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Our Journal is turning 20!

It is refreshing to have a reason to celebrate in these turbulent times when fear and pain are attempting to set up residence in our daily lives. In navigating these turbulent times, it is comforting to have psychotherapists who can help bring awareness to the sources of this fear and pain.

If we were more mature, we would not put as much blame on governments and invisible viruses as we do, but would rather look into ourselves for the reasons why this is happening to the planet right now. We would look for resources and long-term solutions that could remedy the situation.

Scientists claim that it is the destructive influence of humans on nature that leads to the development of such viruses in the animal kingdom. Non-distressed, healthy animals do not carry viruses. What is hurling towards us is the boomerang we ourselves have thrown. Heightened awareness would be the best vaccine against such a future. For 20 years now, our aim and mission at the Journal has been to publish content that expands the knowledge and consciousness of those who help everyone else grow and expand... because, as the Chinese wrote on the aid packages they sent to Italy this past spring, we are all waves in the same ocean and leaves on the same tree.

In this 20th anniversary edition, we have brought together articles that reflect the maturation, depth, and inclusivity of our somatic field. Anchoring in our history, the editorial team interviews the Journal’s two founding mothers, Jaqueline A. Carleton and Jill van der Aa. We continue the historical journey with Luisa Barbato, who highlights the essential importance of Reich’s functionalism, and Andrew Howe, who connects us with Jungian and post-Jungian attitudes towards the body. We travel forward with Genovino Ferri and Giuseppe Cimini, who reflect on concepts of energy and their application in the psychosomatic field, and Milena Georgieva and George Milo-shhev, who share their research on the influence of epigenetic factors on emotional intelligence.

We are consistently amazed by the richness and diversity of the articles we receive, and by the innovative directions emerging in current authors. We hope you will agree that the articles in this issue reflect the coming of age of our field. Danielle Tanner’s case study explores shame from a relational and neurological perspective; Karyne Wilner looks at body therapy methodologies to help regulate the long-term effect of fetal distress in adults; Meredith Antonucci introduces a compassionate approach to the integration of body psychotherapy in the treatment of sex offenders; Elizabeth Long gives us a new understanding of body armor as observed through the lens of the fascial system; Gillian O’Shea Brown connects two modalities, IFS and EMDR, for
the treatment of C-PTSD; and Ila Anemone Zeeb explains how the concept of embodiment can support multicultural and social justice competency.

The Research section presents a study by Barbora Sedláková, Tomáš Dominík, and Marek Kolařík that examines the effects of process-oriented psychology in working with body symptoms. The section on Body Psychotherapy Around the World features Rubens Kignel, who traces the development of body psychotherapy in Brazil, and our editor-in-chief, Madlen, gives a personal account of her experience of the stunning creativity of our Brazilian colleagues. Madlen also offers a body contemplation extracted from her current book. Finally, in the Book Review section, Chris Walling and Aline LaPierre present an overview of two significant publications by seasoned and influential body psychotherapists Nick Totton and Kathrin Stauffer.

Cooperation and growth are the themes that flow through this issue’s articles – values the Journal has promoted throughout its 20 years of publication, values that give core meaning to our profession, and values this 21st century is in urgent need of because...we are all waves in the same ocean and leaves on the same tree!

Your Editorial Team,

[Signatures]
To celebrate our 20th anniversary, the editorial team wanted readers to meet the Journal’s two founding figures: USABP founding editor Dr. Jacqueline A. Carleton, and EABP founding managing editor Jill van der Aa, who both nurtured and guided the Journal’s evolution to its adulthood. We asked them about the source of their inspiration, and discovered two women bonded in mutual respect who, for years, worked together in joyful dedication. They were sustained by their profound belief in the importance of body psychotherapy and somatic psychology and encouraged by the creative discussions of a diverse field in quest of common ground.

“I’m thinking about Gandhi’s famous saying, something like: “There go my people, I must follow them.” You know, that’s the kind of leadership: leadership, but also not. That’s how a journal needs to be.”

Jacqueline A. Carleton

Antigone: We would like to know about the inspiration, the struggles, the good points, and the challenges you encountered during the Journal’s early years and maturing process.

Madlen: Jacqueline, what motivated you to start the Journal 20 years ago? What was your vision for its development?

Jacqueline: I thought that body psychotherapists needed to be more literate and connected, and this was of interest to me. So, I started a small USABP journal in the United States first. This was before Jill and I met at a conference and hatched the idea of an international journal.

Aline: Did you have any experience with publishing before you started the Journal?

Jacqueline: No! In fact, for the USABP, I volunteered to edit the journal, and Robyn Burns volunteered to be the managing editor and do everything I had no idea how to do. Basically, do all the publishing tasks I had no idea how to do.
Jill: The crazy thing is that before Jacque started, there had been a lot of back and forth between EABP and US-ABP members. Around 1997–98, the USABP was just starting, so EABP was offering them a lot of support. There were discussions, between Michael Heller and Christine Caldwell in particular, about starting an international journal. But the USABP didn’t have any money then, and in 1999 the EABP lost a lot of money because of its Congress, so plans were shelved for years. Then, quietly, Jacque started the USABP Journal.

Jacqueline: I remember now, I was on the Board of Directors of the USABP. I forgot about that, and that was sort of my little job on the Board. I was trying to do something with publication.

Madlen: [Ironically] Yes... very little job! What was the state of body psychotherapy and somatic psychology when you started to publish the USABP Journal 20 years ago?

Jacqueline: Initially, there was some difficulty between the Europeans and Americans about the name. For Americans, to call something body psychotherapy sounded like, I don’t know, gym classes or something. I kept trying to call it somatic psychotherapy. I wanted to use the term somatic, not body. But somatic work was very new. Obviously, Reich was here, but in the larger frame, the field was established in Europe earlier than here in the US.

Jill: Yes, the roots go a long way back, don’t they? Look at all those wonderful articles in the Handbook of Body Psychotherapy and Somatic Psychology, this great handbook that Gustl Marlock and Halko Weiss edited with Courtenay Young and Michael Soth’s help. It has several excellent diagrams showing the roots of body psychotherapy going back to the previous century and even further back. That book brought the field together a bit, didn’t it? You had done a lot of that with the Journal, and then the Handbook came.

Jacqueline: It would never have happened without the Europeans. In fact, it’s part of why I loved working with the Europeans. The Americans were not as interested in the intellectual and wider frame of it. I hope they are more on board now, and looking at the contributors published in the Journal now, they are. But at that time, people weren’t interested.

Jill: The exciting thing about Europe is the different languages, the different cultures, the different modalities and backgrounds. Over the years, there have been lots of discussions and arguments because of these differences. I’ve always thought that Europeans are not as academic perhaps, or not as strict in their thinking, as Americans.

Jacqueline: Jill and I thought the opposite! Europeans have a broader ranging intellectual focus which is a positive in my book. So, I don’t see it the same way.

Jill: Something about diversity... before the Journal started there were two other modality journals. There was the Biosynthesis Journal, and the Bioenergetics Journal. They had been around for quite some years and doing well. But our idea for the EABP and IBPJ was to incorporate all the modalities, to create a place for everybody to have a voice. This is what it has become! A diverse platform that brings everyone together. We talked about finding common ground, and that’s what it was for many years: trying to find a place where people would agree with each other, and then, when they didn’t agree with each other...

Jacqueline: When they didn’t agree with each other, which is good...

Jill: ...there was argument and discussion.

Jacqueline: It was terrific! I don’t think we ever felt that we all had to agree. Our focus was to have diversity, and to let all speakers be heard. At least that was always mine as editor.

Aline: I’m curious what these first discussions or first frictions were about. What were the voices trying to find common ground, and what were the difficulties in coming to some common ground?

Jill: In content or in direction?

Aline: In content and in direction.

Madlen: Do you remember the titles of the first articles?

Jill: I know you concentrated on three very important people at some stage, didn’t you Jacque? Stanley Keleman in 2007, Charlotte Selver in 2004, and David Boadella in 2006. These issues are in the Archive on the website.

Jacqueline: Yes, at various times, I published issues that focused on important leaders in the field.

Antigone: How was it for you to work alone at the beginning? Was it easy? What inspired you to go on despite the frictions and everything?

Jacqueline: I really never felt I worked alone. When I was at the USABP Journal, I worked with Robyn Burns. Then, I was beyond delighted when Jill and I got together to do the EABP Journal. I felt that with Jill, I had a real equal, a colleague, and I was always delighted to rely on her judgment. It was a delicious cooperation. I don’t think I did it alone at all.

Jill: I’m not an academic. I’m just somebody who puts on the gumboots, and it was a real privilege to work with Jacqui, who seemed to know all that was happening in the field. She was able to look at different aspects of the field and think: “Oh! This is what we need to present now.” It was a privilege to work with Jacqui.

Jacqueline: Well, who you were, and the fact that you were that way, gave me more license to look around and think. I would dream: “We could...”, this kind of thing. And then Jill would bring it all together. It was honestly an incredible professional collaboration all those years.
Jill: The important thing is that we loved it! We were enthusiastic and we loved it, and I sense something of this with this new team. We missed the collaboration when Assaf’s team worked in isolation. They were good, but they worked in isolation and then felt thoroughly overworked, so they handed it back.

Then Madlen, we approached you. I still remember the first phone conversation Lady and I had with you and Virginia in Bulgaria. I had never heard of any body psychotherapists from Bulgaria, and here were these wonderful women. I was so inspired! I was never disappointed. Years later, you seemed to be that perfect, enthusiastic person who just might take the Journal on. And you did.

Madlen: Yes, I remember it was very emotional for me. And do you remember Jacqueline, when I was in New York four or five years ago? I was giving a lecture at a university, and I invited you. Unfortunately, you were busy. It was unthinkable then that two years later, I would be editor-in-chief of the same Journal. For me, your name was: “Ah! Jacqueline Carleton, the editor-in-chief of the Journal and its beginning founder.”

Jacqueline: Wonderful! I’ll take it! Thank you for sharing that! That’s so sweet!

Madlen: Yes! It was an honor.

Jill: Madlen, you have such a team in Bulgaria. It doesn’t seem like you are alone, you have a group of people. Christina, you are one of them...

Christina: Yes, I’m one of them.

Madlen: Anton Darakchiev, Meglena Beneva, and Alexandra Algafari are also part of our team.

Jill: Wonderful! When you came in, Aline, here was once again the EABP and the USABP working together. We have been longing for that, because after Jacque left, we lost the collaboration. Then you came. Jacque had always said: “Aline. Get her, find her, yes.”

Aline: I remember when the Journal started. I was a fledgling therapist studying at Pacifica Graduate Institute in Santa Barbara. I remember the first USABP Congress and the new journal and hearing the terms somatic psychotherapy for the first time. I had a rush realizing that what I did had a name! It’s hard to remember that there was a time, at least here in the U.S., when this work had no name.

Jacqueline: Certainly not any name that was respectable.

Aline: Right. The thrill was that I could have a professional identity, because I didn’t feel I had an identity in traditional psychotherapy nor in the world of bodywork. You were instrumental Jacque, in the sense of naming so that we could have an identity, in that sense of being a mother.

Jacqueline: That had been my struggle too! I was into psychoanalytic and intellectual stuff, but then, for God’s sake, I was going to Reichian therapy! What kind of weirdness was that? I hid it. In fact, to get into the program I was in at Columbia Medical School, I hid the fact that my psychotherapist was Reichian. You know... that would have been intellectual suicide.

Aline: It took courage to initiate – to be part of a team that brings something into being. Of course, there was Reichian therapy, but it felt, I don’t know, like it wasn’t us.

Jacqueline: It was stultifying, ultimately. Yes, it went somewhere else.

Madlen: From these last two years, I see how many absolutely new ways I have learned. What did working for the Journal give you? What did you learn?

Jacqueline: Oh my God! I would hardly know where to start. Actually, it was eye-opening, because I had the privilege of corresponding and interacting with all the various Journal contributors. I also had a place at conferences, which gave me an immediate entrée to all sorts of people. In addition, of course, to the working relationship with Jill, this was incredibly enlightening and delicious. It was just beyond wonderful.

Antigone: Jill, how was this journey for you?

Jill: Antigone, first I have to say I was so grateful when after all these years, I could hand the Journal over to you as managing editor. I am very, very grateful that you took it up, that there was follow up, that you took it further.

What did it do for me? I came from a very mental family, and I always felt a bit lost. I couldn’t ever find my way. So, I got into theater and then into personal growth. Looking and looking to find some place. When I found body psychotherapy, and eventually the EABP, I found a home. I found a whole lot of absolutely crazy, highly intelligent, argumentative people who seemed to have something in common. The secret they had was that the body and the mind were a whole. We had something to say. This was a home for me. Anything I could do to be part of this home, and to participate in it, was pure joy.

We are on a journey and let me say something about that journey. We talked about common ground, that we were looking for common ground. Here in the EABP, there is a think tank, and they are going one step further searching for an overall theory that will include the different methods and approaches. This is a wonderful development and something where the Journal has a place. They are looking at discussions and subjects that could pull development further forward. That’s exactly what you are doing as well. You are contributing to the field by discovering what is exciting, where growth needs to happen, and also, what is lagging behind that needs attention. All this is bubbling! I’d be interested in how you see your role.

Madlen: We also found a home. We were lucky to find a home with a mother like you inside. Warm and wise.
Antigone: Jill, when I took over from you, even after a year of training with you, I asked myself: “What am I doing here? How am I going to step into your shoes?” All this work you have done. For me, as Madlen said, it was amazing to be in this family, but I didn’t know what to do in this family. Thanks to your training, I survived. Then, with Madlen and Aline, we became a great team, and when Christina stepped in, the team became complete. I hope we will continue what you have started. Sometimes I ask myself: “What am I doing here?” At other times I say: “Yes, we did it!”

Christina: I’m the newest member of the team, and I am very happy and thrilled to be part of it. I’m wondering what your inspiration for all the devoted work was during these years. What motivated you? Probably you had hard times as well. I can only imagine.

Jacqueline: The support and collegiality carried me forward more than any intellectual inspiration. It’s not like I had huge aspirations for myself. I had huge aspirations for body psychotherapy. Leaving the body out seems stupid. That’s important for us to be supporting. But it was the work and the contributors. I was always fascinated by the editorial interchanges with authors, and the variety of articles that came in. And the conferences, especially in my role as editor of the Journal, were always enlightening and sent me back with new inspiration. It was a wonderful, wonderful 20 years.

Aline: Do you miss being editor of the Journal? Or being more involved with the Journal?

Jacqueline: Honestly, not at all. I’m delighted to see what others are doing. In that sense, is there anything you would like to see in the Journal in the future?

Christina: In that sense, is there anything you would like to see in the Journal in the future?

Jacqueline: More of what you’re doing. I absolutely love it. I’m more excited to see: “Oh! what will you do next?” I’m totally into it. I don’t have any agenda.

Jill: I keep listening and looking at what’s happening in the field. Where are the exciting developments? You are leaders in the field, the Journal is a kind of a leader. It’s a follower in some ways, but it’s also a leader, because you are showing the creative aspects that a lot of us would not see otherwise. You’re bringing the field together. And along with the EABP think tank’s looking for a unified theory, this is highly important.

Jacqueline: As you speak, I’m thinking about Gandhi’s famous saying, something like: “There go my people, I must follow them.” You know, that’s the kind of leadership: leadership, but also not. That’s how a journal needs to be.

Aline: Madlen and I were looking at where article submissions are coming from. Here in the United States, many of the submissions are coming from graduating students who are adapting their dissertation research for publication. New directions are emerging from the creativity of these practitioners entering the field with their fresh ideas...

Madlen: …with such interesting topics, so different.

Jacqueline: I definitely enjoy supporting the academic programs here, supporting the students, and making a pipeline to the Journal and into the field.

Jill: Thankfully the European Training Institutes now require students to write a paper to graduate. This is happening here too. You are right, new directions are emerging here as well. It’s great to see what students are doing. In addition, Courtenay on the Science and Research Committee has been promoting the need for case studies.
Madlen: We have included a case study in each of the last four issues. The new rubrics are also very well-received. Not only the Case Study rubric, but also Body Psychotherapy Around the World and Professional Ethics.

Aline: Jill, you had mentioned previously that the current direction of the Journal is running between a scientific journal and a magazine. Antigone conducted a survey in the beginning to help shape our direction. Members wanted a sense of dropping into what their community is up to, and not just an immersion into science. So, we’re trying to ride an edge that brings both together. We hope that practitioners who are turned off by research and hard science can get introduced to it, and practitioners who love science can drop into the more human, relational, emotional part of our community.

Jacqueline: That would be superb! Beautiful mix!

Antigone: Our goal is to make the Journal the voice of body psychotherapy. We want to reach this diversity, and have people feel that there is something for them in our Journal. As Aline said, both academic articles and not so academic ones.

Madlen: We are still attentive to the quality of every article.

Jill: It’s important to keep the quality of the writing up, and you are doing that. It requires a slightly upbeat content. Yes! It’s a great job.

Aline: Many submissions come from authors whose first language is not English and therefore are hard to understand. We’ve discussed how to keep the essence of their writing while increasing the ease of reading. We believe the level of writing should be high, honoring of the authors, yet easy to understand. In such cases, we are stepping in with heavier editing to support non-English-speaking authors, so that their level of clarity matches that of English authors.

Jacqueline: That’s really important for the reputation of the Journal. For its acceptance.

Jill: You’ve done an excellent job on that. There are a couple of authors whose writing I knew before they came into your version of the Journal, and I realized you had done a lot of work to make them readable because they just weren’t readable.

Aline: Exactly. We cannot maintain a professional standard if there are articles in the Journal that are not readable because sentences are literal translations that makes no sense in English. Readers move on without getting the benefit of that author’s contribution.

Jacqueline: Or they make a judgment: “It’s illiterate.” This is quite problematic for the whole field of body psychotherapy in general: “Body? They must not have minds…”

That’s been a mission of mine in New York. I’ve often given presentations at psychoanalytic institutes and other organizations that don’t incorporate the body in psychotherapy at all. I’ve tried to open that up a bit over the years, not recently, but in the past.

Madlen: My impression is that the other schools, other modalities, step-by-step are speaking more and more about the body. I see many of our colleagues from the other psychotherapeutic modalities here interested in reading the Journal.

Jacqueline: The flowering of neuroscience has made a huge difference. It opened huge doors.

Aline: It did. It struck home strongly some years ago, when I was attending Allan Schore’s study groups and he said something to the effect of: “We now have this beautiful neuroscience, but we don’t yet know how to apply it clinically.” I sat there as a somatic practitioner thinking: “But we do know what to do clinically. Come and hear what we have to say.” That is when I realized that as a field, we have to step up and show what we know.

Jacqueline: In their language...

Aline: They didn’t know to come and listen to us back then. We had no research.

Jacqueline: I totally agree. You and I were clearly in the same position. And absolutely, we had to modify, make articulate, and translate so that the larger field could understand what we were about, and realize how important it is. It is so important, Aline.

Aline: I don’t know if body psychotherapy was as marginalized in Europe as it was here.

Madlen: Yes, yes; it was the same.

Jill: It was at the beginning. Looking back at the history of EABP, the first board believed that they had to keep in contact with all the European psychotherapists, because otherwise body psychotherapy would be marginalized.

So, they worked very hard, and are still working hard, to make sure that we are not marginalized, and you said it so clearly, to bring the body back into the dialogue.

Madlen: Here, during our last national conference where all the schools participated, the biggest surprise for us on the first day, before the lectures, before the workshops, was to see the colleagues from the psychoanalytic school open with: “First, we need to start by warming our bodies.” It was a very big surprise for us!

Jacqueline and Jill, what do you think about the future of body psychotherapy?

* When an article is available in an author's native language, it is published on the IBPJ website in its original language.
Jill: Joop Valstar was a mentor for me. At some point, he said: “You know, we’re working very hard now, but maybe we won’t even exist in a few years. Maybe everyone will have taken everything we know into their own fields, and we’ll die out.” That’s always stayed on my mind. Are we going to survive?

As we talk today, I have this feeling that of course we are going to survive! We are strong, we are stable now. We have our feet on the ground. The EABP is 30 years along the road. The IBPJ is 20 years along the road. The USABP is also 20 years along the road. We are here now. I think the future is to keep on going and keep working. As I always say, put on your gumboots and get stuck in.

Jacqueline: Another way of thinking of success would be for us to simply be folded into the larger space. I’m not so sure that’s a bad idea, but I understand.

Jill: I fully agree with you actually, but it’s nice to exist.

Jacqueline: It can’t happen right away, so we might as well exist!

Jill: Well, from the two old moms to the four new moms: Good luck! We have become the grandmams now and you are the moms!

Antigone: Thank you very much for being with us today.

Jill: Thank you from us also. It’s been wonderful to feel your enthusiasm and your expertise going forward. Impressive.

Madlen: We’re grateful, and a big, big hug. Warm hug. Virtual.
Neuroscience has revolutionized our knowledge and we can say that the official validation of body psychotherapy has come precisely from neuroscience.
ABSTRACT

Body psychotherapy is almost 100 years old, and extensive research and a wide-ranging variety of clinical practices have supported its development. What are the common points between its different orientations? What are the recent scientific discoveries that validate its clinical experience? What are the new clinical practices? The author gives an initial overview of these important questions.

Keywords: body psychotherapy, functionalism, holism, integration, neurosience, mindfulness

The Beginning of Body Psychotherapy

Until a few decades ago, talking about body psychotherapy was almost heresy. For years, the descendants of Wilhelm Reich were treated kind of like sorcerers who did strange things with the body – half shamans and half practitioners. The image of official psychology was anchored to classical psychoanalysis: to the couch, to dreams, to interpretations.

Gradually, things have changed, and today there is an increasing interest in body psychotherapy. Above all, there are now very few models of psychotherapy that do not try to include the body in their practices of introspection and in their analytic paths.

Why is the body so important in the connection to our interiority?

By no means trivial, this question, which goes beyond the realm of body psychotherapy, has elicited hundreds of answers. It was first asked thousands of years ago all over the Earth as humans began to explore their interiority, when this line of inquiry was still the domain of religion and philosophy. Those who searched within themselves invariably met the body. Asian cultures aside, at the dawn of our Western civilization, the ancient Latins wrote: “Mens sana in corpore sano,” declaring that a healthy psyche cannot exist without a healthy body.

Wilhelm Reich, founder of modern body psychotherapy, did not discover anything new, but his merit was in connecting the ancient body-centered traditions with the nascent modern psychology emerging in the work of Freud and his successors.

As body psychotherapists, how do we answer the question: Why the body? We are embodied, because our aliveness cannot be ignored even as we strenuously attempt to deny it. Our material, corporal dimension somehow gives consistency to something that otherwise would be impalpable, inconsistent: our life. For this reason, I am convinced that sooner or later, modern psychology could not have continued to ignore the dimension of the body.
Reich postulated a fundamental concept: that functionalism – or functional unity – is the inextricable interrelation between mind and body. He understood this concept not as a connection between the two, not that what we feel and think has an impact on the body, or vice-versa. For example, if I am sad, my body will probably get sick, or, on the contrary, if I spend a lovely day in the mountains, I will feel more cheerful and relaxed psychologically. No, even the most orthodox doctors now agree. Reich meant something deeper – namely that the mind, the psyche is matter, that the body is made up of impulses, also of nervous impulses. In summary, Reich meant that body and mind are the same thing, they are one.

The concept of functionalism has been refined, and has currently evolved into two main lines of thinking:

1. The systemic approach as expression of complex thinking, a deeply psychosomatic understanding in which body, emotions, mind, and spirit are different experiences of our oneness. This is very different from the holistic New Age concept that everything is indiscriminately “one.”
2. An integrated approach that attempts to combine the different aspects of body and mind.

The systemic approach is unitary and intrinsic to the body psychotherapy tradition. The integrated approach is clearly used by the models of psychotherapy that do not have the investigation of the body in their theoretical tradition. They therefore try to integrate it into their already consolidated psychic knowledge.

After all, Reich, who was first a psychoanalyst and one of Freud’s best students and collaborators, began his work by attempting to integrate the body into psychoanalytic knowledge and practice. However, this path led him to thinking that in reality the human being is, on one side, a vibrant nucleus of energy with a center – a core – that constitutes the soul, the spiritual or energetic part, or the bodily self. On the other side, the human being is also a corporeal periphery that interacts with the world. All the components – matter, energy, vital impulses, emotions, thoughts – are included in this vibration of the being. The more the self is connected with the periphery in a continuous energetic exchange, the more the human being is vital and “healthy.”

**Different Orientations**

The history of body psychotherapy, almost 100 years of research and clinical activity, can be read in the light of these concepts, in their assimilation and evolution. In the field of body psychotherapy, recent decades have seen the great development of a multitude of approaches, schools, and specializations, often with little exchange between them. I would like to mention some of the major approaches: Lowen’s Biodynamics, Pierrakos’ Core Energetics, Boyesen’s Biodynamics, Liss’ Biosystemsics, Boadella’s Biosynthesis, Rispoli’s Functionalism, Kurtz’s Hakomi, Downing’s Development and Interaction, Navarro and Ferri’s Character Analytic Vegetotherapy.

Each of these schools developed its own epistemology, emphasizing some aspects of clinical intervention and research such as character structures, contact, energy flow, and a transpersonal paradigm. We might then ask ourselves what unites these sometimes radically different schools? Is there still a common denominator in body psychotherapy that is not a superficial attempt to include the body, as is now the trend?

Yes, there is if we consider that the common underlying ground must always be anchored in the original Reichian concept of functionalism.

**The New Factors**

Recent years have seen interesting new developments that have revolutionized our research and clinical practices. I refer to two great factors: the discoveries of neuroscience and the inclusion of meditation practices.

Neuroscience has revolutionized our knowledge and we can say that the official validation of body psychotherapy has come precisely from neuroscience. The main clinical discoveries of body psychotherapy have in fact been scientifically proven by neuroscience. It is of great satisfaction for us to observe that what we know from decades of clinical observation, of empirical working with our patients, I would say most humbly, today rise to the fore through the neuroscientific observations.

Damasio “discovered” that the primary self is “corporeal.” Panksepp highlighted the importance of emotional circuits in constitution our emotionality. He showed that our primary core identity does not reside in the most evolved mind, in the neocortex, but in the depths of the reptilian brain, which is instinctive, primitive, and preverbal. Porges demonstrated the functioning of the neuro–vegetative system and the alternating vagal and sympathetic systems. In this regard, we recall how Reich initiated a clinical practice he called vege-to-therapy, which was based precisely on the responses of the neuro–vegetative system.
And what about neuropsychoanalysis? Schore brought to light that the child’s mental development is bodily, that the development of the two cerebral hemispheres are structured through the primary attachment relationship with the mother.

All these discoveries, part of science’s ongoing evolution, allow us to be more precise in our clinical work. We better understand, not only how we can use bodily activation to trigger emotions and memories, but also what areas of the brain and nervous system we are activating, and which hormonal and neurotransmitter responses are being stimulated.

And now, we come to the second development of recent years which widens the spectrum covered by body psychotherapy from the physical, emotional, mental, and existential to include the transpersonal or spiritual components of our interiority. We can summarize this as an opening to include meditation practice in our clinical work, so that meditation becomes a tool for knowledge and personal healing. The hypothesis is that the human being has subtle components that ancient traditions have cultivated, such as spirituality and religiosity – components made of silence, self-observation, openness to the universe, and transcendence of the ego. More generally, we speak of our relationship with the “sacred” as a spiritual dimension existing first of all within us.

Thus, according to the canons of psychotherapy, after having worked so hard to find, unify, and strengthen the ego, the path of knowledge and inner evolution comes to a point where this ego is finally transcended to make room for a new level of consciousness – to merge with the whole universe. Here too, nothing is really new. At the end of his career, which was unfortunately cut short soon, Reich had written about the possibility of letting go of the moorings of one’s beliefs and personal identifications to arrive at total contact with the sea of orgone energy of which the entire universe is made, and in which we are constantly immersed.

Then and Now

So, what is the difference between then and now? Perhaps it is that mindfulness has allowed present-day Western culture to discover meditation, and readily integrate it into many psychotherapeutic approaches. But it is only with body psychotherapy that the evolution of the individual is fully seen within the whole spectrum of the living – from the physical to the spiritual, in a unity that is functional. At advanced levels of inner knowledge, as the subtle planes reverberate on the physical–bodily level, it is somehow possible to spiritualize matter. This might sound like science fiction, but we can learn to perceive a fully embodied level of consciousness.

Reich’s final books tell us about this possibility: that energy is simultaneously matter and consciousness, that the union with the universal orgone energy allows us to make our matter, our body, aware. This continues to be difficult to understand and experience and it is perhaps for this reason that Reich’s final writings are still so difficult to understand – even today, almost a century after his life. But in this oneness of matter, energy, and consciousness lies our unification as body psychotherapists, of our spirituality, and of its contemporary secular version represented by mindfulness.

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ABSTRACT

Reflections on concepts of energy and their scientific application, followed by examinations of the literature regarding energy, first from a historical perspective and then from a Reichian viewpoint, are discussed by the authors. Next, the negentropic–systemic code will be presented, which can be used to appropriately interpret the concept of energy in contemporary Reichian analysis and in the context of its dialogues with both complexity and neuroscience.

Keywords: energy, complex living systems, negentropy, the arrow of time and psychotherapy, orgone, Reichian analysis

Due to the fact that today's school of Reichian analysis is based on a concept of energy found in the interpretation of the negentropic–systemic code (see below), we would pose a question: Is there room for a concept of energy in the framework of psychiatry, psychopathology, and psychotherapy, which are currently dominated by a growing operationalization of its fundamental concepts?

What is the definition of “energy”? This term often raises doubts and suspicion, especially when used in the context of “healing traditions” such as psychiatry, psychopathology, and psychotherapy. Therefore, can a satisfactory, scientific definition exist for energy?

In our discussion, “psychiatry” should be understood in its original meaning of “healing the psyche,” apart from its medical and biological associations. Using instead an earlier definition, it refers to the complex world involved in the study of illnesses afflicting the human spirit and their remedies – the world of the psy[1]. Psychiatry “does not belong to the true sciences, but rather represents a set of doctrines and practices which are not without scientific elements” (Gozzetti, 2008, p. 7).

Being a psychiatrist means working with something that really does not sit completely comfortably with any medical model; there is no doubt about this. But that does not mean that it can be labeled as unscientific, which would risk evoking the hieratic, priestly, or even shamanic parts that live within us, and that are seen in certain forms of behavior, ritual, and use of the spoken word to facilitate healing.

It is no wonder, therefore, that forms of energy have always been greeted with an air of suspicion, especially whenever they have

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1. The contemporary model of Reichian analysis is characterized by the passage from an exclusively energetic drive concept to a relational concept, and by the transformation of the setting to become a complex systemic setting – from a clinical point of view, the decisive repositioning of therapeutic practice with the methodology of analytical–character vegetotherapy, as recovered and systematized by Ola Raknes and Federico Navarro, and later developed by Genovino Ferri.

2. Negentropy refers to the evolutionary organization of living organisms as ordered and dissipative structures.

3. The statement refers to the psy-world, which is composed of psychiatry, psychology, and psychotherapy.
been introduced to the world of psychiatry. However, forms of energy really do need to be part of the conver- sation. There is indeed no all-embracing definition of energy. Energy is not something tangible and material that can be directly observed, but is, rather, defined by what it does, or could do, in its various forms.

As the dictionary states, energy is the capacity that a body or a system of bodies has to do work. Energy can be possessed by a body or released from it in various ways. Through movement, it is expressed as kinetic energy; from position, as potential energy; through temperature variation, as internal or thermal energy; in chemical reactions, as chemical energy; in an electrical current, as electrical energy; and so forth (Treccani Online Encyclopedia, 2020). Thus, we define energy by the form in which it manifests.

**Brief History**

In the realms of medical science, concepts of energy have appeared ever since Hippocrates’ *vital force*, Stahl’s “De motu tonico vitali” on tonic motion, Caspar Friedrich Wolff’s ideas on epigenetics, which traced the birth of every body back “to the life forces inherent to a primary substance without definite form” (Zilboorg, 1963, p. 222); Barthez’s *principe vital* (life principle), and vitalism, according to which the vital force is responsible for all the functions of the organism; Boissier de Sauvages, who held that “the power of the life force expressed itself, in the Self, as consciousness, and, in connection with the sense organs, as movement” (Zilboorg, 1963, p. 249), and then Reil, who gave his name to an area of the brain (island of Reil), and founded *Archiv für die Physiologie* in 1796, with an article on *Lebenskraft* (life force) in the inaugural issue.

The concept of life force had a significant impact on the whole field of psychiatry. “For the first time in the history of medicine, a doctor who did not wish to leave mental illness in the hands of the theologians was suggesting a new type of information. He was suggesting a new biological factor, because it was, indeed, biological despite the fact that it could not be measured or taken by mouth. The concept of energy had not been developed at the time of Stahl and doctors had to wait until science had advanced sufficiently” (Zilboorg, 1963, p. 452).

More recently, when psychiatry started to take on more precise connotations, Beard interpreted neurasthenia as a state of functional exhaustion of specific nervous ener- gies, and numerous models of the psyche began to take shape. These models were based on the isomorphism of physical and mental energy, which were largely derived from the positivism in fashion at the end of the 19th century, for which behavior was influenced by endogenous energy. The models were expressed in language and vocabulary derived from the terminology of physics.

Helmholtz influenced Freud’s energetic model: “the only active forces in biological organisms could be re- duced to physical–chemical forces inherent to matter and to forces of attraction and repulsion” (Freedman, A. M. *et al.*, 1980, p. 104).

Living organisms were considered as aggregates of atoms “governed by physical forces according to the principle of conservation of energy” (Freedman, A. M. *et al.*, 1980, ibid.) Additionally, European research in neurophysiology was dominated, as emphasized by Freed- man and Kaplan, by the triumvirate of Brucke, Exner, and Meynert, whose beliefs included the idea that “the nervous system operates through the transmission of a variable quantity of energy from the afferent nerv- ous terminals to the efferent nervous terminals. Brucke considered this nervous impulse to be electrical in nature and it was conceived in hydraulic terms as a sort of fluid transported in nervous fibers as if it were in a hollow tube” (Freedman, A. M. *et al.*, 1980, p. 106).

We underline the fact that an impression of Freud’s ideas on energy can be gathered from his *Project for a Scientific Psychology*. This work was redrafted after a two-year period of development from 1895 to 1897, and then abandoned in a drawer by the author, destined for destruction. However, it is not hard to see how the structure of *The Interpretation of Dreams* and *Beyond the Pleasure Principle* are closely derived from the concep- tual formulations in the abandoned work. Freudian energetics owed much to the nature of the problems pre- sented by the physics of the time.

The basic assumptions entailed the concepts of entropy and conservation,4 and the tendency, therefore, of the energetic content of systems to remain constant and homogenous. The psychological interpretation trans- lated to the principles of pleasure5 and of nirvana6.

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4. The first law of thermodynamics, also known as the Law of Conservation of Energy, states that energy cannot be created or destroyed in an isolated system. It can only change forms. The second law establishes the direction in which processes occur, from order to disorder. Clausius expressed this direction of the evolution of physical systems through a quantity called entropy, which will tend to increase over time in an isolated system. Since this evolution is accompanied by decreasing disorder, entropy is a measure of disorder.

5. Pleasure principle: the view that human beings are governed by the desire for gratification, or pleasure, and oriented towards the discharge of tension that builds up as pain or “non-pleasure” when gratification is lacking. In the classical psychoanalytic theory of Sigmund Freud, the pleasure principle is the psychic force that motivates people to seek immediate gratification of instinctual or libidinal impulses, such as sex, hunger, thirst, and elimination. It dominates the id and operates most strongly during childhood. Later, in adulthood, it is opposed by the reality principle of the ego. It is also called the pleasure–pain principle. APA dictionary of psychology online, 2020. Entry: pleasure principle.

6 Nirvana principle: in classical psychoanalytic theory, the tendency of all instincts and life processes to remove tension and seek the stability and equilibrium of the inorganic state – that is, death. This is the trend of the death instinct, which Sigmund Freud believed to be universal. APA dic- tionary of psychology online, 2020. Entry: nirvana principle.
When used in medical contexts, the word energy still suffers from a lack of clarity. It is often used as an all-encompassing, multi-faceted term. This can obfuscate or dilute its meaning, sometimes conveying more extreme aspects such as material and non-material, corporeal and psychic. It is a concept capable of grasping its own disparate meanings until its fate is sealed by becoming an explanatory model. Neurophysiological contributions have led to the inclusion of information systems, and even within the world of psychoanalysis, the unconscious tends to lose its energetic dimension, thanks to Lacan, Bion, and Matte Blanco.

The term unconscious also becomes semantically corrupted, losing the more powerful sense that would have it in a “meta-position” that is “beyond”, and which should limit the simple, or simplistic, common usage into which it has slipped.

Energy itself is a slippery, protean concept, which should be handled with great care as it can easily be misunderstood while trying too hard to follow its various manifestations. On the contrary, it inhabits the realm of complexity, and its heuristic potential can be fully revealed only from that perspective.

Whether it is an informational concept, which itself hints at a modernist reflex, or a vector space, both are far from resolving psychiatry’s fundamental problem – the psyche–soma dichotomy.

**Reichian Analysis – A Brief History**

Reich, indebted to Bergson, recognized the problem: “I was instinctively aware of the validity of his efforts to reject both mechanistic materialism and finalism. It was impossible to deny the principle of a creative force that supported life.” Reichian vital energy was defined by Kammerer as being “a form of energy which is neither thermal or electric, neither magnetic or kinetic (as it is neither oscillatory or radioactive), nor is it a combination of any or all of these types of energy, but, rather, it is a type of energy which specifically characterizes the processes to which we give the name life” (Dadoun, R., p. 46).

*We shall pay our dues to Reich!*  

Dadoun asserts that “should you analyze the emotional life–experiences and the different means of expression of patients... should politics or anthropology be under consideration... should great natural phenomena, such as thunderstorms, hurricanes, or the aurora borealis, be examined from unheard of perspectives, it is the same primordial reality, the same specific vital energy – in a word, it is ‘bioenergy,’ that we see coming to greet us and functioning in the same shapes that isolate it, that historicize it and that naturalize it” (Dadoun, 1976, p. 47). “Bioenergy is therefore not,” in Dadoun’s words, “so much the name of a principle or a theory, and even less is it a philosophical vision, but rather it is the global designation of a unique field of investigation” (Dadoun, 1976, p. 47).

However, within our (the authors’) energetic concept, it has a different connotation – the condition of a human being as a nucleus of focused cosmic energy, which is not dissimilar to an elementary particle that “is only a small area of an electric field in which the intensity can reach particularly high values, indicating that an enormous part of the energy is concentrated in a small space” (Weyl, 1949, as cited in Capra, 1982, p. 246). Human beings, as nodes of energy, do not appear to be clearly distinct from the field in which they are immersed. Elementary particles move through empty, space–like waves on the surface of a lake, and the move–
ment of the plasmatic energetic current of the organism, which participates in the pulsation of the universe, is similarly undulatory. It is important to bear in mind the concept of equivalence between energy and matter, which in reality is no more than a metaphor for the dynamic situation of living energy.

In the context of energy medicine, this is usually described, in whichever tradition is chosen for reference, in terms of “flux models,” which foresees a continuous energetic exchange between the individual and the environment. Our model, however, foresees the presence of a field together with the concept of energy and flux, as we have already mentioned. The organism is, indeed, a flow of energy immersed in a great flow of energy, the field.

We can speak of the field each time we encounter the space of an “object” that has been conditioned so that another “object” experiences its forces. There is an example of this in ethology—the attachment and, naturally, the bonds that are formed between mother and fetus and newborn baby, and then in the family and society. A further example is “Frärec-Gefühl,” which is our perception of feelings of schizophrenia, which is the desolate sense of emptiness that comes from psychosis. You grasp it, as Minkowski says, in the immediate intelligibility of the feeling as the breath of life that has escaped from it. In other words, our energy field interacts with the schizophrenic emptiness, which it simultaneously perceives.

We are dealing with a concept of energy/field taking a qualitative step forward compared to the models we have examined. We are proposing a different vision, which is global and unlimited. The cultural background in which we are operating has profoundly changed. Contemporary physics, for example, is prepared to investigate the real possibility of creating matter from the energetic fluctuations of a vacuum, which would have been an impossible idea in the cultural scenario in which Reich operated.

It is difficult for us to imagine what is moving around us. Our senses are not capable of conveying the greatness and richness of life that is all around us. “It is possible that we are living our lives in a dimension that is remarkably larger than we suspect” (De Finetti, 1984, p. 45).

An energetic concept of existence must speak a language that agrees with a systemic approach to reality and uses descriptions of dynamic models of life that go beyond Cartesian reductionism to reach out towards wider horizons. Bioenergy is the vital energy that underpins biophysical processes and the expression of the organism’s emotions; it is the unifying element of the psyche–soma dichotomy.

Let us clarify.

The gene of complexity existed in Wilhelm Reich, and it is natural that we, as representatives of this specific genealogical branch, are open to this evolutionary development.

“... We feel today that we are at the end of the period that started with Galileo, Copernicus and Newton and culminated in the discovery of quantum mechanics and relativity…” (Prygogine in Tiezzi, 1996, p. 1).

“... Classical science emphasized stability, order and balance. Today we are discovering instability and fluctuation everywhere and, instead of dealing with certainties, we are dealing with possibilities…” (Prygogine in Tiezzi, 1996, p. 1).

“... On every level we see nature emerging from narrative elements – cosmological history includes the history of matter, the history of life, of human beings and so on, right through to our own personal histories, associated with our own consciousness…” (Prygogine in Tiezzi, 1996, p. 1).

“...On every level novel occurrences associated with the creative potential of nature can be seen to emerge…” (Prygogine in Tiezzi, 1996, p. 1).

It is easy to associate with the Reichian vital energy. In the last few decades, a new type of language has appeared that is suited to understanding highly integrated, complex living organisms. Different scientists give it different names: dynamic systems theory, complexity theory, non-linear dynamics, or network dynamics.

Central nodes of the new paradigm become chaotic attractors, self-organization, fractals, structural coupling, dissipative structures, autopoietic networks, entropy, negentropy, information, bifurcation points, the arrow of time, and evolution.

A paradigm is “a variation in the visual gestalt,” as Kuhn would say — a variation in the mental architecture of observation that has emerged from a different way of feeling, we might add. It appears, on closer inspection, that the new language and new paradigm were already present in Reichian thought.

Ola Raknes, the only European teacher trained by Reich, was the teacher of Federico Navarro, our teacher, who affirms that “vital energy is negatively entropic, that is to say that the strongest concentrations attract more energy than the surrounding weaker concentrations. This negative entropy opposes mechanical entropy and is essential for the creation and maintenance of life. ... natural concentrations of orgone energy tend to form systems that develop, reach their peak and then decline until they have dissolved. Such systems may be galaxies, stars or planets and, in the Earth’s atmosphere, may be hurricanes and other cyclonic systems, as well as individual clouds; even living organisms are systems of orgonic energy.”

“... the free flow of orgone within living organisms is an indispensable condition for the healthy functioning of the organism” (the founding principle of open systems).

“... the orgonic metabolism of the organism also depends on the external orgonic field,” another founding principle of open systems (Raknes, 1967, p. 68–69).
Being interested in complexity certainly does not mean ignoring the necessity for mechanical laws that function in their sphere of well-defined intervals in the reality of life and must, at least, serve as operating concepts.

We will again pay our dues to Wilhelm Reich!

With regard to functional thought, Reich affirmed that “...functional thought does not tolerate any static condition. As far as it is concerned, all-natural processes are in motion, even in the case of rigidified structures and still forms... Even nature flows in each of its various individual functions as it does in its totality... Nature is functional in all of its areas, not only in those regarding organic matter. Obviously, there are mechanical laws, but the mechanics of nature is, in itself, a particular variation of functional processes” (Capra, 1984, p. 286).

Nor, on the other hand, can the functional nature of vital processes be completely separate from a vision we define as systemic: “Reich’s approach, which he called organismic functionalism, is in perfect agreement with the idea of processes as defined by modern systems theory” (Capra, 1984, p. 286).

The “all-integrated,” which our I-environment-life represents, cannot be restricted to the separate existence of the single parts of which, for the record, the system is formed. These parts are not living their own separate autonomous lives but are totally interdependent.

According to Koestler, in the scope of each system two opposite tendencies exist: one “integrative” in nature, which guarantees its function as a part of the whole, and the other, which is “auto-assertive,” which tends to preserve individual autonomy. A balanced system must necessarily oscillate between integration and self-assertion, reaching equilibriums that cannot be static, but can be identified in the connection between the opposite, yet complementary, orientations of which they are composed. In this way, the system becomes ductile, elastic, and open to change and development. All of nature is organized through pluristratified structures that are not simply “overlaid layers” – the parts are connected, and the functionality of the whole depends upon the functionality of the interconnected parts, or, in other words, of the subsystems that it is composed of. In no case can its properties be reduced exclusively to those of only one of its parts (Capra, 1984, p. 39). Such systems are more functional than rigid or rigidly hierarchical systems, and they have a greater probability of survival.

Thus, we have said that “were Reich’s theory to be reformulated using modern system language, his relevance for research and for contemporary therapeutic practice would become even clearer” (Capra, 1984, p. 286).

Contemporary Reichian Analysis and Its Position On Energy – the Negentropic-Systemic Code

Before the 1940s, the term “system” – meaning that the whole is greater than the sum of the parts – had been used by many scientists, but it was the concepts of open systems, and the theory of von Bertalanffy that consecrated “systemic thought” as an important scientific movement.

He focused attention on the dilemma that had disconcerted scientists since the 19th century, when Newtonian mechanics, the science of eternal forces and trajectories, had been integrated by two diametrically opposed views of evolution. In other words, a new type of science was required – the science of complexity.

The first formulation of this new science was classical thermodynamics, with its second law: the law of dissipation of energy. This was first stated by Carnot, the French physicist, as physical phenomena tending to move from order towards disorder. Every closed or isolated physical system will proceed spontaneously towards ever greater disorder.

Entropy was introduced (from energy and τροπή, transformation). The ideas of irreversible processes and of an arrow of time, which we today define as entropic, were introduced by the thermodynamicists from the second law, and from the concept of entropy. This slightly terrifying picture of cosmic evolution was in sharp contrast with the evolutionary thought (Darwin) of 19th century biologists who had observed that the living universe evolves from disorder towards order, and towards states of increasing complexity.

Who was right, Carnot or Darwin? Bertalanffy was not able to resolve this dilemma, but he took a crucial step: “living organisms are open systems because they need to feed themselves with a continuous flow of matter and energy from their environment to remain alive” (Capra, 2001, p. 61).

