

INTERNATIONAL **BODY PSYCHOTHERAPY** JOURNAL

Published by the European & United States Associations for Body Psychotherapy & Somatic Psychology

The Art and Science of Somatic Praxis



Volume 20 ■ Number 1 ■ Spring/Summer 2021

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The World Has Changed!



Madlen Algafari
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Managing Editor



Christina Bogdanova
Assistant Deputy Editor

T

he world is changing... *the world has changed!*

Until now, the world changed mostly through guillotines, Kalashnikovs, bombs, concentration camps, plagues, and disease. This begs the question: could the world change without the “help” of trauma and violence? What if we did not wait for misfortune to push us into change, but instead mobilized our hearts and willpower to embrace it? What if we took responsibility for our growth, and changed ourselves from within! Changed our bodies and souls, our ethics, and values. Embracing responsible change is THE opportunity of our times! It is also at the core of our professional mission as body psychotherapists and somatic practitioners – and is more needed and essential than ever.

For a year now, we have been living in times of “*we don’t know.*” Where knowledge ends, faith begins! Twice knowing, we are still on a path leading to our own destruction. This time of “we don’t know” is our chance to look within and know ourselves! Only then can we grow out of the rigidity of our shells and divest ourselves of our armor.

It is urgent, critical, *vital* that we increase our *emotional intelligence*. It is the only way we will maintain our leadership over the exponentially growing power of the self-learning artificial intelligence we have created, which may soon be capable of overtaking us. Reconnecting and developing our emotional intelligence may well be our only chance of maintaining our advantage over computers so that they don’t grow to know more about us and how to manipulate us than we know about ourselves. Only then will self-learning machines remain a tool in the service of humanity and the organic world, instead of controlling the destiny of a world for which they have no heart.

We know very little about the most powerful computer on the planet – our human brain – yet we are hard at work building artificial ones. We do not yet understand how to heal ourselves, yet we invent medicines and prosthetics that we hope will do what we don’t understand. We cannot invent a pill or vaccine against ignorance. Can we reliably build a prosthetic substitute for our human brain?

Our incredible technologies are meant to ensure our survival and give us dominion over our planet. But we have built them *outside ourselves*. It is more than time that we turn our attention to inner engineering! Our machines create relentless noise. We need silence so that we can hear our body-mind – so that we can hear the organic Truth of nature and the ecosystem of which we are a part. It is time we mature as a species, take responsibility, and change our values from competition to collaboration, from dominance to cooperation, from greed to attuned stewardship. We must get to

know ourselves in these times when our culture is becoming less and less embodied, and human contact more and more virtual. This is disaster prevention for our future.



Before we review the content of the Journal, we would like to introduce Christina Bogdanova, our new Assistant Deputy Editor. She has been supporting the Editorial Team's work every step of the way, and her expert knowledge in graphic design, layout, and publishing has been instrumental in shaping the new look of our Journal.

In this issue, the *Journal* continues to serve the process of self-knowledge started 20 years ago. We pay homage to David Boadella, who turns 90 this year. In conversation with Lily Anagnostopoulou, David talks about his life's work and experience as a pioneer in our field. In **Our Practice** section, we have several articles full of wisdom eminently inspiring to our daily practice. Genovino Ferri reminds us that as recently as the 1980s, doctors still believed that babies do not feel or remember pain. He presents the science behind the lifetime effects of pain experienced during the first 500 days of life, when pain circuits are highly plastic and still maturing. Will Davis takes us beyond the world of the nervous system to explore research that reveals a heretofore unknown communication system among the three nervous systems and the body, resulting in the formulation of a more integrated bodymind model. Judith Blackstone, creator of the Realization Process®, describes how her method of body psychotherapy includes a series of inward attunements for experiencing unitive consciousness, the basis of deepened contact with one's own being and with other people. Bernhard Schläge details the sophisticated touch techniques Postural Integration® has developed to support client needs for affect regulation.

In the section **Trauma Work**, Hodayoun Shari, whose work is based in object relations theory and neuroscience, and was influenced and supported by Robert Hilton, analyzes how relational trauma disconnects us from the here and now, and keeps us prisoners of the past who worry about the future. In **Interdisciplinary Approach**, Muriel Moreno presents the results of a fascinating research question: are there common phases and elements within transformational and healing processes induced by different therapies or methods? What do they have in common, and what are the differences between them? Jennifer Taylor suggests that the current application of neurodevelopment principles in play therapy can be bolstered by somatic interventions that foster integration between the body and mind of the developing child.

Body Psychotherapy in Pandemic Times offers three presentations given at the international online conference organized by the Società Italiana di Biosistemica in Bologna in December 2020. These three responses to the pandemic were given by colleagues living in some of the countries that suffered most – China, Italy, and Brazil. In Wuhan, China, a research team led an investigation on post-traumatic stress disorder (PTSD) during and as a result of the epidemic, in the hope of providing targeted services that better serve the demands of the public psychological health care system. In Italy, Enrica Pedrelli, sponsored by the Ministry of Health, implemented a project called *Free Listening Psychological Service*, using a methodology developed over the years by the Functional Psychotherapy Society (SIF). And from Brazil, Rubens Kignel offers a profoundly inspiring view into human evolutionary psychology and our enormous difficulties in evolving toward a better future by refusing to build inclusive systemic alliances with other humans, ecosystems, nature, animals, and microorganisms.

In **Body Psychotherapy Around the World**, Yasuyo Kamikura introduces the development of body psychotherapy in Japan. In addition, the Editorial Team is expanding this section to include a new rubric – **National Associations and Committees in Action**. One of our goals at *IBPJ* is for all body psychotherapists and somatic psychologists to share their professional contributions, not only on an individual basis, but on a group and institutional level as well. Thus, we invite the National Associations and their Committees to share their successful ideas and actions in presenting new

knowledge to their members, refreshing or reframing old knowledge in the light of present-day developments, as well as offering opinions and strategies for the expansion and safety of our profession. We hope that creating a space to share tools, strategies, thoughts, and feelings will support and inspire our sense of community and belonging, and increase all of our organizational competencies. Antigone Oreopoulou, chair of the Greek National Association for Body Psychotherapy Ethics Committee (PESOPS) for the period of 2017–2021, opens this new rubric with an account of the committee’s presentation on the increasing importance of ethics and ethos. She highlights the fine line between legal and ethical provisions and the need for constant updating, monitoring, and reflection. Her account focuses on preparation for the event, from conception to its rewarding conclusion.

Lastly, in our **Book Reviews**, Adam Bambury returns to bring us a brilliant analysis of Marcel Duclos’ reflections on being an Internal Family Systems therapist, and Antigone Oreopoulou walks us through Louis Cozolino’s two foundational and carefully crafted companion books on becoming a therapist.

We have also added a new section inviting you, our readers, to write and let us know *if and how* the Journal is landing in your busy lives.

Please comment, share, and follow us on Facebook and Instagram, and remember to take advantage of the book discount that follows our Book Reviews.

Enjoy reading!

The IBPJ Editorial Team



P.S. Growing awareness is the path to change!

ON THE COVER

Nautilus

The chambers of the nautilus can be seen as a symbol of psychological growth. The nautilus reveals that growth is not linear, or circular, but a spiral movement. Each new chamber makes room for new insights that increase awareness and consciousness – each chamber opening to a larger perspective, inviting reflection, and prompting the renewal of our personal meaning, purpose, and integrity.

From Our Readers

Dear Colleagues,

Congratulations on the current issue of the IBPJ.

I had a bittersweet feeling about the article Body Psychotherapy in Brazil, which seemed biased, and to me, gave the impression that this is all there is and has been. It is well written and creative, and I congratulate Rubens for it, but I felt disappointed with the scope of its representation of body psychotherapy in Brazil.

Please note certain inaccuracies. Pethő Sándor published a modest book about body psychotherapy in 1974 (second ed. 1982), prior to the date Rubens claimed to have published “the first book about body psychotherapy” in Brazil. Most importantly, Calatonia is an authentic Brazilian method, and Sándor made sure to give credit to the Brazilian professionals who embraced his method as the co-developers of its clinical applications, even though one of the techniques was created during WWII in the refugee camps – I dare say possibly the first technique born from war trauma to treat war trauma.

I also wish to speak for other approaches that have been created in Brazil since the 70s, which shaped the beginning of body psychotherapy in many ways – particularly methods derived from drama and dance, which have been practiced since then, many in the context of group therapy. In particular, innovators with their own methods, such as Maria Fux (Dançaterapia), Angel and Klaus Vianna (Terapia através do movimento [TAM]), and Ivaldo Bertazzo (Reeducação do Movimento), are all part of the remarkable history of body psychotherapy in Brazil.

Anita Ribeiro Blanchard



I was very pleased to receive a hard copy of the *Journal* today. It looks great; well done on this. The content shows the breadth and depth of body psychotherapy and somatic psychotherapy.

Carmen Joanne Ablack
President, EABP



I finally got a chance to skim the issue tonight. All I can say is WOW! What an incredible resource for our field! I hope you are all three incredibly proud of the tremendous efforts put forth to compile the scholarship, insights, and contributions from so many into an incredible volume.

Chris Walling
Past President, USABP



Dear Wonderful Ladies,

Yesterday, your wonderful issue of the *Journal* arrived. I wept some tears of thanks. It seems to me, looking in from the outside, that the IBPJ is playing an important role in combining the efforts of the two Associations, as well as playing a part in supporting the development of content.

And when I look at the beautiful copy of the last edition, the tree with all its green leaves seems a good symbol for future cooperation.

What I am most grateful for is that the spirit of the two Associations is beautifully presented. I was a little fearful that the *Journal* would become so “scientific and triply peer reviewed” that the spirit would disappear.

So, I must get back to my reading. And my weeping of thankful tears! And commune with the spirits.

Jill van der Aa
Past IBPJ Managing Editor



First, I wanted to thank you for all your assistance in getting my article published in the current issue of the *IBPJ*.

Second, Madlen, I was touched by your piece on *Everything Has Meaning*. Aside from expressing some basic truths about what it means to be human compassionate beings, I loved the message of hope and growth and moving forward in a new way. I plan to share this with some people I know.

Alan Fogel



I have just received the hard copy of the current journal. It is Beautiful!!! Thank you so very much for all your work! and I LOVE the cover!!! It is almost so tactile. Congratulations and Thank You!

Judyth O. Weaver



Congratulations and thank you for the enormous work done! This is a big step in the development of a perfect product and the best business card for body psychotherapy and our associations that we can have.

Vladimir Pozharashki
EABP Treasurer

HOMAGE TO DAVID BOADELLA

Immersion in Deep Waters

A Conversation with David Boadella on his Life's Work

Lily Anagnostopoulou

— *Dear David, you are turning 90 this year, and what a nice coincidence and an honor to be invited to interview you on your life's work. Let me start with the present and go backwards in time. What is closest to your heart these days?*

Together with Silvia Boadella, I am very happy with how Biosynthesis has developed over the last thirty-five years – since 1985. Our hearts are deeply touched by the gratitude shown to us by our students and patients, and by our many trainers, including you, Lily, who have enriched Biosynthesis for many decades with their own unique creativity.

An important part of this development was when I founded the journal *Energy and Character*, in 1970, as a medium for publishing articles not only about Biosynthesis, but from the whole community of body psychotherapists. Peter Freudl created a content archive on the internet.

The past has sown the seeds for the present and for new developments in the future. Currently Silvia and I are completing a thousand-page book on our method, which we hope will be published in 2021.

— *I have known you for over 35 years, and what made me to want to meet you had no direct connection to psychotherapy. I had heard that you had written a thesis on D. H. Lawrence and the body. I was at the time reading all of his books, and I felt, Oh! here is a kindred soul. You didn't start as a psychotherapist. So, what brought you to the field, and how did your background influence your work? How important is it for psychotherapy to have roots in other fields of knowledge?*

In 1950, I was deeply influenced by the English author D. H. Lawrence. His view of life, love, and sexuality was in many ways similar to Reich, who I discovered in 1952. My first book, *The Spiral Flame* (Ritter Press, 1956), explored these connections in depth. Against this background, I decided to train in education, where I could influence what Reich called “the children of the future.” I took my training in Vegetotherapy in parallel, in the early fifties. For me, psychotherapy needs to link with re-education, social awareness, and somatic knowledge based on neuroscience. In addition, it needs to be open to explore the transpersonal roots of being human.



— *Who do you consider to be your great teachers, people you are grateful to, people you learned a lot from?*

My most important influences, after Reich, were the following:

- Paul Ritter, with whom I trained for five years in Vegetotherapy.
- Ola Raknes, with whom I took additional Vegetotherapy sessions.
- Nic Waal, a Reichian doctor from Norway, who wrote me in 1952 warning of the importance of not pushing clients into catharsis if they had weak boundaries or borderline tendencies.
- Stanley Keleman, the founder of Formative Psychology in California, who was a close colleague and friend for sixty years.
- Frank Lake, who developed the understanding of polarity tendencies in character development. He was the founder of Clinical Theology, which emphasized the treatment of prenatal disturbances.
- Bob Moore, a Danish teacher of psychosomatic principles and energetic meditations.

■ *In your long journey what did you find easy, what was difficult, and what was truly inspiring?*

What I found easy was working with the body and learning to read body signals. I worked with my first client in 1956, and helped him to overcome his compulsive and rigid tendencies until he learned to trust himself enough to find his first secure relationship with a woman.

What I found difficult was organizing trainings. I traveled a lot at the invitation of others in many countries, but I was not a good organizer.

What was truly inspiring was my relationship with Silvia, who was and still is a very creative therapist and trainer, but also an exceptionally good organizer. She created the International Institute for Biosynthesis (IIBS) in Zürich in 1985, and we have combined our skills together ever since then.

■ *As I grow older, I feel a certain inner alignment that is expressed in an inner certainty; something in me says, "I was right." Do you also feel this?*

Yes, I have this feeling you describe when I can get beyond stress, relax, and learn to trust the deeper messages from my body, and be in contact with my deeper self and with the hearts of others. In Biosynthesis, this relates to what we call the essence, or what Donald Winnicott calls the "true self."

■ *We say every method is somehow influenced by its creator. How do you think the person David Boadella shows through Biosynthesis?*

I think a deep aspect of my personality is the understanding of the three lifestreams: centering, grounding, and facing. In 1975, I was offered a one-hour massage by three group members I had met in a weekend workshop in Albany, USA. Against all expectations, I accepted this offer. The session was the deepest I had experienced in my life, and lasted four hours after the massage was finished.

The session was given by a man, his wife, and his sister. The man had weak boundaries, but helped me to find my boundaries and to strengthen my grounding. His wife had problems with her own breathing, but helped me to go deeper into my center and trust my own inner rhythms. His sister had difficulties normally in making eye contact, but helped me face her and others with my deeper feelings.

On returning to England, I met Stanley Keleman, who told me that this five-hour session was like a baptism after immersion in deep waters. Out of this deep personal encounter, I learned to trust myself and others much more than before, and began to teach the principle of the three lifestreams, which is at the foundation of Biosynthesis. This also opened up important links to the understanding of embryology in its relation to the development of the body as a whole.

■ *What criticisms have you received about Biosynthesis, and which ones do you consider to be valid? I know, for example, how you had to support concepts of energy and spirituality in modern views of psychotherapy, which have difficulty with the scientific aspect of these concepts.*

We have received on the whole very little criticisms from within body psychotherapy. Rather, I have been invited to teach within many other modalities, which have welcomed learning about Biosynthesis. I always had good contact with Alexander Lowen and with Gerda Boyesen.

An exception is a recent critique of the transpersonal aspects of any therapy, including ours, from the Gestalt therapist Peter Schulthess, published in a Swiss journal of psychotherapy. This has opened a debate within the EAP, with many articles published on the relationship between psychotherapy and spirituality, including my response "Boundaries to the Transpersonal."

Also, my earlier article, "Essence and Ground" was first published by the EAP in the *International Journal of Psychotherapy*.

■ *There have been great changes in body psychotherapy over its short life. Which ones do you like in particular?*

Body psychotherapy began to organize its first congress in 1979, in Davos, Switzerland. I was elected as the first president of the EABP at Seefeld, Austria, in 1981. We created the Board and the various subcommittees, which have continued to this day. The biggest changes have been the emphasis on the importance of research and the publishing of an extensive bibliography of body psychotherapy books and articles.

■ *How do you see the modern trend of supporting our work with neuroscience findings?*

Neuroscience is an important part of psychosomatics, so an understanding of how the brain works is part of understanding the body. However, we have to be very careful not to identify with reductive materialism, which sees the brain as creating the mind.

Many years ago, I received a letter from the quantum physicist David Bohm, who sent me his book *Wholeness and the Implicate Order*. Bohm was emphasizing mutual influences between matter and mind, without reducing one to the other. He called their interaction "soma significance." In Biosynthesis, we speak of soma semantics, the meanings of the body. An important chapter I wrote on this was published in the *Handbook of Body Psychotherapy* (Marlock et al., 1985).

■ *I think Biosynthesis is especially important today for young people as our culture becomes less and less embodied, and human contact becomes more and more virtual. What do you think?*



David with his wife Silvia and son Till

Young people implies not only young adults, but also children. For nearly thirty years of my life, I worked with children in parallel with working with adults. Each process helped the other. My work with maladjusted children was the basis of my master's degree in education (1960). This work was influenced deeply by my therapeutic knowledge. An article published about me in an educational journal when I was a headmaster was called "The Head with the Healing Hands." The work with children also greatly helped my psychotherapeutic work with adults.

Both approaches involved embodiment and touch, which classical therapies avoid. In the corona age, verbal contact with clients, or school children, can be maintained, but touch goes out of reach.

In Biosynthesis, Silvia and I developed the concept of the four elements of touch at a workshop in Greece in 1984. The four elements are *earth touch* related to bounda-

ries, *water touch* related to the flow of movement, *air touch* related to inner rhythms and breathing, and *fire touch* related to the transmission of warmth through the hands in the energy field. At the same time, we developed important principles regarding the ethics of touch. All this is much more difficult to communicate through virtual contact.

■ *What is your vision for the future of Biosynthesis? How would you like to see it developing?*

An important principle within Biosynthesis is the understanding of the seven life fields of experience. These are closely related to the seven segments of the body as recognized by Wilhelm Reich. The life fields are a common basis in all trainings in Biosynthesis which have developed in many countries.

Silvia and I formed the European Association for Biosynthesis (EABS) in 1988, the Overseas Association for Biosynthesis (OABS) in 1990, and the International Foundation for Biosynthesis (IFB) in 1991. Since then, many different national and regional institutes have been developed, led by creative trainers who invite leaders from other countries. Lily, you are yourself a wonderful example of what you have created in your own country, Greece, but also in sharing your training skills with many Biosynthesis Institutes from other countries.

I hope very much that this mutual connectedness will continue during the coming years. It is greatly helped by Biosynthesis Institutes, organizing in different countries international therapist meetings, conferences and congresses.

■ *Anything else you would like to add that I didn't give you the chance to talk about?*

I would like to emphasize that there is in Biosynthesis a deep connection between theory and practice. This means that our students, or clients, are also our teachers, and that we learn new principles and methods in our interactions with the uniqueness of individual developments. In this sense, the therapist does not cure the client, but provides an environment of care within which the client is able to develop a self-cure.



Lily Anagnostopoulou, PhD, is a psychologist and psychotherapist. She is the Founder and Director of the Greek Biosynthesis Centre, an International Senior Trainer in Biosynthesis, and President of EABS. She has a BA in psychology from Deree College, Greece, and a PhD from the University of Edinburgh, Scotland. She has studied Biosynthesis with David and Silvia Boadella, Bioenergetics with Alexander Lowen, hypnosis with Ernest Rossi and Nachi Alon, Group Analysis at the Institute for Group Analysis, Greece, Jungian Dream Analysis with Winnifred Rushforth, Rogerian Counseling at the University of Edinburgh, and Family Systems with Vasso Vassiliou. Lily has worked for many years as a psychotherapist in private practice, as a school psychologist, and a university teacher. Currently, she primarily works as an international trainer of Biosynthesis and likes big group events because of the powerful healing field they create.

HOMAGE TO DAVID BOADELLA

On Writing Poetry

David Boadella

I have written poems all my adult life, for the past 70 years. This particular poem was useful to Silvia and to me, as a positive preparation for each new day of the week. We used each verse as a meditation after breakfast.

Writing poetry, for me, is a valuable process of connecting with deep feelings and sharing the essence of an experience. A poem is an expression of creativity that records the meaning of an event. So, the poems are important ways of capturing the most valuable memories of my life.

Until last year I wrote, on average, one poem a month. Since I retired, I have had more time and am writing about two poems a week. This keeps my heart fresh and is a direct form of easy communication.

The Strengths of the Week

by David Boadella

When there is peace in our hearts
on the first day of the week,
then it's time to recognise
all we have achieved
with *satisfaction*.

On the second day
we need to remember
all that we take in on our way
as nourishment for body and mind,
welcoming every chance
for renewal
with a deep kind
of *acceptance*.

The third day is time for *trust*
that life can move forwards
without any "must,"
listening to our inner calling,
as we breathe the fresh air,
happily, with no risk of falling
into despair.

The fourth day is making space for *hope*
that our deepest wishes can be met
even when the slope
in front of us seems steep,
there is no risk of disaster
if we can be open still to deep
laughter.

The fifth day
is the deep breath
of *optimism*
that can fill our lungs
and flow through our body
to overcome pessimism
and act as a gift to take forwards
without the stress of anxiety.

The sixth day is without sorrow
as we look forwards with *faith* towards tomorrow
with all the time we need,
without having to speed.

The seventh day
greet us on our way
celebrating the end of the week
with all the *help* we could give to each other,
or take from another,
with thanks for all we could live through,
in seven days of enrichment.

Get ready for seven more days
and all within them that can brighten our gaze
and lighten up the next passage of our lives
with gifts of grace.

19th October 2020 Poem no. 980
© Copyright David Boadella 2020



HOMAGE TO DAVID BOADELLA

When Truth Touches Us

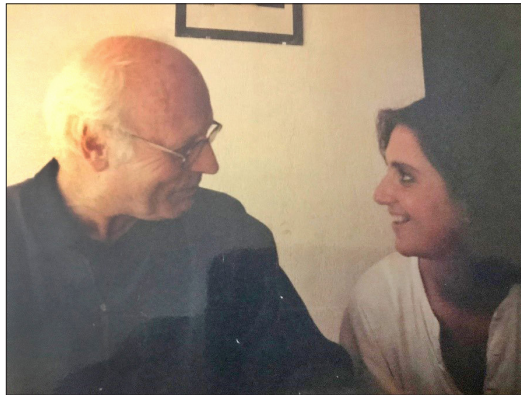
Lily Anagnostopoulou

It always happens when truth touches us.

One cannot think of Biosynthesis without seeing David nor think about David without seeing Biosynthesis. The man has become the work and the work is the man. This is a great spiritual achievement. There is a great spiritual force that leads him into the dedication, the commitment, the insight, the offering of his work. Whoever has seen him working is touched by his core of being as it always happens when the truth touches us.

And I believe that this deep contact with truth is the characteristic of Biosynthesis that keeps for so many years, so many people, committed to this work throughout the world. This international group of Biosynthesis trainers, students, therapists, clients share a valuable piece of truth about human nature and the offering of help that is immediately recognized as a special type of contact, presence, and encounter, irrespective of the different ways in which everybody practices his therapeutic task.

It becomes a life task for the whole of the community to shape it, ground it, put it in words, make it work. In this way it also gives a deeper meaning and value in the lives of the members of the community.



I was a Ph.D. student of Psychology in Edinburgh in the 70ties. Going to the big bookshops in London, I found the book

Bioenergetics by Alexander Lowen, which I bought, since I had an interest in Reich's work from my studies on human sexuality. This book I read only after I completed my doctoral studies and I felt that it contained more valuable psychological knowledge than all the other books I had read until then, put together. So, I decided to pursue this type of work.



I met David at a Bioenergetics Conference in Belgium, and it was his way of using touch that persuaded me to continue my training in Biosynthesis, which he was just beginning to organize at that time. Body psychotherapy is not necessarily a touch therapy, but Biosynthesis is, even if you don't use physical touch. I believe this is characteristic of this modality.

My understanding is that because it captures a deep truth about human nature, with which any therapist in Biosynthesis has been in touch during their training, it moves through them to their clients, and leads immediately to self-care and compassion about the self, irrespective of the specific words or techniques used. It is in the contact. This is what I mean by touch therapy. And for this gift especially, I would like to return to you David a deep gratitude, as a gift for your 80th birthday. May God always bless you and all of us who have been influenced by you. Thank you for what you revealed to us, for all that you did to us and thank you for what you did not do, as it allows space for us to continue in the same path. I wish you to stay well for many more years to continue to teach, to guide, to share and to inspire us all.

*Published by permission. First edition in "Something always goes further ..."
Festschrift in honor of the 80th birthday of David Boadella, Orgon Verlag Erwin Kaiser, Switzerland.*



HOMAGE TO DAVID BOADELLA

How Biosynthesis Enriched Our Lives

Tribute from Biosynthesis Therapists



W

e asked the participants of the First International e-Meeting of Biosynthesis Therapists to share how Biosynthesis had enriched their lives. Here are some of their tributes.

Biosynthesis brought transformation, clarity, structure, understanding, calm, and wholeness to my life. And a connection among mind, soul, heart, spirit, essence, and body. It supported my journey into therapy and helped me understand the other, not only through academic knowledge but with my heart as well.

Thank you, David and Sylvia, from my whole being!

Antigone Oreopoulou
Greece



Biosynthesis brought into my life more mindfulness and centering; it became more structured, as are David's poems.

Diana Nikolaishvili
Georgia, Tbilisi

Biosynthesis has given me a very deep and global grasp of the way I function, and as a consequence, of the way other people function. It has deepened my spiritual awareness. And mainly, it has moved the tectonic plates of my psychological organization.

Marilyn Pisante
Greece



Biosynthesis gave me the opportunity to feel that I belong somewhere that embraces my whole being as it is. I feel that Biosynthesis is a community that fits every human being, accepts all feelings, all thoughts, and all differentiation. The community's field supports its members to develop themselves.

Stavroula Sofrona
Greece

He is a teacher – he was, in his younger years, also working with the young, learning from them and with them, while he was asked to educate, to teach, to accompany them, through and despite the hardships of their lives...

He is a dancer – he has learned from inspiring teachers himself, about movement(s) and moving, the body and its impulses, the diverse and fine qualities that come with dancing, and living itself...

He is a poet – he loves language and literature, is putting words, creating sentences in a most imaginary way, to express, reach out and touch life and all that comes with it...

He is a scholar – his intellectual scope is huge, his reading profound, his horizons are wide, the agility of his mind just impressive, opening new spaces, again and again...

He is a therapist – “ein Gramm Kontakt ist wichtiger als eine Tonne Energie,” this is what he showed us, this is what we have learned, what we can keep in mind, wherever we are going, whatever we are doing...

He is a citizen of the world – he never restricts himself to a national or social ground, he welcomes everybody from everywhere, welcomes learning from others, from other histories, other cultures, other countries.

He is just a great spirit, he is just – and he is human.

David, I am deeply grateful for all I could learn, witness and share with you. With love, Susanne.

Susanne Maurer
Germany



Biosynthesis brought me to my center and saw me in my inner power as a person.

It saw Me!!!!

Supriti Zanna Mantzorou
Greece



Biosynthesis gave me a profound understanding of healing and helped me personally transcend some difficult history, reaching back to prenatal and perinatal life. It enabled me to gain strength, confidence, and a deep, growing trust in my own inner ground! As David used to say, “There is always fire beneath the ashes!”

Carine Nussbaumer
Switzerland

I come from a multidisciplinary educational background. Different psychotherapy approaches led me to the Biosynthesis Centre, where early on I understood it was the missing piece of the puzzle for me, the one that made the picture whole, that made sense, that was missing from the other approaches I had known. It helped me bridge the gap between what my mind was thinking and what my body was telling me, and had told me throughout my life! I felt at home studying there, combining all the knowledge I had gained, connecting to my core truth, to benevolent colleagues, and to the higher purpose of life – that is, to give and receive help while enjoying the path in parallel.

Thank you, David and Silvia, for creating this system that holds us all, excludes nothing and no one!

Sofia Koukidou
Greece



Biosynthesis helped to bloom the Sonia that was hidden in a tangle of standards, fear of expanding, insecurities, and lack of trust in herself. To experience a deep therapeutic process in the Biosynthesis approach, to do the training, to participate in many meetings in Heiden allowed me to further integrate my multiple layers, find my place in the world, find the meaning of my existence, make contact with my qualities, and let me express them in my personal life in my work as a psychotherapist and as a member of Centro de Biossíntese da Bahia.

My deep gratitude for being a part of this family. Special thanks to Eunice, David, and Silvia.

Sonia Souza Coutinho
Brasil



A dynamic trajectory that gives new perspectives and shape to life.

Penny Zikou
Greece



Meeting David has brought my life full circle. Coming from the Elsa Gindler tradition, it was an enormous enrichment to get to know David and his work, and to unite these two paths for my own unfolding and for the benefit of my patients. I am very grateful to be part of the Biosynthesis community.

Nimai
Germany

Biosynthesis came into my life as a gift from heaven. It gave my life a direction, and taught me to accompany fellow humans in their journey towards healing with deep respect, gentleness, and a holistic understanding of each individual's precious being. It has been my honor to have had the chance to meet David, feel the amazing quality of his presence, and witness his art as a therapist.

Marina Chandoutis
Greece

Biosynthesis has enriched my life on many levels. On the deepest level, it has helped me connect with hope, and ground in trust of life. It has helped me in my everyday life to reconnect with my own hope when patients, clients, or loved ones lose their ground. Thank you to David and Silvia and the whole community for creating and keeping alive a method that resonates with the soul of life at its deepest.

Paz Cardín
Spain



To Ανήκειν...

Η γη έχει στερέψει και η μαργαρίτα έχει πια από καιρό μαραθεί
στο φερμουάρ της πράσινης ζακέτας σου.

Ο ήλιος, μια ξεθωριασμένη κηλίδα στον ορίζοντα
όπως το βλέμμα των ματιών σου...

Το ιερό σώμα, κείται κομματιασμένο στο βωμό του
γενετικού "ανήκειν" χάνοντας την ουσία του,
ενώ η ψυχή απογυμνωμένη γυρεύει να βρει τόπο
να κατοικήσει...

Γυρεύει ένα σώμα ενωμένο, με ρυθμό και συνέχεια,
συμπαγές και αέρινο μαζί,
με καρδιά που χτυπά ζωντανά και
χέρια που μπορούν να ανοίξουν σαν φτερούγες
και να το αγκαλιάσουν.

Γυρεύει το ανήκειν από τη βιολογική οικογένεια
σε μία οικογένεια που μπορεί να τροφοδοτεί
το υγιές ανήκειν σε Εσένα, ως σώμα, ψυχή και οντότητα.

The Belonging...

The earth has dried, and the daisies have long since withered
on the zipper of your green cardigan.

The sun, a faded spot on the horizon,
like the look of your eyes...

The scared body lies, torn to pieces, on the altar
of genetic *belonging*, losing its essence,
while the naked soul seeks to find a place to live...

It seeks a united body, with rhythm and continuity,
solid and airy at the same time,
with a heart that beats fiercely and
hands that open like wings to embrace it.

It seeks *belonging* away from biological family toward a family that nourishes
the healthy *belonging* to You, as body, soul and entity.

Eudokia Katsiana
Greece

CURIOUS COMPASSION COMPANION*

Your Trauma Narrative
Is important.

Are latent in
Your Body

It will be
The window
You enter

Just waiting
For you
To show up

In order to
Start the journey
Of recovery.

With a
Curious Compassion
Companion

However,

Who has walked
Her own way

This is only
The beginning.

And can shine
The light

Trauma is more about
What happened
Inside you

To show you reconnection.

When you had to
Freeze,
Fawn,
Fight or Flight.

Until,

You become your own light
You become your own regulator
You become your own saviour

The impulses for
A healthy corrective
Experience

You become

Free.

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Ireland



* Inspired by the lifetime work of my friend and teacher Dr. David Boadella.

The 500 Days of the Primary Object Relationship

Nociception or Pain?

Genovino Ferri

ABSTRACT

After defining the difference between pain and nociception, the author likens that binomial to another featured in the international debate on analytical psychotherapy – subjectivity and pre-subjectivity. He places the focus of comparison of those binomials during the period of the primary object relationship – the first 500 days of a person's life, from conception to weaning.

A wide range of factors – anatomical, physiological, hormonal, and cytochemical – are given, supporting the hypothesis that awareness of pain is not necessary for marks to be incised in the implicit memory of the bodily unconscious as a basis for possible relational suffering.

Keywords: Nociception, pain, primary object relationship, intercorporeity, implicit memory

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In evolutionary terms, pain represents a form of sensorial intelligence that is fundamental for survival – a symptom indicating a threat attacking health and full vitality. Pain is a sensorial experience in which it is important to distinguish between nociception and pain.

The term *nociception* refers to neuronal events that occur when a damaging stimulus comes into contact with any part of our organism where nociceptors are present. Nociceptors (from the Latin *noxa*, meaning damage) are the unmyelinated ending of sensory neurons, which signal tissue damage through the skin, muscles, joints, and visceral sensations (Wikipedia).

Pain means becoming aware of nociceptive information so that information from the thalamic nuclei is integrated into the limbic and cortical areas (Zimmermann, 1997). No complex living system, however primitive, is without a means to signal harmful events, nor without the capacity for self-medication with endogenous opiates (endorphins, enkephalins) to relieve pain. (This holds true from insects to crustaceans and birds to mammals.)

Each species has its own means of transmission, such as vocalizations, olfactory communication, or visual messages, as in the case of human facial expression.

As for all forms of communication, intensity can vary, as for *whispered, quiet, or shouted* verbalizations, for example.

Nociception and pain have therefore represented part of bodily-analogical communication ever since the very beginnings of the evolution of living systems. Even in humans, life has surprising characteristics from conception onwards. A dialogue begins between mother and child, which is spelled out in hormonal

“
**Experiencing pain during
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when pain circuits are
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and psychiatric disorders.**”

messages such as “allowing the little one to pass,” and “not rejecting them as extraneous,” thus “being able to welcome them in the womb.”

The dialogue between mother and child is analogical, pre-subjective, and intercorporeal, being made up of the language of the biochemical exchanges that accompany the evolution of the little one “from the embryonic state to becoming a fetus and then a newborn baby” in the various stages of the primary object relationship. It is a journey that takes place in three stages over 500 days, moving from conception to implantation (the autogenous stage), from the seventh day to birth (the tropho-umbilical stage), and, finally, from birth until weaning (the oro-labial stage). This journey is structural and structuring, and these 500 days will be fundamental for building the personality on various levels. (Ferri G. & Cimini G., 2012)

Pre-Subjectivity and Subjectivity

The distinction between nociception and pain can be associated with the distinction between pre-subjectivity and subjectivity, which is a widely discussed topic in international psychotherapy.

Without having a mind capable of subjectivity, we would have no way of knowing that we exist and even less chance of knowing who we are or what we are thinking... (Damasio, 2012, p. 14). *There is no dichotomy between the Self-object and the Self-subject, which is founded on the Self-object...* (Damasio, 2012, p. 21). The self-subject originated from the self-object at a very clear turning point in biological evolution – the upright stance with bipedal deambulation. The I subject, and its field of consciousness, progressively emerge from the functional prevalence of the neopallium (neocortex) over previous brains (reptilian complex and limbic system). This emergence occurs during ontogenesis, from weaning onwards, because of increasing neuronal pyramidalization, with myelination and striated muscular dominance, which represents an increase in the complexity of motor circuits. (Ferri G., 2017)

As well as the association between nociception and pain, and between pre-subjectivity and subjectivity, another similar distinction emerges between implicit and explicit memory.

This topic has been widely researched in neuroscience. The hippocampus handles the selection and codification of information in explicit memory. It is part of the limbic system and is not mature before the age of two, which means that memories connected to explicit memory cannot be formed before that time. Along the arrow of evolutionary and evolutive time, the hippocampus overlies the earlier systemic organization of implicit memory, which is related to the amygdala.

It is clear that the field of consciousness of the neopallium, with its new capability of three-dimensional vision,

introduces the localization of objects in space and time, in before and after, and in where and when. In other words, it permits the traceability of memories on the arrow of time, as well as their recall in subjectivity. It is likely that the enormous quantity of information generated by the complexity of motor circuits and by stereoscopic, three-dimensional vision leads to the development of the new central depository – the hippocampus!

Returning to nociception in pre-subjectivity, there are two initial questions:

- Is it possible, etiologically and epigenetically, to consider nociception to be significant in terms of relational suffering during the time of the primary object relationship?
- Can relational suffering represent a platform that predisposes a certain type of phenotypical expression or particular relational trait patterns in the future personality?

Contemporary Reichian analysis (an international school of body psychotherapy) establishes an unconscious at the time of implicit memory, in relational-intercorporeal pre-subjectivity, which marks the individual, peripherally and centrally, in very precise relational areas.

I would like to suggest some indicators from the fetus that reinforce this hypothesis. The fetus experiences nociception.

Anatomical Indicators

The fetus has sensorial capacity from the first few weeks of its existence onwards. First, it has touch; secondly hearing, taste, smell; and then sight.

- Cutaneous receptors for sensitivity indeed appear in the perioral area at seven weeks; they spread then over the rest of the face, onto the palms of the hands, and onto the soles of the feet at 11 weeks, on the trunk and the proximal part of the limbs at 15 weeks, and over the whole of the cutaneous and mucous surfaces by 20 weeks.
- The fetus' heart begins beating on the 16th day of life.
- The most important part of the brain for pain perception is the thalamus, which forms from eight to 12 weeks.
- The thalamic-spinal pain pathways are formed between the seventh and 20th weeks.
- The thalamic-cortical connection is established between the 17th and 26th weeks.
- Myelination of neurons is already occurring in the 22nd week.
- The limbic anterior cingulate gyrus, which is responsible not only for the fetus' nociceptive capacity, but also for relational suffering, begins to form during the 26th week (Cesari E. et al., 2011).

How can we fail to associate Porges' polyvagal theory, which indicates that the maturation of the ventral vagal circuit occurs in human mammals only during the final period before birth and the first year of life – with times that belong to the primary object relationship? Isn't this a fundamental circuit for the activation of affiliation behavior and reciprocal affectivity? (Porges, 2014)

Physiological and Hormonal Indicators

- From the 16th week onwards, if the fetus finds itself under stress (hypoxemia, hemorrhage, reduction in uterine blood flow), it is able to redistribute its own hematic flow, protecting organs like the myocardium and brain, and regulating vasoconstriction in certain regions, such as in the splanchnic, cutaneous, and renal areas.
- The fetus already has a motor reaction to being pricked with a needle after eight weeks of life.
- After the intrahepatic vein is punctured to take a sample of fetal blood, plasmatic cortisol and beta-endorphin levels increase from two to six times, compared to cordocentesis in which the fetus is not pierced (Giannakoulopoulos, 1994).

These responses do not occur if analgesic opioids are administered. Some authors (Fitzgerald, 1985; Lee, 2005 in Cesari E. et al., 2011) claim that these responses do not indicate fetal pain-nociception but, rather, are reflexes. However, these affirmations are associated with an unthinkable negation of the unconscious in the body!

Cytochemical Indicators

- Substance *P* (a substance that is a pain mediator) has been shown to be present in the fetus from 8 to 10 weeks onwards and enkephalin (a neurotransmitter in the endorphin family) from 12 to 14 weeks onwards.
- The μ (Mu) and κ (Kappa) morphine receptors are present in the spinal cord at very early stages of development, while the δ (Delta) receptors appear later (Cesari et al., 2011).

Memory of Intrauterine Suffering

At 25 weeks, the fetus in the womb can respond to the acoustic stimulus of the mother's voice, and at birth, they recognize, through a sort of memory, the acoustic stimuli they heard before birth.

The fetus not only also notices prosodic variation in the voice, but also physical activity and the mother's heart rate.

I would add that the taste of the amniotic fluid translates the taste of the intra-

uterine primary object relationship, which I defined a few years ago as being a "mirror-taste." Jacobsen's vomeronasal organ had resolved the question arising from psychopathological certainties: "How could the unborn child know about the taste of the relationship in a liquid environment and in which they were not breathing?" (Ferri, 2017)

By injecting sweet or bitter substances into the amniotic fluid after the 24th week of gestation, a preference of the fetuses for sweetness and an aversion to bitter tastes was observed. In the first case, they swallowed double the amount of amniotic fluid, and their facial expressions showed pleasure, whereas in the second case, their facial expressions showed disgust, and they immediately stopped drinking.

During the embryonic-fetus period, the vomeronasal organ, which is located above the incisors, transduces odorous substances in liquid solution into flavor, and permits the fetus to recognize the flavor of the relationship with the mother. This organ, which is also present in fish, normally atrophies in humans after birth.

The fetus in the uterus at 20 weeks can experience more intense nociception compared to a newborn child or an adult. The fetus has a greater density of nerve receptors, their skin is not very thick, and they have not yet developed the descending neuronal circuit, which will attenuate pain as it develops after birth.

Various studies have shown the dangerous effects of maternal depression during pregnancy on the child's mental development. Prolonged, constant rejection of the child by the mother is an example of significant fetal relational suffering. Another example is that of children born to women who have not yet elaborated their grief *after a previous miscarriage or abortion*. These children can develop the replacement child syndrome in which they report living with the perception of being a substitute (Sabbadini., 2008).

More generally, maternal stress, such as anxiety while waiting for the results of a karyotype test, adapting to a new psycho-emotionally unbearable situation, losing a loved one, or trauma from a fall, for example, can be dangerous because they occur in a critical phase during which the brain is still "plastic and flexible." A given genotype can express different phenotypes according to the environmental influences it experiences.

Although the discovery of transgenerational epigenetic effects for mammals is relatively recent, transgenerational epigenetic effects in nature have long been rec-

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ognized. One fascinating example is that when exposed to chemical traces of a particular predator, the offspring of one freshwater crustacean, *Daphnia*, are born with a phenotypical defensive helmet to protect them. This occurs despite the fact that in a predator-free environment, this could be disadvantageous for survival and reproduction compared to helmet-free individuals (D'Udine).

Nociception in Newborn Babies

Birth is the first great separation. It is the dividing line between the first and second phases of the primary object relationship. It involves moving from water to air, from amniotic fluid to epidermic contact, from dark to light, from the uterus to the breast, from inside to outside, from the umbilical cord and placenta to the lips and nipple, and from the sixth relational bodily level – the umbilical-abdominal area – to the second relational bodily level – the mouth.

The seven relational body levels are the places in the body that carry the imprints and peripherally incised tracings from object relationships during the time of the evolutionary stages. (Ferri, 2020)

In reality, threats of potential separation can occur even during pregnancy. However, these are very different from separations, and is confirmed by the fact they stimulate production of the noradrenergic (NA) alarm neuromediators. Potential separation during gestation is not merely equivalent to loss, which usually causes serotonergic depletion, but represents real, vital alarm. In this regard, 5HT is the neuromodulator that plays the greatest role in nociception and pain. Depletion of 5HT, in fact, increases pain, including relational pain, while an increase in 5HT lowers the perception of pain, again also for relational pain, improving mood. (McGuire & Troisi, 2003)

At birth, we move into the analytical time of the orolabial stage, which lasts until weaning, the last port of call for the primary object relationship!

Oxytocin

Oxytocin is the hormone that causes mother-child attachment. It is the chemical messenger that is essential to initiate labor and permit birth by stimulating contractions of the smooth muscle tissue in the uterus. Oxytocin then stimulates cells in the lactiferous ducts in the breast, causing contraction of muscle cells and the secretion of milk, all as a response to the stimulus of breastfeeding.

Oxytocin is, therefore, the key hormone for this evolutionary window, in which specific patterns of relational suffering can be imprinted from the **transitions between stages**, onto what will become the *multistory building of the individual personality*.

In the presence of symptoms of **psychotic depression**, which are extremely painful from a relational perspective and are found in egocentric, persecutory, self-referential situations often correlating analytically with this evolutionary period, administering an oxytocin spray results an easing of the clinical picture.

- It increases the amount of time spent observing the ocular region and improves the ability to recognize facial expressions.
- It reduces the degree of arousal when confronted by threatening visual stimuli.
- It reduces the possibility that positive or neutral facial expressions are erroneously perceived as negative (Pallanti, 2015).

Neurophysiological and Neurovegetative Indicators in Newborn Babies

Until the 1980s, surgery was performed on infants without any kind of analgesic. Only in 1987 did Anand demonstrate that cardiac surgery on newborn babies was followed by a significant increase in adrenaline and cortisol values, and that these parameters did not increase when opioid analgesics were used.

It was believed that the lack of myelination of the nociceptive fibers prevented the newborn infant from experiencing pain, and that the cells in the dorsal horns of the spinal cord, which transfer sensorial information from the periphery to the higher centers, did not respond to nociceptive impulses before the second week after birth!

Using an MRI, in newborn babies aged from one to seven days, 18 of the 20 regions of the brain associated with pain were illuminated. These were the same 18 of 20 regions that were illuminated in adults, but with greater sensitivity (Salter, 2018). It should be remembered that the density of nociceptors is greater, and the presence of substance P is higher in newborn babies than in adults.

In newborn babies, invasive procedures (tracheal aspiration, mechanical ventilation, and venous sampling) cause crying, tachycardia, diaphragmatic contraction, and sudden, violent motor responses.

With regard to venous sampling, Bellieni's study on sensorial saturation is illuminating. This technique produces a reduction in pain and sometimes works as a real analgesic for newborn babies (Bellieni, 2007). It is based on the concept that a painful stimulus can be contrasted to other sensorial stimuli such as touch, taste, smell, and the sound of the voice talking (3T). The study was performed on four groups of newborn infants, all requiring venous sampling.

