapist needs to be aware of his or her own movement and impulses to move. Ida stressed the importance of a therapist being aware of his or her intentions during a session, while Jan emphasized that a therapist should be aware of the client's process.

### **Process and Interventions**

When asked to describe a session in which she utilized developmental movement, each interviewee talked about both specific interventions and about the process of therapy throughout a single or multiple sessions.

Two interviewees highlighted the letting go of form in favor of relationship or process. Ida claimed that she likes to “let go of teaching developmental movement once the client's body can use what is there for his own process”. Similarly, Sue stated that “eventually your method goes into the background and the relationship stays in the foreground”.

Other significant statements were about the general process of a session, in which the therapist and client begin with awareness, move on to having an experience, and then do some kind of integration or appreciation at the end of the session.

Specific processes and interventions within each session might also be employed. Bringing awareness to maladaptive patterns was a theme that two therapists mentioned as being important to address in their interventions, including bringing awareness to a client's “unconscious gesture” (Gertrud) and helping a client identify her own “responses and reactivities using the language of developmental movement” (Sue). Following this, Jan said that she does interventions that help a client “re-work something in a positive direction”.

#### *Sequencing movement*

Sequencing movement may have been the most significant category, as it was named as part of the interventions for all five therapists. For example, Sarah likes to encourage “sequencing within a particular developmental movement pathway”, saying things like “good, let that go all the way through”. Jan related an example where she had a client bring a hand closer to his face and mouth, do a sucking pattern and “see if they can feel it all the way down”. Ida and Gertrud talked about the importance of completing a movement experience and allowing the body to develop, learn, and experience movements.

#### *Patterning exercises*

The most responses fell into the category, patterning exercises. Some of the experiential developmental movement patterns used with adult clients consist of the following: “going back and attempting to crawl” (Sue); asking a client to “find the connections of the limbs into the torso, and into the naval center” (Ida); having a client push evenly through the feet on the floor (Sarah); and having a client do the “hand to mouth” pattern (Jan).

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*Client empowerment*

Empowering the client was noteworthy among the interviewees. Both Jan and Sue stated that helping a client “find her own power” is important. Ida said that she finds ways to “promote client growth and self-efficacy”, and Sarah stated that the greatest effect of doing developmental movement with adult clients is “self-directed and empowering growth”.

**Perceived Outcomes**

All interviewees noted some positive outcomes of using developmental movement in body psychotherapy.

Being able to “Connect with Feelings” was noted as an outcome by three of the interviewees. A “Decrease in Anxiety” was mentioned by two interviewees. The category of “Integration” (a general mind-body integration) was noted by three of the therapists. Gertrud stated that a client “feels more connected to himself” after an experience in session, and Sue claimed that the patterns support body, emotional, and structural integration.

The three therapists who participated in a live interview all mentioned that their clients changed their ways of being in relationship after doing developmental movement work. Ida recalled a session with a client who was also a therapist in training who reported that “she was emotionally more available and present” for her own clients. Jan claimed that the patterns help clients have “more connection to themselves as they deal with other people”, and Sue said that the patterns affect her clients’ “ability to be present in communication”.

**Risks and Cautions**

Although not to such a great extent as with the other categories, the interviewees agreed on some key risks and precautions about utilizing developmental movement with adult clients.

Jan and Sue both made it a point to caution therapists about overwhelming a client with a body-based intervention. “When you’re working on a body level, it can bring up emotional responses”, Sue provided. Similarly, Jan advised that some clients have “had such trauma, that to actually experience their body in any way is too much”.

All three therapists who engaged in live interviews shared anecdotes that point to the category of “Survival and the Nervous System”. The survival element is from the body’s natural response to fight, flee, or freeze when faced with a life-threatening situation, which Sue stated that she likes to educate clients about. What is interesting here is the theme of “Respect” which arose from this category. Ida describes a session during which she invited a client to do a level change (from walking to coming down to the floor). As she described the situation, Ida appeared astonished that the client was unable to go to the floor, that she got stuck “hanging over” and she portrayed the posture of the client with her arms hanging in front and her upper body stiff. Regarding this incident, Ida stated that her client’s body “really didn’t want to go down on to the floor, and that one needs to respect”.

Similarly, Jan emphasized that “you need to have a healthy respect for how primitive the feelings and patterns are”. Sue looks for the health behind an

inability to do a pattern or sequence movement. She seeks out the positive intent of a client's habitual pattern and theorizes that the pattern may be there as "some kind of protection, or it's trying to provide stability when there wasn't any". Whether for protection or survival, all three of these examples point to acknowledging and respecting a client's habitual pattern that might not be serving her or him in the moment.

### **Session Examples**

One of the questions asked of the interviewees (a list of which can be found in the appendix) was to describe a session in which developmental movement was used with an adult client. The following are examples of interviewees' responses, which give some idea of how a session with developmental movement might look.

Sue gave an example of a client who was activated and needed help with self-regulation. In that session, Sue started with one of the developmental actions of the ability to push. She asked the client to push down on the arms of the chair in which the client was sitting during the session, and "just see if they feel a different sensation in addition to their activation". Sue stated that this could be a good intervention for someone who is not yet comfortable with a lot of movement.

Sue gave another example of a client who complained that her life was miserable. Sue stated that her goal at this point was to educate the client about the satisfaction cycle; to show how the actions of yield, push, reach, grasp, and pull originate from a baby's experience as a part of learning, and are the fundamental actions for feeling physically and psychologically "satisfied". Using a doll as a prop, Sue recounted how she demonstrated the movements, pushing the doll into the floor to show how a "push into a reach allows an infant to raise its head and have more curiosity". In this way, Sue showed how the development of movement at an early age affects the learning of emotional and relational patterns throughout life.

When asked to describe a session in which developmental movement was used, Jan recounted her work with a client whom she described as having "underbound structure", with issues of anxiety, fear and suspiciousness. Jan stated that she worked with this client on early "hand-to-mouth reflex". It was her observation that the client's hands and limbs looked like they didn't belong to him. Therefore, Jan invited this client to bring in a sense of his hands, to "become more aware of his hands, to bring them together, to bring them toward his face, toward his mouth". Jan stated that her observation was that this movement was an organizing, containing and grounding movement for the client.

### **Discussion**

As outlined previously, this research was conducted to consider the following questions: Among therapists who utilize developmental movement as a part of their treatment model, what are the perceived benefits? How do these therapists use developmental movement in sessions? Interviews were conducted via Skype with two therapists, via Skype and email with one

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therapist, and via email with another two therapists, one of whom responded with a brief page and a half response, for a total of five interviewees. Data from the interviews was analyzed and categories and themes emerged from this data.

The themes that emerged outlined the Qualities of a Therapist, Process and Interventions, and Perceived Outcomes. Some categories, most notably Therapist Qualities, included themes that are shared by anyone practicing psychotherapy. It seems that a few of the themes in other categories, such as a therapist relating from an “animal knowing” part of the brain, could be seen as skills specific to utilizing developmental movement with adult clients, but also as useful skills for any body-based psychotherapy interventions. Some of the interviewees’ definitions of developmental movement were also interesting to consider as part of a larger framework movement-based patterning interventions into the world of body psychotherapy.

Regarding the original research questions of the perceived benefits of developmental movement and how developmental movement can be brought in to body psychotherapy, the category of Perceived Outcomes directly addressed the first question.

The word “perceived” here is significant as these are what the interviewees reported based on their observations and not what was actually measured with scientific instruments. Through the interviews, the main positive themes to arise from this category are as follows: an increase in a client’s ability to Connect with Feelings; a Decrease in Anxiety; and emotional and physical Integration; a Change in Ways of Being in Relationship; Increased Self-Efficacy and Empowerment; emotional and physical Stability; more Freedom and Ease; a greater sense of Organization, Containment, and Grounding; a Change in the way a client relates to her/his Body; New Insight/Perspective; a greater Engagement in Life; a learning of Adaptive Patterns; an Increased Efficiency of Information Processing; a Release of Unconscious Material; and finally an Increased Capacity to Pay Attention.

Although many different modalities could result in the benefits listed above, developmental movement is unique in its ability to address the nervous system directly and lead to an increased efficiency of information processing. It is true that other modalities do affect the nervous system through means of emotional regulation and creation of new experiences that require the client to integrate what was presented during a session, but developmental movement allows a movement to directly impact the rewiring of the nervous system, allowing for integration and processing to happen later.

The major category of Qualities of a Therapist addresses the second part of the research question: how to bring developmental movement in to a body psychotherapy session. The following are some of the emerging themes which the interviewees felt were important Qualities/Abilities of a Therapist: Theoretical and Experiential Knowledge of developmental movement; Embodiment; Emotional Regulation of Self; Adaptability; Connection/Contact with the Client; Body-Level Relating; Awareness of her/his own movement; Awareness of Therapeutic and Client’s Process; and Awareness of Intentions. Other themes in this category related to psychotherapy in general, such as Attending to the Relationship with the Client. The overwhelming response from

participants indicates that the most important part of what a therapist can do before attempting developmental movement interventions with a client is to have an embodied, experiential knowledge of the patterns integrated in her or his movement repertoire.

The category of Process and Interventions also addressed the question of how to bring developmental movement into a body psychotherapy session and consists of the following themes regarding interventions specific to developmental movement: Help the client develop Awareness of Maladaptive Patterns; Help the client Sequence movement; Demonstrate a movement for the client; and use Patterning Exercises with clients. Themes regarding interventions that were not specific to developmental movement but are nonetheless important when utilizing developmental movement, include the following: help the client develop Self-Awareness, along with other levels of awareness, help the client find Full Engagement, help the client feel Empowered, work with the client's Regulation Skills, Work Alongside the Client, help the client Balance Inner and Outer Attention, help Bridge Therapy Work with the client's Life, and help the client find her or his own Motivation. Other themes involved various ways the interviewees viewed the Process of Therapy. This list gives an idea of how a therapy session might look in which developmental movement is used (both structurally and with specific interventions).

The category of the Definition of developmental movement was included to give a framework for how the interviewees view this modality, which may be reflected in the interviewee's responses. In addition, Risks and Cautions were included as an important consideration for utilizing developmental movement.

The Qualities/Abilities of a Therapist, Process and Interventions, and Perceived Outcomes included themes that point to greater awareness of self, the environment, body, breath, and the themes of integration and empowerment. It seems that a great strength of utilizing developmental movement, as mentioned repeatedly by interviewees, is the way that working with the body and re-patterning leads to a greater sense of self, and that working with patterns is a way to work directly with the nervous system. This way of working has the potential to create profound and lasting changes for clients who are suffering from a variety conditions, from emotional regulation difficulties, to depression and anxiety, to a lack of social and self-awareness. For body-based psychotherapists, or those interested in bringing more body-based interventions into therapy sessions with clients, developmental movement could be an effective way to enhance treatment and provide both the practitioner and client with valuable tools.

One limitation of this study was that it was not able to address specific changes that a client would experience while undergoing treatment with developmental movement. In addition, this study was limited by the number of participants and the method of sampling. It is worth noting again that the interviews were via email, Skype or both, and that the length of response varied, which has an effect on the data that was gathered from this research. Also, it is notable that each participant already practices developmental movement and thus were perhaps more likely to have positive responses regarding its effectiveness.

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To further current understanding about the effectiveness of developmental movement used with adult clients, future research could include testing the effects of developmental movement in a setting in which changes in behavior and feelings of adult clients could be monitored and measured. This study acknowledges the difficulty of quantifying the deep healing that can happen when a person is in a therapeutic setting in which one is witnessed, attended to, and allowed to move in a way that expresses an underlying blueprint of health. Still, it is this researcher's hope that this article provided some insights for therapists who are considering using their knowledge of developmental movement in session with adult clients.

### BIOGRAPHY

Rebecca Snell graduated from University of Colorado Boulder with a Bachelor of Arts Degree. Later she pursued a graduate degree in Mental Health Counseling and received her Masters Degree in Body Psychotherapy from Naropa University in Boulder, Colorado. Rebecca did an extensive internship at Noeticus Counseling Center and Training Institute which emphasized a variety of creative arts therapies. Rebecca is a professional counselor, training for licensure. She presently works as a crisis counselor, in which she has developed extensive experience in trauma work and crisis intervention.