It was not until the seventies that Ilya Prigogine re-examined the second law, using more recent developments in mathematics, and resolved the contradiction between the two 19th century visions of evolution. In reality, the contradiction is only apparent: “entropic balance must be global and must include both the organism (be that plant, animal or man himself) and the environment with which the organism is continuously exchanging energy and matter” (Tiezzi, p. 15). In other words, organisms can develop and die through the increase in the amount of entropy that they cause in the surrounding environment. The entropy of the universe has been increased, so the second principle has not been violated.

8. “I-environment-life” refers to the complexity of the biopsychosocial system.
As a city, or an organism, is an open system, it is fundamental to calculate its entropy and negentropy. In this way, it can be seen that any increase in negentropy is at the expense of external disorder, but that average disorder also increases.

We have again used the term negentropy; let us explain. Many take 1944 to be the starting date for biophysics. It was when Erwin Schrödinger, Nobel prize-winner for physics and founding father of quantum mechanics, published his Dublin lectures on biological problems in “What is life?”, where he introduced the concept of negentropy – a negative variation in entropy, starting from an original value (the birth of an individual, the origin of life, the beginning of biological evolution, or the origin of a relationship in the setting), and not of absolute negative entropy, given that, according to the third principle of thermodynamics, a value of entropy of less than zero cannot exist (Tiezzi, 1996, p. 16).

In Schrödinger’s assertion is the secret of the origin of life on earth, of the story of biological evolution, which has a protagonist, photosynthesis. It is the history of a special, intelligent planet that learned to capture the sun’s energy and feed itself on the negentropy of the universe so as to create ordered, dissipative structures that are living organisms. The biosphere is this negentropy’s geometric space (Tiezzi, 1996, p. 16).

Negentropy is held to be a negative variation in entropy towards ever greater order. It seems to us (Reichian analysts) that negentropy is something more than negative entropy, or should at least be interpreted differently, because the direction of the arrow of time reverses on this planet and in every living form. It is a bottom-up representation of the drive and the pulsation of life, and of the élan vital, in Bergson’s words, which emerges both phylogenetically and ontogenetically.

This leads to certain different analytical interpretations on evolutionary time, and on psychopathological nosography regarding appropriateness, and regarding the body being indispensable in psychotherapy. This is because relationships, from intrauterine time onwards, leave incised marks on the body (etymologically, “character” = incised mark), and the body then expresses these over the course of time, as relational patterns.
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Jungian Psychotherapy and the Body

Andrew J. Howe

ABSTRACT

The Body is subject to a paradox within Jungian psychotherapy. At times, it is described as an isolated system, with its drives, desires, and workings. At others, it is linked to the mind and viewed as part of the psyche. This alleged ambivalence percolated to the post-Jungians, resulting in the body receiving comparatively little interest in analytical psychology until recently. In a psychology that seeks to understand communications from the unconscious, dismissing the body is a missed opportunity. Jung did use the body and bodily expression in his academic and psychotherapeutic work. He did not write on the subject in depth, however. While his attitudes have a reputation for ambiguity, a consistent theory relating to the mind, body, and their heterogeneity can be discerned from his writings. In this review, this theory will be discussed, along with the Jungian and post-Jungian attitude towards the body. A Jungian contribution to the field of body psychotherapy has the potential to offer new insights, given the expansive subject matter in Jung’s collected works.

Keywords: Jung, Analytical Psychology, Mind–Body Problem, Body Psychotherapy

From his early work to later descriptions of movement as part of active imagination, the body has a specific place as a communicator of unconscious content in his work.
body, the body as a shadow, and working with the body in therapy. Situating Jungian concepts within the body is not of relevance to this review. Regarding each theme, Jung’s writing will initially be reviewed, followed by post-Jungian thought where applicable.

A Brief History of the Mind-Body Problem

The mind-body problem, concerning the nature of the relationship between the physical body and the experience of consciousness, has a long history. A brief description of this topic is of relevance, given the subject matter of this review. A paper by Kaylo (2003) details this history and begins in the medieval period, where he alleges the body and soul were inseparable. However, as the Enlightenment period started, the body’s separation from the soul began. Descartes applied mathematics to the body, giving mechanical explanations to biological processes while keeping the mind separate and elevated. This split was named Cartesian dualism, derived from the Descartes family name in Latin: Cartesius (Cunningham, 2014). In the Western world, dualism would be the accepted way the mind-body connection was explained until the 1900s.

Following Descartes, further studies of anatomy led to locating mental disturbance in the nervous system, and some, such as physician Thomas Willis, suggested that the soul could be situated in the body – in his case, the location being the arteries at the base of the brain that still bear his name today (O’Connor, 2003). This assertion notwithstanding, in general, the soul and consciousness became concentrated in the mind and wholly separate from the body. Mental illness became either a purely physical illness requiring medication, or a behavioral one requiring moral therapy. Moving into the Romantic era, Mesmer, who thought that a “subtle physical fluid” connected all matter, used this physical connection to enact treatment for mental disorders. Mesmer’s students and other academics attributed a more psychological (i.e., of the mind) explanation for his cures, and thereby set a precedent for a new psychological treatment of mental disorders. Mesmer’s induced trances contained the “unsolved problem of the relationship between psyche and soma,” according to the physician Charet. Mesmerism progressed into hypnotism, and brought us to the time of Charcot, Freud, and Jung at the turn of the 20th century.

A summary of the mind-body problem in the 1900s (Fodor, 1981) noted that dualism started to fall out of favor after further philosophical analysis of the mind-body problem. The main issue was with dualism’s failure to account for causation; i.e., how can the non-physical (mind) give rise to the physical (body)? It is suggested this would violate the physical laws of conservation of energy. As an alternative to this approach, John B. Watson suggested behavior of an organism is an observable response to stimuli. The non-physical mind was removed in this approach, which was termed radical behaviorism. There were difficulties with this approach, not least that it denied the existence of the mind. A subsequent alternative theory, the central state identity theory, equated mental states and events to neurophysiological processes. This brought the mind back into the discussion, but relied on its physical makeup. More recently, in the age of computer science, functionalism was postulated as a solution to the mind-body problem. Here parallels are drawn between the mind/body and software/hardware. In contrast to central state identity theory, the behavior of an individual does not depend on its physical (e.g., neurons) makeup, but rather on the way the physical attributes are organized. Multiple attempts to address the mind-body problem have still not resulted in anything conclusive. The more recent psychological theories have attempted to transgress the border of mind and body. However, it is also important to note the parallels between more modern discussions and the work of, for example, Thomas Willis, who suggested the mind had a physical location. This speaks to the timelessness of this discussion. Returning to Jung, he saw psychology as having something to offer in evolving the mind-body problem. He stated that a psychological explanation “forces us to go forward and overleap that seemingly impassable boundary” between the mind and body (Jung, 1975, para. 622). We will now consider Jung’s attempt to transcend this impassable boundary, which must also include an understanding of the body within his work.

Early Work

Early on in his life and work, Jung was aware of the body and its significance. We learn from Jung’s account of his early life in Memories, Dreams, Reflections (Jung, 1989) that he was aware of the importance of movement and being aware of bodily sensations. He describes, for example, hating being told how to move in gymnastics. He also details an experience of his heart pounding and diaphragm feeling as though it was made of iron, expanding into his chest. At the start of his professional life, Jung’s use of the body is noted in his investigation into unconscious motor phenomena while considering the work of mediums. An example he gives focuses on table-turning, but he remarks that unconscious motor phenomena are also frequently found in “hysterical persons” and that they indicate the presence of a subconscious “independent of the conscious self” (Jung, 1970). Jung also postulated that stereotypic movements of the body that occur in psychosis could have meaning, referring to one case that illustrated the body’s ability to communicate a patient’s history. In his example, he describes the movements of a patient that were similar to those made when making shoes. After this patient’s death, he spoke to a relative at the funeral, and discovered that she had become unwell after a romantic relationship broke down. The significant other in this relationship was a shoemaker (Jung, 1960). Other incorporations of
the body into Jung's work occur in his word association tests described in \textit{CW} 2 (Jung, 1973). These were used as experimental proof of unconscious complexes. The tests relied on recording bodily reactions and reaction times to a list of one hundred words put to the test subjects. He concluded that breathing, shown on a pneumograph, was a measure of consciousness, and not useful in discerning unconscious content. The electrical conductivity of the skin, however, measured by a galvanometer, was concluded to be connected to unconscious processes. Galvanometer readings, combined with reaction times, were shown to prove the existence of complexes defined as “the living units of the unconscious” (Jung, 1975, para. 210). In summary, the body in Jung's early work has the place of a communicator of unconscious content.

Body-Mind Heterogeneity

Jung's attitude towards the body in his writings was somewhat ambiguous (Saban, 2010). At times it seems he took an idealist position where the mind was more significant than the body; at others, he appeared influenced by Cartesian dualism and Kant. He also suggested an alternative viewpoint that saw the mind and body as poles on the same continuum. It is this viewpoint that was unique and had the potential to provide new insights into the mind-body problem that we will now discuss.

In describing Jung's alternative concept, the body must first be of equal importance compared to the mind. Within his Zarathustra lectures, Jung (1988) states that there can be “no meaning without the body.” He argues this because there can be no meaning without consciousness, and consciousness is a body phenomenon. This raising of the importance of the body leaves it on the same footing as the psyche. Supporting this, in \textit{Specific Problems of Psychotherapy} (1966), Jung states the body is required for the unconscious not to have a destructive effect on the ego. This is because the body “gives bounds to the personality.”

Further on in his seminars of Zarathustra (1988) Jung delineates the mind-body connection as one of interdependence. He alleges that the mind-body split is an artificial one made for easier understanding. He describes the mind and body as if they are on opposing poles of the same “living body,” in essence, part of a greater whole. The body is a physical or visible expression of the psyche, and the psyche is a psychological expression of the body. Essentially, they are “just the same.” Saban (2010) also notes this view in Jung's \textit{Tavistock} lectures, where he states “body and mind are the two aspects of the living being.” We learn from work by Brooke (1991) that Jung considered the idea of a separate body and mind a “most lamentable” situation in modern thought, reiterating the body and mind being part of a whole living body. Saban (2010) goes on to describe Jung's mind and body link as moving away from a post-Cartesian dualistic view, having more in common with “Eastern philosophies, astrology and alchemy.”

This polarity is also represented within one of Jung's definitions of an archetype, which he called the psychoid archetype. Fordham (1957) eloquently summarizes Jung's definition as an archetype with two poles, one of instincts and drives (i.e., the physical body) and the other consisting of fantasy (i.e., the mind). Within the psychoid archetype, the mind and body are not split and can interrelate (Durchslag, 2016). An analogy for this would be a spectrum with a psyche ultraviolet pole and an instinctive, corporeal infrared pole (Saban, 2010).

While Jung sees the body and mind on equal footing, he does not necessarily denote them as primordial structures. Saban (2010) quotes Jung, suggesting that the self is ontologically prior to and more fundamental than the body and mind. The self gives rise to both body and mind. As evidence for this, Jung states that an injured body does not heal itself, but that it is “some vital principle” that does so. The body must have something that supplies it with this vital principle, i.e., the self. It is in this account that Jung leans towards idealism.

We are left with the mind and body being “heterogeneous, overlapping fields of the self”. This counter-contemporary view has the potential to allow for new ways of thinking about the mind and body. However, this view was not consistently held by Jung in his work. As mentioned, he also describes a more classical and Cartesian dualistic mind and body split. This is noted by both Saban and Brooke (1991), who both express frustration at Jung's failure to articulate his mind-body heterogeneity further. Saban puts this down to Jung's wish to elevate the psyche, thereby elevating psychology, and Jung's reading of Kant.

Furthermore, Jung seemed to have a fear of falling into reductionism in bringing the body on equal footing with the mind. This may have been influenced by his reading of Nietzsche, who alludes to this. Jung was ambivalent to Nietzsche throughout his writings for reasons that could have included his fear of becoming mentally unwell as Nietzsche did. To quote Saban, it was “regrettable” Jung could not read Nietzsche as an ally. Brooke (1991) felt poor clarity, combined with Jung's presumed wish to steer his theory away from a more bodily-based (i.e., sexual) psychoanalysis, prevented the body from being a significant part of analytical psychology in the novel way described above. This lack of clarity on Jung's thought would also make the body a difficult subject to take up in the post-Jungian world, which has mostly been the case.

Perhaps contrary to some writers, I believe Jung's heterogenous approach to mind and the mind-body problem is clearly defined by him. It is that mind and body are on opposite ends of the same pole, akin to infrared and ultraviolet light. The mind is the body, and the body is the mind. However, it is Jung's consistency in using this model that is lacking, and it is here that frustrations arise. I would agree with Saban that the idea of the self being primordial to the living body suggests an idealist...
standpoint. I would suggest this also shows parallels with gnosticism, in which Jung was greatly interested (Hoeller, 2002). It also appears that Jung would, at times, take a dualistic view. The reasons for this deviation from what seems to be his central understanding appear to be personal, as opposed to the actual development of a theory. I do not feel the discussion of the theory in itself has progressed in the post-Jungian world. Work has centered around attempting to define what Jung’s stance on the body was, and how it developed. This is understandable, given Jung’s changing opinion within his work. However, the papers discussed offer a comprehensive understanding of the different views expressed.

The Body as a Shadow

Work by Greene (2001) suggests Jung made an association between the body and the shadow, i.e., the “thing no one wishes to be” (Samuels et al., 1997, p. 138). He suggests that we do not look at the shadow side of ourselves, trying to cast it off completely. He states that this leaves us as “two-dimensional” beings, and with this loss of shadow, we also lose the body. This is because the body produces things we wish to ignore and cannot be spoken about, e.g., urine and other bodily fluids. He therefore describes the body like the shadow of the ego. While some physical aspects, such as sexual urges, are spoken about more in today’s society, Jung’s connection between shadow and body still has contemporary relevance. Sassenfeld (2008) moves one step further, suggesting that working with the body “is equivalent” to working with the shadow. He supports this absolute statement by discussing one of Jung’s definitions of the shadow as an autonomous phenomenon that is antagonistic to the unconscious, but also linked to the personal unconscious. I found that the direction of this particular argument is hard to follow, as there is no clear link given to the body in his explanation. Furthermore, his assertion is weakened by its all or nothing quality as it allows for no flexibility and accounting for the individuality that is a hallmark of Jungian analysis.

I feel the link between the body and the shadow is a useful one, and it elevates the body’s unconscious communications to the level of dreams and other processes. The reality of the body as a shadow falls short of Sassenfeld’s absolutist statement that the body is equivalent to the shadow, as this limits the possibilities of its use in other ways.

Jung Working with the Body in Therapy

Despite reports to the contrary, it seems that, while sparse in his disclosure of it, Jung did use the body within his therapeutic work. In The Transcendent Function (Jung, 1975, para. 180), he explains that the hands “know how to solve a riddle” even if the mind does not. Jung reaches this conclusion by noting that when his patients draw, paint, or model their dream and fantasy content with their hands, they are often able to work further with and eventually integrate the problem. In the same work, he comments that movement can allow access to unconscious material. He suggests that the therapist record the movements on paper in order that they not be forgotten. Jung also advises that the process of automatic writing can yield useful results. All of these forms of active imagination require the body in order to work. Dance also entered Jung’s consulting room. In his Commentary on the Secret of the Golden Flower, Jung describes how one patient danced her mandala instead of drawing it. We learn from Chodorow (2013) that this occurrence has been independently verified by the (presumed) same patient to another author. Chodorow also informs us that Jung mentions the dancing of mandalas by patients in his seminar on dreams.

Post-Jungian working with the body in therapy has shown little progression since Jung. However, some authors have described its use. Referring to the idea of the body as a shadow, Sassenfeld (2008) discusses the work Jung and Reich: The Body as Shadow by Conger, which advises paying particular attention to and verbalizing bodily sensations and repeating spontaneous movements while commenting on the accompanying inner experience. In doing so, aspects of the shadow may be made conscious. Greene (2001) revisits Jung and Conger’s work, stating that the body is a “bound energy” that contains a history of one’s life and consequently can be a record of our rejected side (i.e., shadow). From her own clinical experience, Greene attests the body can be a “carrier” of the shadow, giving away our rational intentions with its unpredictability and physiological responses. Using the clinical example of patients with eating disorders in her work and that of Woodrow, she describes the alienation of the body and distorted body images as an alienation from the shadow. This can be an explanation of pathology in these disorders. Greene concludes, in line with Woodman, that the “bodily symptom speaks as loudly as the dream image.”

Chodorow, a Jungian analyst and dance psychotherapist, discusses the use of the body in analysis (2013). She draws parallels with sand play, and sees dance as a “non-verbal symbolic process” to which the analyst is a witness. The initiation of movement, she suggests, can be by either the analyst or analysand, spontaneous or planned. The subject of the movement can be direct- ed, for example, to further a dream image as a form of active imagination, or without a conscious purpose. She comments that analysands may need workshops or other forms of instruction outside of the analytic hour before using movement in therapy. In the practicalities of incorporating it into a session, Chodorow suggests flexibility, but notes that sometimes a predetermined time frame might need to be agreed. The movement should work in synchrony with the verbal work, and not be a separate entity. A warm-up and stretch are advised, and Chodorow comments that the eyes should be closed to better allow the patient to experience inner sensations.
and images. However, this comes with a practical caveat that if movements become grand and expansive, there may be a risk of collisions with furniture and risk of injury. During movement, Chodorow suggests that the unconscious manifests in two ways, through images and bodily sensations. Some may experience more imaginal manifestations, but as they become more experienced with movement and appreciative of their body’s communications, Chodorow explains that a balance is struck between the two. Overall, Chodorow sees dance as a way for individuals with “motor imagination” to fully engage in active imagination. The term motor imagination is quoted from Jung as someone who imagines with and about their body. In such an individual, movement is the most immediate way to “give form” to the unconscious.

Conclusion

Jung was aware of the importance of the body as a part of his psychology. From his early work to later descriptions of movement as part of active imagination, the body has a specific place as a communicator of unconscious content in his work. This standpoint is in slight disagreement with the paradox described at the start of this review. Through work by post-Jungians, a heterogeneous living body with the body at one pole and the psyche at the other has been defined. As of yet, it is not clear how this new definition could explain other bodily-presenting psychopathologies, such as psychosomatic conditions or dissociative seizures. The difficulty of understanding how psychological causes can be manifested as presenting physical symptoms remains largely unexplained in analytical psychology.

The body could have a place within analytical psychology, but at present this is in a theoretical understanding only, with the body as communicator being a further way to interpret the workings of the psyche. Chodorow’s work seems to counter this conclusion however, but it must be noted that she is also a dance and movement therapist, resulting in her work not being purely Jungian. The current status quo notwithstanding, Jung’s mind-body heterogeneity and interrelatedness allows for the physical aspects of traditional body psychotherapy to be used within the Jungian consulting room. It may be that this is already taking place, but there have been no studies of these kind of practices in Jungian academia. The familiar scientific academic adage of further work being needed holds true in this case. What may be said, based on the work identified in this paper, is that Jungians at least have permission to do so from none other than Jung himself. In a psychotherapeutic world that, like other schools, can be accused of adherence to dogma for its own sake, this is an important factor for the creation of novel ideas.

In keeping with the theme of interrelatedness, this connection of Jung and the body works both ways: perhaps Jungian concepts can now find a place in the body psychotherapist’s work. The respective incorporation of these different, but related, ways of approaching treatment may allow new approaches for the individual in therapy. By way of an example, a case study on body psychotherapy for a combat veteran with PTSD notes the myriad of difficulties in therapeutically treating this condition (Whiting, 2013). Analytical psychology has its own understandings of trauma, uniquely using the concept of trauma complexes and archetypes within its therapy (Downing, 2017, chap. 7; Wilson, 2004). In the case example mentioned, the patient uses his body to express himself, enabling him to discuss his trauma and other difficult topics. The concept of a warrior archetype or the Jungian complex creates a similar safe distance that facilitates disclosure and working through. Would a greater safe distance be created if the body could express the autonomous needs of the complex, or understand these needs in an archetypal, less personal way? Would this increase efficacy of treatment, reducing time in therapy, or allowing treatment of more severe cases? This proposition is used by way of illustration, and makes no claims to fully understanding either the case involved or how Jungian ideas could have been incorporated into it. An in-depth discussion of this kind is perhaps an example of the next steps that could be taken on the subject of Jung and body psychotherapy. The exciting potential in this suggested synthesis could go further than the topic of trauma. However, in order to approach this potential new understanding, there is much theoretical and practical work to be done.

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I close my eyes and set off on an inward journey to lovingly meet myself.

**Hello, my loyal heart!** Hello, source and home of love! You loyally and consistently serve me. Day and night, you beat and pump the flow of life through my veins while I focus on living this life of mine. Thank you, my loyal heart, for never stopping your work. My attention turns to you. I see you beat devotedly, no matter if I love or hate. I embrace you, my heart. I shower you with gratitude. I see how, through your each and every cell, light flows into you and heals you.

**Hello, my lungs!** Hello, my loyal guardians of life. I see you fill with oxygen and push out carbon dioxide. Oh, how every single second, you diligently and selflessly take care of life without my need to think to inhale or exhale! I take a deep breath and thank you for your trust in life, for taking the responsibility of filling my blood with oxygen. I shower you with healing love, gratitude, and light.

**Hello, my brain!** You work day and night just like the heart and lungs. You work tirelessly even while I sleep. You sift through and reorganize information and knowledge. You decide what to keep, what sinks deep, and what should be expelled so that I can make connections, grasp meanings, and see choices. I embrace you with love and gratitude. I see healing light flow through you and wash away what is no longer needed.

**Hello, my stomach and intestines!** Though I never tell you what to do, you so perfectly know your job. Minerals, vitamins, nutrients – every day, you process the fuel for life and distribute it to every cell. You digest each of my emotions – the sweet-love, the sour-anger, the bitter-pain. You produce the hormones of each of my experiences and diligently expel the waste. I shower you with love, gratitude, and healing light.

**Hello, my kidneys** – the system that purifies fluids and emotions, the filter of fear and weakness, of poison and pain, the quality barometer of my relationships. I embrace you with love, gratitude, and healing light.

**Hello, my liver!** Constant monitor of liquid life, you cleanse my blood of toxins. You give me hints when my anger, sedimentary and unexpressed, calcifies in my gall bladder. I shower you with gratitude, love, and healing light.

**Hello, my senses!** Receptors and transmitters of information, you are my steady connection to life and people. You gather the signals of the eternal here and now. You keep me in reality, shielding me from it yet showing me its beauty... that beauty that will save the world. Because of you, I see life, I hear life, I smell life, I taste life, I feel life with my skin. I thank you my eyes, for seeing the beautiful and the ugly. I thank you my ears, for listening and hearing the pleasant and unpleas-ant. Thank you, my nose, for smelling the appealing and the repulsive. Thank you my mouth, for tasting the sweet, the savory, the sour, the bitter, and the spicy. Thank you, my skin, largest of my...
senses, for drawing my boundary, for letting me know the difference between inside and outside, for separating me and letting me merge with the ones I love. I send you gratitude, my senses, I embrace you with love and healing light.

Hello, my hands and feet! My loyal hands! You work, you embrace, you push away, you give, you take, you create, you connect me to others. My loyal feet! You run, you jump, you dance, you kick, you carry me through life, you connect me to the Earth, to my roots. I send you gratitude, love, and healing light.

Hello, my blood vessels and nerves! Highways and pathways of lifeblood and information, you help me be, feel, and act. Thank you for tirelessly and diligently working day and night. I shower you with gratitude, love, and healing light.

Hello, my muscles and bones! Because of you, I stand tall and stand my ground, I move and relax, I defend my boundaries, I stand up and bend down, able to adapt to the changes of life. Because of you, I successfully Do. Thank you for your Doing. I send you gratitude, love, and healing light.

Hello, my glands – control panels of my hormones, messenger-ambassadors of my actions and of my experience of people and the world. My materialized emotions, thank you for letting me feel and be! Thank you for showing me the happy, the dangerous, the pleasant, the painful, the scary, and the divine! Thank you for embodying the sacred feminine and masculine so that I can reproduce life. I send you love, gratitude, and healing light.

Hello, my immune cells – loyal soldiers fighting my body’s enemies. I thank you for the tireless vigilance, for being on guard day and night to stop foes from invading, for defending my body with unaltering devotion, even when, at times, I refuse to defend my soul. I send you love and gratitude. I shower you with healing light.

Hello, my genitalia! Hello altar to the sacred feminine and masculine. Hello, portal of life! Magical staff and wondrous incubator of life, gateway to the great sacred mystery of life. I thank the womb from which I came, and from which life will continue to evolve. I thank the seed which eternalizes humankind! Thank you, my reproductive organs – meeting point of masculinity and femininity, conception center of humankind and love. I embrace you with love and gratitude, and I send you healing light.

Hello, my only body! Hello, my loyal body! Just as you are, you are mine – the trusted carrier of my soul! Thank you for your symptom-signals that tell me when I lose balance and harmony in life. Thank you for materializing the words of my soul. Thank you for carrying me through life, and at times, for being wiser than me. In fact, my trusted body, you are me. Thank you for recruiting my muscles to protect me from the earliest time when my mind and actions could not yet defend me. Thank you for never ceasing your work even when I forget you. Thank you for showing me how your 50 trillion cells function in unity and harmony, never hurting each other because they know that harming another cell is harming the whole organism, causing harm to themselves. Thank you, my body – my loyal teacher and healer. I promise to listen to you attentively, to trust and take care of you with love and gratitude. I let healing light flow through each of your pores, and I feel all your cells celebrating and dancing hand-in-hand, grateful that I remember you, listen to you, and love you every moment of every day!

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ABSTRACT

This paper seeks to explore the issue of embodied shame through a clinical vignette from the perspective of a relational body psychotherapist. Through this therapeutic journey, key themes became evident. First, the body of shame develops in response to familial patterns of behavior, relational rifts, and social shaming. Second, the body of shame can also have a transgenerational impact and, in this case, extensive and damaging consequences.

In the relational turn, there is a departure from the classical psychoanalytical paradigm, which views shame as a sign of immaturity. This paper will contribute to a growing body of relational psychotherapy theory and practice that suggests that, in order to heal, the body of shame requires external support, a neurobiological approach in psychological treatment, and an internal validation of desires.

Keywords: shame, pain, body, relational, neurobiological

You left and I cried tears of blood.
My sorrow grows.
It’s not just that You left.
But when You left
my eyes went with You.
Now, how will I cry?

Rumi

1 “Listening for the Longing” was conceived by Robert Lee in 1995 regarding shame.
method. I believe that an individualistic strategy that changes according to the evolving needs of the client is the most appropriate way to work.

Both shame and guilt are experienced in interpersonal relationships, and the adverse events that generally cause them are similar. Tangney and Dearing (2002) reported that these emotions are very close in nature, but also differentiate them from each other, based on specific characteristics. For example, shame involves the negative evaluations of the global or whole self (I made a mistake), whereas guilt involves the negative evaluation of one's behavior (I made a mistake). Guilt often includes feelings of tension, remorse and regret, which can be physically or emotionally painful, but guilt does not affect our core identity. In contrast, shame is an acutely painful emotion that can make us feel exposed, worthless, and powerless. Another critical distinction is that people who feel shame are concerned with evaluation by others, whereas people who experience guilt are concerned with their effect upon others. Finally, a desire to hide and escape is a typical motivational feature of shame, while with guilt, people want to apologize or confess and take reparative action (Lewis, 1987; Tangney, 1995; Tangney & Dearing, 2002).

Lewis (1987) concluded that shame often results in feelings of anger and hostility, combined with a tendency to project blame outward. This can be seen in the dynamics of Grace’s marriage, which will be discussed within the clinical vignette. Tangney (1995) further emphasized the link between shame and anger by noting that shame-prone people are not only likely to experience more anger, but are more likely to manage their anger in maladaptive ways, such as acting out their particularly hostile intentions. Shame-prone people may experience resentment and feelings of being unappreciated or humiliated, which contribute to hostility, hypervigilance, and volatile expressions of anger. Additionally, shame-prone individuals can often believe that these angry feelings were likely to result in negative or destructive long-term consequences; thus, they may suppress or hide their feelings or intentions.

The Shame of Grace: A Clinical Vignette

Grace is a sixty-six-year-old woman. She sports a head of short, tightly-curled hair. She is organized, articulate and well-educated. She speaks with animation and smiles often. Grace spent her entire career in social work with families and children. She shows warmth, empathy, and compassion for others, and appears to be naturally reflective, insightful, and curious about movement towards “feeling more comfortable in my own skin.” I enjoy being with her. We have worked together for three years.

At the beginning of our therapeutic relationship, she had a desire to explore issues that had become pertinent in her marriage. Her constant criticism, irritation, and frequent angry verbal outbursts towards her husband had become detrimental to their relationship. Over time, we uncovered several pivotal traumatic events that had led her to a “seething stalemate” with her husband. Most recently, her beloved dog had died, and her sorrow had immobilized her. She was unable to share her profound grief, and the projected fear of ridicule or rebuke, that someone would say, “It’s just a dog.” She had become frozen and socially withdrawn. Her already tumultuous relationship with her husband had dramatically deteriorated further.

A Personal Reflection

During initial supervision, I had noticed my own internal apprehension when we engaged in sessions. I had embodied a sense of urgency for change, to solve this “dilemma” quickly. Through reflection with my supervisor, I began to identify the transference anxiety that I had, inadvertently, adopted. I determined to slow the process down. Instead of halting the flow, we were both able to relax, as I held onto the internal idiom, “We have all the time in the world.” This phrase became a crucial locus as we began to uncover the subconscious drives that underpinned her anxiety that “time is running out.” She had moved into retirement, and what she regarded as the end of her “usefulness.” She had become painfully aware of the aging process in the human body as it affected her and her husband, and mortality through the death of her most beloved dog. The specter of death had become very real, as she felt it was “just around the corner.”

Over time, her desire to please, both in the therapeutic alliance and in the outside world, became evident. With this identification, there came a liberation. We both spoke with increased candor and directness, as our rapport became established and our therapeutic intimacy deepened. However, our emphasis shifted from her marital relationship to her relationship with her body.

Shame and the Body of Pain

After several months of working together, I could see that she was in pain as she shifted, with some discomfort, in her seat. Her back was straight and stiff, and as she began to speak of the pain in her stomach, her shoulder girdle became rigid. Her breath became shallow, then more ragged and rapid, and she began to swallow. As her eyes widened, I too began to feel a rising panic in my own body as I resonated with hers. “Oh, this pain,” she said, as she moaned softly.
Over time, we began to explore her experience in her body. For a long time, her body had been in some considerable pain. It started with sudden “horrific” and debilitating “attacks.” Then daily, she experienced “excruciating” pain, nausea and diarrhea. Eventually, after many attempts to find a solution, she was told by a consultant that she had microscopic colitis, and the inflammation was covering her entire bowel, “straight the way through.” No effective cure was offered, and it would have to be “managed.”

Since this diagnosis, she had developed severe hypertension, and become asplenic, which entails a significantly increased risk of severe sepsis. Additionally, she became hypothyroid due to Hashimoto’s, an autoimmune disease in which the body attacks the cells of the thyroid tissue. However, with all of these potentially life-threatening diseases, the one that she was primarily concerned with was her stomach pain. “I’ve been trying very hard to manage the problem, but I’m frustrated and depressed,” she said quietly, her eyes downcast and her shoulders hunched. She looked utterly defeated.

The Effects of Trauma and Stress on the Nervous System and the Gut

Inflammatory bowel disease (IBD) is a result of disordered immune activity in the gut. Emotions profoundly influence, and are intimately involved, in the nervous system. Emotional influences acting through the nerve and immune pathways of the psychoneuroimmunology (PNI) system can create inflammation. Chronically stressful emotional patterns could induce inflammatory disease (Ainman, 1996), and adverse life events and chronic stress increase the likelihood of relapse in people with quiescent IBD (Mawdsley and Rampton, 2005). The gut is more than an organ of digestion. It is a sensory apparatus with a nervous and ecology system of its own, connected to the brain’s emotional centers. Emotionally upsetting events can be “gut-wrenching,” and many of us intuitively understand this, or can recall experiencing the “sore tummy” of an anxious child. “Gut feelings” help us to interpret what is happening in our environment, as to whether it is safe or not. Nausea and pain, or a warm, comforting feeling in the gut are sensations that orient us to the meaning of events.

Thus began the somatic narrative of Grace’s IBD. After some reflection, we determined that the pain started almost immediately after her daughter had suffered a distressing ectopic pregnancy. Her daughter had miscarried in a bathroom cubicle in a public toilet, while her family had been dining at a restaurant. Grace had been called in to attend to her daughter and faced “a room full of blood,” which they just “cleaned up,” even though her daughter was later told by the medics that “she had nearly lost her life.” Although the incident had happened nine years previously, Grace had never reflected further on it. In the last three years, she had also witnessed her husband’s journey through bladder cancer, seen the blood in his urine, cleaned his post-operative wounds, and helped the district nurse with his dressings.

She told these stories in a pragmatic tone, yet her body and face were frozen and still. Her eyes were wide, her voice barely audible, and her breath shallow. The dissonance between the narrative and her body-story was striking. I was acutely aware of the quiet trauma hidden within the narrative.

Nourishment had become intrinsically merged with blood, pain, and loss, which made self-care and nurture almost inaccessible for Grace. She had lost her resilience and the ability to nourish herself: “I don’t eat properly…” “I had to eat it, even though I knew it was wrong, that it would cause me pain…make me tired,” “I just wanted something nice.” Grace recounted how she was “ashamed to say” that she would secretly eat chocolate bars in her car, and hastily dispose of the evidence.

Shame and its Relationship to Self-Care and Nourishment

In a society full of shaming behaviors, we are social beings who are deeply vulnerable to its undercurrents that dictate much of our behavior. Grace felt shame for not practicing the self-care that she thought she should or wanted to engage in, but was caught by a more insidious shame that quietly questioned whether she actually deserved care and compassion in the first place. Shame became a toxic bedfellow to self-care, and a powerful accelerator of self-loathing.

In thirty-five years of social work, Grace had never taken a day off sick. With great courage and passion, she had become “the neglect expert,” gathering “concrete, factual evidence” to protect children. She was a mother, wife, and social worker – a nurturer of humanity, and yet she had forgotten how to nurture herself, which we came to believe had contributed to her illness.

Utilizing her words, I was instrumental in building and developing a metaphor in which she likened her human body to the soil. Excessive ploughing and unmindful practices by farmers ruin the life and health of our earth. She spoke of how land is left “barren, exposed, degraded” and stripped of its life-giving power. This means that when hard times strike – like a severe drought – the once nutrient-rich soil becomes lifeless dirt. The earth is devoid of any nourishment, and without en-

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3 In clinical trials of medication for IBD, placebos can affect a positive response in up to 60% of patients. This does not suggest that the disease was “all in the mind,” but that when these patients felt that they had agency over their disease, this enabled the neurological and chemical process in their body to be activated to allow for healing (Hershfield, 1997).
richment, nothing can grow. There is no resilience, and humanity has the potential to starve.

Her spiritual ecosystem, if you will – the soil of her soul – had become exposed to negativity and constant self-doubt. She recognized how she was repressing her emotions, and no longer felt that she could innocently and authentically respond to events. Instead, she was driven by her constantly unfolding anger. We began to explore how she could cradle and accommodate her own sometimes extreme and erratic emotional responses, rather than relying on external objects. In her instance, “busyness” and the predetermined judgments of others that she had internalized to “get on,” “don’t make a fuss,” “be useful,” “don’t fall apart...” Through the soil metaphor, she came to see how she risked ending up living in a “dust bowl” of self-judgment, hopelessness, and cynicism. I frequently returned to this metaphor in our sessions to explore dialogues around self-care. She also came to see that her disease had its roots in anxiety and stress, created by her innate perfectionism. She had faithfully passed on this perfection, imbued from her soul – had become exposed to negativity and constant richness, nothing can grow. There is no resilience, and humanity has the potential to starve. Her spiritual ecosystem, if you will – the soil of her soul – had become exposed to negativity and constant self-doubt. She recognized how she was repressing her emotions, and no longer felt that she could innocently and authentically respond to events. Instead, she was driven by her constantly unfolding anger. We began to explore how she could cradle and accommodate her own sometimes extreme and erratic emotional responses, rather than relying on external objects. In her instance, “busyness” and the predetermined judgments of others that she had internalized to “get on,” “don’t make a fuss,” “be useful,” “don’t fall apart...” Through the soil metaphor, she came to see how she risked ending up living in a “dust bowl” of self-judgment, hopelessness, and cynicism. I frequently returned to this metaphor in our sessions to explore dialogues around self-care. She also came to see that her disease had its roots in anxiety and stress, created by her innate perfectionism. She had faithfully passed on this perfection, imbued from her own mother, to her daughters. “They never stop; B. just keeps going with her hectic life, she’s a lawyer... and she has children, and she’s in pain every day, riddled with awful endometriosis. I really worry about her.”

I resolved to ensure that within our sessions, we would not repeat her patterns of failure to attend to her pain, and we would actively engage in self-nourishment. Whenever Grace came into the session with pain in her body, we would sit and silently attend to the pain. Our work style changed from talking therapy and became more centered around breath work, grounding, and bodywork (touch and movement). This happened over a year, when Grace and I felt more comfortable with negotiated touch, a broader modality, and a more dynamic approach. Gradually, we would explore the feelings around the pain. We came to the agreement that we would attend to ourselves first, as an act of mutual self-care. She would sit and breathe into the area of pain, and I too would attend to my own body, then resonate with her body and the intersubjective field between us. We would attempt to feel what was “behind” a flare-up. Eventually, she identified that the only “feeling” there, behind the pain, was a “withdrawing,” “cringy,” self-flagellation and a “desperate and angry” anxiety. Whenever we explored her body sensations, she said, “It’s always there, the same feelings.” She blamed herself for eating the wrong things. She also felt resentful “It’s always there, the same feelings.” She blamed herself for eating the wrong things. She also felt resentful “It’s always there, the same feelings.” She blamed herself for eating the wrong things. She also felt resentful “It’s always there, the same feelings.” She blamed herself for eating the wrong things. She also felt resentful “It’s always there, the same feelings.” She blamed herself for eating the wrong things. She also felt resentful

During one session she was recounting how, during a social outing to the cinema, she became upset that she could not eat an ice cream at the break. She had become grumpy and belligerent, “quite unlike myself.” She spent several minutes scolding herself for her “shameful” behavior. It was then that I felt we could begin our exploration of her shame, which became a central theme in the therapeutic journey.

**Grace and her Shame**

Shame is a universal feeling, and also one of the most potentially disorganizing of all affect experiences (Wheeler, 1995). Shame had shaped many of Grace’s adult experiences. She primarily felt shame that she had had an affair with her second husband, and that their first daughter had been the product of her first marriage, not of her current husband. She clarified that she did not feel guilty, but ashamed. She felt crushed by the weight of her shame, and unable to take any reparative action.

In the initial event, she had not admitted to her first husband that she was having an affair, but it was discovered. She had gone to meet her lover in her car, and had parked it beside the lake. As she had the opportunity to spend a few days with him, she had left her car there. The car was spotted by the local police, who felt moved to investigate. As her husband did not know her whereabouts when questioned, her parents were informed that she had disappeared, and the police suspected foul play. Eventually, she returned home, to her parents, who were “worried sick” that she had either drowned or been abducted. “Shame-faced,” she had had to explain where and with whom she had been. In this moment of abject humiliation, she felt unable to speak, as she was so confused and disoriented. Her desire had met an unwanted limit in a sudden, overwhelming, physical experience of shame – of sweat, racing heart rate and diffuse anger. This powerful affect was the beginning of her journey with chronic shame.

This shame was compounded when, upon leaving her husband for her lover (soon to be her second and current husband), she discovered she was pregnant with her first daughter, the conclusive result of a union between her and her first husband. She decided to conceal her first daughter had been the product of her first marriage, not of her current husband. She clarified that she did not feel guilty, but ashamed. She felt crushed by the weight of her shame, and unable to take any reparative action.

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The whole scenario also highlighted her fear of conflict and negotiation.

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4 There was a consideration of ethics and safety in that the touch was consensual. Each time we engaged with touch, there was a renegotiation.

5 Despite her “retirement,” she occasionally worked both as a paid facilitator with the social restorative justice team, and in a voluntary capacity as an “appropriate adult” (AA) for vulnerable youth in police custody. She often spoke and educated others about shame and its adverse impacts on restorative justice. She spoke eloquently on her understanding of the difference between self-blame and self-responsibility, and the difference between guilt, shame, and remorse.

6 Nathanson (1992) and his mentor Tomkins (1963) both describe the very concrete physiological affect of shame.
Grace felt that there was nothing she could have done to redeem herself and had no opportunity to change her parents’ diminished (as she perceived) opinion of her. They both passed away without her having had the chance to address it with them. “They didn’t say anything, but I could see in their faces how disappointed they were with me, and I had caused them so much distress. Imagine how it must have been for them to think I was in that lake, and I still don’t know what damage I have done to my daughter.”

She had experienced both direct social shaming and the concomitant withdrawal of support from her first husband’s family, as well as uneasy feelings of anticipatory shaming from her parents. She felt she had let them down, as well as experiencing her own internalized shame. She felt humiliated by the whole experience, and her growing belly of pregnancy was a testament to her shame, which she felt should be concealed. Society has often held up women’s bodies as markers of sexual immorality, in that women are supposed to be paragons of purity and virtue. Therefore, female sexual transgression can often be condemned or punished harshly (Fischer, 2016). We discussed the politics of gender and shame in our sessions, and later her “belly shame.”

I had to be sensitive to my client in our ongoing dialogue about her embodiment of shame. Offers of support can themselves lead to feelings of shame, which could be seen in her conversations in therapy; “Why aren’t I managing this better? Why aren’t I finding a creative way out of this?” It took time and careful, attuned negotiation to move through her own condemnation of herself, of not “quite measuring up” and of not being “good enough” – phrases she frequently used, which all exemplified her own feelings of perceived personal inadequacy and shame.

### The Crucial Element of Support in the Journey Through Shame

Grace and I then began a new phase of therapy together. The therapeutic journey subsequently became a discovery of how crucial support, and its absence, are in the experience and development of shame.

I was aware that this area could prove to be challenging for the shame-prone client. Because the psychotherapy situation can easily provoke feelings of inadequacy and perceived moral judgment, shame-prone clients often blame or feel blamed concerning the issue of whether they are functioning satisfactorily in treatment. They may explicitly blame themselves for failing to improve, or they may blame the psychotherapist for their lack of improvement, as a defense against a devalued self-schema. I wanted to be mindful to avoid countertransference and handing the “blame” back.

By paying attention to shifts in my own self-evaluation, I remained sensitive to a projective identification of devalued self-schemas, as advocated by Goldstein (1991). The shame-prone client is vulnerable to feeling deflated in the course of delving too rapidly into various aspects of an experience. Therefore, I was careful with the pacing of our engagement together, as I was mindful of the emergence of my client’s devaluing-other internalization; when this arose, it became a signal to employ a “tactful slowness,” a process described by Horowitz (1989), to re-establish or deepen the alliance between us. In the case of projective identification of this devaluing-other agency, the therapist may be caused to feel and behave toward the client in accord with an internalized, and often covert, critical agency. Negative countertransference reactions with shame-prone clients often signal instances in which the therapist is pressured to accept a disapproving stance toward the client, and function as a spokesperson for the client’s self-contempt. Understanding this function enabled me to maintain a supportive stance, while reflecting and encouraging an exploration of those self-critical attitudes that the client generally turned toward herself.

The therapist, in response to this scenario, might feel pressured to accept projections as a disapproving parent criticizing their client’s self-schemas. This enforced positioning may allow us to understand better, when we briefly become the “spokesperson” for the client’s self-contempt, which may have resulted from an accumulated experience of a critical caregiver. However, it is another tactful dance that requires skill (and probably a few therapeutic mistakes) of not colluding with the client’s degrading self-beliefs, while still offering support.

Grace would berate herself for engaging in a damaging internal dialogue and admonish herself further for “not knowing better.” It took time to assume a supportive role where I was not colluding with this dynamic. Instead, I challenged her by gently reminding her whenever she was berating herself. However, within this interaction, I became the critical parent; loving and warm, but also critical. It was only by making this double-bind as transparent as I could that we were able to examine the impact her shaming behavior was having on her sense of self-worth. We began a conversation around shame and shaming behavior, self-deprecation, and internalized shame (“we even shame ourselves for shaming ourselves”). We attempted to counteract these shaming behaviors with playfulness, and a stance of open curiosity.

These feelings of shame had led to her chronic stomach pain; the indigestibility of her shame had led to inflammation and feelings of vulnerability and powerlessness over her digestive system. She often minimized her discomfort, tried to conceal it from others, and felt that she had no control over her symptoms. “When I’m out in the open, exposed to others, I don’t want them to see me like that.” Her condition was robbing her of her own sense of strength and agency, two traits that she believed had been an integral part of her self-identity. Her shame had created a field in which she could not “face others” in her position of weakness and powerlessness:
thus, the close connection between these feelings of shame and her sudden disorganized outbursts of rage, turned against herself, her husband, and the world.

Shame was not merely manifest in her stomachache, but also in her averted eye contact and her hunched shoulders. When she spoke of her disquieting sense of shame, she could not bear sustained eye contact, and it became “intolerable.” Eventually, it rendered her silent, her speech dried up, caught in the light of exposure, and she became inaccessible. She felt that in these moments, the examination of herself created a self-consciousness that was “paralyzing.” Shame had become the source of many of her complex and distressing internal states: her depression, her feelings of alienation, isolation, perfectionism, and deep-seated feelings of inadequacy and loneliness.

Touching the Body of Shame

Grace and I decided to move onto a floor mat to explore the pain in her “belly.” She would often sit stiffly upright or move away when she was in pain. We looked at how we could make her as comfortable as possible. She looked at me warily, and then shyly as I passed her blankets, cushions, and covers to support and cover her. She lay down and spoke of her pain. Drawn to touch her, I asked if I could put my hand on her belly. She stiffened, but acquiesced. Feeling her reluctance, I explained that I felt moved to pay attention to the pain in her belly, she carefully pulled up her top. Gently, I placed my hands on her she froze, and I waited as the musculature in her abdomen softened. When I eventually followed the impulse to place my hand on her “sore belly,” Grace instinctually reached up with both of her hands as if reaching out, grasping into the air, and then pulling her closed fists towards herself. Her breathing slowed, and she closed her eyes. I noticed that she smiled. It was a closed-mouth smile, but her body movements appeared young and playful.