- In the 1st group, the sample was simply taken.
- In the 2nd group, a 10% glucose solution was given orally by cannula during the sampling.

- In the 3rd group, the glucose was given before the sampling.
- In the 4th group, a nurse gave the babies the glucose solution during the sampling, allowing them to suck it from a pipette while *stroking them and talking to them*.
- In the 1st group, there was crying and prolonged motor agitation.
- In the 2nd and 3rd groups, there was only crying, but less prolonged.
- In the 4th group, utilizing sensorial saturation, the babies did not cry, and were not agitated during the sampling.

The importance of the relationship in neonatal suffering is evident from this study in terms of epidermic contact (gentle stroking), visual stimuli (including joyous eyes), and prosody (a kind, warm voice). Again, how can we fail to remember Porges' ventral-vagal circuit and his accurate neologism *neuroception* – the capacity of the infant to evaluate their environment as being safe or dangerous? (Porges, 2014)

Conclusion

Experiencing pain during the first 500 days of life, during the time of the primary object relationship in which the pain circuits are highly plastic and still maturing, can influence the physiological development of the central nervous system, the hypothalamus, the pituitary gland, the adrenal gland axis, and the immune system. This can produce long-term vulnerability to inflammatory disease, psychodynamic difficulties, and psychiatric disorders.

It is not essential to be aware or conscious of pain for it to alter the development of these systems, and cause difficulties and disorders!

From a psychopathological and psychotherapeutic perspective, this means that pre-subjective, nociceptive imprints from the person's life story, received during the primary object relationship evolutionary stages and stage transitions, can represent a platform for disturbances and for beyond-threshold relational patterns. By extending this "temporal" observational perspective to include intrauterine life, the current psychopathological nosography could be revisited, and research in psychotherapy could make a significant contribution towards improving therapeutic, psychocorporeal, and psychopharmacological appropriateness.



Genovino Ferri is a psychiatrist and Reichian analyst; member of the New York Academy of Science (N.Y.A.S.); Director of the Italian School of Reichian Analysis (S.I.A.R.); trainer for supervisors in Berlin, San Paolo, Athens, Sofia, and Rome; author of the following books: *Psicopatologia e Carattere* (Ed. Alpes 2012), *Il Corpo sa, Storie di Psicoterapie* (Ed. Alpes 2017), *Il Tempo nel Corpo* (Ed. Alpes 2020), *Body Sense* (e-book, Ed. Alpes 2017), and *Psychopathology and Character* (e-book, Ed. Alpes 2018). President of the Italian Association of Body Psychotherapy (A.I.P.C.); Editor of the CorporalMente (BodyMind) Series of books by Alpes Edizioni; former director of the U.O.C. of Psychiatry and Psychotherapy in Atri, Asl Teramo, Italy and Chairman of the Studio Analysis Centre for Psychotherapy and Social Medicine in Atri, Italy.

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Keeping the Body in Body Psychotherapy

A Neurobiological Approach to Connective Tissue

Will Davis

ABSTRACT

Body psychotherapy has been strongly influenced by far-reaching research in neurology. While these influences are easily justifiable, there has been a concomitant influence of moving away from the body to a brain-based model. Concurrently, research in the manual therapies in connective tissue, and specifically fascia, has revealed how and why body-based techniques can have such a profound effect on a patient. Taking this further, this research has revealed a heretofore unknown communication system among the three nervous systems and the body, resulting in the formulation of a more integrated body/mind model. I will highlight the growing connections between connective tissue (CT) and the three nervous systems in the body and show the role CT plays in these connections. The main theme is connective tissue's *plasticity*; its ability to adapt and readapt to changing conditions locally and systemically, externally and internally, as well as physically and emotionally. The plasticity of CT lies at the heart of any therapy that involves either movement or touch. It is the biological, body-based means of body psychotherapy's efficacy.

Keywords: fascia, Reich, interpretive interoception, plasticity, connective tissue, nervous systems

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T

wo of Reich's founding concepts in body psychotherapy, "muscular armor" and his emphasis on plasmatic functioning, are prescient to recent research in connective tissue (CT), resulting in a deepening and strengthening of the body/mind unity model. Until recently, connective tissue was ignored by anatomists and medicine as a lifeless, inert, "packing" material around organs and the more important tissues, e.g., heart tissue, with a special fascination for the most important evolutionary development, the central nervous system (Schleip, in Schleip et al., 2012, p. xv).

In response, in 1977, Ida Rolf, founder of Structural Integration (Rolfing), called for a "down-grading of the nervous system."

Fascia was the white packing stuff that one needed to clean off in order to 'see something'. Similarly, anatomy books have been competing with each other how clean and orderly they present the locomotor system by cutting away the whitish or semitranslucent fascia as completely and skillfully as possible. ... showing the "shiny red muscles each attaching to specific skeletal points" (Schleip, in Schleip et al., 2012, p. xv).

Research now shows that connective tissue plays a major role in all of life's functions: disease control, movement, creating shape/form, thermal regulation, creating spaces within the body for tissues and organs to function, insulating the nerves by producing myelin sheaths, protecting the body from stress and impact, healing and tissue regeneration, erectness, producing collagen and elastin fibers, plasma/ground substance (GS), blood cells, lymph cells, heparin, and antibodies (Davis, 2018). More recent

Stated simply, the structural framework of the body is simultaneously an energetic and informational framework. This explains how life could function for 2.5 billion years before a nervous system was developed.

The main theme is connective tissue's plasticity; its ability to adapt and readapt to changing conditions locally and systemically, externally and internally, as well as physically and emotionally.

research has shown how CT is involved in the sensory activities of proprioception, nociception and even interoception informing the three nervous systems: central, autonomic, and enteric of the subjective experiences of the body (Schleip, 2012; Myers, in Schleip, 2012).

In 1997 I published *The Biological Foundations of the Schizoid Process* (Davis, 1997), showing the similarity between CT/plasmatic functioning and the physical defense system employed by the schizoid character. More recently, I have shown that Reich's model of muscular armor needed an update (Davis, 2018). A muscle cannot contract and hold for 20 minutes, so how can contractions remain for a lifetime? And how can these contractions release? The answer is in the connective tissue element of the myofascial system. Collagen fibers develop in the direction of the stress, supporting the muscle – Wolff's law (Oschman, 1981). When the stress is released, the tissue reorganizes itself and returns to its prestressed state. I believe that all the physical therapies rely on the same underlying principle: this plasticity of the connective tissue. In body psychotherapy (BP), the effects of all movements, exercises, and respiration depend on connective tissue's ability, under the right conditions, to reorganize itself.

A Case Example

A patient of mine suffered from a rare, life-threatening disorder called Dunbar's Syndrome (MALS). Due to a buildup of fascial tissue, the passageway of the aorta through the fascial plane of the diaphragm ligaments near the 12th thoracic vertebra was compressed.

In BP, the emotional history of the patient is in the body's form and functioning. With a disorder like Dunbar's, we ask ourselves why and how is the aorta compressed, endangering this woman's life? The train of thought is as follows. The diaphragm is involved in breathing. In normal full inspiration, the diaphragm would relax and move downward as the lungs inflate, fully allowing for what is referred to in body psychotherapy as "belly breathing." In surprise/shocking moments, only the upper part of the lungs inflates in a short burst of inspiration, creating an upper thorax expansion with the lower ribs protruding.¹

What would cause a continuously recurring contraction of the diaphragm? Fear. In talking about her childhood, it was revealed that her first five years of family life

were not remarkable, but everything changed at five years old when her parents divorced; all her mother's anxiety and unhappiness was directed at her and her sister. "I never knew what

was going to happen. One day as I was walking around a corner into the next room, my mother suddenly slapped me, knocking my glasses across the room, breaking them when they landed. She then slapped me again for breaking my glasses!"

This model holds that from five years old onward, she lived with a background fear state. Her diaphragm was chronically overburdened, resulting in CT fibrous buildup in the aortic hiatus where the aorta passed through, thus narrowing the passageway. The treatment is surgery, whereby an incision is made in the ligament tissue (median arcuate ligament – MALS) and the celiac ganglia, the nerve tissue in the upper abdomen, which is the sympathetic part of the autonomic nervous system (ANS), is removed. Surgery itself is invasive and can cause anxiety in a patient, especially if she is already anxious. It didn't help that the first surgery was performed incorrectly, and she needed a second operation. The two operations were not successful in eliminating the symptoms or in allaying her fears.

It is interesting that the treatment is less successful with older people and people with psychiatric problems.

This study supports previous findings that surgery improves QOL [Quality of Life] ... In addition this study provides evidence of the relevance of psychiatric comorbidities in patients with MALS and predictive impact of presurgical psychiatric disorders in adult patients with MALS indicate a need to support these patients from a biopsychosocial perspective with a comprehensive multidisciplinary program, including psychological services. (Skelly et al., 2018, p. 1420)

She was in her middle 40s, so age was not a problem, but she certainly had emotional problems, that had never been properly addressed. From a body-oriented psychotherapy view, the surgery was ineffective because her psychological stress, her fear, was the original source of the fascial buildup in the aortic hiatus. "There is no evidence to suggest that the changes in QOL from surgery improve all psychological symptoms. This analysis supports the need to continue to study this population and to consider psychological interventions as an adjunct to surgery in adult patients with MALS" (Skelly et al., 2018, p. 1420).

In addition, there are two possible speculations about age. One is that as we get older, the CT tissue loses its

1. This is a traditional description. But there are disorders – "Costal Paradox", "Diaphragmatic Paradox" – where the diaphragm rises during in-hale. And in working with respiration in therapy, it is not uncommon to find paradoxical breathing with no medical diagnosis.

plasticity, so older people would not respond as well to the surgical intervention. It could also be understood that older people have suffered through more stressful events than younger ones, and so the fibrous buildup is more extensive and ingrained into the surrounding tissue and character structure.

From this perspective, this case fits in well with our model of chronic diaphragmatic tension caused by fear. Firstly, because of the held inspiration, the fascial tissue is overloaded, begins to thicken, and becomes fibrous, narrowing the passageway. Surgery is needed to clear this excess tissue away. But it will grow back if the cause of the buildup, the stress of chronic fear, is not resolved. This is the physical basis of Reich's muscular armor. Secondly, the sympathetic nerves of the autonomic nervous system (ANS) are severed. Sympathetic system activation is associated with anxiety/fear states. And thirdly, people with "psychological symptoms," i.e., elevated anxiety, respond poorly to the treatment, which brings us back to point number one: the cause of the ANS imbalance, her fear, had not been addressed.

The above explanation is all very well and good, except it is not possible to continually contract any muscle. The model offered contends that typically someone who is anxious would be stressing their diaphragm and raising their shoulders for years in a startle reflex position – a chronic Moro reflex. But we know it is not possible to do this for years. The nerves desensitize, the muscles tire, and the shoulders fall back down. To complicate matters further, body-oriented therapists of all disciplines know that patients do hold their shoulders high for many years. And we help them to release that tension. In addition, in a BP model, it is understood that our personal history is represented, "held," in our musculature. If this were true, all that would be necessary would be to receive muscle relaxants, we would all have "a good cry about Mama or Papa" or our first "broken heart," and then we would be free to move on in our lives. But we know this is not the case.

Yet, interestingly, these responses do happen in the manual therapies (MT) when tissue is manipulated. In massage, Rolfing, osteopathic treatments, etc., as well as BP sessions, emotions, memories, and repressed movements emerge. How can all these seemingly contradictory statements be true? The answer lies in the plasticity of the connective tissue (CT) element of the myofascial system.

Connective Tissue's Plasticity

The efficacy of the manipulation and movement techniques of all body-oriented therapies are dependent on CT's plasticity. We work with CT's incredible ability to change its structure and function according to *local* input, and to change back again under the right conditions. This plasticity is what produces the change that brings the body back into balance and health. The right

conditions are pressure, heat, and electricity. All touch, movement, exercise, and stretching will affect the state of the fibrous quality of connective tissue, because they all create pressure on the tissue. Stecco (2015) described how collagen production responds immediately to changing conditions in the body through the activity of the fibroblasts [cells that produce collagen and elastin fibers], which produce additional fibers. These changing conditions can be any activity the person engages in, including rest and sleep, exercise, and injury. Collagen regeneration is a continuous process but is accelerated by increased activity or injury; it will adapt to all local conditions and influences, both positive or negative, physical, and psychic.

Tissue damage induces fibroblastic mitosis. Fibroblastic proliferation and degradation is a normal occurrence in everyday mechanical loading such as walking, running and most movements. Even mechanical loading in rest and sleep stimulates CT function. Collagen synthesis in the patellar tendon increases by nearly 100% as a result of just a single bout of acute exercise, and the effect is still evident three days later. In the initial training period, collagen turnover in tendons (i.e., the balance between synthesis and degradation) is increased and there is a net loss of collagen. This enables a tendon to restructure and adapt to an increasing loading pattern. It is not until training continues that there is a net gain in collagen synthesis. (Stecco, 2015, p. 6)

Oschman (2000) described how this process happens from a bioelectric perspective.

The mechanisms by which cells lay down or reabsorb supporting materials (collagen) in bone and connective tissue are understood. Electric fields generated during movements signal cells (fibroblasts in connective tissue, osteoblasts in bone) to lay down collagen in the direction of tension, and thereby strengthen the tissues. With less loading or movement, the electric fields are weaker and less frequent, and the cells reabsorb collagen. (Oschman, 2000, p. 157)

In addition, Rolf (1977) wrote about CT's metabolic plasticity from another perspective, a more primary level: ground substance (GS), which is mostly an amorphous semiliquid gel, similar to the white of an egg, and is the universal, internal environment. (The term ground substance has replaced the term plasma, and is used in different formulations in biology, anatomy, and the manual therapies.) All fibers and cells from every tissue type are embedded in the plasma/ground substance. She emphasized that, while fascia is made up of collagen and elastin fibers, these fibers are embedded in GS, which is the source of CT's plasticity. Her explanation helps us to understand the previously inexplicable responses I began to see in my patients and hear from them once I began working with a CT-based model. This plasmatic, primary plastic quality in GS is also the rea-

son why I have stayed with a systematic, matrix-model of CT in the touch technique in Functional Analysis (FA), and not with any particular anatomical model, such as the myofascial system, fascia, tendons, or ligaments.

Stecco's (2015) description of collagen synthesis in the patellar tendon and Oschman's (2000) bioelectric description of collagen synthesis comment on how quickly collagen can change. In explaining this plastic quality of CT, Rolf pointed out that compared to the metabolic changes in ground substance, collagen responds more slowly.

Therefore, the speed so clearly apparent in fascial change must be a property of its complex ground substance. The universal distribution of connective tissue calls attention to the likelihood that this colloid gel is the universal internal environment. Every living cell seems to be in contact with it, and its modifications under changes of pressure should account for the wide spectrum of changes seen in Structural Integration. (Rolf, 1977, p. 42)

Colloid gels, such as ground substance, are easily broken down, which is how Rolf understood the rapid changes induced in the body by applying pressure. It is the connective tissue fibers and GS, not the muscle fibers, that are relaxing, or, better said, reorganizing.

Studies have shown that

... application of pressure results in a flow of interstitial fluids and ground substance away from a region of pressure. If stress, disuse, and lack of movement cause the gel to dehydrate, contract, and harden the application of pressure seems to bring about a rapid solation [return to a sol i.e., more liquid] and rehydration. Removal of the pressure allows the system to rapidly re-gel but in the process the tissue is transformed, both in its water content and in its ability to conduct energy and movement. (Oschman, 2000, p. 170-171)

The exercises used in many forms of body and movement psychotherapies involve stretching, which applies pressure to the tissue. This is the same as what manual therapies do in terms of force, shear as well as exercise. Even though practitioners are affecting the connective tissue, which is what releases the muscular contractions, BP still thinks in terms of muscle tissue tension and release.

The Points & Positions Touch Technique in FA is specifically designed to take advantage of the plasticity of connective tissue, but in a different manner than either the manual, the movement therapies, or traditional body psychotherapy. There are three differences. FA is interested in all forms of connective tissue within a systemic CT matrix throughout the entire body, not just fascia or the myofascial system. The second is we do not manipulate the tissue in the classical sense, but apply light, specific pressure with a fingertip, or gentle compression in the Positional Release manner of Jones (Jones, 1983).

As well, we rarely use exercises, although spontaneous movements may arise during treatment and, depending on their quality, we may support them.

This transformative phenomenon as a restructuring of the CT tissues is best described by the word *metaplasia*: the transformation of one type of adult tissue into another. With metaplasia we are back to plasma: *plasia* comes from *plasis*, Greek for molding.

The differentiated cell of connective tissue is unique in that it retains its embryonic capacity for multiplication and transformation into other lines of specialized cells. Under ordinary conditions these cells are quiescent and inconspicuous: however, under extenuating circumstances (growth stimulus, injury, disease) ... their progeny transform into the specialized cells required to meet the altered circumstances.

Of equal significance is the activity of these cells in the process of metaplasia; the remarkable regenerative capacity to differentiate into the elements forming the replacing tissue is most manifest. (Snyder, 1956, p. 67)

When a muscle is chronically stressed, either from a physical or a psychic/emotional event or a combination of the two, the translucent CT "envelope" surrounding that muscle, easily seen as the thin shiny membrane around meats, will thicken up, the number of CT fibers woven through the muscle will increase, and the tendons that form at each end of the muscle, which is a combined extension of the CT envelope and the intramuscular CT fibers, will also thicken. (See Diagram 1).

In addition, if the stress is strong and chronic, involving other muscles in that region of the body, adjacent muscle envelopes will "glue" to each other, resulting in a loss of mobility and function, as typically seen in men and women who do "body building." When they turn, the whole torso moves. There is a loss of differentiation in the muscles, which results in a loss of differentiation in finer and more specific movements, and consequently sensations and emotions. It is also possible that, where the stressed tendon is attached to the bone, that area of the bone will enlarge itself, creating more surface area

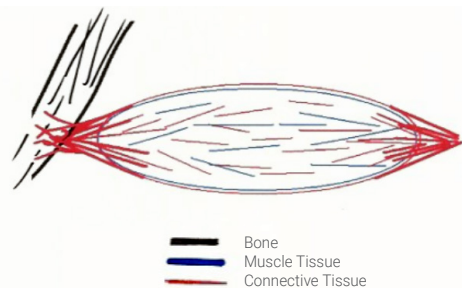


Diagram 1

for the additional fibers of the tendon to anchor. This is muscular armor: chronically stressed areas of the body now acting as a unit, and thickening up to resist external and internal, physical, emotional, and psychic stress. We can now update Reich's muscular armor concept to Connective Tissue Defense (CTD). The good news is that due to CT's plasticity, we can slowly and safely address these conditions. There was always too much risk in BP with certain types of character structures in using forceful techniques to break through the muscular blocks. As I have argued (Davis, 1997), the plasticity of CT allows us to continue working on the body, but safely, and, in fact, more profoundly.

There are three terms I would introduce now:

- **Anisotropy.** The first term is *anisotropy* (Greek: *aniso* – unequal, unsymmetrical, a dissimilar condition, and *tropy* – turning towards, having an affinity for), which manifests as responding differently to the same external stimulus in different parts of the body. This phenomenon is utilized through the properties of connective tissue in our touch techniques and exercises. Input to the system through touch or movement varies according to the condition of the individual's tissues. Different patients respond differently to the same input. The patient's body "decides" how to utilize the information experienced through touch or movement. It is not so much what is being *transmitted* by the therapist's touch, but what the patient "decides" to receive. The touch is "interpreted" by the patient.

In psychotherapy, it is understood that the patient's past experiences produce present-moment behaviors, thoughts, and emotions, so the physical phenomenon of anisotropy fits in nicely with a body/mind model.

- **Hysteresis.** As an additional explanation as to how anisotropy works, we can include *hysteresis*, a concept from the physical sciences, whereby the output of a system depends not only on its input, but also on its *history of past inputs*. This is because the past history of any system affects the value of its internal state; even steel or iron in a bridge is historically dependent. Applied to a psychotherapy model, this is the understanding of past experiences affecting present behavior, and that the therapist intervention does not determine the patient's response. This is a body-based, biological way to explain parental transference in therapy. The therapeutic response is dependent on "past inputs." What is transmitted is not necessarily what is received. Again, the patient is in control, unconsciously "deciding" what the experience will feel like and mean – interpretive interception.
- **Thixotropy.** The third term is *thixotropy* (Greek *thixis* – a touching, plus *tropy*). Thixotropy describes the quality of a gelatin, such as plasma/GS, to become more fluid when pressured or heated, and more solid

when at rest. This is the plasticity of CT and, more specifically, of the GS. It is in constant reorganization, responding to both the local and systemic needs of the individual body. It reorganizes in response to positive and negative, internal, and external, as well as physical and emotional stimuli. CT can change its viscosity from a liquid to a gelatin to a solid, and even to a crystalline state, whereby dehydrated collagen takes on the energetic properties of crystals. This is all due to the plasticity of the CT. All these changes can be reversed, at least up to a point. Older patients will respond more slowly and to a lesser extent than younger patients.

The plasticity theme had a major update in 2003 with a two-part article by Schleip (Schleip, 2003, a&b) on fascial plasticity. It is common in any therapeutic approach using touch for the practitioner to feel a change in the patient's tissue. I typically experience it as in the analogy of putting light fingertip pressure on a small piece of ice, and the ice melting. The changes manual therapists and FA practitioners report feeling in the tissue of their patients were usually attributed to thixotropy; GS, as a colloid state, responding to pressure and other forces by changing from a gel to a more liquid sol state. "This gel-to-sol transformation has been positively confirmed to appear as a result of long-term mechanical stress applications to connective tissue" (Schleip, 2003a, p. 12). But studies showed that the effects of the thixotropy phenomenon could not appear so quickly. Longer application of applied force is needed to result in "... permanent deformation [change] of dense connective tissue" (Schleip, 2003a, p. 12). And these effects are only present while the force is applied, returning within minutes to the original gel state, when released. A question arises: what is happening in the tissue that therapists are feeling, and patients are reporting? Comments from patients in FA include a melting quality, softer, an opening, a warm flow, a liberation and "you are touching me now." Yet, because of the time element, it seems that these subjective experiences are not a result of thixotropy.

Another explanation has been the piezoelectric effect. Because of CT's crystalline qualities, electrical currents can be created in the tissue when force is applied. This too has typically been mentioned as a possible explanation for the immediate plasticity change in tissue felt by both practitioner and patient. But Schleip again pointed out that this process also requires more time than when applying pressure during treatment. Both collagen fibers and GS changes can occur because of the piezoelectric effect, but ... "both life cycles appear to be too slow for immediate tissue changes that are significant enough to be palpated by the working practitioner" (Schleip, 2003a, p. 12). Additionally, the slower softer techniques, as used in FA for example, are not strong enough to create these immediate tissue responses.

Plasticity, Fascia, and the Central Nervous System

As mentioned earlier, all CT, fascia included, was considered relatively unimportant “packing.” Vascularization and innervation were estimated to be low. And if CT was appreciated at all, it was seen only for its mechanical properties. Following that, Schleip (2012) pointed out that by the 1990s, fascia was seen as playing an important role in proprioception. He then goes on to describe the importance of the fascial network as “... one of our richest sensory organs ... the overall mass of which may be larger than the surface area of any organ of the body including the skin. Depending on how one calculates fascial sensory nerves and related sensory receptors ... the quantity of fascial receptors might even be more than the retina, which was always considered the ‘richest sensory human organ’” (Schleip, in Schleip et al., 2012, p. 77). The understanding of its innervation has been updated to show that the fascial system has six times more sensory nerves than muscle tissue. “... for the sensorial relationship with our body – whether it consists of pure proprioception, nociception or the more visceral interoception, fascia provides definitely our most important perceptual organ” (Schleip, in Schleip et al., 2012, p. 77).

Considering how quickly and efficiently CT’s plasticity responds to stimuli, Schleip (2003a) then introduced the need for a “rapid self-regulatory system” based on the organism’s ability to perceive its interactions with the external environment.

It then seems logical that this ability of being more rapidly adaptable is mediated by or is at least connected to – a body system which is involved in the perceptions of our needs as well as of the environment. Traditionally this body system has been called the nervous system. (Schleip, 2003a, p. 13)

For Schleip, the analogy of a nervous system as an old-fashioned telephone switchboard is outdated, and has been replaced by current concepts in neurology that see the brain as a “liquid system” whereby:

... *fluid dynamics* of a multitude of liquid and even gaseous neurotransmitters have come to the forefront. Transmission of impulses in our nervous system often happens via messenger substances that travel along neural pathways as well as through the blood, lymph, cerebrospinal fluid, or ground substance. (Schleip, 2003a, p. 13)

... the fascial system has six times more sensory nerves than muscle tissue ... for the sensorial relationship with our body – whether it consists of pure proprioception, nociception or the more visceral interoception, fascia provides definitely our most important perceptual organ.

He advised the reader to view the nervous system not as a hard-wired cable system, but as a “wet tropical jungle” (Schleip, 2003a, p. 14), a self-regulatory field that is complex, always adapting throughout life.

Without disagreeing with this model, all the activities described above happen in ground substance in one way or another. Even with the involvement of a nervous system, how is new information passed through the body without changes in the GS as Rolf suggested? (Rolf, 1977) Why or how is it that these transmissions of “impulses via messenger substances” now are flowing, whereas earlier they were not? What has changed? Additionally, many life forms don’t have nervous systems, yet they manage to adapt to their internal and external environments.

In staying with the fascial/CNS relationship, Schleip wrote that Golgi receptors are proprioceptive tension-detecting sensors wrapped around tendinous collagen bundles where the muscle’s tendon attaches to the bone. These receptors embedded in the tendon give afferent nerve information about the tension state of the muscle. They are involved in the lengthening of the muscle, stretching, or contraction. Ninety percent of these receptors are located at the myotendinous junction: the interface between the muscle and the tendon. Where the muscle inserts onto the bone through the tendon attachment, there is only 10%. But later research showed that “... passive stretching of a myofascial tissue does *not* stimulate the Golgi tendon receptors” (Schleip, 2003a, p. 14). Yet there is still a possibility that the Golgi receptors may be involved, since 90% of them are in myotendinous junctions and other attachment structures. For example, there is evidence that they are also involved in fine proprioceptive, antigravity motor movements that are too quick for transmission from the brain to the leg.

There are also three other *intrafascial* mechanoreceptors that are involved with the CNS: the Pacini corpuscles, the Paciniform corpuscles, and the Ruffini organs. These are all found embedded within “dense proper connective tissue: i.e., in muscle fascia, tendons, ligaments, and joint capsules” (Schleip, 2003a, p. 15). Each responds differently to different types of applied force. The Pacini and smaller Paciniform corpuscles respond to vibration and rapid change in pressure, but not to constant unchanging pressure. This is of particular interest for the Points & Positions Touch Technique, which employs a light, pulsing type of pressure. The Ruffini organs respond to long-term pressure and can be activated by slow and deep “melting quality” soft-tissue techniques, which are also sometimes employed in FA. Schleip pointed out that stimulation of Ruffini corpuscles results in lowering sympathetic activity, which supports the “... common clinical finding that slow

deep tissue techniques tend to have a relaxing effect on local tissues as well as on the whole organism” (Schleip, 2003a, p. 15). This is an explanation of how local pressure can cause a distant response, as seen in Functional Analysis.

Further evidence for CNS involvement in fascial manipulation is that the greatest amount of sensory input to the CNS comes from myofascial tissue. According to Schleip, a typical muscle nerve will have three times more sensory fibers than motor, and only 20% of these nerves are the well-known types I and II. The other 80%, type III and IV, are what are called interstitial muscle receptors – receptors within the GS of spaces between muscle fibers. (Schleip prefers the term interstitial myofascial tissue receptors. It’s my suspicion that they were named “muscle” receptors because of the traditional bias that connective tissue is not important.) Type IV comprise 90% of this type of nerves; they are unmyelinated and usually have their origin in free nerve endings.

A word here about free nerve ending (FNE); generally, we think of the nervous system as a continuous line of interconnected nerve fibers passing information along, much as a telephone line carries messages from one point to another. These nerves are myelinated – insulated, enclosed – by a connective tissue sheath, much as telephone lines are also insulated, keeping the flow of information coherent and directional. But information must enter the nervous system to then be transported. As Reich pointed out, nerves only carry impulses; they are not the origin of these impulses. The CNS must get its information from somewhere. Uninsulated, sensory free nerve endings are more like open-ended receptors in the tissue, which pick up information and feed it to the brain, much as a satellite dish or an antenna is open-ended, picking up transmissions within its range.

Uninsulated, sensory free nerve endings are more like open-ended receptors in the tissue, which pick up information and feed it to the brain, much as a satellite dish or an antenna is open-ended, picking up transmissions within its range.

FNEs are peripheral, afferent nerve endings, and their unmyelinated filaments extend freely into the tissue, allowing them to pick up and send signals to afferent neurons that bring information from the body towards the brain. As mechanoreceptors, they respond to mechanical tension and/or pressure, and about half of them respond to light touch, “... as light as a painter’s brush.” This is of interest to the emerging movement in the body-oriented therapies to work with a softer touch and helps to explain some of the physical and emotional effects registered by patients treated in the Points&Positions touch style.

Diagram 2 indicates how touch can set off a chain reaction in the tissues, resulting in overall bodily changes, both local and systemic, in tissue and in nerves.

Plasticity and the Autonomic Nervous System

The ANS is also involved through type III and IV receptors. “Type III and IV receptors ... have been shown to have *autonomic functions*, i.e., stimulation of their sensory endings leads to a change in heart rate, blood pressure, respiration, etc.” (Schleip, 2003a p. 17). Using the model of Mitchell and Schmid, Schleip (2003b) presented their “Intrafascial Circulation Loop” to show the relationship between tissue manipulation and the ANS.

Fascia is densely innervated by interstitial tissue receptors. The autonomic nervous system uses their input (plus that of some Ruffini endings) to regulate local fluid dynamics in terms of an altered blood pressure in local arterioles and capillaries plus in

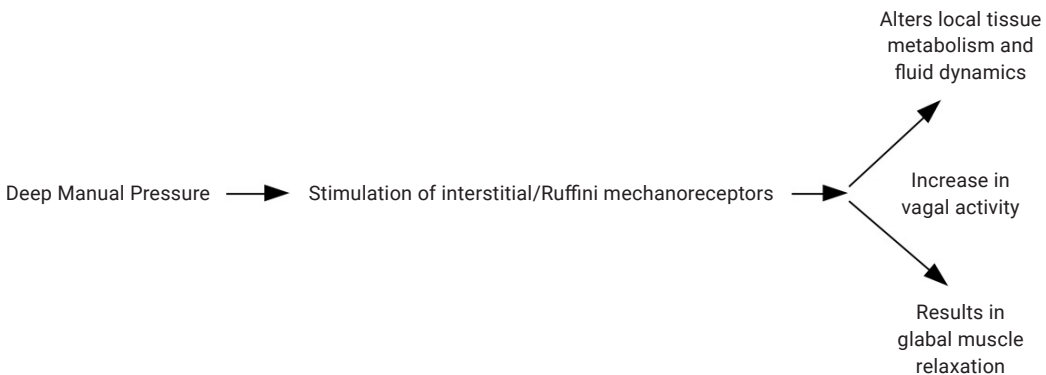


Diagram 2 (Adapted from Schleip, 2017, p. 141)

plasma extravasation [fluid leakage] and local tissue viscosity. This change might be felt by the hand of a sensitive practitioner. (Schleip, 2003b, p.105)

Back to Rolf and Ground Substance

In Part II of his article on plasticity, Schleip (2003b) brought the theme of CNS and ANS involvement in fascial release together and returned to Rolf's model of gel to sol changes "... *but this time with the inclusion of the central nervous system*" (Schleip, 2003b, p. 105, italics added). Here is a working body/mind model. Schleip has exposed the inner workings of how the body and the nervous systems are intimately entwined. Activation of the interstitial receptors, which offer most of the sensory input from myofascial tissue, changes the pressure gradient in fascial capillaries and the viscosity of the ground substance, as Rolf suggested in 1977. When the Ruffini corpuscles are stimulated, there is a lowering of sympathetic activity. Schleip also suggested that with an increased renewal speed in the GS, the piezoelectric phenomena could now be understood to play a role in the immediate effects felt in the tissue by practitioners and patients.

If myofascial manipulation affects both local tissue blood supply as well as local tissue viscosity, it is quite conceivable that these tissue changes could be rapid and significant enough to be felt by the listening hand of sensitive practitioners. (Schleip, 2003b, p. 105)

With the involvement of the feedback loops between fasciae and intrafibril receptors with the CNS, we now have a model of how GS and the fibers can change rather quickly, remain this way after pressure has been applied, *and* explains what practitioners have been sensing in their touch during treatments, as well as in patients' subjective experience.

Plasticity and the Enteric Nervous System

Just as the ANS and CNS can affect CT plasticity, it is also necessary to include the enteric nervous system (ENS) for the same reason. The ENS is sometimes called the intrinsic nervous system and the "second brain" (Gershon, 1981), or the "brain of the gut" (Goyal & Hirano, 1996). The ENS is embedded throughout the gastrointestinal system, starting at the lower third of the esophagus, into the stomach, through the intestines, down to the anus. It governs the function of the entire gastrointestinal tract, except for defecation.

It has been called the "second brain" because it acts independently, although it is in direct contact with the ANS, CNS, and the vagus nerve. It has its own reflex circuitry independent of input from the brain and spinal cord, creating local, autonomous functioning.

To a surprising degree, these neurons and the complex enteric plexuses in which they are found (*plexus* means "network") operate more or less independently according to their own reflex rules; as a result, many gut functions continue perfectly well without sympathetic or parasympathetic supervision (peristalsis, for example, occurs in isolated gut segments *in vitro*). Thus, most investigators prefer to classify the enteric nervous system as a separate component of the visceral motor system. (Purves et al., 2001, p. 603)

Exactly how the ENS is anatomically described varies. It is sometimes considered part of the ANS, and at other times considered separate. Many ENS functions in the gut continue without sympathetic or parasympathetic control. Sometimes it is defined as the largest part of the ANS or, on the other hand, having extended connections to it. Even the number of neurons in the ENS is disputed, ranging from five times as many as the spinal cord to equal numbers. What is clear is the interaction between CT and the ANS, CNS and ENS. The information flow between these is bidirectional. Specifically, the ENS and CNS communicate via the vagus and pelvic nerves, as well as via sympathetic pathways. Ninety percent of the fibers in the primary visceral nerve, the vagus, go directly to the brain. The CNS in turn is sending messages "down" to the ENS with 10% of the fibers involved. The ENS informs the CNS. This is a classic bottom-up arrangement. As Schleip (2003a) has indicated, many of the sensory neurons of the enteric "brain" are mechanoreceptors as described above. Manipulation stimulates these receptors, which causes afferent feedback via ANS and ENS pathways to the brain, which in turn signals the muscle to release.

Because of this dense but lopsided interaction between the ENS and the CNS, pathological disorders in the CNS often have enteric manifestations, resulting in both disease and psychosomatic disorders. According to Rao and Gershon (2016), ENS anatomy and neurochemistry are similar to that of the CNS, whereby pathogenic mechanisms that give rise to CNS disorders might also lead to ENS dysfunction, and nerves that interconnect the ENS and CNS can be conduits for the spread of disease (Rao & Gershon, 2016). Rao and Gershon reported that:

Transmissible spongiform encephalopathies, autistic spectrum disorders, Alzheimer disease, amyotrophic lateral sclerosis, and varicella zoster virus infection [a herpes virus causing chickenpox and shingles] are examples of disorders with both gastrointestinal and neurological consequences (2016, p. 520).

In addition, irritable bowel syndrome, the most common gastrointestinal tract disorder, is associated with the relationship between ENS and CNS, as well as some forms of depression. Also, Crohn's disease, ulcers, problems with swallowing, colitis, and, as indicated by some research, Parkinson's disease (Hadhazy, 2010;

Shprecher & Derkinderen, 2012) are associated with an ENS/CNS linkage. Many of these diagnoses are considered psychosomatic in origin.

Returning to the “second brain,” the similarities between what seem to be quite distinct functioning structures are in fact rather striking. Rao and Gershon (2016) indicated that signaling pathways and neurotransmitters are shared. The ENS and the CNS share close to 30 identical neurotransmitters, such as serotonin, dopamine, and acetylcholine, which besides being active in the CNS, is also the main neurotransmitter in the parasympathetic branch of the ANS. In fact, about 50% of the body’s dopamine and 90% of the body’s serotonin lie in the digestive tract. The neurons of both systems use these neurotransmitters to communicate biochemically. There are also common underlying anatomical properties. Arising from neural crest cells 28 days after conception, the rudimentary CNS structure, the neural tube, is the embryonic forerunner to the central nervous system. The ENS also emerges from these same cells, which then migrate and house themselves in the gut during intrauterine life.

The “second brain” is of interest, because it brings up the “piggyback” concept: the same brain area – the cingulate anterior cortex – registers both physical and emotional pain. Dewart (DeWall, 2010, Pond et al., 2014) pointed out that, rather than create another neural system to process emotional pain, the brain adapted the phylogenetically earlier physical pain center to include emotions. Is it possible that the CNS “piggybacked” onto the earlier ENS? When describing the ENS, the biobehavioral psychiatrist Mayer commented, “The system is way too complicated to have evolved only to make sure things move out of your colon.” (Hadhazy, 2010, p. 7)

In the same vein, Goyal and Hirano (1996) wrote:

Subsequent examination of the functional and chemical diversity of enteric neurons revealed that the enteric nervous system closely resembles the central nervous system. ... The enteric nervous system may perhaps best be regarded as a displaced part of the central nervous system that retains communication with it through the sympathetic and parasympathetic afferent and efferent neurons. (1996, p. 1106)

Goyal and Hirano’s position would imply either that the CNS came first, which makes no sense, as living organisms have survived four billion years without any central nervous system, relying on plasmatic, tropism responses. Or, the “displaced” terminology is reflecting the top-down bias of neurologists, whereby both the CNS and the ENS were created by the same cells of the neural crest as described above, but the ENS was a “leftover” part? It is my considerably uninformed opinion, that if either is the result of the other, the ENS is the forerunner of the CNS. Phylogenetically, digestion evolved before a centralized nervous system. Individually,

the digestive system is the first system to develop in the fetus.

One last word on fascial and neuronal connections. Although he did not have access to today’s technology, Jones had moved the focus of manipulation from the myofascial system to the neurological over 40 years ago. In 1983, he had anticipated the neurological role in manipulation with his Positional Release Technique, an adaption of which makes up the “Positioning” half of the Points & Positions Touch Technique. Citing the influence of Knorr and Ruddy, Jones reported: “I am sure that all of these earlier concepts directed my thinking to neuromuscular dysfunction as the basis of joint disorders” (1983, p. 9). He emphasized that in applying his gentle positional release method, “... there are no surprises for the CNS” (1983, p. 23). The old-style Reichian discharge work often “surprised” the patient’s CNS, causing increased contraction/resistance, projection and sometimes even re-traumatization. This is one of the reasons I began working with the instroke process and a CT model many years ago (Davis, 1999).

Discussion

The research presented verifies our work, and more than that, offers explanations as to how our methods and techniques have been effective over the years in grounding BP further in the biological body. It also helps to resolve the mind/body split and supports the intimate intertwining of both body and mind, myofascial tissue, and nerves.

CT is the vessel within which all our systems function. Nothing happens in the body without the direct involvement of GS and CT. For this reason alone, it is primary. It is now seen as the largest sensory organ: “... one of the most vital relationships in the body has to be the relationship between connective tissue and the neuronal process” (Oschman, in Schleip et al., 2012, p. 104). Knowing how CT responds to body-oriented methods helps us not only to understand more, but to tune our methods and techniques to the patient. Different responses arise from different neural receptors – FNEs, interstitial myofascial receptors, intrafascial and interfibrillar receptors, Pacini & Paciniform corpuscles, and the Ruffini organs – depending on the *quality* of our physical interventions, i.e., strong, light, stretching, compression.

CT automatically resists stress, which results in the buildup of fibrotic structures. “Each fiber, before it reaches its maximal stretching point, recruits the adjacent fiber, which in turn will be have in the same way, and before it reaches its own maximum stretching point it will recruit another fiber and so on” (Guimberteau, 2018, p. 86). Classic BP techniques, as well as many of the manual therapy approaches, have challenged the body, and the result has been activation of the body’s CT-based defense systems: resistance, stiffening, and

rigidity. If we work sensitively *with* the body and not just *on it*, we join the emerging movement towards slower, softer techniques supporting the ideas put forth recently in this journal.

“The therapist must therefore learn to slow down the pace of the interaction at certain moments of the session and, in a respectful and non-directive attitude, learn to slow down and wait, to tolerate uncertainty. Immediately, however, the problem arises that “waiting without being active, without ‘doing anything’ easily creates anxiety, a sense of ‘uselessness’ or ‘doing nothing’”. (Helferich, 2020)

... with biofeedback, the clinician is not seeking definitions of feelings that are coming from the frontal lobes; the biofeedback clinician asks about how it feels physiologically ... The clinician is looking for physiologically felt sensations. (Kerson, 2019/2020, p. 198)

My own work over the years has been in this direction, both physically in terms of the non-invasive P&P technique, and psychically in terms of the emphasis on the self-to-self relationship by working with the inward, gathering force of the instroke of the pulsation.

Importantly, CT is directly involved in creating the body’s form. Form is structure and structure is behavior. Echoing Reich’s concept that the patient’s body determines his behavior, Rolf wrote: “In any energy system, however complicated, structure ... is experienced as behavior” (Rolf, 1977, p. 31). The pathologist Ingber, takes the same position on the cellular level:

The important principle here is the manner in which a structure shapes itself and holds its subcomponents together in three-dimensional space; this characteristic is what defines the way the structure as a whole will behave. (Ingber, 1998, p. 56)

Updating Reich’s plasmatic model, CT is a semi-conductor of all the body’s *energies*, which re-sults in a body-wide, non-neural, communication system; “... the ‘living matrix’ is not only me-chanically interconnected, it is energetically and informationally continuous. Stated simply, the structural framework of the body is simultaneously an energetic and *informational* framework (Oschman, 1997, p. 8; italics added). This explains how life could function for 2.5 billion years before a nervous system was developed (Brooks, 1999, p. 81). We can speak to the body and mind simultaneously by touch, the forgotten language.

And finally, this CT matrix is the foundation of all later phylogenetic development, creating a classic bottom-up model of evolution, development, and maybe even therapy (Brooks, 1999, as cited in Anderson, 2003, p. 95). Again, echoing Reich, in discussing tissue regeneration, Dudas et al. described, in a pulsatory manner, how “higher” systems are built upon and dependent on “lower” earlier systems. Newer developments do not “replace” the earlier systems but build on them and include them.

... their mutual interactions do not appear as a plain hierarchical relationship. Rather, the simpler (lower) levels form a foundation for, and *are contained within*, the more complex (upper) levels, and complex feedback loops exist as well. ... their *recursive containment within each other* and their mutual dependence. (Dudas et al., 2008, p. 503, Italics added)

If we wish to do in-depth therapy, we should take this into consideration. A brain-based theory of psychotherapy is a top-down model, but it is becoming more and more clear that a CT-based bottom-up model would be more appropriate in order to touch, or rather help the patient to touch, their deepest self.



Will Davis has 45 years of experience practicing and training in America, Japan, and Europe. He developed Functional Analysis, which focuses on the energetic instroke, the plasmatic origins of early disturbance, the energetic qualities of connective tissue and its role in character development, the endo self, the gentle self-oriented release technique of Points & Positions, and a unique synthesis of verbal therapy. He is a member of the editorial boards of two journals, the Italian Society of Psychologists and Psychiatrists, the EABP, AETOS, and teaches as a guest trainer. He lives with his wife Lilly Davis in the south of France.

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Inhabiting the Body as Unitive Consciousness

Judith Blackstone

ABSTRACT

This paper presents the Realization Process, a method of body psychotherapy that includes a series of inward attunement exercises for experiencing unitive consciousness as the basis of deepened contact with one's own being and with other people. The paper focuses primarily on this method's understanding and facilitation of embodiment. In the Realization Process, embodiment is viewed as the experience of being present everywhere in one's body simultaneously, as unitive consciousness. This is a shift from being aware of the body, to inhabiting the body. The paper describes how the Realization Process utilizes the embodiment of unitive consciousness to heal deficits in contact with oneself and others, and to refine the therapist's capacity for empathy. Brief attunement practices from the Realization Process are included to illustrate this shift.

Keywords: embodiment, Realization Process, body psychotherapy, consciousness

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Embodiment is the primary focus of body psychotherapy. How we organize our experience of being in, or as, a lived body in relation to our environment, how trauma affects us somatically, and how we can help people heal and mature through bodily interventions have been explored by all of the innovators in our field. Early in our history, Wilhelm Reich (1945) wrote about an energetic realm of embodiment that he called orgone energy that became bound into "character armor" in reaction to painful or overwhelming experiences. Stanley Keleman (1979) also wrote about how we shape our personality through the way we live in our body, especially with regard to how we organize or contain excitation and pulsation. Embodiment is also often understood as interoception, the awareness of internal experience, such as sensations and emotions, and as proprioception, the ability to sense our physical location and movement in space (Fogel, 2020).

This paper presents an understanding of embodiment as our potential to experience ourselves as present everywhere in our body simultaneously. This is a shift from being aware of the body to inhabiting the body. When we inhabit our whole body, we uncover a dimension of undivided, unitive consciousness that we experience as the fundamental ground of our being. We know ourselves as the undivided stillness of unitive consciousness, disentangled from and allowing for the free flow of the movement of life, including our energy system, and our cognitions, emotions, sensations, and perceptions. As the unified ground of being, unitive consciousness enables us to be in contact with ourselves as a whole, and to function as a whole; for example, thinking and feeling at the same time.