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## APPENDIX

## Interview Questions

1. What is your definition of developmental movement?
2. What is your training? (Including educational background, specialized trainings, modalities you've trained in, etc.)
3. What kinds of clients do you work with? Do you have a specialized clientele?
4. What qualities do you feel a therapist needs to have in order to facilitate a session utilizing developmental movement?
5. How do you determine whether or not to use developmental movement with a client?
6. Please briefly describe an example of a session where you use developmental movement to work with a client.
7. What types of clients do you feel benefit the most from developmental movement in sessions?
8. Do clients report changes in their reported symptoms (such as anxiety or depression) either in session or throughout treatment when developmental movement has been used? If so, what kinds of changes do clients report?
9. Are there clients with a disorder or disorders that you would not recommend using developmental movement with? If so, which disorders?
10. What do you think might be the greatest benefit of utilizing developmental movement with adult clients?
11. What do you think is the greatest risk of utilizing developmental movement with adult clients?
12. How do you view your role when utilizing developmental movement with clients? Do you view yourself as teacher, counselor, observer, guide, etc.?
13. How do you help the client bring what they learned in session into his or her life?
14. Have you followed up with clients over periods of time to determine long term success or failure? If so, what did you discover?
15. In general, how do you rate developmental movement as a therapy compared to other therapies? What do you think are the strengths and weaknesses of this modality?

## Body Psychotherapy for Couples: Exploring the Somatic Components of Mutual Regulation

Jennifer L. Buczko

### Abstract

Numerous couples therapy models now incorporate the tenets of attachment theory into a greater understanding of working skillfully with core relationship issues. Concurrently, researchers are gaining new insights into the neuroscience of relational dynamics, including impacts on the nervous system when individuals become dysregulated in relationship. However, the application of body psychotherapy and the integration of the body's role in this process have yet to be fully explored. The present qualitative study was conducted with established couples therapists to identify and explore the somatic components of mutual regulation. The results highlight themes that may be relevant in body-based couples therapy. The purpose of these findings may enhance couple therapist training and provoke discussion about development of and future research on effective body psychotherapy models for working with couples dysregulation.

**Keywords:** Couples therapy, mutual regulation, attachment theory, neuroscience

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Being in relationship is one of the most beautiful and challenging facets about the human experience. In order to survive as a species, humans are neurologically hard-wired for connection. Thus, it is the biological, physiological, and emotional longings that keep humans continually looking for this connection through relationship. However, these desires and longings also bring challenges, hardships, and often, painful times. In every relationship, each person brings years of previous experience that shape and influence who they are (Siegel, 2012) and how they show up in a couple dynamic. These cognitive and behavioral patterns are deeply grooved in the neural networks of each individual's brain, most often originating from infancy. Years of repetitive patterns can therefore be extremely difficult to notice, change, and rewire. With intimate relationships simulating dynamics of the original infant caregiver

relationship, an individual's partner is often the person that triggers them most.

### **Attachment Theory and the Infant Nervous System**

According to attachment theorists, an infant's ability to regulate affect comes through experiencing thousands of split second, rapid, unconscious, nonverbal (and verbal) interactions between themselves and their caregiver (Beebe and Lachmann, 1998; Bowlby, 1988; Lapidès, 2011). According to Lapidès (2011), "These neurological affect-regulating mechanisms formed in early childhood shape later-forming attachment relationships, including those of adult romantic dyads which depend on intimacy and stability, on the same right brain, nonverbal, modulating capacities" (p. 161). Thus, one's ability to self-regulate emerges from their direct experience with their first external regulator, the primary caregiver.

When a primary caregiver is able to effectively self-regulate, it lays this same template for the infant. This translates to an individual's ability to be an effective modulator of one's own feelings of anxiety, fear, sadness, anger, and excitement (Tatkin & Solomon, 2011). If parents consistently fail to match and attune to the changing affects of their infants, then the infant's ability to regulate affect is compromised (Lapidès, 2011). Parents become external regulators as they communicate with their infants through body-to-body, skin-to-skin contact, deep mutual gazing, facial expressivity, vocal intonation, and vestibular and prosodic interactions (Lapidès, 2011; Tatkin & Solomon, 2011). Later in life, the role of external regulator shifts from parents to friends, lovers, or therapists (Tatkin & Solomon, 2011).

### **The Effects of Pervasive Misattunement Without Repair on the Nervous System**

Although caregiver attunement is essential in secure attachment and an infant's ability to self-regulate, misattunement will also occur. When this happens, timely and empathetic repair is key for maintaining a safe and securely attached relational dynamic (Fonagy, Gergely, Jurist, & Target, 2002; Laridso, 2011). Consistent and regular interactions of attunement and repair are remembered implicitly and stored in the deep subcortical structures of the infant's right hemisphere as models for how to be, and what to expect in healthy, intimate relationships (Laridso, 2011). According to Feld (2004), "Repair organizes violations of expectations and subsequent attempts to resolve these breaks. The capacity to repair a disruption is learned implicitly in patterns of regulation in the family of origin" (p. 425). When acknowledging the importance of attunement and repair for healthy regulation of arousal states, it becomes more evident that problems will arise when ruptures go regularly unrepaired. When there are prolonged periods of misattunement between two people, extreme arousal states are more likely to occur, which in turn people, increases the probability of the internal and mutual mismanagement of such arousal states. Dysregulation may occur in these moments of misattunement. It is the frequency of these ruptures without repair, or error-correction that may ultimately lead to an intensification of negative experience and a perceived

sense of threat (Tatkin & Solomon, 2001).

In relationships where insecure attachment occurs, the ability to self-regulate is compromised, since less than optimal neural networks are formed. In these circumstances, dysregulation becomes much more frequent (Schoore, 1994). As Lapidès (2011) claims:

When chronically hyperactivated and hypersensitized in critical periods of infancy, an individual's stress response, especially in reaction to relational injuries, launches more quickly, reaches higher levels, and persists (Schoore 2003a) setting the stage for rapid bouts of dysregulated conflict in distressed adult couples. These eruptions are marked by anger, blame and defensiveness and may jeopardize or destroy relational intimacy and trust. (p.162)

Tatkin and Solomon (2011) define partner regulation as the "process whereby at least two individuals co-manage and dynamically balance autonomic nervous system arousal in real time" (p. 103). *Dysregulation* can occur when one is exposed to threat and the autonomic nervous system (ANS) is stimulated in a way that results in either sympathetic hyper-arousal or parasympathetic (dorsal-vagal-mediated) hypo-arousal states. From these states, primal defenses (flight, fight, freeze, or faint) are engaged. Often, dysregulation can result in what is called *flooding* or *emotional flooding*; the process by which an individual experiences an emotional shutdown.

When becoming familiar with how dysregulation occurs in the body, it is important to consider that these arousal states happen on different levels. In between the upper limits and lower limits of these arousal states is a zone that has been identified as the "the window of tolerance." Corrigan, Fisher, & and Nutt (2010) illuminate researcher Daniel Siegel's description of the *window of tolerance* as, "Between the extremes of sympathetic hyper-arousal and parasympathetic hypo-arousal is a 'window' or range of optimal arousal states in which emotions can be experienced as tolerable and the experience can be integrated" (p.1). Understanding the window of tolerance helps a therapist identify a partner's ability to use their higher cognitive functions during conflict and triggering states, specifically abstract thinking and self-awareness (Siegel, 2012).

### **The Value of Integrating Attachment Theory into the Therapeutic Relationship**

Couples therapy can be highly effective if the therapist has a developed understanding of how these early relational patterns and arousal states are showing up in the couple dynamic. A skilled therapist can act as a healthy regulator for their clients, and thus create a reparative experience, while also training the couple to create repair with one other. If early interactions have been problematic or misattuned, later relationships can provide second chances for the potential to love and remain in the type of contact that occurs from having a secure attachment (Wallin, 2007). Wallin (2007) cites theorist John Bowlby's claim that "... the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world" (p. 1). Lapidès (2011) also describes this process:

The wiring of one brain through resonant interaction with another brain is the psychoneurobiological basis for the healing potential of important adult relation-

ships, including romantic partnerships, the deeply attuned dyad in psychotherapy, and the triad of a couple and their psychotherapist. Thus, effective couples therapy uses the same processes that occurs between parents and infants in secure attachments (attunement, empathy, and resonance) to reactivate and rewire right hemisphere procedural templates from childhood (Schore, 2003b; Atkinson, 1999, 2002; Cozolino 2002; deBellis et al. 2002). (p.162).

Herein lies the connection for the therapeutic relationship to be the fertile ground for the combination of interactive regulation and attachment theory in the therapeutic context. Since attachment insecurity and dysregulation go hand in hand (Tatkin & Solomon, 2011), a therapist's first goal with couples is to actively aid in teaching each individuals to self-regulate, and then to aid in partner regulation during times of distress (Lapides, 2011). In the psychotherapy process, clients have the opportunity to form new attachment relationships that can reorganize their previous neural networks.

When applying the concepts of attachment theory to adult intimate relationships in couples therapy, the therapist and clients are informed of their own working template which influences how they function in intimate relationships (Benson, Sevier, & Christensen, 2013). While non-attachment theory based therapists might view distressed partners reacting from a place of immaturity, weak communication skills, personality flaws, or co-dependent attributes, an attachment-oriented therapist can identify the "primal panic" or the secondary reactive emotions to this panic (Benson et al; 2013). With knowledge of how attachment patterns arise in couples therapy, the therapist can consciously create a safe container for the couple to explore their neurological wiring and how it influences their system as a couple. Key components of rewiring relational networks are embedded in the therapist's ability to foster a development of understanding, accessibility, and responsiveness to both partners. Safety is created in the therapeutic context when a therapist can provide a holding and facilitating environment that supports the expression and exploration of each individual's relational patterning and the couple's relational processes (Feld, 2004). With the combination of a safe holding environment, an attachment-informed therapist, and an understanding of each partner's behavioral patterns, a couple has the opportunity to learn how to engage in their relationship in a secure-functioning manner.

### **Components of Interactive Regulation: Understanding Arousal Regulation**

As explored earlier, understanding regulation and the early formation of neural networks is an essential component within effective couples therapy. Arousal regulation, as defined by current researchers Tatkin and Solomon (2011) is "The process of managing our arousal states and the transitions between them" (p. 99). Arousal regulation occurs through different internal and external systems. Internally, regulation can occur through a non-conscious (involuntary) means by way of the automatic nervous system (ANS).

The ANS is comprised of neurological circuits involving subcortical features such as the insula, the anterior cingulate (AC), amygdala, hippocampus, hypothalamus, midbrain, brainstem, spinal cord, and dorsal vagal motor pathway. These physiological features work together in the regulation process

to calm an individual or infant under stress. The hypo-thalamus-pituitary-adrenal axis (HPA), activated by the stress response, releases neurosteroid hormones (Lapides 2011) such as cortisol.

The voluntary internal regulatory functions are executed by the frontal limbic structures: the ventromedial prefrontal cortex, orbitofrontal cortex, anterior cingulate, insula, and ventral vagal motor pathway, the higher cortical areas (Tatkin & Solomon, 2011). When these arousal states occur, there are multiple ways a person can regulate themselves, including: autoregulation, self-regulation, external regulation or interactive regulation.

Autoregulation is an internal strategy for self-stimulation and self-soothing that is non-relational. Strategies for autoregulation are formed in infancy and become more complex as individuals age (Tatkin, 2012). Autoregulation is the most innate and basic form of arousal regulation. An individual's attachment orientation will directly influence how they autoregulate. Tatkin & Solomon (2011) explain some differences between interactive regulation and autoregulation:

Whereas autoregulation is fundamentally self-absorbed, internally focused, and pro-self, interactive regulation is fundamentally interpersonal, externally focused, and pro-relational. An individual's reliance on autoregulation (one way, do it myself) or external regulation (one way, do it for me) is a sign of a one-person psychological orientation that is rooted in non-mutuality. Reliance on interaction regulation (two-way, do it for me) on the other hand, points to a two-person psychological orientation that is rooted in true mutuality (p.103).