As I slowly stroked Grace’s belly, my concentration became single-pointed, and my hands soft and warm. I felt maternal and loving toward Grace. I felt a state of being for the other, in which there was a sense of responsibility, and vulnerability. The sensation felt so reminiscent of the moments when I stroked my young daughter’s back and she, enraptured, would soften under my touch. All my attention was focused on Grace’s breath, and her shy smile and the softness of her belly. I felt engaged and entranced in the simple movement. Grace’s body relaxed under the longed-for touch that she was unable to ask for directly. At the end of the session again, I could see her shyness re-emerge when we spoke about the touch. Still, she talked of how she felt transported back to the moments when her mother had “rubbed her tummy,” of how good it felt, and how difficult it was for her even to acknowledge that need, let alone ask for it to be met.

I was familiar with the various interpretations of the movement of reaching out in somatic psychology. This action of reaching and grasping is explored in the five fundamental developmental movements (Bainbridge-Cohen, 1997; Apostyan, 1998). Reaching is an action that supports going beyond the sense of self. It is a way of extending out towards others or objects. Psychologically, reaching manifests as curiosity, desire, longing, and compassion. This action may, however, expose one to risk-taking and a sense of vulnerability.

Reaching for What We Want: A Recognition of Longing

This movement of grasping began another phase of our exploration: that of desire or longing. Shame has a “modulator affect” (Tomkins, 1987, Haufman, 1963) in that it has a protective mechanism to modulate or regulate our desire or excitement for an object or state in the outside world. We place ourselves into a state of vulnerability when we extend ourselves towards that which we desire, and shame can be the warning light that can reel us back from exposure. As we reach out, when we need something, we are dependent upon the field, and dependency has an inherent vulnerability. The dynamic interplay between the protective mechanism of shame and Grace’s desire or need then became our focus in bodywork. Theoretically, this therapeutic approach is a movement away from the individualistic paradigm of classical psychoanalytical ideology, which sees shame as an immaturity (Hazard, 1969). From a more relational field perspective, rather than shame being a deficiency, the person may not be receiving enough external support.

To understand what was underpinning the rage that she felt, I began to question Grace about her felt sensations around external support. At first, when I questioned if she felt she received ineffectual support from her partner, there would be a series of protests and then she would deflect or become dismissive. However, over time, this dialogue changed; she would no longer discount this as a possibility. I attempted a different dialogue, exploring whether she felt supported, affirmed, held, or seen the way that she wanted. She became curious. When we engaged with more direct felt experience, she was able to engage: “What does it feel like in your body to be affirmed? Who would do that? Who does that for you now? Where do you remember receiving that before in your life?” It became clear that she yearned for more support and connection.

The Loneliness of Shame

Grace began to recognize that her shame subsumed her sense of longing. She longed for a deeper intimacy with her husband, to be seen and held tenderly by him. However, her core belief was that to be seen as dependent on anyone was “needy.” Grace was aware that she and...
her husband were in the autumn years of their life together. Nevertheless, her sense of dissatisfaction was further preventing her from acknowledging and naming her desires. She took these realizations back home. She entered into a dialogue with her husband, first through an admission of her loneliness, then by disclosing the realization of how she had used this hurt, defensively, against her partner. Gradually, she began to transform her firmly-held conviction that she was alone in this desire. By acknowledging and talking about her need for greater intimacy, her need became a shared challenge that was beginning to form into an intimately-held desire by both partners. Her husband decided to enter into his own psychotherapy, having mocked it for many years. She was no longer alone, and they were no longer legitimizing their long-held belief in hyper-autonomy.

Through our exploration, she realized that, as a result of the deep shame she had experienced at the inception of the relationship, she had become overly self-reliant. She had no-one to regulate herself against; she was ostracized by her family at a time when she was at her most vulnerable, and, unknown to herself at the time, also pregnant. She felt alienated from those closest to her. Her “loving” parents could not understand their daughter or her behavior at a time when she needed their emotional attunement and regulation. She left her familiar home environment to begin a new life and family with a man who “looked like he was shell-shocked.” In her own words, “We just had to pull ourselves together…we barely had time to look at each other.” She experienced a visceral experience of herself disintegrating in response to an acute and then sustained misattunement from her parents. Her sense of self was fragmented with shame.

Her high-octane performance at work (“the only criticism I received was that I never took time off”) and as a doting, attentive mother who still makes multiple trips a year to look after her grandchildren, all put distance between her shaming experience. However, she still harbored the thought that underneath it all, in her belly, lay a shameful creature of rage, bitterness, bile, and desire. Her negative self-belief allowed her only to be seen one way, while disowning all those aspects she believed would be unpalatable. Therefore, the loneliness seemed to stem from the fact that by disowning parts of our self that we deem unacceptable, no one can truly know who we are.

Initially, Grace would become defensive when I asked her about feelings of longing, and would retort with, “Well, I live with my husband, we see each other every day.” However, I became aware of her sense of loneliness that often accompanied her shame. She was devastated by the loss of her dog, and upon closer examination of her bodily sensations of grief, we came to see how her loneliness stemmed from her separation from her mother, and her perceived emotional loneliness (Weiss, 1989) from her husband: “If only we felt closer…if only he could talk to me.” Grace was not physically alone in her relationship with her husband, and she had dependent and long-term friendships. However, loneliness is a subjective experience. It does not necessarily equate to social isolation (Peplau & Perlman, 1982).

One highly significant event that had a profound effect on Grace was when her husband suffered with bladder cancer, and she saw his penis “pissing out blood.” She was traumatized by this, and it had long-lasting effects on her sense of intimacy with her husband. It had been deeply shocking to her, and she responded with dissociative professionalism, rather than as a wife and lover. It had so shocked her to the core that even the words she used were so dissonant from this well-mannered and articulate woman that they sounded like an alien language passing from her lips. Trauma had lent itself to dissociation. Together we tentatively explored how the familiarity of bodily horror had destroyed their intimacy.

In terms of therapeutic outcome, there has been progressive improvement within her relationship with her husband. By entering into his own therapy, they have found another shared commonality and language. They spend time together, she feels less irritated with him, the emotional outbursts have lessened, and she feels better able to manage her temper. Her inflamed bowel, however, had not disappeared; there was a transmogrification in that she no longer used words like “my bloody stomach,” and she no-longer attached to the word “pain,” but had replaced it with “hunger” as a somatic experience. She began to identify her body sensations as an internal barometer, which educated her on her own needs and desires.

Over a few weeks, I encouraged Grace to keep a journal of her bodily or somatic experiences to build on this felt understanding. Using this journal in our sessions allowed her to become more compassionate, empathic and even curious about the sensations she was experiencing and how to attend to them. Her greater body awareness allowed for more pain-free days. Her semantic dialogue about her stomach pain changed, and she was able to make the cognitive link between her somatic experience and her hunger for more adventure and higher risk-taking; to engage with the “unlived life” that she so wanted to experience.

Like other negative social emotions, shame, guilt, and loneliness may arise from early relationships (Leary, Koch, and Hechenbleikner, 2007). However, I was also aware that in Grace’s journey, I could not entirely match my client’s reality with theory. I was alert to any signs of trauma in Grace’s early childhood which would have predisposed her to shame; however, at each turn I was presented with a loving and sensitive family unit. According to attachment theory, the interaction between

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7 Herman (2011, 2012) and Schore (2012) cite studies that find significant correlations between PTSD, shame-proneness, and dissociation.
the infant and primary caregiver predicates how a child develops working models, including judgments and evaluations of the self and other people (Bowlby, 1969, 1988). Shame and guilt are defined as moral affects, so parenting practices and discipline styles can shape the emotional and moral functioning of children (Baumrind, 1979; Hoffman, 1998). However, Tangney and Dearing (2002) also emphasized that throughout children’s developmental process, family interactions may not, directly, model guilt and shame behaviors, but rather reflect general interactions within the family system. This statement suggests that shame and guilt may be more intensely affected by the socialization process than by attachment relationships. Grace felt that her shame revolved around her affair as an adult, not through a narrative of childhood shaming.

Towards the middle stage of the therapy, during one session, I suddenly noticed the semantics of her pain, her “sore poorly tummy.” It was an unusual phrase for her to use, strikingly childlike in its language and tone. I asked her old she felt as she spoke it. “Oh, I don’t know… quite little…maybe 3 or 4….” Placing her hands on her abdomen on the area that was so painful, we explored this simple phrase. She smiled and looked up at me. It was a phase that her parents had used; it brought to mind the warmth and comfort of her parents. “I have to say it in a Scottish accent…like my mum,” she said. Her parents were strict Scottish Presbyterians, but Grace described them as warm and often indulgent. She remembered her mother rubbing her “tummy” when she was not well, and spending hours massaging it when she had painful menses as a young teenager. When the pain was severe, her mother would send her father to the next room and install her daughter into their bed, so she could sleep with her mother, and be soothed if she needed attention during the night. She commented that she remembered that her father “wouldn’t mind being turfed out” of the marital bed.

I introjected, “So you were placed above all others.” “Yes,” she affirmed, and she began to cry. “I never cry, but thinking about my mother and how kind she was to me, it felt so good, so warm, so loving…and my stomach ache has stopped.” Not only did Grace never cry, but she had never seen her mother cry, and her father only cried at her mother’s funeral.

In coming to a clearer understanding of the somatic presentation of trauma, I was surprised when my client’s pain stopped; it was an extraordinary experience. It is rare to experience such a clear clinical picture, and to be able to make so many connections, and even rarer for the symptoms to, simply, go away. It was here, in the later stages of Grace’s therapeutic journey, that we became more aware of the transgenerational link. Grace yearned for the love and affection that her mother, who had been dead for over 30 years, had given her; she wanted someone who would rub her “poorly tummy” all night. I was aware that mothers become a pertinent theme in our understanding. Grace, as a child and later as a teenager, had been attended to by her mother for her “sore poorly tummy.” Grace, in turn, attended to her own daughter as she witnessed her first daughter’s traumatic miscarriage. Her daughter, at that time, was also pregnant with her first child; she was a mother, with a “poorly tummy.”

Slowly we explored these connections. Supported by the insight of my supervisor, we saw the interconnection with her first daughter, the shame that she had embedded around her parentage, and how the “poorly tummy” had been passed down to her – first through her miscarriage, and then her severe endometriosis that had come after the birth of her own daughter (Grace’s first grandchild) following her miscarriage, and finally with the removal of a large teratoma tumor, which, like a horror film, contained hair and bone tissue. In direct opposition to Cartesian dualism, Grace’s shame had become embodied, particularly with respect to her experience of pain, and, eventually, through her child’s body, it became material. Embodiment is experienced twofold, lived as well as material.

I began to see the link between Grace as a little girl with her stomachache who, even as she moved into adolescence, continued to have her “tummy” rubbed for her menstrual pain. Though supervision, we identified the little girl who does not know the difference between the womb and the intestines; it was all the homogenized “tummy.”

Sources of Shame: The Body, Sex and Food8 or “What I Take in or Keep out”

Through my reflexive practice, I became aware of what I had left out in the countertransference. Initially, I did not discuss, either in supervision, or in the first drafting of this case, the “penises.” I had not let the penises in. I will elucidate what I mean.

In my psychotherapy practice, I often talk about sex, and how our sexuality or sexual activity can change or acclimate to the landscape of our bodies in sickness and the aging process. Aware of how often I discuss alternative sexual acts to women after menopause, I noticed that I had omitted to discuss this with Grace. Following her husband’s operations and the resultant impotence that

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8 The self-conscious emotions (SCE) of guilt, shame, pride, and embarrassment are moral emotions, which motivate adherence to social norms and personal standards, and emerge in early childhood following the development of self-awareness. Shame and gender are inexorably linked within our society. Gender stereotypes of emotion maintain that women experience more guilt, shame, and embarrassment, but men experience pride more often. Gender differences in SCE about domains such as the body, sex, and food or eating tended to be larger than gender differences in SCE about other domains. (Else-Quest, et al, 2012)
had occurred, and the difficulty he had in achieving an erection with the prescriptive aids (penile prosthesis implants), together with the added complication of her own dyspareunia, they were “no longer having sex.” My supervisor appeared surprised that I had not addressed this, or discussed sex without penetration. Grace’s desire for deeper intimacy with her husband had been an essential aspect of our relational work. However, she had not spoken of how they were circumnavigating their changing bodies, their sexual intimacy, and how she may not be letting her husband in, penis or otherwise. Why had I left this out? The answer is simple – shame and embarrassment.

Through my recognition of my own internal shaming, of my own self-imposed limitations guided by what I believe will be acceptable to people, I was again reflecting Grace’s narrative of choosing what I take in or keep out. Had I finally met my edge, my own internal shamer? Also, I was aware that in writing my case, I was presenting my work to external agencies, and inhibition had come in. I was concealing my own practice from organizational structures, with the belief that if they knew all of me, I would be unacceptable/marginalized/excluded. This countertransference replicated Grace’s own struggle. She wanted to be the kind of person who says “poorly tummy,” but she was also the woman who rages and “bays for blood.”

Reflexivity involves coming as close as possible to an awareness of the way I am experienced and perceived by others. It is the ability to stay with personal uncertainty and hold onto critically-informed curiosity as to how others perceive things as well as how I do, while maintaining the flexibility to consider changing deeply held ways of being. The role of a trusted other, my supervisor, has been vital in understanding how I relate with others, and how we, as psychotherapists, can shape organizational realities through shared practices and language. If I conceal part of my practice, this can detrimentally affect my profession. I believe that reflexive thinking, this critical focus on beliefs, values, professional identities, and how they affect and are affected by the surrounding cultural structures, is my social and political responsibility.

**Conclusion**

We have explored multiple issues in this paper. We have looked at Grace’s convoluted therapeutic journey from her marital conflicts, aging, the grief of losing her dog, her husband’s cancer, her daughter’s miscarriage, endometriosis, and tumor, as well as Grace’s experience of having an affair and falling pregnant. We have seen how Grace’s somatic–emotional system presents many physical symptoms, including various bowel and immunological issues, as well as some sexuality issues. However, we explored three main themes, which were nourishment (self-care), shame, and loneliness.

At the outset of our therapeutic journey, Grace was shattered by her shame, as her sense of a coherent self had disintegrated. Shame is experienced in response to a perceived (or inferred) devaluation by others (Tangney & Dearing, 2002). There had been little relational reconnection with her parents, and this continued into her relationship with her husband. Her ensuing struggle for coherence was, paradoxically, causing her to physically and emotionally come apart at the seams. Grace’s shame had a relational origin, and the unbearable pain of her shame had been pushed away, deep into her “tummy.” I came to see the importance of the need to be compassionately and viscerally present with her body of shame throughout the time of our exploration.

In the course of therapy, there has been a transformation from self-inhibition and internal disorganization into new self–development and growth. Grace has developed a greater awareness of self–care; she no longer dismisses her symptoms as “nothing,” or engages in comparative suffering – “Well... there are so many other people in the world, with so much more pain than I have, experiencing so much more suffering.” She has become more attuned to her pain, its causal connection with stress, and the care or nourishment that she requires, as illustrated in her journals.

Our work encompassed a movement from the idealized self to an acceptance of her real self in relation to another. The relational emphasis enabled a repair of Grace’s fragmented sense of self within a relationship of empathic attunement. In line with Schore’s (2012) affect regulation theory, shame was not healed by words alone, but we also repaired this relational rift through right–brain language, with appropriate eye contact, voice tone, rhythms of response, body language, and consensual touch.

Shame and longing are evident in Grace’s body, beliefs, emotions, and behavior. Grace’s body shame was centralized in her belly, and this was evident in the present as well as in many times in her past. She yearned for a deeper, more supportive, and loving connection with her husband, but felt unable to ask for it. As a result of buried and undischarged emotional stress caused by incidental events and periods of her life that had been overwhelming, her body’s response was to store the trauma and tensions within her tissues – namely her belly. The physical symptoms presented themselves as

“The Body of Shame

“Shame is most importantly a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how very much one wants to connect with others. There is a loss of the sense of empathic possibility, others are not experienced as empathic, and the capacity for self–empathy is lost.”

(Jordon, 1997: 147)
chronic pain and complex immunological syndromes. Her psychological symptoms were resentment, uncontrollable anger, dissociation, and depression. Grace came to understand the role of her pain as an indicator in her somatic–emotional system and in her relationships, and how her belly holds shame and longing. She realizes that her pain is an attempt by the body to call for healing.

Grace was adamant that her early childhood was not involved in her somatic experience of shame, but instead felt that it began with her shame about her affair and the pregnancy. Grace talked about her experience as a child and adolescent getting loving attention for her stomach pain, and then losing parental support during her divorce and pregnancy. When entering the prototypical shameful state of mind, the individual has a sense of an exposed, vulnerable, devalued self being scrutinized and found wanting in the eyes of a devaluing other. In Grace's case, this was in the eyes of her parents. She responded to their silent withdrawal in her adulthood by internalizing the pain of her shame back into her belly, but without the ability to call for her "tummy" to be rubbed better by a loving parent.

Touch is central to the resolution of the pain, both throughout her life and in therapy. The seeming miraculous resolution through touch of Grace's stomach pain seems like the climax of this therapeutic journey. However, the pain did, gradually, return, and Grace is currently undergoing treatment for two small tumors found in her small intestine. She feels that the legacy of a lifetime of shame has finally become material. I am saddened by the weight of her shame and its long-term consequence. Nevertheless, both Grace and I felt that this touch intervention provided a key to her understanding. Grace spoke of how, after that moment, she felt enlivened and hopeful, that she could find resolution to her physical pain, and she believes it was instrumental in her seeking further medical help. Through exploring her longing for her mother’s attention and “being placed above all others,” she became enabled to find her voice in asking for what she needed without explosive rages, whether this was asking for help, nurturing, or for emotional support from her husband. Reparative and engaged touch has affected her emotional, relational, and behavioral responses and her physical symptoms. Unlike the state of shame, which is alienating and lonely, she has begun to feel able to connect to others, and to see others as sources of comfort and support, and that she deserves that.

Finally and consequently, the isolation and loneliness that Grace had been experiencing as a result of her shame could be acknowledged. We explored appropriate expressions of anger, rage, and grief and, finally, relational support. She was incredibly independent and self-reliant, and imbued these characteristics into both of her daughters. However, she now acknowledges that “I see that sometimes they are a little too much like me, and like me have brushed away events, and got on with things, events that I now recognize as traumatic.” She now feels that she has become more honest with herself and others, and is better equipped to heal the loneliness in her relationships with her husband and her family, and she hopes to pass on a better model of self-nurture and connectivity to her daughters.

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REFERENCES


Process-Oriented Approach to Working with Body Symptoms

Barbora Sedláková, Tomáš Dominik, Marek Kolařík

ABSTRACT

Objective. This study examines the effects of process-oriented approach to working with body symptoms on clients' symptom severity, well-being, and satisfaction.

Method. We used an additive design. Quantitative repeated measures were obtained from 67 participants randomized into experimental and control groups. Thirty-five participants from the experimental group underwent an experimental session by using Process-oriented Psychology, and were administered questionnaires immediately before, immediately after, and one week after the session. Thirty-two participants in the control group were administered questionnaires twice—one week apart, while no session was provided in the meantime. We used the following methods for data collection: Brief Symptom Inventory (BSI), Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), Individual Symptoms Scale (ŠIP), and Outcome Rating Scale (ORS). The effect of process-oriented approach was assessed using a two-way ANOVA for repeated measures, supplemented by Tukey’s post-hoc test and descriptive statistics on subjective session rating scales.

Results. Compared to the control group, the experimental group clients displayed a subjective alleviation of reported symptoms, a significantly larger improvement in subjective well-being, and higher satisfaction (in society) after the session.

Conclusions. Process-oriented approach to working with body symptoms seems to be effective in reducing the severity of subjectively reported symptoms and increasing well-being and satisfaction in society.

Keywords: Process-oriented Psychology, Process Work, body symptoms, psychosomatics, psychotherapy

Most psychotherapeutic approaches work with clients’ thought awareness, i.e., their inner conflicts, relationships, workplace problems, trauma, fears, discontentment, etc., and only a few of them include body awareness and body symptoms in the therapeutic work (Tress, Krusse & Ott, 2008).

However, in accordance with the current holistic paradigm, the etiology of illness is complex, including physical, mental, and social factors (Faleide, Lian & Faleide, 2010; Morschitzky & Sator, 2007), and a large portion of clinical and empirical literature is devoted to this issue (Bauer & Kächele, 2005; Bob & Vymětal, 2005; Grawe, 2007). There also exist medically unexplained physical symptoms (hereinafter referred to as MUPS) which can relate to somatic illness, whose etiology has not been satisfactorily explained (Řiháček, Pavlenko & Franke, 2017). Moreover, there are also several other illnesses generally considered to be caused mostly psychologically (Tress, Krusse & Ott, 2008).

Bob & Vymětal (2005) state that the goal of psychotherapy should be to influence the mind and body’s health through the psychotherapeutic effect on clients’ biological function. Research in this
Process-oriented Psychology (also called Process Work) is a phenomenological approach developed in the 1970s by Arnold Mindell, who researched body symptoms and Jungian analysis of dreams (Diamond & Jones, 2005). It is used by hundreds of psychotherapists and facilitators around the world in the fields of psychotherapy, psychiatry, social work, conflict resolution, group work, care, organizational change, and community building (Diamond & Jones, 2005). Exploration of symptoms can give clients meaning; for instance, symptoms can be perceived as a reaction to something or a direction of change in life (Mindell, 2001; Morin, 2019; Weyermann, 2006). In Process-oriented Psychology, the main goal is to bring awareness to what is happening right now (Diamond & Jones, 2005). The attention of the therapist is divided between two processes:

1. Noticing signals of identity, which are close to personal awareness and include elements with which the client is identified (primary process)
2. Marginalized elements (secondary process) (Diamond & Jones, 2005)

By marginalized, we mean that they are set aside from the focus of identity. Sometimes they are unconscious but could be also conscious – but we do not follow them. Signals of these two processes emerge in different ways, through channels. Channels are divided into: visual, auditory, movement, proprioceptive, relational, and world channel (Diamond & Jones, 2005). The marginalized aspect of a client’s wholeness will emerge as a disturbing signal (e.g., a symptom) (Mindell, 1990). By unfolding this signal with sensory-grounded awareness, we unravel, in a more tangible way, a new quality to which the client did not have access before (Mindell, 1998). Through unfolding this quality, the client can then experience a “dream figure”, that is, an embodied experience of the originally marginalized quality (Mindell, 1990). The last part of the work includes integration of the experience into the client’s daily life (Diamond & Jones, 2005).

Although Process-oriented Psychology is used by practitioners around the world who present cases and qualitative research results featuring the benefits of this method (Fukao et al., 2007; Mindell, 2001; Morin, 2019; Panáková, 2003; Weyermann, 2006), quantitative research is missing. However, there already exist several studies presenting other psychotherapeutic methods of working with a client’s body symptoms bringing encouraging results (Akasheh & Sadoghi, 2010; Limburg et al., 2018; Lyonne et al., 2012; Rutledge, Redwine, Linke & Mills, 2013).

The above-mentioned findings inspired us to conduct a study by using additive design. In the additive design, a specific ingredient is added to an existing treatment (Borkovec, 1990), and so there is a reason to believe that the ingredient added to the treatment will augment the benefits derived from the treatment (Ahn & Wampold, 2001). The main hypothesis is to find out whether using the Process-oriented Psychology method can cohere with subjective decrease of symptoms and an increase in well-being and satisfaction.

**Methods**

**Participants**

**Clients.** Sixty-seven clients (47 females and 20 males) participated in this study. Their age varied between 18 and 63 (mean = 38.4, SD = 11.3). The sample represented three types of clients: 31 participants were hospitalized in psychiatric clinics, 26 regularly attended a psychological outpatient facility, and 10 clients were individuals experiencing common medical care and self-supportive methods (such as yoga, meditation, and physical exercise). Hospitalized and psychological outpatient facility clients represented a variety of mental illnesses: 46 were diagnosed with anxiety, stress-related and somatoform disorders, and 11 with affective (mood) disorders.

**Symptoms.** Each participant chose one symptom to work with on the experimental session. In the experimental group, the following symptoms were treated: anxiety and nervousness (14), digestive diseases (4), back and joint pain (4), headache (3), body pain (3), respiratory diseases (3), eczema (1), sleep disorders (1), varices (1), and eye diseases (1). The control group was concerned with these symptoms: anxiety and nervousness (13), digestive diseases (5), back and joint pain (3), eczema (3), body pain (2), sleep disorders (2), respiratory diseases (2), headache (1), and eye diseases (1). Forty-nine participants described the chosen symptom as chronic, and 11 as acute. Further, nine participants mentioned that they suffered from other mental problems, 14 from somatic symptoms, and 44 from both. Twenty-one participants were regularly taking psychopharmaceuticals, nine participants somatic medication, 19 both, and 18 were not using regular medication.

**Procedure**

**Recruitment.** The selection criteria were as follows: men and women aged 18–65, hospitalized in psychological outpatient facilities (with diagnosis of F3 or F4 categories in ICD-10) or using self-healing methods, currently having a body symptom that they would like to explore (except oncological symptoms). The exclusion criteria were as follows: clients with diagnoses of F0, F1, F2, or F6 categories in ICD–10 attending another individual psychotherapy session during involvement in our research. The participants were selected through a non-random sampling mediated by institutions (Miovský, 2006). Potential participants received informa-
tion about the research via handouts distributed in the institution (at two wards in a psychiatric clinic, at four offices in two psychological outpatient facilities, and in one place of group meditation), or during communication with their therapist. Of the total of 71 participants, 67 were analyzed. Two participants didn’t complete the questionnaires, and two did not meet the inclusion criteria.

Participants were randomly assigned to a control or experimental group using an alternating assignment during the recruitment process; i.e., we assigned odd participants to the control group, and even participants to the experimental group. The control group consisted of 32 participants, with treatment as usual. The experimental group included 35 participants who attended one experimental session to work with one of their symptoms, in addition to their usual treatment. Participants from the control group, however, received a session later, so that none were denied potential benefits of the method. Informed consent was obtained from all participants in written form.

Table 1 presents detailed demographic data broken down by groups.

**Study design.** The first author (female with almost five years of full-time therapeutic and diagnostic practice, attending the second phase of the diploma training in Process-oriented Psychology) conducted experimental sessions and administered a questionnaire one week apart, while simultaneously collecting data individually from each participant. Participants from the experimental group underwent an experimental session (hereinafter referred to as session) using process-oriented approach, and were administered the questionnaires named below immediately before, immediately after, and one week following the session. Participants in the control group were administered questionnaires twice, one week apart, while no sessions were provided in the interim. The research complied with ethical conditions for psychological research by APA.

**Test battery.** Participants from the control group completed the following methods on the first questionnaire that was administered: Demographic questionnaire, Brief Symptom Inventory (BSI), Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), Individual Symptoms Scale (ŠIP), and Outcome Rating Scale (ORS). On the second questionnaire that was administered one week later, the test battery was identical, except for the missing demographic questionnaire. Participants in the experimental group completed the following methods right before the session: Demographic questionnaire, BSI, CORE-OM, ŠIP, and ORS. Immediately after the session, they completed the ŠIP for the second time. One week later, the questionnaire administration was the same as the second administration for the control group. All methods were administered in the Czech language.

**Brief Symptom Inventory (BSI)** is a shorter, multidimensional version of the Symptom-Checklist 90-R (SCL 90-R), the questionnaire used to detect the presence of psychopathological symptoms (Derogatis, 2017; Derogatis & Melisaratos, 1983). The instrument consists of 53 items using a five-point Likert scale covering nine subscales: Somatization, Obsession–Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, and Psychoticism, as well as three general indexes: Global Severity Index (GSI), Positive Symptom Total (PST), and Positive Symptom Distress Index (PSDI) (Derogatis & Melisaratos, 1983). The psychometric properties of the Czech version of the method were investigated by Kabát et al. (2018). The nine-factor model was found to be valid, the method exhibited satisfying level of internal con-

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Experimental group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean age (SD)</strong></td>
<td>40.57 (10.47)</td>
<td>36.03 (11.79)</td>
</tr>
<tr>
<td><strong>Sex (frequencies)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td><strong>Client type (frequencies)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-clinical</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>clinical, inpatient</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>clinical, outpatient</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td><strong>Diagnosis (frequencies)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety, stress-related and somatoform disorders</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>Affective disorders</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>
sistency (Cronbach’s $\alpha = 0.97$, McDonald coefficients $\omega_h = 0.84$ and $\omega_t = 0.97$), and its convergent validity was supported by moderate-to-high correlation with the related SF-8 questionnaire. The Global Severity Index, representing BSI total score, showed excellent internal consistency (Kabát et al., 2018).

**Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM)** is a 34-item self-report instrument developed for monitoring changes in clients during therapy within four domains: well-being, symptoms, function and risk (Evans et al., 2002). We administered the Czech version of the method, followed the four-factor model recommended for the similar Slovak version of CORE-OM (Bieščad, 2007), and analyzed the total score and the well-being, symptoms, and function factors accordingly (the risk factor was of little interest to us, as this study did not focus on risky behavior). After we finished data collection, a study of psychometric properties of the Czech version of CORE-OM was published (Juhová et al., 2018), showing satisfying internal consistency (Cronbach’s $\alpha = 0.933$) and parallel validity, demonstrated by moderate-to-high correlation with related methods (SCL-90 and RSES). Juhová (2015) also demonstrated test–retest reliability by $r = 0.70$. However, the recent study (Juhová et al., 2018) showed little support for the four-factor model of CORE-OM. With regard to recommendations given by these authors, we will in this paper present only the CORE-OM total score.

**Individual Symptoms Scale (ŠIP)** is a Czech self-report instrument created by Professor Kratochvíl to evaluate the effect of psychotherapy (Timuľák, 2005). The instrument contains 10 empty boxes where the client writes symptoms and evaluates them on a prescribed five-point scale. At the end of treatment, the client receives the completed form with initial symptoms, and evaluates them again (Kratochvíl, 2006). The difference between the score before and after the therapy is an indicator of changes (Kratochvíl, 2006). The instrument is widely used in the Czech psychotherapeutic domain as well as in research (Turbová & Cargaš, 2004).

**Outcome Rating Scale (ORS)** is an instrument to evaluate the effect of therapy, and is based on the concept of the widely-used OQ-45 questionnaire (Miller, Duncan, Brown, Sparks & Claud, 2003). The ORS includes four visual 10-centimeters long analog scales: personal satisfaction, in relationships (family, close relationships), in society (work, school, friends) and overall (total satisfaction) (Zatloukal, Žákovský, Věžník, Řiháček & Tkadlčíková, 2006). The client’s task is to rate the scales by marking how satisfied they felt in the given area during the previous week. Preliminary analyses of psychometric properties of ORS show satisfying internal consistency (Cronbach’s $\alpha = 0.80$), lower test–retest reliability (test–retest $r = 0.58$), and low-to-moderate correlation to related methods SCL-90 and RSES (Juhová, 2015).

**Experimental Session**

We were inspired by a previous qualitative study conducted by Weyermann (2006) and consulted it with skilled process-oriented therapist Ivan Verný. The session represented both structured and creative work by using Process-oriented Psychology and lasted between 50 and 60 minutes.

**Step 1: Primary identity.** Participants were questioned about their everyday identity: Who were they during the last few days, and who are they today? How do they live?

**Step 2: Symptom description.** Participants described a symptom they have chosen, as well as their attitude to the symptom, and explained how they perceived it.

**Step 3: Symptom drawing.** In this step, participants simply drew themselves with the symptom and named it.

**Step 4: Disturbing quality.** Participants described the symptom and its manifestations in detail. A sensor-y-based description was used (for instance warmth, tingling, pressure), and the most disturbing quality was identified.

**Step 5: Amplification.** Further on, the participants were supported to develop the quality in the way it emerged (through movement, proprioception, sound, imagination). At the end, the quality was given a form of a mythological or historical entity – “a dream figure” – that represents this quality naturally.

**Step 6: Self-drawing.** Participants drew themselves with the identified embodied quality, named it, and were questioned about their current attitude toward the symptom.

**Step 7: Integration.** Participants were asked a few questions to help integrate the experience into their everyday life. For example: Where and when have they already noticed this quality in their life? When and how could this quality be helpful in their current life?

**Step 8: Encouragement.** Finally, participants were encouraged to return to the discovered quality or mythological figure, and to try to experiment with it during the following week.

**Analysis**

All available data were aggregated in an MS Excel spreadsheet. We used MS Excel version 1902 to detect and remove outliers (based on the Tukey’s $1.5 \times IQR$ rule, see Tukey, 1977), and to analyze demographic data (i.e., clients’ ages and clinical backgrounds). The rest of the data were analyzed in Tibco Statistica 13.3 software using ANOVA for repeated measures, followed by Tukey’s post-hoc tests in the case of significant results. Residual normality assumption for ANOVA was checked by using the Shapiro–Wilk test. In the case of suspected non-normality, the original data were transformed using natural logarithm and the analysis was performed again. Log-transformation has traditionally been used to correct positively skewed data (Bland & Altman,
1996), although its use bears significant limitations and might even fail to normalize the data (Feng et al., 2014). If log-transformation failed, the fact was noted by the respective results, together with information on whether corrected (i.e., log-transformed) or uncorrected data were used for the final analysis. We used parametric ANOVA for repeated measures even if the ANOVA assumptions could not be fully satisfied, for two reasons. One is that from its principle, it is possible for the Shapiro–Wilk test to yield false positive results in larger samples, simply because statistical test sensitivity generally increases with increasing sample size. Second, we are unaware of a non-parametric substitute for two-way repeated measures factorial ANOVA. Therefore, we proceeded with the parametric analyses even in cases of suspected violation of ANOVA assumption while transparently admitting the fact.

Results

Before further analyses, the experimental and control groups were checked for differences in sex ratio, age, education, and subjectively reported symptoms severity on a scale from 1 to 10. No significant difference between the experimental and control group was found for sex ratio ($\chi^2(1) = 1.861, p = 0.173$), age ($t(65) = 1.669$, $p = 0.100$), education ($\chi^2(4) = 4.017, p = 0.404$), or reported symptom severity ($t(65) = 0.738, p = 0.463$).

Changes due to therapeutic work were analyzed separately for individual scores, which were identified to be of interest to the present research.

In Brief Symptom Inventory (BSI), we were specifically interested in Global Severity Index (GSI) and Somatization subscale. In the case of GSI, the model built on the original data was non-normally distributed ($W = 0.956, p = 0.024$ for the pre-test and $W = 0.945, p = 0.007$ for the post-test). Therefore, we log-transformed the Somatization scores, which increased by 2. Again, the pre-test residuals were successfully corrected ($W = 0.971, p = 0.137$) while post-test residuals remained non-normally distributed ($W = 0.957, p = 0.028$). We conducted an analysis on the corrected data. We found significant effect of measurement ($F(1,61) = 9.259, p = 0.003, \eta^2_{partial} = 0.132$), while the main effect of group remained insignificant ($F(1,61) = 0.070, p = 0.793, \eta^2_{partial} = 0.001$). The interaction between measurement and group is significant ($F(1,61) = 4.288, p = 0.043, \eta^2_{partial} = 0.066$). Tukey’s post-hoc test clearly shows this to be due to a significant decrease in reported symptoms in the experimental group ($p = 0.002$), while the corresponding difference in the control group remains insignificant ($p = 0.911$). Furthermore, no significant difference was found between the groups in pre-tests ($p = 0.907$). For an overview of Somatization subscale analysis, see Figure 1b.

Identical analysis was applied to the overall score of Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM). The original data led to normally distributed residuals in the pre-test ($W = 0.975, p = 0.202$), but non-normal residual distribution in the post-test ($W = 0.956, p = 0.019$). Therefore, we log-transformed the CORE-OM data, which increased by 3, by which we achieved normal residual distribution for both pre-test ($W = 0.981, p = 0.387$) and post-test ($W = 0.967, p = 0.080$). We used the corrected data for the analysis. A significant main effect of measurement was found ($F(1,64) = 14.121, p < 0.001, \eta^2_{partial} = 0.181$), while the main effect of group was insignificant ($F(1,64) = 1.979, p = 0.164, \eta^2_{partial} = 0.030$). A significant interaction of measurement and group was found ($F(1,64) = 5.921, p = 0.018, \eta^2_{partial} = 0.085$) and further supported by Tukey’s post-hoc test, showing significant improvement in the experimental group ($p < 0.001$), while this difference remained insignificant in the control group ($p = 0.800$). The groups did not significantly differ in the pre-test scores ($p = 0.925$). For an overview of CORE-OM analysis, see Fig.2.

Unlike the previous cases, the Individual Symptoms Scale (SIP) was analyzed in two ways, because in the experimental group it was administered immediately before, immediately after, and one week after the session (unlike the other methods, which were administered only twice – before the session and one week

1. In some cases, integer 1, 2, or 3 was added to all values to avoid calculating logarithm from values equal to or near 0.
Figure 1a Shift in the means of GSI score between pre-test and post-test for the experimental and control group. The vertical lines denote 95% confidence intervals.

Figure 1b Shift in the means of BSI somatization score between pre-test and post-test for the experimental and control groups. The vertical lines denote 95% confidence intervals.
Therefore, while the first analysis follows the pre-test/post-test template presented so far, the second analysis adds a within-subject repeated-measures comparison of situations before, right after, and one week after the experimental session. The first analysis was conducted on the uncorrected data, since no deviation from normal distribution was found in either the pre-test ($W = 0.967, p = 0.087$) or the post-test residuals ($W = 0.978, p = 0.323$). The outcomes of the model show a significant main effect of measurement ($F(1,61) = 54.556, p < 0.001, \eta_{partial}^2 = 0.472$), a significant main effect of group ($F(1,61) = 7.288, p = 0.009, \eta_{partial}^2 = 0.107$) and significant interaction between measurement and group ($F(1,61) = 5.332, p = 0.024, \eta_{partial}^2 = 0.080$). Tukey’s post-hoc test revealed a significant decrease in reported symptoms in both the experimental and the control groups ($p < 0.001$ and $p = 0.006$ respectively). However, the improvement seemed larger in the experimental group because, while no significant difference between the groups was found in the pre-test ($p = 0.795$), a significant difference was found in the post-test ($p = 0.003$). For the ŠIP results overview, see Fig. 3a.

The additional analysis of the ŠIP data aimed to examine the within-subject differences of the ŠIP score before, immediately after, and one week after the session in the experimental group. The residual normality assumption was satisfied for all three consecutive measurements ($W = 0.951, p = 0.139; W = 0.967, p = 0.404$ and $W = 0.938, p = 0.061$, respectively). The one-way repeated-measures ANOVA showed a significant main effect of measurement ($F(2,64) = 77.236, p < 0.001, \eta_{partial}^2 = 0.707$). The main effect of group cannot be assessed, because no control comparison was available for the situation right after the session. Tukey’s post-hoc test revealed that all examined differences are significant – there was a significant decrease of the reported problems right after the session compared to before the session ($p < 0.001$), a milder, but still significant increase in the reported problems one week after the session, compared to right after the session ($p < 0.001$), but also a significant decrease between the measurement before the session and one week later ($p < 0.001$). For an overview of the results, see Figure 3b.

The Outcome Rating Scale (ORS) contained four scales that are of interest to us (personal, in relationships, in society and overall). All four scales exhibited negatively skewed residual distribution (see Table 2). Logarithmic transformation did not help correct the data, as it is used to correct positively skewed distributions. Therefore, a parametric ANOVA was used, but caution is advised in interpreting the results. For detailed results, see Table 3. In the case of all four ORS scales, the main effect of measurement was significant in all scales. The main effect of group was insignificant in all scales. The only significant in-

Figure 2 Shift in the means of CORE-OM overall score between pre-test and post-test for the experimental and control groups. The vertical lines denote 95% confidence intervals.
Process-Oriented Approach to Working with Body Symptoms

Figure 3a Shift in the means of ŠIP score between pre-test and post-test for the experimental and control groups. The vertical lines denote 95% confidence intervals.

Figure 3b Shift in the means of ŠIP score between measurements before the session, right after the session and one week after the session. The vertical lines denote 95% confidence intervals.
Interaction between measurement and group was found in the in-society scale, which Tukey’s post-hoc test clearly showed to be due to differences between the first and second measurements in the experimental group ($p < 0.001$), while other differences remained insignificant. Interactions between measurement and group in all other scales were insignificant. Even though these interactions were found to be insignificant, Tukey’s post-hoc test revealed a significant difference between the first and second measurements in the experimental group ($p = 0.042$ for personal scale; $p = 0.002$ for in relationships scale; and $p = 0.002$ for overall scale), while the corresponding difference was not found to be significant in the control group ($p = 0.955$ for personal scale; $p = 0.710$ for in relationships scale; and $p = 0.990$ for overall scale).

**Discussion**

In our study, both GSI and Somatization subscales in BSI were found to be influenced by interaction between group (experimental and control) and measurement (before and after the session for the experimental group, or before and after the waiting period for the control group). Post-hoc tests revealed this to be due to a decrease in symptom severity in the experimental group, clearly suggesting that process-oriented approach to working with body symptoms lowers the reported severity of experienced symptoms.

<table>
<thead>
<tr>
<th>Scale</th>
<th>$W_{pre-test}$</th>
<th>$p_{pre-test}$</th>
<th>$W_{post-test}$</th>
<th>$p_{post-test}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>0.952</td>
<td>0.012*</td>
<td>0.932</td>
<td>0.001**</td>
</tr>
<tr>
<td>In relationships</td>
<td>0.945</td>
<td>0.005**</td>
<td>0.903</td>
<td>&lt; 0.001***</td>
</tr>
<tr>
<td>In society</td>
<td>0.948</td>
<td>0.007**</td>
<td>0.936</td>
<td>0.002**</td>
</tr>
<tr>
<td>Overall</td>
<td>0.942</td>
<td>0.004**</td>
<td>0.934</td>
<td>0.002**</td>
</tr>
</tbody>
</table>

*Note: * signifies $p < 0.05$, ** signifies $p < 0.01$, and *** signifies $p < 0.001$*
A similar effect was found in CORE-OM and ŠIP. Nevertheless, contrary to our expectations, the control group reported a significant decrease in ŠIP, although to a lesser extent than the experimental group. This could be attributed to the attention the clients gave to their symptoms while completing the ŠIP scale, which might have led to actual relief due to simple externalization of the reported symptoms. An alternative explanation might be that mere expectation of the upcoming treatment might induce a drop in reported symptom severity.

Additionally, we analyzed ŠIP data with regard to reported symptom severity before, right after, and one week after the session to examine the course of the change in more detail. The results shown in Figure 3b show a large drop in reported symptom severity immediately after the session, followed by a slight, although significant, increase during the follow-up week period. It should be noted that this three-time-point analysis is limited, as we cannot conclusively attribute the effect to process-oriented approach due to a relevant control group missing from our methodological arrangement. Further research in the temporal course of the effects of Process-oriented Psychology might be needed, especially with a focus on longer-term effects (months or years).

The ORS contains four scales generally reflecting changes in respondents’ satisfaction attributable to the therapy. Post-hoc tests on all of these four scales showed a significant increase of subjective well-being in the experimental group, while in the control group it did not. However, a significant effect of the interaction between measurement and group was found only in the in-society scale, so the results should be accepted with caution.

A review of all analyzed scales (GSI, BSI Somatization, CORE-OM, ŠIP and all ORS subscales) also revealed a significant main effect of the measurement, suggesting that certain improvements might be found in both the experimental and control groups. Nevertheless, this is not surprising, because all participants, including those in the control group, were subjected to treatment “as usual,” and so a certain amount of improvement was to be expected. A larger degree of improvement in the experimental group in most scales, however, still supports the idea of effectiveness of process-oriented approach to working with body symptoms. Results of this study may supplement theoretical literature and scarce empirical research of Process-oriented Psychology and similar methods. Generally, the process-oriented psychology literature says that examining the subjective experience of symptoms can broaden perception of who we are, and support self-healing potential (Mindell, 2001; Mindell, 2004; Morin, 2019; Weyermann, 2006). Unfortunately, no such quantitative research of Process-oriented Psychology has been done yet, so we do not have the opportunity to compare our results to previous studies.

**Limits and Future Research Implications**

**Symptoms.** In our study, symptoms were understood as disturbing body manifestations, regardless of whether they were acute or chronic. For a future study, it would be interesting to focus on one specific group of symptoms.

**Participants.** The sample represents a population of individuals suffering from personal problems and body symptoms motivating them to seek treatment in some form. Selecting only certain defined groups of clients in a future study would allow us to compare these groups, and to obtain more specific findings.

**Study design.** The method we used for the data creation – i.e., quantitative analysis of repeated measures – is listed by Timulák (2005) as one of the recommended methods for studies of psychotherapy’s effect and is commonly used in similar psychotherapy research design. Using self-report questionnaires limits the full range of variables possibly worth examining. Although participants were supported to answer truthfully and be critical in questionnaires, the Hawthorne effect (participants know that they are part of an experiment and could react in ways they want in order to please the experimental therapist) might be involved in the results (Adair, 1984). So it is advisable that further research employ different methods for data collection.

**Data analysis.** Even though log-corrected GSI and BSI Somatization scores exhibited normal distribution in the first measurement, the data tended to shift into positively skewed distribution in the second measurement. The same phenomenon can be observed in the entire ORS scale, even though in those cases, the residual distribution was not normal, even in the pre-test. This was clearly caused by the tendency of the participants in the experimental group to report an improvement, while control group participants reported only a small, mostly insignificant, improvement. Even though none of our analyses contradict each other, a different approach to statistical analyses might be utilized in future research, although as stated earlier, we are unaware of a non-parametric substitute used for two-way repeated measures factorial ANOVA.

**Amount of psychotherapy.** Lambert, Hansen & Finch (2001) consider that two criteria predicted improvement in psychotherapy related to the number of sessions completed: severity of input problems, and early positive response to therapy (which means that the client improved rapidly during the first three sessions). However, a larger number of sessions in future research on this topic should be a promising step.

**Dual role – researcher and therapist in one person.** Given that our study is a first step on this topic, it was clear from the beginning that only a small team of researchers would be available. We made sure that the primary data analysis was carried out by the second author,
who was not subjected to being in a dual role, and that the researcher with a dual role was maximally flexible between the role of therapist and researcher. A promising step for a future study would be to separate the two roles between two independent researchers.

Conclusion

The presented study offers encouraging findings, where using process-oriented approach to working with body symptoms seems to be effective in reducing the severity of subjectively reported body symptoms, and increasing well-being and satisfaction (in society).

Practitioner Points

◼ This article presents a research study using process-oriented approach to working with body symptoms in 67 clients randomized into experimental and control groups.
◼ Process-oriented approach seems to be effective in reducing the severity of subjectively reported body symptoms, and increasing well-being and satisfaction (in society).
◼ The study findings are encouraging, support the psychosomatic approach, and suggest including working with body symptoms in psychotherapy by using Process-oriented Psychology.