When we live within our body, our experience of our identity is not just an idea, constructed by our imagination. We can also ex-

... embodiment is viewed as the experience of being present everywhere in one's body simultaneously, as unitive consciousness.

perience that we are not just our physical anatomy and physiology. We can access an experience of ourselves on the more subtle level of our energy system – the pulsing, streaming flow that is mentioned in Reichian (Reich, 1945) and Bioenergetic (Lowen, 1976) forms of therapy, and in subtle forms of body therapy such as Craniosacral therapy (Kern, 2001). When we inhabit our body as a whole, we can attune to an even more subtle level than energy and experience our primary identity as unitive consciousness.

Context for Unitive Consciousness

The direct experience of a unitive ground of being appears only rarely in the literature of the psychotherapy field. Roberto Assagioli (1977), a contemporary of both Freud and Jung, developed a method called Psychosynthesis. He claimed that one could have an actual experience of the self, and of pure self-awareness. Jung (1968) also wrote about a self that was beyond or behind the fragments of our personality, and he theorized about a collective unconscious, in which the deepest contents of all of our minds were somehow shared. However, Jung presented these as ideas and symbols, rather than as accessible experiences. Abraham Maslow (1994), one of the founders of the humanistic movement in psychology, described peak experiences of unitive consciousness, which he considered to be indications of personal maturity. However, he described these as intense, temporary experiences that one necessarily returned from in order to live a normal life.

Ken Wilber (1980), a transpersonal theorist, included the realization of unitive consciousness as the pinnacle achievement in his stages of development. The Diamond Approach, developed by A. H. Almaas (1998) as an integration of mystical Islamic concepts with psychodynamic psychology and Tibetan Buddhism, also points directly to an innate essence of ourselves. Almaas wrote that we could dissolve and live without our learned object-relations templates, and that this was necessary for knowing ourselves as our underlying essence.

Recent research in the field of contemplative neuroscience has begun to explore the neural processes that may mediate unitive consciousness (Josipovic, 2014; Josipovic and Miskovic, 2020).

There are many descriptions of unitive consciousness in the Asian spiritual literature, especially within some lineages of Zen (Hinton, 2020) and Tibetan Buddhism (Rabjam, 2001), and the Hindu traditions of Advaita Vedanta (Sankara, 1989) and Kashmir Shaivism (Muller-Ortega, 1989). The 14th century Tibetan Buddhist teacher Longchen Rabjam (2001) described unitive consciousness: “This vast expanse, unwavering, indescribable, and equal to space, is timelessly and innately present in all beings” (p. 83).

In the Asian traditions, unitive consciousness has been called buddha-nature, pure consciousness, Self, *rigpa*,

and the clear light of wisdom mind, among many other names. The twentieth century Zen philosopher Nishitani (1982) described it as “primordial subjectivity” (p. 32). The Buddhists describe unitive consciousness as “self-knowing”, rather than as self-object knowing (Rabjam, 2001). It is consciousness that has become conscious of itself (Tolle, 2008). We know ourselves to be the knower. We experience that we are the unified ground of fundamental consciousness.

Asian metaphysical systems often view unitive consciousness as impersonal because it is considered to be universal, and even to pervade the whole universe. However, when we uncover this ground within our own being, it feels like who we really are. We have a sense of finally shedding the constructed images and superficial layers of our being to uncover our authenticity. Nishitani (1982) calls it “the original self in itself” (p. 151).

I do not make an ontological claim for unitive consciousness in the Realization Process, as is often done in traditional spiritual teachings. Instead, I describe it as an experience that we can access through subtle, inward contact with our body (Blackstone, 1991, 2007).

There are relatively few references in the Asian spiritual literature that focus solely on the embodiment of unitive consciousness, but there are some. The contemporary Tibetan Buddhist teacher Lama Thubten Yeshe (1998) writes, “Buddha’s body is not crowded with blood and bones; it is transparent and light. It is a conscious body, a psychic body” (p. 104). The twentieth century Japanese philosopher Yuasa (1987) says of embodied consciousness, “The ‘mind’ here is not the surface consciousness but is the ‘mind’ that penetrates into the body and deeply subjectivizes it” (p. 105). The Japanese philosopher Nishida (1979) writes, “To immerse oneself in the world does not mean to lose the body, nor does it mean that it becomes universal. On the contrary, the self is deepened or, rather, it is thoroughly at the base of one’s body” (pp. 324-5).

In general, the field of psychotherapy has ignored or dismissed the notion of an essential aspect of ourselves beyond our learned and constructed templates. Even within Asian spiritual traditions, there is debate regarding the existence of a foundational ground of being. Tibetan Buddhism has delineated two main categories of spiritual realization – those believing that there is a ground of being, or *buddha-nature*, referred to as “empty of other” teachings, and those that assert that there is no ground or any sort of uncompounded, permanent aspect of human experience, referred to as “empty of itself” teachings (Hookham, 1991). The long-standing conflict between these two points of views was imported to the West along with the Buddhist teachings.

The dominant understanding within the psychotherapy field has been of human nature as made up of mental constructs and nothing else (Mitchell & Black, 1995). This had the effect that when Buddhism began to gain popularity in the West, many psychotherapists were

"[Mindfulness techniques] ... instruct the practitioner to become increasingly attuned to even tiny shifts in their internal experience, and they calm the mind by gradually reducing and eliminating mental elaboration. However, the focus of these practices is specifically on the content of experience. They do not approach inhabiting the body as a unified ground of consciousness."

ready to embrace and incorporate into their work the school of Buddhism that denied any inherent ground of being. Today, in the West, as it was even in ancient Tibet, the "empty of itself" concepts of Buddhism are more widely known than the Buddhist teachings that point to a fundamental ground of being. The integration of psychotherapy with the no-ground, empty of itself theories and practices of Buddhism have led many psychotherapists into increasingly disembodied forms of therapy.

The popularity of mindfulness forms of meditation, and its incorporation into Western psychotherapy modalities, although focused on bodily experience, has supported Western psychotherapy's rejection of an essence or ground of being. Mindfulness techniques cultivate and refine the ability for monitoring interoception. They instruct the practitioner to become increasingly attuned to even tiny shifts in their internal experience, and they calm the mind by gradually reducing and eliminating mental elaboration. However, the focus of these practices is specifically on the content of experience. They do not approach inhabiting the body as a unified ground of consciousness.

As an example of how fully the Buddhist "empty of itself" philosophy, and the focus on interoception that is associated with it has been accepted in Western psychology, here is a quote from Peter Levine (2010):

Paradoxically, the only way that we can know ourselves is in learning to be mindfully aware of the moment-to-moment goings-on of our body and mind as they exist through various situations occurring in time. We have no experience of anything that is permanent or independent of this. Thus, there is no ego or self, just a counterfeit construction. While counterintuitive to most of us, this is common 'knowledge' to highly experienced meditators (p. 287).

However, this is not the knowledge or experience of all highly experienced meditators. Experienced meditators have been debating exactly this point for many centuries (Duckworth, 2017, Gyamtso, 2001).

The Realization Process

This paper presents a method of body psychotherapy that facilitates the shift to living within the body as unitive consciousness, and that utilizes this subtle dimension of self-experience to heal deficits in contact with oneself and others resulting from childhood relational

trauma. This method, called the Realization Process(tm) (Blackstone, 1991, 2007, 2008, 2011, 2012, 2018), was developed by the author as a method of personal and relational healing and nondual spiritual realization. It includes a series of inward attunement exercises for living within one's body, and for deepening the innate capacities that are found in the body, such as our capacities for love, understanding, and sensual pleasure.

The Realization Process also includes an original method for releasing trauma-based constrictions from the body by focusing within these constrictions from a subtle channel that runs vertically through the innermost core of the torso, neck and head, known as *shushumna* in Hindu Yoga, and the central channel in Tibetan Buddhism. The Realization Process relational practices help couples heal, balance and deepen their contact with each other from this subtle vertical channel, and as the unitive consciousness that they can both attune to pervading both their bodies. The Realization Process practices for nondual realization uncover unitive consciousness pervading our internal and external experience at the same time. This aspect of the work helps people know themselves as whole and separate at the same time as they know themselves as unified with their surroundings. This paper will focus only on the embodiment and relational aspect of the Realization Process.

The description and benefits of inhabiting one's body that I present in this paper are based on my experience teaching the Realization Process. Exercises such as the ones included here, although generally taught as longer and more elaborate than these, have yielded consistent self-reports from students of feeling more authentic, unified, spontaneous, grounded, and self-confident, based on their increased contact with themselves (Blackstone, 2018).

Context for the Realization Process

The Realization Process differs from the majority of other body psychotherapy approaches, such as Somatic Experiencing (Levine, 1997), in that instead of focusing directly on the nervous system as the main arena of trauma, the Realization Process focuses on the fascia. The fascia is everywhere in our body, surrounding every part of our physical anatomy, and serves as an interface between our mind and our body (Lesondak, 2017). We brace and constrict ourselves through the medium of the fascia in order to protect ourselves in relation to our environment. Over time, through repeated movements into constriction, we rigidify patterns of holding back our own behaviors that might evoke disapproval or punishment, such as our anger or tears, and we protect against situations of perceived danger and overwhelm in

our environment, such as parental criticism, shaming, and abuse. We may create patterns of limitation in our fascia in order to obstruct the impact of abrasive stimuli, such as loud noises or cigarette smoke. We may also mirror the patterns of constriction of important people in our early lives. We do this automatically as we open to the contact and warmth of other people, and as we close off those parts of ourselves that are not met with contact and warmth. For a more detailed discussion of this, see Blackstone, 2018.

Through the medium of the fascia, we can constrict ourselves anywhere where fascia is present within the interior space of our body. By inhabiting our whole body, we can experience shifts in the fascia that occur within the internal depths of our body in reaction to painful events, or in the recounting of those events for therapeutic purposes. We can also discern even small rigidities within the interior space of our body where fascial tissues have glued together to create rigidly held limitations in our functioning, such as our ability to feel emotion or experience sensual pleasure. It is possible, through the medium of the fascia, to limit our ability to love, for example, with a movement so small within the depths of the chest that it would not be visible to most observers or accessible to a person who was not deeply in contact with the internal space of their body. In this way, the Realization Process refines and can supplement those methods of somatic observation offered by Sensorimotor Psychotherapy (Ogden & Fisher, 2015).

By accessing and living within the subtle vertical energy channel (shushumna) that is experienced within the innermost core of the torso, neck, and head, we can achieve a focus that is deep and subtle enough to focus within the constrictions within the interior space of the body. When we focus within these constrictions, there is a spontaneous movement further into constriction, and then a release along the exact trajectory that was used to create the constriction. This precision often also yields access to the memories and intentions of the constriction and produces a lasting release of the pattern.

By providing a technique for uncovering the unitive ground of our being throughout our body, the Realization Process provides a container for the release of the

energy and tissue bound up in somatic constrictions. We do not just become more open, energetic, or self-aware as we release trauma-based constrictions. We become more whole, more internally unified. We release into the unitive ground of our being.

The Realization Process also differs from those therapeutic methods that view our basic nature as consisting of parts (Schwartz & Sweezy, 2020; Howell, 2005). Schwartz (2020) wrote that he views the psyche as “a relational milieu that is populated by independent entities” (p. ix). As unitive consciousness, we experience our primary identity as undivided and unchanging. The constantly changing content of our experience flows through the unified ground of our being without changing this underlying experience of primary identity. We have an ongoing sense of internal coherence, a felt experience that we are basically one and the same being, even as our understanding, behavior, and depth of self-contact change over time.

The experience of ourselves as an ongoing, undivided internal wholeness means that we can tolerate greater intensities of pleasure and pain without fear of being overwhelmed or shattered. We can encompass the depth, intensity, and free flow of our perceptions, cognitions, emotions, and physical sensations. We can more easily tolerate the intensity of emotional release that often accompanies the release of traumatic wounding.

The Realization Process contributes to the body psychotherapy field a step-by-step method for arriving at embodiment that is not just self-awareness, not just physical sensation or instinct, but that uncovers a subtle primary dimension of self-attunement encompassing every facet of our experience.

Inhabiting the Body

To live within the body is to be in contact with the internal space of the body. To inhabit our hands, for example, means that we are in contact with the whole internal space of our hands. To be in contact everywhere in our body produces an experience of internal wholeness, a unified ground of being (Blackstone, 2018).

Embodying the Ground of Consciousness

Here is a brief exercise to illustrate the shift from being aware of the body to being within it

Rest your hands in your lap. Take a few moments to become aware of your hands. As you do this, you may experience sensations in your hands, or the temperature of your hands, how hot or cold they are. You may experience how relaxed or tense they are. Now enter into your hands, inhabit them. Feel that you are the internal space of your hands. Feel that you are living and present within your hands.

You may be able to feel the difference between these two experiences: aware of your hands and inhabiting them.

This contact is consciousness. When we inhabit our body, we feel that our consciousness is everywhere in our body. This is a tangible experience. We feel that we are made of consciousness. This is a shift from knowing ourselves abstractly, from having an idea about who we are that may change in different circumstances, to embodying an unchanging, non-conceptual ground of consciousness. As the embodiment of unitive consciousness, we know our basic identity experientially, rather than conceptually.

Inward contact with one's body is at the same time inward contact with our human capacities. For example, inward contact with the internal space of one's neck is contact with one's voice, one's potential to speak. If we constrict our neck and limit our ability to live within it, we limit the use of our voice. Inward contact with the internal space of one's chest is contact with one's capacity for emotional responsiveness. When we constrict and limit our embodiment of our chest, we also limit the depth and fluidity of our emotional responsiveness. For this reason, inhabiting the body is crucial for recovering from early psychological wounding. For it is these innate capacities of our being that we constrict in reaction to overwhelmingly painful or confusing events in our lives.

We cannot suppress either our perception of the world around us, or our own responses to it, except by clamping down on our own body. For example, we cannot keep from crying, except by tightening the muscles in our chest, neck, and around our eyes. We cannot shut out the sound of our parents fighting, except by tightening the anatomy of our hearing. For this reason, we cannot recover ourselves, the depth of our emotional responsiveness, for example, or the acuity of our senses, without freeing ourselves from these bodily constrictions.

These rigid somatic configurations obstruct our ability to inhabit the internal space of the body. They therefore diminish our experience of contact with ourselves and others, and limit both our internal coherence and our capacity for intimacy. In the Realization Process, the process of accessing and finally inhabiting the internal space of our body facilitates our ability to discern and release these constrictions and regain the freedom and depth of our innate capacities.

As an antidote to the denial of our reality that is often an aspect of childhood trauma, the free flow of our experience through the unchanging ground of our being can help us to know what we really feel, really perceive, really know.

As the embodiment of unitive consciousness, we experience no distinction between our body and our being. We experience that we are the internal space of our body. Unitive consciousness is experienced as stillness. But it is not emptiness; it is not hollow. It feels like our own presence. It feels like the deepest, most direct contact that we can have with our own being.

As unitive consciousness, we can experience all of the parts and aspects of ourselves at the same time. We can experience our legs and our head at the same time, for example, because we experience the internal space of our whole body at once. When we inhabit both our head and our chest, we can think and feel at the same time. Our thoughts, emotions, physical sensations, and perceptions occur as a single, integrated experience.

In one of the main Realization Process exercises, we practice inhabiting the body, part by part, and then inhabiting the whole body at once (Blackstone, 2007). Even this simple process of embodiment has much to contribute to psychological health. Through the cultivation of living within one's body, we are able to experience increased self-possession, and as a result, increased self-confidence. The experience of having internal volume, of "taking up space" in the body, can help us feel less overwhelmed by other people. It can help us to stay in contact with our own perceptions and needs in relationship with other people. The felt experience of one's own being can also engender self-love.

When we inhabit our body, we uncover qualities of our being that appear to be innate, since we discover them rather than construct them. We can experience the actual feel of our intelligence and understanding within our head, the quality of our voice within our throat, the feel of our love within our chest, the quality of power within our midsection, the quality of sexuality and, for those who identify as having a gender, the quality of gender (as a feeling, not an idea) within our pelvis and genital area. Uncovering these qualities also supports our recovery of compassion for ourselves. It becomes harder to tell ourselves that we are stupid, for example, when we actually feel our intelligence. It is hard to dislike ourselves when we actually feel that there is love in our chest, even when we are alone. We feel less intimidated or diminished by other people when we embody a quality of power.

Clinical Illustrations

I worked with a woman who was severely depressed and had made several suicide attempts. She described herself as "garbage" and as "damaged goods." Since she knew many Hebrew blessings from her religious upbringing, I suggested that she take a moment to bless each part of her body as she inhabited it. After several months of practice, she seemed to glow from inside. She began to sit up straighter, even though we had never mentioned posture. And she began to make better choices in her life. Of course, we also had many conversations about the painful events that she had endured as a child, and a warm relationship developed between us as I listened to her. But it was after several months of practicing the embodiment exercise that she told me she had suddenly realized that she was "too precious to throw away."

The importance of inhabiting the body is often ignored because we, as a culture, are accustomed to the state of disembodiment. In general, we do not question it. Where do we live, if not in the body? The answer is that we live in front of ourselves, and above ourselves, or in just a part of ourselves.

Recently a man in a workshop I was teaching asked me what I meant by the instruction: inhabit your feet. The instruction had no meaning for him. I asked him where he lived in his body. He had to think about this, it seemed like an odd question to him, but finally he pointed to his head. I suggested that he take a moment to experience what it felt like to live in his head, not just to be aware of his surrounding from his head, but actually to be living within the internal space of his head. It took a moment, but he was able to feel himself living in his head. "Now let yourself have this same experience in your feet," I said. This took even a little longer, but he did come down and enter into his feet, so that there was, visibly, as lively a quality in his feet as there was in his head. When he entered into his feet, he also began to inhabit his legs, and his lower torso. This internal foundation allowed him to soften in his chest. Over the course of the workshop, he began to feel, and to look, alive in his whole body. He reported that he felt much stronger, and at the same time, somehow softer when he lived in his whole body, and that it changed his sense of relationship with everything around him.

Embodiment in Relationship

When we inhabit our body, we not only experience our internal wholeness as unitive consciousness, we also experience unitive consciousness pervading our environment. We experience that we are made of consciousness, and that everyone and everything around us is also made of the same one ground of consciousness. As an undivided ground, unitive consciousness appears to pervade and coincide with the substance of everything that we perceive, so that everything appears to be both empty and substantial at the same time.

Although I have not found references to this experience in the psychotherapy literature, there are many in the Asian spiritual literature. Muller-Ortega (1989) wrote, "No longer do finite objects appear as separate and limited structures; rather, the silent and translucent consciousness out of which all things are composed surfaces and becomes visible as the true reality of perceived objects" (p. 182).

This pervasive, unified consciousness provides a sense of continuity between ourselves and other people, and enhanced contact and "mutual transparency" when the other people have also attuned to unitive consciousness (Blackstone, 2011).

The internal space of the body can experience contact with the internal space of other bodies (Blackstone, 2011). Contact with other bodies depends on our contact with the internal space of our own body. If two people both inhabit their hands, the contact they will feel if they touch each other's hands will be more vibrant and intense than if they were not inhabiting their own hands. They will each experience the contact within the internal depth of their own hands. This is true for any part of our body that we inhabit. We can experience contact with the internal depth of another person's body and being from within the internal depth of ourselves.

The contact between inhabited bodies does not necessarily require physical touch. It can even be felt across distance. If two people each inhabit the internal space of their chest, for example, they can experience contact with each other within the internal depth of their chests, across the distance of a room.

This exercise will produce an automatic connection between your love and the other person's, a connection of love with love (Blackstone, 2011). This is not an emotional response to each other, and not a mirroring or entrainment of each other's emotional state. It is even more subtle than energetic resonance, although it includes and can facilitate that level of connection and exchange as well. Rather, this is the subtle contact of the ground of one's own being with the ground of another

Meeting in Unitive Consciousness

This exercise needs to be practiced by two people at the same time.

Stand or sit across the room from another person. Each of you inhabit the internal space of your chest. This means to experience yourself as present within the internal space of your whole chest. Next, from within your own chest, without moving from your own chest, find the space inside each other's chest.

You can take this contact exercise a step further.

As you just did, each of you inhabit your own chest. Next, attune to the feeling of love within your chest. Without moving from within your own chest, let yourself experience the feeling of your own love in your own chest and the other person's love in their chest at the same time.

person's being. It is an attunement to the unmoving, but quality-rich ground of unitive consciousness pervading one's own body and the bodies of other people.

This exercise can be practiced with any part of our body and any quality of our being, such as the qualities of understanding, voice, power, and sexuality or gender. I often do this and other similar relational attunement exercises with couples to help them feel where they easily connect with each other, or where there is some obstruction in their mutual contact. Then these obstructions, whether they be caused by chronic constriction in one of the partner's bodies, or by specific issues between the partners, can be understood, released, and resolved. Their mutual attunement to the pervasive, unified ground will itself contribute to the release of the barriers to the contact between them.

It is important to note that this is not a projection of oneself (of one's focus or energy) into the other, which would be felt as invasive. Nor is it a merging of oneself with another, which would mean loss of contact with oneself. When we meet another person in the pervasive space of unitive consciousness, we do not leave the internal space of our own body in any way. To find oneself and another person at the same time within this space is a more subtle attunement than projecting or losing oneself in another person.

This is a contact rather than a perception or information-gathering exercise. It may facilitate our ability to see and feel, to some extent, the specific emotions or sensations that another person is experiencing, even within the internal space of their body. This can be thought of as a refinement of theory of mind, which usually relies on more superficial cues, such as facial expression and bodily posture, rather than on the movement of feeling within the body, to reveal another person's experience (Baron-Cohen, 2000).

Body psychotherapy modalities such as Sensorimotor Psychotherapy (Ogden & Fisher, 2015) and Polyvagal Theory (Porges, 2011) have made huge strides in the understanding and treatment of attachment disorders by helping people closely observe their somatic responses in relation to other people. The relational exercises of the Realization Process contribute to this self-observation by allowing us to perceive and understand the ways we obstruct the pervasive space of unitive consciousness when we attune to it pervading our own body and the body of another person (Blackstone, 2011). These exercises can also help heal relational difficulties by teaching a way to experience intimate connection with another person without losing inward attunement to our own authentic responses and needs. We neither have to cut off contact with others in order to protect the integrity of our own existence, nor give up our own connection to ourselves in order to experience intimacy with others.

Unitive Consciousness in the Therapeutic Relationship

When we embody unitive consciousness, we experience ourselves as both whole within our individual form and as part of the spacious expanse of consciousness pervading our own form and our environment at the same time. This experience can enhance the effectiveness of the psychotherapeutic process in several ways. As the embodiment of unitive consciousness, we are present, open, and responsive to our client at the same time as we are contained and separate. This allows the client to feel fully received by the therapist without feeling intruded upon in their self-exploration. Put simply, they may feel more space to be themselves, to focus inwardly, and to access the memories and emotions that they need to uncover for their healing (Blackstone, 2018).

Unitive consciousness also facilitates the free, unobstructed flow of our responses. This fluidity of responsiveness, and lack of self-manipulation or agenda on the part of the therapist, can help the client feel safe to be more authentic themselves, to more fully reveal themselves both to the therapist and to the mirror of their own self-inquiry.

The spontaneity that arises as we allow our responses to flow also appears to facilitate the spontaneous emergence of the healing process. It facilitates the functioning of more subtle phenomena such as synchronicity and intuition (Blackstone, 2006). Both the client's insights and the therapist's guidance seem to arise directly out of the pervasive space of unitive consciousness with less effort and error.

The capacity of embodied consciousness to connect across distance with the internal space of other bodies refines our ability not only to connect deeply with other people, but to know, to some extent, what other people are experiencing. This knowing is more subtle than the experience of entrainment. Instead of feeling another person's emotions in our own body, as many sensitive people do, we can feel them "over there" in the other person's body. In the Realization Process, we call this type of perception across distance a "see-feel." It is not intuition, but rather a subtle range of our normal senses, and seems to yield a mixture of tactile and visual information. It is a kind of "trans-interoception." Almost everyone that I have trained to teach the Realization Process has found they have access to this ability. It seems mystifying at first – how can we possibly feel what is going on within someone's body across the room without mirroring it ourselves? What sense is that? But apparently, it is a subtle capacity of our senses that we can access as unitive consciousness.

This "see-feel" is a refinement of our natural human capacity for empathy, our ability to know, "what the inner life of man is, what we ourselves and what others feel and think" (Kohut, 1977, p. 306). As it requires that we know ourselves as the unified ground of unitive

consciousness pervading our own and the other person's body, it also requires that we remain within our own body. For this reason, it is not an invasive energetic movement into the other person's body or space. It also means that we can clearly feel our own responses to the other person, whether it be an answering grief, or compassion or aversion, without becoming the other person. Without running the other person's feelings through our own body, we can more clearly experience the distinction between the other person's experience and our own responses.

We can also sometimes experience when, where, and how the pervasive ground of unitive consciousness is obstructed in our relationship with our clients. Where the pervasive space is open, we are in contact with each other, and where it is obstructed, we are not in contact. Just as with intimate partners, this obstruction may be caused by areas of chronic disembodiment, based on childhood trauma, in the client's or the therapist's body, or by areas of temporary disembodiment/constriction in reaction to obstacles in their specific relationship. This gives us a new pathway in which to explore a client's responses to the person and behavior of the therapist, or the superimposition of the client's earlier, formative relationships onto the therapist. In the same way, we can track our own obstructions to the pervasive space in relation to our clients, and better understand even our most subtle responses to them.

In the Realization Process, the direction of healing is toward both a more complete experience of internal wholeness and a more complete experience of self-oth-

er oneness. We combine the embodiment exercises with a method for releasing trauma-based constrictions from the body, along with verbal dialogue to understand and encompass the client's painful past and its effect on their present life. As the client is able to live more fully within their body, the pervasive consciousness between the client and the embodied therapist becomes increasingly open.

Conclusion

By inhabiting our body, we heal the rift between body and mind, between perception, cognition, emotion, and physical sensation, and between self and other. Whenever we inhabit our body, we are both in contact with ourselves and open and available to the present moment in our environment. In the internal depth of our body, we access an experience of unified consciousness pervading our body and environment. This ground feels like our own true nature, the basis of our authentic connection with ourselves, with our environment, and with other people.

Understanding and facilitating the experience of embodiment as inhabiting the body can enhance the healing potential of the clinical encounter. If we view the therapist's art as maturing in the direction of empathic attunement and close attention to subtle, unspoken aspects of the therapeutic encounter, then it is important to extend our attention to the quality and configuration of the embodied contact between ourselves and our clients.



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Touch and Affect Regulation

Postural Integration, Trauma Skills, and Tools for Body-Oriented Psychotherapy

Bernhard Schlage

ABSTRACT

Based on new neurophysiological research, this article explores how touch influences different areas of our brain via nerve receptors, and how different techniques of touch support a client's need for affect regulation. Following Allan Schore's proposed approach to affect regulation, the article demonstrates what supports emotional expression and the development of a resilient inner self. It details how to work with the affect cycle and trauma and deepen our understanding of the window of tolerance concept in order to support clients who suffer from overly strong and painful emotions, as well as those who struggle with a general lack of emotions.

Keywords: Touch and affect regulation, skin-mechano-receptors, affect-cycle-charts, window of tolerance

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In the Beginning

Let's start by considering the very first contact between a client and therapist. Let's suppose that we get in touch with a new client via phone; the client, a woman, introduces herself, and we hear each other's voices.

As usual, we begin to relate through the signals sent and received:

- How does the client express their interest in therapy? Is it primarily in technical terms? Is it in terms of needs and desires? Do they have difficulty making themselves understood because of emotions that arise?
- How does the client's voice resonate within us as a therapist? Our social engagement system (Porges 2001) often associates faces and bodies with people simply by hearing their voices. What feelings arise about the other person, even if we are not trained in sensing the "primary Chinese element" in their voice (Ohashi, 1992)?
- Where in our own body does the client's voice resonate while we listen to them?
- Which sensory language does the client use? Do they visualize? Do they refer to their senses and body sensations? Do they use an inner voice dialogue?

We perceive an abundance of information from clients before we physically meet them.

PHASE 1 How Bonding Regulates Touch Possibilities

In our first live interaction, we address the relationship between the inner image we may have created and the reality of the client. Which facial expressions does the new client show in this first

In this final phase, therapists need to view their clients in a new light. They must stop seeing them through deficit-oriented diagnosing eyes, and instead look at their human potential.

contact? Smiling or close to tears? Does the face-to-face contact feel like there is great distance between us? Are we faced with skeptical eyes watching us? What is the quality of the handshake? Is it heavy, like a bulldog squeezing our bones, or limp, like a duster? And how does this relate to the overall tension of the person in front of us?

This initial scene is full of detailed sensorial information about your client's style of interaction. As body psychotherapists, we use our own body as an interactive psychobiological regulator for the emotions that arise in our client (Diamond et al., 1963; Schore, 2001b). Courtois (1999) describes how a traumatized client, because of their painful past experience, can have difficulty feeling at ease communicating in a therapeutic relationship. Therefore, we as therapists are called upon to be creative regarding conscious, as well as unconscious, patterns of interaction.

On a fundamental level, we can sense if a client lacks feeling, and presents a more or less friendly mask. Their emotions may be in hypo-arousal (for a description of hyper- and hypo-arousal, see Post et al., 1997), and it may seem there is nothing to relate to. Possibly, there is even less – a silence we do not understand; something like a deep black hole, a void that opens when in contact, but cannot be touched in any way. Perhaps it is the opposite. The basic level of interaction is hyperaroused, with a great deal of pain coming up during our first contact – tears caused by something that has happened on the way to the session, or in the days before our meeting. Possibly, a client has fantasies concerning our skills as therapist. They have perhaps read something on the internet that was deeply touching, or seen something in our eyes that triggers distrust.

How, as therapists, do we relate to this bonding situation? Do we take the emotional feedback personally; for example, as being a result of our good or bad marketing? Do we lean back with a calm face (Hornak et al., 1996), merely observing what we sense? Do we try a variety of interactive actions to explore how to cope with the situation? Are we aware of the change in our voice during this first contact?

What about the self-organization of our own body during client contact? Are we feeling comfortable? Are our arms crossed... our legs? Is our reaction to our client one of ease, of open gestures? Do we sit facing them with relaxed arms, mirroring and adopting their facial expressions? Are we able to follow their gestures to get closer to grasping their meaning? Do we give them feedback about their facial expression and gestures? Do we begin regulating their emotions during this first contact, or do we feel overwhelmed by their emotions? (For the endogenous intent of the human brain to stay in relationship, see Dunn, 1995, p.724.)

During this first phase, we tend to our own and our client's social engagement system (Porges, 2001) to find attuned interactions that allow both of us to share in-

ner core feelings as well as to support clear boundaries and co-regulation. This is necessary for both of us. To accomplish this, we need a setting of near symmetrical connection, with only a small amount of hierarchy and a reliable reciprocal feedback system. This altogether differs from the old therapeutic paradigm of the therapist as a blank slate viewing the client's transference struggles from an objective perspective. "The observer of a situation is part of the situation" (Greene 2004, about Heisenberg's "uncertainty relation theory") Above all, our social engagement system is a good internal regulator for the questions of contact and interaction that may arise.

In this first phase, as we share space and time within the therapeutic relationship, we begin to give feedback about our experience in the here-and-now. We consider feelings that both of us may or may not be conscious of, such as the sound, strength, or rhythm of the voice, tiny bodily movements or gestures, or how we feel about the bonding in process. We train our client's ability to receive and give feedback in a body-wise way in the same way good parents interact with their children – by giving feedback, by being present with all human aspects of being – body expression, posture, attention, and bonding information. Later, we include the unconscious components of interactions as well. And when a reliable therapeutic base has been established, we add body reading (Prester & Kurtz, 1976).

Later, we may switch between these early regulation strategies and the following self-regulation methods to continue recreating therapeutic situations of trust and safety. We provide the space that enables a learning environment for both client and therapist.

In this early phase, we can decide whether to proceed with our specific body psychotherapy modality or focus on trauma-oriented therapeutic strategies. Even though, since the 90s, there has been a cultural ground suggesting that all clients are traumatized, some clients seek help only to cope with strong experiences of anxiety. Only some of our clients present with the type of trauma defined as the subjective experience of a life-threatening situation without the possibility of fight or flight, and leading to the experience, following the traumatizing situation, of a lack of nurturing bonding to calm the autonomic nervous reaction (Levine, 2010).

PHASE 2

How the Body Regulates the Quality of Touch

In the second phase, the intention is to track the body in order to resource clients (Ogden, et al., 2010). This means supporting them to imagine a good and safe place, improving their sense of being centered in the body, and in particular, strengthening their ability to differentiate between a body sensation and the emo-

tional interpretation of a body sensation. This will later support their ability to calm emotional hyperarousal, or, if they find themselves hypo-aroused, to support emotional self-activation.

Whatever our body psychotherapy specialization, from the initial meeting on, we must take into consideration the details of our initial experience of the bonding situation:

- The distance we choose when working with a client.
- How we support their gestures, and the kind of gesture we find meaningful for the work ahead – for example, we may want to encourage a client to expand a gesture in order to discover its meaning.
- Playing with the unconscious body signals we perceived in the initial meeting.
- Bringing more awareness into a certain body area where they feel comfortable and inviting them to breathe more deeply into that area.
- Bringing their attention to small changes in that area – differences in temperature or perception of color under the skin.

This list describes *grounding*, a term originating in Bioenergetics (Lowen, 1975; Ogden et al., 2010), and later developed into the concept of *embodiment of experience* (Hüther, 2011). Grounding is not merely a term; it is a basketful of techniques, each allowing us to track good, strong somatic resources alongside, or beneath, traumatic memories.

During this second phase, it is the client-therapist connection that teaches therapists to choose their interventions, and clients to keep emotional arousal in an optimum range within the *window of tolerance* (Ogden et al., 2010, p. 67). On the one hand, there is a need for enough emotion to work with (Breuer & Freud, 1955, GW1; p. 85); on the other hand, there is a need for enough emotional regulation for the social engagement system to stay in charge of emotions, and within a degree of intensity that allows for a regulated process – even if some initial *rapids* must be crossed (Levine, 1997). The social engagement system teaches the therapist about the choice of techniques that support regulation with a particular client, and the client about how to handle emotional arousal without falling into the post-traumatic cascades of reactions they have experienced in the past.

To support client awareness means to first establish body areas where clients can feel safe and comfortable, where they can later balance their fear of traumatic memories even if they feel separate from their body (if they have a tendency to get hyperaroused) or to establish something like a sensory presence in a body area which can later be developed into an emotional response (if they have a tendency to stay in hypo-arousal). We are now establishing several aspects of client self-regulation.

As therapists, we must be aware that if we have a client with an eating disorder, fasting is not part of the

solution! If our client belongs to the twenty percent of Europeans suffering from sleeping problems, not sleeping is definitely not part of the solution! And the same is true with touch: If we have a client who has been traumatized by violence or sexual abuse, their avoidance of touch is part of the problem, and does not lead to any relief of the client's trauma. As a body psychotherapist, after making our client aware of the physical part of the interaction, we develop ways to come into closer contact with them, and this involves touch. Touch is part of the client's self-regulation process (Bion, 2004; Winnicott, 1990).

During this second phase, touch is not a one-way medical palpation, or a physio-therapeutic training exercise. This is often misunderstood by clients who have not experienced body psychotherapy and are not familiar with therapeutic kinds of touch. Touch in body psychotherapy and in Postural Integration is embedded in the therapeutic process. Touch is part of the *holding environment* of the therapeutic relationship. How to touch and where to touch is not a prescribed, fixed, theoretical protocol. This kind of touch originates in sensing and feeling the therapeutic issues. Where to touch, the quality of holding, leading, activating, or releasing while touching is embedded in the therapeutic connection between therapist and client. Of course, touch should be done according to the EABP ethical guidelines (see principle 7 at <https://eabp.org/ethics>). In the clinical treatment of touch dysfunctions such as depression or schizophrenia, the manuals Röhricht created for touch studies in psychotherapy in Great Britain can be consulted (Röhricht, 2009).

Some years ago, while videotaping Virginia Satir, Fritz Perls, and Milton Erickson, Bandler and Grinder (1976, p. 37f; Ogden, 2010) discovered that the unconscious body dialogue between therapist and client is a key factor in the success of therapy. Bowlby (1988) demonstrates the role our body plays in the regulation of contact and therapeutic healing. Gelder (2015) explains that mirroring posture – called *postural resonance* – activates the same parts of the brain in all participants. Rizzolati (Rizzolati et al., 1996) figured out that mirror neuron activity is part of our brain's response when attuning to people with whom we are in communication.

In this second phase, we implicitly start doing something new that later, in the third phase of the work, we will do explicitly. We begin to develop a history of the comfortable touch our clients received and feel comfortable with. Some traumatized clients have fragments of memory about their original traumatic experience (Rosenberg, 1989). Others discover, through other sources, that something must have happened. Or, during the interview at the beginning of the work, we may have noticed our client showed some signs pointing to an unresolved traumatic situation. Often, the original situation cannot be recalled. In fact, the opposite is the case. Clients often lack any memory of long spans of life, and especially a lack of memory about early childhood.

Therefore, we start making clients sensitive to their personal touch history; for example, their mother's touch during nursing, the contact of caregivers' hands with the baby while changing diapers, the sensation on the skin of their stuffed animal, hand or body contact with their brothers and sisters, memories of a pet's paws, if they had, for example, a cat, dog, guinea pig, or rabbit; body contact with family relatives while being read fairy tales or watching TV, experiences of physical contact while doing sports or dancing, or, last but not least, good bonding contact through touch in previous or current relationships.

In these ways, we gradually help our clients develop a map of the comfortable body contact they have received – a gallery of touch sensations. We begin to create a memory puzzle. Initially, there may not be much memory at all, but step by step, some islands of memory will arise about a special time in childhood, perhaps associated with a photo or a certain age. Sometimes, without knowing its origin, a small detail appears, such as a wallpaper color or the smell of a room. We begin to reactivate the forebrain memory (van der Kolk, 1996) and we break the pattern of amygdala-dominated traumatic reactions (Brewin, 2001, p. 381) while increasing the activity of other brain areas.

This is achieved not only by talking. In a parallel process, we awaken a client's interest for different kinds of touch and body areas that feel safe, while we also look ahead to a new kind of tracking – the tracking of touch itself, and the sensing of different qualities of touch. This may happen actively, as in remembering the skin of a mother's hands, and inviting the exploration of the skin on one's own hands, or of the therapist's hands. It may happen passively, as therapists offer, and clients receive, different qualities of touch. In the beginning, touch is without intention. It is not a technique, like Reiki, or pressing an acupressure point, or melting an area of fascia. It is simply placing a hand on a specific area where clients feel comfortable, and bringing awareness to this contact.

PHASE 3 Supporting Clients to Receive Touch

While keeping clients in the here and now (Stern, 2004) and supporting the awareness of the difference between a body sensation and an emotional interpretation of the sensation, body psychotherapists support tracking a variety of touch experiences:

- Sensing the quality of the touch itself – is it warm or cold; does the surface of the skin melt beneath the touch, or does the sense of separation and inability to connect with the touch remain?
- Do clients feel a need to relate to the warmth of the therapist's hands, or on the contrary, do they fear the hand is an intrusion upon their body? (See also suggestions for different kinds of hand contact in Busch, 2006.)
- Pain clients often have an unconscious pattern of using touch as a *lightning rod* to discharge their pain. What happens when therapists give them feedback about this pattern? This process trains clients to be aware of the difference between the interpretation of a therapist's touch intention, and their own emotional reaction to the quality of touch.
- Vary the quality of touch by bringing in slight movement, or changing warmth or hand pressure (Schlage, 2016). Again and again, use the strategies client and therapist learned together in the earlier phases of the work to support the client's capacity for self-regulation, or apply the therapist's capacity for co-regulation through social engagement. In the beginning of phase 3, the main goals are to establish somatic resources (Hermann, 2003; Bundy, Lane, & Murray, 2002), identify peritraumatic memory (Janet, 1925), and map the qualities of touch (Lowen, 1976).

Memories can be auditory as well as visual – the sound of a mother's voice, the engine of a father's car, or the voice of a client's inner dialogues. Some clients may focus on memories of smells and, especially in body psychotherapy, many have kinesthetic memories of past osteopathic or Shiatsu sessions. They may have feelings of being repelled by touch manipulations, or they may sense autonomic micromovements reestablishing body awareness in areas where they feel stiff or dull.

It is possible to track clients as they are moving their body, even while they receive continuous touch. We can explore different areas of the body: center to periphery, front to back, legs and arms, face, or head. Therapists can use emotional maps of these areas (Marcher, 2010; Painter, 1987), influence sensory input to regulate dyadic arousal, and regulate affect to establish a more secure relationship between therapist and client. Schore (2003, p. 219) wrote that stabilization of the neurophysiological patterns of the orbitofrontal cortex is based on better self-regulation by the client, on a more differentiated social engagement system, and on the client's more secure bonding pattern. He describes how sensory input makes development possible.

In the beginning of the third phase, therapists do not focus on trauma. They only work with accessing memories. If a therapist interprets memories too soon, it will influence what is remembered, especially when it concerns sexual abuse. It takes time for client and therapist to understand the differences between a memory:

- that is a client's unconscious sexual fantasy with an adult or close relative indicating an unresolved conflict in the oedipal phase of normal psychosexual development,
- that follows an induced false memory syndrome (Steffens, et al., 2007),
- that is a remembering of sexual abuse that really happened.

Even though clients in this phase of the work may be ambivalent about trauma memories, therapists must hold back any interpretation until both have collected enough pieces of the puzzle about the original situation to decide what did happen, when, where, and who was involved.

A question clients ask again and again is: “How much detail of the event do I need to recall in order to be free of the traumatic emotional cascade?” There are various answers to this question. Some clients need to identify what exactly happened, and whether the perpetrators are still alive. Others are in continuous contact with these family relatives, while yet others remain in an ambivalent phase and need to become more curious or courageous in order to follow where their memories will take them. In the end, it is sufficient for both client and therapist to realize that emotions find new ways of expression, and can be released more easily, when the client’s ability to self-regulate their emotional reactions and their memory-reactions are more aligned with their growing natural affect cycle.

Regulating Emotional Processes

In this third phase, while keeping the somatic resources developed in phase 1 active within the client-therapist relationship and in the client’s own sense of self-regulation, the therapist continues to work on more specific traumatic sequences by touching:

- different areas of the body – for example, the front sides of the legs, arms, and shoulders;
- different layers of those areas – for example, superficially in the areas of meridians and acupuncture points, into the memories of muscles, in between the fascia of organs, or deeper to the periosteum;
- with different qualities of touch – for example, by following the contact, inviting micromovements, evoking deeper emotions, or covering something.

While doing so, we continue to map a client’s history and track traumatic memory sequences. All the while, we note changes in areas of the body during emotional arousal, as well as changes in orientation and awareness. We activate the client’s somatic resources to support their capacity to tolerate these changes.

We interrupt post-traumatic stress cascades by using the basket of grounding and embodiment techniques established in phases 1 and 2 of the work, and we look for incomplete defense reactions. Traumatized clients have frozen motor patterns that can be recognized in the small peripheral movements of the body, such as movements in the fingers or feet. These can be tracked to explore if defensive reactions or beginning fight-or-flight activity are there to reactivate. As there are about 700 nerve receptors in a square centimeter of skin (Juhán, 1987), body psychotherapists use various kinds of touch to stimulate those receptors that regulate the autonomic nervous system. For example, Golgi organs decrease reactions in muscle motor fibers, Pacini re-

ceptors increase proprioceptive feedback, and Ruffini receptors help embody sympathetic activity (Rywerant, 1983; Schleip, 2012; McGlone, 2017).

When using these approaches, emotions suppressed by the limbic system may come up. Contrary to the old therapeutic paradigm that encouraged acting out (van der Hart et al., 1993, p. 165), we now recognize different emotionally charged phases. We work with the affect cycle model (Schlage et al., 2012; pp. 209–223), which shows that every emotion goes through different phases, and in some phases, we must be particularly watchful when dealing with traumatized clients. For example:

- Some clients can be hyperaroused and overwhelmed by feelings before they have achieved a sufficient capacity to ground their experience. They may not yet be capable of tracking activated body areas, or differentiating between the emotional interpretation of a body sensation and the sensation itself, or they may be running from one activation to the next without being sufficiently capable of separating themselves from the triggering signal. In such cases, we reactivate strategies from former phases of the work to slow down the arousal. We need to focus on using techniques that enhance centering and detachment in order to regulate emotional arousal.
- In the opposite case, if clients cannot connect with their emotions enough to work with affect related to their memories, we use techniques to charge their breath and motor activity to reestablish their emotional energy in body areas that are blocked, frozen, stiff, or rigid.

A Brief Case Study Working with Blocked and Frozen Feelings

This client had received a total of 42 body psychotherapy sessions over a period of three years. During a workshop on shamanic dreams, several childhood memories emerged. After working with shamanic techniques, we suspected sexual abuse in early childhood, which prompted her to seek a female therapist. While focusing on tracking the original scenario (Rosenberg, Rand, & Asay, 1985) and analyzing transferences, they found muscular tensions in her torso, and encountered symptoms such as trembling and feeling cold, especially in emotional situations (Reich, 1967; Levine, 1997). Now in touch with these symptoms, she decided to work with me again on clearly defined goals.

First Experiences with Touch and Being Touched

Safety and trust. Usually, we started sessions by talking, and then turned to role play, which allowed her to express her need for separation and distance, and trained her capacity for self-regulation. During a particular role play, she marked her personal space with a rope on the floor, and I encouraged her to allow herself to feel different emotions at different places within the circle. We

explored various positions: What did she feel when she was closer to the center, or at its periphery? What happened when I came closer to the rope, or kept more at a distance?