Additionally, Tatkin and Solomon (2011) define partner regulation as the "process whereby at least two individuals co-manage and dynamically balance ANS arousal in real time" (p. 103). When two individual nervous systems learn how to interact with one another, a new system is created. Mutual regulation, or partner regulation, therefore co-creates a dyadic system in which both nervous systems have achieved this balance (Feld, 2004). Tatkin and Solomon (2011) are careful to note that while strong foundations of mutuality and reciprocity are often developed during infancy through play, if these foundations are not in place, the infant will turn towards autoregulation as an adaptation to interpersonal neglect.

When discussing the potential of couples regulating on an interactive level, one facet has left to be integrated: the role of the body in this process. As humans, our existence is a miraculous compilation of cognitive and somatic internal working systems. Dysregulation and regulation are merely parts of one system in this compilation. However, for interactive regulation to be effective, the therapist and clients must become aware of their own somatic sensations and expressions of arousal in themselves and their partners. It is through the body that we gain an expanded wisdom of ourselves, others, and how there is mutual influence in all relationships.

### **How Integrating the Body Enhances Couples Therapy**

The voice of the body is found in nonverbal cues. Within the discrepancy between verbally expressed cognition and the body's "voice," therapists can find an entry point into a client's authentic experience. This is why it is crucial for therapists to be aware of the non-verbal and psychophysical behavior and

movements of their clients (Hendricks & Hendricks, 1999). According to the pioneering body-centered therapist Wilhelm Reich, the therapist "... has a sacred duty to observe body language as a key to repressed feelings," (Hendricks & Hendricks, 1990, p. 408). Lowen (1975) claims that the tone of a person's voice or one's look often has a greater impact than the words they utter. Statements such as "The body does not lie" (Lowen, 1971, p. 100) and "The body tells the truth" (Rubinfeld, 1999, p. 194) are significant in stressing that the psychotherapist not overlook the communication of a client's somatic wisdom.

It is in the awareness and tracking of somatic micro-expressions and macro-expressions that the therapist and clients gain significant insight. Tracking is the continuous process of looking for signs of a person's present experience (Kurtz, 1990). Ogden, Minton, and Pain (2006) describe tracking as the "therapist's ability to closely and unobtrusively observe the unfolding of nonverbal components of the clients' immediate experience: movements and other physical signs of autonomic arousal or changes in body sensation," (p.188). This can include moisture in the eyes, facial expressions, tone of voice, gestures (particularly small gestures), changes in posture, movements, and vocal quality. This somatic language is something that the client is constantly speaking and the therapist is consistently listening to. Individuals express in the body what is often left unsaid by their words. Kurtz (1990) explains that these somatic expressions are "... even more than just signs of present experience, they are direct expressions of the unconscious," (p.83).

Since research suggests that somatic components offer essential insight into what is left unsaid, tracking these non-verbal cues is key for effective couples therapy. Hendricks & Hendricks (1999) created a body-centered approach after realizing that the therapist's awareness needs to be on the non-verbal and psychophysical instead of the verbal and mental. It is the nonverbal behavior that usually has more significance for the therapist than the verbal communication. Hendricks and Hendricks (1999) also distinguish two types of therapists: those that overlook the essential information the body is sharing, and those who have both the skills to identify the information and the courage to bring it to the client's attention.

Due to nonverbal behaviors being an effective form of communicating affect, psychotherapists are finding ways to integrate more than just the verbal dialogue (Bucci, 1995; Burgoon, Le Poire, Beutier, Bergan, & Engle, 1992; Davis, 1985; Greenberg, 1984; Mahrer & Nadler, 1986). A psychotherapist must have "floating attention," a perpetual state that is highly sensitive and curious about the non-verbal information observed (de Roten, Darwish, Stern, Fivaz-Depeursinge, & Corboz-Warnery, 1999). Configurations of posture or body positioning within a session also offer an informative snapshot of the therapeutic interactions (Schefflen, 1964).

De Roten et al. (1999) considered how body posture correlates to relational engagement in the therapeutic alliance by following the creation of a new classification method to observe and document the triadic body formations, they found evidence for clear relations between non-verbal behaviors and the therapeutic alliance. Observation of body formations within parent/child interactions gives insight to the attentional and emotional engagement of the therapeutic adult triad, and can also be a distress level indicator. When multiple individuals



Are present, it is not sufficient to look at only one client at a time. It is imperative to observe and listen to all of the participants, including the therapist, as a collective unit. Through careful attention to their own body, while in relationship to the other bodies, the therapist can be informed from a multi-dimensional level including the societal level (Schefflen, 1964).

While the role of arousal stimulation and regulation in couples therapy is critical, understanding how the nervous system plays a part in human arousal provides invaluable knowledge and insight for clinicians and couples. The present study aimed to help identify somatic regulation techniques and discuss body-based processes that might aid couples in down-regulating the couple unit and how the therapist may also facilitate this process.

### **Methodology**

A phenomenological study was conducted through use of interviews conducted in person, over the phone and via Skype. The interviews were conducted in order to answer the questions “What somatic components in the therapeutic triad are required for effective mutual partner regulation?” and “How does a therapist use somatic-based techniques to aid in facilitating effective partner regulation. Phenomenological analysis was completed through the process of *in-vivo* and descriptive coding for content analysis. The coder was the author and primary investigator.

### **Participants**

Purposive sampling was the method used for recruiting and choosing participants whom had long-term experience with couples in addition to somatic informed training. The author selected three participants based on their extensive clinical experience working psychotherapeutically with couples. Two of the participants have somatic-informed training. The three participants identified as Caucasian or white, male, and range in age from early to late 50's. The participants have all worked with couples in private practice settings and train other counselors at established training institutions or organizations.

### **Data Collection**

The three participants were asked an identical set of open-ended interview questions, previously reviewed by the Institutional Review Board (See Appendix A). After each open-ended question was asked, the participants were allowed to speak freely on each topic. Furthermore, the author asked spontaneous follow-up questions for further exploration or clarification. Participants were asked to reflect on the non-verbal behavior they identified while working with their clients in addition to their own somatic responses within therapeutic sessions. Participants were asked about their initial interventions for working with a couple when only one of the partners became dysregulated during the session. Lastly, they were asked about specific somatic interventions they used to aid in individual and partner regulation. The interviews were conducted either in person, over the phone or through Skype. All interviews were audio recorded and ranged from 35 to 85 minutes and were promptly transcribed and coded by

the author.

## Results

Three main themes that arose from the interviews are: 1) Tracking and integrating non-verbal communication, 2) Techniques for self-regulation of the therapist and 3) Mutual regulation in couples therapy. The eight subthemes that emerged were categorized and cited verbatim from the interviews that support the main themes.

### **Tracking and integrating non-verbal communication.**

Tracking and integrating the use of non-verbal dialogue provides the therapist with profound insight into the unconscious levels of each client. In this context, non-verbal dialogue includes any body-based information including, but not limited to micro or macro movements, visual shifts in states, tension in the body, or facial expressions. Before the brain cognitively appraises emotions and labels them, they originate from sensations first felt in the body (Fishbane, 2007). One participant explained, "Emotions and soma are tethered together because one of the key differences between emotions and an isolated thought, is that emotions are typically experienced in the body." By tracking non-verbal cues, the therapist gains new insight into whether the emotional and somatic content of the client's conscious dialogue is congruent with the unconscious cues showing up in their bodies.

### **Specific areas of interest for somatic tracking.**

Each participant identified somatic areas they track in their clients. Examples from the interviews included: breath, eyes, chest, facial expressions, skin tone, pupils, position of chest, and position of body in relation to partner or therapist. In regards to body position, some of the participants note, "Is the client turning towards or away from me and/or their partner?" Voice was named as another essential component. Each participant notices when a client cannot get their words out, changes their volume, gulps, or gets stuck on a word or phrase. One participant also mentioned noticing smells claiming that "people under stress smell differently." This same participant claimed, "I pay attention to everything. The therapist is really using all of their senses to pick up the greatest show in town. There are always things happening...and it's happening faster than people know." *Cross-tracking*, a technique implemented by one of the participants is used to track the partner who is not speaking, so they notice how the partner is reacting to what the other is saying.

### **Tracking tension and levels of arousal in clients.**

All three participants mentioned the importance of tracking tension in their clients' faces and bodies. (Tracking tension in the therapists' own bodies also came up in all three interviews and will be addressed later in the paper.) It is in the tracking of tension or "held states" that important information is gained for both client and therapist. One participant explained, "In healthy regulation, the body systems are flowing...there is fluidity in the process." Another participant claimed, "Anything that the muscles affect can be an indicator that something is going on emotionally."

Tension may indicate a shift in emotional states, arousal, or a spike in the sympathetic nervous system. One participant looks specifically for the point in which a client will hold their breath and go into a “frozen state.” A tense client may stop breathing or hold their breath when they sense that their partner has become a threat to them. By noticing the client’s spike in arousal of their sympathetic nervous system, the therapist tunes in to key information as to when each client feels threatened, and can later inform conflictual patterns. Conversely, when tension decreases and is not related to hypo-arousal, the client feels more emotionally safe and relaxed. By linking tension in the clients’ faces and bodies with arousal levels, the therapist can aim to keep the clients within their window of tolerance.

### **Observing and noticing baselines.**

An individual’s baseline is witnessed when one is relaxed, at rest, or experiencing a sense of homeostasis. Baselines occur when an individual is neither hypo nor hyper-aroused. The importance in noticing baselines lies in knowing how a person behaves, looks, stands, sits, and speaks when they are relaxed and in their natural state. One participant described:

In order to get baselines, I have to devote a certain amount of time in the beginning [of the session] to banter that is relaxing and that maybe uses humor, so that I can see their faces relaxed and hear their voices relaxed. I want to get as much information about their faces at neutral in the beginning so I can start to look for “tells,” start to look for changes that are unique to them that mean something.

By knowing each client’s baseline, the therapist can then rule out the movements, facial expressions, or changes that are typical for them, while catching the shifts that may indicate something other than what the client is expressing verbally. Another participant discussed that in order to track baselines in a couple unit, one of his roles is to become an audience member. He explained:

A lot of this is the therapist being the audience to the couple. And you just have to sit through it. As an audience member, you are also beginning to feel what it’s like to be them and what they do very badly. But also what they do really well. But the big [big big] problem is the therapist staying centered, relaxed, and clear on what the goals are and what the job is. This is by far the hardest part of couples therapy.

Another participant’s orientation also supports this observer and witness role. Before he can be active and intervene, he says it’s important to see the system at work, “...to identify the negative emotional, neural, somatic, mental dance that happens between the two and how [they’re] caught up in it.”

### **Using the non-verbal communication of the body to inform therapeutic interventions.**

A somatic intervention mentioned by one of the participants speaks to provoking dysregulation to gain information that the body portrays, but is often overrun by the mind. This clinician will instruct a client to say a statement to their partner in order to track the somatic reactions in both individuals. By using a specific interview style the intervention aims to “bypass higher cortical areas

to get the down and dirty reflexes in the body that really expose.” The therapist uses these techniques of probing, poking, and surprising in such a way that the “body betrays them,” sending a different or incongruent message than their verbal dialogue. The therapist explains, on an “arousal level, we can’t let them think too much, because as soon as [they] have time to think, [they] change the information.” Since certain areas of the brain are set up for “error-correcting data,” the cognition and verbal dialogue is therefore compromised. “It is not as reliable as the body; which includes the face ... and the voice.” This participant elaborated about the use of voice in this process, saying that the voice is an incredibly reliable marker: “It doesn’t tell us exactly what the source is or what it’s reacting to, but it tells us that it’s reacting.”

In summary, by provoking and identifying incongruent messages from the clients, the therapist can become aware of underlying and often unknown beliefs, values, or feelings that are the root of ongoing conflict in the couple dynamic. Once light is shed on these areas of incongruence, a deeper level of work is possible.