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People don’t have perfect babies. Internal events, such as anxiety, or the mother’s blood pressure rising to a dangerous level, and external events, such as smoking, spouse abuse, or lack of an adequate supply of food, can impact the fetus and even change the DNA (Amblagan et al., 2013; Bosch, 2010; Janus, 2001; Paul, 2010; Schulz, 2010). On “Chopped,” a popular cooking show, excellent chefs compete to prepare a meal before the timer pings. Even the best chefs make mistakes and present the judges with food that is overdone, tough, or bitter. Similarly, during the nine months in the womb, fetuses are subjected to undesirable consequences. Because they share a bloodstream with their mothers, they absorb toxins like nicotine, biochemicals such as adrenaline, over-the-counter or prescribed medicines – some of which can cause birth defects, and they experience loud noises, noxious fumes, food with little nutritional value, violent behavior, and strong emotions, such as rage and anger (Amblagen et al., 2013; Boadel-la, 1987; Bosch, 2010; Meany, 2018; Netherton & Rohr, 2019; Paul, 2010; Schulz, 2010; White, 2010; Zhau et al., 2018). Given these factors, psychotherapists and counselors need to understand how nine months in the womb can affect mental health, and they need to incorporate methods and techniques into their practices to use with clients who have experienced gestational trauma (Ball, 2011; Hunter & Struve, 1998; Janus, 2001, van der Kolk, 2014; Levine, 2010; Lipton, 2005; Masters & Houston, 1978).

Epidemiological data cited by Netherton and Rohr (2019) show that physical abuse is experienced more often by pregnant than by non-pregnant women. Physical abuse during pregnancy correlates highly with miscarriage, low birth weight, and infant mortality (Muzik et al., 2016; Paul, 2010; Seng et al., 2001). I saw
this firsthand in my practice when my client, Jennifer, began living with her boyfriend after learning she was pregnant. Although they looked forward to having a baby together, neither parent-to-be had experienced a stable family as a child. Jennifer’s alcoholic mother continued to drink throughout her childhood, and her father, diagnosed with schizophrenia, lived either with his sister or on the street. Therefore, when Bob came home late after drinking with his buddies, his use of alcohol triggered Jennifer’s long-suppressed rage. She asked him to stop drinking in a sarcastic, angry, and demeaning tone of voice. In response, he threatened her, threw food, put his hands around her neck as if to strangle her, and stomped out of the apartment. Her body responded with rising blood pressure and an anxiety attack. Cortisol flowed into the bloodstream she shared with her baby. This pattern continued throughout the pregnancy.

Research shows that many substances pass through the placenta; it is no longer considered to be a strong barrier that keeps a baby safe (Dunn et al., 2019; Paul, 2010; Sapolsky, 2017). Using data from the Avon Longitudinal Study of mother and child pairs, Dunn et al. (2019) discovered 38 sites with methylation distortions in children prior to age seven following prebirth and birth trauma and adversity. Exposure to maternal cortisol during pregnancy was found to slow development one year after birth, as measured by the Baily Scale of Infant Development (Davis & Sandman, 2010). Because growing fetuses are affected by the chaotic lives their parents live and by the medicines their parents take, they respond symptomatically to the external and internal stress they experience – if not immediately, years later (Netherton & Rohr, 2019; Paul, 2010). More mental and physical illness and dysfunctional behavior patterns are found in those whose fetal life was colored by traumatic events, such as the Dutch Hunger Winter Study described by Schulz (2010).

From her review and analysis of hundreds of academic journal articles involving epidemiological research, as well as empirical studies of the fetus, Paul (2010) determined that life in the womb can predict one’s future life on earth. The science of fetal origins shows how prenatal experiences determine one’s destiny (Lange, 2011; Paul, 2010). Lange’s (2011) findings from a review of numerous animal studies show that primates who experienced prenatal stress suffered later life consequences. Somatic therapists have opportunities to make interventions prior to pregnancy, during pregnancy, immediately after the child is born, and into adulthood to reverse these negative effects. Janus (2001) reports that dream analysis helps clients resolve trauma that occurred prior to birth and during birth. According to many clinicians, a holistic approach that integrates work with mind, body, spirit, and emotion, and is designed to heal trauma experienced before conscious memory, has been found to help clients suffering from traumatic prenatal or birthing experiences (Ball, 2011; Boadella, 1998; van der Kolk, 2014; Levine, 2010; Rand & Caldwell, 2004; Wilner, 1999).

DNA, Genetics, and the Environment

Humans receive a recipe for life while still in the womb. Genetics, external stressors, and events internal to the mother’s physical body shape the personality, behavior, belief systems, values, fears, and sexuality of the person the fetus becomes (Amblagan et al., 2013; Dunn et al., 2019; Meany, 2018; Paul, 2010; Sapolsky, 2017). Research supports the theory that genetic, epigenetic, and biochemical programs fetuses download in the womb can be rewritten; bodies, personalities, and belief systems can change (Hunter & Struve, 1998; van der Kolk, 2014; Levine, 2010; Lipton, 2005; Masters & Houston, 1978). Our goal as body therapists is to help our clients rewrite prenatal programs by working through the richness of the body, the senses, emotions, and the mind (Boadella, 1987; van der Kolk, 2014; Levine, 2010; Pierrakos, 1990).

John C. Pierrakos, M.D. (1998), my mentor in Core Energetics, used the word “plastic” to describe the body and the cells that make it up. He believed that by applying techniques that helped clients free up energy that was blocked in the muscles and the connective tissue of their bodies, prohibiting natural movement, he could help them achieve healthier outcomes, experience pleasure, and replace negative, self-defeating behaviors with positive ones (Pierrakos, 1990). Current research results support this theory, demonstrating mind-body plasticity. For instance, stroke patients who lose one pathway in the brain can, with practice, open new pathways in their brains (Cozolino, 2002). Cozolino’s (2002) research on brain development integrated findings from ecological studies, his clinical practice, attachment theory, developmental psychology, and neuroscience. If the plasticity he describes did not exist, people would be locked into a rigid system of being, unable to change. Somatic therapists can approach their clients knowing that cells are flexible, and that movement will create positive pathways into the future (Boadella, 1998; van der Kolk, 2014; Levine, 2010; Masters & Houston, 1978; Pierrakos, 1990).

Bruce Lipton’s (2015) research shows that inherited DNA does not define one’s future as once thought. Studies from the field of epigenetics conclude that the stressful situations people and fetuses are exposed to change the protein inside their genes. The behaviors supported by those genes then change, in some cases for the better and in others for the worse (Lipton, 2015). Fetal trauma results in changes in the personality, behavior, and body of the adult who the fetus becomes, leading to more mental health and behavior problems (Lange, 2011; Paul, 2010).

Women, Despair, and Pregnancy

Many women experience ambivalence upon learning they are pregnant (Bibring, 1961). The new mother looks at her baby and realizes that her life has changed in ways
over which she has no control. Grete Lehner Bibring (1961), a psychiatrist at Beth Israel Hospital in Boston, wrote that a woman’s inner and outer life changed along with her body during pregnancy: unresolved issues from the past emerged, old coping skills no longer worked, new and unfamiliar roles arose, unexpected issues with partners created stress, and changes at work became necessary.

Women from the ages of 20 through 40 experience more depression and anxiety than do women at any other phase of life (Netherton & Rohr, 2019), and they experience depression and anxiety during the period that they are most likely to give birth (Meany, 2018). Empirical studies show that twenty percent of pregnant women are moody or anxious, ten percent develop major depression, and pregnant mothers diagnosed with depression are two times more likely to have premature births (Paul, 2010). Their babies display more depressive symptoms and have lower birth weights than those of non–depressed mothers (Paul, 2010). Meany (2018) reports that biochemical imbalances found in pregnant, depressed women cross the placenta and compromise fetal brain and nervous system development, shaping how emotions will be experienced in the future. New babies of depressed mothers have been found to be irritable, hard to soothe, impulsive, and emotional (Meany, 2018).

Ambivalent parenting affected one of my clients as well. Louis’ body showed signs of receiving a dose of hate while still in the womb. He was thin and wiry, with a bony chest and ribs that stuck out. Scoliosis twisted his spine, and his eyes appeared vacant. These physical attributes can indicate that he experienced rejection in the perinatal or prenatal period (Pierrakos, 1990). When the fetus does not receive maternal love, nourishment, and safety, the lack of affection or its loss can manifest in psychological disorders: schizoid responses, depersonalization, fragmented energy, and depression can result (Janus, 2001; Lowen, 1976; Pierrakos, 1990).

Louis’ biological mother abandoned him, and the woman who adopted him wanted a baby girl. She never missed an opportunity to let him know about her disappointment. Not feeling loved or welcomed by either his birth or adoptive families, deep within Louis’s unconscious lurked a terror of life, and strong hate for those who abandoned and betrayed him. Ignoring the body that housed these feelings, he distanced himself from the physical structure below his neck.

The mother of another client, Linda, complained that her life would have been much better if Linda had never been born. This woman suffered domestic abuse for many years, even during her pregnancy with Linda. Born prematurely, Linda was diagnosed with both arthritis and lupus by age seventeen. Emotionally over-reactive as an adult, she is easily hurt and quick to anger, experiencing a loss of control and erupting into violence at times.

Techniques to Promote Healing Fetal Trauma

As fetuses, our clients had no control over their experience, but now as adults who are choosing to let go of the negative story their bodies carry, they are able to create a new script (Lipton, 2005; Wilner, 1999). Bodies, personality, behavior, and belief systems can all change by using techniques designed for the treatment of perinatal injuries or trauma (Boadella, 1987; van der Kolk, 2014; Levine, 2010; Lipton, 2005; Pierrakos, 1990, Rand & Caldwell, 2004). Therapists who work with wounds received during one’s sojourn in the womb use techniques to bring into conscious awareness experiences from the earliest time. These experiences are locked in the body (Boadella, 1987; van der Kolk, 2014; Levine, 2010; Pierrakos, 1990, Wilner, 1999). Some researchers and psychotherapists believe that psychological pain and illnesses are caused not by trauma alone, but by the victim’s inability to provide words and language to describe what their body experienced (White, 2010). The following exercises are designed by the author to elicit a verbal description and increase conscious awareness:

1. Knowing what you know about yourself, in your notebook write a paragraph or a poem, describing what you were like as a fetus.

2. Sit back, relax, and shut your eyes. Imagine that you are a fetus, and the environment is warm and nurturing. You float gracefully in your amniotic fluid. You love touching yourself as you float, and you wiggle your tongue. Notice how you feel and what you experience in your body. Now the scenario changes. Imagine that you are floating in a hostile, unwelcoming environment, and you don’t have enough room to move. You are pushed up against the walls of the uterus. You hear loud noises and your fetal body contracts. You feel like you are receiving something toxic through the placenta, and you contract even more. Your fetal heartbeat quickens. Again, notice how you feel and what you experience in your fetal body. In your notebook compare these two experiences.

3. Finish the following sentence in three different ways. Write in your notebook “When I was in my mother’s womb, I experienced...” three times, and then finish each sentence in three different ways. If you know what happened because your mother or someone else told you, use that material. If you don’t know what happened to you in the womb, make up three events that could have happened according to your memory concerning what your mother may have been like at that time, where she worked, and with whom she lived.

Because the right side of the brain that governs emotion and feeling develops before birth, fetal healing involves revealing suppressed emotions, and employing exercises that tap into the right brain (Ball, 2011; Janus, 2001; Malhotra & Sahoo, 2017). Guided visualizations, dance,
and art therapy are useful tools because they work with images rather than words (van der Kolk, 2014). Furthermore, early right–brain memories can be addressed by exploring dreams and symbols through role–playing, hypnosis, and active imagination (Janus, 2001).

When I adopted my daughter from China, she played a game I called “being born.” In the game, she would slide down my body as if she were coming down the birth canal. She would play the game over and over again until one or the other of us would tire. Your clients can create similar experiences for themselves that will help them reenact a happier and healthier time in the womb or during birth. I suggest that they initiate their unique healing processes by creating a birth drama that can be reenacted in an individual session or a group process.

Because the fetal brain operates at a low vibration – theta – Paul (2010) reports that it mixes imagination and reality to make meaning, whereas mature consciousness occurs at a higher vibration. Before your clients can accept reality, Pierrakos (1990) suggests that they need to bring the images shaped by their fetal brain into conscious awareness. Additionally, Solm’s (2014) work with brainstem mechanisms reports their association with affective consciousness, another indication of mental activity prior to birth. Therefore, consciousness can emerge through fetal memories that make themselves known in dreams and through visions (Janus, 2001). Dreams about boating and water are particularly relevant (Freud, 1913). Using crayons, pastels, pencil, or charcoal drawings, clients can bring meaningful dream images to life and consciousness.

Many of the interventions that somatic therapists use to heal trauma that occurred in the womb involve movement (van der Kolk, 2014; Masters & Houston, 1978, Pierrakos, 1990). Although fetuses sleep between 85 and 95 percent of the time depending on the trimester, they move as they float in the amniotic sac (Paul, 2010). Healing involves having your clients engage in simple movements reminiscent of those made in the womb. Based on my studies with John C. Pierrakos (1990), I suggest that your clients mirror you as you model the following fetal behaviors, and then they do the exercises alone attending to their bodies’ sensations and reactions.

- The fetus hiccups by nine weeks.
  
  *Mirror hiccupping; you hiccup, the client hiccups.*

- The fetus reacts to loud noises by nine weeks.
  
  *Make a variety of loud noises (drumming, horn honking, breaking a glass).*
  
  *React to the noise spontaneously, allowing the body’s impulses to respond.*

- The fetus bends its body by nine weeks.
  
  *Bending exercises; bend in and out of the fetal position.*
  
  *Stand up and do a forward bend exercise, bending at the waist and touching the floor.*

- The fetus moves its arms by ten weeks.

  *Arm exercises; bending the arms, pushing away with the arms and hands, pulling toward you with the arms and hands, stretching the arms up and down.*

- The fetus breathes in and out by ten weeks.

  *Breathing in and out exercises. Slow deep breath in, slow deep breath out; staccato breathing exercise, yoga breathing.*

- The fetus opens its jaw by ten weeks.

  *Stretch your jaw, open and close it, move it up and down, move it right and left.*

- The fetus stretches by ten weeks.

  *Full body stretch, stretch different body parts, a leg, an arm, the neck.*

- The fetus yawns at twelve weeks.

  *Yawning practice.*

- The fetus sucks at twelve weeks.

  *Sucking; place the fatty part of the thumb in your mouth and suck; make sucking sounds with your lips.*

- The fetus swallows at twelve weeks.

  *Practice swallowing.*

- The fetus feels at twelve weeks.

  *Roll around and feel the fabric or the carpet with your body and your hands.*

  *Put yourself in a tight space and explore it with your hands and feet.*

- The fetus smells at twelve weeks.

  *Smell essential oils such as pine, lavender, or lemon.*

- The fetus can taste the food of its culture by thirteen to fifteen weeks.

  *Client brings in food that was most likely eaten by their pregnant mother; share and taste the food together.*

- The fetus moves its tongue at eighteen weeks.

  *Tongue exercises; stick out your tongue, move it from side to side, move it in circles, touch the soft palate with the tip of your tongue.*

- The fetus touches itself.

  *Touch hand to face, touch one hand with the other, clasp your feet, touch the opposite leg with the foot, place a hand on your belly button.*

- The fetus hears at the end of the second trimester.

  *Client selects womb music and you listen together.*

  *Client moves their body to the rhythm of their mother’s speech (therapist mimics the mother’s speech patterns and tone of voice).*

Ask your clients to spend a few minutes doing each of these exercises, being aware of what they feel in their bodies, and writing down or discussing the material that arises – emotions, images, and thoughts – in their sessions. The exercises should be done slowly and repeated later as homework.
When food was scarce, low birthweights and ener-
Rage and anger with strong movements and verbal ex-
Somatic therapists can help those who carry deep with-
In your work with fetal wounding, integrate touch when
To help clients who experienced fetal trauma accept
Because the right brain is predominant at birth and
John Pierrakos (1998) suggested engaging in exercises
The seeds for psychopathy and sociopathy are plant-
Similarly, seeds for schizophrenia, masochism, sad-
In the story of the Dutch winter of 1944, emphasizes
Similarly, the seeds for schizophrenia, masochism, sad-
Somatic therapists can help those who carry deep within-
Put your clients into one side, or walking on their heels.
A recap of the benefits of touching - and integration of touch as adults is uncomfortable. These clients need
To one side, or walking on their heels. Have them walk
The wounding womb
 Appendix
Here are some findings from Paul’s (2010) review of the research on fetal origins.
- The seeds for psychopathy and sociopathy are planted during gestation if parents use drugs, alcohol, or other substances. Once grown, the fetus can become involved in criminal activity or antisocial behavior.
- Similarly, seeds for schizophrenia, masochism, sadism, oralty, and even suicide are planted prior to birth. Genes associated with mental illness express themselves in the fetus before birth – some at levels higher than those found in adults. There is a higher risk of developing schizophrenia after severe maternal malnutrition and after maternal infections, such as a respiratory infection. During wartime, twice as many babies are born who later develop schizophrenia than during periods of peace.
- When food is scarce, low birthweights and energetically collapsed bodies result. Undernutrition at critical periods in the womb changes cardiovascular, metabolic, and endocrine functions. Heart disease develops as the little food there is must support the brain, such that the heart does not get enough. In 1959, when China suffered a terrible famine killing 30 million people, the widespread starvation affected fetuses in the womb. They were twice as likely to develop schizophrenia than those born during normal years.
- The story of the Dutch winter of 1944 emphasizes the impact of war and hunger on the fragile patterns of DNA during the prenatal period. German troops turned away all shipments of food that were meant for western Holland in the fall of 1944. A severe winter followed, and some people survived on as little as 500 calories a day. Of the 40,000 fetuses in utero, there were a large number of stillbirths, birth defects, and infant deaths. An examination of the adults – then in their sixties – who were fetuses at the time found more obesity, diabetes, and heart disease than among those born during other periods. In addition, the amount of schizophrenia doubled.

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Scarcity of food can program fetuses to expect a world filled with hunger. Babies are born prepared to eat less, but instead they receive too much food after birth. Because their bodies are not accustomed to receiving so many calories, many struggle with obesity, diabetes, and heart disease.

Maternal weight gain during pregnancy can lead to overcharged muscles, body fat, obesity, diabetes, and other health issues in the developing child. Birth defects are two times higher among babies born to obese mothers. Findings also show the intergenerational transmission of obesity; the more weight gained during pregnancy, the heavier the child is at age three. A woman’s weight gain in pregnancy predicts her child’s future size.

The environment also affects developing fetuses. According to Yawea Zhang’s study in the International Journal of Epidemiology, among eight thousand mothers living in Lanzhou, China who experienced high levels of air pollution, more birth defects, such as larger heads, and more complications giving birth were found, as well as obesity and breast cancer among those who had been fetuses at the time.

In a 2008 UCLA study that looked at partner abuse and violence, Christine Dunkel Schetter, Ph.D., found that women who reported high aggression and physical and emotional abuse in their relationships had higher cortisol levels prior to pregnancy, resulting in lower birthweight in their infants. Low birthweight correlates with illness and disease in adults and is related to problems in development.

Some studies report that fetuses inherit the wounds of their ancestors. Trauma causes a chemical change in cells and cell behavior that can be passed on to each new member of the family. Wolynn’s book It Didn’t Start With You supports this theory.

Dr. Gerhard Rottman identified four types of pregnant women: a) ideal mothers who want their babies and generally have healthy offspring; b) catastrophic mothers who reject the idea of motherhood, have medical issues, and give birth to premature, low birthweight, and emotionally disturbed infants; c) ambivalent mothers who doubt their ability to mother, and have infants with behavioral and gastrointestinal problems; and d) cool mothers who believe pregnancy may cause them to lose their jobs and are unprepared to raise their babies have apathetic, lethargic, and confused babies (research from the University of Salzburg, Austria).

Fetuses share their mother’s blood, and because blood carries the mother’s body chemistry, it shares her emotional state. If she feels love, the fetus glows. But if she experiences fear, as many expectant mothers do, a different set of chemicals is released, and the fetus may contract.

Healthy, resilient fetuses become healthy babies and healthy adults when mothers do yoga, meditate, exercise, eat well, keep their weight down, attend therapy sessions, and have social support.

Moderate levels of stress benefit the fetus, toning the nervous system and accelerating development. Babies show faster neural development and better motor development by age two when stress is not extreme.

Fetuses of pregnant women who exercise have better heart rates and cardiovascular health, and bigger brains that could correlate with higher intelligence when grown.

Women who ate lots of fish and omega-3 fatty acids produced smarter kids with higher verbal IQs, superior motor skills, and better social and communication skills.

Pregnant women who ate chocolate every day had babies who showed less fear and smiled and laughed more often at six months of age.

In the growing fetus, the right side of the brain, which governs affect, feeling, and creativity, develops more fully than the left side, which emphasizes language, prior to birth. The left side remains dormant until the child reaches age two. Therefore, feelings control fetal thought and have a strong impact on later personality and behavior.

Maternal hormones influence sex determination and differentiation in the prenatal period. All fetuses display female genitalia until approximately seven weeks of age. At that point, a gene on the Y chromosome leads to development of the testes, and the production of testosterone. This process can be sabotaged if the mother has hormonal issues. In that case, masculine factors fail to activate, and embryos of both sexes feminize. When a killer fog hit London in 1952, the stress created by that event caused fewer male births – 144 females to 109 males, versus the normal 105 boys to 100 girls.

The placenta does not protect the fetus from as many toxic substances as was originally thought. People are more vulnerable to these environmental toxins during the prenatal period than at any other time in life. Two tragedies that have occurred include thalidomide, which caused deformed bodies, and DES, which led to aggressive cancers and fetal alcohol syndrome.

Smoking is also a concern. When pregnant women smoke, blood vessels contract, and their fetuses receive less oxygen. Nicotine crosses over the placenta, increasing the risk of cancer and disease in later life. Smoking has been tied to miscarriage, stillbirth, preterm delivery, low birthweight, and sudden death syndrome.
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REFERENCES


Perseveration – a rigid, habitual pattern of repetitive thoughts – is a common symptom of depression, anxiety, and other mood-related emotional disorders. Perseveration, including rumination and worry, has historically been challenging to treat clinically. Most therapeutic treatments for perseveration are currently comprised of top-down, cognitive therapeutic techniques and the use of pharmacological methods to reduce symptomatology. Perseveration can have cognitive, affective, and somatic impacts on individuals. Sustained perseverative thinking can lead to adverse health conditions connected to cardiovascular, autonomic, and endocrine systems. A theoretical body psychotherapy model, Pause, Breathe, and Feel, which addresses somatic regulation and interoceptive experience, is proposed to work with perseveration. Using body psychotherapy interventions like breathwork in counseling can help clients interrupt perseveration’s cyclical pattern by learning to be present, utilizing their interoceptive capacities, and identifying specific areas of their bodies to promote emotion regulation and self-regulation.

Keywords: body psychotherapy, somatic psychology, perseveration, rumination, worry, conscious breath, emotion regulation, somatic regulation, and self-regulation

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Pausing obstructs emotion regulation, which seems to exacerbate abstract thinking about potential threats or stressors.
Therapy interventions can help promote self-regulation of the nervous system, which could allow individuals who perseverate to use alternative strategies to reduce stress or effectively respond to stressors.

Review of the Literature

Perseverative Cognition: Rumination and Worry

Historically, literature on rumination and worry placed these cognitive processes into the category of repetitive negative thinking (RNT). In order to remove the assumed negative valence, this author chooses to refer to rumination and worry as perseverative cognition or perseveration. Perseverative cognition or thinking has most commonly been defined as a rigid, habitual, or cyclical pattern of repetitive thoughts (Brosschot et al., 2006). It is often conceptualized as incessant thinking about potential stressors – regardless of whether they are anticipated for the future or have happened in the past – that has physiological effects on the body’s systems and stress responses (Brosschot et al., 2006). The content of perseveration often involves some perceived threat. Brosschot et al. (2010) argue that, in daily life, people experience the most stress-related physiological activity not by actually experiencing stressful events, but instead by thinking about them, which often lasts longer than the stressful event itself.

Psychopathology has historically been viewed as the study of mental illness or mental distress, and looks at the causes, components, and consequences of psychological disorders. Much of perseverative cognition literature repeatedly references traditional pathology definitions and understandings. For instance, rumination is most often associated with major depressive disorder (MDD) whereas worry is most often associated with generalized anxiety disorder (GAD) (Fresco et al., 2002; Nolen-Hoeksema et al., 2008; Watkins et al., 2005; Watkins, 2004, 2008). Perseverative cognition is often considered a “hallmark” feature of depression and anxiety symptomatology (Wannaker, 2015, p. 310). Anxiety and depressive disorders are highly comorbid, which also suggests that rumination and worry are often associated with one another (McEnvoy et al., 2013). Siegel (2012) offers a reframe of psychological disorders and pathology by suggesting each symptom of each disorder shows “chaos or rigidity that results from impaired integration” (p. 4–5). Siegel’s (2012) concept of interpersonal neurobiology states that integration links different aspects of a system and is seen as the “definition of good health” (pp. 4–3). Aligning with Siegel’s (2012) framing, this paper posits perseveration as potentially creating chaos or rigidity versus integration.

Rumination and worry have similar features and are often associated with “unpleasantness” (Wahl et al., 2019, p. 46). However, rumination and worry differ in their pathological associations, orientation to time, content focus, sense of certainty, and perceived ability to control as well as potential intention behind the thoughts (Nolen-Hoeksema et al., 2008; Watkins, 2005). Rumination is often associated with “uncontrollability,” whereas worry is associated with “abstractness” (Wahl et al., 2019, p. 46). Rumination is associated with depressive symptoms and tends to have a past-oriented focus, whereas worry is associated with both depressive and anxious states and tends to have a future-oriented focus (Hong, 2007; Kertz et al., 2012; Nolen-Hoeksema et al., 2008; Watkins, 2005, 2008).

Rumination and worry also share similar cognitive processes, but involve different thought content. Rumination content tends to focus on themes relating negatively to loss, self, and others, whereas worry content tends to focus on themes relating negatively to time, upcoming events, and perceived future threats or distress (Nolen-Hoeksema et al., 2008). Ruminators seek to utilize cognition, consciously or unconsciously, to gain insight whereas worryers seek to utilize cognition, consciously or unconsciously, to prepare for potential threat or distress (Lyubomirsky et al., 2015; Nolen-Hoeksema et al., 2008; Querstret, 2013; Watkins, 2005, 2008).

Engaging in rumination or worry is sometimes considered constructive or a normative response to stressors (Watkins, 2008). Perseverative cognition is commonly considered to be maladaptive and more likely to be associated with pathological disorders when the repetitive thoughts are relatively uncontrollable or focused on distressing content, whereas perseverative cognition is typically considered adaptive when the thinking helps problem-solve, increase preparedness, or decrease distress (McLaughlin, 2011).

Understanding Rumination

Rumination is commonly defined by its passive, repetitive, and perseverative qualities. It has a cyclical quality to it and can cause a seemingly “downward spiral” (Lyubomirsky et al., 2015, p. 7). Nolen-Hoeksema (1991) defined rumination as “behaviors and thoughts that focus one’s attention on one’s depressive symptoms and on the implications of those symptoms” (p. 569). Rumination can worsen negative affect, such as hopelessness, which can lead to and extend depressive episodes (Nolen-Hoeksema, 1991, 1998; Nolen-Hoeksema et al., 2008). Since ruminating often leads to inaction and more perseveration, Nolen-Hoeksema (1991) conceptualized rumination as a maladaptive style of regulating emotions and responding to distressing material or experiences. Gross (2013) states emotion regulation is recruiting a process to "up- or down-regulate either the magnitude or duration of the emotional response" (p. 359).

Response style theory proposed rumination is both triggered by depressive mood and simultaneously prolongs depressive symptoms because rumination facilitates further cognitive biases and more repetitive thinking, which inhibits adaptive strategies that aim...
to problem-solve and interrupt the perseveration (Nolen-Hoeksema & Morrow, 1991). Similarly, Koster et al.'s (2011) impaired disengagement hypothesis argues that rumination occurs due to real or perceived incongruity between one’s goals and one’s current state, which creates more negative, self-focused thoughts and sometimes existential questions like, “Why aren’t I not good enough?” that can further distract and impair problem-solving for the ruminator (Nolen-Hoeksema, 1991; Nolen-Hoeksema et al., 2008; Nolen-Hoeksema et al., 1993).

Literature often divides rumination into two subtypes – brooding and reflection (or pondering) (Nolen-Hoeksema et al., 2008; Treynor et al., 2003; Wannmaker, 2005). Brooding is viewed as an abstract and passive focus on one’s challenges and suffering, leading to its association with depression in both the short- and long-term because it prolongs cyclical perseveration (Treynor et al., 2003). Reflection or pondering, on the other hand, is viewed as a self-referential or self-reflective process in which one engages in cognitive problem-solving with the intention of reducing perseveration and one’s suffering. Reflection is related to depression in only the short-term because it more commonly promotes effectual problem-solving, which can interrupt perseverative patterns (Treynor et al., 2003). Self-reflection is a more adaptive style of emotion regulation because it aims to glean insight, problem-solve toward resolution, or change behavior (Lyubomirsky et al., 2015; Nolen-Hoeksema, 1991; Nolen-Hoeksema et al., 2008).

Understanding Worry

Similar to rumination in its repetitive quality, worry has been defined as a “chain of thoughts and images, negatively affect-laden and relatively uncontrollable,” which tends to have a future-oriented focus (Borkovec et al., 1983, p. 9). Wories are often intended to help strategize or mentally problem-solve for anticipated threats, or to create a sense of control over circumstances or situations, particularly when the outcome is perceived as uncertain and negative (Watkins, 2008). Borkovec et al.’s (1998) cognitive avoidance model proposes that worry is a cognitive strategy that aims to control the physiological arousal associated with anxiety and fear-inducing mental imagery or thoughts, but, in actuality, usually obstructs emotional processing and emotion regulation. Wories are conceptualized as perseverative cognition that are commonly composed of “inaccurate expectations and beliefs” (LaFreniere & Newman, 2019, p. 7). The cyclical and repetitive nature of worrying could make worrying more distressing than the actual stressor or anticipated event.

Although worry is common in most individuals, if it becomes chronic and uncontrollable, it is most commonly associated with GAD and with abstract versus concrete thinking (Kertz et al., 2012; Makovac et al., 2018). Individuals experiencing GAD have been shown to use their worries to try to control emotional or physiological arousal as well as increase perceived preparedness (Makovac et al., 2018). Worrying is considered maladaptive if the repetitive thought process exacerbates the initial worry or leads to a negative affect state, rather than creating a sense of control or preparedness for the worrier. For example, worrying about something the individual has no control over is seen as maladaptive because there is no potential for more preparedness or mitigation of the concern. Worry can cause increased negative mood, cognitive functioning challenges, and physiological disturbances (Borkovec et al., 1998).

Conversely, worries that are viewed as “objective, controllable, and brief” are considered “constructive” (Watkins, 2008, p. 163) or adaptive, and signal awareness of an imminent danger or a potential threat (Tallis & Eysenck, 1994). Worry can be viewed as constructive or adaptive if the worry leads to action that helps mitigate the concern. For example, repeated worries about affording rent might encourage an individual to work another shift for additional income in order to afford rent.

Physiological Effects of Perseverative Thinking

The perseverative cognition hypothesis suggests that repetitive internal thoughts can impact psychology and physiology almost as if actually facing an environmental stressor (Brosschot et al., 2006). Perseveration can activate one’s sympathetic nervous system or fight-or-flight response regardless of whether the perceived threat is real or imagined (van der Kolk, 2014), and can cause physiological activity long after or long before stressful events occur because perseveration tends to be associated with past and future time orientations. It is therefore not surprising that perseverative cognition has been extensively shown to increase physiological stress responses, which can lead to adverse health conditions connected to cardiovascular, autonomic, and endocrine systems (Brosschot et al., 2006; Crolepy et al., 2017; Gerin et al., 2006; Glynn et al., 2002; Ottaviani et al., 2016; Schwartz et al., 2000; Querstret, 2013; Zoccola et al., 2008). Sustained perseverative thinking has the potential to result in prolonged sympathetic activation, which could lead to increased heart rate (Crolepy et al., 2017), blood pressure (Gerin et al., 2006; Glynn et al., 2002), and elevated stress hormones like cortisol (Ottaviana et al., 2016). Sustained perseveration may also result in long-term physiological consequences like cardiovascular disease and other chronic health conditions (Querstret, 2017). Thus, perseveration can impact an individual’s nervous system and physical body in addition to affecting their cognition, which is potentially dangerous because the health and strength of one’s nervous system is strongly correlated to good overall physical health (Seigel, 2012).

Perseveration and Neuroplasticity

Perseveration can affect brain structure. Neuroplasticity is the brain’s ability to change. Changes in neural path-
ways and synapses occur because of various factors, such as behavior, experiences, or environment (Siegel, 2012). Using attention to alter brain activity can also alter the brain’s architecture (Siegel, 2012). Hebb’s (1949) neuroscientific saying “neurons that fire together, wire together” is frequently used when discussing neuroplasticity. Neural connections that are perceived as essential or useful are strengthened, whereas neural connections that are perceived as unessential or not useful are removed through synaptic pruning.

According to Siegel (2010), we can get stuck in a habitual pattern if we utilize or access only one synaptic pathway, which can “limit our potential” (p. 38). Perseveration can be viewed as a recurring pattern, and the synaptic pathways of ruminations or worries can become strengthened and reinforced through repetition. Conversely, the synaptic pathways of adapting or self-regulating may be weakened because they are rarely utilized in someone prone to perseveration. Instead, focusing one’s attention on different or alternative ways of thinking and being may help transform the brain’s structure, and potentially lead to new ways of experiencing or relating (Siegel, 2012).

**Current Clinical Modalities Used for Perseveration**

It is important to establish effective treatment options for perseveration because perseveration increases vulnerability to mood-related emotional disorders like anxiety and depression (McLaughlin et al., 2007; Watkins, 2008), and is considered transdiagnostic, meaning it is a present symptom in many different emotional disorders (Ehring & Watkins, 2008; McLaughlin, 2011; Sauer-Zavala et al., 2017; Spinhoven, 2015).

**Cognitive Behavioral Therapy**

Cognitive behavioral therapy (CBT) is based on the premise that changing the way one thinks about something has the potential to change one’s feelings and behaviors. Cognitive, verbal therapies rely on the theoretical foundation of correcting cognitive distortions in order to reduce the individual’s mental, emotional, and physiological symptoms of the negative or maladaptive thinking (Beck, 1979). CBT aims to correct or reframe one’s unrealistic, hyperbolic, or exaggerated thoughts or ways of thinking to reduce symptomatology (Beck, 1979).

Currently, CBT is the predominant clinical modality used to treat unipolar depression (Hvenegaard, 2019). Research from randomized control trials shows CBT is an effective treatment for depression; however, less than half of patients experience remission from symptoms (Hvenegaard, 2019). Querstret et al.’s (2017) meta-analysis of the effects of clinical treatment on reducing preservative cognition found that CBT and mindfulness-based interventions can be effective in decreasing rumination and worry.

**Rumination-Focused Cognitive Behavioral Therapy**

Due to rumination’s strong association with depression, depression treatment should target rumination to potentially make treatment more effective (Hvenegaard, 2019). Watkins (2008) tailored CBT to place specific emphasis on reducing rumination and created rumination-focused cognitive behavioral therapy (RFCBT), which was “designed to coach individuals to shift from unconstructive rumination to constructive rumination, through the use of functional analysis, experiential/imagery exercises and behavioral experiments” (Watkins, 2008, p. 318). Within the proposed RFCBT framework, rumination is seen as a method of avoidance. It uses functional analysis to facilitate more constructive approaches and to help individuals acknowledge their rumination can be viewed as useful or not. If the rumination is considered unhelpful, RFCBT teaches individuals to shift to a more helpful style of thinking, including the use of imagery to reconstruct previous positive or more helpful mental states or ways of thinking.

**Mindfulness-Based Cognitive Therapy**

The concept of mindfulness has been extensively researched. The core of mindfulness, which has been described as a practice as well as a state of mind, is learning to focus one’s attention on present-moment experience in a nonjudgmental way (Kabat-Zinn, 1990). Many mindfulness theories claim that a state of present-moment awareness can also enhance self-regulation in the presence of negative emotion (Siegel, 2012). Mindfulness-Based Cognitive Therapy (MBCT) combines concepts from CBT with mindfulness practices, and encourages individuals to notice cognitive patterns non-judgmentally (About MBCT, n.d.).

**CBT Worry Techniques**

The Worry Outcome Journal (WOJ), a CBT intervention, is for clients experiencing GAD to document their worries, evaluate and rate the costs associated with the worries (such as distress or distraction), and record the actual outcomes of events or interactions they were worrying about (LaFreniere & Newman, 2019). LaFreniere & Newman (2019) found that 94% of the worrisome predictions in clients’ WOJs did not come true, which suggests that worries and actual outcomes are often incongruent. The WOJ aims to illustrate that worries are often inaccurate and cause more unnecessary stress than benefit (LaFreniere & Newman, 2019).

A worry map (see Figure 1 below), another CBT tool, is intended to engage the brain to change the thought if the worry’s outcome is perceived to be unchangeable. For example, an individual worrying about outside judgment is encouraged to stop worrying (through changing the thought) because they cannot control the other person’s opinion. This approach implies a hierar-
body of mind over body, and assumes the mind is in control of the body and behavior.

Understanding Body Psychotherapy

Body psychotherapy is a branch of psychotherapy and a form of somatic psychology. Caldwell (1996) states that “soma” refers to the body and “psyche” refers to the mind. The “body reflects the mind, and the mind reflects the body” (Aposhyan, 2004, p. 12). At its foundation, body psychotherapy is a therapeutic mental-health approach that acknowledges and incorporates the concept that mind and body are integrated. A body psychotherapy approach addresses and includes a client’s body as an integral aspect in their overall health and wellbeing (Caldwell, 1996). This could potentially include exploring physical movements of and in the body, awareness of the body and its sensations, breathing practices, and nervous system regulation. Caldwell (1996) refers to the body’s way of communicating as “body speech,” which includes sensation, breath, and movement (p. 4). Body psychotherapy utilizes body-centered approaches and techniques to “assess and treat psychological distress and support the process of change and transformation” in clients (Shapiro, 2013, p. 43).

Benefits of Using Body Psychotherapy to Work with Perseveration

Body psychotherapy aims to make the body a resource as well as a tool to interrupt the cyclical pattern of repetitive perseveration. As argued, the symptoms of perseveration affect cognition, and can negatively impact the cardiovascular, autonomic, and endocrine systems (Ottaviani et al., 2016). Since perseveration can impact physiology, the body can affect one’s cognitive and affective states. Thus, offering a therapeutic approach that includes the physical body in treatment through breath, present-moment awareness, interoception, and utilizing specific areas of the body to promote self-regulation can be helpful in reducing perseverative thinking, and can also add generally to the field of psychotherapy.

Top-down versus Bottom-up Processing

Top-down processing ultimately uses cognition to form perceptions whereas bottom-up processing uses perception through the senses to inform cognition. For instance, Siegel (2012) offers an illustrative example of someone seeing a rose; the bottom-up experience senses the rose “as if it were the first time” with openness and curiosity, whereas the top-down experience recognizes it as a red flower and identifies it as a rose based upon a coalesced summary of previous experiences with roses. Top-down processing utilizes knowledge, anticipation, and judgement based on previous experiences (Siegel, 2012). Many top-down approaches to mental health tend to pathologize, whereas bottom-up approaches tend to promote wholeness and integration (Caldwell, 1998, 2018). Utilizing the five basic senses – sight, hearing, taste, smell, and touch – can help direct one’s attention to the present moment through bottom-up processing (van der Kolk, 2014).

Caldwell (2018) states top-down processing is when behavior is modified through awareness of thoughts and perceptions, whereas bottom-up processing utilizes the body and somatic movement to change behavior. Bottom-up processing includes somatic regulation and interoceptive experiences, such as sensing and experiencing the petals of the rose flower (van der Kolk et al., 2014). Most perseveration treatment modalities are cognitive, verbal therapies utilizing top-down processing. For example, encouraging perseverative thinkers to acknowledge, contemplate, and then alter a thought. As argued, for more effective treatment working with perseveration and its range of cognitive, emotional, and physiological symptoms necessitates utilizing both top-down and bottom-up approaches in order to facilitate healing by reducing or, in some cases, eliminating symptoms (Ogden et al., 2006; Schwartz, 2018; van der Kolk, 2014).

Figure 1 Example of a Cognitive Behavioral Therapy Worry Map

Pause, Breathe, and Feel
Body Psychotherapy Interventions Used for Working with Perseveration

Breath

Breath is an unconscious process that sustains life and can be made conscious through one’s awareness. Breath is typically considered conscious when one’s attention is placed on the breath and the breath becomes more “smooth and balanced” (Caldwell, 2013, p. 94). Intentional or conscious breathing can potentially interrupt one’s unconscious and passive state, like rumination or worry, through present-moment and somatic awareness, as well as promoting self-regulation and emotion regulation (Hendricks, 1991; Ogden et al., 2006). Caldwell (2013) argues that unconscious breath “relies on imprint patterns” that might have stemmed from genetics or early development. Breathing has a lot of variability based on factors like one’s physiology, lung capacity, genetic predisposition, and trauma history. Victoria & Caldwell (2013) elucidate the complexity and nuance of potential contraindications of various breath interventions in some individuals with trauma histories.

Literature shows the positive effects of intentional breathing practices on physical, psychological, and emotional health (Farhi, 1996; Fogel, 2009; Kuppusamy et al., 2017, Pramanik, 2010; Saraf, 2016), including integrating intentional breathwork or breathing practices into clinical counseling sessions (Caldwell, 2013; Hendricks, 1991, 1995; Vialattea et al., 2009). There are potential positive psychological effects of breathwork, including mood elevation, negative emotion reduction, and increases in positive emotion, emotion regulation, and building the capacity for social engagement (Caldwell, 2013). The physical effects of breathwork can have significant influence on psychological well-being being due in part to the vagus nerve and specifically increased vagal tone (Caldwell, 2013; Hendricks 1991, 1995; Vialattea et al., 2009). The vagus nerve is a primary contributor to the parasympathetic branch of the nervous system, which provides humans the opportunity to rest and digest (Porges, 2011). Increased vagal tone correlates to more adaptive responses to stress, whereas decreased vagal tone correlates to staying in a state of fear, or being more negatively affected by stressors. More increased vagal tone means mammals can enter into a parasympathetic response to stimuli more quickly after a stressful situation.

A person experiencing stress or perseveration will most likely not consciously choose how to breathe, because there is likely dysregulation of the nervous system. Practicing conscious breathing can help clients handle stressful situations, including moments of perseverative thinking, in a more adaptive and healthy manner (Caldwell, 2013). According to Caldwell (2018), “good breathing” is said to consist of three aspects – inhale and exhale balance, easeful flow of breath, and to be adaptive to changing circumstances internally and externally (p. 68). Conscious breath may help to interrupt the cyclical pattern of perseveration because of its support of nervous system regulation, and thus its promotion of adaptive strategies and responses.

Present-Moment Awareness

Bringing awareness to the present moment can potentially interrupt the cyclical pattern of being cognitively future- or past-oriented through worry or rumination, respectively. According to Cardaciotto et al. (2008), present-moment awareness is the “continuous monitoring of experience with a focus on current experience rather than preoccupation with past or future events” (p. 205) that can help create “adaptive stress-responses” – versus more avoidant strategies like distraction or denial (Donald et al., 2016, p. 30). Present-moment awareness can help broaden the range of possible responses to stress, which makes the responses more likely to be adaptive and effective. Similarly, Caldwell (1996) explains that remembering and planning can happen in the past and future, whereas action can only happen in the present.

Since rumination tends to have a past-oriented focus and worry tends to have a future-oriented focus, the person ruminating or worrying is most likely not engaged with the present moment (Hong, 2007; Nolen-Hoeksema et al., 2008; Watkins, 2005, 2008). The physical body structure exists in the present, whereas one’s brain can leap forwards into the hypothetical future or jump backwards into the already-lived past. The nervous system of a person experiencing rumination or worry may be activated, as if the individual is actually experiencing a stressful event as they mentally relive or jump backwards into the already-lived past. The nervous system of a person experiencing rumination or worry may be activated, as if the individual is actually experiencing a stressful event as they mentally relive or anticipate it. Put differently, the brain has a challenging time discerning between a real or imagined threat (Pascual-Leone et al., 1995; Siegel, 2012). Perseverating about threats can cause the brain and nervous system to function as if they need to be actively engaged in handling the perceived threat. Thus, intentionally experiencing the present moment can potentially interrupt the habituated pattern of perseveration’s future- or past-orientation.
Interception

Interception helps people understand what is happening inside their bodies (Siegel, 2012). Interception enhances awareness of self as well as the capacity for empathy (Siegel, 2012). When functioning properly, interception receptors inside one’s organs send information about what is happening internally to the brain, which then regulates vital bodily functions. The body receives messages before the brain registers them; interception informs the brain of hunger, thirst, digestion, breathing pace, and heart rate, which suggests that noticing inner sensations is vital for the body’s ability to care for itself (Caldwell, 2018). Learning to listen to the body and building somatic awareness can improve self-regulation (van der Kolk, 2014).

When any muscle in the human body is not used it may atrophy, whereas when it is used and engaged regularly, it strengthens. The same principle applies to building interoceptive ability. It is possible to train one’s attention to focus on noticing, feeling, and sensing one’s internal sensations or noticing one’s “internal landscape.” Mindfulness has also been conceptualized as training one’s attention to intentionally focus on their internal and external experiences that are occurring in the present moment (Deyo et al., 2009). Seigel (2012) refers to turning attention inward on sensations, emotions or thoughts as “time-in,” and views it as fundamental to establishing mental well-being (p. 25-2).

Somatic Anchors

Focusing, a specific psychotherapeutic technique, aims to increase one’s awareness of and sensitivity to internal sensations, or felt sense (Gendlin, 1981). Felt senses are often linked to an individual’s experiences of issues, tensions, or unclear situations. By focusing one’s attention – cognitively and somatically – the felt sense can glean insight and promote change. Caldwell (2018) suggests the concept of mindfulness has “centralize[d] and valorize[d]” the mind and thinking, which has perpetuated the separation of our minds and bodies (p.xxi). Instead, she proposes a new concept, “bodyfulness,” which, like Gendlin’s (1981), incorporates bottom-up body-centered practices with more traditional contemplative top-down mindfulness practices (Caldwell, 2018, p. xxiii). Bodyfulness could also be described as somatic mindfulness.

Building on Gendlin’s (1981) concept of focusing and Caldwell’s (2018) concept of bodyfulness, locating somatic anchors is the act of bringing awareness and attention to specific areas of the body in order to help promote emotion regulation. Utilizing one’s attention or attentional skills to notice somatic sensations, including sensations occurring in the internal landscape, can potentially help someone regulate. For example, this author frequently places her attention on her sitting bones (ischial tuberosities) and lengthens her breath in order to down-regulate her nervous system and feel more grounded.