Experiences with different kinds of touch. We went on to explore her reactions touching herself or being touched at different areas of her body. We began with areas she chose herself, and this later changed to other parts of the body that were chosen by me.

We took time to explore her inner reactions to different types of touch – such as feeling warm or cold, tense or relaxed, and we engaged in dialogue about the quality of touch and her experience of these qualities. Additionally, she allowed herself to sense the touch itself – did the skin of the therapist’s hand feel separate from her skin, or did it feel like a fusion of both? What was the quality of the temperature at the point of touch, and did some of the sensation from the therapist’s hand flow into her body, or vice versa? Could the tension or pain be felt with the touch of the therapist’s hand, or by the therapist through his hand? Did this happen by itself, or was she able to regulate the direction or amount of sensation? We also tracked the reactions she felt in the core of her body, depending on the place of touch (Ogden et al., 2006; pp. 262–264) – closer to the periphery, or on distant parts – in order to explore the different (or even at times paradoxical) body reactions she experienced in response to the type and location of the touch.

Later, for about five sessions, we practiced various freeing or unlocking techniques used in body psychotherapy – making use of breath, movement, and sound to deepen contact with chosen body parts (Rothschild, 2000). By changing her awareness of touch, by focusing on her breath, by tracking micromovements, and by trying to amplify or diminish the intensity of these experiences, we gave her expression of movement a wider radius, greater strength, or more speed through the use of movement expression. We encouraged her to make sounds to support her expression, if needed. This detailed work was intended to support her so that she could deepen her trust in her own abilities for self-regulation and self-encouragement (Schoenaker, 2011). She began to practice these with some members of her family.

Reaching deeper layers and releasing deeper tensions. Moving forward, we focused on deeper muscular tensions, particularly those she felt in her upper torso. After a while, although she felt the need to honor her personal boundaries, especially around her upper chest area (not including her breasts), we managed to find ways of touching her ribcage directly.

As described in my previous article (Schlage, 2016), we were now using fairly deep and strong physical touch accompanied by deep breathing, and exploring awareness of any internal movement. Peter Levine (1997) describes how the counter-pulsation – what he called tension in certain areas – tends to increase initially. At first, the client found herself with a strong muscular

resistance against “something:” her inhalation became fixed, her posture defensive, she pressed her wrists to the front of her chest, made fists, and sensed an unknown scream in her throat.

Because of our preparatory work, she was increasingly able to transform this frozen gesture into movement, and finally tried different kinds of voice work, even screaming, to bring relief to this area. This was the emotional climax (Erken et al., 2012; p. 209) that we approached several times, until she developed some trust in this process.

While following this path of contact, movement, and sound – probably for the first time in her adult life – the client was able to gradually reconnect with her traumatic memories, and associate these with her bodily experience. She often found deep relaxation after these sessions. Liberation was a step-by-step-process in which she reconnected to her body, emotions, and movements, and to her growing confidence. She occasionally passed through phases of deep shame as well as – paradoxically – deep laughter, which emerged several times when repeating this body-oriented process.

Finally, she felt much more relaxed, especially in her upper chest, and her ability to breathe and the capacity for movement in her shoulders significantly increased. She then decided to continue therapy with her Gestalt therapist (Schlage 2018; the client gave an informed written consent for publication.)

Summary

Postural Integration uses touch to process emotions as they shift into what Peter Levine calls “rapids,” and to support a process of “melting the frozen energy,” a metaphor for reactivating micromovements. We develop our clients’ trust in their capacity to hold and contain emotional waves – those processed internally as self-regulation, and those visible externally, such as fight-or-flight patterns. Throughout treatment, we continue to use autonomic social engagement regulation, which we help clients develop in the early phases of treatment.

Usually most human schemata follow the affect cycle described above – stimulus, expansion through nourishing, climax, and relaxation. When working with traumatized clients, we consider specific phenomena; we might be faced with sudden interruptions or jumps within the affect cycle, such as a jump from a small stimulus to a climax, or an absence of relaxation. We help clients transform these phenomena into appropriate choreography. We remember that clients in these specific situations feel they are in life-threatening situations. This means that a lot of brain activity is channelled toward survival responses such that a significant amount of normal brain capacity is not available.

Early amygdala hyperarousal is identifiable by high emotional load, or by its opposite hypo-arousal – the

absence of emotional contact, contraction of muscles, and even the collapse of muscle tonus and blood circulation.

We support orientation and grounding of body sensation in areas where clients feel safe, or when they cannot activate their fight-or-flight responses; we support body resources built up in early phases of the work; we track micromovements and support clients' self-regulative activity to move out of blocked or dissociated states. We support the ability to handle ever deeper and more powerful emotions while at the same time encouraging clients to remain conscious of the present. In accordance with their characterological conflict, we choose different types of affect cycle choreography to support clients in becoming healthier and better adjusted – see Marivoet (2016) on bodymind integration defined from several angles: (<http://icpit.org/philosophical-backgrounds/>).

Finally, we support developing close bonding connections, thereby supporting our clients' final reorganization. Ogden (2010) describes the need for correlation between the muscles of the surface of the body and the deep inner musculature (quoted in Kurtz & Prester 1979). The completion of unfinished defensive responses is also needed; if clients show impulses of fight or flight, indicated by the way the arms are mobilized to gain more distance, or the legs to step on something or show the desire to run away, we seek ways to complete these unfinished movements.

PHASE 4 Embodying Therapeutic Experiences

The fourth phase of the work establishes successful embodiment experiences and integration in daily life.

Although this article describes body psychotherapy work with trauma in a phase model, therapeutic relations may not unfold this way. Often, during the fourth phase, unknown memories may emerge, or at the prospect of ending therapy, new trauma memories may come up that had previously remained unconscious (Steele 2005).

In this fourth phase, the goal is to support clients to use the self-regulation and social engagement tools they have learned in therapy in their daily lives (Brown et al., 1998). Additionally, we take time to stabilize their bonding capacities with the protective and self-empowerment patterns developed in the early phases of work. We also support their need to expand intimacy to include other people or relatives (Brown, 1998). Often, after traumatic life experiences, the bonding system is damaged so that clients are unable to have satisfying relationships. Some may move too quickly to take care of someone else (Sable, 2004) or become intimate too quickly without regulating distance and self-awareness. They may be drawn into parentification patterns (Minuchin, 1975) in which they take care of relatives who, in a healthy family, ought to be the ones taking care

of them. Clients must learn that grounding, centering, bonding, sounding, eye contact/facing, and their social engagement system make it possible for them to diversify their need for contact and intimacy. They must learn appropriate self-regulation and distance to keep in various relationships – for example, with work colleagues, close friends, or family members.

Juhan (1987, p. XXIX) writes that therapists create new waves of sensory and motor information in their clients' brains that takes them beyond the limited repertoire of their life experience. The new possibilities for sensitivity and movement that informs their body's sensory lack of experience supports clients to relate in new ways to nature, their environment, and their relationships.

Janet wrote (1925, p. 988) that the main characteristic of a successful therapeutic treatment is to improve a client's ability to be happy and joyful. We should consider that particularly traumatized clients, because of painful bonding experiences, and possibly due to dopaminergic neurotransmitter problems (Cabib & Puglisi-Allegra 1996), are naturally deeply afraid of this opening process. On the other hand, Frijda (1986, p. 368) describes how "enjoyable sensations will unconsciously form in the body to open to possibilities of new habit patterns." Consequently, in this fourth phase of the work, we need to invite clients to create more positive sensations in their relationships as well as through self-regulation. This may lead to new hobbies such as dancing, engaging in sports, listening to good music, choosing new colors to wear, or creating changes in their environment. We support them to follow the new waves of energy, the new orientation in brain function, and the new desires of the personal self.

In this final phase, therapists need to view their clients in a new light. They must stop seeing them through deficit-oriented diagnosing eyes, and instead look at their human potential (Dychtwald, 1977; chapter 9) and realize the archetypal pattern of their soul. (Jung, 1978).

From Tragedy to Triumph (Ogden, 2010)

Religions struggle with this age-old question: Why do people suffer from life experience? Even though we know that some of the world's problems result from people's commercial interests, we also know that people relate differently to similar life experiences. Some can reflect on what they have experienced with a soft heart, and realize that, through struggle, they have personally grown in a good way. On the other hand, traumatized people repeat the patterns that cause them suffering again and again. It seems that they do not find a way out.

Body psychotherapists offer solutions that seem natural. Even though we use learned techniques, we also use our voice to calm, we use our social engagement system to regulate our capacity for embodied presence, and we use touch to support containment of what has happened. I believe that we can transform alienation from

life and re-establish basic life functions, such as feeling good in our own body, having satisfying relationships, and living in a healthy environment.

I hope this article offers clues to both clients and body psychotherapy colleagues.



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The Present Moment, Trauma, and Relational Somatic Psychotherapy

Homayoun Shahri

ABSTRACT

In this paper, I discuss how life is lived in the present moment, and how this is connected to living a joyful life. I show that living in the present moment is related to embodied living and connecting to the body. The role of relational trauma in disconnecting from the body is then examined. The parts that early bad object relations play in the inability to live in the present moment are examined from the perspectives of object relations theory and neuroscience. The healing role of the good object – that is, the therapist – is discussed, and a technique based on insights from relational somatic psychotherapy is presented that may shorten the therapeutic process.

Keywords: neuroscience, object relations, present moment, relational somatic psychotherapy, transitional objects, trauma

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The Present Moment

Countless people since ancient times have talked about the present moment. The list includes philosophers, yogis, Buddhists, mindfulness practitioners, and more recently, even psychologists. From an objective perspective we live in the present moment. We live neither in the past nor the future, even though our minds can certainly travel in either direction.

Let me first quantify and objectively define what is meant by the present moment. The present moment is a “lived story” with a beginning and an end (Stern, 2004). Stern defines the instantaneous view of time as “Chronos.” Chronos represents the moment-to-moment passage of time. It has no beginning and no end. The moment we focus on the “now” it is gone! Effectively, there is no present instant (Stern, 2004). Our sensory system, however, has short-term memory built into it that captures sensations into the feeling experience of here and now. In other words, it integrates the Chronos moments into a lived story. Stern suggests that this short-term memory is between one to 10 seconds, with an average of three to four seconds. Effectively, this period represents a window of awareness into the here and now, and is called the present moment. This is the window within which life is lived. Stern (2004) refers to this window as “Kairos.” He writes: “Kairos is the passing moment in which something happens as the time unfolds. It is coming into being of a new state of things, and it happens in a moment of awareness” (p. 7).

It takes about 150 to 1000 msec for a word to be spoken, and phrases take up to about 10 seconds to be spoken, with an average of about five seconds. The present moment is roughly the same as the length of a phrase (Stern, 2004).

Our brain is also endowed with short-term working memory that decays over time. It loses its acuity after about two seconds, and the degradation continues. The decay of short-term memory is

*The body only experiences
the here and now, even though
the mind is fully capable of time travel
to either the past or the future.*

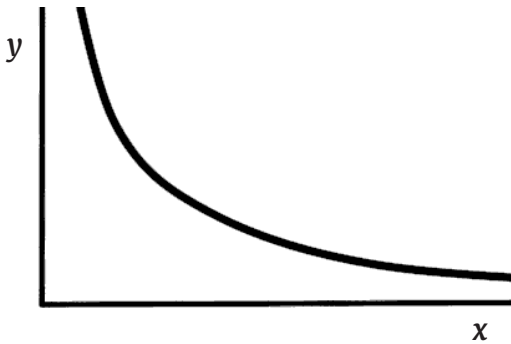


Figure 1 Working memory span –
X: Time, Y: Acuity of short-term working memory

depicted in figure 1. The present moment, however, is not the same as short-term working memory (Stern, 2004). The present moment is an integrative whole. It does not decay, and is the felt sense of what happens within the moments of Kairos. The present moment is how one experiences the here and now. Working memory decays, but one's experience of the here and now remains intact within the present moment window. Short-term working memory is an objective concept and can be measured, but the present moment is a subjective experience.

From a neuroscience perspective, we know that in response to a stimulus, a group of neurons (neural network) might become activated and start firing. A second group of neurons might fire in response to the first, and then a third, etc. These second, third, and subsequent groups of neurons feed information (by firing neurons) back to the first group, effectively forming a feedback loop (recursive or recurrent neural networks). Every iteration of this feedback loop further integrates the event (stimulus) into awareness. When these iterations stabilize, they give rise to the present moment and consciousness (Stern, 2004).

The prefrontal cortex is mostly implicated in the storage of short-term working memory. However, memory of the present moment also involves the limbic system. The present moment is deeply related to the sensory nervous system of the brain, and as such, is very strongly related to the body.

The Present Moment and the Body

We experience the present moment through our body. Our experience of here and now starts with our sensory nervous system. These are the sensory nerves that send signals to the brain and announce what goes on in our surroundings as well as our position in space (proprioception). Sensory nerves eventually reach the somatosensory cortex, resulting in activation of a set of neural networks that are interconnected and recursive. The feeling of what happens (Damasio, 2000) is the result

of the activation of these neural networks by the sensory nerves. The present moment is felt and perceived when activated neural networks reach a certain degree of stability.

The body does not experience the past, except possibly through scars from past traumas, and the body does not experience the future. The body only experiences the here and now, even though the mind is fully capable of time travel to either the past or the future. Thus, the experience of the present moment is predicated on awareness of the body and embodied living. Conversely, one will not fully experience the present moment if one is not aware of their body. Embodied living is the prerequisite for the experience of the present moment.

Although it was Freud (2002) who first introduced the notion of the pleasure principle, it was Wilhelm Reich (1980) who elaborated on Freud's ideas, and taught us that life evolved based on the pleasure principle. Had life not been based on pleasure, we would not have evolved as a species to the extent that we have, and our species would have become extinct a long time ago (a painful life will not last very long). Pain is a necessary part of life, as it is a message from the body indicating that one's life is out of homeostasis and balance. Pleasure is felt in the body, and to feel it one must be connected to the body.

When clients are not connected to their body, have numbed their body, and have little sense of self and a weak sense of proprioception, I start by working on grounding. Grounding techniques are effective and can help clients become more aware of their bodies. A grounding technique that I have experienced as being very effective is the bioenergetic grounding exercise (Figure 2) introduced by Lowen (1977), in which clients place their feet about 20 inches apart, bend their knees a little, bend down with their head dropped and neck muscles relaxed, and touch the floor with their fingertips. They then bend their knees further as they breathe in, and flex their knees as they breathe out. When they stretch and flex their knees, they might notice vibrations in their leg muscles which might travel all the way to their head. When contracted muscles are stretched, they vibrate, and more blood flows through them, resulting in greater awareness.

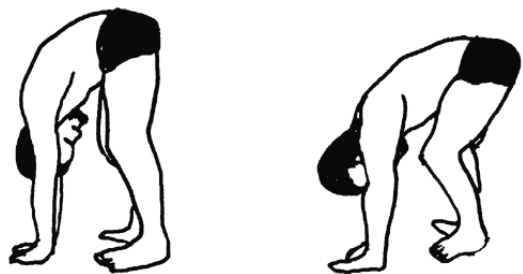


Figure 2 Bioenergetic grounding exercise

In a recent study (Ko, Sim, Kim, & Jeon, 2016), the authors found that whole body vibration (WBV) can be employed as a novel way to improve proprioception, balance, and motor skills. The authors write: “Vibration may directly stimulate muscle spindles and Golgi tendon organs. Increases in proprioceptive sense have been observed in healthy young adults after WBV exercise.” In my practice, I have noticed that when I ask clients with little sense of their body to do this grounding exercise, they develop a stronger proprioceptive sense – in most cases, immediately. This increased awareness of their body might last for several hours. But it is not easy to remain grounded and connected to the body. In the following sections, I will elaborate on this and will also discuss what healing may be predicated on.

Why does one disconnect from their own body? The short answer is trauma. I will discuss the connection between body and trauma in the next section.

Body and Trauma

Trauma can alter the individual at the very core. Trauma changes the way an individual interacts with the environment, the flow of information, and the flexibility of responses to their surroundings. Trauma can change the body, making it rigid at times or flaccid (collapsed) at other times, resulting in a loss of motility and limiting aliveness. It can also change the functioning of the internal organs. Trauma can change an individual’s energy metabolism, and the exchange of energy with the environment. Traumatized individuals are prone to primitive self-protective responses when they perceive certain stimuli as threats (Shahri, 2014).

The pain of trauma and traumatic experiences is felt in the body. The body and bodily feelings then become a source of pain. It is the avoidance of this pain that results in numbing and disconnecting from the body. There is an old saying in Bioenergetics (attributed to Alexander Lowen): we deaden our bodies to avoid our aliveness, and then we pretend to be alive to avoid our deadness. Once individuals are disconnected from their body, they will seek refuge in their mind, and will not be fully aware of the present moment. He will be obsessed with the past and the future, resulting in possible depression and anxiety. Obsession with the past and future manifests itself as a “chatterbox” that runs constantly in one’s head, which makes one’s life hellish.

Relational Trauma

Inside our head lives a chatterbox that runs throughout most of the day. This chatterbox is a constant reminder that we do not measure up, in a somewhat continuous internal dialog. It creates a seemingly eternal internal competition. The internal dialog mediated by the chat-

“We deaden our bodies to avoid our aliveness, and then we pretend to be alive to avoid our deadness.” – Alexander Lowen

terbox makes us anxious, angry, or uneasy. This seemingly quiet and devious chatterbox makes our lives a living hell! The chatterbox is the sum total of our negative experiences and punitive measures in relation to our significant caretakers, that is, our negative introjects or internalized bad objects (Shahri, 2019).

The chatterbox is formed by internal psychological conflicts or simply “internal conflicts.” Internal conflicts are the result of conflicts between our true self and what we were told (and internalized) during the important formative years of our childhood. These powerful messages from childhood become part of our psyche, and when opposed to our true self, make our lives a constant internal war zone.

In the remainder of this paper, I will first give a theoretical formulation of the formation, origins, and function of the chatterbox in our head, and will show that it operates in a manner similar to transitional objects that reside in the mind. I will describe processes and techniques for muting or making it quieter. Once the chatterbox has quieted down, we can live in the here and now, and experience the present moment with all its rewards.

Relational Somatic Psychotherapy

Robert Hilton (2008), my former psychotherapist for over 10 years, introduced relational somatic psychotherapy, which is closely related to object relations theory and somatic psychotherapy. In this section, I will first describe the process of how the internal chatterbox forms, based on object relations theory (Shahri, 2019), and will then present a relational and somatic technique for muting this chatterbox. Object relations theory describes the dynamic process of development and growth in relation to real others (external objects). The term “objects” refers to both real external others in the world as well as internalized images of others. Object relations are formed during developmental phases through interactions with the primary caregivers. These early patterns can be changed and altered with experience, but frequently continue to have a strong influence on one’s interactions with others throughout life. The term “object relations theory” was formally introduced by Fairbairn (1952). He posited that the Infant internalizes the object (as well as the object relations) and splits the object toward whom both love and hate were directed into two parts – namely, the good object and the bad or repressive object. The good object (idealized) representation is important, and necessary to go on in life. The ego identifies with the repressive object (the bad object) and keeps the original object-seeking drive in check (Shahri, 2014).

Partial Internalization

At this point, I would like to introduce the notion of *partial internalization*, which Fairbairn and other object relations theorists did not fully discuss. Dorpat (1976) distinguishes between structural conflicts (full internalization) and object-relations conflicts (partial internalization). Structural conflicts result from the fully internalized objects in which both aspects of the conflict are fully owned by the individual, as in “I want to do this, but I know it is not right and I will not do it.” In the case of object relations conflicts, however, the person might experience strong opposition between their own desires and wishes, and those of internalized others. This opposition is experienced as an agonizing chatter and can be viewed as partial internalization of external objects (Dorpat, 1976).

The fully internalized object is egosyntonic and will assure contact with the object, since the object is fully accepted, and its wishes are adhered to. In essence, fully internalized objects are idealizing self-objects (Shahri, 2019), where self-objects in self psychology (Kohut, 1971) are internal representations of external objects that are experienced as parts of the self. Idealizing self-objects are the primary resources and object relations that the “Self” utilizes for support. The result is that the contact with the object is maintained, while the sense of self is diminished.

Partially internalized objects are egodystonic, and result in object relations conflicts. In the case of partially internalized objects, there are constant conflicts between the wishes of the Self and those of internalized others. Every decision is difficult and agonizing, with a concomitant disturbing chatter. In this case, only weak contact with the external object is established and maintained, resulting in anxiety, irritability, anger, and guilt, etc. This is the phenomenon that I call relational trauma (Shahri, 2019).

Transitional Objects

Winnicott (1951) introduced the concept of *transitional objects* to explain the use of external objects by the infant to compensate for the anxiety related to temporary disappearance of its primary caregiver. Regarding the transitional object, Winnicott (1951) writes: “The object is affectionately cuddled as well as excitedly loved and mutilated.” He further writes: “The mother lets it [the transitional object] get dirty and even smelly, knowing that by washing it she introduces a break in continuity in the infant’s experience, a break that may destroy the meaning and value of the object to the infant.”

In the case of partially internalized objects, there are constant conflicts between the wishes of the Self and those of internalized others ...
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Winnicott (1949) writes about the overactivity in mental functioning in response to certain failures by the primary caretaker, resulting in a conflict between the mind and the psyche-soma. In this situation, Winnicott writes that the thoughts of the individual begin to dominate and facilitate caring for the psyche-soma.

I would like to suggest that relational trauma (the chatterbox inside the head) functions in manner very similar to the transitional objects that reside in the mind (Shahri, 2019). It creates the illusion that one is not alone, insofar as there is a chatterbox in the head. The subject (the “I”), however, does not discard the illusion of the return of the good object, from whom he seeks approval and affirmation. Object relations conflicts therefore function as thoughts and mental activities that take over and organize care for the psyche-soma and form the illusion that someone is out there, and one is not alone, thus reducing fears of existential abandonment. So long as the object relations conflicts function, an illusion is created in the mind that there exists an object that one relates to, and thus the person can, to some extent, avoid their fears and anxieties related to isolation and abandonment. The person, in their mind, treats the object relations conflicts very similarly to the transitional objects, in that they are subjected to love and hate, and to affection and mutilation. The conflicts are made dirty, messy, and smelly, very similar to the transitional objects. In short, the person is imprisoned in the old object relations. Throughout this paper, I will refer to relational trauma, object relations conflicts, and internal conflicts interchangeably.

Mind Object

Corrigan and Gordon (1995) introduced the concept of *mind object*, which can be very similar to object relations that reside in the mind. The space between stimulus and response is mediated by the mental world. When this world is important, one creates a mind to protect and preserve the subject mind. This is the mind object (Boris, 1995). Corrigan and Gordon (1995) write:

We suggest that the mind object – an object of intense attachment – substitutes for a transitional object and subsumes intermediate phenomenon to its domain. But the mind as an object is an illusion. The clinical task is to reestablish an intermediate area as the place where life is lived – where there can be delight in the use of the mind that is expressive and mutual. (p. 21)

Thus, based on object relations theory, the relational trauma or object relations conflicts can be seen as mental equivalents of transitional objects that reside in the mind or simply mind transitional objects. One should also note that the intermediate area that is between internal psychic

reality and the external world is related to the previously discussed present moment.

If my hypothesis is indeed correct – that object relations conflicts (or relational trauma) operates as transitional objects that reside in the mind – then when the good object returns, the transitional objects will no longer be needed and are given up. Winnicott (1951) writes:

Its fate [the transitional object] is to be gradually allowed to be decathected, so that in the course of years it becomes not so much forgotten as relegated to limbo. By this I mean that in health the transitional object does not ‘go inside’ nor does the feeling about it necessarily undergo repression. It is not forgotten and it is not mourned. It loses meaning, and this is because the transitional phenomena have become diffused, have become spread out over the whole intermediate territory between ‘inner psychic reality’ and ‘the external world as perceived by two persons in common’, that is to say, over the whole cultural field. (p. 233)

It is seen that object relations conflicts or relational traumas create the illusion that one is not alone, and that there is someone there with whom they are in conflict. These object relations conflicts function, as I discussed earlier, in a manner very similar to transitional objects, which I named the “mind transitional objects”. Here Winnicott also discusses the intermediate territory between psychic reality and external reality as perceived by two people in common, which is a notion related to the present moment in a relational world.

The Return of the Good Object

Why is the return of the good object healing? Lewis, Amini, & Lannon (2000) write “In a relationship, one mind revises another; one heart changes its partner” (p. 144). Our brains, and more specifically our limbic systems, wire through experience. New neural networks form as the brain conforms to novel situations. Lewis et al. write: “When a limbic connection has established a neural pattern, it takes a limbic connection to revise it” (p. 177). Similarly, Guntrip (1994) writes: “If it is bad human relationships that make people emotionally ill, it can only be a good human relationship that can make them well again” (p. 401). In other words, limbic attractors can change in relationships.

An attractor network is a type of recurrent dynamical network composed of interconnected nodes (neurons) that evolves toward a stable and persistent pattern over time. And in therapy, this change occurs when the new attractors, in the limbic

It is seen that object relations conflicts or relational traumas create the illusion that one is not alone, and that there is someone there with whom they are in conflict.

system of the client, form such that they become closer and more like those of the therapist. This process is iterative, and with every iteration, the newly formed neural pathways of the client, which are initially weak, become stronger and form the new limbic attractors and move closer to those of the therapist. Therapists have a set of indispensable tools that are their strong sense of self, self-knowing, and self-relatedness. The strong sense of self, self-knowing, and self-relatedness of the therapist can result in limbic revision within their clients. This puts a great onus on us, the therapists. We need to have done our own work, we need to have resolved our own object relations conflicts, and to have experienced this in our own therapy.

The question that might be raised is whether clients can accept and take in the good object that is now manifested in the therapist. It is not easy! Clients have spent years building defenses against receiving contact, due to their early relational traumas. The key to the success of therapy is for clients to become vulnerable in the presence of the therapist, that is, to give up their defenses and resistance. Due to (negative) transference, it is frightening for clients to feel safe enough to trust the therapist, to become vulnerable in the therapist’s presence, and let the therapist witness their pains. Clients generally function and behave from the old object relations upon which their transference is based. From a neuroscience perspective, transference is nothing but the activation of old neural networks that were formed in relation to early (old) objects. And resistance is the persistent activation of these early (old) neural networks.

Wilhelm Reich (1980) quite correctly and aptly wrote that psychotherapy is about consistent analysis and working through of the transference and resistance. Without the working through of the transference and resistance, clients will repeat the old behavioral patterns through the activation of the familiar old neural networks, and healing may not take place. When clients feel safe enough with their therapist to work through the transference, they can become vulnerable and will lower their resistance. Fairbairn (1943) writes: “The resistance can only really be overcome when the transference situation has developed to a point at which the analyst has become such a good object to the patient that the latter is prepared to risk the release of bad objects from the unconscious.” (p. 332)

“If it is bad human relationships that make people emotionally ill, it can only be a good human relationship that can make them well again.” – *Harry Guntrip*

When clients can become vulnerable in the presence of their therapist (give up their defenses), that is, when they no longer function from old neural networks... their limbic brain will be ready to form new neural networks based on their experience and relationship with their therapist.

When clients can become vulnerable in the presence of their therapist (give up their defenses), that is, when they no longer function from old neural networks (transference and resistance), their limbic brain will be ready to form new neural networks based on their experience and relationship with their therapist. Over time, these new networks become stronger, and the old networks become weaker and go through modification. Recall the Hebbian axiom that neurons that fire together wire together (Hebb, 1949). The weaker old neural networks do not disappear, and under severe stress will get activated again. However, as the new neural networks get stronger, they increasingly govern clients' emotional response and behavior. Connection and contact with the therapist will be internalized by the client. This is the essence of healing in psychotherapy from the perspectives of neuroscience and object relations theory. The client can then live in and experience the present moment.

The Technique

Resolving object relations conflicts takes a long time. We must analyze and work through the transference and resistance. While the transference and resistance are being worked through, new neural networks are formed, based on the relationship with the therapist. Recall that new neural networks are formed in the brain based on new experience. This is, however, a lengthy process. Once I developed insight into the process of relational trauma and object relations conflict, I started to look for ways to reduce the length of the process. In my work with clients, I asked them to stay in contact and feel their connection with me (the good object) as they were feeling and expressing their internal conflicts. Every time that I repeated this process with clients, the chatterbox became quieter (based on Hebbian plasticity – new neural pathways get stronger as they get (re) activated).

The results were surprising. When clients spoke about their object relations conflicts and relational traumas while being aware of their bodies and feeling their connection with me, the internal chatter became quieter. Every time that we repeated this process, the internal voice became softer. In my experience, after repeating this process several times (sessions), the internal voice (chatter) becomes essentially muted – at least temporarily. I must point

out that the old neural networks are still present, and will, at times, get activated, but they will lose their strength over time. This may point to a practical way of speeding up the process of resolving object relations conflicts. Before describ-

ing the technique, I must mention that this exercise is predicated on clients having a relatively strong ego, so that the process of contact and connection with their own body and with me is not threatening and re-traumatizing. This exercise is contraindicated for clients who cannot connect with and feel their body and have a diminished sense of self. Clients must first be able to connect with their body for this exercise to be effective.

In figure 3, I show the process of working with relational trauma. Throughout the process, I ask clients not to think. I pull my chair a bit closer and ask them to stay aware of their body (from the neck down, to avoid staying in their heads) and breathe normally. I may have to coach clients to stay aware of their bodies. Being aware of the body is the somatic correlate of the sense of self. Once clients are aware of their body, I then ask them to stay in contact with me. Frequently, I must coach clients as to what staying in contact with me is. I maintain gentle eye contact and look at their left eye, and ask them to look at my left eye gently so that we can make a right-brain to right-brain connection. I also ask them to be aware of the space (distance) between us, and I do the same (become aware of the space between us). Feeling and awareness of the space between us can be thought of as the somatic correlate of the connection. This step makes clients aware of the presence of the good object, which is felt at the somatic level. I then ask them to remain aware of their body as well as maintaining their contact with me, simultaneously. After a bit of practice, clients can follow these steps.

I then ask them to talk to me about their object relations conflicts, relational traumas, or interpersonal conflicts, or to simply remain quiet and reflect internally on such conflicts, while they remain aware of their own body and their connection with me. They notice very quickly that as they talk about their relational traumas, their emotional reactions become muted or more subtle. Clients report to me that every time they talk about their relational traumas while staying in contact with themselves and me during sessions, their emotional reactions become more muted. They further report that even if they try very hard, they cannot easily think about the past or the future, and for the most part are aware of the here

When clients spoke about their object relations conflicts and relational traumas while being aware of their bodies and feeling their connection with me, the internal chatter became quieter.

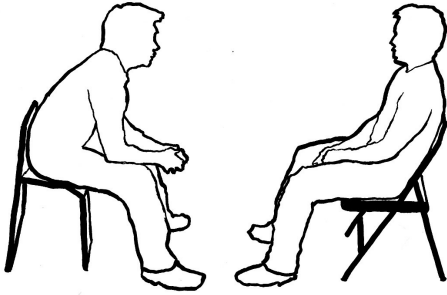


Figure 3 Working with relational trauma

and now! Even when clients attempt to recall the past and think of the future, they report they are not triggered anymore.

In a variation of this exercise, I ask clients to stay in contact with themselves and with me as described above, and just remain silent (not think), until I notice a shift in their emotional state, usually after a few minutes. I then ask them to simply be aware of my presence with them, and to stay in contact with themselves. At this point, I check to see if they are still triggered or bothered by their object relations conflicts, and the answer is usually no! If need be, I repeat this exercise. If clients are agitated and triggered during the session, I do the first variation of this exercise. Otherwise, if the conflicts are not as strong, I have noticed that the second variation may be more effective.

Internalizing contact with the good object will occur over time, and is a long process. Once contact with the good object is internalized, clients do not need the presence of the therapist (good object) any longer. To shorten the length of this process, I devised the following addition to the second variation of the above exercise, in which clients remain silent and simply stay in contact with themselves and with me. I must mention that clients must have reached a certain degree of trust within the therapeutic relationship to be able to become vulnerable (to drop their defenses and resistance) for this step to be effective. I also indicated above that a certain level of ego strength is needed for these exercises to be effective.

I ask clients to feel their body (the somatic correlate of the sense of self), and to feel the space between us while maintaining eye contact with me (the somatic correlate of connection and contact), similar to what I have described above – thus connecting to their body and to me. After a minute or two, or when I feel it is appropriate to go to the next phase, I ask clients to close their eyes and imagine I am getting closer to them (as close as they are comfortable) until they experience my energetic presence in their body. Then I ask them to stay with this sensation and feeling for about a minute, or until I sense that they feel their contact with me in their body. I

believe that this last step is the somatic correlate of internalization. Thus, through this energetic and somatic exercise, clients first connect with themselves, and then connect to the therapist, and finally internalize the contact. After this exercise, clients typically feel much calmer and feel a deeper connection with me and their own body. My clients have reported that after this exercise, they can self-soothe in between sessions or when they feel overwhelmed emotionally. I must emphasize that connecting with the self and to the good object and internalizing it is a long process. This exercise may simply speed up the process by letting clients feel the connection with themselves and with the good object and form a psychological imprint of these processes through developing new neural networks (initially weak) that are formed during their experience in this exercise. Future therapeutic work is then built upon strengthening these newly formed neural networks.

Case of Sally

Sally is a 40 year old single woman who came to see me about six months ago. Her presenting issues were anxiety, a diminished sense of self, and self-deprecating thoughts. Her self-esteem was low, and despite being very attractive, she was not satisfied with her looks. She also ruminated about the past and was worried about her future. Sally had worked with a couple of cognitive behavioral therapists, and more recently with a Jungian analyst. She had developed a lot of insight from her therapies, especially her Jungian analysis. Our work proceeded relatively slowly, as she was unfamiliar with relational and somatic psychotherapy. We spent several sessions on the analysis of her developmental traumas, from which she gained further understanding and insight regarding her life and her choices. She understood how her choices in life were affected by her traumas, and how she was repeating her traumatic past. She also gained the insight that the lack of contact and connection with her primary caretakers early in life had a significant role in her life experience today. She developed positive transference to me early in our work. I processed her transference and resistance in our sessions, over time. Recall that from a neuroscience perspective, the analysis of transference and resistance helps to weaken old neural networks that were formed in the brain based on the past object relations by allowing the formation of new neural networks that are based on the therapeutic relationship with the therapist (the good object). This occurs when clients can take risks and become vulnerable in sessions. It is then that they give up their resistance.

During the course of our work, and when I felt it was appropriate, I asked Sally to stay in contact with herself and with me, as I discussed in the technique presented above. With every iteration of the technique during different sessions, she was able to connect with me more deeply, and felt safer to risk becoming more vulnerable. She reported that she could also recall and utilize our

connection outside our sessions when she needed it. But this time the connection was satisfying and not traumatic, and there was not an infantile dependence on it. In other words, she had found a good object.

The internal chatter in her mind became quieter, her self-esteem increased, and she reported that she started loving who she was. She also reported that the infantile attachment in her relationships had become much weaker. She had developed a much stronger sense of self. I felt that at this point it was appropriate to work with her on internalizing her connection with me, and thus I added the last part of the technique to our exercises in the sessions. After several weeks of working with Sally on internalization of her connection with me, she reported that she did not need to recall our connection to soothe herself outside our sessions, and she felt more secure in who she was and more confident in herself. She knew that the connection was there. In other words, she had internalized our connection. In conclusion, I must mention that Sally was not a typical client. She arrived in

my office with deep insights, and the work with her progressed more quickly compared to many other clients. However, this case study, I believe, demonstrates the application of the ideas and the therapeutic techniques that are discussed in this paper.

Conclusion

In this paper I discussed the present moment as the felt sense of here and now, and showed that it is deeply related to and predicated on connection with the body. I further discussed trauma and its role in numbing the body and disconnecting from it. I analyzed relational trauma, based on object relations theory and neuroscience, as well as its effects on disconnecting from the here and now, and becoming a prisoner of the past and worried about the future. I also introduced a technique based on insights from relational somatic psychotherapy that may reduce the length of the healing process, which is to live in the present moment, and relatively conflict-free.



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The Correspondence Between Phases and Elements in Transformational and Healing Processes Induced by Different Therapy Methods

Muriel Moreno Ojeda

ABSTRACT

This paper compares the author's observations of the processes of transformation and therapeutic change in herself and her clients. Nine phases were observed and titled the EsenciArt System: The 9 Phases of Transformation. The research question is: Are there common phases and elements within transformational and healing processes induced by different therapies or methods? What do they have in common, and what are the differences between them? A 21-question survey was used based on the 9 phases observed by the author. 155 practitioners from 35 countries and from 32 therapies/modalities took part in the study. 120 participants were female; 35 participants were male. Ages ranged from 18 to 74 years. Expertise ranged from no professional experience (students) to 40 years of professional practice. These participants classified their work within one of these three approaches: Mind approach, Body approach, and Body-Mind approach. Results show that professionals from different modalities and approaches do identify and value common phases and elements in transformational and healing processes as described in the EsenciArt System: The 9 Phases of Transformation, with an average correlation of 9 out of 10. The Body-Mind approach was found to be closest to the EsenciArt System. All professionals rated the 9 phases with average correlations ranging between 7.8 and 9.9. The qualitative analysis also showed correlation by pointing towards the importance of practitioners being present, connected, respectful, trusting, and caring – these being the right conditions to activate an organic healing process in human beings.

Keywords: body psychotherapy, therapeutic change, body-mind therapy, EsenciArt System, psychosomatic

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A

fter years of supervising and teaching students the art of healing processes at the Barbara Brennan School of Healing¹ and the Psychoenergetics Training Program², as well as mentoring students on how to engage with clients to allow healing to occur, students and supervisees have repeatedly asked: "How do I begin a session with a client? How do I enable deep transformation in my clients?"

Definition of *EsenciArt's* 9 Phases of Transformation

Nine phases of transformation were observed by the author based on the application of her Body-Mind approach and work with Es-

1. Brennan, B. *Brennan Healing Science*. Retrieved December 15, 2018, from <https://barbarabrennan.com>

2. Tobler, I., & Mervosh, M. (2006). Retrieved August 11, 2019, from <http://www.psentraining.com/>

enciArt. The author's observations of the transformational and healing process are described in the following nine-phase system or protocol. The transformational, therapeutic, and healing process refers here to the conversion of the unconscious into conscious awareness, to the path towards reconciling all aspects of the self and integrating them into wholeness and wellbeing.

Phase 1. *Connecting with the self. Connecting with the client. Presence and contact in the therapist-client relationship: establishing safety and trust.*

The purpose of this phase is to establish safety resources that will allow the client to relax and open. For that, therapists must be present, open, available, genuine, and non-judgmental. To accomplish this, there are different helpful techniques that assist therapists before their sessions with clients begin, such as the practice of compassionate observation, mindfulness, grounding, etc. Practitioners may have their own ways to help direct attention inwards to connect with themselves and focus their awareness on the present moment. Once practitioners connect with themselves and ensure they are open, present, and available, they can then connect with clients by including them in this process. This phase covers the whole cycle, as it is the basic ground from which the transformational process unfolds organically.

Phase 2. *Discovering the issue. Discovering the client's complaint or aim. Detecting the issue. Finding where the discomfort, pain, or numbness is located. Noticing the client's self-motivation/intention – or lack thereof – to heal.*

Once clients feel safe within the connection, they can connect more deeply and discover their complaint, their aim, what is interfering with its fulfillment, as well as a possible lack of purpose. In other words, this phase entails discovering why a client is coming to the session.

Phase 3. *Localizing the issue in the client's body. The issue as somatic experience and feeling.*

When clients express or wonder what the issue is (an aim or complaint), their body will also somehow reflect it through gestures, postures, or stiffness. Since this problem represents something important in the life of a client, there is usually some kind of intensity or load associated with it, which is usually reflected through physical stress or discomfort in the form of tension, pain, or numbness. During this phase, therapists can help their clients become aware of their sensations and feelings while speaking directly with them about their condition or analyzing it. This phase allows the issue to be experienced fully in the present moment through the body, so it is not only a mental process.

Phase 4. *Entering the core of the issue and its discomfort. Directing attention, intention, breath, and physical contact towards the core of the issue and the discomfort or numbness around the client's body. Opening to the senses.*

Once clients localize the issue in their body, that area becomes the door to access the unconscious roots of the present condition. The practitioner assists by slowing down and bringing attention to the affected area of the client's body, by encouraging them to breathe, as well as through touch if indicated. By being mindful of their perception, clients gather information and gain a deeper understanding of their issue. Here, clients might describe sensory information: perhaps an image "looks like an iron knot," "is like a black hole," "tastes bitter," or "reminds them of a smell or a song." This allows clients to go deeper into their unconscious, enabling them to get closer to the big picture in terms of the unconscious roots of their present complaint. This process of opening to their sensory perception helps clients stay curious about their issue and grounded in the present. It is a way of focusing attention and activating energy on the vitality and information encoded within.

Phase 5. *Feeling the issue. Allowing emotions time and space to be felt as they flow out.*

Entering the core issue usually activates the experiences that are connected to the issue that were blocked and repressed at an unconscious level to avoid suffering. Now, with this activation, the uncomfortable feelings associated with the suffering will surface, and clients will usually start to feel the emotions connected to the issue.

Phase 6. *Expressing the issue. Allowing for necessary expression of discomfort, pain, or numbness as part of the shift from repressed energy and lived experience towards healing. Encouraging clients to express themselves freely through their body and voice.*

As emotions are felt, the issue is expressed through the client's body and voice, allowing the energy or vitality that was first repressed at an unconscious level to flow again by moving the body and allowing words or sounds that were not voiced, due to possible past trauma, to be expressed.

Phase 7. *Recovering memories. Remembering the origin of the issue, blockage, discomfort, or wound. Enabling body-mind reconnection as the unconscious becomes conscious.*

As the repressed energy begins to move again, memories associated with the moment that energy/vitality was inhibited or became repressed – usually because of pain, wounding, or trauma – will spring into the client's consciousness. Thus, clients recover those memories

that then become a conscious part of them, deepening their understanding of the cause of the issue.

Phase 8. *Creating a new healing response for the old wound or trauma. Considering a new prospect, changing the habitual pattern. Reprogramming experience.*

With the new understanding that stems from the previous phase of remembering, clients can now appreciate what happened, and what they needed at the time the traumatic event or wound took place. This need is usually linked to children's basic rights and needs: protection, safety, care, attention, respect, being nurtured and loved, listened to, seen, respected, etc. By understanding what they needed at the time they experienced pain, they can now open to receiving a healing response by making use of the therapeutic relationship and their own imagination. For instance, if clients did not feel loved or respected as children, that lack of love and respect will have an influence (whether conscious or unconscious) on how they relate to others and experiences life in the present. When clients become aware that their inner emotional self is lacking this experience of love and respect, and that it has become a pattern – a fixation – in their present life, they will then be able to consciously decide to do something about it. They now have the freedom to create a new pattern, a new program, a new habit of learning to create an experience of self-love and self-respect for themselves – through the therapeutic relationship or their own imagination. Therefore, they will need to learn how to receive such experiences, for in the beginning it will be challenging to identify and accept love and respect, since they have not experienced anything like this before. The brain does not know the difference between “real” and “imagined,” which can be helpful if we want to use our imagination to reprogram our experience. Here, a new prospect can be created, which will require a conscious choice on the part of clients to move away from the pattern they already know to a new one. This new prospect will need to be repeated long enough to develop new neural pathways, thus allowing for lasting therapeutic change. Deep understanding coupled with this new healing response will enable a deeper acceptance and reconciliation within the self of the client.

Phase 9. *Integrating. Allowing time for the integration of the healing response. Integrating the new healing response at all levels of life experience: imaginary, emotional, physical, mental, “spiritual,” and in relationships. Noticing what is new.*

When clients take in the new healing response, there is a tendency to revert to old patterns because they are more familiar. It is important for clients in this integration phase to remain present and mindful of what is new long enough for it to become integrated in their life.

Rather than open new issues, this is a time for clients to experience new sensations and remain aware of how they affect the relationship to the issue in their lives.

This 9-phase process can sometimes occur during a single session. In other cases, it may occur in a few sessions, or over many years. As each process is unique, the order and timing of these phases are not fixed; they can happen at the same time or at different times, durations, and order.

Although EsenciArt's 9 Phases of Transformation are considered as an integrated body-mind approach, for the purposes of this study and its comparative analysis, we can say that Phase 3 Localizing and Phase 5 Feeling are more focused on the physical body, while Phase 2 Discovering and Phase 7 Remembering focus more on the mind.

Table 1 *The focus of EsenciArt's phases*

EsenciArt's Phases	Name	Focus
Phase 1	Connecting	Body-Mind
Phase 2	Discovering	Mind
Phase 3	Localizing	Body
Phase 4	Entering	Body-Mind
Phase 5	Feeling	Body
Phase 6	Expressing	Body-Mind
Phase 7	Remembering	Mind
Phase 8	Creating	Body-Mind
Phase 9	Integrating	Body-Mind

Other protocols have been developed based on other modalities and approaches. The work of two authors is compared here to the nine EsenciArt phases. These two authors are C. G. Jung and Peter Levine. In *General Problems of Psychotherapy. Problems of Modern Psychotherapy*, Jung wrote about the difficulty of accessing the psyche, and defines the four stages of analytical psychology:

- **Stage 1 Confession.** He affirms that secrets, inhibited emotions, and repressed sins lead to neurosis, and that these need to be confessed for clients to recover their integrity. Here, Jung says that the transference from client to doctor must be severed.
- **Stage 2 Elucidation.** In this second phase, Jung asks clients to clarify this transference and analyze their fixation.
- **Stage 3 Education.** This third phase is a process where clients need to be drawn out of themselves to attain normal adaptation.
- **Stage 4 Transformation.** In this fourth phase, Jung affirms that both client and doctor must be transformed by

their treatment interaction. He encourages doctors to search for cures – not only for the body, but for the psyche as well – for themselves and their clients.