### **Self-regulation of the therapist.**

The importance of the therapist’s self-regulation came up in all three interviews. One participant uses the metaphor of the initial flight safety instructions on an airplane for staying regulated in session; the therapist needs to put on their “own oxygen mask” before they can help anyone. One participant explained that nervous systems are like tuning forks and will “wire together.” This is true not only for the couple, but for the triad as well. The strongest nervous system will set the tone for all others in proximity, and it is the therapist’s job to resonate at a frequency that is both self-regulating and externally regulating. While the methods and techniques for staying regulated vary for each therapist, one common theme was identified: use of breath. Other techniques included awareness of tension in their body, oscillation of attention, and movement.

### **The use of breath.**

Self-regulation of the nervous system occurs through finding methods for relaxation and staying centered or grounded. Since a relaxed state is critical to one’s ability to regulate self or others, the therapist must find a way to remain grounded throughout the session. Once the therapist starts to become dysregulated, they are more likely to “over-respond.” One participant described that one of the most challenging aspect of couples therapy is the ability to stay regulated in the room when intense emotion and dysregulation are present.

The first step in regulation is being able to relax one’s body. A quick and efficient way of doing this is by bringing conscious, focused attention to the breath. Using more deep and abdominal breaths in states of anxiety or dysregulation will aid in down-regulating a nervous system that is becoming sympathetically aroused. One participant also noted, “What I try to teach my clients and myself as well, is that in states of dysregulation, use it [breath] as a tool. Breathe more in states of anxiety or dysregulation.” Fluid and relaxed breathing can prevent both clients and therapists from experiencing “held states.” It is in these more fluid states that the therapist has the ability to feel into the emotional climates of the clients. If the therapist becomes dysregulated,

then all individuals are “drowning” because there is no source for grounding, and emotional safety is compromised.

### **Oscillation and scanning for tension and movement.**

Other techniques for self-regulation include: oscillation of attention, scanning for tension, movement, and slowing the session down. One participant explained that his most effective way for staying regulated is regularly scanning his body for tension. He explains that he sweeps his body for tension and then lets it go; thinking of it as continuously resetting, over and over. By using the arousal of his body scanning to counteract the continual “letting go” and “resetting” of his nervous systems, this process “keeps [him] in the middle.” The participant continued, “It allows for self-regulation without expending too many resources.” Summarizing the importance of balancing both outward oscillation and somatic awareness, he said, “I have to stay focused outward and present while also staying present with my body.”

### **Movement as a regulator.**

The use of movement was mentioned by several participants in both the context of regulating themselves and aiding the regulation of their clients. This section of the results will address both specific interventions for assisting in the regulation of the therapist, and will also include techniques originally mentioned for aiding in regulating clients. Data and interventions posed in this section can be used for therapists and clients interchangeably. One participant uses chairs on wheels and described his movement interventions in the following way: “I also have my chair movements. I can pull back, I can roll forward, I can roll to the side, I can move my chair up or down. All of that changes my state.”

Another participant speaks about teaching his clients “How to ride their energy.” When this buildup of energy shows up in one’s body, one participant will use somatic interventions such as having the client first notice or become aware of the tension, and then facilitate shaking or moving their body and limbs in a way that the energy can also move into the arms and legs. If the therapist is also experiencing this similar state of arousal, the act of moving, standing, shaking or breathing will all aid in down-regulating their nervous system.

### **Considerations for mutual regulation in couples therapy.**

Three subthemes arose from the interviews when looking at the components of mutual regulation in the context of couples therapy. These subthemes include 1) establishing safety in the therapeutic context to facilitate change, 2) understanding a mutually influencing couples’ system and how to shift the other’s state, and 3) the use of somatic tracking to aid in mutual regulation.

### **Establishing therapeutic safety to aid in facilitating change.**

In order for couples therapy to be effective, the emotional safety of the clients is invaluable and necessary. Subthemes identified included building trust with the clients through “empathetic presence” and attunement. Titration of dysregulation was also mentioned for emotional safety to be in place. In the therapeutic triad, trust, specifically on an emotional level, allows for genuine

expression of emotion and vulnerability in the relationship. By accurately and consistently attuning with his clients, the clients can know and feel a sense of safety in the midst of charged emotions. However, emotional dysregulation must be titrated carefully, for without titration the clients may become flooded in the office often and "... then somatically, coming to my office is not a safe experience." Conversely, if the clients show up in therapy and they don't have any form of emotional experience, "...then we don't get any work done. So I'm looking for that sweet spot."

Creating a sense of emotional safety is also accomplished through the use of connection and empathy. One participant explained that if anger arises, he will redirect their attention towards himself, "... so that I can empathize with them, because it's very hard to have empathy and compassion for anger when it's directed at you...." In allowing each partner to be heard, validated, and attuned to, defenses are more likely to be lowered. Lower defenses ultimately allow for contact and connection; with this emotional connection, bonding moments for a couple are more possible.

### **Understanding how systems mutually influence each other.**

Partners might want to know how to aid in regulating their partner's state, specifically when their partner is visibly upset. For instance, partner A becomes hysterical during the session and partner B does not know what to do. One clinician explained that the reason partner B has a hard time responding in a helpful way is because partner B has now become threatened by partner A's charged state. This clinician explained further, "And the threat is disabling [partner B] from being able to do something other than his/her own defensive reaction, which is to protect themselves from danger. So there are several layers to this. None of this is binary." Throughout this dysregulation process, a reactionary feedback loop takes place. (See Figure 1). Here is an example: Partner A is hysterical and becomes angry. Partner B sees this happening and becomes afraid of partner A's anger. However, Partner B's fear is not conditional to only Partner A's anger in that current moment. This anger comes from all "previous experience with this kind of intensity, emotion, volume of voice, movement, et cetera." The fear in Partner B now influences Partner A's dysregulation, and two systems are reacting to each other's dysregulation.

This same participant gave another example: in the case that only one partner is dysregulated, it is the other partner's job to figure out how best to regulate their partner's state. It is important that each partner knows exactly what is bringing the other down in that moment, and then additionally knows how to relieve or soothe the other. This participant stressed that if one goes down they both go down. When action steps are taken out of affection, rather than fear or threat, they become an advocate for the best interest of their partner. Thus, in mutual regulation, the best way to shift one's own state is to shift your partner's.

One participant's personalized model steers away from focusing solely on self-regulation and emphasizes the learned skill of shifting a partner's state. This clinician explained:

We still live in a culture that thinks, 'I can take care of myself and you should take care of yourself.' But actually, when it comes down to it,) it's a very inefficient way to work. The best way to relax myself is to relax you. The best way to



**Figure 1.** This figure demonstrates how emotional arousal occurs in a mutually influencing feedback loop.

shift my state is to shift yours. That takes a reorientation of thinking. And this holds water because this is actually what happens in the mother/infant dyad. The regulation comes from the outside in. When one partner is able to relax their partner, they are also able to relax themselves. Additionally, in order for one partner to provide relief to the other, they must not appear to be a threat. They must act in a way that “immediately feels friendly,” for when one partner feels threatened and dysregulated, it’s a reaction to feeling like their partner has become predatory. The hardest part of this process is when both partners are feeling threatened at the same time and are both becoming highly dysregulated. In this event couples will seek therapy, so there can be a third party present to assist. And by assisting, the therapist will slow everything down.

Slowing down the process is central for regulation. When someone is triggered and possibly flooded, they will be reacting from their triune brain, also known as their reptilian brain. The triune brain is responsible for survival,

and thus will be choosing options such as fight, flight, freeze, or faint. Unfortunately, these reactions are not coming from the higher cortical areas that provide the integration of abstract thinking or problem solving. By slowing everything down during these times of dysregulation, the higher functioning areas of the brain can integrate, which gives the person the opportunity to make different choices.

### **The use of somatic tracking to aid in mutual/partner regulation.**

Interactive partner regulation starts with the teaching of tracking self and other. This awareness and focus comes in the form of tracking each other's movements, facial expressions, body positions, voice, and other somatic components. When the author asked, "Do you implement any somatic or body-based methods, techniques or skills to support couples in partner regulation?" one participant's response was affirmative: "Yes, my focus on their face and body directs them to notice the same thing. ... My orientation, orients them to pay attention to each other."

Tracking came up as major theme in all three interviews. Whether it be tracking of self and one's own body sensations or tracking the somatic components of one's partner, this becomes a skill and intervention that opens the door for a deeper understanding and awareness of the dyadic system. By modeling how to become an observer of their partner, the therapist can continue to benefit from tracking the couple while also giving the clients a framework for how to do this themselves.

### **Discussion and Limitations**

Somatic tracking as an essential component for mutual regulation was salient among the three themes. Firstly, each individual must develop a sense of somatic awareness in regards to their internal and external arousal states. Secondly, each individual is also then responsible for tracking the somatic states of their partner in order to develop the ability to notice when these states shift in real time. Noticing such shifts can then prompt the partner to pause, notice, and find a way to become less threatening to their partner. Thirdly, the therapist must be aware of the somatic responses occurring in their own body and then identify ways to effectively self-regulate, be it through movement, use of breath or other interventions. Lastly, it is through covert and overt role modeling of this somatic awareness in self and other that the therapist aids in building the skill-set needed for mutual regulation in the couple unit.

The primary limitation of this study is the potential for biases due to the primary investigator, author, and coder being the same individual. If replicated, triangulation would be used to ensure internal validity. Additional limitations include a small and analogous participant pool. Only three subjects were interviewed due to constraints pertaining to resources and geography. All participants were Caucasian males over the age of 50, which limits the diversity of experiences by gender, age and culture. Due to the limitations of this study, universal truths are not proposed; rather a collection of knowledge gained from lived experiences are offered to aid with informing future applications.

Future research on this area of interest would allow for more



mutual regulation including clients experiencing hypoarousal. By working with a larger sample size and a more diverse demographic, exploring applications and interventions specific to various attachment styles and the ways in which people are best regulated, a better understanding of mutual regulation may be gained. The researcher holds the question as to whether categories of personal regulatory preferences might also be identified for effective mutual regulation indicators.

### Conclusion

Results from this study illuminate the importance of embracing somatic awareness through the interface of arousal regulation, attachment theory and couples therapy. The body is the system through which our sensations, fears, threats, and joys travel. As more insight is gained from a neurobiological, psychological and physiological understanding of couples dynamics, it continues to inform the effectiveness of techniques used for mutual regulation within the therapeutic context. The foundation of one's ability to regulate resides in attachment theory. That being said, neuroplasticity provides the capacity for rewiring through mutual regulation. When mutual regulation occurs, regulation happens within the dyad and the individual simultaneously. It is within this systemic process that a mutually benefiting positive feedback loop is created. With respect to knowing and understanding one's own system, the body cannot be separated or excluded. Through lived experience, our bodies and minds encounter the same events; yet, we must remember that our bodies offer an expanded wisdom. The integration of the body's role in couples therapy therefore provides an avenue for working on a deeper level with clients towards healthier and more emotionally connected relationships.

### BIOGRAPHY

J. Buczko is a recent graduate of Naropa University's Somatic Counseling Psychology program with a concentration in body psychotherapy. Buczko pursues her passion for working with individuals and couples through her internship site at the University of Colorado's Employee Assistance Program, where she integrates body psychotherapy techniques with faculty and staff. Buczko is continually inspired by the complexities of relational dynamics and enjoys working with couples towards healthier and more connected relationships. Body Psychotherapy, Somatic Counseling Psychology, Naropa University, Boulder, CO, USA      E-mail: [jenni.buczko@gmail.com](mailto:jenni.buczko@gmail.com)

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## Clinician Experience with Addiction Treatment: Implications for Body Psychotherapy in Relapse Prevention

Elizabeth Powers

### Abstract

Individuals have effectively utilized therapeutic methods to improve their body-mind connection for countless years. Recently the field of addiction treatment has begun to employ these practices to address emotional dysregulation, a commonly occurring symptom of addiction and frequent reason for relapse. This investigation sheds light on the relationship between body psychotherapy and recovery from substance use disorders as well as other behavioral forms of addiction. This investigation was a pilot study conducted in the Southwest United States using qualitative data gathered through interviews with licensed therapists in the field of addiction treatment to determine the implications of using body psychotherapy with individuals participating in treatment. Results suggest that body psychotherapy is used by practitioners and shown to be an efficient and effective way to restore emotional balance, body-mind connection, address trauma responses, self-regulation and internalize a locus of control regarding emotional reactivity.