Koster et al.’s (2011) impaired disengagement hypothesis suggests that rumination is largely correlated to the inability to move one’s attention away from negative emotional material. Thus, Koster et al. (2011) propose adding training or interventions focused on improving attentional control, in addition to cognitive therapies focused on verbal interventions, in order to reduce ruminative thought patterns. Similarly, Martin and Tesser (1996) propose that rumination thinking can be interrupted through distraction or detachment from the ruminator’s goal or perceived attainment of the ruminator’s goal. Noticing, sensing, and feeling somatic anchors can become an active and engaged process or skill that one builds through the practice of attentional control, and can help interrupt or reduce perseveration (Koster et al., 2011).

Using Body Psychotherapy to Work with Perseveration

Perseveration is a cyclical and repetitive (Lyubomirsky et al., 2015) feedback loop or spiral ultimately leading to more perseveration (as seen in Figure 2). The time between perseverative thoughts can shorten as the feedback loop continues. The spiral can be seen as leading to inaction because the individual perseverating tends to place more focus on the perseveration, and less focus on possible strategies to address the perceived stress-
or. The synaptic pathways of rumination or worry can become strengthened through repetition, whereas the synaptic pathways of adapting, self-regulating, or thinking creatively can be weakened or pruned through lack of use.

Utilizing the aforementioned body psychotherapy interventions can interrupt perseveration’s cyclical pattern and strengthen synaptic pathways that encourage emotion and self-regulation. Since perseveration can affect physiology, this body psychotherapy model (see Figure 3) rests on the foundation that regulating the nervous system can affect one’s cognition. CBT's worry maps (Figure 1) attempt to interrupt perseveration’s cyclical pattern through a top-down and unidirectional approach that places the mind in control of the body and behavior. Perseveration and its top-down nature can be viewed as facilitating types of thoughts suggesting worst-case scenarios, whereas bottom-up approaches could help create space for innovation or utilizing adaptive strategies. This model offers a bidirectional approach that encourages a dynamic relationship between mind (noticing perseveration) and body (emotion and self-regulation) in order to interrupt or shift the cycle of perseveration.

This model is also bidirectional in its promotion of top-down and bottom-up processing. The underlying support of this model is conscious breath, which occurs when one’s attention is intentionally placed on the breath, and the breath typically becomes smoother and longer (Caldwell, 2013). Breathwork is a top-down and bottom-up process; the breath can be consciously controlled to allow direct access to the autonomic nervous system (Mulloy, 2019). Caldwell (2018) states “breathing can be a powerful agent in creating both physical and psychological regulation (Caldwell, 2018, p. 71). Emotional steadiness and positive feelings can be facilitated through good breathing habits (Caldwell, 2018; Siegel, 2012). Choosing to make the breath intentional can help clients move from inaction to action and passivity to engagement, as well as potentially interrupt unconscious and passive states like perseveration. Conscious breath also facilitates and supports all the body psychotherapy interventions in the model – experiencing the present moment, utilizing the sense of interoception, and locating somatic anchors.

Applications

This body psychotherapy model can be used as an educational resource for therapists and other clinicians to help guide and support their clients experiencing perseveration. Once therapists have supported clients through utilizing this model and clients illustrate some familiarity with its elements, they can be encouraged to practice and embody the model independently. To support clients in safely exploring this model, understanding one’s scope of practice as a clinician is crucial. Clinicians utilizing this model should have some previous training and knowledge of somatically-oriented psychotherapeutic practices and techniques. Additionally, this model will most likely be more effective if used after therapeutic rapport has been established and cultivated in the therapeutic relationship.

This model can be used on its own, or another possible application is to embed it into a CBT worry map after “Notice the Worry” (see Figure 1) since this model builds on the cognitive acknowledgement of perseveration. Awareness of a pattern is critical in order to change the pattern. Noticing or naming the action of perseverating is a typical CBT intervention, and is also the first step in this model. Once there is awareness of the perseveration, the individual perseverating is encouraged to pause and notice their breathing. If it is...
Pause – i.e., the therapist's intentional highlight or pause, allows the client to build their attentional control through focusing on the breath, which can support present-moment awareness and interrupt the pattern of future or past orientation to time (Caldwell, 2018). It is important to state that, during this process, the therapist is also utilizing skills to self-regulate in order to modify the use of the body psychotherapy interventions and trajectory of the session to best support the client (Ogden et al., 2006). The therapist can even utilize the elements of this model to help support regulating their own nervous system so that the client can co-regulate with the therapist. The therapist and their regulated autonomic nervous system act as an external regulator of the client’s autonomic nervous system, which can facilitate emotional stability and physical health (Schwartz, 2018).

If it is accessible and appropriate, conscious breath becomes an integral support throughout this model and process. Learning to consciously smooth and lengthen the breath can also support more curiosity about what is happening internally for the individual. Using interoception or noticing one’s “internal landscape” can potentially help an individual bring their focus more inward (versus outward on external forces or feared outcomes) and locate somatic anchors, which can promote emotion regulation as well as self-regulation of the nervous system. An individual is more likely to access or consider a broader range of possible responses to stress or stressors when the nervous system is regulated. This might allow the individual who is ruminating or worrying to become more self-reflective, and consider alternative responses to stressors that might be more adaptive or effective.

Different specific interventions might be utilized for each step of the process in this model. For instance, guiding the client to consciously breathe might look like encouraging them to lengthen their exhale, or could look like offering a more formal breathing technique. A clinical example of this approach in action is a therapist working with a client expressing repeated worry about the anticipated outcome of a future election. In this example, the body psychotherapy approach might look like the therapist guiding the client to:

- Notice the worry or the narrative associated with the worry, such as “I worry for my safety if wins.”
- Pause – i.e., the therapist’s intentional highlight or reflection of the client’s worry facilitates a pause in the client’s verbal content.
- Lengthen and smooth their breath, if accessible and deemed safe based on client history – i.e., the therapist may softly and supportively verbally count the client’s breath to make the inhale, pause after the inhale, exhale and pause after the exhale, each four counts.
- Increase awareness of the present moment through conscious breath and utilization of the senses – i.e., the therapist inviting the client to use their eyes to scan and track their physical space, including noticing colors, shapes, objects, entrances, and/or exits.
- Increase somatic awareness – i.e., the therapist verbally inviting the client to scan their body for somatic sensations, notice placement or posture of the body, or allowing intuitive movements to occur through the body.
- Identify somatic anchors that promote emotion regulation – i.e., the therapist verbally guides the client to locate literal or figurative areas of their body that help them feel more calm or steady, such as the feet or, more figuratively, the heart center.

Overall, the model aims to help the individual perseverating glean insight, problem solve, increase preparedness, or decrease distress (McLaughlin, 2011). Combining conscious breathing, present-moment awareness, interoception, and somatic anchors can help interrupt and slow the cyclical pattern of perseveration. The elements of the model might be explored in the order listed in Figure 3, or explored more creatively. For instance, a clinician might support a client in building their interoceptive capacity for multiple sessions before guiding a client to locate somatic anchors, or vice versa. Bodies can become helpful tools in establishing new neural pathways that reduce perseveration and instead promote self-regulation. Reducing focus on stressful events that have either happened in the past or might happen in the future also helps to reduce many physiological effects associated with prolonged sympathetic activation, like cardiovascular disease (Cropley et al., 2017; Querstret, 2017). Pausing and noticing the present moment can allow for an interruption in ruminative and worrisome cycles by reducing future and past focus. Interoception can help bring more awareness to cognitive, affective, and somatic patterns. Interoception and increased attentional control can increase the capacity to pause and reflect, instead of attaching to perseverative cyclical cognitive patterns. Locating somatic anchors can help regulate emotion and the nervous system. All of these aspects can allow for more space between impulse and action, as well as more time spent in the present.

Specific Applications

This body psychotherapy model is intended to be a supportive tool for individuals experiencing perseveration. For rumination, in particular, this model aims to support the client in gleaning useful insight through self-reflection with a regulated nervous system (Lyubomirsky et al., 2015; Nolen–Hoeksema et al., 2008). Gleaning insight may help change one’s behavior or help promote adaptive strategies to problem-solving (Fresco et al., 2002). Distraction has been shown to help reduce ruminative thoughts (Nolen–Hoeksema, 1998). This model can help distract someone from ruminating by encouraging them to build their attentional control through focusing on the present moment, utilizing interoception, and locating somatic anchors (Koster et al., 2011).
For worrying, in particular, this model aims to support the client in experiencing a sense of control through emotion regulation. Worrying obstructs emotion regulation, which seems to exacerbate abstract thinking about potential threats or stressors (Borkovec et al., 1998). Inviting the client to notice, sense, and feel what is happening in their “internal landscape” through interoception and locating somatic anchors encourages more focus on what is concretely happening in the moment in the body sensationally, versus abstract, cognitive worries about the future. Additionally, this model supports emotion regulation and self-regulation of the nervous system, which can help a person experiencing worries strategically and adaptively increase their preparedness for perceived threats (Fresco, 2002). Increased preparedness might feel like a sense of control, which worries aims to experience, consciously or unconsciously (Watkins, 2008).

Potential Contraindications

If smoothing and lengthening the breath are not accessible to the client, bringing awareness or attention to the breath (noticing without changing it) can also help to regulate emotion (Doll et al., 2016). For some clients, changing and bringing awareness to the breath might be challenging, inaccessible, or even contraindicated (Levine & McNaughton, 2014; Mulloy, 2019; Ogden et al., 2006). For instance, some clients with histories of trauma might experience more dysregulation of the nervous system (Mulloy, 2019). It is also contraindicated for some clients whose bodies are not considered safe due to trauma or dissociative disorders. In any of these circumstances, it is important for the therapist or clinician to continuously monitor the client’s cognitive, affective, and somatic experiences throughout the session to modify the interventions used and support the client’s safety. Additionally, this model is contraindicated for use with highly dysregulated clients, and is instead most likely to be effective with clients who are able to modulate their arousal and have some somatic awareness.

Discussion

Through the lens of neuroplasticity, this model aims to support the brain’s ability to change and establish new neural pathways that intentionally interrupt the pattern of perseveration through focusing one’s awareness and attention on the BP interventions. Focusing one’s attention on alternative ways of thinking may help transform the brain’s structure, and lead to new ways of experiencing or relating (Siegel, 2012). Through practicing this body-centered psychotherapeutic model, the objective is to establish new neural pathways that reduce perseveration and instead promote self-regulation and adaptive strategies to manage stressors. Moreover, this model aims to promote overall health by reducing the physiological effects of perseveration that often result due to prolonged sympathetic activation, like cardiovascular disease or other chronic health conditions (Cropley et al., 2017; Querstret, 2017).

This model does not claim to end perseveration completely. Instead, this model is intended to help individuals lengthen the time between perseverative thoughts and grow the range of possible responses to perceived stressors to include more adaptive and effective alternatives. Caldwell (2018) proposes that “contemplative practices help us break the cycle of suffering,” like the cyclical patterns of perseverative cognition (p. 9). Perseveration can be viewed as a habituated avoidant strategy; rumination can be viewed as a strategy in search of insight, whereas worry can be viewed as a strategy in search of control. This model is intended to help generate a range of new adaptive strategies stemming from a regulated nervous system and sense of curiosity.

Multicultural Considerations

Historically, the mental health field was predominantly formed by white Euro-American society, norms, values, and beliefs, which can be potentially problematic or harmful while working with diverse or marginalized groups of people (Sue & Sue, 2016). Systemic oppression may affect an individual’s propensity to perseverate. Individuals experiencing racism, classism, sexism, ableism, ageism, heterosexism, or any type of oppression might be put into circumstances that potentially exacerbate perseveration (Sue & Sue, 2016). For instance, someone who considers themselves queer might be more likely to perseverate on disclosure of their sexual orientation at work than a heterosexual-identified counterpart. Clinicians must understand their own personal biases in order to work with clients in culturally aware and sensitive ways.

Conclusion

This paper aims to examine utilizing body psychotherapy interventions to work with perseveration and its cognitive, affective, and somatic effects. Perseverative cognition is commonly included as a symptom in both depression and anxiety. Thus, understanding and addressing perseveration is highly relevant to improving the field of psychotherapy. This body psychotherapy model, “Pause, Breathe, and Feel,” encourages therapists to support their clients in creating a dynamic relationship between their minds (noticing perseverative thinking) and bodies (emotion and self-regulation). The integration of the physical body and nervous system in therapeutic treatment of perseverative cognition is largely missing in the field of psychotherapy, which mostly focuses on top–down, cognitive therapeutic techniques. Using body psychotherapy interventions like breathwork in counseling can help clients interrupt perseverative thinking by learning to be present, utilizing their interoceptive capacities, and identifying specific areas of their bodies to promote emotion regulation and self-regulation.
While this paper addresses gaps in the literature, it is important to consider limitations and further research ideas. One limitation is that this model speaks broadly of perseveration, while rumination and worry have overlapping and also distinct features. Another limitation is not specifying how to use this model with various psychological disorders; nor does it provide an in-depth discussion on contraindications of using breathwork in clinical sessions. The model also assumes some familiarity with somatic psychology and somatic approaches to mental health care. The therapist is assumed to have some knowledge and training in facilitating somatically-oriented psychotherapy sessions, including tracking hypo- or hyperarousal of clients’ nervous systems. The client is assumed to have some somatic awareness, as well as a sense of safe access to their bodies and internal sensations.

This paper was developed to contribute a somatically-oriented approach to working with perseveration to the field of psychotherapy. However, it is only the beginning of the discussion on integrating more body-based approaches into clinical mental healthcare. Addressing the physical body and nervous system in clinical treatment is essential for effective care. Future research should consider isolating rumination and worry in order to elucidate their distinct features and somatic effects in more depth. Additionally, anxiety and depression, although often present together, have distinct features. Further research might consider using this model to work with perseveration and anxiety, depression, and co-morbid anxiety and depression. Future research might also explore perseveration in various populations and sociocultural identities to better understand if there are differences or similarities across cultures and lived experiences.

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Sex Offender Rehabilitation

A Five-Phase Body-Mind Model

Angelo Avila

ABSTRACT

Sex offender treatment has changed and evolved drastically since its inception. Relapse prevention, behaviorism, and cognitive behavioral therapy currently dominate what is considered best practice in the field. While effective, these treatments can be enhanced with the integration of body psychotherapy, a holistic organism-focused form of clinical treatment. Together, body psychotherapy and cognitive behavioral therapy create a mutually beneficial theoretical orientation that emphasizes the client’s self-awareness, skill-building, and greater ability to regulate affect and impulses. A five-phase model of the treatment progression of clients who have committed a sex offense is presented alongside the primary therapeutic goals of each phase, and how the skills of cognitive behavioral therapy and body psychotherapy apply. It is hypothesized that the implementation of this model with the confluence of theoretical orientations therein might lead to greater therapeutic success in sex offense treatment.

Keywords: sex offender, adverse childhood experience, rehabilitation, body-mind model

Over the years, the literature discussing the treatment of those who have committed sexual offenses has grown and shifted. Today, cognitive behavioral therapy (CBT) is considered the dominant form of treatment for those who have committed a sexual offense (Maletzky & Steinhauer, 2002; Moster, Wnuk & Jeglic, 2008). It focuses primarily on aspects of the mind, logical contradictions, and self-control (Beck, 2011). This has been shown to reduce recidivism in sexually-offending populations (Maletzky & Steinhauer, 2002; Moster, Wnuk & Jeglic, 2008). However, there are some opportunities to improve upon CBT’s application to this population. The efficacy of this treatment can be enhanced by integrating other treatment modalities.

Due to high levels of Adverse Childhood Experiences in sexually-offending populations (Levenson, Willis & Prescott, 2015; Levenson, Willis & Prescott, 2016), the treatment of those who have committed sexual offenses can be deepened and enriched by integrating a theoretical orientation that emphasizes Trauma-Informed Care (TIC) (Levenson, 2014). Trauma-Informed Care is a three-part value system that emphasizes the importance of familiarity with and sensitivity to the presence of trauma alongside other mental health issues (Bath, 2008). If CBT is to remain the primary mode of treatment for sexually-offending populations, then it is important that its practitioners familiarize themselves with forms of treatment that emphasize the acknowledgment of trauma and effective ways to treat it – such as body psychotherapy.

Body psychotherapy is a form of mental health treatment that has made large contributions to the clinical literature regarding
trauma (Herman, 2015; Eckberg 2000; Parker, Doctor, & Selvam, 2008). While the body psychotherapy literature regarding traumatic victims has been extensive and helpful, the somatic literature in general has not yet adequately addressed how the treatment of trauma relates to offending populations. The aim of this paper is to propose a union of CBT and body psychotherapy in the form of a five-phase model of treatment progression of those who have committed a sexual offense.

By bringing both CBT’s and body psychotherapy’s own strengths and theoretical lenses, a more balanced and well-rounded mental health treatment can be delivered to clients. Using a treatment model developed from this perspective has the potential to further decrease the recidivism rate of those who have committed a sexual offense as a result of successful treatment.

**Societal Attitudes**

Societal attitudes toward general criminal behavior ranges from apathy to outrage. Within the population of criminal behavior, societal attitudes regarding people who commit sexual offenses are viewed more negatively by the general population (Lees, & Tewksbury, 2006; Petrunik, 2003). As a result, laws regarding control and monitoring of convicted sex offenders, such as GPS monitoring, sex offender registry boards, and public notifications, have been in effect for over three decades (LaFond, 2005). In a nationwide study conducted by the University of Texas at Tyler (Klein, 2015), an inverse relationship was found between an individual’s accurate information about sex offenders and the intensity of their disdain towards them – i.e., if an individual has a lower level of accurate beliefs about sex offenders, then it is more likely that they have a stronger, more negative view towards them. With these societal preoccupations and stigmas in mind, it may be difficult to envision those who have sexually abused others as human beings with emotional strife, traumatic histories, or deserving of compassion.

**ACE Research and the Prevalence of Trauma in Sex Offenders**

A somewhat common societal assumption about those who have committed a sexual offense is that they are former victims of sexual abuse themselves; this conclusion is varied in its statistical support (Levenson, Willis & Prescott, 2016). While the evidence for the presence of early sexual abuse is somewhat inconclusive, the prevalence of early childhood trauma is not. This can be seen by examining research regarding ACEs and their presence in criminal offending populations.

Adverse Childhood Experiences (ACEs) are potentially traumatic events that are experienced during the developmental ages of a minor (ages 0–17) (Centers for Disease Control & Prevention, 2013). The presence of ACEs in adults is associated with illicit drug use (Dube et. al., 2003; Schilling, Aseltine & Gore, 2007), prescription drug abuse (Anda, Brown, Felitti, Dube & Giles, 2008) depressive symptoms, antisocial behavior (Schilling, Aseltine & Gore, 2007), chronic disease (Centers for Disease Control & Prevention, 2020) and sexual offending (Levenson, Willis & Prescott, 2015; Levenson, Willis & Prescott, 2016). The association between ACEs and sex offenses identifies a potential source of emotional/behavioral patterns that may contribute to committing not only a sexual offense, but other forms of criminal offense, as an adult. This association is the pathway suggesting that body psychotherapy modalities, which are known to effectively address trauma, have great potential for people with past trauma who have committed sexual abuse.

Acknowledging this association in sexually-offending populations opens up a need for treatment that incorporates the treatment of trauma into clinical practice. While treatments that do not stress the presence of trauma can, and have, lowered recidivism rates, there will always be the potential for important clinical issues to go unaddressed – even if the client has successfully completed treatment. Thus, the recidivism rate stands to potentially be lowered even further than it already has. Body psychotherapy and its integration of TIC offers a way to fill this need.

**The Role of Body Psychotherapy in Treating Adverse Childhood Experiences**

The presence of ACEs can be thought of as the presence of traumatic experience in childhood. Through the works of Levine, Van der Kolk, and many similar researchers, the idea of Trauma-Informed Care (TIC) has developed in the field of body psychotherapy. TIC practitioners recognize the adverse effects of trauma in the development of individuals, and honor the subjective experience of trauma as integral to the healing process (Levenson, Willis & Scott, 2016). Using the perspective of TIC, as well as the clinical skills of body psychotherapy, can contribute to a more holistic form of treatment than is currently utilized with the sex offender population.

When treating trauma through the lens of body psychotherapy, the development of self-awareness and self-regulatory skills are heavily emphasized (Levine, 2010; Van der Kolk, 2015) as the initial goal in treatment before exploring the client’s history or story regarding traumatic events. In this way, the therapist is bolstering the client’s ability to regulate their emotional state so that the traumatic experience can be explored without causing the client to become dangerously distressed (Rothschild, 2003). The skills needed will vary from client to client, based on their personal history and the skills they have managed to develop throughout their lives.
Contemporary literature regarding sex offender treatment has begun to stress the importance of individualized treatment plans that cater to each client’s individual needs and risks for reoffending (Andrews & Bonta, 2010; Colorado Sex Offender Management Board, 2020). The Good Lives Model (GLM) is a theory that has gained some attention in sexual offense literature. As a theory of why sexual offenders offend, the model posits that a sexual offense is the product of a maladaptive coping strategy attempting to fulfill a basic human need (Ward & Brown, 2004; Ward, Yates & Willis, 2012). The Good Lives Model emphasizes client self-actualization while building affective and behavioral self-regulation skills (Ward & Brown, 2004; Ward, Yates & Willis, 2012). While The Good Lives Model comes close to being considered TIC, its treatment modality is more in line with positive psychology due to its emphasis on strength-based treatment (Ward & Brown, 2004).

While strength-based treatment is an important part of TIC and body psychotherapy, an emphasis on strengths does not address the full experience of trauma from the client’s perspective. Both TIC and body psychotherapy respect the profound impact of childhood trauma, but body psychotherapy in particular integrates both the psychic and somatic impacts of trauma (Levine, 2010; Smith, 2010; Van der Kolk, 2015).

With this in mind, the implementation of a form of therapy that addresses identifying mental, emotional, and behavioral patterns, and building emotional awareness, emotional regulation, and the ability to identify, access, understand, and respond appropriately to the patterns of internal signals known as interoceptive awareness may be helpful in continuing to refine mental health treatment for those who have committed a sexual offense. This paper argues that this form of treatment includes the integration of body psychotherapy.

**Body Psychotherapy: A Holistic View**

Despite its relative obscurity, the field of body psychotherapy has been present in one form or another since the writings of Freud (Smith, 2010). Since then, the field has seen a wide berth of different theories and modes of treatment. However, its fundamental perspective has maintained that the proper way to view humans in both physical and mental health is organismic, and with a particular emphasis on the body rather than solely the mind (Smith, 2010). This particular perspective has allowed writers within the field, such as Peter Levine, to develop new theories regarding trauma’s inception within an organism, as well as clinical practices to treat it. In doing so, the field of body psychotherapy has contributed its own insights into traumatic experience: sexual abuse, domestic violence (Herman, 2015), political violence, torture, societal trauma (Eckberg, 2000), and natural disasters (Parker, Doctor, & Selvam, 2008). From these perspectives, the treatment of trauma is primarily the development of emotional awareness while simultaneously building emotional coping tools that allow the client to effectively manage distressing affect (Van der Kolk, 2015). As these skills are already present in CBT treatments, body psychotherapy offers a way to deepen through developing the client’s understanding of their interoceptive shifts in emotional state and deftness in using coping skills by tracking sensations and movement impulses.

**Cognitive Behavioral Therapy in Sex Offense Treatment and Its Limitations**

Historically, sex offense treatment has taken the form of relapse prevention, using similar treatment techniques to addiction therapy (Laws, 1989). This, combined with CBT, is the current prevailing mode of treatment for those who have committed a sexual offense. While this method has been shown to lower recidivism in sex offenders (Maletzky & Steinhauser, 2002; Moster, Wnuk & Jeglic, 2008), this type of treatment is geared mainly towards symptom reduction and relapse prevention, and potentially overlooks other process-oriented factors of treatment that might contribute to greater therapeutic change (Miller, Duncan & Hubble, 1997).

In recent years, CBT research has begun to acknowledge the importance of emotional processing and its role in therapeutic change (Goldfriend & Samoilov, 2000). For example, exposure therapy is predicated on intentionally raising levels of emotional distress in order to facilitate therapeutic change (Foa & Kozak, 1998). For example, a client who experiences extreme arachnophobia, a fear of spiders, might choose to be exposed to images, or even live specimens of, spiders in order to “rewrite” the emotional structure in their brain that maintains the arachnophobia through desensitization (Samoilov & Goldfried, 2000). In a meta-analysis of exposure therapy carried out by Parsons & Rizzo (2008), 300 participants across twenty-one studies examining the effectiveness of exposure therapy carried out through virtual reality technology showed that exposure therapy is effective in reducing the intensity of phobias in all areas examined. However, the treatment does not work for everybody, and each individual in these studies experienced different degrees of improvement from this treatment. What makes this treatment more effective for some than others?

For those experiencing post-traumatic stress disorder (PTSD), exposure to the initial trauma may re-traumatize them, causing massive emotional distress (Dirks, 2004). Depending on the client, exposure therapy might or might not be an effective form of treatment. However, therapy aimed at resolving trauma does involve exposure to and confrontation with traumatic material. Before going into traumatic material, therapists from the body psychotherapy perspective work to build up the client’s self-awareness and self-regulation tools so that the client can navigate exposure to the emotionally charged material (Rothschild, 2003). This is done
by emphasizing awareness of many internal domains at once: cognitive, emotions, interoceptive, movement impulses, and sensory input. This creates a level of mastery and familiarity in the client regarding their internal landscape. This is the primary contribution that body psychotherapy can bring to CBT sex offense treatment.

Body Psychotherapy and Cognitive Behavioral Therapy

In a study conducted by Drapeau, Körner, & Brunet (2004), it was found that those undergoing sexual offense treatment considered their therapeutic relationship with their therapist more important than the type of treatment provided. Using body psychotherapy as a supplementary treatment to CBT can deepen the quality of the therapeutic relationship by using body psychotherapy’s focus on nonverbal communication and sensation tracking. While both CBT and body psychotherapy therapists work to build a therapeutic relationship with their clients, the information tracked, and skills used by body psychotherapists stand to deepen the relationship in a way that is similar to how attachment roles are established between caretakers and newborns.

Diana Fosha (2000) asserts that our emotional expression is integral not only to self-regulation, but also to the regulation of others. This relationship can be seen in newborns and their mothers – the emotional expression of the infant demands a particular response from their mother, and her ability to fulfill this demand is what quells or exacerbates the newborn’s signals of distress. This is the foundation of attachment theory – the mother may respond with a material need such as milk or a new diaper, but the mother responds with affective signals that show the newborn that their emotional state is recognized, and that it will be resolved with the support of another, hopefully resulting in an emotional pattern which enables the developing newborn to generally trust that other humans will recognize their needs and help fulfill them (Bowby, 1978).

As previously stated, body psychotherapy is a particular mental health clinical theory that stresses the holistic relationship of body and mind. Nonverbal communication tracking is taken into account alongside verbal communication to form a more comprehensive understanding of the client’s overall affective state. In this way, body psychotherapists attempt to attune to their clients in ways that are similar to a caregiver attuning to their child.

Self-awareness and self-regulatory skills are heavily emphasized in body psychotherapy treatment (Levine, 2010; Van der Kolk, 2015). Being cued into the somatic nonverbal cues of the client is how body psychotherapy clinicians develop an awareness of their client’s emotional state, which then gives them important information to relay back to the client, assisting them in building emotional management tools. These skills foster an affective awareness in the client that may help them process emotional content as well as proactively regulate their affective state towards a less distressing state, thus giving them the emotional resources to make healthier choices that aren’t motivated by a desperate drive to fulfill a particular need. Similarly, CBT stresses the identification of and changes to thoughts and behavioral patterns that might not be consciously known to the client (Beck, 2011). However, changing long-standing behaviors that have fulfilled particular needs in unhealthy or harmful ways can be emotionally distressing to the client. It is important that these identification and behavior-changing treatments are supplemented with providing the client with self-regulatory tools that help them navigate new behavioral territory. These are the very skills that body psychotherapy has to offer in a union with CBT.

A Body-Mind Model of Behavioral Change

Sex offense treatment has evolved into using various modalities and theoretical approaches. In this section, a five-phase body-mind model is posited. Body psychotherapy orientations and techniques are infused within a CBT-laden frame as a means to address treatment components missing in current sex offense treatment.

The previously mentioned The Good Lives Model is a theory of why individuals may sexually offend. Simply stated, the model identifies nine to twelve “Goods” such as, life, agency, peace of mind, intimacy and sex, community, and creativity. When these Goods are not achieved in an individual’s life, they will find a way to fulfill these needs, and depending on their individual flaws or weaknesses, the strategies they choose to fulfill them may be either unhealthy or harmful to others and themselves (Ward & Brown, 2004; Ward, Yates & Willis, 2012). For those who have committed a sexual offense, their offense was a response to the lack of fulfillment in one of these Goods, according to the GLM. For some, their offending behavior is a long-term coping strategy that, though unhealthy and harmful, succeeded in helping them feel as though their needs were being met. In this model, the GLM will be used as an orienting tool for both the client and therapist to find direction and focus in the treatment.

However, it is not enough to simply identify what need is not being met, or to hypothesize new, more healthy behaviors for the client. The immediate change of these behaviors is likely to cause emotional distress in the client – their need will not be met with the same degree of satisfaction as before the change in behavior. Even if an individual recognizes the harm that they cause and attempts to change their behavior, if they cannot navigate the emotional distress caused by discarding a coping strategy, they may fall back into offending behaviors just to experience emotional relief.
CBT excels at behavior and cognitive pattern recognition as well as in planning ways to enact change in the client’s life. Body psychotherapy excels in developing physiological and emotional awareness to use in developing healthy coping skills. Together, these two perspectives form a more holistic treatment than either of them used individually.

The following section identifies different phases of therapeutic development in sex-offense treatment. In these stages, the skills of both CBT and body psychotherapy will be used to create five phases with clear goals for the client to strive for in order to advance through treatment. In all stages, the mental awareness and forward thinking/strategizing of CBT as well as the self-regulatory skills of body psychotherapy are present and directed by The Good Lives Model.

Five Phases

1. Acknowledgement

**Client goal: Accountability and responsibility**

The primary goal during this initial point in treatment is to help the client not only understand the severity of their actions, but also accept responsibility for these actions as well as accountability for changing their behaviors. Clients who begin sex-offense treatment rarely enter into treatment by choice. Clients who do come to treatment present differing levels of remorse for their actions, and/or empathy towards their victims. Some clients spend very little time in this phase, while others may spend months or even years in this phase. For the client, this means acknowledging that they chose to sexually offend, causing harm to others, as well as accepting that there is a great need to change their behavior for the good of others and themselves.

The presence of trauma is often the result of a disempowering relational pattern directed towards the traumatized. These disempowering patterns experienced in childhood elicit anxiety, anger, helplessness, and depression (Felitti, 2002; Felitti *et al.*, 1998; Whitfield, 1998). Poor affective-regulation patterns combined with strong negative affect may have led to desperate coping strategies and behaviors that the client has learned to use to get their needs met. For the person who has committed a sexual offense, these feelings likely have resulted in coping strategies that return their sense of agency to them at the expense of others.

The therapist treating sexual offending populations has the opportunity to demonstrate compassion and understanding while maintaining healthy boundaries that contradict the client’s previous patterns of relating with others. As the therapist establishes their sincere compassion and respect for the client’s agency, the client learns that their abusive pattern is not necessary to have the psychological safety that they desire. Establishing this relationship with the client lowers their psychological defenses and creates safe opportunities to practice more confrontational therapeutic techniques that contribute to positive emotional changes and developing new prosocial social skills.

A body psychotherapist may utilize body language mirroring, quality of eye contact (attentive vs. confrontational), as well as an awareness of the client’s physiological arousal that emulates the caregiver bond and gives the therapist valuable information about whether or not the client is emotionally overwhelmed while exploring content. Additionally, the therapist may also consider attempting to see the client’s position from their perspective and try to communicate this through basic reflections. Though treatment will ultimately attempt to challenge the client’s denial and/or lack of empathy towards their victim, the client may show higher levels of resistance if they do not feel understood by the therapist. Using such subtleties, the therapist can more effectively ally with the client, and move towards collaboration rather than court-mandated direction.

2. Information Gathering

**Client Goal: Exploration**

After the client has taken responsibility, and the therapeutic alliance between therapist and client has been given time to develop, then it is time to identify what unmet needs contributed to the client choosing to offend. If ACEs are present in the client’s developmental history, then learning about these events is necessary if the therapist is to deliver TIC. However, exploration of traumatic material must be done with care on the clinician’s part. While this information may be useful in directing treatment, revisiting traumatic events may present varying levels of discomfort to the client that range from uncomfortable to completely dysregulating their affective state. In this and all future phases, it is important that the therapist begins by helping the client learn to “pump the brakes” when discussing distressing material, enacting new relational patterns, and using new emotional coping strategies (Rothschild, 2000).

When approaching traumatic material, a body psychotherapist should track the physiological state of the client. Has their quality of eye contact changed significantly? Have they become unexpectedly fidgety or deathly still? Has their breathing pattern shortened or significantly? Have they become unexpectedly fidgety or deathly still? Has their breathing pattern shortened or significantly? Have they become unexpectedly fidgety or deathly still? Has their breathing pattern shortened or significantly?

When these behaviors manifest, the therapist can help the client navigate the affective states by coaching them through coping strategies. These strategies can be deep breathing, asking the client to describe the room with their five senses, or simply getting out of the chair and moving throughout the room to indicate that the client is not trapped in their current state. If a client responds in this way, then it is most beneficial to stop the exploration of the story, and instead to explore the affective...
shift with the client before moving forward. This affective shift may indicate the need that the client has attempted to fulfill in the past with their abusive behavior. Exploration of the client’s process may prove to be more helpful than historical facts about the client’s life. As the therapist learns about these events and emotional processes, they might be able to understand how the client’s abusive behavioral patterns were adaptive at one point in their lives. Communicating this understanding is important in further developing the therapeutic alliance between the therapist and client.

Using The Good Lives Model can be helpful in guiding the client to develop an understanding of their primary needs (or “Goods”), as well as identifying which unmet needs may have contributed to their choice to offend. Educating the client about the Goods as a whole before fully delving into any one of them can help the client feel more secure and oriented in their exploration. Providing structure for the exploration will help the client remain grounded and prevent them from getting too “lost in the weeds.” Without the structure provided by a theory like the GLM, a thorough investigation of the quality and strategy of need fulfillment in the client’s life can feel somewhat amorphous and difficult to begin.

After the client has been made familiar with the Goods, the use of homework can be helpful in this phase of treatment. At the beginning, it can be beneficial to move slowly, assigning one exploratory writing assignment per week that focuses on a single Good. These can be as simple as a stream-of-consciousness journal entry shared with the therapist, or a formal worksheet prepared by the therapist. Examples of prompts include: What does creativity mean to you? How have you found ways to fulfill this need in the past? Can you think of times in your life where you have felt very creative or not creative at all? Additionally, you can introduce Likert scales that rate the client’s self-perceived importance of these Goods in their lives before, during, and after their offense. These can be used to gather measurable data that can be referred to later in treatment. The purpose of these prompts is to facilitate exploration within the overarching structure provided by theories like the GLM.

Therapists may use this as an opportunity to ask more confrontational questions that were not as easily addressed in the previous phase. After the client has assumed accountability and responsibility, they might be more receptive to confrontational questions as well as education about thinking errors and accept that their old beliefs and behaviors might need to change.

A body psychotherapy must pay close attention to many aspects of the way a client shows up in discussing their Goods. Sensorimotor Psychotherapy, a body psychotherapy treatment modality, stresses the importance of tracking what is called the five core organizers: cognitions, emotions, somatic sensations, sensory information, and impulses to move (Ogden, Kekuni, & Pain, 2006). As the therapist tracks this information, they may choose to use these as investigative tools by prompting the client to consider them as new memories or topics arise in treatment. This technique deepens the client’s analysis of their Goods into a more experiential body experience by accessing more internal information and weaving it into a more personally meaningful exploration.

This step in the process might not move linearly—that is, the client might already know what was lacking in their life but be unsure of the coping strategy they used to fulfill it. Likewise, the client might have some understanding of their coping strategy, but little awareness of the need the behavior is attempting to address. At this point, the therapist’s main goal is to facilitate exploration into the client’s history related to the GLM set of Goods. For example, have they always felt satisfied with their need for sex and intimacy? Did they feel unsatisfied during the time of their offense? If they found themselves feeling unsatisfied, how would they go about fulfilling their need for sex and intimacy? Keeping the Goods in mind, the therapist can begin to collect and organize information for the client as they begin exploring their past and their behavioral patterns.

3. Orienting

Client Goal: Strategizing

The goal for this phase is to begin strategizing ways to integrate new behavioral patterns into the client’s life while transitioning out of old behavioral patterns. It is important to consider the client’s ability to manage distress tolerance during this phase. Before introducing radically different modes of being into the client’s life, the therapist must be certain that the client has access to internal and external resources that allow them to manage the distress that may arise from replacing behaviors that may have served as effective (though harmful) coping strategies. Much in the way that a scuba-diving instructor checks their students’ oxygen tanks, the therapist must be certain that the client is able to breathe through the distress.

In the case of a client who sexually abused adolescents, seeking an age-appropriate relationship may present emotional difficulties that the client is not prepared to experience. For example, an age-appropriate partner may perceive the client with a more critical lens—the eyes of an adult—than a partner who is an adolescent. If the client struggles with low self-worth or high levels of self-criticism, then the client may experience strong emotional distress, and choose to reoffend another adolescent, who will not trigger the same level of distress.

A cognitive behavioral therapist may use this time to engage in role play. The CBT therapist could initiate role play of the client’s adult partner while engaging the client in a relationship context, possibly triggering feelings of emotional distress. A body psychotherapist
could extend this opportunity to help the client begin to build internal awareness skills if they haven’t already used the five core organizers of Sensorimotor Psychotherapy. The body psychotherapist may pay attention to different elements of the client’s experience: information about the client’s cognitive, emotional, somatic, sensory, and movement sensations are all prompted by questions from the therapist, which links them together in a way that more easily facilitates a “meaning-making” response from the client (Ogden, Kekuni, & Pain, 2006). This can begin by asking the client to notice what emotions are felt when they think of a certain need, or Good, and their relationship to it.

An example of a client considering their relationship to the Good of Relatedness:

- **Cognitive response**: My parents were both addicts, and their addictions didn’t leave much room for me in their life.
- **Emotional response**: I didn’t really notice until I got older, but I spent my whole childhood feeling alone, sad, and tossed aside.
- **Somatic sensation**: When I think of them, I feel as though my whole body is collapsing in on itself – like I’m getting so small that nobody will notice me.
- **Sensory information**: I can hear the sound of their pill bottles rattling in the bathroom.
- **Movement impulse**: There is no impulse to move. I just want to curl up on the floor and stay still.

By linking these different sensations, the therapist can help the client develop a sense of familiarity and mastery over not only the cognitive memory, but all of the subjective experiential characteristics of the therapeutic topic in question (Ogden, Kekuni, & Pain, 2006). Depending on the client’s response to these memories, the therapist may have to educate the client about the body’s stress response and begin practicing down-regulating techniques such as deep breathing and mindfulness meditation. Additionally, the therapist can also educate the client about using external resources – such as using information gathered by the five senses in the present moment. The therapist can ask the client to visually describe the office space, to physically touch their own arms, describe the smells in the air, etc. These techniques deepen the feeling of mastery within the client as they explore their relationship to the Goods in their lives.

Social resources are useful to emphasize as well. As a consequence of being charged with a sexual offense, the client might find themselves in a situation where they have less access to supportive friends, family, or significant others than they did before their conviction. As group therapy is the primary form of treatment for those who have committed a sexual offense, it may be beneficial to encourage the group members to exchange contact information, and to use each other as informational and emotional resources outside of treatment.

After sufficient exploration identifies areas that need development, and emotional distress and emotional regulation techniques are known and available to the client, then the therapist and client can collaboratively work to form plans and strategies for implementation into real scenarios. This can be practiced with further role play of varying intensity, depending on the client’s current ability to regulate themselves, or homework assignments that involve practicing these techniques at home or in situations that are only mildly emotionally distressing.

It is important that the therapist is certain that the client is able to handle emotional distress as it arises. If the client is not appropriately equipped to handle this distress, they might regress to using old behaviors that, while harmful to others, helped them find temporary emotional satisfaction. Since those who commit sexual offenses have negatively affected others (victims), it is a matter of public safety to ensure that the client has the ability to manage their emotional distress while making positive changes in their lives. If a client does not have sufficient knowledge of what emotional regulation skill to use in most situations, then they might not be ready to advance to the next phase.

### 4. Implementation

**Client goal: Taking action**

After the client is educated in and has practiced using emotional-regulation techniques, then it is time for them to begin using their replacement behaviors out in the world. At this point in treatment, the therapist may find homework activities that involve the use of these behaviors helpful. Ideally, these would be collaboratively chosen by the therapist and client. They could include finding community by joining a group of like-minded people with shared interests, reigniting an old hobby, abstaining from porn use, abstaining from substance use, etc. The primary goal of treatment in this phase is to begin actively engaging in (or abstaining from, in some cases) these behaviors, and reporting back to the therapist about the challenges that arise from attempting these changes. Further practice in emotional management skills can be practiced during treatment, but at this point in treatment, the client is expected to know enough about them to use what is appropriate when difficulty arises. The work of the client is to begin using these skills outside of treatment in an effort to begin positive personal change. The therapist’s job is to continually monitor the client’s ability to self-regulate, as well as the changes they are making in their lives. Is the client making genuine efforts to develop healthy social relationships? Are they, with intent, using behaviors that fulfill the unmet needs that contributed to their offense? Are they showing effective skill in navigating any emotional distress that comes up when making these changes? These are all signs that the client is approaching completion of treatment and is ready to move on to the final phase.
5. Maintaining

Client and Therapist goal: Vigilance

In this phase, the client has developed an awareness of behavioral changes, internal cues that signal when to regulate themselves, and has also demonstrated an ability to do so outside of treatment. As the name of this phase suggests, the main goal of this phase is to continue practicing and perfecting the changes that were implemented in the previous phase of treatment. Feedback from the therapist regarding the client’s successes and failures is used to further refine the interventions.

Clients must remain vigilant for anything that may upset the changes they have worked so hard to achieve. While the client has developed strong emotional management, social resourcing, and a healthier lifestyle by this point in treatment, a sudden and emotionally disruptive life event – such as the loss of a loved one – could still potentially disrupt the client if their new coping skills are still relatively new. The job of the therapist is to support the client through these difficult challenges, and educate the client on the power of large, unexpected events, as well as the strength of new behaviors growing over time, so as to emphasize that new patterns may be vulnerable to disruption. The client may be resistant to consider these events because they believe they have truly changed for good, or the thought of these events may be uncomfortable. The client may regress to old behaviors, thinking that how they coped in the past was successful. Depending on whether or not the client chooses to continue treatment after their parole/probation is complete, the therapist may not be present to help the client manage unexpected stressors in life as they arise. So then, the therapist must focus on keeping the unexpected within the client’s frame of mind, as well as continue to check in with the client to see how they are using their new skills outside of treatment to be sure that the skills remain in use as the client eventually transitions out of treatment.

Conclusion

In sum, both cognitive behavioral therapy and body psychotherapy in conjunction with one another can form a well-rounded, holistic mode of treatment. Cognitive behavioral therapy offers a wide array of tools that facilitate deep, questioning cognitive thought and personal investigation, as well as an emphasis on future planning and homework assignments that keep the client engaged in treatment outside of the office. Body psychotherapy provides physiological awareness tools that integrate into emotional management skills that deepen introspective exploration, as well as equip the client to maintain new behaviors over an extended period of time.

This body-mind model provides a roadmap for treatment that therapists can use to guide and track treatment of those who have committed a sexual offense. Future research regarding this model would develop ways to measure progress in each phase of treatment, so that the client’s progression through treatment could be better structured and understood. Average time taken to complete treatment, clinical effectiveness, and comparisons to other forms of treatment for those who have committed sexual offenses are all areas of study that could be investigated in this way.

This model is predicated on the assumption that those of us who have committed a sexual offense have done so because of poor emotional regulation skills, and unmet needs that were desperately fulfilled in short-sighted ways that harm other people. It is the hope of the author that further work will be done by others in the field of sex offense treatment to emphasize these elements that contribute to sexual offenses. In this way, the social stigma around this topic may be lessened somewhat so that constructive dialogue about sexual offense prevention and recovery can continue to be had, and the frequency of sexual offense recidivism can ultimately drop over time.

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Somatic Psychotherapeutic Fascial-Work

Elizabeth C. Long

ABSTRACT

Observed through the lens of the fascial system, a new understanding of body armor and its relevance in body psychotherapy emerges. Body armor is recontextualized as layers of fascial tensions and atrophy patterns elicited from socio-emotional contexts and physical traumas such as surgeries and falls. Fascial work and psychotherapy have remained separate due to ethical considerations, cultural taboos, and the resulting moratorium on research in this area. Whether or not a body psychotherapist wishes to include myofascial release in treatments, it behooves clinicians to familiarize themselves with the fascial system due to its intimate connection to the nervous system. The author applies fascia research familiar to bodyworkers to body psychotherapy. The author shows that indirect myofascial release and body psychotherapies, like Sensorimotor Psychotherapy, are viable frameworks for the integration of fascial work and body psychotherapy by utilizing a composite case example from the author's practice. Body psychotherapists with touch licenses can integrate fascial work to address body armor. The result is that clients simultaneously address fascial tensions and atrophy patterns created by both emotional and physical events while examining conscious and unconscious meaning-making.

Keywords: body armor, body psychotherapy, fascia, myofascial release, adaptive behaviors

Clients have long used bodywork and body psychotherapy together to provide for the changes that they seek in their emotional experience and behavior patterns. Reich (1933) introduced the idea of body/character armor and developed a classification system for different types of body/character structures. His approach attempted to address client issues by dissolving armoring through breathing, moving, and hands-on tissue manipulation. While psychotherapeutic value exists in addressing body tension, the classification system proposed by Reich is limited by today's standards. The author proposes a new conceptualization of Reich's aim to integrate bodywork and body psychotherapy within a current understanding of the two disciplines. The author provides an update of Reich's body armor as the imprint of procedural learning regarding behavioral adaptations on the fascial system across contexts. It behooves body psychotherapists to gain knowledge of the fascial system. The body psychotherapy field has emphasized the understanding of the brain and nervous system in psychological treatment over the last few decades, and one can hardly distinguish the fascial and the nervous system (Myers, 2011). Therefore, a similar emphasis needs to begin regarding our recognition of this powerful system.