The author has found common elements between this text and her own, where Jung’s first Confession stage correlates with EsenciArt’s first Connecting phase, second Discovering phase, fourth Entering phase, and sixth Expressing phase.

Jung’s second Elucidation stage could include EsenciArt’s Recovering Memories seventh phase, where clients realize when and how an unhealthy pattern was established, and how it is affecting them in the present. It might also be projected onto another situation, person, doctor, or facilitator through transference.

Jung’s fourth Transformation stage could encompass EsenciArt’s Creating/Reprogramming eighth and ninth Integrating phases. As a new prospect is learned, new awareness is integrated by both the client and facilitator.

No correlation was found between the author’s work and Jung’s third Education stage as expressed in the following quote: “*The importance of drawing the patient out of himself/herself is stressed, through education, in order to attain normal adaptation.*” In EsenciArt, the focus is on the opposite of drawing clients out of themselves. What is important is for clients to become more connected to their true self. Hence, a process of self-awareness emerges from this deeper connection.

However, in EsenciArt’s Creating eighth phase, clients consider a new prospect, that of creating what they longed for in the past, yet didn’t have, due to painful or traumatic experiences. Here, a new awareness emerges from this new prospect – which could be considered *re-education* – but it comes from clients going deeper into themselves and connecting to their longings. It is not about drawing clients out of themselves, although it could be understood that clients are stepping out of

their comfort zone, habitual patterns, and fixations – what they already know – toward a new prospect.

There seems to be no correlation between Jung’s stages and EsenciArt’s third Localizing phase and fifth Feeling phase. This could point towards a psychoanalytic mental approach such as Jung’s not giving much value to those EsenciArt phases that consider the physical body (Table 1). However, Jung ends his text by calling on doctors to include in their search for cures not only the body, but also the entire psyche. Thus, although there is a search for cures for body and psyche, there is no focus on the body, and it is not deemed to be an important source of information.

Table 2 Comparison between C. G. Jung’s 4 stages and EsenciArt’s 9 phases

C. G. Jung’s 4 Stages	EsenciArt’s 9 Phases	
Confession	Phases 1, 2, 4, 6	Connecting Discovering Entering Expressing
Elucidation	Phase 7	Remembering
Transformation & Education	Phase 8	Creating
Transformation	Phase 9	Integrating

The other author cited in this analysis is Peter Levine, who described nine steps in Somatic Experiencing®. The many correlations between the EsenciArt nine phases and nine steps in Peter Levine’s Somatic Experiencing can be seen in this chart:

Table 3 Correlations between Peter Levine’s nine steps in Somatic Experiencing and EsenciArt’s nine phases

Peter Levine Nine Steps of Somatic Experiencing	EsenciArt Nine Phases of Transformation
Step 1. Establishing an environment of <i>relative safety</i> .	Phase 1. Connecting: Becoming present. Establishing trust and safety. Connecting with authenticity and self-awareness.
Step 2. Supporting initial exploration and acceptance of sensations.	Phase 2. Discovering: Detecting the issue, the discomfort.
Step 3. Establishing pendulation and containment: the innate power of rhythm.	Phase 3. Localizing the issue in the body. Awareness of physical sensations.
Step 4. Using titration to create increasing stability, resilience, and organization. Titration carefully delving into the smallest drop of survival-based arousal, and other difficult sensations, to prevent retraumatization.	Phase 4. Entering towards the core of the issue or discomfort. Phase 5. Feeling, embodying, matching the issue or discomfort.

Peter Levine <i>Nine Steps of Somatic Experiencing</i>	EsenciArt <i>Nine Phases of Transformation</i>
<p>Step 5. Providing a corrective experience by supplanting the passive responses of collapse and helplessness with active, <i>empowered</i>, defensive responses.</p> <p>Step 6. Separating or uncoupling the conditioned association of fear and helplessness from the normally time-limited but now maladaptive biological immobility response.</p>	<p>Phase 8. Creating: Receiving a new healing response to the old wound or trauma. Considering a new prospect.</p>
<p>Step 7. Resolving hyperarousal states by gently guiding the discharge and redistribution of the vast survival energy mobilized for life-preserving action, while freeing that energy to support higher-level brain functioning.</p>	<p>Phase 6. Expressing the issue or discomfort.</p>
<p>Step 8. Engaging self-regulation to restore dynamic equilibrium and relaxed alertness.</p>	<p>Phase 1. Connecting Phase 8. Creating</p>
<p>Step 9. Orienting towards the here and now, contacting the environment, and reestablishing the capacity for social engagement.</p>	<p>Phase 1. Connecting: Becoming present. Phase 9. Integrating the healing response. Assuming the change. Integrating the new pattern into one's life. Sharing what is new.</p>

The only phase not mentioned is EsenciArt's phase 7: Remembering/recovering memories. However, the focus of Peter Levine's Somatic Experiencing seems to be on healing trauma, which is about working with

memory or traumatic experience from the past. So EsenciArt's phase 7 could be seen as inherent to all nine steps of Somatic Experiencing, and not only to one specific step.

Table 4 Comparison between Peter Levine's steps and EsenciArt's phases

Peter Levine's 9 Steps	EsenciArt's 9 Phases
Step 1	Phase 1 Connecting
Step 2	Phases 2, 3 Discovering, Localizing
Step 3	Phases 2, 3 Discovering, Localizing
Step 4	Phases 4, 5 Entering & Feeling
Step 5	Phase 8 Creating
Step 6	Phase 8 Creating
Step 7	Phase 6 Expressing
Step 8	Phase 1 Connecting
Step 9	Phase 1, 9 Connecting & Integrating

Table 5 Comparison between EsenciArt's phases, C. G. Jung's stages, and Peter Levine's steps

EsenciArt's Phases	Jung's Stages	Levine's Steps
Phase 1 Connecting	Confession	1, 8
Phase 2 Discovering	Confession	2, 3
Phase 3 Localizing		1 through 9
Phase 4 Entering	Confession	4
Phase 5 Feeling		4
Phase 6 Expressing	Confession	7
Phase 7 Remembering	Elucidation	1 through 9
Phase 8 Creating	Transformation, Education	5, 6, 8
Phase 9 Integrating	Transformation	1, 9

Modalities Included in this Study

For the purposes of this study and its hypotheses, both complementary and traditional medicines have been considered.

The World Health Organization (WHO) defines Traditional Medicine (TM) and Complementary Medicine (CM) as follows:

“Traditional medicine has a long history. It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illness.”

The terms “complementary medicine” or “alternative medicine” refer to a broad set of health care practices that are not part of a country’s own tradition or conventional medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries³”

The author is aware that in certain countries, for legal reasons, the words “therapeutic,” “therapy,” or “therapist” can be used only when referring to conventional medicine. These words aren’t legally used when referring to complementary medicine, but instead, words like “modality,” “method,” “approach,” “professional,” “practitioner,” or “facilitator” can be used.

Therefore, in this paper, for the purpose of clarity, when the word “modality” or “method” is used, it is meant to include both TM and CM. And when the words “practitioner,” “facilitator,” or “professional” are used, they are also meant to include both TM and CM professionals.

We are aware of the controversy in complementary medicine caused by the use of the words “patient” and “client.” In this text, the word “client” has been chosen as a means of including both of these terms, due to their use in various modalities. The only exceptions can be found in direct quotations where the terms have not been changed.

The survey for this study was sent to 155 healthcare professionals from 35 countries and 32 different modalities. For a comparative analysis between the different modalities, the 155 professionals interviewed were asked to define – by means of answering a survey – which of these three modalities would best describe their area of work:

1. Mind Therapy
2. Body Therapy
3. Body-Mind Therapy

For this study, the author has defined the three approaches as:

- **Mind Therapy.** Modalities that focus on the mind and psychological aspects. It does not include touch and does not focus on the physical body.
- **Body Therapy.** Modalities that focus on the physical body and may or may not work with touch, but do not focus on psychological components.
- **Body-Mind Therapy.** Modalities that work with both the physical body (through touch, movement and/or observations) and psychological aspects.

For the 32 modalities included in this study and the self-classification of participants among the different approaches, see *Supplementary Table 1*. Although definitions of terms may vary from country to country and from health system to health system, definitions from at least two different sources have been used in this study. The definitions used to define traditional medicine and therapies are those of the Merriam-Webster dictionary (United States). To define complementary medicine in this work, both the Cochrane Library (based in the United Kingdom with the collaboration of 90 countries) and the specific web pages of the founder of each method have been used.

Definitions of Traditional Medicine and Therapies

(from the Merriam-Webster dictionary, 2019)

- **Psychotherapy.** Treatment of mental or emotional disorder or of related bodily ills by psychological means.
- **Psychology.** The science of mind and behavior. The study of mind and behavior in relation to a particular field of knowledge or activity.
- **Psychoanalysis.** A method of analyzing psychic phenomena and treating emotional disorders that involves treatment sessions during which the patient is encouraged to talk freely about personal experiences and especially about early childhood and dreams.
- **Psychiatrist, Psychiatric Social Worker.** A medical doctor who diagnoses and treats mental, emotional, and behavioral disorders. A specialist in psychiatry: a branch of medicine that deals with mental, emotional, or behavioral disorders.
- **Social Worker.** Any of various professional activities or methods concretely concerned with providing social services and especially with the investigation, treatment, and material aid of the economically, physically, mentally, or socially disadvantaged.
- **Physician, Medical Doctor.** A person skilled in the art of healing specifically, someone educated, clinically experienced, and licensed to practice medicine as usually distinguished from surgery.

3. World Health Organization. (2014). Traditional, complementary and integrative medicine. Retrieved August 11, 2019, from <https://www.who.int/traditional-complementary-integrative-medicine/about/en/>

- **Physiotherapist, Physical Therapy.** Therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by disease, injury, or disability that utilizes therapeutic exercise, physical modalities such as massage and electrotherapy, assistive devices, and patient education and training.
- **Nutritionist.** A specialist in the study of nutrition, the act or process of nourishing or being nourished.

Definitions of Complementary Medicine and Methods (from the Cochrane Library, 2019)

- **Acupuncture.** This therapy is used to relieve pain, improve well-being, and treat acute, chronic, and degenerative conditions in children and adults. In Asian medicine, acupuncture needles are inserted at specific points to stimulate, disperse, and regulate the flow of chi, or vital energy, and restore a healthy energy balance.
- **Homeopathy.** This medical system uses minute doses of natural substances—called remedies—to stimulate a person's immune and defense system. A remedy is chosen individually for a sick person based on its capacity to cause, if given in overdose, physical and psychological symptoms similar to those a patient is experiencing.
- **Gestalt Therapy.** This psychotherapy aims to help clients achieve wholeness (gestalt is the German word for whole) by becoming fully aware of their feelings, perceptions, and behavior. The emphasis is on immediate experience rather than on the past. Gestalt therapy is often conducted in group settings such as weekend workshops.
- **Osteopathy.** Like medical doctors, osteopathic physicians provide comprehensive medical care, including preventive medicine, diagnosis, surgery, prescription medications, and hospital referrals. In diagnosis and treatment, they pay particular attention to the joints, bones, muscles, and nerves and are trained specially in osteopathic manipulative treatment, using their hands to diagnose, treat, and prevent illness.
- **Massage Therapist.** This general term describes a range of therapeutic approaches with roots in Eastern and Western cultures. Massage therapy involves the practice of kneading or otherwise manipulating a person's muscles and other soft tissue with the intent of improving a person's well-being or health.
- **Pilates Personal Trainer.** Pilates Method.
- **Cranial Sacral Therapy.** A manual therapeutic procedure used to remedy distortions in the structure and function of the cranosacral mechanism which includes the brain and spinal cord, the bones of the skull, the sacrum, and interconnected membranes. The procedure is used to treat chronic pain, migraine headaches, temporomandibular joint disease, and

a range of other conditions and is performed by a range of licensed health practitioners.

- **Bach Flower Essences.** Popularized by Edward Bach, M.D., flower essences are intended to alleviate negative emotional states that may contribute to illness or hinder personal growth. Drops of a solution infused with the captured essence of a flower are placed under the tongue or in a beverage. The practitioner helps clients choose appropriate essences, focusing on their emotional state rather than on a particular physical condition.
- **Naturopathy Medicine.** This primary health care system emphasizes the curative power of nature and treats acute and chronic illnesses in all age groups. Naturopathic physicians work to restore and support the body's own healing ability using a variety of modalities, including nutrition, herbal medicine, homeopathic medicine, and Asian medicine.
- **Shiatsu Practitioner.** The most widely known form of acupressure, shiatsu has been used in Japan for more than 1,000 years to treat pain and illness and for general health maintenance. Using a series of techniques, practitioners apply rhythmic finger pressure at specific points on the body to stimulate chi, or vital energy.
- **Shamanic Healing Work.** Practitioners of spiritual healing and shamanic healing often regard themselves as conductors of healing energy or sources from the spiritual realm. Both may call on spiritual helpers such as power animals (characteristic of the shaman), angels, inner teachers, the client's higher self, or other spiritual forces. Both forms of healing can be used as part of treatment for a range of emotional and physical illnesses.
- **Reiki.** Practitioners of this ancient Tibetan healing system use light hand placements to channel healing energies to the recipient. Although practitioners may vary widely in technique and philosophy, Reiki commonly is used to treat emotional and mental distress and chronic and acute physical problems, and to assist the recipient in achieving spiritual focus and clarity.
- **Energy Field Work.** Practitioners of this range of therapies look for weaknesses in the person's energy field in and around the body and seek to restore its proper circulation and balance. Energy channeled through the practitioner is directed to strengthen the natural defenses of the body and help the person's physical, mental, emotional, and spiritual state. Sessions may or may not involve the physical laying-on of hands.

Complementary Medicine and Methods (not defined in the Cochrane Library. They are defined by their own authors or web pages.)

- **Body-Mind Process.** Accredited by an international university as MSc in Psychosocial, Complementary and Integrated Health Science, the Body-Mind Pro-

cess looks at the relationship between the physical body and the mind (that is, beliefs, thoughts, emotions, behavioral patterns, etc.), looking into how some of the affections of the physical body have an origin in the mind, and vice versa. It understands the human being as an integrated unit, where all systems are interconnected. BMP is an efficient response to processes where physical symptoms are produced by our unconscious. It allows the Body-Mind connection to be reestablished in any place where either dissociation of body-mind or any other unconscious defense mechanisms are at play.⁴

- **Brennan Healing Science.** An enlightening system of healing that combines hands-on healing techniques with spiritual and psychological processes touching every aspect of your life. Based on the living dynamics of our Human Energy-Consciousness System and its relationship to the greater world of which we all are intimately a part, Brennan Healing Science can transform a client's life into the balanced, enlightened experience of mystery that they have always wanted it to be.⁵
- **Psychoenergetics.** A multidisciplinary, body-mind approach to understanding and applying depth psychology to a particular style of process facilitation. The method supports a deepening and awakening process through the embodied and mindful presence of the practitioner which accelerates and amplifies the practitioners' professional development, as well as their clients' personal healing and growth. This leads to significant, meaningful, and sustainable transformational work.⁶
- **Somatic Experiencing.** The Somatic Experiencing method is a body-oriented approach to healing trauma and other stress disorders. It is the life's work of Dr. Peter A. Levine, resulting from his multidisciplinary study of stress physiology, psychology, ethology, biology, neuroscience, indigenous healing practices, and medical biophysics, together with over 45 years of successful clinical application. The SE approach releases traumatic shock, which is key to transforming PTSD and the wounds of emotional and early developmental attachment trauma.⁷
- **Family Constellations.** A method that takes place in a group under the guidance of one person. It helps people uncover the backgrounds of failure, illness, disorientation, addiction, or anything similar. Family Constellation is useful wherever there is a direct need for action or decision-making. Bert Hellinger is the founder of Family Constellations.⁸

- **Yuen Method.** The Yuen Method is the resulting product of ancient Chinese Shaolin temple energy harnessing methods combined with the knowledge offered collectively by anatomy, physiology, structural analysis, energetic techniques, quantum physics and Qi and Shen Gong. The Yuen Method was created by Dr. Kam Yuen as a result of his lifelong study and experience with martial arts, nutritional therapy, homeopathy, and in-depth experience as both a structural engineer and chiropractic doctor.⁹
- **Hakomi.** Mindfulness-based assisted self-discovery, originally developed by Ron Kurtz.¹⁰

No definitions were found for Exercise Specialist, HSP, Energy Polarization.

Methodology

A survey was conducted – combining both quantitative and qualitative analyses – to test the hypothesis of this research.

Correspondences and differences between various approaches were extracted from responses to this survey consisting of 21 questions posed to 155 practitioners from 35 countries from 32 therapies and modalities. 120 participants were female; 35 participants were male. Ages ranged from 18 to 74 years old. Expertise ranged from students with no professional experience to practitioners with 40 years of professional experience.

Survey Development

For this study and its research questions, the author developed a survey to be answered once. No control phases or control group were needed. The survey was conducted by first describing the 9 phases observed by the author in the transformation/healing processes she experienced personally, and during sessions with clients and students.

The survey has three parts:

1. **Questions 1 to 10** gathered information about the practitioners: modality, years of training, years of professional practice, self-classification of their work, other trainings, gender, age, country, etc.
2. **Questions 11 to 19** asked the practitioners about how relevant they considered the EsenciArt 9 Phases of Transformation to be in the work they usually carry out with clients.

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3. **Questions 20 and 21** gathered information about the practitioners' careers, focusing on how they expressed in their own words the healing process they have witnessed with clients as well as personally as practitioners.

This survey made use of quantitative and qualitative analyses:

- **Quantitative analysis** – Questions 11 to 19
The description of the phases was established in the survey with the request to practitioners from different modalities to consider how relevant those phases were in their work and assigning each phase a value between 0 and 10, with “0” being not relevant and “10” very relevant.
- **Qualitative analysis** – Questions 20 and 21
As optional questions, the practitioners were asked the following:
Q20: Please describe what you witnessed in a case that was healing/transformational for a client.
Q21: Please describe what you witnessed in your own experience as a therapist or practitioner at that moment.

Selection Criteria

Participants were selected using two different channels:

1. The survey was first given in writing to a group of practitioners, colleagues, students, and teachers from the Master of Science degree in Psychosocial, Complementary, and Integrated Health Science at the Inter-University College Graz, Seggau, to be filled out through an alphanumeric code of two letters and two numbers in order to maintain the anonymity of practitioners and their responses.
2. Three different channels were used to obtain further responses from professionals:
 - Two emails were sent, one in Spanish and the other in English, to members of the author's contact list, describing this study and asking for volunteers. These healthcare professionals were asked to fill out the survey.
 - On Facebook, the author searched for groups and healthcare pages linked to the three approaches analyzed in this study (Mind therapy, Body therapy and Body-Mind therapy). Several Facebook groups and pages were contacted by the author, who posted a description of the study and a request for professionals to participate.
 - The last channel chosen was WhatsApp. A text message was sent to members of the author's contact list with the description of the study and a request for professionals to participate.

For online responses, the data was collected using Survey Monkey, an online survey development cloud-

based software. The data collected were used only for this study. Participants agreed to a privacy policy. The Survey Monkey software guaranteed confidentiality through the General Data Protection Regulation (GDPR) of May 25, 2018, as described on its web page <https://www.surveymonkey.com/mp/gdpr/>. Ethical approval was obtained from the Inter-University College Graz's Ethics Committee, Seggau (Austria). No institutions were involved in this study except for the Inter-University College Graz, Seggau (Austria).

The study faced some limitations in terms of data gathering. First, there are so many kinds of therapies and healing modalities in the world that rarely can enough data be gathered from all of them. Many participants came on board through social media, where the project was presented in as many therapy Facebook groups as possible. Not all those groups accepted the project, and not all the existing therapy Facebook groups in the world were contacted – only groups the author found to be more receptive to the project. Also, some therapy schools that were contacted did not provide a response. Therefore, further data gathering would be desirable and necessary to conduct further research.

Participants

155 practitioners from 32 modalities, 35 countries, between 18–74, responded to the “call” and completed the survey. 120 were female and 35 were male.

The survey was not stratified, so the results are not statistically significant. This is only a descriptive article, although it also uses statistical methods.

Years of Experience

Of these 155 practitioners, 21 (13.5%) had between 20–40 years of experience; 24 (15.5%) had between 11–19 years of experience; 42 (27.1%) had between 6–10 years of experience, 52 (33.5%) had between one to five years of experience, and 16 (10.3%) had less than one year of experience.

Approaches

Practitioners were asked to classify their work into one of the following three groups.

Table 6 Percentage of professional per approach

Approach	% Professionals
Mind	31 (20.0%)
Body	39 (25.2%)
Body-Mind	78 (50.3%)
Others	7 (4.5%)

All professionals agreed on the approach for their modality, except for psychotherapy, where five of the 17 professionals classified theirs under the Mind approach, while the remaining 12 did so under the Body-Mind approach.

Countries

Practitioners from 35 countries participated in this study. 49 participants (32%) were from Spain, 20 (13%) from the United States of America, and 31 (20%) from Germany, Pakistan, Portugal, the UK, and Northern Ireland. Supplementary Table 2 shows the details.

Inclusive and Exclusive Criteria

- Only students and professionals from the health-care/therapeutic field were included in this study.
- For the research and hypothesis of this study – and to carry out a comparative analysis within different

groups regarding approaches, years of practice, gender, etc. – all 155 practitioners who volunteered to complete the survey were included.

Results

Quantitative Analysis Results. The responses of the 155 practitioners to how much value and relevance they gave to each of the EsenciArt 9 Phases of Transformation show that on a scale from 0 to 10, with 0 being not relevant and 10 very relevant, the average given was 9 for all the 9 phases. Phase 1 Connecting, Phase 2 Discovering, Phase 8 Creating, and Phase 9 Integrating were given a value higher than 9. Phase 3 Localizing, Phase 4 Entering, Phase 5 Feeling, Phase 6 Expressing, and Phase 7 Remembering were given a value between 8 and 9 (see Figure 1). Supplementary Table 3 also shows a summary for the maximum and minimum values participants assigned to the 9 phases.

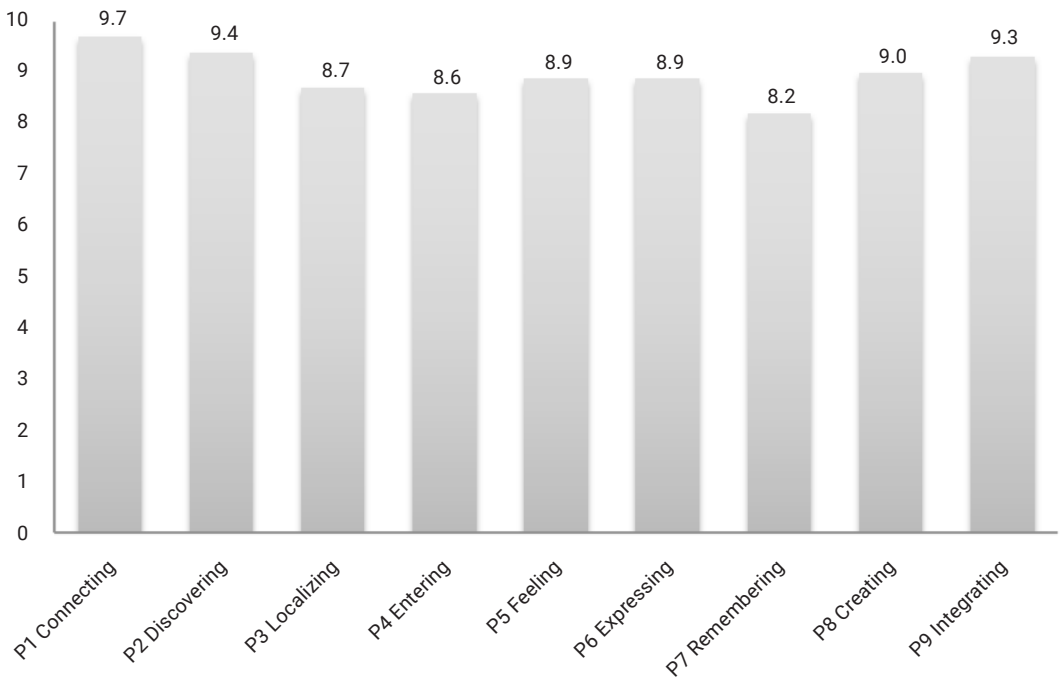


Figure 1 Average values per phase for all participants and modalities

The results show that in terms of gender differences, there was a slight tendency of female participants to rate the 9 phases a little lower than males (see Supplementary Figure 1), by a maximum of 0.3 points.

In Supplementary Figure 2, a comparative quantitative analysis among the three approaches, where the practi-

tioners classified their own work, revealed the following results:

Participants from all approaches assigned an average value of 9 to all 9 phases. This confirms the hypothesis that there are common elements in the therapeutic process beyond the methods used.

It might also be a confirmation that there is an inherent human tendency to heal, given the right conditions.

The Mind-Body approach group gave the highest values to each of the 9 phases (100%), with the average value of all 9 phases being 9.3. On the other hand, the Mind approach as well as the Body approach groups gave an average value of 8.6 to all 9 phases.

It can be understood that the Body-Mind approach would give higher values to the 9 phases because it is the same approach from which the author made her observations.

The Mind approach group's highest values: There was a tendency from the Mind approach to give lower values in general (8.6 average for all phases) than those of the other two approaches. This tendency changed for phase 6 Expressing and phase 7 Remembering, which were given the highest values. Phase 7 being the phase that focuses most on psychological aspects. Phase 6 "Expressing" can also be considered Mind-oriented when expression occurs mostly through words and by using analysis.

The Mind approach group's lowest values: The phases that were given the lowest values by the Mind approach were phase 3 Localizing in the body (8.1) and phase 4 Entering (7.6). Phase 3 is one of the phases that focuses most on the physical body. Phase 4 in turn requires both the mind (focusing attention and curiosity) and body (breathing and/or touching).

The Body approach group's highest values were for phase 1 Connecting (9.6) and phase 2 Discovering (9.4). The phases that were supposed to focus more on the physical body – phase 3 Localizing (8.4) and phase 5 Feeling (8.7) received neither the highest nor lowest scores.

The Body approach group's lowest values were for phase 6 Expressing and phase 7 Remembering, which are the two phases that focus most on psychological aspects and have a more mind-directed approach, where (as noted above) expression happens mostly through words and by using analysis.

Considering the different approaches, as well the years of professional experience, there were no significant differences between the values given to the 9 phases among practitioners with more than 20 years and those with less than one year of professional experience (see Supplementary Figure 3).

By comparing the three groups to each phase, we found the following statistically significant differences:

1. Regarding phase 1, there was a statistically significant difference between the Mind and Body-Mind groups ($< .01$), but not between the Mind and Body nor between the Body and Body-Mind groups.
2. Regarding phase 3, there was a statistically significant difference between the Mind and Body-Mind

groups ($< .05$), and between the Body and Body-Mind ($< .05$), but not between the Mind and Body groups.

3. Regarding phase 4, there was a statistically significant difference between the Mind and Body-Mind groups ($< .001$), and between the Body and Body-Mind ($< .05$), but not between the Mind and Body groups.
4. Regarding phase 5, there was a statistically significant difference between the Mind and Body-Mind groups ($< .001$), and between the Body and Body-Mind ($< .01$), but not between the Mind and Body groups.
5. Regarding phase 6, there was a statistically significant difference between the Body and Body-Mind groups ($< .01$), but not between the Mind and Body, nor between the Mind and Body-Mind groups.
6. Regarding phase 7, there was a statistically significant difference between the Body and Body-Mind groups ($< .05$), but not between the Mind and Body, nor between the Mind and Body-Mind groups.

Qualitative analysis results. Two optional questions were included in the questionnaire in order to undertake a qualitative analysis for this study. Practitioners were asked to describe in their own words the healing processes they had witnessed in their work with clients and within themselves. These two questions were:

- Q20: Please describe what you witnessed in a case that was healing/transformational for a client.
- Q21: Please describe what you witnessed in your own experience as a therapist or practitioner at that given moment.

Of the 155 practitioners, only 85 responded to Q20 and 70 to Q21. From these answers, the author observed correspondence with the *EsenciArt 9 Phases of Transformation* and analyzed the content and wording of every answer to see if there was any correlation with any particular phase.

- *The following results were obtained for Q20*

The self-classified Mind approach group did not include the physical body in any of their descriptions, with Phase 3, Localizing in the physical body, not mentioned at all (0%). The phase that was most described was Phase 2, Discovering (40%), together with phase 1 Connecting (33,30%), as well as phase 7 Remembering (33,3%). Both phase 2 (discovering the issue) and phase 7 (remembering the issue's causes) are the two phases featuring the most psychological elements out of the *EsenciArt 9* phases.

The only phase not mentioned by the self-classified Body approach group was phase 4, Entering towards the core of the disturbance (0%), which has both psychological and physical body elements (when the disturbance is a physical pain or a physical issue).

The phases that were most described were phase 2: Discovering, and phase 8: Creating/Reprogramming, which again have both psychological and physical body elements (when the Creating/Reprogramming is, for instance, a readjustment of physical posture).

The self-classified Body-Mind approach group was the only group that included elements from all EsenciArt's 9 phases in their descriptions.

■ *The following results were observed for Q21*

When it comes to the analysis of the practitioners' responses regarding what they personally experience during a healing process, session, or moment, most practitioners (60 out of 70 responses) – beyond their own approaches – describe elements from phase 1 Connecting with the self and client by becoming present, available, curious, respectful, etc. This points towards the importance of practitioners being present, connected, respectful, trusting, and caring as optimal conditions to activate an organic healing process in human beings.

Discussion and Conclusion

There are countless approaches to healing and transformational processes. By looking at what these approaches share in common, this study aims to find a common system or protocol, a language that can be useful to describe the inherent human capacity to heal, and the right conditions for this process to emerge.

Our results show that professionals from different modalities and approaches identify and value common phases and elements in healing and transformational processes, as described in the EsenciArt 9 Phases of Transformation Protocol, with an average of 9 out of 10 confirming the hypothesis of this study.

As stated previously, Jung (1966) identified four stages in analytical psychology. No correlation was observed between them and EsenciArt's third phase, Localizing in the physical body.

As Jung was psychoanalytic, a comparison was made to the results obtained from the psychoanalytic group. This psychoanalytic group self-classified themselves as part of the Mind approach. For this group, the *EsenciArt* third phase, Localizing (in the physical body) had the second lowest values, although the value was still high, with an average of 8.1. (Figure 3).

A similar tendency was observed after carrying out a qualitative analysis: The Mind group did not mention any element that included the physical body in their description. Therefore, the third phase: localizing (in the physical body) was not alluded to (0%).

The Mind group rated this third phase the lowest (for being related to the physical body), as was estimated.

Hence, our results show certain differences amongst the three approaches. Consequently, the Mind approach group was defined as different from both the Body and the Body-Mind approach groups, with the latter being the one with the highest values and therefore the most representative of the EsenciArt system.

There is no evidence of the most experienced professionals identifying and evaluating the EsenciArt 9 phases more clearly or with higher values. On the contrary, all professionals, beyond their years of experience, rated the 9 phases with averages ranging between 7.8 and 9.9.

At the beginning of this study, we wondered if human beings have – as part of their inherent nature – an organic healing “protocol,” process, or tendency to heal that is activated under the right conditions of presence, connection, respect, trust, and care. At the end of this study, we can confirm the first part of the statement, and linked to it in regard with the possible existence of a healing process that professionals can recognize, regardless of their background and modality. The qualitative analysis also pointed towards the importance of practitioners being present, connected, respectful, trusting, and caring, with these being the optimal conditions to activate an organic healing process.

Bigger samples should be analyzed, and we encourage future researchers to test a higher number of professionals and include different ways of measuring the impact of presence, connection, respect, trust, and care in healing and transformational processes in order to help answer the questions “what heals, and how does healing proceed?” We believe this could lead to profound changes in our health system, lifestyle, and ways of relating to oneself and each other.

We hope this study can help people in their vital research towards understanding themselves and their potential for optimum health and wellbeing.



Appendix

Supplementary Table 1 The 32 modalities included in this study and the self-classification of participants amongst the different approaches

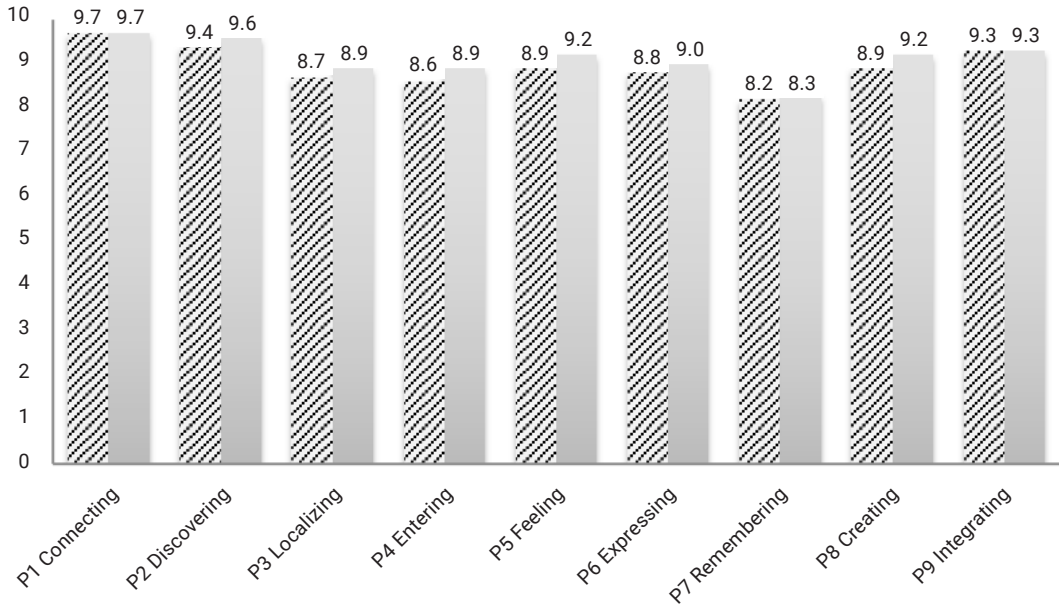
Modalities	Approaches			
	Mind	Body	Body-Mind	Other
Brennan Healing Science®			25	
Psychologist	23			
Psychotherapy	5		12	
Brennan Integration Work® (BIW)			13	
Physiotherapist		11		
Massage Therapist		10		
Body-Mind Process			9	
Gestalt			7	
Psychoenergetics			6	
Osteopath		4		
Acupuncturist		3		
Pilates/Personal Trainer		3		
Homeopathy			3	
Psychoanalysis	2			
Physician. Medical Doctor		2		
Psychiatrist/Psychiatric Social Worker			2	
Family Constellations practitioner				2
Hypnotherapy	1			
Cranial-Sacral Therapy		1		
Exercise specialist		1		
Reiki (& Yuen Method)		1		
Naturopathy Medicine		1		
Shiatsu Practitioner		1		
Nutrition		1		
Somatic Therapy			1	
Bach Flower Essences				1
Being with HSP				1
Energy Polarization				1
Hakomi				1
Shamanic Healing Work				1

Supplementary Table 2 *Participation by country*

Country	Participation	Country	Participation
Spain	49 (31.6%)	Italy	2 (1.3%)
United States of America	20 (12.9%)	Slovenia	2 (1.3%)
Portugal	9 (5.8%)	Turkey	2 (1.3%)
Pakistan	8 (5.2%)	Andorra	1 (0.6%)
Germany	7 (4.5%)	Argentina	1 (0.6%)
UK and Northern Ireland	7 (4.5%)	Australia	1 (0.6%)
India	5 (3.2%)	Chile	1 (0.6%)
Switzerland	5 (3.2%)	Côte d'Ivoire	1 (0.6%)
Belgium	4 (2.6%)	Croatia	1 (0.6%)
Mexico	4 (2.6%)	Greece	1 (0.6%)
Austria	3 (1.9%)	Ireland	1 (0.6%)
El Salvador	3 (1.9%)	Luxembourg	1 (0.6%)
Netherlands	3 (1.9%)	Nigeria	1 (0.6%)
Canada	2 (1.3%)	Philippines	1 (0.6%)
Colombia	2 (1.3%)	South Africa	1 (0.6%)
Czech Republic	2 (1.3%)	United Arab Emirates	1 (0.6%)
France	2 (1.3%)	Vietnam	1 (0.6%)

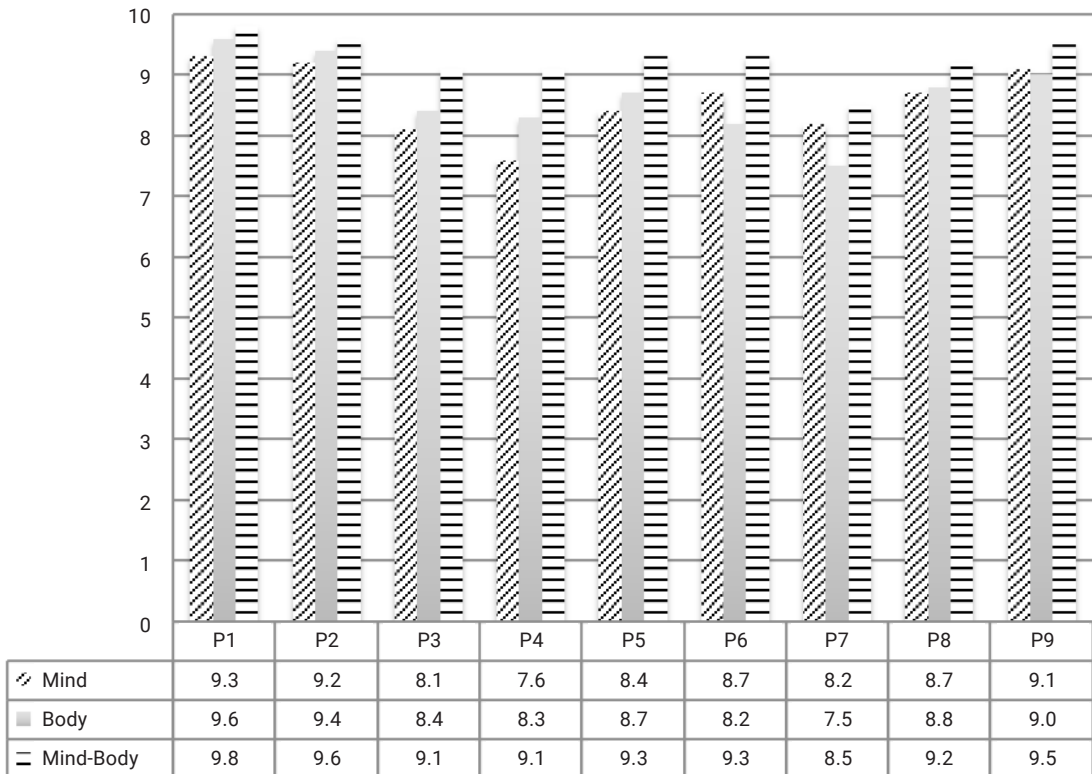
Supplementary Table 3 *Relevancy of phases results*

	Total	P1	P2	P3	P4	P5	P6	P7	P8	P9
<i>Participants</i>	155	132	130	130	126	127	128	127	128	129
<i>Max value</i>	10	10	10	10	10	10	10	10	10	10
<i>Min value</i>	0.0	5.0	4.0	2.0	2.0	4.0	0.0	2.0	4.0	4.0
<i>Average</i>	9.0	9.7	9.4	8.7	8.6	8.9	8.9	8.2	9.0	9.3

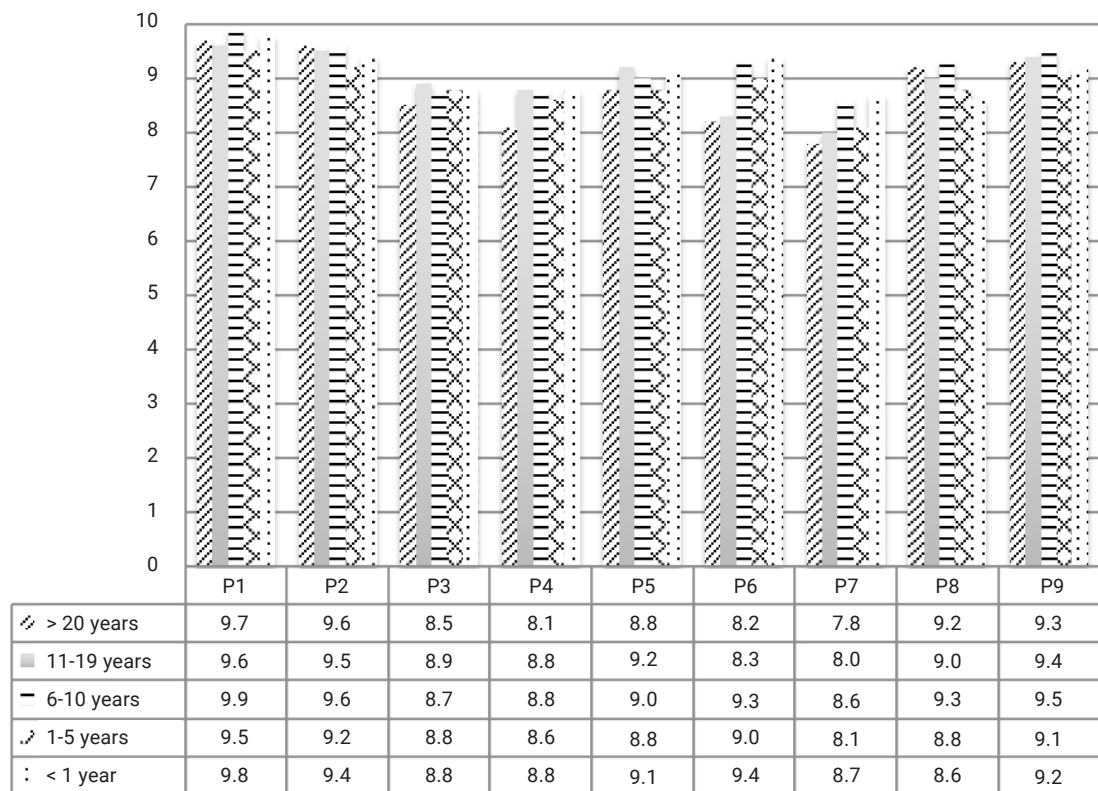


Supplementary Figure 1 Value of the 9 phases by gender

▨ Female ■ Male



Supplementary Figure 2 Approach-based rating given to the 9 phases



Supplementary Figure 3 Value of the 9 phases according to years of professional experience



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Body Psychotherapy in the Playroom

A Somatic Approach to Working with Child Clients

Jennifer L. Taylor

ABSTRACT

This paper proposes a theoretical model of play therapy that blends developmental neurobiology perspectives with tenets of body psychotherapy. The author suggests that the current application of neurodevelopmental principles in play therapy can be bolstered by somatic interventions that foster integration between the body and mind of the developing child. The topics of regulation, attunement, and interoception are explored from a somatic lens, and therapeutic applications are considered. This paper sets forth an integrative, trans-theoretical approach of incorporating body psychotherapy principles in the playroom.

Keywords: body psychotherapy, play therapy, somatic psychology, regulation, attunement, interoception

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his paper explores a theoretical model that melds the disciplines of play therapy and body psychotherapy. The topics of regulation, attunement, and interoception will be explored from a somatic lens, underpinned by the current literature in attachment and developmental neurobiology. While many varying models of play therapy exist, this paper offers an integrative, trans-theoretical approach of incorporating body psychotherapy principles in the playroom.

Literature Review

Contending with chronic stress, neglect, abuse, or trauma is detrimental to the physical and emotional health of all beings, but it is especially deleterious to the brain and nervous system of a developing child (Perry, 2006; Schore, 2009; van der Kolk, 2015). Adverse experiences in early infancy and childhood can have lifelong impacts on the emotional, physical, neurological, and behavioral health and wellbeing of the child (Kain & Terrell, 2018; Ogden, Pain, & Fisher, 2006b; van der Kolk, 2015). It is estimated that 74% of individuals who contend with mental health issues in childhood will continue to cope with similar concerns in adulthood (Leggett & Boswell, 2017). Thus, addressing childhood mental health concerns is important not only for the child, but for the adult they will become, and ultimately carries larger societal implications.

It is imperative that therapeutic interventions are developmentally appropriate and match the physiological and emotional needs of the child in order to be successful (Perry, 2006). Play is a basic and essential component of childhood and development; thus, play therapy offers a developmentally appropriate modality when working with children (Dion, 2018; Leggett & Boswell, 2017).

Children operate from a sensorimotor, bottom-up, emotional system, and are not yet able to effectively utilize their higher cortical functioning and cognitive reasoning capacities.

Play Therapy: An Overview

Play is the way in which children learn to construct their world, gain social skills, develop expressive language and emotional capacities, and cope with their inner feelings and external surroundings. Play therapy is an especially appropriate approach to working with children because it is how children inherently communicate their inner worlds through the projective process of play. Often, more can be deduced by how a child plays than through the words they use, as language is not yet fully developed and emotions are not easily articulated (Lin, 2015).

The Association for Play Therapy (2014) broadly defines play therapy as the ways in which trained clinicians employ the therapeutic powers of play to help child clients work through and resolve psychological, social, and emotional difficulties in order to achieve optimal growth and development. There exist four main theoretical models of play therapy: psychoanalytic, humanistic, behavioral, and developmental (Gil, 1998). Each model has its own theory on how best to approach play in a therapeutic context. Play therapists typically fall into directive or non-directive orientations, differing in opinion on how involved the therapist should be in setting up, participating, intervening, and creating meaning during play. While empirical evidence for the effectiveness of play therapy interventions is notably lacking, a 2005 meta-analysis showed favorable treatment outcomes for a more humanistic orientation to play therapy as opposed to non-humanistic models (Bratton, Ray, Rhine, & Jones, 2005).