**Keywords:** Body psychotherapy, substance use, somatic psychology, addiction, process addiction.

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Therapeutically working with addiction clients can be frustrating. The rate of relapse is high. The clients themselves are dysregulated, plagued by fear and anxiety both as emotional states and often as an appropriate response to their current reality and circumstances. They seem incapable of honesty and basic perspective taking which are requirements for effectiveness in traditional cognitively based treatment. Although there have been many improvements made to addiction treatment programs, most continue to employ therapeutic approaches that focus mainly on improving cognitions and incorporating adaptive behaviors. Research examining outcomes of traditional treatment found that the number of people achieving long term sobriety was far lower than anyone expected. If we are to improve our chances of success with these clients it seems necessary to consider alternative treatment tactics that rely less on coherent narrative and may help modulate arousal.

The present pilot study found that body based modalities show a lot of potential with this population, are being utilized with some success in a limited way within the field, and may be able to affect long term recovery through increased internal perception/insight and arousal/stress modulation. These preliminary findings have identified a need for research on addiction treatment and suggest an important role for body psychotherapy in long-term recovery and relapse prevention.

### **Research on Addiction Treatment**

Substance use disorders are categorized by compulsive drug seeking, excessive drug use, and a reduction in daily functioning driven by dysregulated neurocognitive processes (American Psychiatric Association, 2013; Garland et al, 2014). This disorder is characterized by a combination of cognitive, behavioral and physiological symptoms, which indicate that, despite increasing consequences, the individual continues use. Some significant indicators include craving, social impairment and risky use of the substance or behavior.

Due to its popularity in common language and accessibility to the general public, addiction will be the term used in this paper to define substance abuse disorder and corresponding process addictions. The use of this term will serve to reduce possible confusion related to diagnostic terminology and focus upon addressing the treatment of various substances and process issues, which affect a large number of the population, either directly or indirectly.

There are many theories of addiction, including the disease model, the developmental model, and varying personality models all which agree on the symptoms, but disagree on etiology. These theories are covered extensively in research regarding addiction and its treatment. The current study will avoid the debate regarding the most accurate theory of origin, as it is irrelevant to the content of this study and focus upon contemporary addiction treatment while concluding that addiction is a prevalent, multi-dimensional disorder, affecting the mind body and spirit.

Addiction treatment “engage(s) addicted patients in a program of care that promotes abstinence from alcohol and illicit substances, decreases their medical and psychiatric risk, and improves their psychosocial functioning” (Breslin, Reed & Malone, 2003, p.247). There is a variety of treatment programs available today, including inpatient treatment, outpatient treatment, transitional living facilities, and community based support groups. The field has sought, through research and standardization, to provide empirically validated approaches including cognitive behavioral therapy (CBT), rational emotive behavioral theory (REBT), psycho-educational, confrontational, Stages of Change Model, Motivational Interviewing (MI), 12-step model, and family systems theory (Ross, 1997; Molbak, 2010; Breslin, Reed & Malone, 2003). Many of these traditional approaches, which are found in most treatment centers and common practice of many providers, have proven helpful to individuals in their efforts at long term recovery (defined in this paper as one or more years). But these approaches on logical thinking and acute addiction clients have a proven inability to accurately perceive reality (Goldstein et al., 2009). Thus alternative, complementary modalities seem appropriate to look into regarding addiction treatment.

### Body Dysregulation and Relapse Prevention

Early research on traditional addiction treatment identified an interesting association between body dysregulation and relapse prevention (Gorski, 1982). Although traditional approaches were shown to be efficacious in the short term, they seem to lack an effective means to address dysregulation. Gorski (1982) suggested that there are changes in brain function as a result of addiction including: disruption of normal sleep and thought processes, emotions, moods and concentration, sensitivity to stress and overreaction. These physical symptoms made abstinence difficult to maintain and were barriers to long term sobriety. As such, incorporating body functions and processes into addiction treatment may improve long term recovery through self-regulation and empowerment.

In an eloquent meta-analysis on contemporary addiction treatment, Ross (1997) suggested the need for a new approach to treatment due to lack of efficacy following studies on relapse and the in depth work of Gorski in the early eighties. Gorski's research examined outcomes of traditional treatment and found that the number of people achieving long term sobriety was far lower than anyone expected (Gorski, 1982). Since then, much has been written about the effects of addiction on the brain which begins with changes in the mesolimbic dopamine system and deep neuroadaptations created which affect dysregulation in critical brain structures (Erickson, 2007; Koob & Volkow, 2010; Maté, 2010). There have also been studies which have established inherent interconnectedness of the body and mind (Pert, 2000). These studies along with anecdotal information from individuals in recovery and treatment providers, who deal with clients that are dysregulated, impulsive, lacking awareness and uncomfortable, suggest a need for a more integrative body-mind approach for the treatment of addiction that address somatic awareness and interoception (Goldstein et al., 2009). The goal of which would be to increase self-regulation, relieve tension and possibly improve the probability of long term recovery through improved coping skills and the ability to release and/or sit with uncomfortable emotions and stress.

During active addiction, the body and brain become more dependent upon the external regulation of sensation, emotion, and body function (i.e. needing drugs to go to sleep, manage stress, get out of bed or avoid withdrawal) due to the reduction of natural, hormonal emotional regulation in the brain. The neurocognitive changes create hypersensitivity to physical discomfort, stress, negative affect and often this experience overwhelms the individuals, shutting off rational thought and engaging instinctual drug seeking responses (Forsythe et al., 2003; Garland et al., 2014). With individuals in recovery this can be dangerous as they are likely to revert back to their addiction (relapse) because it has long been their primary coping mechanism, rather than being able to access the healthier coping mechanisms that they have learned in treatment.

Trauma is another key component to acknowledge in this context as it has an established correlation to addiction (Carruth & Burke, 2006; Weichelt & Straussner, 2015) and body dysregulation. Studies have shown that "unresolved trauma frequently plays an important role in initiating and maintaining substance abuse or dependence" (Shapiro, Vogelmann-Sine, & Sine, 1994, p. 383). The percentage of addicts with trauma histories is incredibly high

(Maté, 2010) and yet trauma is not widely addressed in traditional, acute addiction treatment. Some resistance to addressing it comes from the need for stabilization, detoxification and basic functioning, which are rightly seen as the priority in acute treatment. But for long term recovery to be a possibility for those with a trauma history, the trauma will have to be addressed and treated. Trauma is known to have a deep impact on one's ability to self-regulate and handle stress (Maté, 2010). Thus drugs and alcohol frequently become an external regulator and coping mechanism, which has to be replaced with healthy coping skills in treatment.

As trauma "differs from other events in that it is often non-verbal, somatic, implicit memory" (Staunton, 2002, p.101), body psychotherapy has long been associated with its treatment. In fact there are specific modalities within the body psychotherapy paradigm that are "explicitly trauma-oriented methods" (Marlock et al., 2015, p.16). It makes sense then to look into its possible application in treatment, to begin the process of self-regulation and laying the groundwork for trauma therapy to support long term recovery after stabilization has been established.

### **Body Psychotherapy in Addiction Recovery**

Many modalities of body psychotherapy have developed innovative techniques that may address trauma and be incorporated into addiction treatment. Some modalities including Dance Movement Therapy, Containment and Autonomic Regulation (CAR), Eye Movement Desensitization and Reprocessing (EMDR), Sensorimotor Psychotherapy, mindfulness meditation, expressive arts therapy, yoga, Informed Touch (IT), and improvisational music therapy have been shown to be effective in addiction recovery. One study found that "participants benefited substantially from [a] comprehensive residential, group yoga lifestyle program. This was confirmed by both qualitative observations and by responses on the questionnaire instruments. Improvements were most encouraging in the BASIS-32 scores and the subscales on this questionnaire suggesting that the subjects exhibited improvements in a wide range of self-reported symptoms, problems and difficulties over the course of treatment" (Khalsa et al., 2008, p.). A study of EMDR in addiction treatment (Shapiro, Vogelmann-Sine, & Sine, 1994) found that increased tolerance of affect has been found, along with being "helpful in accelerating recovery and prevent relapse" (p. 388). It went on to report that "EMDR sessions were extremely helpful in curbing urges to use and remembering to implement positive coping skills" (p.387). A study of improvisational music therapy with clients identifying as both addiction and depression clients found significant improvement in psychologist rated depression, increased motivation for personal exploration, and decreased fear sharing difficult life events (Albornoz, 2011). It went on to say that "improvisational music therapy and regular treatment seemed to lead participants to: feel more relaxed with regard to both substance urge and symptoms of depression such as anxiety" (p. 222). Another study explored the incorporation of holistic modalities such as dance movement therapy and tai chi with traditional treatment and found improvements in substance free stress reduction, increased ability to express emotion, and increased patient

satisfaction (Breslin, Reed, & Malone, 2003).

These studies suggest that body psychotherapy can enhance traditional addiction treatment by focusing on the mind-body connection and releasing tension, which affords relief and balance to those in recovery. One of the most salient potential improvements is in their ability to self-regulate. The ability to self-regulate allows an individual to be able to hear others, to think clearly and let in new information, and finally to help them engage in activities that have proven to aid in long term addiction treatment such as peer support groups (Kelly et al, 2010; Krentzman et al, 2011; Watson et al, 1997), getting a sponsor, engaging in service work and the 12 step process.

Although the field shows promise in the integration of body psychotherapy and addiction treatment by suggesting correlations between body psychotherapy and recovery (Albornoz, 2011; Khalsa et al., 2008; Milliken, 1990), there are limitations to this body of research. First, the research is minimal and the majority of the work is theoretical in nature. Secondly, the empirical studies that have been conducted have short study duration and limited sample sizes (Albornoz, 2011; Khalsa et al., 2008). Few studies looked at the rate of recidivism and long term success in recovery, which is difficult for any research in the field to properly quantify as recovery is a lifetime journey with continued possibility of relapse. Additionally, the field of body psychotherapy is splintered because although it has been a practice dating back over 125 years, most of the literature and study has focused on a particular method (Marlock et al., 2015). Also, there are few practitioners utilizing body psychotherapy in the acute or long term addiction treatment field and it is currently not an established evidence based modality within this framework which is a requirement for widespread implementation.

Therefore this study was conducted to continue the dialog toward evidence based practice, should it prove as promising as the background literature suggests. This study gathered information from experienced providers about their use of body psychotherapy in their current practice or interest in adding it as a modality, as well as the effectiveness they have seen with individuals in addiction treatment.

The main questions under investigation:

Is body psychotherapy an effective treatment modality to address emotional dysregulation?

Does it promote mind-body connection?

Does it improve chance of long term recovery?

Can body psychotherapy be a complementary modality to traditional addiction treatment?

## Method

### Design

A pilot case study design was used incorporating five 30-minute qualitative semi-structured interviews.

### Participant Information

Participants of this study were practicing psychotherapists. Inclusion criteria included (1) licensed mental health practitioners (i.e., Licensed



## CLINICIAN EXPERIENCE WITH ADDICTION TREATMENT

Psychologist, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker) (2) a minimum of five years of experience as a licensed therapist and (3) direct experience with individuals in addiction treatment. Levels of care varied from residential to outpatient, individual or group work. They were solicited through well-known local providers and professional networks.

Five therapists were chosen, four female and one male. The age range of participants was 44 – 64 years old, with a mean age of 53.8 years. The range of therapeutic experience was 7 to 25 years with a mean of 16.4 years. Employment included private practice (2 individuals), contract work for a residential program (1), intensive outpatient (1), residential care (2) or a combination of levels. Four of the participants held master's degrees and one a doctoral degree. Three of the five participants were trained in body psychotherapy techniques, which included EMDR (x2), play therapy, body centered psychotherapy, and sensorimotor psychotherapy, in addition to traditional modalities. Two were regularly utilizing body psychotherapy techniques in therapy with individuals in addiction treatment.