Accessing the fascial system concurrently with the nervous system provides a synergy to change somatic patterns, adaptive behaviors, and repetitive emotional experiences. Often, body psychotherapists regard the body as a lever for the nervous system.
Somatic Psychotherapeutic Fascial-Work

Somatic Patterns, Body Armor, and the Biology of Fascia

Somatic patterning is persistent unconscious movement habits of a body along with related tension and atrophy patterns in the tissues (Foster, 2007). Body armor is the tension and atrophy aspect of somatic patterning. Reich (1993) viewed body armor as the physical expression of the conflict between our natural impulses and the imposed constructs of culture. It befits body psychotherapists to understand what happens biologically on the tissue level, because bodymind communication is a two-way street by means of afferent and efferent pathways. That means that movement patterns and fascial topography communicate with the central nervous system as much as the line of communication goes the other way. The emotional landscape of the psyche shapes the soma, and the topography of the soma shapes the psyche (Keleman, 1989).

Somatic Patterning and Body Armor: A Positive Feedback Loop

Somatic patterning creates body armor, and body armor supports the deeper instillation of somatic patterning. Humans observe their various contexts and adapt to situations in order to better socialize with others and get their needs met. Momentary adaptations become somatic patterns that form, particularly in early childhood, and affect the physical structure throughout the lifespan. In the words of Alan Watts (1973), “the problem is this: [one] is a self-conscious and therefore a self-controlling organism...there is a point in which control becomes self-paralysis – as if I want simultaneously to throw a ball and hold it to its course with my hand” (p. 62). Watts highlights the nature of the ongoing physical and energetic tensions humans experience when meeting the demands of various contexts. For example, one may simultaneously want to express anger physically, and also hold it in. The personality, i.e., adaptive behaviors, of an individual expresses as body armor (Reich 1933; Kurtz, 2007; Lowen, 1975; Smith, 1985; Barnes, 1990). Persistent emotions or states elicit somatic patterning. Body armor supports repeated expression of past somatic patterning because the persistent need to defend against impulses across contexts transforms conscious muscular contractions into unconscious contractions over time (Hendrickson, 2003; Aposhyan, 2004; Lowen, 1975).

Body Armor: Fascial Topography – The Landscape of Tension and Atrophy

Body armor is patterning of fascial tension and atrophy. Researchers discuss the emergence of this patterning as voluntary muscular contractions becoming involuntary over time as well as involuntary fascia (aka plasmatic system) contracts that remain contracted involuntarily. Emotional inhibition has been described as showing up in the body as contractions of the voluntary musculature (Traue, Kessler, & Deighton, 2016; Bischoff et al., 1989). Fascia research suggests that chronic inhibitory patterns in the tissue do not include the voluntary musculature, but rather occur at the fascia level as a plasmatic response to stress (Davis, 1998). Persistent unconscious inhibition of one’s natural impulses creates body tension (Traue, Kessler, & Deighton, 2016; Bischoff et al., 1989) as well as tissue atrophy (Hendrickson, 2003). Given enough time under the stress of persistent inhibition, parts of the body will begin to shut down feeling receptors on a cellular level (Aposhyan, 2004). When cells and feeling receptors shut down, patterns of atrophy and thickening emerge in the fascial system (Hendrickson, 2003). Tissue areas get stuck in contraction patterns, partially due to mechanisms in the nervous system continuing to tell muscles and/or the fascia to contract (Traue, Kessler, & Deighton, 2016; Bischoff et al., 1989; Davis, 1998). The fascial system supports contractions becoming unconscious, automated, and habitual by changing its topography via fascial restrictions made of collagenous crosslinks (Guimberteau, & Armstrong, 2016).

Different layers of body armor exist in an individual because one frequents different contexts regularly in...
which they must defend themselves differently. One stops a behavior deemed inappropriate by the surrounding culture through body tension and will inhibit it in different ways in different contexts. Even though inhibition causes stress (Foster, 2007; Traue, Kessler, & Deighton, 2016; Niknamian & Zaminpira, 2018), both self-control and body tightness are adaptive when one acts consciously (Lowen, 1975). Conscious self-control and body tightness became maladaptive somatic defenses when one is too often in an environment that demands one to behave in ways that feel unnatural (Lowen, 1975). Exposure to multiple inhibitory environments makes layers of armoring in the body that therapists can palpate in the fascia (Aston, 2019; Barnes, 1990).

Adaptive Behaviors

As we have seen, unconscious defenses mold the body armor over time, which classical body psychotherapy defines as character strategies or personality (Lowen, 1975). In this paper, the term adaptive behaviors refers collectively to character strategies, personality, and adaptive strategies. Today’s understanding of body armor is less of a fixed personality trait, and more of a flexible adaptation to one’s environment. The more unconscious, automated, and inflexible these responses are, the more they resemble a way of being or a personality trait. However, at their foundation, they are still adaptive behaviors that result from the dialectics between physical and psychological demands. From infancy to adulthood, adaptive behaviors emerge in order to maintain social connection with others. Different behavioral adaptations present as unique combinations of traits and expressions (Lowen, 1975). Kurtz (2007) and Smith (1985) categorize adaptive behaviors into distinct sets of behaviors and body presentations, yet emphasize that no individual personality maps onto one set of behavioral adaptations. Instead, individuals employ a variety and combination of behaviors across contexts.

The Biology of Fascia

In this paper, the connection between the central nervous system and the fascial system is almost impossible to delineate (Myers, 2011). The field of body psychotherapy has a significant focus on accessing and regulating the nervous system. Therefore, understanding the biology of the fascial system, and its connection with the nervous system, will shed light on future innovations in the field. The following is a brief overview of this complex biological system. At the macro level, fascia is like the clay of the body (Still, 1892). At the microlevel, the fascial system is a three-dimensional web that surrounds all structures in the body down to the cells, and is essential for balance and coordination (Guimberteau, & Armstrong, 2016; Travell & Simmons, 1999). The fascia contains a high concentration of nerve and inflammation cells, while it also protects the body against shock by distributing loads (Inger, 1998). Fascia moves and contracts on its own, independent of muscular contractions (Schleip et al., 2019). Tensional areas become immobile due to adhesions or restrictions that form in response to the inflammation caused by a persistent contraction (Inger 1998; Stecco, & Hammer, 2015). On the one hand, restrictions provide support to compromised tissues; on the other hand, restrictions also generate pain and affect coordination and inflammatory receptors, interfering with movement, which reinforces somatic patterning of the individual (Stecco, & Hammer, 2015; Upledger & Vredevoogd, 1983; Barral & Mercier, 2005; Barnes, 1990; Guimberteau, & Armstrong, 2016).

One’s relational context, emotional content, and meaning—making shape one’s somatic pattern. Sometimes a cigar is just a cigar, and the somatic meaning of a pattern merely reflects repetitive mechanical activities of the body such as sitting, standing, exercising, and working (Travell & Simmons, 1999). Most of the time however, emotional meaning also exists behind one’s postures and movement (Aposhyan, 2004; Foster, 2007; Pert, 1997). For example, someone who stands with rounded shoulders and a bent upper back might do so in response to feeling self-conscious about their relative smallness; someone who collapses around their stomach might feel ambivalent about taking in nourishment; someone who locks their knees and tightens their hips might feel resistant to having a grounded life. While these examples illustrate the point to some degree, one should take them as a small corner of innumerable possible meanings behind body movements and postures. Postures and movements have different meanings to different people, and one should not rely on stereotypical descriptions of these postures across all subjects and contexts.

To summarize, one’s somatic patterning presents differently across a multitude of contexts, so does one’s presentation of physiology in general, and body tension in particular (Kurtz, 2007). The fascial system lays down collagenous crosslinks (restrictions), or it atrophies and removes collagenous fullness in response to repetitive events in the body (Hendrickson, 2003). Body armor in an individual is not a single pattern, but rather many layers of discrete and blended patterns that show up in

1. For more about the biology of the fascial system, see the works of Robert Schleip et al. (2012), Jean–Claude Guimberteau (2016), and Paolo Tozzi (2012; 2014). Guimberteau’s (2005) video “Strolling Under the Skin” (ADF Video Productions, 2005) is an excellent visual resource for this information.

2. A fascial adhesion or restriction is a maladaptive collagenous bond that forms between two structures in the tissues that should not be bonded (Stecco, & Hammer, 2015; Upledger & Vredevoogd, 1983; Barral & Mercier, 2005; Barnes, 1990). “Scars” are the same thing as adhesions, except scars are at the surface of the body and visible (Barral & Mercier, 2005). Adhesions (i.e., collagenous crosslinks) form when trauma to the tissues (like an impact or surgery), glycation, or inflammation occurs in an area (Guimberteau, 2005).
different contexts with perhaps as much variation as parts of the personality. Reich’s body armor, therefore, is the manifestation in the tissues of the body of procedurally-learned daily movement patterns and repetitive body responses to different emotions and contexts. Fascial restrictions and atrophy patterns mold the clay of the body such that the fascial record of procedural tendencies becomes detectable by sight and sensation.

Accessing the nervous system alone to change fascial patterns and associated emotional expression is not enough. Body psychotherapists should consider the body at the tissue and cellular level. Often clinicians look at the body as a lever for the nervous system when, in reality, neither the material nor the energy that flows through it should be emphasized over the other. Clients get stuck in patterned behaviors that are rigidly held in the belief system and also reinforced through the fascia, and vice versa. That a client can attempt to change the way they think or choose to hold their posture differently, but might soon find themselves back to where they started, can be summarized in the following inquiry. (Remember, personality is a behavior adaptation.)

Is the skin the outer surface of the brain, or the brain the deepest layer of the skin?...

The body is not just a reflection of the personality; it is the personality....Therefore mind-body awareness are two sides of the same coin, immutable, joined, inseparable, connected, influencing, and communicating constantly. (Barnes, 1990, pp. 27–29)

It is not enough to work on the fascia alone, since the psyche will affect the fascia once the session is over. Nor is it enough to mold the psyche alone, because the fascia, without appropriate bodywork, is slow to adapt to new patterns. Hence, a more accessible model is working simultaneously at the meaning-making and the fascial level.

To be clear, this is not an attempt to override resistance in a client (which never “works” anyway). Both the psychotherapeutic and the fascial work processes require change to occur slowly over time. The psychotherapeutic and the fascial work processes are so linked and intertwined that it is more effective and ethical to perform the processes simultaneously: more effective because they are “two sides of the same coin” (Barnes, 1990), and more accessible because the practitioner understands the soma-psychic process at a deeper level. Thus, the client is less likely to have to spend more time and money seeing multiple practitioners. To combine bodywork and psychotherapy in one practitioner increases accessibility. Furthermore, an SPF practitioner is more likely to understand the purpose and nature of resistance in a client, because such a practitioner is able to feel and assess that resistance in both the psychic and physical structure.

An Integration of Structural Bodywork and Body Psychotherapy

If clinicians are to help clients change habitual patterns that show up in the belief system, behavior, and the body, it makes sense to address the fascial system and other somatic body patterns while also attending to the associated beliefs and behaviors. Working with the body, beliefs, and behaviors in an integrated way is no news to body psychotherapists. The author’s approach differs from current body psychotherapy practices by integrating body psychotherapy with indirect fascial work aimed at balancing tissue structures. The following model genuinely integrates indirect myofascial release (MFR) techniques with experiential body psychotherapy interventions. This model is specifically for clinicians with training in both body psychotherapy and MFR to create an approach that integrates both modalities.

Direct and indirect techniques are the same insofar as they can be applied all over the body. The kind of touch used with indirect methods affects larger patterns in the body. Direct techniques rely on the direct application of periodic intense shearing force to the center of a restriction. Indirect techniques rely on the time element to slowly and gently release tissues that have lost their mobility (Barnes, 1997). MFR holds take at least a few minutes to effect change in the system. Therapists induce change in the fascia by gently but firmly displacing the fascia on the periphery of the restriction and slowly and gently allowing the tissues to unwind (Minasny, 2009). Since fascia is one piece, therapists can displace the targeted fascial area indirectly. For example, the therapist can work the diaphragm by displacing the diaphragm itself (closer to the area), or by gently pulling on the arms (farther from the area). Thus, indirect techniques can be used farther away from the release site if that approach makes the client more comfortable, or if it is safer for the client’s condition.

The author chose indirect techniques to integrate with body psychotherapy for three reasons:

1. The clinician can work on different parts of the body without having to touch those parts of the body (e.g., therapists can work on the pelvis from the feet, and avoid performing work that might be too intimate for some clients).

2. Indirect techniques require a relatively light touch compared to the, at times, heavier-pressure touch used with direct techniques, like Rolfing. Direct techniques are very helpful, but are harder to integrate into psychotherapeutic contexts. The use of direct techniques can be discussed and used on a client-by-client basis as they become clinically relevant, or the clinician can refer out to a Rolfer for sessions that include only bodywork.

3. Indirect techniques are also more appropriate for psychotherapeutic context as they allow for the client to be fully clothed, if desired. In a typical myofascial release session, the client wears shorts or...
two-piece clothing, which allow for movement while working and for hands-on-skin manipulations. For some clients, this level of vulnerability will be tolerable and welcome, and for other clients, it will be too much exposure. Again, therapists can use indirect techniques to perform releases all over the body without ever having to touch more than the endpoints of the body. Even though having access to only these parts of the body can limit therapists’ leverage in the fascial system, much can still be done without violating clients’ sense of safety and comfort.

Somatic Psychotherapeutic Fascial-work: Arc of Treatment

In this model, the touch and movement approaches come primarily from the John F. Barnes Myofascial Release technique. The author chose this technique due to its gentleness, emphasis on listening and feeling over following protocols, its ability to work on vulnerable areas of the body by touching less vulnerable places, and its relative ease to learn. Upledger’s (1997) craniosacral therapy, Barral’s (2005) visceral manipulation, Aston Patterning (2019), and other gentle fascial modalities would also work. Though this article focuses on illuminating the use of indirect myofascial release, modalities such as the Bodinamic and Biodynamic approaches would also provide valuable insight to the MFR and SPF orientations to soma-psychic transformation. Sensorimotor Psychotherapy (Ogden, Minton, & Pain, 2006) informs the talk portion of this model, Somatic Experiencing, Hakomi, and other body psychotherapy approaches would also work. The author chose Sensorimotor Psychotherapy (Ogden, Minton, & Pain, 2006) because it includes approaches to trauma processing as well as developmental wounding, already includes some understanding from bodywork, and has a focus on incorporating knowledge of biology. The author uses both initial myofascial contact and sensorimotor dialogue approaches simultaneously to lead the client and therapist into mindfulness or theta-wave states. Theta waves are the brain wave frequencies that occur during light sleep or deep relaxation, as with meditation (Tang, Tang, Rothbart, & Posner, 2019).

Crisis that Inspires Somatic Psychotherapy Treatment

Clients generally start psychotherapy when they have run out of options. Typically, clients come to alternative forms of therapy (i.e., myofascial release, acupuncture, chiropractic, and nutritional interventions) when their symptoms cannot be explained or resolved by modern mainstream medicine (i.e., medication, surgery, and short-term therapy protocols). When modern medicine reaches its limit, clients can experience a particularly vulnerable state due to their disillusionment regarding the efficacy of the medical establishment. Clients find comfort in the idea that medicine has the answers. Thus, clients often arrive with a sense of confusion and loss, unaccounted-for bodymind symptoms, relationship difficulties, ailments, and disease processes that do not register on medical testing. Life transitions are, at times, enough for clients to seek alternative forms of therapy. However, these clients usually already have an appetite for complementary medicine and are on a solid routine of prevention.

Composite Case Example

The presentation of the arc of treatment includes a composite case example that closely resembles the experiences of clients treated by the author. Composite client Linda is a 45-year-old queer female-identified white person. Linda has come to therapy due to some recent losses, including the death of a close friend, choosing to leave a job that was a bad fit, and an amicable break up with her intimate partner of 18 months. Linda presents without organic mental illness. She is an active person who loves outdoor activities and ballroom dancing. However, she began feeling less motivated to pursue her hobbies, both before, but also especially after her recent losses. Her body has begun to feel achy, weak, and collapsed. Linda chose to seek help from a psychotherapist because she noticed that her grief and lack of energy were interfering with her ability to enjoy her activities and feel a connection with others. Tired of grieving alone, but feeling ambivalent about reaching out to friends and family who have come to rely on her being the happy/stable one, Linda begins a course of treatment.

Linda’s experience growing up included some predictable developmental wounding through typical episodes of misattunement by caregivers and her socio-cultural environment. Linda came to believe that her needs could not be met by others, that she alone could provide for herself. Linda adapted to this belief by seldom asking for help. Her community unconsciously reinforced this belief, since they frequently praised Linda for her independence and autonomy. Her adaptation was compounded by her coming out as a teenager. Her parents and community were supportive of her self-expression. However, they were not able to understand the challenges of oppression that Linda faced when she was not in her community. Linda also adopted the belief that she needed to present with positive affect the majority of the time, due to unconscious cultural values. Her childhood community values warmth, strength, and autonomy above other feeling states. Her community value system generally fostered healthy behaviors among members. However, members of the community quietly enforced a subtle rigidity regarding messier feelings, like grief and weakness, by attending to affects that they approved and neglecting those they disapproved. Underneath Linda’s happy-go-lucky disposition lies a vast range of human emotion that Linda hides, in part, in order to keep those around her unburdened by her feelings, and also because Linda does not understand why she feels diverse emotions. As a result of these influences, Linda rarely discusses her less-than-positive feelings.
Linda tries talk therapy first, which helps her begin to name feelings and put words to her limiting beliefs. As Linda’s capacity to attune to herself grows, she begins to notice that she understands herself a lot more, but still harbors various stuck and stagnant feelings that she cannot address with words alone. As those feelings linger, Linda also notices that her body continues to feel weak and collapsed, and that she has an uncanny feeling of not being able to connect with others. No pathology shows up on neurological, biochemical, or musculoskeletal testing, and her physicians suggest her symptoms might be related to her emotions. Linda’s talk therapist recommends that she see a SPF practitioner to address the unnamable feelings, the collapse that Linda feels in her body, and the emotional distance that persists in her interactions with others. In what follows, the paper will cover the different stages of treatment, starting with assessment and followed by the initial stages of therapy, major growth epochs, tasks a client engages for psychosomatic mastery, and termination – using Linda’s example to illustrate the work.

Assessment

Therapy begins with rigorous and varied assessments. The therapist documents visual and palpatory descriptions of body alignment, tissue restriction/atrophy, cranial rhythms, gait, and organ motility. The therapist also takes an inventory of familiar somatic sensations across contexts, as well as of the client’s belief system. Furthermore, the therapist records a biopsychosocial history, history of medical symptoms, and a history of emotional and behavioral patterns. Not only does the assessment give the clinician a more precise picture of where this client is beginning treatment, but it also provides a metric by which the therapist and client can confirm progress. Every individual session begins with an assessment of the fascia through visual observation and palpation, along with the usual mood, affect, and content assessment.

Linda presents with subclinical skeletal misalignment due to fascial atrophy/restriction patterns (aka her body armor), as well as disorganized cranial rhythms and sluggish organ motility. Subclinical means symptoms that impact a client but do not register on allopathic testing. Linda’s biopsychosocial assessment reveals that Linda tends towards avoidant/dismissing attachment, is more depressed than she realizes, relies on assessment and followed by the initial stages of therapy, major growth epochs, tasks a client engages for psychosomatic mastery, and termination – using Linda’s example to illustrate the work.

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Linda presents with subclinical skeletal misalignment due to fascial atrophy/restriction patterns (aka her body armor), as well as disorganized cranial rhythms and sluggish organ motility. Subclinical means symptoms that impact a client but do not register on allopathic testing. Linda’s biopsychosocial assessment reveals that Linda tends towards avoidant/dismissing attachment, is more depressed than she realizes, relies on herself to meet her emotional needs, and carries considerable pervasive unconscious anger and sadness. Her emotional landscape presents in her somatic patterning as collapse, weakness, sluggish organ motility, and disorganized cranial rhythms. Linda’s medical history includes the removal of her appendix when she was eight, and she has experienced several minor to moderate falls during her outdoor activities, which means that she has fascial restrictions directly related to surgery and falls. In general, restrictions related to physical injury still carry emotional components, like shock and grief, but exist for primarily physical reasons. Restrictions have both a physical and emotional impact, regardless of the origin (Barnes, 1990).

Stage One: Initial Stages of Therapy

The initial stages of therapy involve helping the client gain access to experiencing the body and the psychic structure, as well as understanding the relationship and interdependence between the two. Clients often come in with a presentation of somatoform and psychoform dissociation, whether at clinical or subclinical levels. Therefore, the first part of treatment focuses on somato-psychoeducation, followed by increasing the client’s capacity to read internal states. This is offered in coordination with teaching the client how to soften and let go at the tissue level, which is an MFR technique that resembles progressive relaxation and requires client participation. Clients are also instructed on re-toning atrophied fascia areas using gentle isometric exercises (i.e., yoga or other somatic movement and stretching practices). Both client and therapist work together to establish goals for this particular soma-psyche, while holding the principle of letting go of the outcome in mind. Letting go of the outcome allows the clinician and the client to reevaluate and change goals as more information comes to light. Clients also learn to tolerate a wider variety of emotions at varying intensities while they simultaneously begin increasing their capacity for self-observation.

After assessment, Linda’s therapist begins treatment by having Linda report her inner somatic sensations while the therapist performs myofascial leg pulls. For leg pulls, the client lies face up or face down on a massage table. The therapist holds the heels or the tops of the feet of the client and provides gentle traction that displaces the fascia in a telescopic manner. Any myofascial hold displaces the entire system. The fascia is one piece from the top of the head to the tip of the fingers and toes. When the whole fascia is displaced, the therapist can use proprioception to determine where restrictions reside in the body. To clarify, imagine a piece of gauze on a table. The gauze represents the fascia. Now, place objects on this gauze. These objects represent restrictions in the tissues. Pinch a corner of the gauze and pull the gauze with the objects gently across the table. The gauze puller can feel the location of those objects on the gauze without looking at the gauze. Similarly, the therapist can feel the restrictions in the fascial systems just by adding drag. Leg pulls are particularly non-intrusive for most clients and help with the palpatory assessment. Therefore, leg pulls are a great place to start for most clients.

Linda responds by becoming increasingly aware of how her bones line up, and where her tension patterns lie. Linda begins to notice waves of sensations akin to fear and anger that move through her torso. Memories from the past, including her early 20s, teenage years, and early childhood accompany these waves. The leg pulls reveal that Linda’s spine lacks appropriate mobility in the thoracic region, and that Linda perceives
that she stores unmet grief in this area, as evidenced by her becoming tearful when the leg pulls begin to affect her thoracic spine area. Linda and her therapist explore what exercises might help her begin to open, strengthen, and move the thoracic spine area. From yoga, they select cat-cow pose to mobilize, and downward-dog pose to strengthen, because these poses feel good to Linda and she already enjoys yoga. Linda commits to doing these poses for five minutes each morning, along with lying face down on a soft and malleable ball in her diaphragm for another three to five minutes. The ball in the diaphragm serves to free the dorsal thoracic area, because it is often easier to access back tension through the soft tissues in the front body. Opening through the front of the body allows Linda to stand up straight with ease (which is one of her personal goals), rather than feeling forced into a collapse. Releasing and toning these areas allows Linda to breathe more deeply and process grief, both verbally and somatically. Balancing Linda’s body in this way supports Linda to better stay with her own experience, rather than compulsively rescuing others from her natural feelings – which in turn allows her to take the risks she needs to feel more connected with others.

Growth Epochs: Upper Limits and Growth Crisis

As clients receive all the new and familiar information about themselves during the assessment phase and begin developing their soma-psychic skills, they often experience an initial decrease in symptoms, empowerment, and more possibility in their lives. Linda begins to feel more lightness and freedom in her body after four weeks of treatment. She begins to enjoy her activities again, and reports that “it is such a hard feeling to describe, but it seems like the world is colorful again.” She feels more connected to others and has a new friend from her dance class. Still, all change is stressful, including positive change. The upper limit is the maximum amount of growth and progress one’s nervous system can take over a segment of time (Hendricks, 2010). Once one reaches the upper limit, there is often a painful, yet essential, crisis that follows.

Initially, clients can feel so empowered by their new skills and insight. Then, however, grief and fear can set in. Clients often have to grieve not having known the many simple interventions clinicians offer that could have prevented the initial crisis that brought them to therapy. They begin to feel sad about the many years where they were limited, and the lost opportunities they can never get back. Clients become fearful because, as they let go of their limiting beliefs, they face the expanse of their potential. They may feel anxiety at the edge of the unknown, or they can feel worried that they will grow too far too fast, beyond their comfort zones or beyond the capacity of their loved ones to accept them. Also, clients can feel frustrated that the interventions, though helpful, do not cause transformation overnight. This complex mix of feelings often accompanies a flare-up in bodymind symptoms. Linda soon begins to feel wobbly again. Linda can hear her limiting beliefs loud and clear now. Linda begins to realize that she internalized the belief that both her full range of feelings and her identifying as queer are unacceptable to others. Now that she is feeling the inner movement of her feelings during her daily activities, she is becoming fearful that her true self might be revealed and rejected. Her anxiety that she might show emotion and self-expression that she does not know how to navigate accompanies her feeling collapsed and sluggish.

Stage 2: Radical Soma-Psychic Acceptance and Theta-State Processing

During the growth crisis, clients get to re-experience the original crisis that brought them to therapy and are often available for exploring deeper wounds from earlier in their development. Clients begin a new phase of treatment that is characterized by continuing repatterning movement practice and radical acceptance. In this second phase, clients radically accept the subjective and objective human condition, and master the cyclical nature of personal growth. Clients accept limitations that are already known or that emerged over the course of treatment.

Clients also dedicate themselves to practice despite these limitations. Clients learn to let go of the outcome of any particular limitation, which is letting go of “quick fixes” and establishing an intuitive self-care approach. Clients learn to feel their soma-psychic rhythms, and can give themselves what they need, rather than by a rote schedule. Clients, therefore, embody the ability to have goals, but to let go of outcomes and develop self-compasion. Many of their limitations might resolve along the way, but clients and therapists cannot know which limitations will resolve, nor can resolution happen without practice. Soma-psychic practice, much like a meditation practice, must be undertaken not to better oneself but for the pleasure of the practice. Accepting limitations and taking their health into their own hands allows clients to meet themselves where they are, have reasonable expectations for life, and be better able to get their needs met emotionally and socially.

In this stage of treatment, another important goal is to understand and deeply experience the soma-psyche in a way that is appropriate and not overwhelming for the client. In other words, clients experience the affective core of the self (Alcaro, Carta, & Panksepp, 2017) as well as gain access to their landscape of primary emotions. Through phenomenological reports, MFR therapists know that fascial work on its own can produce this state, which is also a goal of body psychotherapy. One of the main inspirations for integrating these modalities emerged from clients’ reports that fascial work on its own, without talking, produces the affective core of the self. Body psychotherapy and fascial work can produce the same results in very different ways. For a client to ex-
experience this state, a shift of consciousness must occur, which the author refers to as the theta-wave state. This deeper relaxation state allows for a client’s maximal tissue response and facilitates the therapist in accessing therapeutic intuition. This state is called mindfulness in Hakomi and Sensorimotor Psychotherapy (Ogden, Minton, Pain, 2006; Kurtz, 2007). The author hypothesizes that the brain exhibits theta waves in this state due to the increased ability of the client and therapist to experience abstract images and sensations often related to memory (Coglin, 2013). Within that state, a somato–psychic dialogue can emerge with specific content.

The content of each particular session can vary wildly from one to the next. However, the author classifies sessions into three different types:

1. The therapist and client address content regarding the client’s family of origin to challenge distorted beliefs at the soma–psyche level.
2. The therapist and client address content emerging from abstract and metaphorical body sensations that can feel unusual, nonsensical, and almost dreamlike. The therapist focuses on supporting the unfolding of the abstract sensations along with the meaning–making processes.
3. The therapist and client address content focused on nervous system regulation and pain management in the present moment more than on meaning–making. This kind of session might look the most like a typical myofascial release session, but still has a psychotherapeutic focus through the clinician connecting the client’s physical experience to the emotions and beliefs.

Each session begins with an assessment and theme selection for that day. Just as ordinary conversation begins to drop client and therapist into the theta–wave state, assessment often slides into treatment and acts as the treatment in and of itself (Finn, 2007; Barnes, 1990). The phase of a session that really looks like treatment can commence with the client either sitting, standing, or lying in a variety of positions on the floor, couch, or bodywork table. The therapist and client drop in to observation mode, accessing mindful theta–wave states. Here, a somatic conversation unfolds; this is a process facilitated by proprioception and mirror neurons that allows the client and therapist to attune, so that new insight can emerge (Kain, Terrell, & Levine, 2018). The therapist monitors the depth of consciousness in the dyad. Excessive ordinary consciousness or excessive theta–wave consciousness can interfere with the flow of the transformative portion of treatment. The balance of alertness and relaxation provides the therapist and client with dual awareness, i.e., the observing part studies the wounded part, and witnesses transformation. The dyad must keep the observing part online because the observing part always resides in the present moment. All who engage in somatic dialogue encounter the mystery of the process, including the therapist, who needs to remain profoundly humble and open. Though a preliminary explanation exists for the underlying mechanism of the somatic dialogue, the experience of it leaves more questions than we may ever answer. A humble therapist makes way for the centering of the client’s process. The more the client joins in the interventions and meaning–making of the session, the deeper the layers of change in somatic, emotional, and cognitive patterns.

Linda begins a session and reports feeling stronger where she felt collapsed before, and shares that connecting to herself and others felt easy before this particular session. Linda reports feeling more collapsed that day, and can feel a belief running inside that “it is not okay to feel my natural feelings. I am a bad person for wanting more support from others.” Linda reports feeling grief because she knows that this belief is not true or helpful, and she feels frustrated that she can know this intellectually, but her body still feels the weight of this belief.

The therapist uses verbal reflections that help Linda elaborate and deepen into her experience. She describes the collapse in her body: “It feels like a thick rubber band is connected to my chin and my belly button. I can pull up against the weight and make myself stand taller, but it takes a great deal of effort to do it, and I just snap back down into this collapse. It’s so tiring, I just let myself surrender to the collapse and the loneliness. When I’m like that, I forget to drink enough water, and my visual focus becomes very narrow.”

The therapist notices that Linda has an anterior tilt in the right side of her pelvis, forward head, a shortened, collapsed and inward pulling through her sternum, atrophy through her posterior thoracic region and hamstrings, and restrictions throughout her respiratory diaphragm and psoas areas. The therapist has Linda lie face up on a massage table for a palpatory assessment. The therapist cups and lifts Linda’s heels. The therapist waits for her hands to sink into Linda’s fascial system, and then leans back gently to create drag in the fascia. The therapist confirms that Linda is restricted in her diaphragm and psoas, and also feels restrictions in Linda’s upper calves and upper trapezius areas – all of which are similar to Linda’s initial presentation.

Both Linda and the therapist decide to focus on that restriction and begin entering into a theta–wave meditative state of consciousness. The dyad’s sense of time and space distorts as the world begins to feel more dreamlike. The therapist has Linda sit on the edge of the table, and performs a seated transverse diaphragmatic release (Linda is sitting on the table, and the therapist’s hands are on either side of her diaphragm, one hand on the back and one hand on the solar plexus). As the release progresses, Linda begins to have a series of sensations related to the release:

**T:** Allow yourself to feel my hands on your back.

[Pause.]

**T:** What do you notice?
The therapist and Linda work together to track the unfolding of Linda’s experience throughout this seven-minute release. (Myofascial release holds require several minutes to obtain a single release). Without prompting, Linda begins to describe a memory symbolic of many experiences she had as a child. She is playing outside with a group of children when she is nine years old. They are riding bikes around the neighborhood. One of her younger friends loses control of the bike, hits a curb, and launches over the front wheel, smacking his face on the pavement. Linda feels her body become numb as she rushes over to tend to her friend. She puts her friend on the back of her bike and rides him home to his parents. His parents take him to an urgent care clinic, and Linda goes back to her friends playing outside.

Even though she feels shaken inside, she continues to comfort her friends, who are in shock. Linda’s community praises her ability to handle stressful situations like this. Linda feels haunted for the next few weeks by the amount of blood and the screaming that came from her friend. However, Linda does not tell anyone about her pain because she feels proud of how the adults praised her competence in an emergency. This memory represents Linda’s repeated experiences of competence and loneliness in emergencies, and it serves as a metaphor for other instances like this one. Linda repeatedly presented as the strong one when other members of her family and community were having physical and emotional difficulties, while hiding the impact this role had on her system. Linda repeatedly was put in the role of being a sturdy support person who could deny her needs on command.

After Linda discusses this crucial memory, the therapist changes the structural hold. The therapist has Linda lie face up again and cradles her occiput. The therapist waits for the tissues to begin to release. The tissues expand in a distal-proximal fashion, and the therapist follows the tissues, release after release. The therapist’s task here is to help the client work simultaneously with the fascial and the belief systems.

L: I just feel like if I show my weakness to others, I will be ignored. It feels so painful. I can be there for others, but I believe that others don’t want to be there for me.

T: Is it okay if we try an experiment? I say a sentence, and we see how it feels to you?

L: Sure.

T: Notice what happens in your body when I say the words... “When you feel weak, I am here for you.”

L: I notice that tightness in my throat more, and I can feel the releases happening around my sternum. I feel like I don’t believe you, and that you’re just saying that because that’s the polite thing to do.

T: Okay. Stay with those sensations. I’m going to say that sentence again... Notice what happens in your body when I say the words... “When you feel weak, I am here for you.”

L: “The tightness in my throat is lessening, and now I feel more tearful. I believe you a little bit more, but now I feel scared.”

T: Stay with that fear... What do you notice as you stay with it?

L: I feel a burning in my belly like churning lava.

T: If that churning lava could speak, what would it say?

L: (after quite a long pause) “You’re going to use my weakness against me.” Huh, how odd. I don’t remember anyone ever doing that to me. I remember being praised for my resilience but never really taken advantage of...

T: It’s okay if this doesn’t make sense. The body stores memories and beliefs in ways that can feel strange to the intellect.

In this session example, Linda studies her soma-psyché in the here and now. As the therapist leverages the results of displacement of the fascial system, Linda can narrate her direct experience of her affective core of self. Linda demonstrates her budding openness to the unknown within her, as evidenced by her ability to let content that does not make sense emerge from her somatic experience. As Linda grows in her ability to tolerate the unknown, she can surrender into the process, letting go of the outcome of the session. Here, Linda practices using her observing ego to track her unfolding experience and to develop self-compassion. Each of these skills translates to Linda’s development of a helpful mindset, namely one that tolerates her limitations, and that can stay regulated as the unknown of her life unfolds. She can now get curious about her range of feelings, rather than numbing when she feels feelings that were unsupported by her community.

This session continues to unfold around Linda's belief that she will be taken advantage of if she shows her weakness. The therapist continues to apply different indirect myofascial holds as feel appropriate in the tissues. At the end of the session, Linda reports feeling markedly calm, yet upright and sturdy, in addition to feeling a slight sense of confusion. Clients commonly report this sense of confusion at the end of sessions, and this can signal that space has been made for new beliefs and structures to come into the body. Linda continues to feel waves of grief, fear, and body aches over the next

3. For clients who would not tolerate a direct diaphragmatic release, the therapist can substitute arm or leg pulls.
48 hours after the session, along with an increased desire to drink water. Her system settles down on the third day. She notices that standing upright has become more comfortable and more natural, as has feeling trust in the people to whom she feels closest.

Stage 3: Termination

Termination in SPF is a whole phase of treatment that can last a few sessions to several sessions. These final sessions are to review the arc of treatment and help the client plan for how they will continue to incorporate what they have learned in therapy going forward in their daily lives. When termination happens appropriately, the soma–psychic wisdom continues to grow in the client outside of therapy, or with minimal therapeutic encounters. Clients, especially ones who have experienced a great deal of trauma, re-establish fun, pleasurable, productive, and creative scenarios and activities. One of the ways a clinician can know that their client is beginning to become available for the termination process is when the client begins to work, play, and have fun again without prompting. The dyad determines when the client has reached their goals, or when goal progress has ceased. Often clients end regular weekly or biweekly visits and begin receiving treatment as needed. Clients may also return for future stints of weekly treatment.

Linda and her therapist know she is ready to terminate around her 50th session. Linda no longer feels stuck in collapse, feels a decrease in her depressive symptoms, and feels enough satisfaction in her relationships and with her self-expression. Linda continues to experience dips in her mood and periods of discomfort around her intimate relationships. She still has the main restriction in her respiratory diaphragm/psoas area, and some of her scars from falls and surgeries will never go away. However, Linda’s established self-care routine and self-knowledge enable her to address these episodes, remaining restrictions, and ongoing scar care, thereby minimizing disruption in her daily life. Linda and her therapist spend five sessions co-creating and discovering together the self-care practice that is sustainable and suitable for Linda, and that supports ongoing myofascial balancing with somatic resourcing. For low mood, Linda uses yoga and myofascial unwinding (Minasny, 2009). She uses self–myofascial release, namely lying on a ball, for restrictions in her respiratory diaphragm/psoas area. Linda addresses her permanent scars using manual soft–tissue mobilization techniques learned from her therapist. She applies shorter and longer versions of her self–care routine at different frequencies, depending on her needs. She finds this routine relatively easy to maintain, although she must work to find motivation at times. Linda continues to receive sessions with her therapist as needed — sometimes a few times a year, sometimes more frequently, depending on the evolution of her needs.

Discussion and Conclusion

Talk, change-oriented touch, and movement applied together offer a new horizon to contemporary psychotherapy. Though body psychotherapists are familiar with this trifecta, the time has come to boldly integrate structural bodywork with psychotherapy, rather than continue to keep these powerful tools separated. This integration differs from Reichian bodywork in that catharsis is not a goal. Clients will, at times, have strong emotions in this process that the dyad can leverage for the ultimate goal: the ability to feel a full range of emotions while remaining regulated, and to simultaneously restore as much motion and function as possible to the client’s body. These goals together give clients more choice regarding their behavior. Reactivity that results from psychological or physiological limitations decreases.

Indirect myofascial release encourages clients and therapists alike never to lead and never to force the system (Barnes, 1990). MFR therapists know that too much effort and guidance applied to the fascial system will never overpower the 2,000 pounds–per-square-inch of force that fascia can exert on the body (Guimberteau, & Armstrong, 2016; Travell & Simmons, 1999). Instead, therapists are taught to listen and feel their way through the releases (Barnes, 1990). In the same way, the structure and approach of SPF organically arose from hundreds of experiences of intersubjective bodywork and psychotherapy. There is room for body psychotherapy and bodywork to integrate, such that structural goals get addressed simultaneously with psychological goals. Fascial goals and psychological goals are, after all, often the same goals. This model provides one way for this integration to occur.

This research of current literature and phenomenological experience supports the notion that “body armor” is a combination of somatic patterning elicited from life contexts and fascial topography. This understanding of body armor implies that using fascia–focused movement and structural bodywork could support clients as they pursue their psychological goals. In turn, body psychotherapy supports clients as they pursue their fascial goals as well. SPF aims to disrupt the positive feedback loop of somatic patterning and body armor creation such that clients can experience the affective core of the self. Clients get to know their expression across contexts, and gain access to the affective core of self by working with the fascial topography and with adaptive behaviors expressed through each layer of body armor.

To understand the impact of SPF, one must experience it firsthand. Barring direct experience, an examination of the underlying biology of this approach can at least provide an intellectual rationale for why one might address the bodymind in this way. One cannot draw a line between the nervous system and the fascial system. They conduct energy in the body in different but complementary ways. The continuity of the fascial and nervous
systems implies that clinicians who value neurobiology for the sake of increasing their therapeutic competency would also acquire similar gains by learning more about the biology of the fascial system.

The integration of fascial work and body psychotherapy can appear in many different ways. That fascial work happens at the same time as psychotherapeutic dialogue is the primary way integration occurs. Fascial work can show up in a session like a Gestalt experiment and occupy the main focus of the session while the client processes psychological material, or anything in between. The composite case of Linda offers an example of a client who wishes to address adaptive behaviors from childhood that no longer support her goals and lifestyle. As was demonstrated, SPF allowed Linda to achieve a number of her goals. Linda spontaneously arrived at new insights in treatment. Her ability to embody the insights she gained in traditional psychotherapy increased. She began to shift the way she feels, both emotionally and somatically, as she moves through her life and connects with others. Linda now has an intuitive approach to self-care, and an arsenal of holistic self-care approaches from which to choose. SPF is not for everyone. For clients and therapists who resonate with this work, however, SPF provides a missing link in holistic treatment that is nothing short of life-changing.

Limitations and Further Research

The main limitation of this integration is the scope of practice. Most states in the U.S. require that a practitioner have at least a massage license to perform myofascial release, and at least a master’s degree to perform anything that could be considered psychotherapy. The author proposes the creation of a touch license for psychotherapists. This license would enable psychotherapists to include specific bodywork modalities under their scope of practice. Furthermore, it is still taboo to touch psychotherapy clients, or to provide psychotherapy to bodywork clients.

Ideally, clients would wear MFR treatment clothes. However, the reality is that clients can usually go deeper emotionally while wearing loose-fitting clothing that still gives the therapist access to areas that require work. That said, the therapist must consider the amount of clothing a client wears during treatment. A client will never be nude in this model as with traditional massage, because nudity would limit more in-depth psychological work for the majority of clients. The author’s background began with traditional massage, so she has a high degree of comfort doing bodywork on people with minimal clothing or no clothing and a drape (the sheets used in a traditional massage). Clients who come for massage are generally comfortable disrobing to nudity or near-nudity and having non-erogenous areas touched for treatment. MFR differs from traditional massage in that MFR is best performed with, at minimum, clothing covering genitalia and secondary sexual features, and, at most, loose clothing that therapists can move with consent for access to release areas. The client and therapist determine the clothes a client wears for treatment by considering the comfort of the therapist and client alike.

Furthermore, the comfort of both the therapist and client determines the use of this model at all. Not all clients will be able to tolerate touch, movement, or talk, or a combination of these. Therapists should not employ this modality with people experiencing active states of psychosis, nor with certain complex trauma cases when touch and movement cause excessive dysregulation. Furthermore, therapists should avoid the touch and movement portions of this modality if a client has had recent surgery and has not been cleared by a doctor to resume all regular activity, unless the practitioner has training in perisurgical bodywork.

That said, for therapists and clients who resonate with this approach, the dyads can perform powerful work that addresses bodymind issues in a holistic and positively life-altering way. The stigma of bringing bodywork together with psychotherapy needs to end. Most therapists are ethical professionals who can navigate the necessary consent and ethical demands of these therapies. Integrating the two should not require more than the normal levels of ethical rigor for therapists already accustomed to using both bodywork and psychotherapy. Detailed research on the ethics of such a practice should be explored.

The composite case study reflects an amalgamation of actual client experiences. Further research should include documentation of client experience and progress in a series of individual case studies. Next, a grounded theory study of physical and massage therapists that addresses psychological changes they witness in clients from doing bodywork would be helpful. On the other hand, a compatible grounded theory study targeting body psychotherapists and the physical changes that they have seen in clients would also be helpful. Finally, empirical research should be conducted using SPF on conditions that do not improve with surgery or pain medication, and that have a significant psychological component—such as fibromyalgia, functional neurological disorders, and certain treatment-resistant spine disorders.
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ABSTRACT
A growing body of literature and educational trainings advocate multicultural awareness in counseling. Traditionally, discussions and measures of cultural competence on race focus on racism’s impact on people of color, and rarely ask white counselors to examine cultural countertransference in relation to racial identity. According to the U.S. Department of Health and Human Services, much needs to be done to address disparities in mental health services, which at least in part can be shown to be a result of counselor bias and stereotyping (2001). This paper aims to highlight the importance of cultural awareness in counseling, and poses the following questions: How can the concept of “embodiment” support multicultural and social justice competency? How can somatic modalities aid counselors’ insight into their cultural countertransference? To establish a current and meaningful framework for a discussion on cultural countertransference and equity in counseling, definitions of race and barriers to equity in clinical practice are reviewed.

Keywords: counseling, social justice, cultural awareness, whiteness, body psychotherapy

The capacity to experience affect related to sociocultural location could be viewed as fundamental to embodiment...
The reader is invited to reflect on personal associations and definitions of race before continuing to read this paper, such as taking note of images that come to mind associated with the term “race.”

Definitions of race or racial categories backed by scientific consensus could not be found in the literature. It is noteworthy that, while sociocultural constructs of race are embedded socially and culturally in the United States and Europe, there is little scientific consensus regarding racial groupings or categories. The discrepancy between widespread belief and scientific consensus may indicate the significance of social constructs about race (Morning, 2008; Lowe, 2009; Fernando 2011) and their influence over popular belief and, potentially, treatment outcomes in counseling.

A relevant concept to consider in this context is the reciprocal relationship between whiteness and ethnocentric monocolonialism (Sue, 2004). Ethnocentric monocolonialism assumes the accuracy and superiority of a worldview, which minimizes and erases the legitimacy of other cultures, beliefs, and worldviews (Sue, 2004). Many discussions on cultural competence focus on counselors’ comprehension of client cultures (Sue et al., 2009). While that is important, this paper posits that when counselors understand sociocultural influences on their own identity and clinical conceptualizations, ethnocentrism is brought into conscious awareness. With an understanding of potential bias affecting clinical perspectives, therapeutic relationships, and interventions, counselors can engage more critically with their cultural countertransference. Removing cultural bias and assumptions from a position of assumed neutrality fosters critical thinking and ethics in psychotherapy.

Literature cited in this paper references terms such as “minority” and “majority.” Concepts of minority/majority tend to be “defined by power and status” (Ponterotto et al., 1991, p. 218), and therefore these terms will be omitted in this paper.

### Racial Constructs

Morning (2008) reviewed 80 high school biology textbooks to examine American public education about race over time. Morning found that how race is presented has been shifting culturally from so-called observable characteristics and differences to race being associated with genetic differences (Morning, 2008). As reflected in textbooks published from 1952 to 2002, racial categories are increasingly explained based on genetics and biology. However, there is no currently existing scientific consensus backing genetic racial categorical assertions (Forster & Sharp, 2002; Brown et al., 1999; Bonham et al., 2005; Pendry, 2012; Fine et al., 2005). A body of research asserts that social classifications of race have little biological significance, and that race-based categories have not been clearly delineated in genetics research (Forster & Sharp, 2002; Brown et al., 1999; Pendry, 2012; Fine, 2005; Bonham et al., 2005).