Neurodevelopment and the Nervous System at a Glance

Garnering a basic understanding of how the brain and nervous system process information and respond to real or perceived threat helps clinicians understand what is going on in the mind and body of their client. This understanding allows clinicians to tailor their approaches in ways that meet the child's needs in real time (Perry, 2006). Thus, acquiring an operative appreciation of neurodevelopment and the nervous system can help the somatically oriented play therapist target interventions in a way that accesses the neural networks responsible for emotional regulation, attunement to self and other, and somatic awareness of self in a developmentally appropriate way.

A neurodevelopmental approach. The brain is structured in a hierarchical manner that moves from primitive (brainstem) to complex (neocortex). All sensory information coming from both inside and outside the body must first enter lower brain regions (Perry, 2006). The brainstem, also referred to as the body brain,

is the only part of the brain fully developed at birth, and is responsible for basic survival functions (Badenoch, 2008; Cozolino, 2006; Ogden & Fisher, 2015). The brainstem also serves as a relay station between body and brain, interpreting sensory information and regulating internal physiological cues, and plays an important role in the interoceptive process – the ability to feel and know what one is feeling – all important considerations for the somatic play therapist. The limbic system is responsible for affective knowing and emotional responses and monitors the environment for danger and real or perceived threat. Lastly, the neocortex allows an individual to think, problem-solve, engage in abstract thought, and offers declarative knowledge; importantly, this area of the brain does not reach full development until the mid-twenties (Siegel & Bryson, 2016; van der Kolk, 2014). However, optimal functioning of the cortex is dependent upon the integration and regulation of lower cortical centers (Badenoch, 2008; Kestly, 2015; Perry, 2006). Thus, play therapists must learn to work with each of the three main brain centers: the body brain (brainstem), the emotional brain (limbic system), and the thinking brain (cortex).

Understanding the nervous system. As Kestly (2015) elucidates, it is more appropriate to refer to the brain as an “embodied brain,” as research makes it evident that brain functions are intricately interconnected and distributed throughout the body, with information processing and signaling moving in both a top-down (brain to body) and bottom-up (body to brain) fashion (Badenoch, 2010; Cozolino, 2010). The nervous system allows the brain and body to communicate in this bidirectional manner.

Developed by Porges (2011), the polyvagal theory offers an expounded explanation of the autonomic nervous system responsible for an individual's fight/flight/freeze/collapse response in the face of threat. Porges (2011) coined the term *neuroception*, which refers to the process by which neural circuits evaluate threat or safety. Neuroception of safety is the somatic felt sense that occurs when an individual perceives the environment to be safe and secure. When safety is established, humans can engage in ways that foster social connection and positive attachment, via what Porges (2011) refers to as the social engagement system. Infants, children, and adults alike will shut down this social engagement system in the face of threat. When frightened, subcortical brain regions take over and physical survival is prioritized, mobilizing the flight/fright/freeze or collapse response (Ogden & Fisher, 2015; Porges, 2011). If

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the individual perceives they can do something about the threat, the sympathetic nervous system will be activated as one prepares to fight or run from danger (e.g., the child that is brought to therapy for aggressive behaviors or anxiety). If, however, the threat seems insurmountable, the collapse response will be initiated, and symptoms of hypoarousal will be apparent (e.g., the depressed child client). Please refer to Figure 1 for an overview of symptoms of hyperarousal and hypoarousal, as tracking these cues will be important for the somatic therapist in the playroom.

Body Psychotherapy

Traditional approaches to mental health have focused on cognitive models of therapy, ignoring the body and its somatosensory experiences (Aposhyan, 2004; Kurtz, 2007; Ogden et al., 2006b). Children operate from a sensorimotor, bottom-up, emotional system, and are not yet able to effectively utilize their higher cortical functioning and cognitive reasoning capacities (Ogden & Minton 2000; Perry, 2006; Siegel & Bryson, 2016). Thus, early traumas and non-integrated stressors are primarily expressed and experienced through the body, not through words or cognitive understanding of events (Levine, 2010; Ogden et al., 2006a; van der Kolk, 2015). It is this understanding that underpins the theoretical rationalization for using a somatic approach in play therapy.

The somatic body psychotherapist facilitates body awareness and sensations in the client, helping the individual to slowly experience feelings and bodily cues that might have been previously heightened, cut off, or denied (Ogden et al., 2006). Body psychotherapists do not eschew the importance of cognition, but rather seek to include the implicit, relational ways of being and knowing that are hallmarks of embodied experience (Levine, 2010; Ogden et al., 2006a). The author has, and will, utilize the terms somatic and body psychotherapy interchangeably throughout this paper in reference to this body-centered approach that purports health is ultimately an individual's integration of their somatic, emotional, and cognitive self.

Attunement

Attachment and attunement. Attachment is the emotional bond between the infant and primary caregiver/s that shape the child's developing brain and nervous system, and has lasting impact on an individual's visceral, somatic, and non-verbal sense of self (Cozolino, 2010; Schore, 2009). The early child-caregiver relationship

is a dance of bodies and right-brain to right-brain attunement (van der Kolk, 2014). Through attuned caregiving, a parent can mirror and help an infant regulate their levels of emotional arousal, facilitate the infant's capacity to develop their own self-regulatory capacities, and come back to a state of homeostasis in the body. The emerging sense of self is first and foremost a body sense, in which an infant feels and communicates via sensations, emotions, and movement (Ogden et al., 2006b). It is this early implicit knowing, and its subsequent influence on patterning, beliefs, and emotional states, that are of interest to the body psychotherapist when working with child clients.

Van der Kolk (2014) states that children who do not receive physical attunement from caregivers are liable to shut down direct feedback from the body, impacting their ability to perceive somatic sensations later in life. Moreover, early attachment traumas impact the developing orbitofrontal cortex, a part of the brain that governs the unconscious processing of social and affective information, regulation of bodily states, and the ability to cope with stress and emotion (Ogden et al., 2006).

It is important to highlight the reciprocity involved in this attuned relationship, noting that both client and therapist impact one another (Dion & Gray, 2014). To truly be attuned to a client's internal and emotional world, it is necessary for the therapist to be open to, aware of, and in communication with their own somatic sensations (Badenoch, 2008; Dion & Gray, 2014). Thus, to foster this resonant relationship with a client, the somatically oriented therapist must work to become an embodied practitioner. It is through this nonverbal, attuned therapeutic relationship that a child can come to know and understand their emotional world, which subsequently impacts their ability to self-regulate through states of emotional intensity (Dion, 2018; Schore, 2012; Wallin, 2007).

Regulation

Regulation and co-regulation. Regulation refers to an individual's capacity to manage their emotional states (Kain & Terrell, 2018). It has been well-documented that regulation is a learned process. Parents play a critical role in teaching children how to soothe themselves in the midst of emotional intensity. Children develop this skill, either effectively or ineffectively, by observing and mirroring caregivers' responses to dysregulation, which in turn impacts how successfully they will regulate their own emotions and cope with stress, even as adults (Kain & Terrell, 2018; Siegel & Bryson, 2016). This process of helping a child manage emotions and find their way back

to a place of optimal arousal is known as co-regulation. Co-regulation is the back-and-forth dance between adult and child that is inherently somatic (Kain and Terrell, 2018). Regulation is

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important in the therapeutic context because cortical functioning goes offline during moments of very high or low arousal. Thus, attempting to talk or reason with a child when they are operating from subcortical regions will be largely ineffective. The somatic play therapist works to help children titrate their somatic and affective experience in ways that keeps the cortex “online.”

Fostering Somatic Awareness

Interoception. Interoception refers to an individual’s ability to detect internal sensations occurring in the body such as body temperature, heart rate, hunger, and other internal sensorial cues (Murphy et al., 2017). Porges (2011) refers to interoception as the infant’s sixth sense. It has been proposed that atypical interoception plays a causal role in the development of psychiatric disorders, with clients demonstrating a reduced ability to read cues from the body on the one hand, and hyperawareness to interoceptive signals on the other (Murphy et al., 2017). The role of the somatic therapist is to help clients become aware of, name, and appropriately respond to their interoceptive experience. Increased interoceptive and somatic awareness involves integration of multiple brain regions, and thus can assist in promoting both lateral and vertical connectedness of neural regions – helping children become aware of their sensations (bottom-up processing) and put words to their experience (top-down processing).

BODY PSYCHOTHERAPY IN THE PLAYROOM: A THEORETICAL MODEL

Language and words are cognitive in nature, and thus are not the natural communication style of children governed by a kinesthetic way of being in the world. Therefore, learning to engage with children on a nonverbal level is essential for play therapists, and provides the perfect platform to integrate somatic work. Many existing play therapy models recognize the importance of attunement, regulation, and somatic interventions in the playroom, though few come from a body psychotherapy orientation. The following framework is inspired by the tenets of Synergetic Play Therapy and the teachings of its creator, Lisa Dion. For a graphic representation of this theoretical model, please refer to Figure 1.

Calming the Limbic System: Attuning Through Mirroring

Understanding how nervous system cues manifest in the playroom has salient implications for the somat-

Feel it to heal it takes the naming of emotional states a step further by proposing the therapist embodies the emotional state in their own body, mirroring back to the child what the emotion looks like in an embodied sense.

ic therapist as they track the micro and macro movements of their clients, and use this information to guide their therapeutic approach. It is the somatic therapist’s responsibility to attend not only to what is said by the child, but also to the nonverbal communication of their body and their play. In this way, the somatic therapist gains insights into what the child client is unable to express consciously and mirrors it back to them in ways that can increase awareness and promote integration.

Naming emotional and somatic experience. Attunement requires connecting with the child and their emotional experience. Siegel and Bryson (2016) state “connect first, and solve second” (p. 36). The somatic therapist tracks the nervous system cues of the client, attunes to the setup and emotional resonance of the play, and reflects back an emotional understanding of what the child is communicating. This is a crucial first step, as this model proposes that emotional attunement must occur prior to any intervention. If the child is in a state of hypo- or hyperarousal, lower brain regions can become flooded with sensations and emotions. The “name it to tame it” strategy (Siegel and Bryson, 2016) serves a few functions. It has a regulatory affect in and of itself by naming and acknowledging what is occurring, which can help calm the amygdala’s alarm bell (Dion, 2018). It also brings higher cortical functioning online, helping children make sense of their emotions and sensations, and put words to their experience.

Attuning through the body. Building off the name it to tame it strategy, this author proposes a novel therapeutic intervention dubbed “feel it to heal it”. Feel it to heal it takes the naming of emotional states a step further by proposing the therapist embodies the emotional state in their own body, mirroring back to the child what the emotion looks like in an embodied sense. As the literature states, observation is one of the central ways children come to understand the world around them, and ultimately themselves (Dion, 2018). Wallin (2007) speaks to this experience as affect attunement, a type of collaborative communication that is emotionally congruent and contingent on what is happening in the moment. Embodied mirroring allows the child to realize their own emotional and sensorial states can be allowed, recognized, and shared by another. Mirroring, or posture sharing, generates a feeling of being with a client in a way that increases communication, a sense of being seen and felt, and builds rapport. It is important to note that mirroring is less about copying a posture exactly, and much more about resonating with the emotionality behind the embodiment, which sets the stage for affect regulation, discussed next.

Talking to the brainstem: regulating with breath, rhythm, and movement. Most children are brought to therapy due to behavioral concerns. It takes a perception shift to realize that all behavior is just an attempt to regulate the nervous system and offers communication about what the child is experiencing internally. If the therapist can hold this in mind, it is easier to understand and befriend the anxious, aggressive, or shutdown behaviors of the child, and help model new ways of coping with somatic and affective experiences.

It is in an environment of safety that one has access to their cognitive resources and social engagement system. Therapists cannot help a child access their higher cognitive brain functions if their lower brain regions are sounding the alarm. Thus, regulation of these sub-cortical structures must be a priority in the playroom. Regulation helps both child and therapist to titrate, befriend, and move through emotional intensity. The brainstem serves as the epicenter for the regulation of arousal (Levine, 2010). This interactive psychobiological regulation is nonverbal in nature, as the brainstem communicates and responds to movement, rhythm, and breath – not words. Regulation is used to allow both therapist and client to move towards the emotional and somatosensory experience together, as opposed to regulating out of any particular nervous system state (Dion, 2018). In this way, the therapist helps the child client to stay with emotion and sensation, thereby expanding their window of tolerance.

The somatic body psychotherapist. As regulation is primarily a somatic interaction, clinicians need to develop their own bodily awareness and regulation capabilities. If therapists are overwhelmed by their affective and somatic experience, or conversely shut off from their implicit bodily knowing, they will be less effective in allowing emotional intensity in their clients. Regulation allows both the therapist and client to develop a relationship with a previously shut off or unconscious emotion, to feel it more fully in their body, and to be able to stay present in the experience. This author encourages therapists to study their own nervous system patterns by referring to Figure 1. Lastly, dysregulation should be welcome in the playroom, as this is where, in real time, therapists get to meet the client and demonstrate a new and novel way of being. What the therapist disallows in themselves, they will often cut off in their clients, as an unconscious attempt to manage their own nervous system. Thus, the therapist must learn to self-regulate so that they can be available to co-regulate with their clients.

Feel it to heal it: regulating through rhythm and movement. As Siegel and Bryson (2016) explicate, bodily movement has a direct impact on brain chemistry. When a child is dysregulated and has lost touch with their cortex, the fastest way to help them come back into balance is through movement. This is where having an appreciation of nervous system states can provide insights and guide a clinician in how best to approach movement

with a client (Figures 1 and 2). A therapist will choose a movement intervention based on whether the client is in hyper-, hypo-, or optimal arousal, and will then model regulation (through a non-directive approach) or propose a movement intervention (through a directive approach). As the therapist and client engage in rhythmic movement, they allow themselves to feel the emotions and accompanying sensations in their body, creating a new implicit understanding that such intensity is temporary and can be both felt and sequenced.

Breath. Breath is an important tool in the playroom, as it is the quickest way to alter nervous system states (Levine, 2010). Many body psychotherapists incorporate breath work in their practice, including but not limited to calming the activated client, charging the nervous system for emotional and physical processing, or as a resource for regulation. Incorporating breath work, either in a non-directive manner via modeling and naming, or directly through purposeful interventions, can be a powerful intervention for the somatic play therapist. The type of breath work used will be dependent on whether the child is exhibiting signs of hyper- or hypoarousal. Children in a state of hyperaroused activation will be best served by taking long, deep, diaphragmatic breaths that focus on extending exhales as this will serve to calm sympathetic arousal. In contrast, children exhibiting hypoarousal symptoms can wake up the parasympathetic nervous system by taking quick, short breaths. Therapists can model these varying breathing patterns in their own body non-verbally, mirroring to the child ways of regulating. One directive approach to breath work is incorporating the use of bubbles. Children needing to calm their activation can be instructed to blow the largest, biggest bubble they can. This will necessitate the child to slow their breath and use their exhalation mindfully. The hypoaroused child can be invited to blow as many bubbles as possible, as quickly as possible, thereby bringing energy back into the system. Body psychotherapists learn to watch and assess their client's breathing patterns, noting how the child's breath manifests both under stress and when relaxed. In turn, this knowledge will inform the breath work interventions the therapist proposes (Caldwell & Victoria, 2011). This section offers only a brief exploration of the use of breath interventions in the playroom. Interested readers are encouraged to learn more about the regulatory capacity of breath and get creative in their interventions in the playroom.

Increasing Interoception

Naming sensations. The somatic therapist helps children recognize internal sensations and provides the child with language to describe what is happening in their bodies. Just as play therapists help children develop a vocabulary for emotions, so too is it important to provide children a lexicon for sensations. Children who operate from a state of chronic hyperarousal often feel a lot of sensation, whereas hypoaroused children might

feel numb or detached from their somatic self. Helping children place mindful, titrated, and guided attention on their body and its somatosensory experience can aid in distinguishing between sensation, emotion, and cognition, and understand how each intimately impact one another.

As interoception involves both higher and lower brain regions, it is important to find interventions that speak to each brain area. Thus, the somatic therapist incorporates both bottom-up and top-down approaches with interventions that are targeted to the regions of the brain responsible for somatosensory processing (brainstem), emotional appraisal (limbic system), and higher-order thinking (cortex). For a directive approach to fostering somatic awareness in a way that promotes integration across brain regions, please see Appendix C: Feel it to heal it: Listening to My Body. This directive helps children to become mindful of their embodied experience and track internal sensations.

The somatically-inclined therapist might ask a child to notice their body with a few prompts: notice your whole body, now notice just your finger. Notice which parts of your body feel loose, notice which feel tight. If those tight shoulders could talk, what might they say? The attached worksheet helps a child to tap into specific sensations and their accompanying emotions, pinpoint where they are feeling the experience in their body, and consider what movement their body might want to take next. Employing the feel it to heal it strategy, the therapist allows the sensation a voice, presence in the body, and a chance to sequence through movement and rhythm. An example of this theoretical approach in action follows.

APPLICATION

The following example draws on observed play themes with child clients, but is primarily fictitious in nature and for illustrative purposes only. Please reference Figure 2 for an illustrative representation of this theoretical model.

Working with Sarah

Sarah is a seven-year-old client with a history of early medical trauma. When Sarah was three years old, she underwent medical procedures that required her to often be immobilized for a series of scans. The following scenario demonstrates the ways in which Sarah plays out her unconscious and implicit memory of her experience. For the sake of demonstration, the projected play in the following scenario is obvious. It is important to note that not all play will be quite so literal, and many times the therapist will not know explicitly what is being played out. Luckily, meaning making is the work of the cortex, whereas the body psychotherapist in the playroom is much more concerned with the nonverbal and implicit felt sense of the child's experience. It is less important to cognitively understand what's transpiring,

and much more salient for the therapist to *feel* their way through the play. This is where the science and art of psychotherapy meet.

Tracking the nervous system. Sarah picks up a baby and begins to tie a scarf around the baby's arms, pinning them to its side. Sarah sets the baby down and walks away, leaving the baby alone on the other end of the room. A body-centered therapist would simultaneously begin to track the affective and somatic experience arising in their own body, while also watching the body language of the client, tracking for signs of dysregulation. The therapist tracks Sarah, and notices her breath is short and shallow, her eyes are open wide, and she is exhibiting tension in her upper body. The therapist senses sympathetic activation, and meets the client in the intensity, both verbally and nonverbally (attunement). Before the therapist can help the client sequence this stuck arousal energy, she must first attune to the emotional and somatic experience, help Sarah regulate through the intensity, and engage her interoceptive awareness.

Regulation, attunement, and interoception in action. The somatic therapist is tracking breath, tension patterns, speed of movement, bodily and facial expressions, cadence of speech, eye contact, and pupil dilation, among other nervous system cues. The therapist sees that Sarah is demonstrating signs of hyperarousal and begins to feel it in her own system. Staying present in the play, the therapist begins to use breath and movement to regulate the activation. The therapist takes a few deep, audible breaths as she rocks side to side, engaging the rhythm necessary to calm the brainstem. The therapist then engages both the name it to tame it and feel it to heal it strategies to assist in attunement and regulation, while also naming somatic experiences to cultivate interoceptive awareness. For example, the clinician (rocking side to side) might state: "I'm feeling really nervous right now, I want to help the baby, but don't know how" (regulation/attunement). "If I were the baby, I might feel stuck and confused. I feel hot and prickly in my own body" (modeling interoceptive awareness). Then the therapist models regulation: "I need to take a deep breath," and can offer a directive probe: "I wonder what you think that baby is feeling?". If the therapist believes the client is within their window of tolerance, they can take this a step further and inquire/reflect, "I wonder what is happening in your body right now, Sarah; some tightness in the shoulders huh?" (using interoception to help the client name her felt sense experience). It is unimportant whether or not the client answers this directive. The simple invitation to notice their body and emotions is often enough to spur at least a momentary curiosity in the child as they scan their own internal landscape. There is no right or wrong way to regulate, move, or feel in a play session. The most important aspect in this somatic approach is staying authentic, attuned, regulated, and emotionally connected to the child and to self-as-therapist.

As Sarah progresses in her therapy, she begins to demonstrate an increase in somatic and affective awareness and regulation capabilities. This is evident in her mounting ability to allow, name, and stay connected to self and her somatic and emotional states, either projectively (e.g., “the baby feels scared right now”) or self-reflectively (e.g., “my tummy feels swirly,” as she takes a deep breath). As Sarah’s play progresses, she plays out similar themes, but in novel ways, eventually leading to the sequencing of the previously thwarted survival movement, her inability to move during the scans.

Therapist self-regulation. Further on in her treatment, Sarah transfers her projective experience from the toys to the therapist. Sarah approaches the therapist and tells her she is “under arrest.” She cuffs the therapist with the toy handcuffs and directs her to sit on the couch, where she instructs her that she “is not allowed to move.” Sarah is now helping the therapist to feel the direct experience of being immobilized.

As play increases in intensity, it is important that the therapist remains regulated and embodied in the experience. If the play scenario is outside the therapist’s window of tolerance, they will engage their own nervous system defenses in an attempt to manage the emotional intensity of the play. In this scenario, it could be easy to imagine a dysregulated therapist naming, “I feel stuck; I need to get away!” removing the restraints, prematurely sequencing activation, and shutting down the play. This author proposes that a child needs to be deeply felt and met in the activation first, and then the therapist can regulate the intensity, thereby widening the child’s (and perhaps the therapist’s) window of tolerance. This example highlights the importance of the therapist doing their own work of staying embodied, developing the skill to track their own nervous system state and window of tolerance, and the ability to remain titrated in the play.

Getting unstuck. Ideally, the therapist uses the aforementioned strategies of breath, movement, and naming/feeling the emotional and somatic experience to stay regulated and attuned with the client, and present in the intensity of the play. The therapist begins to self-regulate while mirroring the intensity in her own body and naming “I feel scared. My chest is tight and I feel fluttery. I’m stuck.” The therapist is helping the client to hear, feel, and name what was previously an unconscious and unintegrated experience. As the therapist allows these sensations, emotions, and feeling in herself, she gives permission for Sarah to allow them in herself as well. As the therapist attunes to the emotional and somatic sensations, she begins to use movement, breath, and rhythm to model ways of staying embodied and attached to self in the midst of the intensity.

It may take multiple sessions for things to begin to shift. In an earlier session, the therapist mirrors hyperarousal in the body while stating, “I want to break free. I feel so scared and alone. My chest is hurting. Can I get out now?” to which the client responds with “No. You

aren’t allowed. You are stuck there.” The child needs the therapist to understand the intensity of the initial experience, to feel the helplessness and stuckness in her own system. As Dion (2018) elucidates, play can become stuck or intensity can heighten until an authentic and equivalent response is elicited in the therapist and is allowed expression. In this regard, this model proposes that the child can go only as deep as the therapist is willing to go, an important caveat.

In this example, let’s imagine the therapist has an emotionally congruent response to the play scenario. This time, instead of naming the desire to break free (hyperarousal) the therapist connects with the sense of hopelessness and powerlessness that is being evoked by the child (feeling into the hypoarousal), and states, “I feel like I will never get out; part of me feels like giving up,” as she mirrors aspects of collapse in her own body through a slumped posture and a heaviness in the upper body and torso. In this moment, the therapist taps into the other side of the nervous system, giving voice to the hypoarousal, and mirroring what it might be like to feel powerless to move (name it to tame it/feel it to heal it). This is important, as a trauma response often carries with it both ventral and dorsal activation and giving authentic voice to both can be necessary for integration to occur (Levine, 2010). This theoretical model proposes that once the entirety of the experience has been felt, named, and co-experienced, the client can then move towards the healing that comes with moving through the intensity, thereby finding integration and empowerment.

Sequencing is a somatic approach to working with trauma, which posits that a previously thwarted survival response (e.g., being unable to engage the fight-or-flight mechanism during a traumatic event) needs allowance to move through the body. In this scenario, sequencing might look like Sarah allowing the doll or therapist to break free of their confines, thus activating the missing defensive response and allowing the body and nervous system to reset (Levine, 2010). The client, having been sufficiently felt, now grants permission for the therapist to break free. The therapist would then shake off the energy in the arms, moving in a way that felt authentically mobilizing in their own system. The therapist can invite the client to move along with her, ask the client what her body would like to do, or co-create a movement sequence together that allows movement back into the body and the arms. Sarah may just witness the therapist and learn new ways of coping through observation, or she might be invited to try on the entire action sequence for herself, going from confined (standing with arms by sides and body tight), to an empowered stage of breaking free (moving arms and body), to sequencing energy through movement, rhythm, and sound (shaking arms, stomping feet, exhaling loudly, or vocalizing). In this way, Sarah has the opportunity to complete the necessary action sequence that was thwarted at the time of her early medical scans.

This is just one small example that highlights the ways in which a somatic therapist might use body psychotherapy principles in the playroom. Mirroring, movement, rhythm, breath, and vocalization interventions can be modified to be more or less directive, based on the therapist's orientation to play therapy. There is an almost limitless potential to the ways in which somatic interventions can be used in the playroom, the only guiding principle being that the therapist stays attuned and connected to their own body and affective experience, as well as those of the client. The attuned and regulated therapist can then model novel ways of dancing between states of dysregulation back to regulation, while staying connected to both self and other.

LIMITATION AND FUTURE STUDY

This theoretical model proposes that attunement, regulation, and interoceptive awareness are fundamental in the health and wellbeing of the child and offers a way to incorporate body psychotherapy techniques in the playroom. This exploration is precursory, and not an all-encompassing look into somatic play therapy techniques. Nor does the author contend that this model is a complete framework in and of itself for working with child clients. Rather, it is intended to set a foundation upon which therapists of differing play therapy modalities can build while incorporating their own orientations and unique lenses. Further, embodiment is a natural outcome of the securely attached child, but is a vast, and oftentimes hard-won, achievement for the traumatized individual. This can be especially true for children suffering from complex trauma, and thus an embodied approach to healing must be approached with care, titration, and consideration so as to not retraumatize the child client with intense somatosensory experiences.

The scope of this paper did not address other vitally important considerations for a somatic approach to play therapy, including but not limited to the therapeutic use

of touch, transference and countertransference considerations, family system dynamics, power differentials between child and therapist, and important societal and cultural implications. These topics necessitate further consideration, research, and conversation as each show up in the playroom and impact the embodied and relational experience of both child and therapist alike. Despite somatic body psychotherapy seeming like a natural pairing to working with child clients, it is an as yet narrowly explored orientation in play therapy. More research and development should be conducted to adapt the work of prominent somatic therapists in the field, including the modalities of Aposhyan, Kurtz, Levine, and Ogden into working with child clients.

Conclusion

Play is a vital component of child development, and facilitates growth and healing across cognitive, emotional, and social domains. Play therapy is predicated on the belief that children will physically enact and express their inner thoughts and feelings through play and relationships. It is this healing relational dynamic that is of importance in the playroom as the therapist seeks to create an attuned and empathetic connection, helping the child regulate through emotional intensity and foster interoceptive awareness, thereby supporting the child to garner a newfound appreciation of their affective and somatosensory inner world. Somatic body psychotherapists work with, and through, the body using movement, breath, and rhythm to help clients access and integrate their physical and emotional experience. Within the framework of attachment-focused therapy and developmental neurobiology, body psychotherapy can provide a novel way of working with child clients, teaching children to regulate through emotional intensity, attune to both self and other, experience and name felt sensations, and ultimately find affective, somatic, and cognitive integration.



Appendix A

Signs of Hyperarousal/ Sympathetic Nervous System activation (Fight/Flight/High Freeze)	Signs of Optimal Regulation/ The Social Engagement System	Signs of Hypoarousal/ Parasympathetic Nervous System Activation (Collapse)
Fast speech	Congruent speech	Slow speech, no speech
Quick movements	Relaxed movement, ease in the body	Slow, heavy movements
Anger/Outbursts/Irritability	Connectedness to others, reciprocity	Tiredness
Difficulty concentrating	Aware of both self and other	Slow to engage
Short, quick breaths	Regulated breath	Slow breath, hard to see breath in body
Quick, rapid eye movements	Ability to make eye contact	Staring into space/dissociation
Anxiety	Regulation/Relaxed	Depression
Overly attuned to sensation and emotion	Ability to feel and name experience	Numbed from sensations and emotions
Exaggerated startle response	Feeling of safety in self and environment	Non-reactivity/lifelessness
Alert, tense, scanning for threat	Present, embodied	Disengaged, hanging head, slumped posture

Figure 1 Tracking the Nervous System. Adapted from the work of Dion (2018), this graphic depicts signs of hyperarousal, regulation, and hypoarousal that offer important insights for the somatic body psychotherapist

Appendix B

Part of the Brain Addressed	Therapeutic Skill Used	Somatic Intervention
Brainstem (The Body Brain)	Regulation- Co-regulation and Self-Regulation	<ul style="list-style-type: none"> ■ Breath ■ Movement ■ Rhythm ■ Feel it to heal it
Limbic System (The Emotional Brain)	Attunement	<ul style="list-style-type: none"> ■ Mirroring ■ Name it to tame it (Siegel & Bryson, 2016) ■ Feel it to heal it
Integration of the “3 Brains”: Body Brain + Emotional Brain + Thinking Brain	Interoception	<ul style="list-style-type: none"> ■ Body Map (Appendix 1) ■ Feel it to Heal It

Figure 2 A Somatic Approach to Working with Children: A Theoretical Model. Adapted from the work of Perry (2006), this figure illustrates a somatic approach to play therapy with neurodevelopmental considerations

Appendix C

Feel it to Heal It: Listening to My Body

Right now, I'm feeling: _____

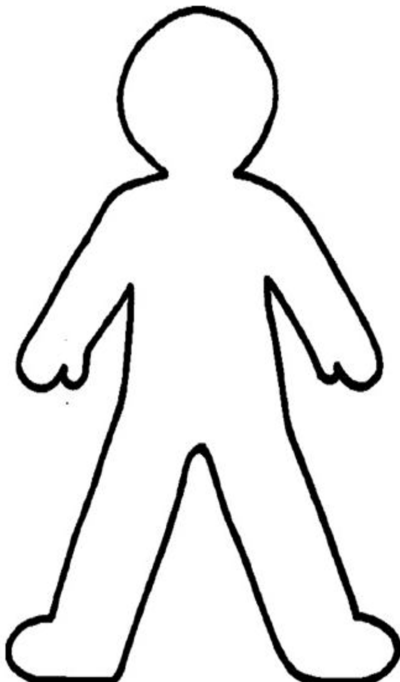
Angry	Cheerful	Embarrassed	Loving	Sad
Alarmed	Compassionate	Happy	Nervous	Scared
Amazed	Confused	Lonely	Playful	Surprised

Some sensations I'm noticing are: _____

Achy	Buzzy	Dizzy	Heavy	Numb
Breathless	Clammy	Energized	Hot	Prickly
Bubbly	Constricted	Fluttery	Knotted	Sore

If this feeling + sensation could talk, it might say: _____

This is where I feel it in my body:



This is what my body wants to do:
(Examples: Run, stomp, throw, curl up)



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Investigation of PTSD during the Coronavirus Epidemic

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ABSTRACT

Aim: We investigated to understand post-traumatic stress disorder (PTSD) during the coronavirus epidemic, and related influential factors. We hoped to provide more basis for targeted services to improve public psychological health care.

Methods: From the psychological aid platform set up by the Wuhan Mental Health Center, we obtained online sample data of Chinese residents during the coronavirus epidemic. We used the PTSD examination scale as the study tool and analyzed the data with SPSS.

Results: A total of 376 data was collected. The PTSD degree of the public was 45.93 ± 17.32 , the positive detection rate was 63.56%, and the PTSD level increased with fluctuation. Participants' gender, educational level, and location were the influential factors. Specifically, women, lower educational backgrounds, and people in Wuhan were more likely to have PTSD.

Conclusions: The epidemic had a great impact on people's psychological status. Although the epidemic has basically been brought under control, PTSD levels have not declined. Therefore, it is necessary to provide timely psychological assistance for people in need, and help them adapt to life as soon as possible.

Keywords: COVID-19; post-traumatic stress disorder; influence factors; timeline changes

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The population began to realize that assistance was limited, and under various pressures, with continued stress and fatigue, various problems became increasingly prominent.

The 2019 Novel Coronavirus (abbreviated as COVID-19) is a new, highly infectious respiratory disease. Since the outbreak of novel coronavirus, it has not only affected people's physiological health, including many clinical symptoms like fever, dry cough, fatigue, muscle pain, and dyspnea, but has also caused great harm to people's mental health, triggering the prevalence of stress, anxiety, and depression among the general population (Bao et al., 2020; Wang et al., 2020). Previous studies have shown that public health emergencies would cause a series of emotional problems (Wang et al., 2003), so we need to pay attention to the problems that occurred during COVID-19. Since the outbreak of the epidemic, the Chinese government took strong measures to control the rapid spread of COVID-19 in China. During the Wuhan lockdown, residents were required to stay home and avoid contact with others (Zhong et al., 2020). As a result of continuous efforts, significant effects have been achieved, and the epidemic has entered a stage of stabilization. However, the experience of the epidemic, the exposure to media information, and the perception of epidemic risk have all affected the population's mood [Dong et al., 2020]. Therefore, people's mental health problems cannot be ignored.

The sudden outbreak of COVID-19 is a serious traumatic event for people all over the world. Epidemiological evidence showed that about 5–12% of people may develop post-traumatic stress disorder (PTSD) after suffering from traumatic events (Ursano et al., 2009). As the epidemic continues to develop, people's stress response to the COVID-19 outbreak may still exist. Studies have been conducted to investigate this situation (Xu et al., 2020; Liu et al., 2020). However, to date, few studies have conducted longitudinal surveys on PTSD for the general population. For that reason, this study analyzed the data collected from March 1 to May 1, 2020 during the epidemic, hoping to obtain data on the changing trend of PTSD and related influential factors, and to better understand the longitudinal psychological changes of the general population. Based on this study, we hope that psychological interventions can be carried out more effectively in the later stages of the pandemic.

On March 9, 2020, a research team extracted the data of Wuhan COVID-19 patients from the infectious disease reporting system for the period of December 2019 to March 8, 2020. They divided this data into five stages [Pan et al., 2020]. This research showed that the daily confirmed case rate per million population in Wuhan continued to increase during the first to third stages, and declined during the fourth to fifth stages. This study showed that due to strong prevention and control measures, the epidemic entered a stable stage in March 2020. Since then, the Wuhan mobile hospitals were closed one after another. The last one was closed on March 10, 2020 indicating that the epidemic had been brought under control. This study referred to this article, and intended to divide the data collected in this study into two phases, namely the "peak period" and the "late epidemic period." March 10 is the dividing point, with the period before March 10 being the "peak period," followed by a "late epidemic period." By comparing the psychological conditions of these two periods, we can better understand people's mental health after the epidemic was contained.

Methods

Participants

In order to better help people in need, the Wuhan Mental Health Center set up a psychological aid platform during this special period. This survey research collected data online through this platform. Research participants were those who contacted the platform and voluntarily provided relevant information from March 1 to May 1, 2020. Participants were informed through WeChat, Weibo, and other channels. The investigation was approved by the Ethics Committee of Wuhan Mental Health Center. All participants were informed of the purpose of the investigation, volunteered to participate, and signed the online informed consent.

Research Tools

■ General information questionnaire

A self-compiled general data questionnaire was used, which included the subjects' gender, age, population classification, education level, physical condition, and current place of residence.

■ Post-traumatic Stress Disorder Checklist (PCL)

The Post-traumatic Stress Disorder Checklist (PCL) is a self-rating scale developed by Weathers (1993) that includes 17 items divided into 3 main dimensions: re-experience, avoidance/emotional numbness, and high alertness. These questions are answered on a scale of 1–5: 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, and 5 = extremely. The total score ranges from 17 to 85. The higher the score, the more severe the PTSD. A total score between 38 and 49 indicates that people may have certain PTSD symptoms, while a score greater than 50 indicates obvious PTSD symptoms. The retest reliability of the scale is 0.96, and the internal consistency reliability is 0.94 (Liu et al., 2015), which indicates that the questionnaire has good reliability and validity.

Statistical Methods

In this study, SPSS 21.0 was used to analyze the collected data. The frequencies of demographic variables were described. The scores of PTSD were compared according to demographic characteristics with independent samples t test, one-way analysis of variance (ANOVA). Multivariable linear regression analysis using all of the demographic variables as independent variables, with PTSD score as the dependent variable, was conducted to identify factors associated with PTSD. In addition, we drew a trend change graph of PTSD on a weekly basis.

Results

Demographic characteristics of participants

In this survey, 390 questionnaires were collected. After excluding the invalid ones, there were 376 valid questionnaires, with an effective rate of 96.3%. In the final sample, the analysis of the distribution of demographic variables showed that the average age was 27.2 years old (ranging from 12 to 60), 294 (78.2%) of participants were women, 271 (72.1%) had associate or bachelor's degrees, and 308 (81.9%) were Hubei (including Wuhan) residents. Other demographic characteristics are shown in Table 1.

Differences in PTSD demographic variables and its dimensions

Results of the analysis of gender differences in PTSD total scores and its three different dimensions during COVID-19 showed that there were significant differences

Table 1 Demographic characteristics of participants (n = 376)

Characteristics	Number of participants	Ratio
<i>Gender</i>		
■ Male	82	21.8%
■ Female	294	78.2%
<i>Age-group</i>		
■ 0-18	55	14.6%
■ 19-25	134	35.6%
■ 26-40	160	42.6%
■ 41-60	27	7.2%
<i>Category</i>		
■ General public	315	83.8%
■ Frontline medical workers	8	2.1%
■ Frontline non-medical workers	16	4.3%
■ Family members of frontline workers	8	2.1%
■ Others	29	7.7%
<i>Education</i>		
■ High school senior and below	65	17.3%
■ Associate and bachelor's degrees	271	72.1%
■ Master's degree and above	40	10.6%
<i>Physical condition</i>		
■ Healthy population	332	88.3%
■ Confirmed novel coronavirus cases	10	2.7%
■ Suspected novel coronavirus cases	3	0.08%
■ Contact with confirmed case	15	4%
■ Others	16	4.3%
<i>Current place of residence</i>		
■ Wuhan city	181	48.1%
■ Non-Wuhan city, Hubei Province	127	33.8%
■ Other provinces in China	65	17.3%
■ Abroad	3	0.08%

es in the total score of PTSD and in the avoidance/emotional numbness dimensions between males and females. The Female scores were significantly higher than those of males ($t = -2.18, p < 0.05$). A one-way analysis of variance with age as the independent variable found that there were significant differences except for the re-experience dimension. For the avoidance/emotional numbness dimension, the scores of 19-25 year-olds were significantly higher than those under 18. For the high alertness dimension, the scores of 26-40 year-olds were significantly higher than those under 18. In general, the effect on people under 18 was less significant. For different education levels, post-comparative analysis found that there were significant differences in the

total scores of PTSD, re-experience, and the avoidance/emotional numbness dimension between high school seniors and below, and those with associate and bachelor's degrees. High school seniors and below were significantly more affected by the epidemic than those with greater academic qualifications. In the current place of residence, in terms of the re-experience factor and total PTSD score, residents of Wuhan had significantly higher scores than those from other regions in Hubei province, and other provinces in China. For the avoidance/emotional numbness and high alertness dimensions, residents in Wuhan had significantly higher scores than residents in other regions of Hubei province.

Table 2 One-way analysis of variance for different demographic characteristics of PTSD

Characteristics	$\bar{x} \pm s$	t / F 值	p
<i>Gender</i>			
■ Male	42.3 ± 17.38	-2.12*	0.04
■ Female	46.93 ± 17.19		
<i>Age-group</i>			
■ 0-18	40.33 ± 18.68		
■ 19-25	47.53 ± 17.19	2.93*	0.03
■ 26-40	47.09 ± 16.99		
■ 41-60	42.52 ± 14.93		
<i>Category</i>			
■ General public	46.18 ± 17.66		
■ Frontline medical workers	40.25 ± 12.35	0.97	0.43
■ Frontline non-medical workers	39.75 ± 13.55		
■ Family members of frontline workers	51.63 ± 19.37		
■ Others	46.59 ± 15.65		
<i>Education</i>			
■ High school senior and below	51.49 ± 16.06	4.13*	0.02
■ Associate and bachelor's degrees	44.80 ± 17.50		
■ Master's degree and above	44.53 ± 16.64		
<i>Physical condition</i>			
■ Healthy population	46.15 ± 17.49		
■ Confirmed novel coronavirus cases	42.20 ± 14.42	0.21	0.93
■ Suspected novel coronavirus cases	48.00 ± 18.52		
■ Contact with confirmed case	43.67 ± 17.82		
■ Others	45.50 ± 16.28		
<i>Current place of residence</i>			
■ Wuhan city	50.46 ± 16.94		
■ Non-Wuhan city, Hubei Province	40.65 ± 16.69	9.05***	0.000
■ Other provinces in China	43.52 ± 16.37		
■ Abroad	48.00 ± 21.52		

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 3 Results of multiple linear regression on factors associated with PTSD

Characteristics	B	$S.E$	β	t	p
<i>Gender</i>	5.25	2.12	0.12	2.467*	0.014
<i>Age</i>	1.34	1.14	0.06	1.166	0.244
<i>Education</i>	-4.74	1.72	-0.14	-2.743**	0.006
<i>Current place of residence</i>	-4.11	1.16	-0.18	-3.516***	0.000

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

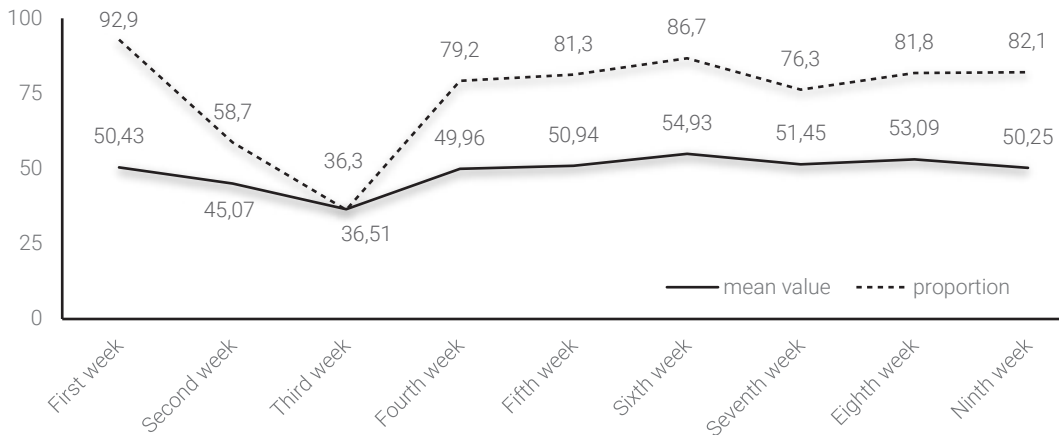


Figure 1 Timeline changes of PTSD

Multivariable linear regression analysis

Multivariable linear regression analysis using gender, age, educational level and current place of residence as independent variables and the total score of PTSD as the dependent variable was conducted to identify factors associated with PTSD. The results showed that gender, educational level, and current place of residence were the influential factors (Table 3).

PTSD timeline changes and comparison between “peak period” and “late epidemic period”

Based on data collected from March 1 to May 1, 2020, the average value and proportion of people with PTSD (with a total score on the scale greater than or equal to 38) were calculated on a weekly basis. The starting point was March 1 (Figure 1). During the first week, the proportion of people with PTSD symptoms was the highest, and in the third week, the proportion of people with PTSD symptoms was the lowest. It can be seen from Figure 1 that the level and proportion of people with symptoms gradually decreased from the first to the third week, and immediately following the third week, there was a rapid increase. This shows that even though the epidemic had stabilized, its impact on people’s mental health had not diminished.

The independent sample T-test was used to test the “peak period” and “late epidemic period.” It was found that the total score of PTSD was statistically significant

($p < 0.001$), and the level of PTSD in the “late epidemic period” was lower than that during the “peak period.”

Discussion

Influential factors of PTSD

This survey’s average PTSD score was 45.93 ± 17.32 , indicating that the epidemic is, to a certain extent, the cause of people’s PTSD. Out of 376 subjects, 239 people scored above 38 points, and the positive detection rate of PTSD was 63.56% among the participants, which was higher than the detection rate of all groups during SARS (Zhang et al.). This showed that the epidemic had a great impact on people’s degree of PTSD, which is noteworthy.

Gender. This study found that gender affects the degree of PTSD. The scores of female subjects were significantly higher than those of male subjects, which indicated that females were more vulnerable to COVID-19 than males. It showed that women may be more susceptible to being affected by major external disasters. During the SARS outbreak, studies found that the severity of women’s fear and anxiety was higher than that of men (Wang et al.,2003; Tang et al.,2006). Yang Ting (2020) also found that women were at higher risk for PTSD. All those investigations and studies showed that women’s psychological coping ability was lower than that of men in the face of major stress events. This may be relevant

Table 4 Comparison of the average score between “peak period” and “late epidemic period”

	Peak Period	Late Epidemic Period	t
Total PTSD Score	51.58 ± 14.79	42.22 ± 17.87	5.52***

to the characteristics of women. For example, women are more sensitive to external events and more susceptible during emergencies and disasters [Ge et al., 2020].

Educational level. The results of variance analysis showed that there were significant differences among groups with various educational levels who developed PTSD. The lower the educational level, the higher the degree of PTSD. The degree of PTSD was higher in subjects with an educational level of high school senior and below than in subjects who had associate and bachelor degrees. Other studies also showed that with higher educational levels, the subjects' emotional scores showed a decreasing trend (Chen, Wang, Xie, & Chen, 2003). Subjects with higher educational levels had a wider range of knowledge than subjects with lower educational levels. They had a better understanding of the epidemic when facing the pressure brought by COVID-19 (Zhong et al., 2020), which helped them gain a sense of control more effectively. Moreover, they paid more attention to their mental health, and could use various available resources to help themselves, such as nonprofit consultations. Therefore, the degree of PTSD in this group was relatively lower. Results suggested that the available helping resources needed to be introduced to the public, especially to people with low academic qualifications.