### Researcher Information

The researcher for this study was a thirty-three year old Caucasian female graduate student specializing in body psychotherapy at Naropa University and a registered psychotherapist in the state of Colorado, currently interning at a premier substance abuse treatment facility in the Denver area. She was seeking her MA degree and has 2 years of experience with research and one year of experience within the professional addiction treatment field. This is her first time conducting a qualitative investigation.

### Instrument

Participants answered six open-ended questions with possible follow up questions for clarification. Demographic information was also requested (See Figure 1).

<p><b>1) Basic Demographics: Age?</b> How many years of experience have you had in the field? Describe your current work environment and schedule.</p>
<p><b>2) Why did you choose addiction work?</b> What is your theoretical orientation? Or approach to treatment? How long have you been working with this population?</p>
<p><b>3) Do you think the body is important in addiction work?</b> Why?</p>
<p><b>4) In your view, are addiction and the body interconnected (awareness of the body, emotional/self-regulation)?</b> How?</p>
<p><b>5) What do you consider to be the factors of success and the rate of recovery with this population, through your own experience?</b> What is the optimal treatment? What is the length (# of total sessions) and frequency/intensity (how many sessions a week, for how long)? What type of treatment? (Group, individual, meditation, etc). And would you combine methods of treatment?</p>
<p><b>6) Would you be willing to/interesting in adding body psychotherapy to your practice?</b> If it is already part of their practice: Are there any other forms of body oriented therapies that show promise with this population?</p>

Figure 1 Demographic information

**Procedure**

E-mails were sent to ten (10) individuals to solicit participation, introduce the researcher and briefly describe the project. If the initial greeting e-mail was responded to with interest, a follow up email was sent which included a more detailed description of the project, IRB approval, ethical considerations and consent forms. If the participant agreed to an interview, a time and place were scheduled. Interviews were conducted either in person, via Skype or telephone, between January 31, 2014 and March 4, 2014. Each interview took approximately thirty minutes. Digital audio recordings of the interviews were made on a recording device. Interviews were then transcribed. All transcribed data was stored in encrypted files and the recording device was locked in a filing cabinet.

**Data analysis**

Interviews were transcribed and coded into “meaningful units” (Davis, Dorsey, Greene, & Soma, 2010), which are reoccurring concepts or phrases within the interviews whose repetition indicated possible saliency. The “meaningful units” were then organized by themes. Once all of the over-arching themes were divided, the most prevalent higher order themes within them were identified (if any were present), those higher order themes make up the sub categories of the results section (Davis et al., 2010).

**Results**

The following over-arching themes represent the overall findings of the study, which include: body-mind connection, coping, stages of change, and optimal addiction treatment plans.

**Body-Mind Connection**

The connection between the body and the mind was most cited over-arching theme. It was referenced 33 times, either being named directly (5 units) as an important element of treatment, 5 out of the 5 participants espoused, as a result of the interview or alluded to by higher order themes. These higher order themes include disconnection from the body (lack of interoception) (11 units), the biological components of addiction and their effect on the actions of the individual (8 units), or the need for awareness (9 units) of this body mind connection for healing.

**Interoception.**

The higher order theme that arose the most frequently in the interviews was the connection between the body and the mind as it related to individuals in addiction treatment. This concept refers to interoception (sensitivity to internal stimulus) (Goldstein et al., 2009). This suggests an individual's ability to perceive physical sensations accurately then to connect the sensation to a thought. Then, above this basic awareness is an individual's ability to understand the interconnectedness of body sensations to the mind and vice versa, and their influence on behaviors. Participant 2 stated that all individuals in addiction treatment, either substance or process, were universally characterized by a disconnection from their body. This idea was echoed in all five interviews and was mentioned 11 times.

**Awareness.**

Another related theme is awareness, specifically somatic awareness, which is to have knowledge, consciousness or perception. This higher order theme was referred to 9 times, to help counteract body-mind disconnection. By creating awareness of physical sensation, the individuals in addiction treatment are better able to perceive affect before they react and revert to dysfunctional coping patterns. It allows the individual a choice – revert to old behaviors or utilize more functional coping skills. Interventions that were mentioned by participants that assist in creating more somatic awareness were: journal writing during emotional arousal, questioning sensations as they arose in session to encourage a verbal description, or asking the individual for a physical description of specific emotional states such as craving or tension.

**Coping**

The second over-arching theme was coping, which refers to the need for skills to compensate for the loss of one's primary external source of regulation, whether it be substance or process addiction. At first, individuals experience a frequent inability to tolerate average emotions, thus suggesting a lack of adaptive coping. This over-arching theme was referenced 25 times and included emotional regulation (13 units), oversensitivity to stimuli (9 units), and sense of agency (3 units) as higher order themes.

**Emotional regulation.**

Each of the participants cited emotional regulation as a major challenge for individuals in addiction treatment. In particular, the emotional dysregulation or poorly modulated emotional response characteristic of individuals in addiction treatment, that most often originates in the body (hormonal imbalance, poor arousal modulation). One participant explained that “negatively perceived experiences of the body are tightly coupled to the symptoms that lead to relapse” (i.e. tightness, overwhelm, frustration which lead to avoidant coping).

**Oversensitivity.**

Participants of this study suggested that individuals in addiction treatment use addiction as a coping skill, which leaves them with few ways to manage stress/tension or affect without it. Individuals in addiction treatment come in with a very narrow “window of [emotional] tolerance” (Siegel, 1999) (heightened sensitivity to emotions which disrupts normal functioning of the system creating a sense of overwhelm which stimulates the urge to numb/use). Treatment requires the adaptation of functional coping skills in order to be successful. The skill of self-regulation or arousal modulation is crucial to early sobriety because of the reactivity to mild stimuli which makes rational decision making challenging. Four out of 5 participants stated that this is where body psychotherapy can benefit the therapeutic process and suggested interventions that they utilize such as breathing exercises, biofeedback, guided collage, resourcing, and developing a somatically based plan for sleep hygiene all help in establishing regular use of adaptive coping skills.

**Sense of Agency.**

Through the employment of coping skills an individual in addiction treatment can then begin establishing a sense of agency over their internal state, a sense of mastery over their emotions, and begin widening their window of tolerance through exposure to previously intolerable feelings. Establishing an internal locus of control is reported specifically by two of the five professionals, as a critical aspect of successful addiction recovery. Affording individuals the opportunity to feel responsible for their own arousal modulation in times when they might be compelled to react dysfunctionally in the past, helps to support the ego strength and motivation for recovery.

**Stage of Change**

There are two higher order themes within the over-arching stage of change theme: voluntary versus involuntary treatment and motivation for treatment.

**Volition.**

All of the participants (5:5) reported that success in addiction treatment was more likely if the individual is voluntarily motivated to participate in treatment and valued personal change.

**Motivation.**

Many of the participants (4:5) mentioned Prochaska & DiClemente's Stages of Change Model (DiClemente, 2003), which is a popular theory used in contemporary addiction treatment to determine the readiness of an individual to change. They stated that recovery and success in therapy could be determined more by their willingness than the modalities used to treat them (body based or otherwise). But an important caveat to that was stated by participant 4, who reported that "a person's Stage of Change can be unpredictable day to day (not linear). An individual can be in the action phase one day and act out in their addiction the next", which is supported by participant 1 who reports that "a person's willingness may lapse due to frustration or stress which most often manifests first in the body, and that body [dysregulation] is tightly coupled with the symptoms of relapse".

**Optimal Treatment Plans**

When asked about optimal treatment plans for individuals with addiction treatment, each participant pointed out that this was a difficult question to answer due to the labile qualities of human nature, particularly for those with substance or process addictions. But there were two higher order themes that emerged: length of treatment and type/level of care.

**Length of Treatment.**

Four out of 5 participants identified and agreed with research which suggests that the longer an individual remains in some form of treatment, the more likely they are to remain abstinent (Gossop, Marsden, Stewart, and Rolfe, 1999).

**Type/Level of Care.**

Three of 5 suggested an individualistic approach to treatment regarding length, modality and focus. Specific treatment modalities were identified by the participants, with 4 out of 5 recommending family based therapies to address the environment and support systems of the individual. Other evidence based modalities for individuals in addiction treatment included CBT (3:5), Motivational Interviewing (3:5), and DBT (2:5). Three out of 4 participants identified the need to explore and address trauma as well as any other co-occurring issues in treatment and the importance of taking these into consideration to create a comprehensive treatment plan. As a result, trauma based modalities were also identified, which included EMDR (3:5), Somatic Experiencing (2:5) which are body based.

**Discussion**

There are numerous variables that make addiction treatment successful. Results of this examination support the hypotheses that body psychotherapy could be a complementary modality to traditional addiction treatment, to support mind-body connection and address emotional dysregulation.

**Implications**

The positive implications of body psychotherapy with this population are unquestionable. Because relapse begins in the body as a result of emotional and physical dysregulation (Gorski, 1982), it seems pertinent to employ interventions that involve the body to increase one's ability to self-regulate. Body based techniques seem uniquely able to help clients relieve tension held in the body as a result of stress. These techniques afford them relief in a way that mimics the appeal of substances: almost immediately, but without all of the negative consequences. Not only would this help increase the possibility of long term recovery without relapse, but it has additional implications for individuals in addiction treatment as well, such as increasing an individual's ability to regulate their emotions. Body psychotherapy may also provide a building block to improve interpersonal connection. Additionally, creating a more regulated nervous system may allow individuals in addiction treatment more stability so that deeper issues can be addressed in therapy, such as family dynamics, core beliefs, and eventually trauma. In fact, the skill of body-mind connection creates the foundation for CBT, as sensations precede the process of thought to behavior. As outlined by Maslow's hierarchy of needs, the physiological state must be addressed and safety achieved before social, self-esteem and self-actualization may be addressed (Maslow, 1954). Finally, one of the major benefits possible through the use of body psychotherapy in addiction treatment is the ability for individuals to directly experience self-regulation, thus allowing them the knowledge and confidence that they can regulate themselves without using.

**Limitations**

Limitations of this pilot study include a very small sample size, as well as biased treatment sample (primarily upper middle class, homogeneous

individuals in addiction treatment). Additionally a question could have been added in the interview to address limitations or cautions that may need to be taken when utilizing body based practices with individuals in addiction treatment. Another limitation could have stemmed from the manner in which information was presented to participants during recruitment. The consent form stated that “the purpose of this study is to determine whether body centered therapy can complement traditional cognitively based techniques in the treatment of addiction.” This may have unintentionally skewed the opinion of the participants and set a positive bias rather than a neutral one in relation to body centered work in addiction treatment. Finally, this study addressed body psychotherapy in a general way, rather than focusing upon specific modalities within the paradigm.

### **Future Research**

The practice of body psychotherapy could benefit by being streamlined, organized, and made into an evidence based modality for treatment, as evidence based modalities are utilized most frequently in treatment programs. This would allow the practice to be experienced by a wider population should it prove to be effective as is suggested in this small sample. To begin this process it may be advantageous to create a structured plan for study, to be implemented with individuals in addiction treatment over 5 sessions. The results could then be objectively examined, perhaps through biofeedback, brain scans, or effects on health, sleep and relationships. These could be based on self-reports, interviews of family/friends and/or observation measures from providers.

### **Conclusion**

Through these interviews, it can be inferred that there is a need for more research to be conducted on the effectiveness of body psychotherapy in addiction treatment. Although body psychotherapy cannot immediately change the brain imbalances inherent in individuals in addiction treatment, the present study suggests that incorporating the body in treatment may reduce emotional reactivity as internal regulation is established and offer some relief of symptomatic tension. In addition to the importance of structure and safety provided in treatment, this study suggests that body psychotherapy can complement traditional forms of therapy, address salient issues presented in this population, and help prepare individuals for more complicated therapeutic interventions which can assist in increasing the chances of long term recovery.

### **BIOGRAPHY**

Elizabeth Powers, MA, LAPC is a graduate of Naropa University in Boulder, Colorado. She holds a master's degree in Somatic Psychology, with a concentration in Body Psychotherapy. She currently works as an addiction counselor in Savannah, Georgia. Any inquiries to the author may be sent to [betsypow911@gmail.com](mailto:betsypow911@gmail.com). The author would like to thank her editor, Dr. Latisha Bader at The Center for Addiction, Dependence, and Rehabilitation in Aurora, Colorado for her tireless support.