Current genetic data also refute the notion that races are genetically distinct human populations. There are no gene variants present in all individuals of one population group and no individuals of another. No sharp genetic boundaries can be drawn between human population groups. However, “frequencies of genetic variants and haplotypes differ across the world.” (Bonham et al., 2005, p. 4) Research on human genome variation increasingly challenges the applicability of the term “race” to human population groups, raising questions about the validity of inferences made about “race” in the biomedical and scientific literature (Royal & Dunston, 2004). Others dispute the assertion that there is no connection between race and genetics but emphasize correlations with ethnicity and cultural ancestry (Collins, 2004) and not race.

Morning (2008) points out that while cultural beliefs about race have changed over time, those beliefs have not become more factually accurate. Notions of what defines racial differences, even as they change culturally over time, continue to be a product of cultural bias. Opinions about definable racial groups’ characteristics often reflect sociocultural constructs, and may have little scientific or factual basis (Fernando, 2011; Yee et al., 1993).

In the absence of scientific consensus on definitions of race, some argue that race-based concepts are “viable as a biological concept only in that there are ascriptive markers (e.g., skin color) that have important social consequences.” (Brown et al., 1999, p. 169) It can be argued that definitions of race originated from colonial times (Okazaki et al., 2008), asserting a hierarchical structure based on so-called biological differences (Lowe, 2009). Since social constructs of race are inaccurate, they can have a harmful and dangerous effect on the health and wellbeing of individuals and cultures (Sue, 2004).

Helms (1994) conceptualized race in three interrelated definitions: the visual or quasi-biological, the sociopolitical history of domination and oppression, and the cultural beliefs and practices based on heritage or racial group (Helms, 1994). This paper focuses on the sociocultural concepts of race, and their potential influence on the counseling relationship.

### Functions of Whiteness in Clinical Work

Sue & Sue (2013) define three aspects of cultural competence for counselors: counselor awareness of own bias, assumptions, and values; understanding the experiences and perspectives of culturally diverse clients; and developing appropriate treatment interventions and strategies.

Kumas-Tan et al. (2007) reviewed cultural competence measures in the helping professions in approximately twenty years of literature, and found that in most of the measures reviewed, “ethnicity and race” were
applied only to groups associated with people of color. The majority of reviewed cultural competence measures rarely examined dominant cultures or acknowledged that members of dominant cultural groups also have identities and worldviews shaped by culture and racism (Kumas-Tan et al., 2007). Therefore, the measures assess only the understanding of the effects of ethnocentrism and racism on people of color, and do not examine the effects of dominant cultures on white people, which speaks to the cultural positioning of whiteness as a norm (Kumas-Tan et al., 2007).

As an implicit, invisible norm, whiteness is a function of racism (Wallis & Singh, 2014). “Making the invisible visible” (Sue, 2004, p. 762) is one of the most significant challenges society and the mental health professions face about racism (Sue, 2004; Sue et al., 2007). Consequently, whiteness needs to be included in discussions and measures of cultural competence (Sue et al., 1982). Norms function as lenses through which therapeutic work and clients’ symptoms, experiences, and lives are viewed. Norms associated with whiteness, if not conscious to the white counselor, function as a dominant lens that filters the clinical encounter and disrupts the therapeutic process (Lee & Bhuyan, 2013; Sue et al., 1982). These norms result in well-meaning discussions and instruments of cultural competency based on deficit models focusing on the disadvantage of ethnic and racialized groups (Wallis & Singh, 2014), rather than dissecting the norms and institutions that could be considered sources or functions of racial inequity. Even when concerns beyond race and ethnicity are considered (which is rare), this view of culture “assumes that the locus of normality is White, Western culture – that ‘difference’ means nonwhite, non-Western, non-heterosexual, non-English-speaking, and most recently, non-Christian – how they are different from us.” (Kumas-Tan et al., 2007)

DiAngelo (2016) explains whiteness as a social process instead of a “discrete entity” such as skin color. Whiteness is a dynamic process, which includes fundamental rights, values, beliefs, and experiences “purported to be commonly shared by all but are only consistently afforded to white people” (DiAngelo, 2016). The conscious inquiry into racial identity and sociocultural constructs and assumptions about race may be especially critical for white counselors due to whiteness’s positioning as a cultural norm. The sociocultural positioning of whiteness as the implicit norm is a significant barrier to cultural competency for white counselors (Sue, 2004; Lee & Bhuyan, 2013). Whiteness as a cultural norm exempts white people from needing to think of themselves in racial terms, rendering their race in a sense invisible, and, therefore inevitably others as highly visible (Wallis & Singh, 2014; Lee & Bhuyan, 2013).

In an empirical study on whiteness in clinical encounters in social work, it was found that practitioners assert Western values as the cultural norm in clinical assessment and treatment options, using discursive strategies to recruit clients to assimilate to unmarked normative values of whiteness (Lee & Bhuyan, 2013). Whiteness was found to interfere with practitioners’ capacity to be client-centered, leading to misguided treatment recommendations (Lee & Bhuyan, 2013). Ethnocentric norms’ invisibility presents a barrier to clinical effectiveness, since unconscious bias can inhibit the ability to weigh appropriate ethical and clinical treatment considerations. Counselors need to have insight and knowledge of how oppression, prejudice, and racism affects their identity and their work (Arredondo, 1999; Hays et al., 2007; Lee & Bhuyan, 2013; Sue, 2004; Pendry, 2012; U.S. Department of Health and Human Services, 2001).

Making the invisible visible for white counselors may mean first and foremost to make whiteness visible and ask, “What does it mean to be white?” (Helms, 1992, 1995). What beliefs, assumptions, and affective responses may result from the conditioning of whiteness (Helms, 1992, 1995; Thompson & Neville, 1999)? According to Helms’s (1992) White Identity Development model, a healthy white racial identity is formed through a two-step process: the abandonment of racism and the evolution of a non-racist white identity.

A growing body of research asserts that exploring racial constructs and privileged statuses fosters professional development and reduces the likelihood of counselors resorting to racial stereotyping while increasing their ability to view problems from a systemic perspective (Arredondo 1999; Neville et al., 2001; Kiselica, 1998). By seeking to understand the unique internalized cultural meaning of sociocultural factors, instead of attempting to assimilate to whiteness as the norm, counselors promote social justice (Lee & Bhuyan, 2013). To adopt a social equity-informed clinical lens, counselors may be required to expand their clinical perspectives from the interpersonal or intrapersonal to the systemic and cultural factors influencing clients’ lives. Counselors are called to consider both the sociocultural and the psychological factors affecting clients’ lives, and acknowledge how systemic issues shape everyday clinical practice (Lee & Bhuyan, 2013). Thompson and Neville (1999) recommend “articulating a personal theory of reality and therapeutic change in the context of an environment of racism” to integrate knowledge of racism with the practice of psychotherapy.

**Barriers to Multicultural and Social Justice Competency**

In 1982, Sue et al. and the American Psychological Association put forth an urgent call: while psychology had long emphasized the importance of self-understanding, it had failed to do so regarding culture and counselor training, and asserting the importance of counselors’ understanding of their own culture, biases, and prejudices (Sue et al., 1982). Sue recommended competencies concerning beliefs, attitudes, knowledge, and skills to increase cultural efficacy (Sue et al., 1982). Sue et al.
(1992) expanded on these original competencies to include 31 specific multicultural counseling competencies (MCC). Sue et al. (1992) highlighted the importance of multicultural approaches to practice, assessment, training, and research, and suggested the necessity for related accreditation standards. The Cross-Cultural Competencies and Objectives (1992) outline requires counselors to know how their cultural background influences their belief systems and clinical work (Sue et al., 1992). Cognitive understanding of social and cultural factors and insight into one’s affective responses may be crucial for culturally-informed clinical practice. However, is cognitive understanding sufficient to avoid harm in the therapeutic relationship?

Studies show that well-intentioned white people may identify as anti-racist and consciously believe in equality while unconsciously acting in a racist manner, committing what can be described as “microaggressions” (Wong et al., 2014). The term was first coined by Chester Pierce, M.D., in the 1970s (Pierce, 1970, 1974). These unconscious acts of racism can be mostly invisible to white people (Wong et al., 2014). The majority of white people are not familiar with being a consistent target of racial bias. Therefore, they may not register microaggressions, or may perceive such actions as isolated rather than systemic incidents. An example of racism that may be invisible to white people is the belief by a white person that they “do not see race or color.” Neville et al. (2013) argue that a “colorblind ideology” (“I do not see race”) is a “modern form of racism.” Research has correlated a “colorblind ideology” with increased racial prejudice (Tynes & Markoe, 2010). Colorblindness can be used to deny incidents of racism (Nelville et al., 2013), and could be seen as indicative of this time, when more overt forms of racism are socially less acceptable than in the past. This does not mean, however, that individual, institutional, and systemic racism is less prevalent. Widespread racism has morphed into “modern forms” (Neville et al., 2013).

Sue (2007) proposed classification of racial microaggressions manifesting in clinical practice, suggesting three types of racial transgressions:

- Microassaults. Conscious, intentional actions or slurs.
- Microinsults. Verbal and nonverbal communications subtly demeaning a person’s racial heritage or identity.
- Microinvalidations. Communications that subtly exclude, negate, or nullify the thoughts, feelings, or experiences of a person of color (Sue, 2007).

Sue explains (2007) that “micro-aggressions hold their power because they are invisible, and therefore they don’t allow us to see that our actions and attitudes may be discriminatory.” O’Keefe et al. (2014) found that repeated experiences of microaggressions can be associated with adverse mental health outcomes, including suicidal ideation. These findings suggest that denying personal, racial-cultural biases, “being colorblind,” and minimizing or ignoring racial and cultural issues could have damaging consequences on the therapeutic alliance, counseling outcomes, and clients’ mental health. The experience of microaggressions enacted by a counselor may be even more damaging, due to the sensitive nature of the counseling relationship (Constantine, 2007). The counselor’s position of power may also reduce the likelihood of clients honestly assessing the counselor’s behavior, potentially causing clients to doubt their perceptions. Therefore, the harm that counselors may cause to clients could be unknown and underestimated (Dovidio et al., 2002; Constantine, 2007).

In essence, anti-racist values can be held consciously and expressed overtly while racist beliefs are held unconsciously, therefore creating a split between explicit beliefs and implicit responses (Devos & Banaji, 2005). Counselors must recognize and examine privilege and oppression issues to avoid unethical and harmful practice (Arredondo, 1999). Counselors who are unaware of the difference between themselves and the client may mistakenly attribute negative qualities to a client (Sue et al., 1992). The invisibility of subtle racism to white people may prevent white counselors from consciously working to change racist beliefs, potentially contributing to harm and barriers in mental health services (U.S. Department of Health and Human Services, 2001). Identifying and monitoring microaggressions within the therapeutic context to avoid harm may be ethically imperative (Sue et al., 2007). Mistrust, based on expectations of racism related to counselor bias and stereotyping, has been found to be a barrier to mental health services for people of color in the United States (U.S. Department of Health and Human Services, 2001).

Considering the potential for harm in the therapeutic relationship, examining cultural countertransference, specifically whiteness, could be deemed as important as evaluating attachment or trauma-related countertransference. Kiselica (1998) highlights that exploring these constructs fosters the capacity for introspection regarding identity, facilitating potentially significant personal and professional growth for counselors.

**Counselor Training, Social Justice, and the Body – Learning Reflections**

As a student of somatic psychotherapy, embodiment became a focus of exploration in connection with modalities and theories on the process of change in psychotherapy. Under the mentorship of Dr. Carla Sherrell, who serves as faculty in the Somatic Counseling Psychology Department at Naropa University, I began to explore embodiment in connection with sociocultural location and social justice. In a course on Social and Multicultural Foundations, Dr. Sherrell would repeatedly prompt students to focus on somatic responses to readings and discussions on identity/sociocultural location, social justice, privilege, and oppression. I then joined a cam-
Body Psychotherapy and Cultural Countertransference

Body psychotherapy modalities can facilitate a conscious experience of somatic manifestations of sociocultural identity, shed light on cultural countertransference, and support self-efficacy in working with whiteness and internalized sociocultural concepts of race. This section will provide a framework for utilizing somatic modalities for work with whiteness and cultural countertransference.

The Moving Cycle, a body psychotherapy and dance/movement therapy theory developed by Dr. Christine Caldwell (1997), can be utilized to map changes in awareness of whiteness from an implicit norm and unconscious aspect of identity to consciously working with reactions, affect, and beliefs. The Moving Cycle is conceptualized into four phases: Awareness, Owning, Appreciation, and Action.

The Awareness Phase

“The Awareness phase is a body experience, in that awareness of physical sensations forms the keystones of my ability to pay attention and wake up. Awareness recovers my ability to know what is actually occurring, to assess what is.” (Caldwell, 1997, p. 104).

Caldwell (2002) describes awareness as a light, and when awareness is focused on a part of the self or experience, attention is like a beam of that light, giving rise to an internal witness. Sensation is viewed as experience, as perspective, rather than “the truth,” which can elicit a mindful surrender to present-moment experience and an openness to change (Caldwell, 2002).

Applying Caldwell’s theory to work with whiteness, mindful attention on present–moment experience, and fostering a capacity to witness sensation and affect may lay a foundation for the ability to witness cultural lenses or vantage points. The capacity for mindfulness can bring whiteness into conscious awareness and out of “invisibility” as a norm, identity, and sociocultural location. Racial microaggressions by individuals who identify as non-racist can be described as a dissociation between explicit beliefs and implicit responses (Devos & Banaji, 2005). Recovering awareness of what is occurring in the body may support the ability to be conscious of implicit responses expressed through the body. This awareness could help counselors track cultural countertransference and microaggressions in the therapeutic relationship. Caldwell explains that the Awareness phase can also be viewed as a deconstruction phase, as it would be used in critical theory (C. Caldwell, personal communication, April 29, 2015). With awareness of body, breath, sensation, and movement, implicit narratives and beliefs about the self are deconstructed, creating the possibility for more inclusive and just narratives (C. Caldwell, personal communication, April 29, 2015).
The Owning Phase
In this phase, one takes responsibility for one’s experience by acknowledging the truth about one’s experience (Caldwell, 1997).

“In the body, it requires that I tolerate and commit to continuing to feel and be curious about feelings and sensations I was disowning before.” (Caldwell, 1997, p. 104)

Caldwell (2002) explains that during the Owning phase, a shift occurs from previously unrecognized or disowned experience to a more profound sense of responsibility, self-efficacy, and internal locus of control. Caldwell (2002) also points out that this phase can include a sense of vulnerability, unfamiliarity, and recovery of integrity. The process of recognizing whiteness as a central aspect of one’s experience that was previously unconscious or disowned can feel vulnerable and disorienting. Simultaneously, the increased sense of self-efficacy and integrity, as described in the Owning phase of the Moving Cycle, may also be a natural result of whiteness transforming in one’s awareness from an invisible norm to a conscious sociocultural location and influence on thinking, feeling, and action.

The Owning phase may include insight into microaggressions. Noticing somatic states, responses, sensations, and affect enables the ability to register one’s microaggressions and the resulting impact. This could be a significant step towards fostering the capacity to experience affect in relationship to whiteness and racial inequity.

The Appreciation Phase
In the Appreciation phase, one is accepting of one’s experience (Caldwell, 1997). Accepting what has been brought into conscious awareness through the Moving Cycle’s previous phases allows a deepening, facilitating understanding and unfolding of newfound awareness and experience (Caldwell, 1997). This phase often includes profound affect and the emergence of a new capacity for remaining in relationship and dialogue with oneself (Caldwell, 2002). Mindful acceptance supports change.

As applied to whiteness, acceptance can be conceived as a general position of kindness towards oneself, but not as acceptance of the condition of whiteness as an invisible norm and the resulting systemic racism. Awareness of whiteness can be appreciated as a tool for social change and forward movement out of unconscious bias (T. Topper, personal communication, April 20, 2018). Caldwell (1997) articulates that this phase indicates a reoccupying or reasserting of a person’s creative force, which can be experienced as a reclaimed sense of movement. Since whiteness may manifest as an inability to feel sensation and affect regarding sociocultural location, a restoring of the ability to feel sensation and affect could be indicative or symbolic of a reoccupying of an aspect of the body, a reclaiming of the ability to be in relationship with oneself and others in a more genuine and embodied way.

The Action Phase
In the final Action phase, change is facilitated by “taking my experience out into the world and manifesting it in relation to others” to make inner change real and meaningful” (Caldwell, 1997, p. 104). In the Action phase, privilege is acknowledged and used consciously to deconstruct systemic bias and the sociocultural positioning as whiteness as the norm. Privilege is used to point out norms centered on whiteness and bring attention to racist systems and events. When whiteness remains invisible to white people, racism continues to be reinforced implicitly and explicitly through thoughts, somatic responses, social interactions, and cultural and institutional norms.

As the Moving Cycle illustrates, awareness of sensation facilitates insight and understanding of what is occurring in the moment, creating opportunities for change. Fostering the ability to feel sensations and affect could be essential for work with whiteness that transcends cognitive understanding. Numbness resulting from privilege perpetuates racism and structural oppression. Fosha (2000) explains that the somatic experience of core affect facilitates change. Core emotions are deeply-rooted bodily responses, offering a royal road to the unconscious and unlocking deeper experiencing and previously unavailable material (Fosha, 2000).

Based on my learning under the mentorship of Dr. Sherrell, I propose that the experience of core affect in relation to whiteness changes the somatic manifestations of privilege in the body, creating the possibility for more profound awareness, feeling, and relating. By taking notice of body sensations, postures, and affect associated with beliefs shaped by whiteness, white counselors may, in a sense, map their personal body landscape of whiteness. Different body landscapes manifest themselves not only in different subjective experiences for the individual, but also in different rates and patterns of speech, different access to internal experience, as well as different qualities of concentration, attention, and relating (Fosha, 2000).

Conclusion
A psychology that does not recognize and practice diversity is a psychology that is truly bankrupt in understanding the totality of the human condition. It will forever perpetuate a false reality that provides advantages for certain groups while disadvantaging and oppressing others. As long as the invisible is not visible, the profession of psychology may continue to operate from monocultural theories and practices that deny the rights and privileges due to all individuals and groups (Sue, 2004, p. 768).

is an “active, developmental, and ongoing process that is aspirational rather than achieved” (p. 48). Tracking somatic and affective manifestations of sociocultural identity may help counselors strengthen countertransference awareness and foster personal and professional development and ethical practice.

Johnson et al. (2018) reflect that the counseling relationship can be both a venue for the unconscious reenactment of microaggressions and a platform for liberation from it. In particular, conscious understanding of the nature of nonverbal communication and its involvement in the establishment and maintenance of privilege, bias, status, and domination can assist both counselor and client in dismantling oppression and understanding trauma symptoms as potentially arising from the chronic trauma of oppression (p. 166).

When whiteness is removed from a position of neutrality and implicit norm, and placed in relationship with the body, people, and environment, it takes shape in the white person’s awareness and experience as something that exists, informs, and impacts. The capacity to experience affect related to sociocultural location could be viewed as fundamental to embodiment, since it means to be able to feel what my body symbolizes in the world that I live in, and how it relates to the experience of sociocultural locations and the bodies of others.

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ABSTRACT

Complex Posttraumatic Stress Disorder (C-PTSD) is a diagnostic entity included in the International Classifications of Diseases, 11th revision (ICD-11). It denotes a severe form of posttraumatic stress disorder (PTSD) and is the result of prolonged and repeated trauma. C-PTSD is associated with a broad spectrum of psychopathological symptoms and transcends the typical diagnostic criteria for PTSD. C-PTSD is conceptualized as including the core elements of PTSD, such as re-experiencing, avoidance, and hypervigilance, with the additional symptoms of poor affect regulation, negative self-concept, and difficulties in establishing and maintaining healthy interpersonal relationships. Eye Movement Desensitization and Reprocessing (EMDR) and the Internal Family Systems (IFS) model share a common treatment approach, and their integration has been found to enhance the efficacy of both modalities in the treatment of complex trauma. This article explores IFS-informed EMDR (IFS–EMDR) for the treatment of C-PTSD. IFS–EMDR creates an integration of the contemporary practice of EMDR with the interweave of the IFS model for positive resourcing. This article will firstly provide an exploration of insecure attachment and relational trauma as diathetic factors to the development of C-PTSD. Subsequently, this article will review how trauma and the emergence of structural dissociation impact the development of the self through the lens of IFS. Finally, through the use of a composite case study, this paper will discuss the benefits of integrating IFS strategies and language into EMDR therapy, with particular attention to challenges and limitations.

Keywords: C-PTSD, Internal Family Systems, EMDR, Trauma, Complex Trauma
The IFS model focuses on the network of internal relationships in which each ego state or part is embedded (Schwartz, 1995). This is reminiscent of how family therapy works, in that it is based on the assumption that for any one family member to change, the entire family system must change. IFS requires therapists to trust that a healing self-wisdom lies within each client. This is one of the commonalities that bridges the two powerful yet diverse modalities of IFS and EMDR, as therapists with a background in EMDR also utilize a client’s innate healing abilities (Twombly & Schwartz, 2008). IFS-informed EMDR integrates the practice of EMDR with the IFS model to promote positive resourcing, cognitive interweaves, and the restoration of balance. The utilization of IFS language and principles can enhance the trauma survivor’s capacity to establish trust, tolerate stabilization, and navigate a core sense of self (Forgash & Knipe, 2008; Lobenstein & Courtney, 2013; Twombly & Schwartz, 2008).

This current paper will first provide an exploration of insecure attachment and relational trauma as diathetic factors to the development of C-PTSD. Secondly, the ways in which trauma and the emergence of structural dissociation impact the development of the self will be reviewed through the lens of IFS. Subsequently, an overview of EMDR as a psychotherapeutic modality for treating complex trauma will be provided. A composite case will then be described to illustrate how IFS-informed EMDR is administered. Finally, reflections of the benefits and challenges of integrating IFS-psychotherapy into EMDR therapy will be discussed, including the existing limitations, and recommendations for guiding future practice.

**Deconstructing C-PTSD**

**A Diathesis Stress Model Perspective**

The diathesis stress model posits that when an individual is exposed to adverse life events in their formative years, they develop a negative self-schema (Slavich & Auerbach, 2018). This schema remains dormant until an individual experiences a traumatic life event that is reminiscent of the original stressor, at which point the preexisting schema or vulnerability becomes activated as a central negative cognition (Ingram & Price, 2001). Psychological diatheses are conceptualized as relatively stable individual differences (e.g., personality traits or cognitive styles) that increase one’s vulnerability to stress and to the development of psychological disorders (Ingram & Price, 2001). According to the additive model, an individual with a significant diathesis might require only a minor stressor or adverse life experience for a disorder to develop (Rutter, 2007).

One particularly potent early life stressor is parental maltreatment. Parental maltreatment is a direct precursor to the development of disorganized attachment in children, and is associated with children displaying comfort seeking, trust difficulties, and fear of rejection, abandonment, or betrayal (Collins & Read, 1990; Granqvist et al., 2017). Adverse or traumatic events in one’s childhood can predispose them to psychopathology later in life, including C-PTSD (van der Kolk, 2015). C-PTSD is a diagnostic entity included in the International Classifications of Diseases, 11th revision (ICD–11), and denotes a severe form of PTSD as a result of prolonged and repeated trauma. Endorsement of the ICD–11 definition of C-PTSD will go into effect on January 1, 2022. C-PTSD transcends the typical diagnostic category of posttraumatic stress disorder (Herman, 1992) in that it includes the core elements of PTSD, such as re-experiencing, avoidance, and hypervigilance, in addition to symptoms of poor affect regulation, negative self-concept, and difficulties in establishing and maintaining healthy interpersonal relationships (Cloitre et al., 2011; van der Kolk, 2015; van der Kolk et al., 2005). Trauma informs identity not just through the development of maladaptive behaviors, such as hypervigilance and psychological reactivity to events, but also through the formation of shame-based cognition (Shapiro & Forrest, 2016). Many children adopt a moral defense as a coping strategy, blaming themselves for their parent’s ineffective parenting. Fairbairn (1943) described the defense mechanism “The Moral Defense Against Bad Objects” as self-destructive, but also a desirable strategy for neglected children in order to remain attached to their needed objects. Fairbairn posits that children actively internalize the “badness” of their parental objects as a defensive strategy, which later causes them to feel deeply ashamed of themselves. Children who use the Moral Defense assume that their punishment or neglect is deserved, perhaps because of their own inadequacy (1943). The experience of trauma in the formative years and/or maltreatment by attachment figures creates a vulnerability to severe emotional dysregulation, along with intense feelings of despair, anxiety, shame, and mistrust of others later in life (Wessellman et al., 2012; Wesselman & Potter, 2009).

The psychological phenomenon of reenacting traumatic events and their circumstances has been coined the “repetition compulsion” (Freud, 1914). Repetition compulsion is attributed to both our predisposition to drift towards the familiar, and our desire to rewrite the past. This further demonstrates that the experience of attachment–based relational trauma in the formative years creates a vulnerability to severe emotional dysregulation along with intense feelings of despair, shame, and mistrust towards others later on in life.
Therefore, clients who meet the diagnostic criteria for C-PTSD are often actively re-experiencing aspects of their early relational trauma. If left unresolved, this attachment reenactment will likely impede individuals’ progress over the course of clinical treatment.

**Trauma and the Multiplicity of the Mind Through the Lens of IFS**

Trauma survivors often present as fragmented in their sense of self (Janet, 1889; Siegel, 1999). Dissociative splitting is a natural part of trauma and allows the individual to survive in a precarious environment through the use of cognitive dissonance (Siegel, 1999; van der Hart et al., 2006). Dissociative splitting enables trauma survivors to disown certain undesirable parts of the self that are related to shameful memories. Trauma-related splitting and compartmentalization creates a dissociative wall for relief from the painful remnants of the trauma, including implicit memories, intrusive thoughts, shame-based cognition, and night terrors (Shapiro, 2007). However, this dissociative splitting leads to a disowned part of the self through the application of selective attention, and thus, internal conflicts are left unresolved and implicit memories suppressed (van der Hart et al., 2006). The central negative belief adopted by many trauma survivors is that the trauma is in some way their fault, and their burden to carry (Fairbairn, 1943; Shapiro, 2007). The disowned parts of the personality are reminiscent of isolated neural networks carrying maladaptive information (Siegel, 1999; van der Hart et al., 2006). When disowned parts are activated, survivors of trauma re-experience the affect, negative cognitions, and behaviors stored in the unmetabolized traumatic memories, which contribute to the client’s fragmented recollection of the trauma, maladaptive behaviors, and negative self-beliefs. There are many therapeutic modalities that work with ego states and schemas, including ego state therapy (Watkins & Watkins, 1997), Gestalt therapy (Perls, 1973) and Internal Family Systems (IFS) therapy (Schwartz, 1995).

Central to the IFS model is the belief that everyone has a self-leadership quality that, when accessed, allows for inherent healing and self-wisdom to emerge. The IFS model proposes that the universal presence of an un tarnished self exists within everyone, and that this self, referred to as “self-energy,” encompasses qualities of calmness, curiosity, compassion, confidence, courage, clarity, connectedness, and creativity (Schwartz, 2001; Schwartz & Sweezy, 2020). The IFS model posits that in addition to the self, there is an ecology of relatively autonomous parts, and that each contains a unique quality and holds a valuable role. IFS healing occurs in a series of methodical steps that include accessing the self, witnessing all parts, retrieval, unburdening, replacing burdens with positive qualities, and integration/reconfiguration of the system (Schwartz & Sweezy, 2020). The initial phase of the IFS treatment process is to differentiate parts from the self, or to unblend parts from the self, as the self can become blended with other parts. When parts become blended to the “self,” the individual is not being “self-led.” Once the self has been accessed and a part has been identified that is willing to work with the self, other parts are asked if they have any objections to the work. Once permission is earned and agreement is established, the process of compassionate “witnessing” can occur. During this time, it can become apparent that certain parts must be “retrieved.” Retrieval is the process by which “the self” takes a part out of the past and into the present. The “self” is best equipped to lead the family system, and to heal the other parts of the mind. Initially, people may have limited access to the self; however, a clear connection to the self develops over time (Schwartz & Twombly, 2008). IFS provides an essential language to access and understand the parts, in addition to working through any unresolved internal conflicts. The IFS therapist works as an ally alongside the client’s self, which eventually becomes the compassionate therapist and leader of the internal family system.

Trauma and attachment injuries may cause parts to become burdened by extreme negative beliefs and worries (Schwartz, 2001). Every part has positive intentions for the person, even if actions at times are perceived as resistant, dysfunctional, or maladaptive. The burdens that parts carry are what cause problems, and parts must be unburdened for deep healing to occur. “Managers” are protective parts that manage an individual’s interactions within their external environment in order to protect them from pain or re-traumatization. In traditional psychodynamic therapy, the manager would be characterized as the defenses. Similar to parentified children, these manager parts protect more vulnerable parts in the system (Schwartz & Twombly, 2008). “Exiles” are disowned parts that are in active pain, shame, or fear. The exile represents the wounded inner child that resides within all of us. By accessing the inner child, we can pave the way for deeper healing, in addition to more profound behavioral and emotional change. Jung (1940/1958) proclaimed that within every adult exists an eternal child that is perpetually in a state of becoming more, and requires nurturing through unceasing care, attention, and education. Similarly, the IFS therapist will seek to affirm and unburden the exile.

Finally, “firefighters” are parts that emerge when managers become overwhelmed or exiles are exposed. The primary role of firefighters is to divert or suppress pain, which is usually achieved through ritualistic, compulsive, comfort-seeking behaviors, or risky action urges. Therefore, firefighters tend to be dominant in people who live with addiction (Schwartz, 2001). Schwartz (1995) states that there is never any reason to fight with, coerce, or try to eliminate a part, and, similarly, the IFS model promotes internal wholeness, balance, and harmony. The length of treatment in IFS is indexed to the systems level of trust for the self, and the level of po-
larization between parts, rather than the severity of the client’s symptoms (Schwartz & Sweezy, 2020). Finding understanding for the different parts of the self can provide a remedy for negative symptoms, and eventually empower the trauma survivor. The IFS model creates a language for the trauma survivors to affirm and unburden their parts, allowing their self to lead the way.

**EMDR and the Treatment of Complex Trauma**

The efficacy of EMDR therapy in the treatment of PTSD has been well established in over 30 positive randomized, controlled studies during the past three decades (Ahmad et al., 2007; Marcus et al., 1997; Marcus et al., 2004; Shapiro, 2014; Wilson et al., 1997). Such research findings have led the World Health Organization (2013) to state that trauma-focused cognitive behavioral therapy and EMDR are the only psychotherapy modalities recommended for the treatment of children, adolescents, and adults who meet the diagnostic criteria for PTSD. It is important to note that most of these study participants differ from survivors of complex trauma with chronic abuse and neglect histories in terms of symptom presentation and capacity for tolerating trauma-focused work (Korn, 2009). The treatment of complex trauma should be phase-oriented, multimodal, and skill-focused, with a core emphasis on symptom relief and functional improvement (Briere & Scott, 2006; Courtois et al., 2009; van der Kolk, 2015). In the treatment of complex trauma, the EMDR model is phase-oriented, highlighting the importance of resource development strategies that address the needs of patients with compromised affect tolerance and self-regulation (Korn, 2009). EMDR is a trauma resolution approach that involves a standard set of procedures and clinical protocols and includes specific types of bilateral sensory stimulation. Specific, focused strategies along with the bilateral stimulation help access the patient’s dysfunctionally-stored memories and related affect. These approaches desensitize the emotions and physical sensations, enabling them to access adaptive material stored in the brain, and forge new, positive associations to the original event. EMDR classically involves eight phases, which include the following steps: (1) history-taking, (2) preparation and stabilization, (3) assessment, (4-7) desensitization, reprocessing, closure, and finally (8) reevaluation (Shapiro, 2007). Importantly, the efficacy of EMDR is challenged when presented with complex layered trauma and dissociation (Forgash & Copeley, 2008).

Akin to the IFS model, EMDR activates a healing process in many clients, in which scenes from the past are witnessed compassionately and parts are unburdened from guilt and shame (Twombly & Schwartz, 2008). EMDR incorporates the adaptive information processing (AIP) model, which posits that memories of distressing experiences are dysfunctionally stored in an unmetabolized state within the memory networks of the brain. These areas tend to keep hold of perceptions, negative beliefs, affect, and body sensations that arose during the initial experience (Shapiro, 2001). These unmetabolized memories, much like a “skipping disk,” will replay the most distressing part of the memory, leading to intrusive thoughts, shame-based cognition, and psychological reactivity activated by sensitivity cues (Shapiro, 2001). Therefore, clients presenting with C-PTSD will have complex relationships with themselves and their attachment figures that must be approached compassionately by providing psychoeducation on dissociation and ego states. Shapiro (2001) further hypothesizes that “there is an innate, physiological system that is designed to transform disturbing input into an adaptive resolution and a psychologically healthy integration” (p. 54). Thus, EMDR therapists acknowledge the presence of an innate physiological healing system. EMDR therapists who understand how to sensitively and respectfully work with the inner ecosystem of clients’ parts experience better outcomes and fewer complications when working with complex trauma (Forgash & Copeley, 2008; Twombly, 2000; Twombly & Schwartz, 2008).

**IFS-Informed EMDR**

EMDR is a modality that incorporates the brain and the body. The foundational steps of the EMDR process involve teaching affect regulation techniques to clients and providing them with an understanding of dissociation and trauma processing through psychoeducation. No healing from trauma can occur until a client experiences a sense of safety in their body (Levine, 1997). The preparatory steps of EMDR involve taking a comprehensive history and establishing an imagined “place of comfort” for the client before they can begin to identify, communicate, and work with their parts. For clients living with dissociative splitting, problems may arise if the standard EMDR procedures are used without additional measures to prepare the client to access painful material (Forgash & Copeley, 2008). IFS-informed EMDR provides a conceptual bridge between the two models, providing additional language and tools to enrich therapist–client communication when exploring the client’s internal processes. Integrating IFS into the standard EMDR protocol provides additional perspective for the IFS-trained EMDR therapist in terms of ego states, defenses, and relational phenomena, which can cause blocking beliefs and resistance to trauma processing.

**IFS-Informed EMDR**

**Adapted Protocol Phases 1 and 2**

The initial phase of EMDR uses history taking as the foundation for treatment planning. History taking involves the therapist conscientiously observing and gathering information about the client’s background information, while assessing their suitability for EMDR. In the initial phase of the history taking, the utilization...
of IFS can be a valuable therapeutic tool for working with clients. Particularly, the use of IFS language during this initial phase of EMDR can help to titrate otherwise overwhelming material (Gomez & Krause, 2013). Highly dysregulated clients may find it overwhelming to access painful and traumatic material, which can have an impact on their affective states (Korn, 2009). Effective treatment of complex trauma requires a therapist to be experienced in working with dissociative parts. An IFS-trained EMDR therapist may begin to listen reflectively and use parts type language during the history-taking phase. For instance, they might say: “It sounds like there are multiple parts of you struggling here -- one part that feels fearful, and also one that wants to numb out. Is that correct?” An IFS-trained EMDR therapist will contract with the part that emerges during this time, become curious about it, and learn about its unique function, role, and desire. The client’s self will compassionately witness this part, ensuring it is unblended from the self. The client will then be encouraged to “go inside” and connect with their reactions to external triggers. During this phase, IFS helps stabilize the client by organizing the sense of self and making sense of the internal experience. This preparatory stage involves psychoeducation, self-exploration, and acceptance of the multiplicity of the mind, and is highly complementary to EMDR phases one and two.

The second phase of the EMDR protocol focuses on preparation and provides clients with tools that will prepare them for EMDR readiness. This involves enhancing their capacity to independently tolerate positive affect regulation. IFS is a tool that can be used within the larger framework of a phase-oriented approach to the treatment of complex trauma and is therefore complementary to the history-taking and affect-regulation phases of EMDR. The self-states identified through IFS can assist with the identification of target development within EMDR. By focusing on befriending and hearing from parts, one can create the healing process of unburdening. However, there are times when protective parts block access to trauma wounds, which is when incorporating EMDR may be most effective. The gentle, affirming attitude of IFS, combined with EMDR’s focused strategies and bilateral stimulation, help access the client’s dysfunctionally-stored memories so that deeper healing can occur (Twombly & Schwartz, 2008).

Case Study

The following case study is a composite case that contains elements and techniques derived from a number of sessions. Grant* is a 27-year-old Caucasian male with a diagnosis of C-PTSD. Grant presented to psychotherapy treatment with symptoms of anxiety and shame-based cognition due to a past history of emotional abuse, which was reported as prolonged exposure to domestic disputes and paternal aggression in childhood. This abuse was attributed to parental mental illness and the acrimonious divorce of his parents during his formative years. Grant described symptoms of cognitive hyperarousal, as well as avoidance and numbing, that were triggered during relational discord – specifically times when he reported that he felt “not in control.” History taking revealed a pervasive negative cognition: “I am powerless.” Grant responded well to imagined affect-regulation techniques, “place of comfort,” and “container” during the stabilization phase. The following excerpt demonstrates introducing the IFS model to Grant; he is guided toward accessing the self while making sure to unblend it from a manager part. Subsequently, Grant’s self is able to compassionately witness the part and perform a retrieval by letting the part know that it is in present time, and the risk of harm has passed.

T: I want to introduce you to a model of therapy that we will use together. It is based on the idea that we all have a core self that embodies our essence and all of our finest qualities, including calmness, curiosity, compassion, confidence, courage, clarity, connectedness, and creativity. We are born with these qualities; this is known as self-energy. However, we are also born with parts that help us relate to and survive in the world. You have heard the language, “One part of me feels sad but another feels mad,” or “On the one hand, I want this, but on the other, I want that.” It will be helpful to get to know these different parts of the mosaic mind. Some of these parts take on the role of protectors, keeping us safe from harm. They may do this in an outwardly positive way; for example, counteracting feelings of inadequacy by overworking and becoming perfectionistic. However, the fears of this part may cause anxiety, exhaustion, and a lack of belief in one’s intrinsic value. Other parts may protect us in ways that have a more negative effect. For example, a part may attempt to protect from painful thoughts or memories by using alcohol as a numbing agent. Though this can be used as a temporary way to avoid inner pain, the damage it causes to health, general wellbeing, and relationships is not helpful. Everyone has “parts” or facets of the self. All parts are welcome, and all parts are in some way attempting to be helpful. In this model, we develop a way to communicate with all the various parts of you, finding a way to hear from them so that they can heal rather than be pushed away. Our goal is to get to know them better, to earn their trust, and understand their underlying hurts. When we heal and unburden parts, they no longer feel the need to lead or be intense, because they begin to trust that you are now safe. You mentioned before that you have a particular part that seems to sabotage your relationships. Would you like to get to know this part better to see if we can help it?

1. A pseudonym has been used to preserve confidentiality.
C: (nods) Yes, I’d like that.
T: How does this part show up? Do you notice it in or around your body... or perhaps visually?
C: It’s visual.
T: Can you tell who and what you see?
C: Yes, this part is a pacing detective. He looks pensive and highly anxious.
T: Are there words that go with this image?
C: Yes, the detective is shouting and cursing. He is so stressed and has no control. He is fearful.
T: It sounds like this is a fearful part; what shall we call it?
C: Yes, he is fearful... we can call it the fearful part for now.
T: How do you feel towards the fearful part?
C: I feel critical of this part. It’s not a helpful response to have.
T: Can you ask the critical part to step back/relax for a moment?
C: No, it doesn’t want to step back.
T: What is this part afraid would happen if it stepped back?
C: It would be too much to handle, possibly overwhelming.
T: If we could take just a few minutes to get to know and hear from the critical part, would that be okay?
C: Yes.
T: Thank you for creating the space to get to know this critical part. How do you feel towards this part?
C: It’s been with me for a long time. It is fearful of getting hurt.
T: Oh, I see... tell me more.
C: It doesn’t want me to get hurt again.
T: This part does not want you to get hurt again. How does this part serve you?
C: Yes, it protects me.
T: What shall we call this part?
C: The protective part.
T: How do you feel towards this protective part?
C: I appreciate it; I know it does not want me to be vulnerable or hurt.
T: Would it feel okay to send this part a signal of your appreciation?
C: Yes.
T: Is this part willing to give us permission to be with the fearful part?
C: Yes.
T: Okay, take a moment to thank this protective part, letting it know you will listen for and appreciate its guidance. And then, when you are ready, you can connect with the fearful part.
C: Okay, this part feels more appreciated. I will listen for it more.
T: How do you feel towards this fearful part?
C: I am interested in this part, but I don’t like his energy – too much pacing.
T: Does this part know you are here with him?
C: No.
T: Would you like to send this part a signal of your curiosity and calmness?
C: Yes.
T: Does this part sense your presence?
C: Yes, but I am very far away.
T: Would it be okay to get closer to the part?
C: Yes, I approached him and placed a hand on his shoulder. He turned around and we are making eye contact.
T: What would you like to say to this part?
C: We are safe; you don’t need to be afraid anymore.
T: Can you ask this part, “What is this part afraid would happen if you did not listen to it?”
C: He is afraid that I would feel vulnerable and hurt.
T: That’s understandable; there have been many times when you have been made to feel this way in the past.
C: Yes, there have been. He is the protector of a younger me.
T: Do you want to tell this part about who you are now?
C: Yes, it’s 2020 now, and I am strong, independent, and live in a peaceful home.
T: Does this part have a response?
C: This part was so busy protecting me, it did not know that so much time had passed. This part has worked so hard. He is exhausted.
T: Do you want to thank this part?
C: Thank you for being there for me, for protecting me. I have felt your presence. This part is focused and powerful.
T: Can we hear from this part?
C: I would like that.
T: I wonder if you would like to let this part know that you appreciate its value and that you will continue to visit it and build a relationship.
C: He would like that.
T: If you like, maybe you could let this part know that you will be listening for its guidance.
C: Yes, that feels good and right. I will check in on him when I feel anxious or fearful.
T: Let’s take a moment to thank these parts for showing up today. In your own special and meaningful way, say goodbye to these parts, letting them know that you will continue to connect with and build a relationship with them.
IFS-Informed EMDR

**Phases 3-5**

Within the parts work therapy, the IFS-trained EMDR therapist can begin to work towards achieving trauma resolution by recognizing parts and giving these parts a voice to express their needs within the internal family system. The objective is to support the client in developing an embodied sense of self that can compassionately hold all disparate emotions, vulnerable sensations, and young parts of self as they strive towards internal harmony. Furthermore, certain ego states can be utilized as positive interweaves when a client demonstrates resistance to processing and cognitive looping (Twombly & Schwartz, 2008). The IFS concept of self-leadership provides a valuable context for the resource installation and the cognitive interweaves utilized in EMDR. Identifying potential target memories for processing can be a very charged and sensitive time in the trauma treatment process. However, careful integration of the IFS-informed preparation and resource development can aid in the assessment and identification of specific targets and core components of memories (Twombly & Schwartz, 2008). From here, the client will develop a sense of readiness and self-energy as they work towards the phases of desensitization and installation. This development of self-energy, catalyzed by interweaving IFS into the EMDR process, increases the connection to positive cognitions and adaptive neural networks. Phases 3-5 of EMDR can be a crucial time for assessing a client’s readiness to tolerate EMDR reprocessing. IFS can be applied to this pivotal process via the integration of parts type language to facilitate development of target memories, central cognitions or schemas, feelings, and the identification of somatic sensations (Twombly & Schwartz, 2008; Krauze & Gomez, 2013).

Even though a client may verbally express a sense of readiness to process the pain of the past, certain parts of self, such as firefighters or managers, may come to the surface and interfere with the process to protect the client. Twombly & Schwartz (2008) caution that EMDR can sometimes override managers and access exiles before systems have been prepared to handle them. Consequentially, managers and/or firefighters will punish the client and/or therapists for violating their rules. This sort of therapeutic backlash can result in the client distancing from therapy, disengaging, numbing out, dissociating, or activating firefighter-like behavior, such as increased alcohol use or risk-taking (Schwartz, 2001; van der Kolk, 2015). Sometimes, hypervigilant managers can become blended with the self. Within IFS, there is a direct access technique that may need to be applied if there is considerable self-energy available to the client, but a protective part is impeding the work (Schwartz, 2001). Direct access is an alternative approach to insight wherein the therapist’s “self” speaks directly to the client’s “parts.” Direct access can be accomplished as an explicit intervention, or implicitly, if the therapist knows but does not reveal that they are speaking directly to the client’s parts. This technique must come from self-energy, or it will exacerbate mistrust (Schwartz & Sweezy, 2020). Additionally, therapists must be mindful of their own affect, thought process, and countertransference. Before commencing with phases 3-5 in Grant’s treatment, we worked through hearing from and negotiating with the part via direct access in order to obtain consent to process a memory of developmental trauma, which had previously been blocked by a protective part.

T: In our last session, you identified a target memory that you would be interested in reprocessing.

C: Yes, I am sitting at the old dining room table with my sister across from me. I am next to my mom in the kiddy corner. It’s in the evening and it is very solemn. I want to process this memory; however, there is a part of me that questions what good can come from it?

T: Can I hear more from that part?

C: I don’t think he wants to talk; he is just pacing.

T: Grant, remember all parts are welcome, and all parts serve a function. Can we be curious about what he has to say? Let’s hear from him.

C: It’s the detective (the fearful part). He is anxious about going into this memory.

T: Tell me more.

C: In the other memories, I did not face my father. I trust you and have felt safe here before when working on the other memories. However sometimes when I think of my father, I feel a pressure in the back of my throat. It is a feeling of frustration, and a sort of despair.

T: I see. It sounds like this part is coming in to protect you.

C: Yes, he comes in when I feel that I am weak.

T: Can we hear from this part?

C: I work very hard to protect him. As far as intelligence and application go, I am doing my job.

T: You have done a wonderful job as Grant’s protector. You served as his protector when no one else did, and you have been loyal to him for all of these years. I am grateful to you for that.

C: I am glad that you can see that.

T: You have worked very hard to protect. What are you protecting him from right now?

C: When he tries too hard, he gets hurt. Then he feels weak.
T: I understand; it sounds like you do not want him to get hurt or to feel weak.

C: Yes, my job is to protect him from pain.

T: You have done a great job of shielding Grant from pain and keeping him safe. Grant, do you have words for your protector, the detective?

C: Yes, I can see that the detective has been my protector for a long time. Growing up, I really did not have anyone who I could rely on, and his pacing and general distrust kept hurtful people away.