Place of residence. The study found that another factor related to PTSD was the participant's current place of residence. The degree of PTSD of residents currently living in Wuhan was significantly higher than that of non-Wuhan residents in Hubei and other provinces. This regional difference was also reflected during the SARS outbreak in 2002. The closer to the epicenter, the more serious the danger and threat people felt, and the higher the possibility of PTSD. When SARS first appeared in Guangdong, the long distance between Beijing and Guangdong did not make people in Beijing feel too uneasy. But when SARS began to spread in Beijing, residents' negative emotions increased significantly (Qian et al., 2003). It showed that the physical distance away from the epicenter affected psychological distance, thus affecting psychological state. In addition, this might be related to the government's containment measures. The outbreak of COVID-19 happened during the Spring Festival, when a large number of people travel around the country, creating high risk for rapid transmission of the virus. In order to prevent further spread, to effectively protect more people by reducing the flow of travelers, and to calm people in other provinces, China made the unusual and difficult decision to place Wuhan on lockdown.

Change in the degree of PTSD over time

Analysis of the data showed that the proportion of people with PTSD symptoms was highest during the first week, because at the beginning of March, the epidemic was in a severe stage and prevention and control measures were relatively strict. During this peak period of the epidemic, people were in a state of worry and fear.

The average and proportion of cases of PTSD were lowest in the third week. Some researchers call this the "honeymoon period" of the disaster (Wang, 2001). There were more external resources at this time, such as condolences from the government, and institutions that may have brought temporary optimism and the belief that the disaster could be overcome, and life would soon return to normal. During the second week, General Secretary Xi came to Wuhan, and the Wuhan mobile hospitals were closed, indicating that the epidemic situation had been effectively controlled. Consequently, the PTSD score was reduced to its lowest during the third week. However, with the passage of time, the proportion of cases increased and fluctuated, and the mental health level returned to its previous state or climbed even higher. The population began to realize that assistance was limited, and under various pressures, with continued stress and fatigue, various problems became increasingly prominent.

At the beginning of the epidemic, people's main psychological problems were depression and anxiety. As the epidemic was gradually contained, the number of people who complained about depression, anxiety, and fear gradually decreased (Li et al., 2020), but the proportion of people with PTSD showed no trend of decreasing. This result was consistent with a PTSD follow-up study during the SARS period (Sun et al., 2005). According to the results of the analysis, although the epidemic is presently basically contained in China, the degree of PTSD and the number of people affected have not decreased, but have even increased with fluctuation. In addition, it was found that the mean value of PTSD in the late epidemic period was (42.22 ± 17.87), which showed that even during the later stage, people still have certain PTSD symptoms. Therefore, keeping an eye on PTSD during the late epidemic period would be the focus of psychological work for the next step.

At present, due to China's strong measures, the epidemic has been effectively contained, and anxiety and depression in the public sector might have been relieved. Nonetheless, according to the results of this study, it can be seen that people who experienced the epidemic are greatly affected. The study reveals that gender, educational level, and the current place of residence were influential factors on the degree of PTSD experienced, indicating that the need for psychological intervention for women, people with relatively low educational levels, and Wuhan residents might be urgent. We need to pay more attention to such groups and provide corresponding psychological help.

Relevant research (Li et al., 2020; Huang et al., 2020) studied the degree of PTSD and its influential factors on medical workers. However, this research sampled a relatively small number of medical workers. Therefore, it is more appropriate to use the general public to generalize this paper's conclusions. Generalization using frontline workers or other special populations should be used cautiously. Additionally, through the analysis

of psychological aid platform data, PTSD in the general population and its influential factors can be largely understood, and changes in the psychological symptoms of the masses can be examined longitudinally. However,

collecting data only in this form has limitations. In order to understand the changes in the degree of PTSD in the general population with more detail and accuracy, supplemental survey data and methods are needed.



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Brief Treatment in an Emergency

Methodological Proposal for Functional Psychology Intervention Implemented During the COVID-19 Emergency

Enrica Pedrelli

ABSTRACT

The COVID-19 pandemic has required mass intervention to offer psychological support to the world population. This article lays out a methodology developed over years of experience and implemented for the Italian population by psychotherapists of the Functional Psychotherapy Society (SIF) for the Ministry of Health project called *Free Listening Psychological Service. National Toll-Free Number*. The Brief Treatment in Emergency (Pedrelli and Sozzi, 2016) according to Functional Psychology (Rispoli, 2004; 2016) is based on years of experience in the diagnosis and treatment of stress, combined with the skills of emergency psychology. It shows how essential it is to have psycho-body skills in emergency treatment, and how it was also possible, even in a context of isolation and remoteness, to use body-oriented techniques. Functional Psychology refers to experiences that form the basis for the development of skills in each of us as Basic Experiences of the Self (BES). In an emergency, we can work on BES to restore emotional stability and security, and reconnect with resources. In this article, the BES of Control and Perception are used as examples to provide a view of potential remote emergency work.

Keywords: brief treatment in emergency, Basic Experiences of the Self, Psychocorporeal techniques, Functional Psychology

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Familiarity with psychophysical processes and stress makes the body psychotherapist an ideal candidate to operate in the emergency context.

For years now I have been dealing with Emergency Psychology as a volunteer and as President of the Italian Society of Emergency Psychology, Emilia Romagna section (SIPEM ER), allowing me to follow, more or less directly, all emergency events in Italy over these past fifteen years. Thus, I was very moved to know that the Italian Functional Psychotherapy Society (SIF) would be part of the ministerial project *Free Listening Psychological Service. National Toll-Free Number* as a member of the Scientific Society FIAP (Italian Federation of Psychotherapy Associations). It is a very important opportunity to be able to share an emergency experience, something so demanding and important to and for us all, with SIF colleagues (see Annex). This is an opportunity to once again reflect on the application of methodology and functional techniques in the specific field of emergency (Pedrelli and Rispoli, 2014; Pedrelli and Sozzi, 2016; Pedrelli, 2019).

Emergency psychology now boasts more than twenty years of presence in Italy and numerous publications (see Consiglio Nazionale Ordine degli Psicologi). There is consensus on noting the importance of the use of psychocorporeal techniques and of competence in assessing bodily signals in an emergency context (Van der Kolk, 2014; Ogden et al., 2006; Giannantonio, 2003; AISTED, 2020). Despite this, contributions from the field of Italian body psychotherapy are rare. After reflecting on the discomfort caused by the pandemic, this article will focus on a methodological pro-

positional arising from Italian body psychotherapy, namely brief emergency treatment according to neo-functionalism.

The Emergency Context

An emergency context is, by definition, one where individuals find themselves lacking sufficient resources to cope with the outcomes the context produces. This always disrupts people's lives to a degree that differs in nature depending on the following factors: economic, housing, work, social, physical, and, of course, psychological. This is why it is said that **in an emergency, it is normal to enter a state of Distress**. The state of Distress is inevitable for the body, which acts to protect itself from the destructive power of the event by activating the system responsible for reacting in the face of danger. It is thanks to the activation of exceptional resources borne by the vital systems – and in particular by the hyper-activation of the autonomic nervous system (ANS) – that individuals manage to face the sense of danger, anguish, and death constellated by such events.

During the COVID-19 emergency we have seen different problems arise, mainly related to three mutually intersecting factors: time, social/contextual criticality, and individual character structure.

- The **time** factor (emergency timing) always ought to be considered in emergencies, as every emergency has its phases, during which the emergence of symptoms varies.
- The **contextual** factor weighed significantly during COVID-19, given the capacities it demanded for adaptation in a variety of areas. These included, but were not limited to, children's home-schooling; working from home or with frequent interruptions; economic difficulties for some families; worries surrounding the impossibility of assisting family members in distress and isolated in their homes.
- These two factors deal with the **individual**, their resources, and their levels of resilience. However, as mentioned, it is normal to be in Distress throughout an emergency, and COVID-19 made the entire Italian population a victim of Distress when we were all forced into isolation following the Ministerial Decree of March 9, 2020. This was an event never before experienced during an emergency. Of course, not all of us experienced COVID-19 first-hand, and some experienced higher levels of victimization than those (such as myself) whose friends or family members were not directly affected (Pedrelli, 2019). However, we all are victims, and this must be borne in mind.

In this article, we will consider work carried out with individuals who contacted the toll-free number activated by the Italian Ministry of Health, but who had not dealt with COVID-19 directly (see Annex). Indeed, in this emergency there are certain categories of victims (healthcare workers, relatives of the deceased, and those

who recovered after contracting the virus) who require particular attention in the treatment of traumatic states and symptoms related to the traumatic experience. For this, the Brief Functional Treatment must be integrated with competence in traumatic and dissociative states (AISTED, 2020).

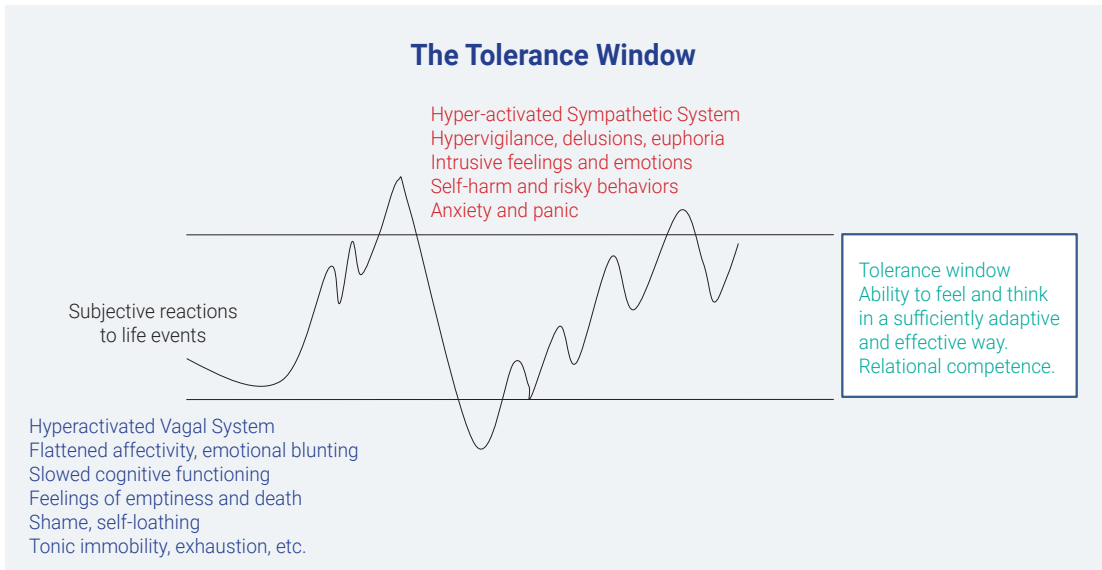
When the toll-free number was activated two months after the start of the pandemic, users requiring support brought up issues that arose from the various combinations of the aforementioned factors, while representing the most disparate conditions, which also led to important differences in treatment. Many instances of previous suffering were revisited and re-experienced. Some were correlated with clear states of decompensation, while others displayed signs that the consequences of persistent stress were becoming chronic. Therefore, we mainly highlighted two macro categories: those for whom the distress alteration was more prominent, and those for whom it appeared to be a reaction conditioned, rather, by the reactions related to previous suffering, and of a more depressive type. This is in accordance with what is noted in the literature (Rapporto ISS COVID-19, 2020; Cervellione et al., 2021).

Nonetheless, despite the difference in severity noticed, we would like to say that the work carried out was configured as a true **brief treatment**. Talking merely while *listening or supporting*, as defined in the Agreement with the Italian Ministry of Health, seemed unsatisfactory to us. It was certainly possible to listen to and support our users during the sessions; however, in our opinion, psychological therapy in an emergency is to be viewed as a **true type of treatment**, which is specific and has its own methodologies (Pedrelli, 2016; 2019). The treatment we are outlining is psychological first aid (Sphere, 2011; and IASC, 2007), but is not limited to this: it is also a true cure, which promotes processes aimed at rebalancing the ANS and vital systems. In fact, it should be remembered that the international guidelines refer to psychosocial operators who may not be professional psychologists, but are instead professionals trained in psychosocial emergencies, with basic skills of the most varied types.

The Body in Emergency Psychology

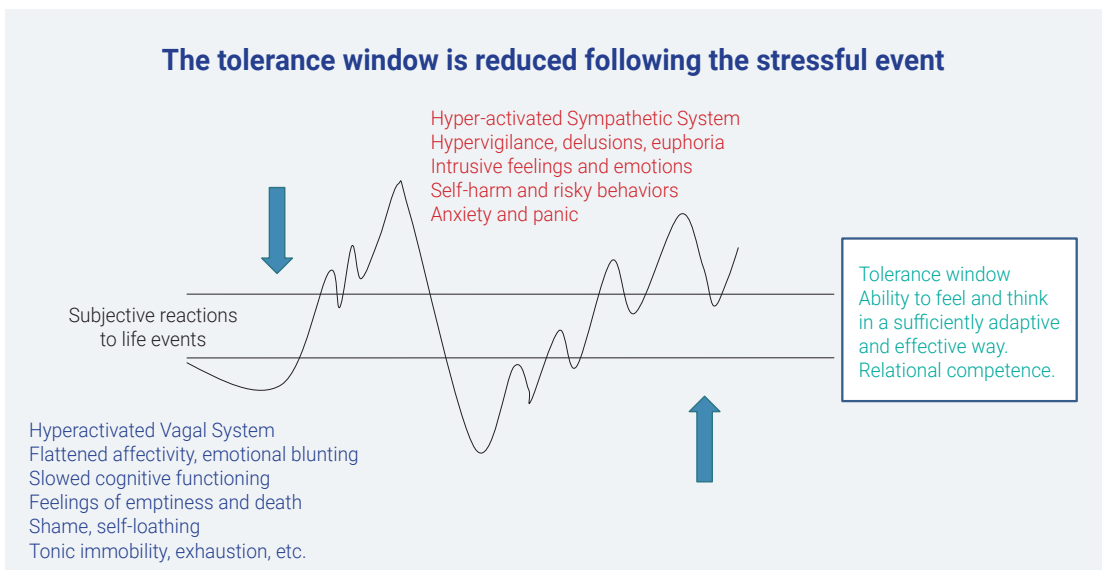
The methodologies used in emergencies stem from the specific objectives that many authors have already dealt with (Giannantonio, 2003; Sbatella, 2007; Iacolino, 2016). However, only through the contributions of trauma treatment has the importance of urgent early treatment in the prevention of psychopathological states resulting from potentially traumatic events become most strongly emphasized (Levine, 2014; Van der Kolk, 2014; Ogden et al., 2006).

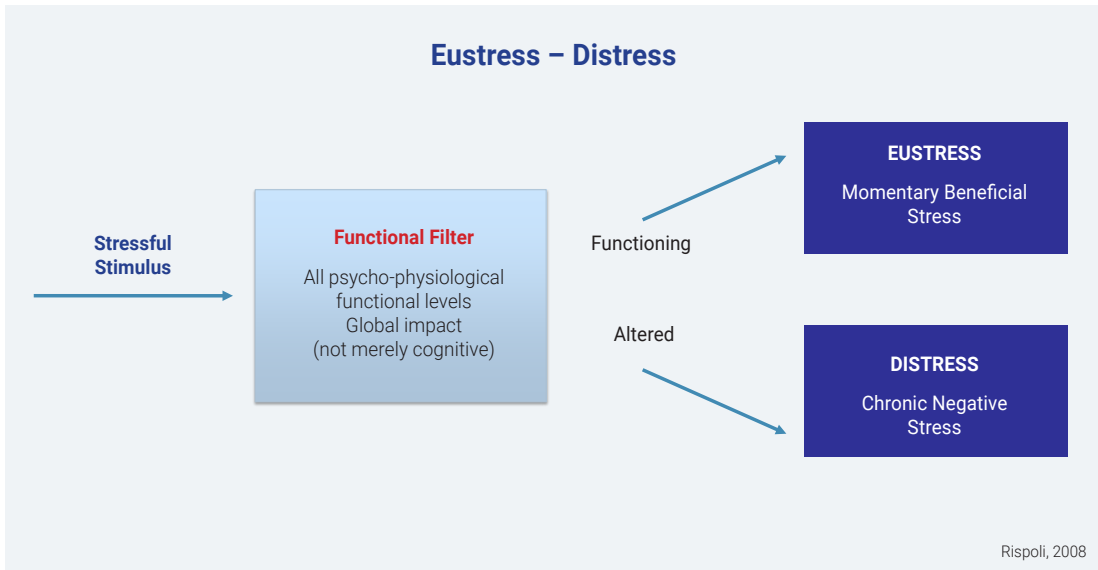
Some authors (Siegel, 1999; Ogden et al., 2006, B. Van der Kolk, 2014) use the concept of a window of tolerance to refer to the boundaries within which victims



define themselves as stable, provided they do not cross these boundaries. Being “outside the window of tolerance” is normal in the face of exceptional events and, as mentioned above, it is normal to go into acute Distress. When this happens, it is assumed that the victim’s reaction is such that all their adaptability is used to cope with the event per se, and that it cannot be used for psychic integration and rebalancing. Indeed, victims do find themselves in conditions of vulnerability and at high risk of breakdown, so they use the few resources available to them to maintain their (albeit unsatisfactory) state of survival.

The window of tolerance is subjective and related to the adaptive capacity of the subject and the levels of resilience that they can implement. Those who, displaying more or less obvious signs of stress, faced this emergency while already in psychophysical states of fatigue were found to have fewer adaptive resources. This suggests that the window of tolerance had a reduced diminished range for those who were already in a condition of stress, and that personal limits beyond which one would feel overexposed and unbalanced would have been very close to the basic condition (baseline), with little margin of stress tolerance.





Neo-Functionalism in Emergency Psychology

Familiarity with psychophysical processes and stress makes the body psychotherapist an ideal candidate to operate in the emergency context. Competence in identifying stress signals within the wide range of psycho-physiological variables, with simple but expert clinical observation, allows the body psychotherapist to access refined tools to guide their interventions. The fundamental concept is that when people are in acute distress, or even in chronic stress as we have seen during this prolonged emergency, their reaction will be a hyper-activation of the ANS in the direction of sympathotonia and/or dorsal vagal activation (Porges, 2011). It is like finding yourself in an overwhelmed state for too long and being outside your window of tolerance – a condition of high cost to the entire organism.

How can we offer resources and resilience to those who find themselves in Distress and who quickly exceed their limits? Neo-Functionalism has introduced a concept that seems to offer a complex vision of the process we are talking about: the Functional Filter (Di Nuovo and Rispoli, 2011). People's adaptive capacity is related to the mobility and range of their Basic Experiences of the Self (BES from now on). BES are lived experiences that influence human development (Rispoli, 2004; 2011; 2016; Di Pasquale et al., 2019), which are considered by Neo-Functionalism in their multidimensional psycho-corporeal complexity. The Functional Filter can appear more or less stiffened, slowed down, and depleted depending on how BES are stiffened and altered. However, if the BES maintain their range and mobility, then they will provide support, adaptability, and resilience and individuals will face stressors in their opti-

mal condition. Never before have we demonstrated the cultural and social changes to which we are subjected, from generation to generation, from decade to decade. Anyone, like me, who has been a psychotherapist for decades can testify to the methodological and diagnostic evolution in clinical practice. This is a necessary evolution, which follows the evolution of the profiles of psychopathologies and social life, as well as the evolution of the human competencies we encounter in social and cultural progress.

Nowadays, adaptability and resilience are becoming fundamental focal points in the promotion of health and wellbeing. Our changing world requires radical adaptability to change in us all (Braibanti, 2015). Feeling good in this world becomes possible if we develop our ability to continually reposition ourselves in our life contexts, are able to see more perspectives, and have the ability to carry ourselves in the best possible manner according to the times and conditions in which we live. The complexity of our time can bring richness, provided we evolve our competencies (Ceruti, 2018). This alone allows us to adapt coherently and in line with our needs. Neo-Functionalism has always based its epistemological vision on the theory of complexity (Rispoli, 2004), and has identified in the BES those building blocks on which to base our skills. Like Life Skills, BES are the learning directions on which to base our educational contribution and commitment. However, unlike Life Skills (WHO, 1997), BES are developed in our organism, and identified through four macro areas: cognitive, emotional, physiological, and postural. Through experiences and specific experiential techniques, we can support the development of the different BES, which will be whole and profound when all vital systems are coherent and contributing to the realization of the experience itself.

BASIC EXPERIENCES OF THE SELF

REDUCED VERSION

- **Being Held**, Being guided, Being Stopped
- **Being Considered**, Being seen, Being Listened to
- **Letting Go**
- **Calm**
- **Control**, Soft Attention, Loosening
- **Sensations, Perceiving**, Knowing, Exploring
- **Empathic contact**
- **Receptive contact**, Asking
- **Active contact**, Taking
- **Love**, Continuity, Belonging
- **Tenderness**
- **Sharing** Opening up
- **Vitality** Joy, Playing
- **Creativity**
- **Pleasure**, Will-being
- **Original strength** Open, Calm
- **Consistency**
- **Affirmation**, Assertiveness
- **Self-affirmation** Making Plans
- **Negativity**
- **Autonomy**, Opposition, Separation

Rispoli, 2011

Health and Wellbeing are indeed correlated to the integration and consistency with which the different Functions manifest (Rispoli, 2016). Working on the same BES will allow the restoration of adaptability and will guarantee greater protection with regard to stressors that will occur, even when it comes to a month-long emergency such as COVID-19. The window of tolerance (Siegel, 1999) will then have greater breadth, and the individual will have more resources to deal with critical events.

The Brief Emergency Treatment

Neo-Functionalism has always been concerned with the original integration of vital systems, and with intervention methods for them. This does not merely include the ANS, but also the central and peripheral nervous system, the systems of Thoughts and Emotions, the endocrine system, and the perceptive-expressive sensory-motor system (Rispoli, 2016). Neo-Functionalism has always dealt with stress and stress treatment, so we have been able to integrate the complex skills of

RESILIENCE: EXPANDING THE TOLERANCE WINDOW

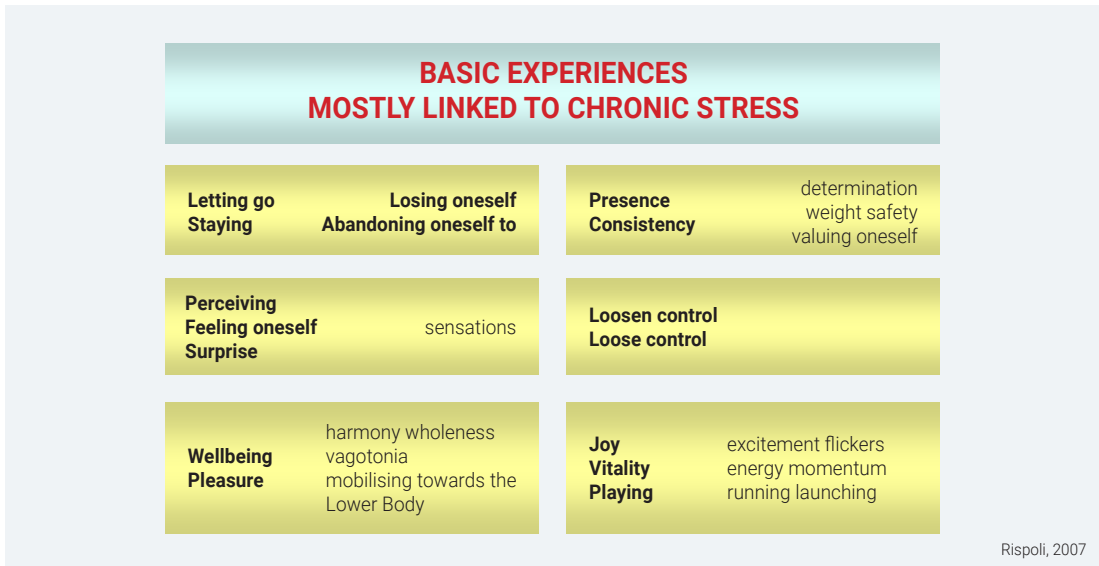


How can we do this?
What type of exercise
do we need?



NEO-FUNCTIONALISM works on the restoration of functions and the Basic Experiences of the Self

Pedrelli, 2019



the functional model in the emergency–traumatic context, to implement a *brief emergency treatment* (Pedrelli, 2014; 2016; 2019).

The most recent contributions in the field of neuroscience have shown how the experiences we offer our users and the psycho–corporeal techniques we use involve activation not only of the mind, of psychic components, or of awareness, but of the entire organism. In each BES, we can identify typical and congruent aspects of the different functioning and vital systems, which ensure that the BES itself is experienced with fullness and intensity. In the **Letting Go BES**, muscle tone is loose and soft, breathing is deep and diaphragmatic, the throat is relaxed, and the voice open and soft. The ventral vagal system is activated, there is cardiac synchrony, and a sense of confidence, serenity, and safety in relying on someone. These are some of the characteristics we can observe, and which are associated with the production of specific hormones and neurotransmitters. The changes that users perceive, and of which they are often (but not always) aware, is due to a modification of all the levels of vital systems, which alter to face that specific type of experience. The very fact of being able to accompany a user in experiencing Letting Go, as well as Calm or other BES, means that the **cure we carry out is specific and profound**.

During this emergency, despite social distancing and the use of video calls, we were nevertheless able to implement specific psycho–body techniques, directing our users towards this or that BES. But more frequently, we found ourselves supporting simple activities and habits that allow users to experience a specific BES, with the aim of re–experiencing it in a more coherent and complete manner. This process is possible if the psycho–therapist has knowledge of those experiences, has ex–

perienced them themselves, and with their presence can accompany the user into the experience with attention and awareness.

Many BES are at risk in an emergency context and, as we know, the alteration they can create is related to the state of greater or lesser integrity of the BES itself, prior to the emergency. If we look at the short list of BES, we see that the first in the list is **Being Held, Being Stopped**. In this pandemic, we have all experienced Being Stopped – for example, being forced to remain in places that for some of us proved to be too constraining. Lockdown rules imposed this on us, but only some of us perceived their protective and reassuring value. For others, the outcome was one of greater anxiety and restlessness, and they reacted by becoming hyper–activated even at home, participating in all available webinars, working all day and keeping busy all the time. Being Stopped is that very important experience that all children have when they exceed limitations, and the adult intervenes to protect and contain them. Yet, when lived out fully and coherently with one’s own needs, being stopped is also the experience that confronts us with the powerlessness surrounding limits: it makes us experience the beauty of letting go and giving in when we understand that the limit cannot be crossed (Rispoli, 2004). If individuals have not experienced the profound sense of protection of Being Stopped, they will react in a more or less spasmodic way to the stop that is being imposed (lockdown, in this case) and will have difficulties in stopping others, children in particular. If an individual does not have their own way of modulating their emotional and nervous state in the direction of Calm BES, the clinical picture will be one of sympathetic nervous system hyper–activation. We will have to work on distress and pervasive anxiety.

When it was possible for us to resume daily activities, albeit with social distancing restrictions, there were people who found themselves in a state of decompensation. Risk perception at that point was no longer based on perceptual competence and reality, but rather on the fear of contagion. Everyday life, potentially more gratifying and normalizing than lockdown life, had become for some a phobic obsession with COVID-19, forcing them to see only the inherent danger. Fear of contagion had made us lose the ability to perceive context, and reset sensations and perceptions to better assess the risk. Some people, decompensated in the Obsessive and Obsessive Compulsive trait, having exhausted resources and energies, found themselves having full breakdowns. No longer having the ability to hyperactivate the dorsal vagal system, they reacted with relational and emotional closure, a sense of emptiness, ineptitude, disorientation, and asthenia. But this decompensation could also have other conditions as a basis, in particular, previous traumas and depressive states.

These two profiles – anxious and depressive – are certainly generic, but as such, they hold together the majority of the issues users report, and are examples of the two macro categories mentioned earlier. Emergency treatment is configured specifically for the urgent treatment of the state of imbalance of the ANS, in preventing psychopathological relapse of the state of Distress. In both situations, the treatment will focus primarily on the rebalancing the ANS in the excess of high or low energy, namely the excessive activation of the sympathetic system or the excessive activation of the dorsal vagal system.

To modulate and reactivate the adaptive capacity, we will work on BES that re-balance the states of excess in which individuals find themselves. Stabilize, calm down, and deactivate are the watchwords that guide the process. In particular, we will work to restore the Control BES that occurs in its extremes of hypo or hyperactivation, and the Perceiving BES, to better focus on the here-and-now and calm down thoughts of danger.

Methodology Aspects

Functional evolutionary psychology (Rispoli, 2004) shows us a rich and complex way of working with children and adults that enhances their personal growth and enriches their basic skills. It identifies BES as the building blocks on which educational and therapeutic intervention are structured. This allows us to have an agile and effective tool when it is difficult to distinguish the need to intervene at an educational level, rather than in rehabilitative or psychological care. The margin between the restoration of skills and care is narrowed in an emergency. In an emergency, it is always difficult to assess the resources of our users, but when we work on BES, we always support them and their learning by enhancing their basic skills. In other words, by working on BES we work on relieving stress, on rebalancing and

supporting capacities, and, as mentioned, on promoting resilience.

Below is a brief outline that exemplifies the brief treatment, although in an abbreviated form. First, we illustrate the work on BES (step 1) and on the techniques aimed at integrating and remodeling them. Competency in psycho-body processes, and practice in the experiences that the body psychotherapist holds, thus becomes the premise on which the brief intervention is structured. Having this observational and operational eye, we will be able to work better in the Creation of Setting (step 2), and in Resource Restoration (step 3).

1. Working on the BES

Here is an example of some proposals that we have often offered our users to reopen and remodel the Control and Perceptions BES. These are divided into two main categories:

- Proposals that adapt to the user's life and are common actions and experiences.
- Proposals deriving from the *Manual of Functional Techniques*, which can be carried out even remotely (Rispoli, 2011).

BES Control in Usual Activities

- *Ask the user to tell you what they see near them and describe it in detail.*

Objective: to restore attention to the context in the here-and-now, to reduce anxiety or agitation expressed in the superficiality with which the user describes their surroundings and, in their difficulty, to stop and slow down etc. This rebalances the user who is in Control hyperactivation.

- *Breathe in a controlled manner.*

Objective: to re-orient the obsessiveness of thoughts and the rigidity of control in an activity that engages the user in a harmonious way and restores a sense of rhythm that leads to calm. This rebalances the user in Control hyperactivation.

- *Support a calm movement with arms or legs in sync with the voice, as if to say, "I am here."*

Objective: to release the power of a movement synchronized with the voice. Rebalances the user when Control is inactive.

BES Control in Functional Psychology Techniques

- Eyes to narrow on exhalation (Tenderness BES)
- Self back massage (Loosen Control BES)
- Throwing arms (Loosen Control, Collapses BES)
- Discover the world with your hands (Loosen Control, Perceiving BES)
- Loosen up head and neck (Loosen Control, Sensations BES)

BES Perceiving in Usual Activities

- Ask the user to perform the movement they are talking about or that they usually do, while slowing down.

Objective: to make individuals aware of movement and experience, to the quality of the gesture and its cost/benefit. and to pay attention to the self and to body sensations.

- Feel your feet on the ground, move them with a little pressure, and then feel them again when standing still.

Objective: to reactivate a little strength, moving downwards to rebalance the upper and lower parts of the body, reopening sensations.

- Voice, opening and modulating it, singing.

Objective: to open, share, re-feel, generate harmony and consistency, creating space for oneself in the context.

BES Perception in Functional Psychology Techniques

- Feeling parts of the body (Perceiving BES)
- Hands: giving themselves tenderness (Sensations, Loving BES)
- Eyes to go open wide (Perceiving, Amazement BES)
- Tired part and pleasant part (Sensation, Tenderness BES)
- Remembering some support received (Perceiving, Contact, Positive Continuity BES)

During treatment we work on the range, modularity, and mobility of the BES. The psycho-corporeal indicators that correlate with the effectiveness of the treatment will be the Voice, the Gaze, and the Posture, which will be more open, soft, and able to consistently reshape the emotional experience; the remodeled muscle and cardio-circulatory systems, which will be more congruent and effective; the Breath, which will be more coherent with the emotional experience.

2. Emergency Setting

The core of emergency psychology is to create **settings**; creating **relationships** with someone we do not know and whom we will see for an hour or so. We clinicians know that almost everything happens during the first therapy session, and the dynamics and history of the person are manifested. In the first session, we collect and grasp those elements that remind us of the patient's essence. In emergency psychology, we have the urgent need to make an analysis of the person in front of us and what their need is. We urgently need to make sense of the information we will be gathering, of the narrative that they will give us. The therapist must rely on their ability to adapt, and on *contact* to intuitively and quickly grasp the direction of treatment to be pursued.

Create Settings

- Build an alliance, accept a request.

We must try to immediately create a connection with the individual, from which to derive the methods of accompaniment and identify the specific need brought by the individual. Empathic listening and the ability to create contact help the psychologist tune into the user's experience. The user's explicit request must be traced back to the emergency context and, if consistent, accepted, or analyzed and re-defined if inconsistent.

- Provide protection and containment.

By building rapport, we create containment; we place ourselves as a reference by creating a sense of protection in the user, who relies on us and can disclose what they have not been able to disclose to anyone. The structure of the Service, which is configured as a support service organized by the Ministry of Health, also contributes to giving our mandate authority. Users attribute an institutional role to us, allowing them to see our work as a strong response from the State, which considers and cares for them in this period of great uncertainty and fear.

- Establish order between thoughts and emotions.

This is a fundamental objective, given that the most frequent and visible symptoms in this period are due to hyperactivation of the ANS. It includes mental agitation and confusion, high reactivity to events, and difficulty sleeping, which contribute to accentuating fatigue and irritability.

- Explain what is happening and make sense of the user's discomfort.

It is very important to share the **meaning**: the meaning and limits of our intervention, the sense of their ill-being and the specificity of an ill-being that is normal in this exceptional situation. Making sense means activating reflective capacity, tolerating frustrations, and promoting integration. This also means creating the basis for the prevention of damage and mental decompensation.

- Re-establish a range of values and tidy up, letting go of what no longer makes sense.

In addition to giving order and meaning, it is important to give direction. We can accompany the user to give value to what is within their reach, where we sense potential. We help them define what their first steps will be, what their priority is, considering the moment of life they have in front of them. The space-time limit of our intervention is clear and sanctioned: a maximum of four sessions and, if necessary, a referral to local health services. The user not only tolerates this limit, but makes themselves strong in it the more they feel like they are acquiring clarity in the direction they are moving towards, and in the objectives they set for themselves.

3. Restore Resources

In an emergency, the setting, and the relationship with our user, which clinically constitutes the framework within which we operate, occur at the same time as the restoration of resources. In fact, we know that states of profound alteration need to be brought back within operating margins that allow the user to feel and feel present in the here-and-now of a relationship with the consultant (window of tolerance). The fundamental work on resources also allows the restoration of the ability to stay in rapport with the other, to enter the setting, and as functional psychologists, we implement it by mobilizing and reopening the BES.

Reopen Functions

- *Stabilize (baseline).*

In an emergency, we often talk about the centrality of emotional stabilization. Anxiety, fear, depressive states, and emotional decompensation are the result of this pandemic, and extensive literature reports on the psychological distress due to the COVID-19 emergency. We emphasize that emotional stabilization is profound and significant for health if it pertains to the biochemical processes – the vital systems and the autonomic nervous system (Rispoli, 2016). The functional psychotherapist knows the fundamental importance of Calm, and the fact that it is not simply the absence of thoughts or muscle relaxation. Each BES is seen through the complexity of the organism’s vital systems (Rispoli, 2004). In the sufficiently good experience of Calm, we find serenity, deep breathing, and a pleasant state of vagotonia. Users prone to sympathetic hyperactivation generally do not know Calm, and brief treatment barely allows them to access this experience. Perhaps they can relax their muscles or lighten their mood a little. We can direct them to experience short moments of relaxation, of slowing down, of feeling lighter, during which they can feel Being Guided and Held by our secure and calm state so that they can feel Calm through our presence and confidence with which we accompany them. On the other hand, users in dorsal vagal hyper-activation benefit from being activated in a gentle way with efforts that aim for the Vitality and Opening BES, and for a taste of Calm Strength. This helps users re-activate without effort and recover a little energy. In this, working with voice and breath to modulate and open is fundamental.

- *Restore Control and Perception by working on the range, mobility, and modularity of the underlying Operations.*

Helping users regain control, direct their attention to presence, and perceive themselves in the present moment and in the reality of their lives. An intervention with simple techniques that support the integration of BES allows the psychologist to promote the restoration of the user’s learning process, rang-

ing from perceiving the here-and-now to restoring control and reflective capacity. Reopen the way from the bottom up, namely from experience to knowledge and awareness of the experience. In states of distress, thoughts are short-circuited and disconnected from perceptions. In the struggle to find integration that gives meaning to the complexity of the moment, confused or chaotic thoughts and emotions pile up. There is a need to return to perception of the here-and-now by integrating the cognitive, emotional, physiological, and postural levels, in a complex systemic perspective (Rispoli, 2004; 2016).

- *Orient towards Vitality and Consistency, pay attention to positive body sensations.*

Body sensations and positive memories can be reopened. Small experiences of Joy are possible for many, having considered a user base that had not suffered direct traumas due to this emergency. With Consistency and its techniques, we redefine values and priorities, the sense of truth and of what is most important.

- *Restore a sense of agency, effectiveness, and planning.*

Grasping the moment in the user’s life in which this emergency is inserted and seeing a first step in Planning. “Being able to leave the house to go shopping with sufficient calmness” or “Visiting their elderly mother respecting social distancing, confident they would not infect her,” or “Being aware of so much inner anger, of the possibility of opening it without acting it out on others” are objectives that can either be suitable or impossible for short-term treatment. Psychotherapists must identify possible steps in the user’s complex inner world; how to divide the macro-objective and support the present potential. We share and support users’ small, simple projects, and when they are distrustful and confrontational, we reread their most adaptive movements in terms of agency and effectiveness, helping them reinterpret themselves more positively.

Conclusion

In life, every moment brings useful learning. Certainly, every experience enriches or impoverishes us, points us either in the direction of evolution and creation or involution and destruction. With every emergency, we face challenges that can positively open feelings and emotions that comfort us and help us feel a little more human. At other times, we face terrible trials, and the road ahead seems too difficult. In this COVID-19 emergency, we helped our users reopen and rediscover their resources, become more aware of them, and take better care of themselves. Being resilient and learning from experience is never easy. Accompanying our users in this difficult phase of their lives means being able to support their skills and growth. As usual, we psychotherapists also grow with them in this process.



ANNEX

Brief Treatment in an Emergency*Considerations regarding the SIF's Toll-Free Number Experience***THE FUNCTIONAL PSYCHOTHERAPY SOCIETY (SIF)
COVID-19 PROJECT****T**

he SIF COVID-19 project is part of a larger campaign by the Italian Federation of Psychotherapy Associations (FIAP), which adhered to the Ministry of Health's initiative to provide a psychological support service to citizens and operators following the declaration of a State of Health Emergency for the coronavirus epidemic of January 31, 2020. The Ministry of Health required associations of emergency psychologists and scientific societies in the psychological field to organize groups of voluntary psychologists to offer free services during this emergency period due to COVID-19. Access to the service is guaranteed through the toll-free number 800.833.833, broadcast by television channels and social media, and is completely free of charge. The psychological support project launched by the Ministry of Health remained active from April 27 to June 30, 2020.

Structure of the Ministerial Project

The Ministry of Health aims to offer a space for competent listening by professionals (psychologists, psychotherapists, psychiatrists, child neuropsychiatrists) which is organized in two levels.

First Level

The first level involves four associations that deal with emergency psychology, enrolled in the registry of the Civil Protection Department: Italian Society of Emergency Psychology (SIPEM SoS), Federation of Psychologists for People (PxP), Italian Corps of Relief of the Order of Malta (CIS-OM), and the Alfredo Rampi Center. The service is active from 8:00 am to 12:00 pm, organized in four-hour shifts. All activity is carried out remotely, the psychological telephone consultation is unique, and has a maximum duration of 20 minutes. First level professionals welcome phone calls to the toll-free number and implement a first access support intervention aimed at establishing a sense of security and reassurance regarding the support the organization can offer its users. First level volunteer professionals carry out the psychological triage and evaluate the user's needs to direct them to the appropriate local services and healthcare providers who have joined the project. These constitute the second level. Subject to the consent of the user, transfer to the second level takes place by forwarding the telephone number of the user to the email address of the identified healthcare provider. The user also has the opportunity to contact the healthcare provider directly via the telephone number or email address provided by the psychologist operator.

Second Level

Many scientific societies have joined the project, including the Italian Federation of Psychotherapy Associations (FIAP) to which SIF adheres, numbering around 1,500 psychotherapy professionals. Through a specific Convention, the Ministry regulated the mandate required of the companies involved in this project. Among the points of the Convention, we point out Article 6 – Incompatibility, which states that:

'The activity provided by the aforementioned professionals does not constitute psychotherapeutic service. Those who offer this collaboration, both for the first and for the second level, are expressly forbidden, for a period of six months from the end of the emergency which led to their collaboration with the service users, to begin remunerated psychotherapeutic treatments with any of the users involved in this project.'

Second level psychotherapists are called to intervene by providing support for users' discomfort caused by the COVID-19 emergency to prevent psychological and psychiatric problems. Following the sending of the user's telephone contact, or in response to a call made by the user, the second level professional determines with the user what times and methods are most suitable for their current needs. A maximum of four sessions are set up by the Ministerial project, with possible follow-up to be carried out within the emergency period. All sessions are conducted via phone or video call. The two levels work in synergy, collaborating in the management of the service and responding in a timely manner to user needs. Discussion meetings are held regularly between representatives of the first and second level and the heads of the Ministry.

The SIF COVID-19 Project

The SIF COVID-19 project came to life on April 25, 2020, following the commitment of 28 Functional Psychotherapists enrolled in the SIF to the FIAP proposal to join the Ministerial Toll-Free Number project, and ended on May 31, 2020.

The Human Resources

- **Enrica Pedrelli**, President of the Italian Society of Emergency Psychology section Emilia-Romagna (SIPEM ER), SEF teacher and supervisor, project manager and coordinator.
- **Sara D'Amaro**, voluntary psychologist at the Italian Red Cross, Functional Psychotherapist, secretarial contact. Retrieval of user referrals via SMS or calls, and distribution of requests to colleagues following psychological triage. Available via phone on Tuesday afternoons from 4:00 pm to 7:00 pm.
- **Teresa Giacometti**, trainee psychologist, secretarial assistant, handling referrals received exclusively via email, and distribution of said cases to SIF Professionals. Enrica Pedrelli, Luciano Sabella, Carlota Benitez, Luisa Passarini, SEF teachers and supervisors. During the sessions, supervisors gave their availability to oversee cases assigned to colleagues and guided reflections on the functional approach to the current emergency.
- **The Functional Psychotherapists Task Force**. Enrica Pedrelli, Sara D'Amaro, Carlota Benitez, Luciano Sabella, Luisa Passarini, Elena Capovilla, Valentina Mascia, Cristiana Salvi, Annalisa Avancini, Monica Sciacca, Massimo Colica, Liliana Argenziano, Silvia Belcaro, Camilla Bertocci, Benazzi Stefania, Elena Sgherri, Antonella Prudente, Monica Ligas, Sara Palermo, Lucia Nicastro, Mariangela Di Meglio, Chiara Pacquola, Anna Massaro, Claudia Tessile, Chiara Dalle Luche, Caterina Iudica, Silvia Mason, Zaira Sardella.

Two training sessions per week were proposed, on Mondays from 21.00 to 23.00, and on Saturdays from 18.00 to 20.00. Saturday appointments were canceled from May 10, 2020 onwards. Daily briefings were held on organizational and secretarial issues and attended by Enrica Pedrelli, Sara d'Amaro, and Teresa Giacometti.

The Numbers

From April 27, 2020 to May 31, 2020, 130 users were directed to the SIF COVID-19 secretariat. The Ministry of Health requested quantitative data on users from all scientific societies, which was collected and sent through FIAP. We will soon be able to carry out a quantitative analysis of the requests processed by SIF, and a qualitative analysis on the methodologies used and on the overall emergency faced. Although the service ended at the end of May, the therapeutic work continued until the end of June. 130 requests for advice were accepted for a total of 285 sessions.

Unfolding of the Project

From April 25, 2020 to May 31, 2020, eight meetings were held involving members of the SIF COVID-19 organization, for a total of 16 hours. These meetings were held on the Zoom video platform and divided into:

- **Training moments.** Enrica Pedrelli introduced her psychotherapist colleagues to the complex world of Emergency Psychology, characterizing it by its specificities inherent in the contingency of the critical moment, and highlighting its differences from the path of psychotherapy. In an emergency, the psychological intervention has as its main objective the restoration – in a short time-frame – of the emotional and psychophysical stability of users who are facing a crisis caused by the emergency.
- **Moments of inter-vision-supervision.** During these meetings, a space was created for each psychotherapist to share their experience with the users with whom they interacted. The group was divided into three sub-groups, each of which was managed by one of the project supervisors (Benitez, Sabella, and Passarini). They shared their knowledge and clinical experience to support their colleagues and sub-groups.
- **Moments of reflection on the relationship between Emergency Psychology and Neo-functionalism.** To make the best use of the tools and resources of Neo-functionalism, within each sub-group, another space for reflection was created. This was dedicated to how the specificities of Neo-functionalism could be integrated in a brief intervention in an Emergency context, and on how work on Basic Experiences (Rispoli, 2006) could be further integrated in this specific context.