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## Body Psychotherapy and Social and Emotional Learning: An Integrative Model

Nicole Calvano

### Abstract

Social and Emotional Learning (SEL) teaches students in pre-school through high school skills to become socially and emotionally intelligent individuals. The Collaborative for Academic, Social, and Emotional Learning (CASEL) has done extensive research to determine the qualities that make SEL programs most effective. Five core competencies have been identified. These include: self-awareness, self-regulation, social awareness, responsible decision-making, and relationship skills. This author examined each of these five competencies through the lens of Body Psychotherapy. Theories and applications such as The Moving Cycle, Focusing, Gestalt, and Dialectical Behavior Therapy were integrated into each of these five areas, establishing a theoretical model for Body Psychotherapy informed SEL. This integrated model could provide a more comprehensive and effective approach to SEL that conserves resources for school districts and promotes more positive student outcomes.

**Keywords:** social and emotional learning, emotional intelligence, body psychotherapy

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In 2007, UNICEF reported that the United States is one of the lowest ranking ultramodern societies with regard to the well-being of children, coming in second-to-last place out of twenty-one countries. Social and Emotional Learning (SEL) has been identified as a possible solution for improving childhood wellbeing (Nelson, 2011; Greenberg, et al., 2003). In this paper, the author will address the five core competencies that have been identified as key elements to effective SEL programming, according to the Collaborative for Academic, Social and Emotional Learning (CASEL). These include: self-awareness, self-regulation, social awareness, relationship skills, and responsible decision-making. The author will examine the relationship between these core competencies and principles and techniques from Body Psychotherapy. This inter-re-

lationship between SEL and Body Psychotherapy could serve to inform SEL education and provide more comprehensive instruction.

## Literature Review

### Overview of SEL

Social and Emotional Learning is rooted in theories of emotional intelligence, emotional literacy, and positive youth development. Much of the research in this field uses Mayer and Salovey's (1990) theoretical model of emotional intelligence which includes four basic skills: (a) accurate perception, appraisal, and expression of emotion; (b) using feelings to help with thinking; (c) understanding emotions; and (d) regulating emotions. Understanding emotions in this way allows for using emotions as a guide to know how to behave or what choices to make in everyday life that align with the desired outcome (Ogunyemi, 2008; Lopes & Salovey, 2004). Much of the research regarding measures of emotional intelligence control for personality traits and general intelligence (Márquez, Martín & Brackett, 2006; Mestre, Guil, Lopes, Salovey, Gil-Olarte, 2006).

The term social and emotional learning dates back to 1994 when the Fetzer Institute held a meeting to address the ineffectiveness of most prevention and health promotion programs geared toward children and adolescents (Nelson, 2011). Out of this meeting, an organization called Collaborative for Academic, Social, and Emotional Learning (CASEL) was formed and has become the pioneer in the field of SEL (Nelson, 2011; Greenberg et al., 2003). Through extensive research on existing programs and their limitations, CASEL identified the qualities of effective SEL programming.

### Five Core-Competencies as Defined by CASEL

CASEL identified five core competencies that comprise effective SEL education and curriculum: self-awareness, self-regulation, social awareness, relationship skills, and responsible decision-making (Rivers, Brackett, Reyes, Elbertson, & Salovey, 2013; Nelson, 2011; [CASEL](#), 2003, Brackett & Rivers, 2014; Greenberg et al., 2003).

The five competencies are defined as follows:

Self-awareness includes the ability to recognize emotions, describe one's interests and values, accurately assess personal strengths, and have self-confidence and hope for the future.

Self-regulation includes: stress-management, impulse control, perseverance in overcoming obstacles, setting, monitoring, and achieving academic and personal goals, and appropriate expression of emotions in various settings.

Social awareness relates to perspective-taking, empathy, appreciation of similarities and differences, and being able to seek out and use family, school, and community resources.

Relationship skills include: creating and maintaining healthy and satisfying relationships based on cooperation, resisting social pressure, and dealing successfully with interpersonal conflict (prevention, management, resolution, and seeking help).

Responsible decision-making takes into account ethics, safety, respect for self and others, consequences, and social norms, whether making decisions at school, home, or in the community. Students are encouraged to use these principles in academic and social situations, that they may make positive contributions to their community. (CASEL, 2003; Nelson, 2011; Brackett & Rivers, 2014).



*Figure 1. Five core competencies of effective SEL programming as identified by CASEL. Adapted from "Transforming students' lives with social and emotional learning" by M. A. Brackett and S. E. Rivers, 2013, Yale Center for Emotional Intelligence, p. 5.*

**Self-awareness:** Ability to recognize emotions, to describe one's interests and values, accurately assess personal strengths, and have self-confidence and hope for the future.

**Self-regulation:** Stress-management, impulse control, perseverance in overcoming obstacles, setting, monitoring, and achieving academic and personal goals, and appropriate expression of emotions in various settings.

**Social Awareness:** Perspective-taking, empathy, appreciation of similarities and differences, and being able to seek out and use family, school, and community resources.

**Relationship Skills:** Creating and maintaining healthy and satisfying relationships based on cooperation, resisting social pressure, and dealing successfully with interpersonal conflict (prevention, management, resolution, and seeking help).

**Responsible Decision-Making:** Decisions are made taking into account ethics, safety, respect for self and others, consequences, and social norms, applying these principles to academic and social situations to positively contribute to the community.

### **Impacts of Emotional Intelligence on Social and Academic Success**

SEL is addressed in academic settings for children in pre-school through high school in order to teach emotional intelligence and promote greater social and academic success for students (Greenberg et al., 2003; Hagelskamp, Brackett, Rivers & Salovey, 2013). High emotional intelligence has been related to greater social and academic adaptation and success at school, including overall psychological well-being, less somatic complaints to stress, and less substance abuse (Mavroveli, Petrides, Rieffe, Bakker, 2007; Ogunyemi, 2008; Márquez et al., 2006; Mestre et al., 2006). The ability to regulate and channel emotions seems to reduce stress that might otherwise impede focus and attention. It also helps to develop intrinsic motivation for learning and to foster relationships between peers and teachers. These relationships facilitate students' adaptation and comfort in the school setting (Lopes & Salovey, 2004; Márquez et al., 2006). In contrast, low emotional intelligence has been related to a greater presence of self-destructive, anti-social, and disruptive behaviors which negatively impact social and academic success (Mavroveli et al., 2007; Fernández-Berrocal & Ruiz, 2008).

### **The Role of the Body in Learning and Processing Emotion**

To obtain the benefits that social and emotional intelligence can provide, SEL uses both cognitive and behavioral components, rather than strictly cognitive (CASEL, 2003). Behavior and the human body are strongly related and have been studied by educators (Hendricks & Hendricks, 1983; Siegel, 2010; Whitescarver, 2010). Movement stimulates the neural wiring throughout the body, making the entire body a tool or aid in the learning process (Hannafor, 2005). Physical movement and emotional safety are foundational to learning throughout the lifespan, as both are key components in creating new nerve cell networks (Hannafor, 2005; Stevens-Smith, 2004; Ozar, 2013). One model of education that is rooted in the inter-relationship between movement and learning is Montessori. Developed by Martha Montessori, the first Montessori school opened in Rome in 1907 and the first one in the United States opened in 1911 (Whitescarver, 2010; Fuchs, 2014). This philosophy of education states that it is through movement that children develop strength, flexibility, balance, and other motor skills that directly impact learning capacity.

### **Theoretical Model**

What follows is a theoretical framework for relating each of the five core competencies of SEL to principles and techniques from Body Psychotherapy.

#### **Self-awareness**

Self-awareness is addressed in Caldwell's (1997) work, specifically The Moving Cycle. The Moving Cycle consists of four phases: Awareness, Owning, Appreciation, and Action, all of which relate to SEL principles. Awareness is defined as a body experience that begins with noticing physical sensations that are present within the body in the present moment (Caldwell, 1997; Cornell, 1996; Levy Berg, Sandell, & Sandahl, 2009). This phase is characterized by sensing, identifying, and becoming awake to something that the client was not previously directing attention toward (Caldwell, 1997).

**Sensing into the body.**

Focusing, a technique developed by Gene Gendlin (1978), cultivates self-awareness through sensing into the body and greeting sensation. In a similar way that two people would greet each other upon meeting, Focusing begins with saying hello to internal sensation. This greeting process is a pathway to heightened self-awareness (Gendlin, 1978; Cornell, 1996). Using descriptive language, the client notices the qualities and characteristics of the sensations and articulates them to the therapist or self. This is a means of internal listening from a place of compassion, rather than assumption, and rooted in an attitude of curiosity (Cornell, 1996). (See Figure 2)

SEL Competency	Body Psychotherapy Approach	Description of Approach
1) Self-Awareness	a) Moving Cycle b) Focusing	a) 1 <sup>st</sup> Phase is Awareness, waking up to the body's messages b) Becoming aware of bodily sensation and greeting these sensations with openness and curiosity
2) Self-Regulation	a) Radix b) Focusing c) DBT	a) Focuses on choosing goals and pursuing them effectively b) Staying present with a range of feelings, including discomfort c) Identifying and labeling emotion and distinguishing between thought, events, emotions, and behavior
3) Social Awareness	a) Focusing b) Gestalt	a) Take on the perspective of parts of the body or others and develop empathy b) Explore relationship between self and environment with present-moment awareness; perspective taking
4) Responsible Decision-Making	a) Gestalt b) Moving Cycle	a) Individuals become aware of their direct impact on their environment and make choices accordingly b) 2 <sup>nd</sup> -4 <sup>th</sup> Phases: Owning, Appreciation, & Action address unconditional self-acceptance and expressing positive inward changes out into the world
5) Relationship Skills	a) Relationship Dance b) Somatic Development c) DBT	a) Using present-moment awareness to determine healthy boundaries and make conscious choices about who to engage with b) Balancing the need for intimacy and separateness and the role of space, energy, and time in setting healthy boundaries c) Specific tools for learning interpersonal effectiveness, including getting needs met, maintaining relationships, and self-respect

*Figure 2.0.* Theoretical model for Body Psychotherapy informed SEL which integrates Body Psychotherapy techniques and principles into the five core SEL competencies as identified by CASEL.

**Assessment of strengths.**

CASEL's (2003) definition of self-awareness includes an accurate assessment of one's strengths, which requires self-reflection. Caldwell's (1997) Moving Cycle addresses the notion that human beings have an innate capacity to observe or witness ourselves, a form of self-reflection and reflecting on who we are in relation to the external world. Through this ability to self-reflect, one can identify personal interests, strengths, and can begin to know oneself. Rubenfeld (1997) uses the term self-observation interchangeably with self-awareness to describe how people come to understand who they are as individuals and the differences between the internal and external worlds. Siegel (2010) coined the term *mindstight* to take this idea of self-observation and expand upon it to include perceiving the mind of others. The development of self-awareness, both internal listening and self-observation, provides a foundation for learning self-regulation, the next core competency of SEL education.

**Self-Regulation**

Self-regulation, also referred to as emotion regulation, involves bridging connections between emotions and behavior (Linehan, 1993). Goleman (1996) defines emotions as impulses to act, instilled in human beings through evolution as a means of handling life from moment to moment. Pinker (1997) takes emotions a step further and posits that they belong to the body, in a similar way that Siegel (2007) affirms that the brain is related to the body. One technique for supporting this bridging of emotions and behavior is mindfulness practice (Hyland, 2014). Mindfulness teaches present moment awareness and seeing things as they are without judgment or criticism (Hyland, 2014; Williams, Teasdale, Segal, & Kabat-Zinn, 2007). Rather than responding impulsively, one can self-reflect and make conscious behavior choices.

**Impulse control.**

Self-regulation involves controlling impulses and expressing emotions appropriately in diverse environments (CASEL, 2003). Gendlin's (1978) Focusing involves learning to become comfortable with strong or uncomfortable feelings. By staying present in the midst of discomfort, Focusing helps teach clients to relate to strong emotions in an open and friendly way, rather than be overcome by them (Cornell, 1996).