In the IFS-informed interweave, it becomes apparent that Grant’s manager was protecting him from the pain of perceived failure. Consequently, he is hesitant to access a memory involving developmental trauma via EMDR. Ultimately, this part revealed it would prefer Grant to avoid and numb out his painful memories, as he had learned to do in his formative years. Trauma often involves numbing and avoidance of memories that are too painful to lean into or hold in the mind for a sustained period of time. This is reminiscent of a “jack-in-the-box motion” – a delicate dance of suppression and intrusion, which can be both pervasive and distressing. Suppression conceals the disowned parts; however, intrusive thoughts and memories can come to the surface and provoke feelings of fear and powerlessness in the trauma survivor. Finding a language and an understanding for the different parts of self can remedy these symptoms and empower the trauma survivor. Grant is guided towards appreciating and affirming that this part has been instrumental in ensuring his survival in a dysfunctional family home. The next step of this IFS-informed interweave involves negotiating with the protector part to obtain its permission to heal the parts that had been previously devastated by disappointment and perceived failure. This protective part believes that pain and suffering are pervasive themes in Grant’s life. The idea of exploring painful feelings seems risky, considering that in his formative years, Grant was shamed and rejected for being “too emotional.” The clients’ distrusting protector monitors trustworthiness to reduce pain. Reconnecting with, honoring, and eventually unburdening that part are the turning points in IFS-EMDR therapy. A hallmark of IFS is the belief that beneath the surface of their parts, all clients have self-leadership. Through Grant’s IFS journey, his self-energy has become more accessible.

T: Thank you for reminding him that he is strong and powerful. Let’s give him the space to respond.

C: I have always known, but sometimes I feel forgotten (laughs a little). He is ready; I will still watch over him, but he is ready.

T: As the protector, you are forever balancing the duty of care versus the dignity of risk. You are his dutiful protector. However, the risk is to give him the wings to fly and a safe space to land. Are you ready to let him process this memory?

C: I am.

T: Let’s take a moment to see if there are any parts of you that need to speak or weigh in on this important decision of processing a memory involving your father.

C: We are all ready.

**IFS-Informed EMDR**

**Phases 6-8**

In the final stages of EMDR, the IFS-oriented psycho-education and resourcing can continue to strengthen a client’s positive resourcing and resilience. For instance, in phase 6 of the body scan, which is designed to bring awareness to the body and process any residual disturbances, the client can connect somatic sensations with certain parts. For example, the somatic symptom of tightness in the throat can indicate the sensations of choking back tears, or the words they never got to say. Therefore, a client may say, “Even though the memory has retreated to a lower level of distress, I continue to experience a tight sensation in the throat.” This would prompt the IFS-trained EMDR therapist to ask, “Is there a part of you that we must hear from who needs a voice?” This gentle navigation of the mind-body relationship promotes closure by ensuring stability at the end of treatment. Once again, remnants of trauma are revisited in a monist perspective during the final stage of reevaluation using IFS-informed language. Furthermore, finding and nurturing the self can be utilized as a resource in both the EMDR processing and the installation stages. This creates a gentle, warm, and empathic integrative trauma approach to guide those suffering from trauma towards a place of healing and self-compassion.

**Conclusion**

EMDR is an effective and empirically-supported trauma modality that can benefit greatly from the integration of the IFS model. The IFS approach enables clients to recognize internal ego states, and to structure and control internal communication. Clients become aware of various parts and are able to identify alliances and conflicts among these parts. By exploring and compassionately connecting with different parts, clients can strengthen their “core self” and connect with their own inter-
nal guiding voice. IFS is a highly compatible adjunctive strategy to EMDR psychotherapy, as it capitalizes on a language optimized to understand the parts of the self in order to foster cooperation and self-energy. Furthermore, EMDR’s adaptive information processing model promotes the development of the internal working model, scaffolding the client through a comprehensive understanding of the mechanisms causing them to unconsciously reenact their trauma. IFS-EMDR creates a unique blend of the contemporary practice of EMDR with the interweave of IFS for positive resourcing. This has been shown to enhance the trauma survivor’s capacity to establish trust, tolerate stabilization, and navigate a core sense of self (Forgash & Knipe, 2008; Lobenstein & Courtney, 2013).

One primary aspect of this approach is the research-based knowledge that trauma is often accompanied by dissociation (van der Kolk et al., 2005; van der Kolk, 2015; Korn, 2009). Importantly, dissociation psychoeducation and affect-regulation techniques are standard strategies in treating complex trauma through psychotherapy. As discussed previously, dissociation is best understood as parts through the perspective of an ego state tradition. An IFS relational approach asserts the need for parts and provides the client with language to engage in a dialogue that facilitates self-compassion and positive resourcing. The ultimate goal of IFS work is to transform the internal dialogue between the parts of the self from disjointed chaos to a smooth, harmonic symphony. The parts are interwoven into the EMDR protocol and work collaboratively toward trauma healing. Consequently, in the healing of past painful events and the negative self-concept, clients are guided through a journey of positive self-energy and empowerment. As EMDR can successfully reprocess maladaptively-stored distressing memories and create new, adaptive associations in the brain, targeting early attachment-related memories with EMDR should have a positive impact on the individual’s internal working model. The IFS model depathologizes trauma-related splitting and empowers the client to ensure that deeper healing can occur. By applying concepts and methods from the structure, strategies, and narrative of family therapy and subpersonalities, the IFS model provides a language necessary to understand one’s parts and work through unresolved internal conflicts. Chronic traumatization can lead to internalized shame and negative cognitions. However, by compassionately hearing from different parts of self and developing self-energy, one can reprocess trauma and become unburdened from feelings of shame, thereby paving the way for trauma healing and self-leadership.

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The Epigenetic Roots of Emotional Intelligence

Milena Georgieva, George Miloshev

ABSTRACT

Emotional intelligence was defined by the American Dialectic Society in 1995 as one of the new terms often used in popular science. Few other scientific theses have engaged the attention of theorists and researchers for as long as has the dynamically expanding conceptual framework of emotional intelligence. Perceived in many ways – as a cognitive ability, as social competence, and a personality trait that is genetically inherit ed – emotional intelligence continues to intrigue people. It finds broad social applications in numerous fields – science, education, medicine, organizational development, economics, politics, business, and interpersonal relationships. The interpretation of the term “emotional intelligence” makes it possible to formulate different definitions and models for research, but academics usually build their theses on the processes of emotional regulation. As emotions are a consequence of the perception of the environment and the interpretation of perceived information, it is clear that these processes are linked with epigenetics. Epigenetics paves the way toward a precise understanding of intelligence, and particularly of emotional intelligence. The roots and fine mechanisms of its manifestation lie in the intimate connection between our genes and the environment.

Keywords: emotional intelligence, genetics, epigenetics, psychosomatics, brain, stress

Intelligence is the ability to adapt to change.
Stephen Hawking

Today, when we apply the words of Stephen Hawking to humans, we might at first say that they seem to contradict the words of Darwin, who long ago wrote: “...not the strongest of the species survive, nor the most intelligent. It is the one that is most adaptable to change.”

Sounds partially contradictory, right?! Whether adaptation generally means being the most intelligent, or the most adaptable, or both, seems confounding. At the same time, it is undoubtedly challenging to come to a precise definition of the term when referring to all the great minds who have discussed this subject. Then again, we should not forget that a hundred years have passed between the origin of these two concepts. Things have changed dramatically in the science of biology and the meaning and wisdom of human adaptation have been redefined.

In past centuries, the idea of adaptation was predominant, but today, we know that the issue is generally somewhat different. The contemporary definition of adaptation is that it is a function of our intelligence and of our ability to sense changes in the environment and react effectively and quickly enough. These capacities are undeniably impossible without rapid changes in our genes. However, any change in the genes sounds frightening. How were we able to preserve the identity of Homo Sapiens for such a long period if our genes were not undergoing constant change? Well, the answer lies in our ability to change through modulating the work of our genes in their adaptation to the surrounding environment. It is this modulating work that makes our
adaption to the fast speed of today’s world possible. It requires a redefinition and a deep understanding of the intricate interactions between our genetics and our environment. Part of this redefinition is our understanding of human intelligence which drives our progress and development as human beings.

Intelligence, Knowledge, and Ideas – the Salt of Life

Intelligence is one of the concepts we have tried, but always failed, to completely define. Studies on intelligence date back to the 20th century, when Dr. Spearman defined human intelligence in a sophisticated way (Spearman, 1961). He unambiguously proved that intelligence could be understood as a general ability permeating all tasks and abilities unique to each intellectual undertaking. In modern terms, and although this does not cover its entire meaning, intelligence is the ability to acquire and apply knowledge and skills (Sternberg, 2012). Since then, different domains of knowledge and skills have developed that apply this knowledge. If indeed there are various aspects and dimensions of intelligence, this seems logical.

Interestingly, when people have certain learning impairments, their brain compensates by focusing on other areas, or by heightening their ability to learn in different ways. Therefore, we now speak of eight distinct types of intelligence: visual–spatial, linguistic–verbal, logical–mathematical, bodily–kinesthetic, musical, inter- and intrapersonal, and naturalistic (Gardner, 1987), thus eliminating the unified nature of the term intelligence. Things are further complicated when these eight types of intelligence seem to coincide in different individuals, or differ most unexpectedly in identical twins (Tocacceli et al., 2018). This stands as clear proof of the complicated and far from easily understood nature of intelligence.

The Biological Roots of Intelligence

Human intelligence is rooted in its underlying brain function, and scientists speculate that individual differences in brain activity are reflected in individual corresponding behavior. This intricacy further increases when we consider how the brain is formed. Just imagine; we all begin life from a single cell – the fertilized oocyte, which after a subsequent number of divisions, forms the fetus with specialized cells, tissues, and organs, all containing the same bundle of genes forming matching genomes (Hussain, 2012). During embryonic development, the process that drives cell specialization is not mutagenesis, i.e. changes in the genes and DNA, but rather the biochemical modifications that happen on the genes. This biochemical make-up of the genome makes genes silent or active, regulates their activity, and thus leads to cell specialization in brain, heart, muscle cell types, and many others (Waddington, 1963).

The brain is indeed the most complex structure in the human body since cell specialization alone appears inadequate to form a complex organism, and since these cells must function in a coordinated manner. Perhaps nowhere is this so deceptive as in the human brain. The brain’s complex structure is built by 100 billion neurons that integrate to form more than 100 trillion connections (Semendeferi et al., 2011). This specialization, along with synchronization, allows our brain to not only manage basic physiologic functions such as breathing, but also to generate the complex thoughts and feelings that make each of us unique. On the other hand, let’s not forget that all 100 billion neuronal cells share the same genome and operate differently depending on their specialization, in addition to which the most important brain and physiological functions are driven through this specialization (Georgieva, Sta-neva, & Miloshev, 2016; Nicoglou & Merlin, 2017). Epigenetics drives this process and is controlled by specific biochemical modifications that arrange genes in active and inactive states, depending on the stimuli that come from the surrounding environment. Recent data suggest that although genetic and environmental factors simultaneously contribute to cognitive test performance, intelligence malleability is a result of modifications of gene expression via epigenetic mechanisms like DNA methylation, histone post–translational modifications, small non-coding RNAs, and the overall organization of chromatin – all of which rely on and are triggered by environmental factors, such as changes in the educational system, overall exposure to stress, traumatic experience, nutrition, and poverty (Georgieva and Miloshev, 2020; Flynn, 1985; Lester et al., 2011).

Specifically, Flynn, in a series of studies demonstrated that due to changes in the everyday life of people in the decades following World War II, the leap in the general IQ and overall cognitive abilities of successive generations was so evident that it could not be explained by change in the underlying genetics (Flynn, 1985; Trahan, Stuebing, Fletcher, & Hiscock, 2014). This obvious jump in the intelligence scores of postwar generations was called the “Flynn effect” by other authors (Trahan et al., 2014). It was argued that various environmental factors, such as the educational system, technological progress, improved nutrition, and lifestyle, all impacted this phenomenon. Bratsberg and Rogeberg published an interesting study (Bratsberg & Rogeberg, 2018) constructively addressing the Flynn effect. The authors used the administrative register data of Norwegian male birth cohorts to look at three decades of information on family relationships and cognitive ability. They were able to unambiguously show that the increase, the turning point, and decline of the Flynn effect can be recovered from within-family variation in intelligence scores. This establishes that large changes in the average cohort intelligence reflect environmental factors, rather than changes in the parental genetic composition, and that these environmental factors act specifically via changes in neurobiological systems relevant to cog-
nition (Kaminski et al., 2018). Possible neurobiological factors that mediate this effect, and link genotype with complex traits like cognition, are epigenetic markers, including DNA methylation, the cortical architecture of the brain, and its functioning. Precisely these adaptability markers might contribute to the “missing heritability” that is present in many studies on intelligence and the genetic variations among individuals.

The term “missing heritability” of human intelligence appeared a couple of decades ago when the sequencing of the human genome allowed scientists to discern changes in the overall physiology and general psychological traits of humans without major differences in the genetics (Tauer, 1992). Around that time, a major search for the missing genetic link in human performance began. A couple of authors determined that in human intelligence, about 20% of genetic variations in certain genes are respectively responsible for brain functioning and structure (Savage et al., 2017; Sniekers & Stringer, 2017), whereas twin studies suggested a 50–70% genetic predisposition to high IQ (Polderman et al., 2015). Although these studies oppose nature versus nurture, they are a major step forward in understanding the neurobiology of intelligence, as well as genetically- and epigenetically–associated neurological and neuropsychiatric traits. Recent genome-wide meta-analyses have identified 205 genomic loci and 1,016 genes associated and strongly expressed in the brain, specifically in striatal medium spiny neurons and hippocampal pyramidal neurons (Davies et al., 2016; Savage et al., 2017), thus revealing genetics at the forefront of shaping the human brain and its manifestations, like intelligence and adaptability. Nonetheless, though the genetic studies were solid, even these authors argue that the above discoveries are too thin to definitively explain individual differences in the intelligence of almost genetically identical humans, and the jump between their IQ values in time, and in response to different surrounding stimuli due to their lifestyles.

Recently, an interesting study was published by Kaminski et al. (Kaminski et al., 2018) focused on genes involved in dopamine–based neurotransmission and their link with IQ scores and cognitive abilities. Dopamine is a hormone and neurotransmitter that plays several important roles in the brain and body (Blandini et al., 2001; Salehpour & Hamblin, 2020), and is linked with the brain’s reward system, thereby modulating drive and motivation. Moreover, any impairment in its metabolism leads to severe neurodegenerative diseases, like Alzheimer’s and Parkinson’s. These findings by Kaminski et al. show a link between epigenetic changes in dopamine neurotransmission and an individual’s IQ test performance. Epigenetic modifications can silence the dopamine receptor gene, leading to reduced signal transmission and fewer dopamine receptors being activated. This, in turn, was associated with lower IQ test results. Stress and dopamine production have both previously been linked to cognitive performance (Nieoullon, 2002). Now, environmentally-induced gene activity can be added to the list of factors known to influence IQ scores.

**Genes and the Environment – The Essence of Epigenetics**

The essence of life is driven by the complex interactions among genes and the environment, in other words, between genetics and epigenetics. It has to be stressed that epigenetics plays a crucial role during development. It shapes the way the genome works in response to all kinds of changes in the surrounding environment (Siegens & Ekwall, 2014). Although epigenetic significance was observed in live creatures in the 20th century (Waddington, 1963), epigenetics emerged as a real science approximately only a dozen years ago (Allis, Jenuwein, & Reinberg, 2007). But if we go even further back, say 2,500 years, and look at the writings of Hippocrates (specifically, “On Air, Water, and Places”), we find that even then he defined, albeit indirectly, the term epigenetics. There, Hippocrates skillfully formulates and explains three main reasons why we get sick. According to him, the first is due to nutrition, the second to the pollutants that reach us from the air and water, and the third to accidental events, including fatigue, stress, and accidental injuries.

Today the modern definition of epigenetics is “a study of mitotically and/or meiotically heritable changes in gene function that cannot be explained by changes in DNA” (Wolffe, 1998; Wolffe & Matzke, 1999). Through epigenetic mechanisms, cells integrate environmental conditions to fine-tune gene expression levels. Thus, it is now believed that epigenetic mechanisms drive biological responses to a plethora of different stimuli, like metabolic, stressful, social, and other issues arising from the surrounding environment. For example, central metabolites like folic acid are the substrates for enzymes that catalyze the deposition of covalent modifications on histones, DNA, and RNA – thus regulating the manifestation of our genes, and hence our adaptation.

**Defining Emotional Intelligence**

The topic of emotional intelligence (EI) is still very dynamically debated and has long engaged scientists. The term “emotional intelligence” was first mentioned in the 1960s in Professor Leuner’s works (Leuner, 1966). Many scientific publications followed, in which attempts were made to define emotional intelligence as a set of abilities, competencies, personality traits, or some combination thereof. Regardless of the ideological and methodological differences of the research teams, it can be more broadly deduced that emotional intelligence is each person’s knowledge of how they perceive, process, facilitate thinking, and manage emotions – both their own and those of others, in a specific environment. These processes of emotional regulation
are a combination of personality traits or a constructed scheme of abilities, e.g., for adaptation, communication, motivation, decision-making, etc. The idea that the structure of emotional intelligence contains the ability to understand oneself and others was introduced by Howard Gardner. In his book *The Theory of Multiple Intelligences*, published in 1983, he brilliantly put forth his idea that there are multiple intelligences. He argues that there is interpersonal intelligence (the ability to understand other people’s expectations, motivations, and desires) and intrapersonal intelligence (the ability to understand oneself, to understand and evaluate one’s feelings and motivation), and that they are integral parts of emotional intelligence. This idea was revolutionary for its time, because it drew attention to the fact that the individual perceives and builds relationships with the environment based on his specific abilities. The book was reviewed by Friedman (Friedman, 1985), who paved the way for the term emotional intelligence in the best way. Later on, professors John Mayer (Stanford University) and Peter Salovey (Yale University) coined the term “emotional intelligence” in 1990 (Mayer, DiPaolo, & Salovey, 1990), and formally defined it: “Emotional Intelligence includes the ability to engage in sophisticated information processing about one’s own and others’ emotions and the ability to use this information as a guide to thinking and behavior. That is, individuals high in emotional intelligence pay attention to, use, understand, and manage emotions, and these skills serve adaptive functions that potentially benefit themselves and others.” It was Daniel Goleman, a journalist, who popularized the concept of emotional intelligence by bringing it into the public arena. Goleman published *Emotional Intelligence* in 1995 (Goleman, 1995), in which he wondered why some people who are blessed with superior intellectual abilities seem to fail in life, while others with more moderate gifts succeed. Like Mayer and Salovey, Goleman hints at the genetic nature of emotional intelligence, but does not prove it. He stresses that IQ contributes about 20% to factors that determine life success, which leaves 80% to other factors, i.e., to the environment. Data from the research of Adrian Fernham and Constantin Petrides are presented on the genetic origin of emotional intelligence (Petrides, Furnham, & Martin, 2004). According to these authors, emotional intelligence is a combination of inherited personal characteristics. Moreover, the authors hypothesized that men would have higher IQ but lower EI than women, and that participants, regardless of gender, would rate their fathers as higher on IQ but lower on EI than their mothers. The results confirmed these hypotheses, supporting the view that people perceive psychometric intelligence as a primarily masculine attribute in contrast with emotional intelligence, which they perceive as a primarily feminine attribute. The results also showed that the intensity of the stereotypical perception of EI as a feminine attribute diminished when the authors asked participants to estimate their scores on a range of specific EI facets, instead of providing a direct overall self-estimate. And although there are no major genetic differences between men and women, still the genetic and epigenetic variations paved the road for endless discussions on the subtle meaning of the role of heritability in intelligence — particularly its emotional component.

**The Epigenetic Roots of Emotional Intelligence**

Epigenetics is reflected in all areas of our existence. Therefore, when we talk about emotional intelligence, we take seriously the important role of epigenetics in our ability to perceive, evaluate, and manage our emotions. Epigenetics also affects our ability to understand the emotions of others in different situations. While emotional intelligence is a relatively new field of study in psychology, the influence of genetics and epigenetics on it is a much younger field of study in biology and medicine. As a result, and thanks to the technology and research advances in this area, we now know that anger, fear, empathy, euphoria, and, in general, all the emotions that accompany our daily lives in one way or another, depend on our genetics and epigenetics.

In 2018, the prestigious journal *Nature* published a large-scale study on the relationship between emotional intelligence and genetics. The aim was to prove or disprove the relationship between the genetics we inherit and our emotional intelligence — in particular, our ability to experience and empathize (Warrier et al., 2018). The study included scientists from the University of Cambridge, UK, the Pasteur Institute and the Université Paris Diderot in France, as well as the genetic research company 23andMe (https://www.23andme.com). A total of 46,861 people were studied. More than 10 million different gene variants were tested. The focus of the research was on empathy as one of the most important components of emotional intelligence. What scientists found was that only 10% of a person’s ability to show empathy is due to genetic characteristics. The remaining 90% is not encoded by genes but depends on environment and lifestyle — on an individual’s epigenetics. If we go back to the famous comparison of the brain with an iceberg, we can understand that the visible 10% of the iceberg in our brain depends on the genetics transmitted to us, while the other 90% is invisible, deeply immersed in our subconscious or unmanifest emotions, feelings, and intellect.

Emotional intelligence determines the quality of people’s communication, and their level of resilience and adaptability. Depending on their emotional intelligence aptitude, people can motivate themselves without waiting for external stimuli, and they can successfully regulate their emotions by reacting without aggression or impulsivity. By using the full range of personal characteristics, skills, abilities, beliefs, convictions, acceptance or rejection, thought patterns and emotions, we are responsible for the quality of our relationship with the environment. Given that everything around us af-
effects the work of our genes, emotional intelligence is the direct bridge and the reflection to all changes in the surrounding environment and its impact on our genetics. Therefore, all mindful choices for improvement of our lifestyles, and thus our psychological comfort, will favorably influence our emotional intelligence and our cognitive abilities. In addition, modern techniques such as body psychotherapy act as influential epigenetic modulations of the comfort of our physiology and psychology and stand as positive examples of how careful modulation of our environment holds the potential to influence the activity in our genes.

The human brain is enigmatic, which is why the interest in it and in the human psyche are great. This is especially true lately, when many academics are actively working in the field of artificial intelligence. Scientists fear that artificial intelligence could replace the human brain when it comes to routine and non-emotional activities, but it cannot express emotions and feelings – specifically empathy. For example, again in 2016, the University of Cambridge opened a center to study the effects of artificial intelligence on humanity (https://www.cam.ac.uk/research/news/the-future-of-intelligence-cambridge-university-launches-new-centre-to-study-artificial-intelligence). At its inauguration, Professor Margaret Bowden, who has been researching artificial intelligence for more than 50 years, said she was not worried about the development of the technology, but stressed that she had not found a way, in her decades of research, by which artificial intelligence can replace the human in activities requiring compassion or emotional intelligence (Boden, 2015).

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ABSTRACT

This article aims to briefly introduce the development of body psychotherapy in Brazil. Initially focused on distinctive Brazilian approaches, methods from abroad were later incorporated.

Keywords: psychotherapy, body psychotherapy, Biodynamics, Biosynthesis, Bioenergetics, body and mind

In the 1970s, the military regime was in full command of Brazil, exercising repression and violence at full throttle.

José Ângelo Gaia-sa and Roberto Freire, and a psychoanalyst, Ana Verôni-ca Mautner, each in their own way, laid the foundation for the Brazilian Reichian movement and were responsible for the dissemination of Reich’s work in Brazil.

José Ângelo Gaiarsa was born in São Paulo, Brazil in 1920. A psychiatrist who graduated from the University of São Paulo and specialized in psychiatry at the Paulista Association of Medicine, Gaiarsa was also a Reichian psychologist specializing in practical ethics and nonverbal communication.

Gaiarsa was deeply involved with the press, and active in television. For ten years (1983-1993), he hosted the program Puzzle of the Day-to-Day on TV Bandeirantes, in which he invited viewers to participate in analyzing emotional problems.

He authored more than 35 books, and introduced body techniques to psychotherapy in Brazil. His publications in the field of psychotherapy contributed to the scientific development and socialization of knowledge about the body and subjectivity, as well as to topics such as family, sexuality, and loving relationships.

Roberto Freire (1927–2008) was a Brazilian psychiatrist, journalist, and writer known as the creator of a heterodox new therapeutic technique called Somaterapia, a body therapy based on the psychoanalytic theories of Wilhelm Reich and anarchist concepts. Somaterapia is practiced in Brazil and in Europe by the anarchist collective Brancaleone.

Freire was a film and theater director, the author of telenovelas, a lyricist, scientific researcher, and staff member of the magazine Realidade. He was also one of the founders of the magazine Caros Amigos.

Ana Verónica Mautner was born in 1935 in Pest, Hungary and killed on January 30, 2019. She was a Brazilian Reichian psychologist, psychoanalyst, essayist, and chronicler. From a non-religious Jewish family, her parents were both Communists who immigrated to Brazil from Hungary when Anna Verônica was three. They arrived a few days before World War II was declared. She grew up in São Paulo, in the Lapa neighborhood, where her parents opened a hair salon.
In 1948, as a teenager, Ana Verônica joined the Dror – a socialist Zionist youth movement, which she abandoned when she decided to attend university. She graduated in social sciences at the University of São Paulo, where she also received a master’s degree in social psychology. She was part of the generation of leftist sociologists and philosophers in São Paulo.

Ana Verônica later lived in Rio de Janeiro, where she was a journalist for the Tribuna da Imprensa and Diários Associados, and she worked in New York, London, and Canada. She also worked as a publicist and chronicler at the newspaper Folha de São Paulo. She was a passionate traveler and forerunner of women’s autonomy.

In the 1970s, she devoted herself to a body therapy approach based on the work of Wilhelm Reich. This approach included individual and group therapy, dance, stretching, and physical exercises that externalized aggression. Ana Verônica became a professor at the University of São Paulo and at the Fundação Getulio Vargas. At the same time as Gaiarsa, she founded the Reichian psychotherapy course at the Sedes Sapientiae Institute, which influenced several generations of therapists.

These three individuals stimulated the birth of the Reichian movement and influenced a great number of psychotherapists in Brazil. At that time, they were real Reichians – that is, disciples of Reich who added the work of other masters in their clinics and theories. Encouraged by these precursors, other neo-Reichian movements emerged: Bioenergetics, Biodynamics, Biosynthesis, Formative Psychology, and Biosystemics.

Brazilian psychotherapists went abroad to train, or invited master teachers such as Alexander Lowen, David Boadella, Gerda Boyesen, Stanley Keleman, Jerome Liss, Frank Hladky, Ronald Robbins, Ebba Boyesen, Lisbeth Marcher, and Clover Southwell to come to Brazil frequently enough for Brazilians to be certified in their approach.

Institutes for Lowen’s Bioenergetics, Boadella’s Biosynthesis, and Boyesen’s Biodynamics were each officially established in the 1980s, and still operate today. Later, Jerome Liss, Stanley Keleman, and Lisbeth Marcher opened their respective schools of Biosystemics, Formative Psychology, and Bododynamics.

After five years of training in London from 1975 to 1980 at the Centre for Biodynamic Psychology with Gerda Boyesen and other teachers, I graduated and had the pleasure of opening the first School of Biodynamics in Brazil. Joining me as trainers were François Lewin, Christiane Lewin, and Ebba Boyesen, among others. Maurizio Stupigga was one of the trainers I invited to Brazil.

With two colleagues, Esther Frankel and Liane Zink, I created the Brazilian Institute of Biosynthesis in 1986, which is still in existence today. I had the honor of publishing the first body psychotherapy books in Brazil in collaboration with The Summus Publishing House, Boadella, and Boyesen.

Colleagues such as Liiane Zink, José Alberto Cotta, Carlos Briganti, Nicolau Maluf, Jr., Sandra Guimarães, Esther Frankel, Miriam Campos, and many others have created their own institutes, and their efforts further honor and disseminate the work of Wilhelm Reich.

In 2005, I was president of the International Congress of Body Psychotherapy in São Paulo, titled “Psychotherapy on the Social Web.” With approximately 800 participants from Brazil and abroad, it was the largest International Congress in South America. We had speakers from America and Europe, and a beautiful presentation by Brazilian artists.

In 2018, I organized a series of international conferences in São Paulo titled Chaos and Rigidity, the two extreme poles of social politics from a psychotherapeutic point of view. We invited the following international guest speakers from Europe and Brazil: Menno de Langen, François Lewin, Christiane Lewin, Maurizio Stupigga, Rosanna de Sanctis, Umberto Galimberti, and Ivan Izquierdo. The Brazilian speakers were Gabriel de Oliveira, José Alberto Cotta, Heloisa Daldin, Mary Jane, Flavia Piovesan, Gilberto Safra, and Marisa Correia da Silva e Wania Cidade. Each conference attracted about 300 participants.

Today, there are training schools in the following Brazilian cities: Natal Recife, Salvador, Rio de Janeiro, Curitiba, Florianópolis, Porto Alegre, Belo Horizonte, Goiânia, Manaus, Ribeirão Preto, Americana, Sorocaba, and Brasilia. As in Europe, we have many approaches: Biodynamic psychology, Bioenergetics, Biosystemics, and Biosynthesis are all widely accepted popular approaches. Both individual and group work are also well accepted.

Touch

As we know, body psychotherapy uses touch to release tension, seek harmonization, stimulate and encourage movement, and often sedate and calm powerful emotions and sensations that flood the body.

In Brazil and in some South American countries, touch is an accepted part of treatment and of the therapeutic process – for example, Biodynamic massage addresses muscle armor and works with movement. There are no significant differences between Brazilian and European practices, although touch is a more accepted social norm in Brazil.

In this post-COVID phase, it is impossible to know how continuity will be affected, but I believe that there will be a recovery with some adaptations.
In Conclusion

The Brazilian movement grew to be so strong that some of us became important trainers in Europe, the Middle East, Japan, USA, and other countries. This included Esther Frankel (deceased), José Alberto Cotta, Carlos Briganti, Liane Zink, and I.

We do not have a Brazilian association of body psychotherapy. Instead, our institutes link to the EABP and USABP.

The future of body psychotherapy in Brazil is established and stable. Institutes are developing and improving, and are constantly updating and integrating the knowledge that originates and develops here and abroad.

Rubens Kignel, PhD is a psychotherapist and teacher in Brazil, Europe and Japan. He holds a doctorate in Communications and Semiotics from the University of Bologna and is a guest teacher at the University of São Paulo.

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Bold Performances from Our Latin American Colleagues

Madlen Algafari

A few years ago, I attended the Body Psychotherapy Conference in Natal, Brazil. It was a truly astonishing experience. For days on and after my return, I reflected on how, from the moment I arrived at the venue, my experiences at the conference could never have taken place in Europe.

To begin, right at the entrance to the conference, someone was lying on the floor covered in tiny screaming alarms used to prevent muggers from stealing handbags. I leaned over and at least moved aside the alarm that was screeching directly on top of his forehead. In the next few minutes, I watched other delegates arrive. I was astonished to see that Europeans and North Americans were more likely to step over this person, while Latin Americans sought contact and tried to relieve his discomfort.

Still affected by this experience, I then found myself in the middle of a large hall full of scattered parts of dolls – heads, torsos, left hands, right hands, left feet, right feet. We were all asked to pick a body part and write our name on it using a Sharpie. I chose a right hand.

In the next hall, a giant human silhouette had been drawn on the floor, and we were asked to stand in the place of the body part we had chosen. Again, a stunning realization surfaced – all of us Europeans had chosen right hands and heads!

In the course of the next few days, while the conference was in full bloom, the body parts were left to hang on a tree right outside the entrance, swaying in the breeze and eerily reminding us to think about our own body, about its integrity, and about its dismemberment.

To this day, I still talk about one of the workshops I attended. The program specified that it was forbidden to take pictures or talk during the workshop. At the designated time, around 30 colleagues and I were led in one at a time and given a piece of paper. It was dark inside. As our eyes adjusted to the darkness, we began to distinguish a naked male body lying on the floor with a multitude of condoms hanging above him on the ceiling, all full of white and red liquid. In turn, each participant was asked to stand above this male body and read the text on our piece of paper. Mine said: “Humankind is growing, but what about humanity?”
We were then directed to write a single word on the body using a glowing marker. I wrote “courage” on his left thigh. When he was all covered with words, the naked man stood up in front of us like Leonardo’s Vitruvian. On his body, we could read: courage, love, truth, nakedness, natural, nature, regress, honesty, togetherness, meaning...

As the words pierced our minds like nails perfectly hit on the head, the naked man proceeded to tear the condoms from the ceiling. Symbolically full of semen and menstrual blood, these condoms guarded against life rather than embraced it. The white and red paint soon covered his whole body, combining with the glowing words.

At the exit, there was a sign: “Before you exit, ask yourselves what you are asking yourselves.” We sat outside speechless for at least another 30 minutes.

Such a performance–workshop would be almost impossible in Europe. I have been pondering this experience for years! I am still stunned by the power of the messages delivered by our colleagues, the body psychotherapists of Latin America.

You might also find yourself pondering it after reading my testimony. It is well worth it!
BOOK REVIEW

Body Psychotherapy for the 21st Century

by Nick Totton

Confer Books, 2020

Nick Totton’s latest book, titled Body Psychotherapy for the 21st Century, is a new, brief introduction to the field of body psychotherapy that provides a succinct overview of the many tributaries that form our multidisciplinary profession. The publisher, Confer Books, is the new division of Confer-UK, a training organization based in the United Kingdom. This title was released as part of their inaugural collection. The publisher states they are “interested in the exploration of psychotherapeutic ideas,” and this short volume is both modest and mighty for anyone who seeks to familiarize themselves with body psychotherapy.

Totton draws upon the depth of his own vast experience and scholarship as he explores four models of embodied practice within the current state of our profession: adjustment (bodywork), trauma/discharge, process, and relational. In the book’s introduction, he reports that to condense his thirty-five years of practice into a brief account was a “mixed blessing” that forced him to balance the task of straightforwardly assessing an immensely complex discipline. The book’s four chapters successfully deliver a satisfying overview of the common themes a typical patient or student might want to know, should they look into the privilege of working with a skilled body psychotherapist.

Totton first provides a historical context, ranging from Freud to Reich, to give the reader some historical and epistemological foundation before exploring what he defines as the “turn to the body.” This turn interfaced with what he sees as a movement to “professionalize” the therapy world and create “Body Psychotherapy 2.0.” Positioned at the intersection of relational psychoanalysis and scientific advances in the neurosciences, it includes mentions of polyvagal theory and infant research.

He further delineates how the last decades of research have contributed to clarify the foundational principles of body psychotherapy and have informed the techniques of the many different embodied methods. He invites us to further consider body psychotherapy as being countercultural in its values, maintaining a strong link to Reich’s own revolutionary benefaction to body politics.

I found Totton’s overview incredibly useful. It is a practical resource for many of my new patients who seek further insights into what they may be getting into when they meet me, a body psychotherapist, for the first time. As I read this book, I noticed that in my own embodied imagination, I envisioned a post-pandemic world where I would place this book on my waiting room table in order to provide a solid presentation of my own clinical sensibilities. Totton’s work has unquestionably well represented the field of body psychotherapy, and we all owe him our sincere gratitude for offering such an elegant compendiumary volume.

Chris Walling, PsyD, MBA, SEP is a licensed clinical psychologist and an active leader in the biobehavioral sciences. He is a Clinical Research Fellow at the Traumatic Stress Research Consortium at the Kinsey Institute at Indiana University where he is working on advancing the science of body psychotherapy and trauma psychology. Dr Walling is the President of the United States Association for Body Psychotherapy (USABP), and a Clinical Associate at the New Center for Psychoanalysis in Los Angeles, California where he also is in private practice.

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BOOK REVIEW

Emotional Neglect and the Adult in Therapy

Lifelong Consequences to a Lack of Early Attunement

by Kathrin A. Stauffer

W.W. Norton, 2020

Aline LaPierre

A sked why she wrote this book, Kathrin Stauffer reflects on the numerous clients she has treated over the years who, although never actively abused, were neglected in some way. Usually grouped together with the abused, adults who were emotionally neglected as children face specific challenges that are not well understood or researched. Although self-help books offer some resources, little has been written for psychotherapists about the suffering and therapeutic needs of the neglected – the ignored, as Stauffer prefers to call them.

Given the limited literature on this subject, Stauffer has relied heavily on her extensive clinical experience. Emotional Neglect and the Adult in Therapy teaches therapists to better recognize the developmental deficits of those who are unparented, uncared for, misconstrued, and whose suffering is often met with professional misattunement. This book rectifies a significant gap in the therapeutic literature by addressing the professional neglect of the neglected.

Neglect is absence. Stauffer compassionately notes that when the origin of neglect is rooted in early preverbal development, at a time when the cortex is not yet online, conscious recall and verbal narratives are missing – adults emotionally ignored as children lack words to express their inner experience. Often parentified too early, they are not aware of their needs, and don’t understand what is wrong with them. The question arises: how can neglect be explained to clients who do not remember that anything bad happened to them?

Adults who have been ignored as children present in therapy with distinctive features: quiet, introverted, polite to a fault, and generally not connected to their feelings. For the ignored, people are not a source of comfort, and the long-term effects of neglect leave serious deficits in their capacity for social engagement. They do not trust closeness, and have no sense of how to engage collaboratively. Never having had their developing self reflected in loving, constructive ways, adults ignored as children live with an underlying terror of being unsafe, and their mistrust of caregivers and professionals who offer help makes safety hard to establish.

Belying this disconnected presentation, their internal world is crippled with shame, and surprisingly protective of their caregivers. If the therapist feeds back relational difficulties too soon, these clients will feel blamed and shamed but will not show it. Stauffer cautions therapists never to assume that what they say will land the way it is intended. As a result, rupture and repair are a large part of the therapy. Adults ignored as children are under the siege of a persistent inner critic – a perpetrator self that operates under the belief that they are at fault, that if only they tried harder, or were braver, or were not so stupid, perhaps life would not be such a struggle. This critic’s job is to avoid rejection by ensuring that they are perceived as “good.” Consequently, they dislike being seen, for fear of being exposed as defective.

From a body psychotherapy perspective, those ignored as children were touch-deprived. The physiology of neglect lies in the spectrum of the schizoid and oral character structures. The ignored usually look a bit starved, unloved, or unwanted. Neglectful caregivers do not touch their children, nor do they share the joy and intimacy needed to establish and strengthen a child’s social engagement system. When a child reaches out, tries to engage, and no one responds, shame takes root.

This book is eminently practical and organized in an easy-to-follow sequence. An overview of primary scenarios introduces the subjective experience of the ignored. Using a range of caregiver scenarios, Stauffer illustrates how the experience of neglect shapes individuals: the absence of caregivers, or of caregivers who are depressed, preoccupied, or traumatized. An important contributing factor is the trans-
generational problem of mothers whose own needs were ignored, so they do not know how to parent their children. These developmental scenarios are grounded in the presentation of four clients whose therapeutic progression we follow through the chapters of the book.

Having discussed the experience of ignored children, Stauffer turns her attention to applying this understanding to clinical treatment based on psychotherapeutic and neuroscience-derived theoretical models. When treating adults emotionally ignored as children, therapists are often troubled by a sense of not knowing how to help. They are concerned by their clients’ lack of therapeutic progress and may experience themselves as useless. Stauffer offers solutions that seasoned therapists may wish had been available when they were in training, and that new therapists can be grateful to access.

The goal of therapy with ignored individuals revolves around giving them the missing pieces they need to be successful in life. Working with developmental and social engagement deficits requires a resource orientation. Therapy follows a slow developmental unfolding that demands long-term patience on the part of the therapist. While traditional therapy is conflict-oriented, when it comes to neglect, absence of resource rather than presence of conflict is the issue. Neglected individuals are slow to trust, and a traditional approach that pushes for anger will make these clients feel even more unsafe. For them, the process of change includes becoming able to tolerate being looked at and seen without feeling shame.

In the last chapters, Stauffer offers detailed descriptions of specific approaches she has found useful in her practice. With developmental deficits, she cautions, you don’t want to undo a client’s coping skills, but rather broaden their competency. To diminish shame, she reports working as does a scientist: first trying an intervention, and then going back to observe the outcome. When an intervention doesn’t work, she tries something else.

Stauffer suggests that therapists take an active role. She has found that modeling what these clients don’t know about their inner experience is effective. For example, she might make a tender offering: “You look as though there might be a feeling there... could it be sadness... or frustration...?” She proposes giving clients options so that they don’t feel the obligation to please their therapist. For some clients, offering words for their feelings, or learning that there are gaps in their capacity to relate to people may be shaming, but for others, it is a relief. A simple invitation such as: “Here is an idea I have... let’s try this” can resource a client in a number of important ways. Generally, if a therapist can take a loving parental position, they can become the much-needed guides that were missing in their client’s early lives.

It is said that narcissism is the problem of our times. Consequently, the number of adults ignored as children is more prevalent than we realize. Stauffer teaches us to look through the lens of neglect so that this suffering does not go unrecognized, adding yet more layers of internal despair to individuals who have internalized ever-present invisibility.

I have already recommended this book to colleagues and clients and all have expressed a sense of relief at having the issues of neglect named in such a thorough, compassionate, and insightful way. The feeling that someone understands is a key piece of attachment repair, and in the words of one client, “I liked this book. She wasn’t just throwing techniques that don’t work at us. There was a lot of heart.” This is a book written for professionals that is also most appropriate for the layperson. It has definitely become a staple of my library.

Aline LaPierre, PsyD, MFT, SEP, is a somatic psychotherapist, creator of NeuroAffective Touch® and director of the NeuroAffective Touch Institute teaching the integration of psychotherapy and the therapeutic use of touch. She is the co-author of Healing Developmental Trauma, Vice President of the United States Association for Body Psychotherapy (USABP), and maintains a private practice in Los Angeles, California.

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If you are interested in becoming part of the Journal family, and wish to contribute your expertise to the field of body psychotherapy and somatic psychology, send your CV and field of competency to editorinchief@ibpj.org

Our deepest appreciation to the peer reviewers who have contributed their expertise to this issue:

CONFERENCE REVIEW

Body Psychotherapy During a Time of Pandemic

International Online Conference
December 19th, 2020 = Bologna, Italy

Madlen Algafari

When Covid brings together a planet of body psychotherapists...

This international online conference, held in Bologna in December 2020, was organized by the Società Italiana di Biosistemica, and presented by Maurizio Stupiggia and Rosanna de Sanctis.

The one-day conference delivered a memorable experience. Offering various perspectives on the pandemic, the gathering was heartwarming, well-organized, mind-opening, and universally unifying. The moderators wisely introduced the speakers, who did a marvelous job connecting psychotherapy, biology, arts, aesthetics, philosophy, and the architecture of space and time.

Our Spring/Summer 2021 issue will present the major talks delivered during this one-day international conference. In preparation for the upcoming issue, Madlen Algafari, our editor-in-chief, gathered some noteworthy thoughts and presentation excerpts.

Maurizio Stupiggia
University of Milan

“Common suffering unites us, connects us to our ancestors, and to those we are close to. We must stop denying the irreversibility of the new! We can react with denial, with panic, with simplification... or with growth. We must talk not only of post-traumatic stress, but also of post-traumatic growth.”

Li Wentian
Wuhan Mental Health Center

“We, the selected 180 volunteer members of the psychological support team at the psychological rescue hotline during the Wuhan pandemic, share our expertise... We have fine-tuned a three-step system to address the psychological health of our population, including the doctors, Covid sufferers, their families and children, the elderly, as well as all those who had suffered from the disease. Our research shows that despite the rising depression levels, suicide rates have not increased. Even though the need for dealing with everyday psychological issues has increased, previous psychological problems have decreased. Our research also showed that somatization among Wuhan citizens has increased more than in other Chinese cities.”

Fabio Carbonari
Reich Institute, Rome

“The words emerge and emergency have the same root. The virus is not a foe. It awakens the search for meaning.”
Frank Rohricht  
London University  
“We examine the positive aspects of this negative situation, and how it stimulates personal growth in the areas of improvement of close relations, social support and mutual help, self-dependence, creativity, searching for a meaningful context, turning toward inner resources.”

Ozden Bademci  
Maltepe University, Istanbul  
“In our research, we evaluated how our body psychotherapy students were dealing with the experience of these months of pandemic. The conclusion is that the pandemic is an opportunity to rely on ourselves, to grow, to turn inwards and question ourselves. An opportunity to get to know ourselves.”

Vittorio Gallese  
University of Parma  
“We have become more distant yet closer. There is no I without You. We are homo duplex... Mirror neurons register the same activity during online contact as with live contact.”

Corrado Sinigaglia  
University of Milan  
“We need to be physically close to perceive the other’s agency, while with online contact something changes in the subjectivity. Interaction between us is hindered, trust decreases, the third neutral space – our office – is missing.”

Genovino Ferri  
New York Academy of Sciences  
“Dialogue becomes triologue in online contact. Instead of here-and-now, we have here-there-and-now with a deficit of sensory stimulation. If we cannot feel, we cannot know, and we cannot feel without a body! We are interconnected with everything on the planet. The virus came along to remind us of this!”

Giovanni Stanghellini  
University of Chieti  
“The pandemic enhances one vector of our lives, and that is disembodiment! The connection with our most primal senses is severed. This dematerialization is dragging us away from our nature... While some patients reveal themselves more through Zoom, others cannot do without physical contact.”

Gabriel Graca de Olivera  
University of Brasil  
“The world is seen as dangerous – where should we seek protection? Masks depersonalize us – we all have the same face... Many patients feel the lack of real physical contact with their loved ones... The Self can only exist in the context of relations. Two presences are necessary for a true meeting! The relation through the screen is more superficial.”

Rubens Kignel  
University of São Paulo  
“Microorganisms live in us just like we live on Earth. The virus teaches us solidarity – just like the cells in our body are in solidarity with the vast number of viruses, bacteria, and fungi within us. We cannot live without this impurity; it is at the basis of life. Otherwise, the striving towards absolute purity will lead us to Hitler, to intolerance and discrimination – to the racial, the religious, the gender– or disability–based... Psychotherapy seeks the truth in order to set us free! Freedom is within! We are finding internal freedom in the contact with ourselves. Silence is freedom!”

Stephen Porges  
Indiana University  
“Until now, we did not link the screen with what is personal. Intimacy was linked to live contact. Now, we have discovered that a screen can also give us that feeling... From the polyvagal point of view, online contact could even be more relaxed and less anxious for some patients... We have a coronavirus pandemic announced by the media, but we also have a pandemic of subsequent consequences.

Massimo Biondi  
University of Rome  
“Visceral resilience in unexpected times positions us between miracle and fear... When we are prepared, we know the possibilities, but lack of preparation calls on resilience... It is as if we had lost our ability to deal with the unthinkable, the unpredictable, the irreversible, the incomunicable, the indefinite, the incomplete, the immeasurable. Adapting to the current situation requires effort... There is individual resilience, but there is also community resilience as a stress coping mechanism. Small joys pave the way towards big survival. Body psychotherapy supports this resilience.”
W.W. Norton & Company

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Emotional Neglect and the Adult in Therapy
Lifelong Consequences to a Lack of Early Attunement
by Kathrin Stauffer

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