Dialectical Behavior Therapy (DBT) developed by Marsha Linehan (1993) also addresses how to manage strong emotions. DBT integrates principles from Cognitive Behavior Therapy, assertiveness training, and Eastern practices in meditation and mindfulness and consists of four modules (Read, 2013). The third module is emotional regulation which consists of identifying and labeling emotions, in addition to learning to distinguish between thoughts, emotions, behaviors, and events (Linehan, 1993). Clients are taught to engage in the opposite action that their emotions are encouraging, rather than becoming the emotion itself and behaving from that place. Clients learn what triggers different emotions, identify the bodily sense associated with these emotions, and use the tool of chain analysis to explore how emotions impact behavior choices (Read, 2013).

**Goal setting.**

Self-regulation also encompasses the setting and achieving of goals (CASEL, 2003). Radix, developed by Kelly (1978), addresses how to choose appropriate goals and pursue them in an effective manner (Caldwell, 1997). This work focuses on how people block fear, anger, or pain, and uses specific body-based techniques to release this blocked energy in order to become more fully alive (Kelley, 2007).

From a Focusing perspective, deep listening to inner body sensations helps a person reconnect to one's own feelings, wants, and needs to set goals based on holistic choice making, rather than logic alone (Cornell, 1996). The body is able to act as a source of information about personal values and beliefs, about what environments are healthy versus more toxic or negative, and about how to be true to oneself in daily life (Cornell, 1996). From an SEL perspective, this internal, bodily-derived information about emotion could support students in determining realistic and appropriate goals and effective steps toward attaining those goals.

**Social Awareness**

The third core competency identified by CASEL (2003) is social awareness, which relates to perspective taking, cultivation of empathy, and recognition of similarities and differences among individuals and groups. CASEL (2003) also includes identifying and accessing resources within a family, school, and community within its definition.

**Cultivating empathy.**

Focusing is again relevant, as it is a Body Psychotherapy technique and skill that directly contributes to developing social awareness (Cornell, 1996). The process of developing a relationship with one's internal sensations and having a dialogue with these sensations, images, narrative, or colors involves cultivating empathy. Rather than placing judgment or shutting out certain internal perspectives, Focusing encourages greeting the sensation with compassion, empathy, and open-minded curiosity. The messages provided through the sensation might be similar or different to what the person had expected, and the person is encouraged to remain kind and curious in the exploration.

**Perspective Taking.**

Gestalt, developed by Fritz Perls (1973) also addresses social awareness. Gestalt takes on a systems perspective, expressing interest in the relationship between an organism and its environment and vice versa (Perls, 1973). Gestalt looks at the impact that one has on another and is characterized by three primary elements: relationship, awareness, and experiment. It also emphasizes present-moment awareness (Clarkson, 2004).

Gestalt's use of experiments includes role playing and taking on the perspective or identity of others, be it parts of the individual or other individuals. One type of experiment is open seat work, which allows a person to use internal listening to hear the perspective of oneself, while imagining that the

other person is sitting directly across. Once the first perspective is listened to, the person will move to the other seat and listen to the perspective of the other, as if becoming that person (Clarkson, 2004). There is an opportunity to gain greater awareness and understanding, which includes empathy, similarities, and differences. Through this form of experimentation, students can cultivate empathic responding by coming to understand how their behavior directly impacts others, be it peers, teachers, or members of the greater community.

### **Responsible Decision-Making**

This author has chosen to address responsible-decision making next, as it overlaps with both CASEL's articulation of social awareness and its relationship to Body Psychotherapy. Responsible decision-making incorporates elements of social awareness and is broadened to include ethics, safety, social norms, respect for others, and consequences of chosen behavior, both within the academic setting and in the greater community (CASEL, 2003). From a Body Psychotherapy perspective, approaches such as Focusing and Gestalt would be used to cultivate responsible decision-making.

### **Respect for others.**

Perls' (1973) Gestalt therapy focuses on the inter-relationship between individuals and their environment, be it peer-peer, student-teacher, teacher-administration, or student-family members. With awareness of the present moment, students learn to make conscious choices about their behavior, rather than acting solely on impulse without considering their impact or consequences on others (Clarkson, 2004). In this way, students can practice taking responsibility for themselves, be it their thoughts, words, or actions, and make choices with an awareness of their impact on community members.

Gestalt emphasizes that each person is responsible for what choices are made or not made, and that there is no separation between an individual and the environment (Clarkson, 2004). There is consideration for personal safety, ethical standards, and how others will be impacted, before choices are made. Gestalt incorporates present-moment awareness, similar to Mindfulness practice as addressed in DBT. Mindfulness makes it is possible to become aware of the choices available at a given moment (Clarkson, 2004; Read, 2013). This is the first step toward making conscious, intentional choices.

### **Choosing how to behave.**

Returning to The Moving Cycle, Caldwell's (1997) four phases are relevant to responsible decision-making. The Owning Phase speaks directly to taking responsibility for what one becomes aware of in the Awareness Phase (Caldwell, 1997). In this process, there is a differentiation between placing blame outwardly and taking personal responsibility. Similar to Focusing and Gestalt, there is encouragement to stay present, even in the midst of intensity, allowing the body to express itself in whatever ways it needs to. The Appreciation Phase emphasizes unconditional self-acceptance, which relates to accepting similarities and differences in others as addressed in the social awareness competency. The final phase of The Moving Cycle is Action. In the



Action Phase, inner changes are encouraged to be expressed outwardly by impacting the community in meaningful ways. The cultivation of self-responsibility and self-acceptance creates a foundation for relating to others in positive and empathetic ways.

### **Relationship Skills**

Relationship skills are the fifth competency to be addressed in this paper. CASEL (2003) describes this competency as creating and maintaining cooperative relationships that are nourishing and healthy, responding to peer pressure, and skillfully preventing, managing and addressing conflict.

### **Cooperative relationships.**

Healthy relationship development considers that human beings need both intimacy and separateness and having an embodied awareness of each of these is a vital source of wisdom (Caldwell, 1997). It is important to be able to move toward that which is nourishing and healthy and away from being self-centered or arrogant. It is equally important to use separation to move away from relational dynamics that are toxic or threatening, and move toward the wisdom of reflection and solitude (Caldwell, 1997).

The Relationship Dance helps people to make conscious choices about who to spend time with and how to behave within these interactions (Hendricks, 1997). By identifying the somatic reactions associated with moving toward or moving away from others, including tracking one's breath and freedom of movement, insight can be provided as to the potential health or toxicity of a relationship (Hendricks, 1997). This information provides opportunity for choice about with whom to engage.

From a Body Psychotherapy perspective, relationships integrate the basic elements of space, energy, and time (Caldwell, 1997). Space includes the amount of space an individual feels allowed or safe enough to occupy, the amount of space between individuals, the amount of personal space one needs to feel comfortable and respected, and the dance of moving into and out of each other's space. The next element, energy, relates to feeling a sense of autonomy and empowerment around the events of our lives, such as a sense of control. Lastly, time integrates personal pacing or rhythms, both as an individual and in relationship to others. It is important to feel respected for one's pace and also learn how to match this pace with another's pace in relationship (Caldwell, 1997). This body-based insight about boundaries could provide additional information for students learning embodied ways of navigating relational dynamics.

### **Addressing conflict.**

Linehan's (1993) DBT includes a module on interpersonal effectiveness. This module consists of learning to identify individual needs and asking for them to be met, saying no, and coping effectively with conflict (Read, 2014). The acronym DEARMAN, GIVE FAST is used to describe the specific skills taught to develop interpersonal effectiveness. DEARMAN addresses getting needs and wants met and includes: expressing one's feelings and thoughts,

being assertive, explaining the consequences of the conflict, staying present, maintaining clear and firm boundaries, appearing confident, willingness to compromise, and taking the other person's perspective and ideas for solution into account. GIVE teaches tools toward keeping and maintaining relationships, and involves using a courteous approach, listening, validation, and keeping a lightness of presence. FAST relates to maintaining self-respect, which includes being authentic and honest with oneself and others and maintaining boundaries. DBT uses research-based techniques that are effective for developing interpersonal effectiveness (Linehan, 1993).

Body Psychotherapy informed SEL integrates principles from Focusing, Gestalt, DBT, The Moving Cycle, Radix, The Relationship Dance, and theories of Somatic Development. Just as there is an overlap in content and skill among the five core competencies, there is an overlap in the Body Psychotherapy techniques that address each competency.

### **Application of the Theory**

Body Psychotherapy relates to Social and Emotional Learning in its philosophy and techniques relating to emotion regulation, self-awareness, creating boundaries and forming healthy relationships, and making responsible decisions that have a positive impact on oneself and community.

### **Clinical Example**

Body Psychotherapy informed SEL could address each of the five core competencies in a variety of ways, with multiple competencies addressed in a given clinical example. In order to illustrate how Body Psychotherapy informed SEL might translate clinically, a scenario is provided. This example involves using Focusing principles to develop self-awareness by teaching a student who frequently feels angry to identify the physical sensations that accompany her anger (Cornell, 1996). These sensations might include hands that feel hot and clench into fists, discomfort in the belly, and tightness in the chest. She can learn to notice when she feels these sensations and use this information to take a time-out, rather than acting impulsively and potentially causing harm to herself or others. Implementing a strategy taught through the self-regulation competency, such as taking on an opposite emotion from anger, the student can transform her anger and return to feeling calm (Linehan, 1993). She can quickly re-focus her attention on learning and minimize classroom disruption.

Additionally, she can start to notice patterns relating to her anger, noting what environments and types of situations act as triggers. With this information, she can avoid situations that she knows might trigger feelings of anger as much as possible. Perhaps one trigger is getting in trouble by her teacher. She starts to notice that whenever she spends time with student A, she gets in trouble. She might consider student A a friend, but perhaps this person is actually a negative influence. Implementing the relationship skills and social awareness competencies, she can use the work of the Relationship Dance and Caldwell (1997) to track her breath and range of accessible movement options when in relationship with this other student (Hendricks, 1997). She might notice that her breath becomes shallow and restricted, that her movements get small and contained, that she feels shorter or smaller than she actually is, and that she

loses her sense of voice. In contrast, with student B who motivates her to get good grades and make responsible choices, she feels an ease of breath, a sense that she is her actual height, options to move in large, medium, or small ways, and freedom to use her voice. These sensations and inner-body experiences provide information. Understanding that spending time with student A causes her to get in trouble which then triggers her anger, she may choose to spend less time with student A, a means of responsible decision-making. Restricted breathing, feeling short, or a lack of voice could all become associated as warning signals that this might not be a healthy or productive situation. On the other hand, ease of breath, freedom of movement, and access to her voice may all indicate healthy relational dynamics.

It is worth noting that most SEL curriculum activities are intended to be applied to a group of students, while the above example includes ideas of working with an individual student. The author believes that these concepts can be adequately applied with both individuals and groups of various sizes.

### Conclusion

There are limitations to this method of Body Psychotherapy informed SEL. First, school budgets often do allow for additional resources to staff Body Psychotherapists. Financial resources are typically quite limited, especially in public school districts. Time resources are also typically limited, as school days often emphasize core academic content in order to meet the demand for successful scores on standardized testing. When looked at in a different way, it is likely that effective SEL interventions could save ample time and money over the long-term. With behavior management issues demanding less attention in the classroom, teachers could direct more attention to educating their students, experience less burn-out, and student learning outcomes could increase.

As a theoretical model, there are inherent limitations with the lack of experimental evidence and research-based application. The next step would be to take an existing CASEL approved SEL program and integrate its specific lessons with Body Psychotherapy techniques and principles. Using this newly developed curriculum, pilot studies are the next step. Research studies should involve various grade levels, including pre-school, elementary school, middle school, and high school. It is also extremely important to examine the role of culture, race, gender, and socioeconomic status when determining the effectiveness of this model. A diverse group of schools in diverse geographic regions would need to be studied in order to determine this model's effectiveness. Ideally, these studies would span the length of the school year and include follow-up in future grade levels.

This article examined the idea of Body Psychotherapy informed SEL which could contribute to creating more comprehensive SEL curriculum.

### BIOGRAPHY

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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. A selection of those received will be published in the next volume of the Journal.

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