Enrica Pedrelli is a psychologist, psychotherapist, and a member of the Functional Psychotherapy Italian Society (SIF). She has been a teacher, trainer, and supervisor in the Functional Psychotherapy European School (SEF) since 2003. A member of the EABP Forum, she has been working for several years in the field of trauma and parenthood.

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Time for Transformation and Creativity

Rubens Kignel

ABSTRACT

The author researches, explores, and proposes a new way of looking at, and living with, the adversities of human life in its environment and within earthly systems. From the beginning of life, and far before human life appeared, nature has demonstrated how, throughout evolution, life forms maintained themselves by relating, adapting, including the necessary, and excluding the unnecessary. We humans can learn from life's millions of years of experience, and from how ecology works to preserve life wherever it exists. The author shows that what are considered *impurities* may well be the very systems we depend on to survive, and makes connections between the human psyche, relationships with the environment, and relationships with others.

Keywords: environment, nature, ecological communication, body psychotherapy, nature and communication, virus, fungus, bacteria, impurities and purities between us, psychoanalysis, Reich

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Usually, when talking or thinking about the origin of human beings, there is a fixation on thinking about monkeys and, eventually, underwater animals.

But the origin of human beings is elsewhere, in a place that is both human and non-human. The encounter that produced life on Earth took place between elements that existed at least four billion years ago, amidst the debris of a supernova explosion during the period called the Hadean Eon¹, which is apparently when everything began on Earth.

So, I begin this article by championing an issue that is present in all of us, in our flesh and bones, and in our subjectivity. It is what I call *the impurities that need to be defended*.

What are these impurities?

The dichotomy between nature and society has been overturned by recent scientific discoveries that prove that bacteria, viruses, and fungi live in our body, and more accurately, *have become our body*. It is a miracle that, among billions of people, we are each unique.

Approximately 43% of the human body is made up of human cells; the other 57% are bacteria, viruses, and fungi, or non-human organisms. Ten percent of the body's dry weight consists of bacteria, and even though some are not congenital, we cannot survive without them.

The natural defense system works like this – it will fight against selfish cells, those that are not supportive and do not want to collaborate.

1. The Hadean Eon is defined by geologists as an extremely long age at the beginning of Earth's formation 4.6 billion years ago until the appearance of the first rocks four billion years ago. More information at: Lynn Margulis and Dorian Sagan, *Microcosmos: Four Billion Years of Microbial Evolution* (Berkeley, University of California, 1997).

Historically, we have believed that the microorganisms present in our bodies were of no importance, in spite of the fact that the microbes expelled in our feces can be identified, and that despite being dead, their DNA remains intact. Today, scientific evidence shows that disturbances to the microorganisms in our body are responsible for gastrointestinal disorders, allergies, autoimmune disease, and even obesity. You see, microorganisms not only affect our physical health, but our mental health as well, ranging from anxiety – the illness of our times – and depression to obsessive-compulsive disorders and autism.² This demonstrates that the microbes in our bodies must be carefully considered and cared for by body psychotherapists.

This coexistence between human and non-human is called “evolution.”

Millions of years ago, bacteria appeared and spread to create compound organisms. When nature shifted from Earth without oxygen to Earth with oxygen, the conditions for living beings dramatically changed. Oxygen was the dangerous result of photosynthesis by bacteria. With the appearance of oxygen, many bacteria, viruses, fungi, and microorganisms had to find places where they could survive, as oxygen threatened to eliminate them. Many of these microorganisms found refuge in living bodies; many years later, the human body was one of their chosen places.

During this quest for refuge, symbiotic processes developed. To this day, our human organism continues to interact with and depend on this microcosm, just as this microcosm depends on us. In the course of a few million years, microorganisms began producing vitamin B12 in our intestines, and became part of our cells. Aggregates of cells became organs. It is not absurd to say that the study of the evolution of the microcosm leads us to the idea that our consciousness probably arose from the combined capacity of thousands of microbes coming together symbiotically to form the human brain.³

Our bodies, like those of all life forms, preserve the environment of a previous Earth. We coexist with today's microbes, and harbor the remains of others that are symbiotically incorporated in our cells. In this way, the microcosm lives in us, and we live in it. This coexistence, which has lasted thousands of years, is responsible for our evolution. Our organism was supportive enough to accept these strange, different, “invasive” presences, and learn to live with them, enter in dialogue with them.

... a group of healers in Mozambique sought out government authorities during the pandemic and offered their services. They told the authorities that when they found out who the virus is, ... they would start a dialogue with these microorganisms to try to understand them and develop communication.

We all learned to include each other in an ecological space that serves the preservation of life.

And the human organism has become the most complex and intelligent there is.

The Earth's eco-social situation, at this moment, is one of intense transformation. Ecosystems are being attacked as never before in millions of years. Much has been destroyed, much is being transformed. It is not yet known which path will prevail. Certainly, humans are adapting – some are resisting, others not.

Solidarity is not only due to the fact that we are nice and good people. Solidarity lies in our ability to create supportive living conditions, share work, food, space, home, and emotional and rational support. Solidarity is not charity.

Solidarity is creative work.

The Mozambican writer Mia Couto says that a group of healers in Mozambique sought out government authorities during the pandemic and offered their services. They told the authorities that when they found out who the virus is, they would communicate with it – they would start a dialogue with these microorganisms to try to understand them and develop communication.

We have a lot to learn from ancestral knowledge about microorganisms. The history of pandemics teaches us a great deal. For example, in Europe, it took many years to discover that the Black Death came from rats and rat fleas, and the creation of an efficient cure took 350 years. During this period, many scapegoats were created. One of them, it is important to mention, was the Jewish religious population.⁴

At the time, it seemed like Jews were not as affected by the plague, so the conclusion by the then-dominant Church was that Jews were in control of, and spreading, the plague. As a result, Jews were intensely persecuted and cruelly slaughtered – at times burned alive. This was the elementary, crude solution adopted to end the plague. Evidently, instead of immediately turning them into culprits, no one thought about why Jews had a certain immunity against the plague. Jews had a religious habit of constantly washing their hands, bathing, and eating in a healthy manner, which was a form of good

2. *10% Human*, Alanna Collen, Harper Paperbacks, 2016.

3. Margulis and Sagan, *Microcosmos*.

4. Stefan Cunha Ujvari, *História das Epidemias* (São Paulo: Editora Contexto, 2020).

A lie should not become a truth, unless it were to imprison, as it did Mussolini, Hitler, Bolsonaro, and many others.

hygiene. This spiritual habit saved many of their lives, but popular ignorance marked them as targets during the plague.

Today, these hygiene habits are the basic recommended lifestyle for our entire population.

Our organism has managed, and still manages, to be supportive of billions of foreign bodies and billions of cells. As it becomes a single body, it evolves and cannot live without its impurities. An enormous complexity co-exists “lovingly and unconditionally” in our body without the slightest sign of selfishness, taking care of what is different, taking care of others at the micro levels. If selfishness arises in the system, it is because something within the trillions of cells is not working properly – that is, it is not supportive or collaborative. And the name of that cell will be cancer, a tumor that selfishly produces others.

The immune defense system has zero tolerance for selfishness. The natural defense system works like this – it will fight against selfish cells, those that are not supportive and do not want to collaborate.

Organic selfishness is entropy itself.

We can see that the organism is a system absolutely contrary to our society, which is selfish in the extreme and, therefore, absolutely tumoral and entropic. As scientist Antonio Nobre ⁵ claims, collaboration and solidarity prevail in nature. Without collaboration, there is no complexity, which is basic to the existence of our self-regulating system and is also the basis of love.

Human beings exist only in coexistence with non-human beings. One depends on the other. Opposites go together. We are all made by “not-us.” Interdependence, as Dr. Genovino Ferri ⁶ says, is naturally present in our lives and on our planet.

Our organism has developed an ecological capacity to preserve life among all its differences. Diversity begins in our own organism. Is that which is not human, or in-human, not its equal? Good question, isn't it?

Even though our organism has achieved the freedom to reinvent itself, this does not mean that it will also happen among us humans. We have a great and disturbing paradox here: humans demonstrate an enormous difficulty in evolving and building systemic alliances that include humans, ecosystems, nature, animals, and

microorganisms in the interest of ensuring a better future.

Survival is due to our ability to reinvent and create. It is a spectacle based on our own fragility.

We need to face or reveal truths that have been repressed, forgotten, or set aside for moral reasons – truths that are scary, but are in short, just truths. The current world is permeated with lies. In reality, we have known other times that were also permeated with lies, and seen that these lies led to disastrous plagues and wars, to slavery, to genocides, to the annihilation of blacks, indigenous people, Jews, Gypsies, Chinese, homosexuals, transsexuals, etc. – in brief, to the destruction of everything that was different or diverged from what people in power considered a threat to the pure white race.

Only truth leads us into the future.

Psychotherapy and psychoanalysis have always sought the truth. For example, Freud, when using free association, sought the truth contained in the unconscious. Reich, in evaluating the musculature, looked for the unconscious truth contained in the body. Jung, using the study of archetypes, looked for truth in the images and fantasies contained in the unconscious. Everyone sought to liberate or find sexuality. Perls, through spontaneous gestures in Gestalt therapy, sought awareness. Moreno, through psychodrama, sought the truth of group affective relationships, while Liss, Boyesen, Boadella, and Lowen looked for truth in the use of body-based techniques.

Once truth, or truths, are found, we become free people with growing possibilities for choice. In other words, truth leads to freedom, to independence, and to increasing choices, while lies lead to narrowed options and imprisonment. The path of psychotherapy is that of truth and freedom. Without truth, there is no freedom, and there is no freedom without truth. A lie should not become a truth, unless it were to imprison, as it did Mussolini, Hitler, Bolsonaro, and many others.

This is a truth to be confronted: we are inhabited by non-human beings, as well as human cells. We have non-human truth within us. We live with the non-human. We must acknowledge it to be free, and not try to exterminate it. In fact, the search for extermination takes years, and is often not found.

If external threats are large enough, normal cyclical processes can be destroyed and schismogenesis can occur. Schismogenesis ⁷ is a word coined by Gregory Bate-

5. <https://believe.earth/pt-br/antonio-nobre-o-cientista-da-amazonia>

6. Genovino Ferri, *Il tempo nel corpo. Attivazioni corporee in psicoterapia* (Rome: Alpes Italia, 2020).

7. Gregory Bateson, *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution, and Epistemology* (Chicago: University of Chicago Press, 2002.)

son, a biologist and philosopher. It refers to cycles in living systems that oscillate uncontrollably. Bateson believed that schizophrenia could be related to a certain type of schismogenesis – in this case, an excess of feedback in the brain that leads to disintegration.

The opposite of schismogenesis is **autopoiesis, that is, the necessity to actively stay alive against the antics of the world.** Life responds to disturbance and uses matter and energy to stay intact. An organism constantly negotiates its parts and replaces its chemical components without losing its identity. We must learn to dialogue with the different, the invisible, the unknown beings that will remain with us forever.

Caution must be an important part of our education and everyday hygiene. Historically, it took human beings a long time to discover vaccines and antibiotics – long after the effects of microorganisms were known. Therefore, if new threats appear, hygiene is basic for the non-dissemination of unknown viruses and bacteria. Essentially, we already know the basic habits, such as handwashing and keeping the body clean, which guarantee some security. Masks become essential when we know that there is “something in the air.”

However, the unknown does not only consist of viruses and bacteria. We humans are always creating “strangers,” adding new possibilities for the unknown to emerge – in new smartphones and new technologies coming out each year. “The faster the better.” What before took millions of years now takes only a few seconds.

Who knows? In a little while we may be able to teleport from one place to another.

While it is fascinating, this incoming novelty to which humans are adapting almost always appears at a greater speed than is possible to integrate, even for the young or very young. What are the consequences? Consequences can be positive or negative. Therefore, to reiterate, we must be attentive to our relationship with the new, especially in relation to technology, the wonder of our time. First, we must know our technology better since, just as a new virus is in the air, the “magic” devices of our technology also communicate through the air. We must not forget that, although created by humans, technology is not human!

Many develop strong emotional connections with their devices, as if they had a soul, a heart. Remember *Blade Runner 2049*⁸ (2017) in which the replicant had a sexual relationship with a virtual woman? Although without a human woman it is not real, nevertheless, he is passionate about his virtual relationship.

... affective problems are understood psychologically, but the neurological ones are reflected in the electrical functions of the organism, which resonate with the electromagnetic waves of our devices...

A human being’s sensitivity, deprivation, and relational difficulties can create confusion around the virtual fulfillment of repressed and unconscious desires. This issue has brought many affective and neurobiological problems. Emotional problems can be understood psychologically, but the neurological ones are reflected in the electrical functions of the organism, which resonate with the electromagnetic waves of our devices, and that goes through the unknown, through the invisible.

If we don’t worry about technology in the same way that we worry about an unknown virus, we will have surprising problems with new impurities. For example, monitors are a new bridge for contact between people. Monitors show us representations, not flesh, bone, and smell humans. Therefore, through non-human elements, we contact the human and the thrilling capacity to create emotional relationships anywhere in the world. This reminds us that again, the “non-human” is part of ourselves, incorporated into our daily lives.

Electronically, distance does not matter, yet when it comes to forming relationships, distance does matter. What I mean is that, when we are physically face to face, there is an important experience of proximity, a distance that is neither invasive nor abandoning. In online internet communication, immense distances are shortened, and we also come face to face with people, penetrate their homes, work, leisure, cars. In the virtual approach, we experience and pay attention to other stimuli, such as the face, the voice, the look, the words, the breath, so that communication is also neither invasive nor abandoning. Both are wonders that allow us to preserve contact, but what will be the outcome?

Our body is always creating antibodies to protect us while adapting to or protecting us from invaders. The vaccine, for example, must work with our organism, using its intrinsic wisdom, infecting the body so that it causes the formation of antibodies, and accepts this new invasive element without danger, without schismogenesis. Today, as always, humans must learn to live and dialogue with impurities and with what is “non-human” in order to find a possible ecological language.

According to the Book of Genesis, God stopped the construction of the Tower of Babel by introducing many languages. The Tower never reached Paradise because its builders, stripped of a common language, became confused. This parable shows the importance of finding a universal language through and with our differences

8. <https://www.youtube.com/watch?v=g-LzzkTi6hk>

with nature. Paradise is nothing but nature with all its epics. As Jerome Liss⁹ said, in an ecolibertarian way: where is freedom?

Confinement could have been a prison, and it was for many. Or it could have been freedom, and so it was for many.

We discovered that freedom is not just out there. Freedom is found within each one of us. Psychotherapy is always looking for it, without illusions, with limits, but without taboo.

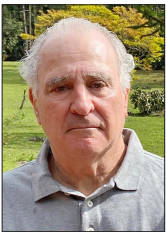
In body psychotherapy, we constantly work to find the body's best capacities to deal with improvisation, with micromovements that affect the macromovements. Micromovements are more precise and bring awareness because we change and learn one thing at a time.

In our microcosm there are changes that affect the macrocosm.

Awareness of the unknown leads to better brain integration and triggers motivation. Integration is the connection of different parts through which we become more intelligent. Different activities, accepting the challenges of the unknown, following the intuition that makes you feel, think, and act are all important.

The search for truth is a challenge towards a better future.

Solidarity is an intelligent process. As Genovino Ferri¹⁰ writes, truth is a relationship of interdependencies. We are all together on this planet, in a unique system that is interdependent with everything that exists, and it is this relationship that will help us develop better, interconnected systemic intelligence.



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9. Jerome Liss and Maurizio Stupiggia, *La comunicazione ecologica. Manuale per la gestione dei gruppi di cambiamento sociale* (publication city: publisher, 2016) and *Dalla sofferenza all'emozione. L'approccio biosistemico al trattamento psico-corporeo della sofferenza emotiva* (publication city: publisher), 2018.

10. Genovino Ferri, *Il tempo nel corpo. Attivazioni corporee in psicoterapia*, I (publication city: publisher 2020).

The Development of Japanese Body Psychotherapy

Yasuyo Kamikura, Ryozo Shimizu

ABSTRACT

This article aims to introduce the development of Japanese body psychotherapy by focusing on Dohsa-hou, an original Japanese psychotherapy created by Gosaku Naruse. First, this article introduces psychotherapy in Japan, including the licensing of clinical psychotherapists and mainstream psychotherapy in Japan. Second, it introduces body psychotherapy, prominent psychotherapists, and people's acceptance of touch in Japan, while comparing Western and Eastern cultures and psychotherapy. In addition, the article shows how Dohsa-hou has been developed in the fields of children with disabilities, by practicing Dohsa training, and people with mental illnesses by using clinical Dohsa-hou. Next, the authors discuss some issues as a Dohsa-hou therapist, current topics in Japanese mental health amid the COVID-19 pandemic, such as "depressed mood brought on by stress from quarantine" and "quarantine fatigue," and the possibilities of online Dohsa-hou. Last, a proposal is made for the future of psychotherapy. The spread of Dohsa-hou will be significant for the development of body psychotherapy in Japan.

Keywords: body psychotherapy, Japan, Gosaku Naruse, Dohsa-hou, Dohsa training, clinical Dohsa-hou

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In Japan, there are two qualifications for psychotherapists. One is for clinical psychologists, which requires a master's degree to take the examination set by the Foundation of the Japanese Certification Board for Clinical Psychologists. The Foundation has qualified 37,249 clinical psychologists since the first clinical psychologist qualified in 1988. The other qualification is for certified public psychologists. Japan's first national qualification for psychologists was formalized in 2018. University graduates are qualified to take the exam, depending on their curriculum. As of 2020, there have been 43,720 successful applicants for the license.

Mainstream Japanese psychotherapy is based on a client-centered approach and psychoanalysis. More recently, cognitive behavioral therapy (CBT) and mindfulness have been attracting attention in terms of evidence. However, therapists tend to practice psychotherapies with unclear supporting evidence because most rely on traditional psychotherapy, and do not always actively examine the clinical evidence. Other therapists use behavioral therapy, art therapy, sandplay therapy, play therapy, hypnotherapy, brief therapy, transactional analysis, family therapy, Gestalt therapy, and EMDR (eye movement desensitization and reprocessing therapy), etc. Hayao Kawai, an esteemed Japanese psychologist, introduced Jungian psychology to Japan, and developed sandplay therapy and dream analysis. Some therapists also practice Morita therapy and Naikan therapy, which are original forms of Japanese psychotherapy.

The number of members in the major Japanese psychotherapy and body-oriented psychotherapy organizations may be some-

Dohsa-hou is not the integration of mind and body, which are separate, but the harmony of mind and body through the transformation of the movement that embodies the mind and body.

what helpful in understanding the actual situation of psychotherapy in Japan (Table 1). These data were obtained from the organization directory by using the Science Council of Japan's search engine on March 22, 2021. The Association of Japanese Clinical Psychology is the largest organization in the field of clinical psychology with 29,227 members, including both clinical psychologists and graduate students studying clinical psychology. Table 1 shows that the Japan Psychoanalytical Association, with 2,939 members, is the largest

organization. The Japanese Association for Cognitive Therapy has 1,700 members, followed by the Japanese Association of Rehabilitation Psychology (JARP) with 1,050 members. The Association of Japanese Clinical Dohsalogy (AJCD), which is based on Dohsa-hou, and the Japanese Society of Autogenic Therapy and the Japan Association of Jungian Psychology, are similar in size, with less than 1,000 active members each. The Japan Dance Therapy Association is the smallest professional body, with 230 members.

Table 1 Main Japanese organizations, the year of establishment and number of members

The name of organization	Year of establishment	Number of members	Year updated
<i>The Association of Japanese Clinical Psychology</i>	1982	29,227	2021
<i>The Japan Psychoanalytical Association</i>	1955	2,939	2021
<i>The Japanese Association for Cognitive Therapy</i>	2016	1,700	2020
<i>The Japanese Association of Rehabilitation Psychology</i>	1976	1,050	2018
<i>The Japanese Association for Humanistic Psychology</i>	1982	918	2021
<i>The Japanese Society of Autogenic Therapy</i>	1978	763	2020
<i>The Japan Association of Jungian Psychology</i>	2012	693	2020
<i>The Association of Japanese Clinical Dohsalogy</i>	1993	685	2019
<i>The Japan Dance Therapy Association</i>	1992	230	2020

Note: Year updated means the total number of members in the year

Many psychotherapists practice an eclectic psychotherapy integrating approaches from various schools. This may be due in part to the unique approach to religion in Japan. The Japanese do not have a deep commitment to any particular religion, but tend to accept many religions. Since ancient times, a worldview that eight million deities (*yaoyorozu no kami* in Japanese) reside in all aspects in nature and the whole of creation (*shinrabansho* in Japanese) – a form of animism – took root in Japan's ancient Shinto religion. The Japanese also practice a variety of religions, depending on the season or event. For example, during their New Year's visits to shrines, they prefer to pray to a Japanese *kami* for their health and happiness in a Shinto shrine, and do the same in front of Buddhist statues in a temple. Christmas is not a religious rite, but an event similar to a festival, and many Japanese couples prefer to hold wedding ceremonies in a Christian style. This flexible acceptance to national and international sources may have led to the practice of eclectic psychotherapy.

Body Psychotherapy in Japan

Before introducing body psychotherapy in Japan, it would be helpful to share the author's understanding of the differences between body psychotherapy in Europe and the United States as compared with Japan. Western body psychotherapy categorizes humans as having physical, emotional, cognitive, and spiritual components, and therapy's goal is to integrate these through therapy. In the background, Christianity and mind-body dualism have been influential, and the words "body," "psycho," and "therapy" might reflect the view that the mind, which belongs to God, and the instinctive body, are two different things. In recent years, mindfulness and the Hakomi method were derived from Buddhism, and influenced by Eastern thought. Mindfulness was reimported to Japan as a form of CBT, although it was developed in the West by adopting meditation that originated in the East; it emphasizes a state of being that is similar to "acceptance of life as it is" (*arugamama* in Japanese) from Morita therapy in Japan.

On the other hand, there is a Japanese Buddhist concept of “*shin jin ichi nyo*” (身心一如 in Chinese characters), which means “body as one.” This concept has led to the development of psychosomatic medicine. However, it is difficult to treat the mind and body as one, and the only way to approach treatment is to treat the mind and body separately. Therefore, Naruse focused on Dohsa as a phenomenon that can be treated scientifically as a true unity of body and mind. Therefore, the goal of Dohsa-hou is not the integration of mind and body, which are separate, but the harmony of mind and body through the transformation of the movement that embodies the mind and body. For that reason, Dohsa-hou does not fit into the category of body-oriented psychotherapy.

The difference in treating the mind and body in the West and the East is reflected in psychological theories. For example, Stern (1985) introduced the mind-body monism perspective to psychoanalysis, partially to developmental stage theories, and proposed the concept of a self-sense that includes the body. More recently, in philosophy, Gallagher (2000) also emphasized the body's role, and proposed the concept of self-consciousness, which he defined as consciousness of external and internal worlds related to self-awareness. Having taken a mind-body dualistic view of humans, he proposed two concepts in self-consciousness: the sense of self-agency (i.e., that one is causing actions and thinking) and the sense of self-ownership (i.e., the sense that contributes to a sense of self and a developmental bias for psychological identity). In contrast, Dohsa-hou proposes a theory for harmonization of body and mind and regards human movement as a means to harmonize the body and mind. In Japanese, Dohsa refers to a holistic process of movements that includes physiological and psychological processing associated with the body's motor activity.

Dohsa-hou is the most popular form of body psychotherapy in Japan. Dohsa-hou has been widely applied to children, elderly people, and those with mental illness. Other psychotherapists have used autogenic therapy, progressive muscle relaxation, and some clinicians have practiced dance therapy. As for body psychotherapies imported from other countries, most Japanese clinical psychologists do not know them well and do not actively practice them.

Autogenic Therapy

Autogenic therapy was systematized by Schultz, a German psychiatrist, in 1932. It is a method to restore balance in the autonomic nervous system by relaxation through self-hypnosis, and is used to treat insomnia, anorexia, and other imbalances. In clinical practice, the psychotherapist asks the client to close their eyes and states the background instruction, such as “You are completely calm,” then gives six instructions to the client in order. For instance, in the second statement, the psychotherapist asks the client to focus attention on their arms and repeat “Your arms are very heavy.” The goal of autogenic therapy is to bring deep relaxation and

reduce stress. The Japanese Society of Autogenic Therapy was established in 1978.

Progressive Muscle Relaxation

This relaxation method was created by Jacobson as a method for stress relief and a treatment for neurosis. In its simplest form, clients start with one part of the body, tense the muscles in that part for about 10 seconds, and then relax those muscles all at once to experience the release of tension. There is no society associated with this therapy in Japan.

Dance Therapy

This is a therapeutic method that approaches the body and mind through movement to promote emotional, social, cognitive, and physical integration. It is a form of art therapy that originated in the United States in the 1940s and was developed by incorporating developmental psychology, psychoanalysis, and movement analysis methods. The Japan Dance Therapy Association was founded in 1992, and its advisor is Sharon Chaiklin, a former president of the American Dance Therapy Association.

Dohsa-hou

Naruse developed Dohsa-hou in two ways, namely, Dohsa training and clinical Dohsa-hou. Dohsa training has been practiced on children with cerebral palsy, and intellectual and developmental disorders, while, clinical Dohsa-hou is practiced on patients with mental health disorders. He established the Japanese Association of Rehabilitation Psychology (JARP) in 1976, and the Association of Japanese Clinical Dohsalogy (AJCD) in 1993.

Psychotherapists who Developed Japanese Body Psychotherapy

One of Japan's most renowned psychological clinicians, Naruse (1924–2019), was the founder of Japanese psychotherapy (Dohsa-hou) and the first president of the Association of Japanese Clinical Psychology, JARP, and the AJCD. He was also the first clinical psychologist and an honorary professor at Kyushu University. He developed clinical psychology in Japan and had a close relationship with Milton H. Erickson through studies and practice in hypnosis. In addition, he introduced and spread Schultz's autonomous training method and hypnosis in Japan.

Mitsuyo Tsuru is a disciple of Naruse and a professor at the Tokyo University of Social Welfare. She also served a term as president of the Association of Japanese Clinical Psychology and is president of the AJCD and on the JARP's board of directors. She had devoted herself to nationalizing psychological jobs. In the clinical field, she developed Dohsa training for handicapped children into clinical Dohsa-hou as a form of psychotherapy.

The fact that both Naruse and Tsuru have served as president of the largest Japanese Society of Clinical Psychology is proof that Dohsa-hou is highly regarded as a body psychotherapy, even though it is not practiced in mainstream Japanese psychotherapy.

Dohsa-hou

Autogenic therapy, progressive muscle relaxation, focusing, and dance therapy are psychological approaches that focus on bodily sensations, and are treatment modalities that have been imported from Western countries. On the other hand, Dohsa-hou is an original Japanese body psychotherapy that emphasizes the harmony of mind and body, as described in Section 2 (Body psychotherapy in Japan), rather than the relaxation effects of movement. It is a unique Japanese idea that movement (*dohsa* in Japanese) itself cannot be done unless the mind and body are working harmoniously at the same time. Therefore, this section focuses on Dohsa-hou.

In the mid-1960s, Naruse et al. found that hypnotherapy is effective in improving the movement disabilities of people with cerebral palsy (Imura et al., 2015). This led Naruse to develop Dohsa-hou as Dohsa training. He focused on the subjective experiences that occur when people try to control their body movements. Dohsa training is effective as a nonverbal approach for children with severe disabilities who have difficulty understanding language. In addition, Dohsa trainers have accumulated clinical experience with children with Asperger's syndrome, who have difficulty empathizing with others. Dohsa training was then applied to patients with schizophrenia in the 1980s and has subsequently been developed as clinical Dohsa-hou. Tsuru further accelerated clinical practice and studies on patients with schizophrenia, and explored the effects of Dohsa-hou on that population.

Thus, Dohsa-hou is not only effective in developmental support for children with disabilities who have difficulty in verbal interaction, but it is also effective for patients with severe schizophrenia who have not had success with verbal psychological approaches. In this way, clinical Dohsa-hou has contributed to the development of Japanese clinical psychology. In a clinical Dohsa-hou session, the therapist focuses on the tension and discomfort in the client's movements and posture, then sets movement tasks such as the shoulder-raising task, arm-raising and -lowering task, or stepping task accordingly. Simultaneously, therapists emphasize the experience that occurs in the sequence of the client's intention, effort, and execution of the body movement. In addition, the clinical Dohsa-hou effects that therapists can easily perceive in the client's movement experience with their hands (movement empathy), makes it easier to have an empathic relationship with the client than through verbal counseling.

However, the most characteristic feature of clinical Dohsa-hou is that it enhances clients' agency and their independence. It also brings about psychological change and ameliorates psychological symptoms. Previous studies have shown that clinical Dohsa-hou brings about psychological changes that are different from those of derived from exercise, such as stabilizing emotions, reducing stress responses, and changes in experiencing behavior, emotions, attention, and effort, in addition to the psychological effects of the short-term intervention. With these changes, it harmonizes body and mind, by for instance, improving various physical disorders, or stiff shoulders and back pain.

Japanese Educational Programs for Body Psychotherapy

There is no specialized university course to train in body psychotherapy because the Japanese curriculum covers a wide range of different psychotherapies. However, some universities offer Dohsa training lectures as part of their undergraduate teacher training programs for working with children with disabilities. Some of these classes fulfill some of the requirements for certification by JARP as Dohsa trainers.

The academic societies have training programs for therapists, and certifications for qualification. For example, JARP certifies Dohsa trainers and the Dohsa training of supervisors. In clinical Dohsa-hou, AJCD verifies the certified Dohsa-hou therapist, the certified clinical Dohsa-hou therapist, and the certified clinical Dohsa-hou instructor. Although JARP and AJCD are not members of the European Association for Body Psychotherapy (EABP), Yasuyo Kamikura and Ryozo Shimizu, board members of the JARP, AJCD, and the Association of Japanese Clinical Psychology, have given presentations at EABP congresses, and published a review in *International Body Psychotherapy Journal* (IBPJ). Additionally, the author has volunteered to translate IBPJ abstracts into Japanese.

Other private organizations, like BIO Integral Psychotherapy School (BIPS), which are members of the EABP, have training courses in biodynamics, bioenergetics, etc., and certify body psychotherapists as EABP-certified. BIPS welcomed Rubens Kingnel as the main director and has invited guest trainers, such as Clover Southwell, Francois Lewin, Achim Korte, Michel Coster Heller, Liane Zink, Maurizio Stupiggia, and Madlen Al-gafari (the editor-in-chief of IBPJ).

Touch

In Japan, touch is not common, and people usually maintain a specific distance from others and usually bow when greeting others. They do not hug, shake hands, or kiss, because physical contact in public is considered immodest. In recent years, the word "healing"

has become common, and people like to have massages to alleviate daily physical and mental fatigue. Practices of oriental medicine – for example, bone setting, acupuncture, and moxibustion – have become accepted as treatments that include physical contact. Therefore, judo therapists and practitioners in acupuncture and moxibustion are nationally qualified.

On the other hand, physical contact in psychotherapy is not common. In Japanese clinical psychology, client-centered therapy and psychoanalysis have been around for a long time, so trainee therapists learn these therapies to acquire therapists' basic attitudes and psychotherapy skills. Therefore, most Japanese therapists tend to consider physical contact as taboo, because they believe touching would affect the transference and countertransference associated with psychoanalysis. Consequently, body psychotherapy is not mainstream in Japan. Dohsa-hou places importance on the fact that clients move their own bodies with intention and effort. However, since Dohsa-hou involves physical contact, some psychotherapists often incorrectly see the physical contact as having the same effect as that of a massage, such as the warmth of touching the body. These misconceptions are often deep-rooted; until recently it was difficult for experts to understand Dohsa-hou.

Some Issues as A Dohsa-hou Therapist

Although Dohsa-hou has shown its effectiveness in clinical practices and studies, other therapists tend to regard it as exercise therapy, not as psychotherapy. Therapists in other disciplines have difficulty understanding the psychological processes that occur in Dohsa-hou sessions because Dohsa-hou's interventions are unique, and its technical terms are difficult to understand. These issues make it difficult to further disseminate Dohsa-hou.

Issues Relevant to Japan's Needs Today

Current issues facing the Japanese population include how to support their mental health during the COVID-19 pandemic. The Japanese government has declared a state of emergency a few times, although it has not imposed a lockdown with legal restrictions, as have some foreign governments. In April 2020, the Japanese government declared a month-long state of emergency for Tokyo, Osaka, and five other prefectures, and made an appeal to limit going out, promote teleworking, and temporarily close schools as well as some stores, cinemas, theaters, and live music venues. Furthermore, universities and technical schools closed voluntarily, and prohibited students from attending class. After the declaration of the state of emergency was lifted, elementary, junior high, and high schools opened their doors, while most university campuses remained closed until the fall of 2020.

As a result, people felt stressed as they were forced to adapt to the new lifestyle. At that time, the Japanese media created new Japanese words: *corona utsu* (depressed mood brought by stress from quarantine) and *jisyuku zukare* (quarantine fatigue). In addition to these issues, there are ongoing problems of isolation associated with self-restraint, and university students' loneliness and anxiety caused by online classes and university closure. Aside from these, teleworking brought physical and mental problems for some employees. As for the elderly, refraining from participating in daycare services led to a decline in physical function and a progression in dementia. Therefore, Japanese clinical psychologists should provide immediate support through contactless methods, or by using online systems.

However, Japan has been slow to introduce and practice online counseling via Zoom or Microsoft Teams, etc. due to certain research and clinical factors. First, research on the effectiveness of online counseling has not been sufficiently advanced in Japan, and nearly all clinical psychologists have a common belief that face-to-face counseling is more effective than online counseling to support clients. Second, many psychotherapists are skeptical about psychological transformation occurring in a virtual space such as that of online counseling. Third, they are concerned that clients' confidentiality might not be adequately protected in online counseling.

On the contrary, recent Japanese studies have shown that face-to-face and online methods have almost the same effect on reducing stress reactions. Murase (2006) reported that there was no difference in reducing anxiety between face-to-face and online counseling for healthy people. In the body psychotherapy field, Kamikura and Shimizu (2020) showed that face-to-face Dohsa-hou and online Dohsa-hou via Zoom had almost the same effect in reducing stress responses, including, irritability, depression, anxiety, and helplessness among adolescents. In addition, it is noteworthy that different counseling styles led to different outcomes for adolescents. Kamikura and Shimizu (2020) reported that online Dohsa-hou was more effective in improving physical stability than face-to-face Dohsa-hou, whereas, face-to-face Dohsa-hou was more effective in increasing a sense of authenticity compared to online Dohsa-hou. Specific counseling situations may have led to these findings. In online Dohsa-hou, participants could pay attention to themselves deeply without being distracted by the surroundings or noise, so that may have affected the semi-conscious and unconscious, and increased the sense of physical stability.

The Future of Body Psychotherapy in Japan

It is important to make professionals, clients, and the public more familiar with Dohsa-hou, so that body psychotherapy can be practiced more widely. First, we need to explain to psychologists and clients that Dohsa-hou

is not a form of exercise, but a form of psychotherapy. Then, we need to present simple terms to explain the process of psychological transformation that occurs through movement tasks. Additionally, it is important to promote evidence-based empirical research, and to build theories that include findings from other psychological fields. As for the preconceived notion that Dohsa-hou is not good for the relationship between

psychotherapist and client because it uses touch, the best way forward would be to develop a method to practice online Dohsa-hou and non-touching Dohsa-hou and accumulate evidence on these modalities. If Dohsa-hou were to be used more widely for the mental health maintenance of healthy people and the treatment of mental health disorders, other types of body psychotherapy will also expand in Japan.



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BODY PSYCHOTHERAPY AROUND THE WORLD

National Associations and Committees in Action

One of our goals is for all body psychotherapists and somatic psychologists to share their professional contributions to our fields not only on an individual basis, but on a group and institutional level as well.

*Thus, the IBPJ Editorial Team is expanding the **Body Psychotherapy Around the World** section to include a new section – **National Associations and Committees in Action**.*

We invite the National Associations and their Committees to share their successful ideas and actions, present new knowledge, refresh or reframe old knowledge in the light of present-day developments, as well as offer opinions and strategies for the expansion and safety of our profession. We hope that creating a space to share tools, strategies, thoughts, and feelings will support and inspire your sense of community and belonging and increase all of our competencies.

We welcome your contributions!

The Editorial Team

Applying the EABP Code of Ethics in Everyday Practice

A presentation by the Ethics Committee of the Greek National Association for Body Psychotherapy

Antigone Oreopoulou

ABSTRACT

During the last four years, the Ethics Committee of the Greek Association for Body Psychotherapy (PESOPS) held four meetings for its members. This article describes the committee's first meeting, titled *The Ethics Committee and the Code: What we need to know in everyday practice*, and relates the story of what happened behind the scenes that led to valuable conclusions.

Keywords: Ethics Code, Ethics Committee, EABP, PESOPS, Ethics workshop

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his article is written in my capacity as Chair of the PESOPS Ethics Committee for the period of 2017-2021. It is written with the agreement of all active members of the PESOPS Ethics Committee and Board during that period.

The article describes a PESOPS Ethics Committee presentation to its members, from its conception to its rewarding conclusion, and the teamwork of the Ethics committee members. The article focuses on the preparation for the event and the members' responses. It does not analyze or interpret their responses.

To maintain the authenticity of the presentation, the slides were translated from Greek to English, and are posted in the Appendix. The slides of the questionnaire could not be translated, thus these graphics are not included.

Why Prepare a Presentation Regarding Ethics?

To become a member of the European Association for Body Psychotherapy (EABP) and the Greek National Association for Body Psychotherapy (PESOPS), members must confirm that they have read and agree with the Codes of Ethics of these Associations. David Trotzig (2020) notes that "*To maintain full membership, members must fulfill three basic requirements: meet the membership criteria, respect the Ethical Guidelines and pay the annual fee... body psychotherapists... have freely joined and signed an agreement to respect and follow its Ethical Guidelines (p. 116).*"

However, the evolution of professionalization in body psychotherapy, the ethical ambiguity that exists in psychological science regarding how we understand each other (on humanistic and/or scientific terms), the increasing importance of ethics and

Before the presentation started, the first questionnaire was distributed, examining how members perceive and relate to the Ethics Code and Committee.

ethos, the fact that we use touch in our profession, and the fine line between legal and ethical provisions, create a complicated situation that needs constant updating, monitoring, and reflection (Sollmann, 2019).

Despite having read and signed the Ethics Code, these factors may create grey zones in everyday professional practice, and lead to difficulties in the actual implementation of the Ethics Code.

Brainstorming

In 2017, a new PESOPS Ethics Committee was elected, consisting of Therapia Mazaraki, Sofia Petridou, and me. Alkis Terstetis was elected as a reserve member. At our first meeting, we discussed our role and goals. There were no cases of complaints to discuss.

Simultaneously, the newly elected PESOPS board established a policy to have regular meetings – presentations to its members – to discuss topics of interest and share opinions. These presentations would include a variety of themes derived from the work of the different committees (Science, Ethics, Public Relations, and Communication), as well as legal and institutional issues, and reflect PESOPS' policy to support connection and promote its members' wellbeing and competence.

With no cases to focus on, we proposed to the Board a series of presentations discussing the principles in the Code of Ethics (EABP Ethical Guidelines, 2019) to see how members perceive the Code, how they apply it in their practice, what kind of difficulties they encounter, and how they solve ethical dilemmas they come across.

After some discussion, we proposed four meetings, one meeting per year of our term, which would also connect with the work of different committees:

1. **The first meeting** would refresh the relationship between the Ethics Committee and the Code of Ethics and underline their importance in our everyday professional life. The tentative title was: "The Ethics Committee: What do we need to know in relation with our everyday practice."
2. **The second meeting**, held in collaboration with the Public Relations and Communication Committee, would frame the use of Social Media in our profession, discussing Principle 8 of the Code (Public Statements). Since Social Media is in the foreground of promoting our knowledge and services, it seemed important to discuss the professional and ethical modes of doing so.
3. **The third meeting**, held in collaboration with the Scientific Committee, would discuss Principle 10 (Research). Considering that science begins from the moment of notetaking up to publishing case studies and research, it is important to bring these steps into the frame of an ethical code.

4. **The fourth and final meeting** would discuss Principle 6 (Professional Relationships). A professional code among colleagues and with professionals in other fields includes referrals, recommendations, and collaborations. It includes professional boundaries around specialization, training, and experience, which are important aspects of everyday professional life, and which may not be clearly defined.

The Ethics Committee would have liked to discuss and present each principle of the Ethics Code separately in additional meetings, which the available time frame unfortunately did not allow.

Planning for the First Meeting

This section is about the first meeting.

The PESOPS Board accepted our proposal for all meetings, and it was agreed that the Ethics Committee would have a first meeting on its own.

The Ethics Committee began planning the first meeting. After discussion, we divided the meeting into three parts:

1. A theoretical presentation
2. A workshop
3. A discussion

We also planned to have:

- A questionnaire exploring the relationship between members, the Ethics Committee, and the Ethics Code.
- An evaluation of the meeting.

Theoretical Presentation

The goal of the theoretical presentation was to reconnect members with the role of the Ethics Committee and the Code of Ethics.

During the workshop, members would be presented with three different cases. They would discuss them in groups, and then join a common discussion.

Several cases were written up. In terms of confidentiality and GDPR, the cases were adapted from real supervision cases (See Appendix A for all proposed cases).

Assuming that a greater number of members could relate to them, the questions finally chosen were the following:

1. Because of the latest financial crisis, some clients ask for an exchange of services. How do you cope with this request?
2. A client comes with a request for compensation for trauma caused by a previous therapist, who is no longer a member of the Association. This therapist purportedly exploited the transference and maintained an ongoing relationship with her, parallel to her therapy. How would you deal with this case?

3. What are the topics that you bring to supervision? Are you in a position to realize when you step into “grey zones” of therapy? How and when do you understand it? How do you cope with it?

The next step was to prepare a questionnaire examining how members perceive and relate to the Ethics Committee and the Code of Ethics. This included demographic questions and outlined the current knowledge and relationship of PESOPS members to the Ethics Committee and Code of Ethics. (See Appendix B).

An evaluation form would allow participants to evaluate the meeting, its content, and the presenter on a scale of 1 to 5 (1: Needs serious improvement, 2: Mediocre, 3: Satisfying, 4: Very good, 5: Extraordinary). It would also require answers to questions regarding topics of interest for the next meetings, related to Ethics. (See Appendix C)

Presentation Day and Feedback

Before the presentation started, the first questionnaire was distributed, examining how members perceive and relate to the Ethics Code and Committee. Although we asked members to complete all the questions, only a fraction of attendees answered the instrument fully. The presentation then started.

1. The Theoretical Presentation

The theoretical presentation focused on reminding members why the Code of Ethics and the Ethics Committee exist. A short discussion followed the presentation. (See Appendix D for the presentation slides.)

The most notable comments from the participants were:

- *“Although I was taught Ethics in school, this is the first time I understand, on a practical level, why Ethics are important, and how I can use and communicate them to my clients.”*
- *“It is important for me to know about Ethics and discuss them in our professional association.”*
- *“This presentation underlined once again the importance of the Ethics Code and the Ethics Committee, and how it frames and legalizes our profession and professionalism.” (In Greece, psychotherapy is not yet an established profession, and it is important to have a description of professional conduct offered by an Ethics Code).*
- *“It is important to bring ethics issues to our PESOPS meetings and discuss them often. To study them, not academically, but on a very practical and experiential level.”*
- *“Ethics are connected with a spiritual dimension, and therapists need to constantly uphold them during both their practice and supervision.”*

Participants commented on:

- The need to expand the frame of ethics and discuss the philosophical dimensions of the code.
- The importance of asking permission before touching a client.
- The need to discuss and expand principles regarding the therapists’ general obligations, and especially their rights.
- The conflict between individuality and universality – how a therapist maintains his or her individuality in the universality of ethics?

They had questions regarding:

- Confidentiality regarding underage clients.
- How to protect relationships among colleagues.

Before proceeding to the next section, the Ethics Committee urged the members to print the Code of Ethics, have it in their offices, show it to their clients, and explain to clients their ethical rights.

2. The Workshop

Following the presentation, we asked members to divide into three groups. One member of the Ethics Committee sat with each group to answer questions and keep time.

- Each group received one of the prepared questions, discussed it, and then wrote down their thoughts and conclusions. The time frame was 20 minutes.
- Each group’s coordinator presented their question and responses/reflections to everyone.

The conclusions and points of view were graded on a scale of 1 to 10 (1: not interesting or relevant to 10: very interesting and relevant). The conclusions were as follows:

Group 1, Question 1: *Because of the latest financial crisis, some clients ask to exchange services. How do you cope with this request?*

A score of 10. All group members found this topic very interesting, and because of the continuing financial crisis in Greece, members found the topic realistic. Some had already encountered this situation.

The group first asked questions:

- Is it important to define the kind of requested exchange? What is the object of this exchange?
- The client proposes the exchange. How does the therapist set the limit?
- Do we use the same frame as when services are offered pro bono?
- Having established a stable relationship with a client, is it ethical to cut off the client’s therapy due to financial reasons? Especially if a person who is food-deprived chooses therapy over food?

Once the questions were answered, the group agreed on the following points:

- In a good therapeutic relationship, therapists must harmonize with their inner ethics and with the therapeutic contract.
- Therapists must avoid conflict of roles during a possible exchange – for instance avoid exchanging services for a massage.
- The client, if possible, should pay even a small nominal fee.
- The frame, duration, balance, and equivalence of exchange should be clearly explained, defined, and honored.
- The duration should be short and defined.
- If the therapist agrees to the exchange, always keep in mind the danger for the therapeutic frame and balance to change.
- In considering the request, always take into account the case and the conditions.
- In a couple of cases, where the clients were in extreme financial need, two therapists asked for a very definite exchange: translation of a text or designing business cards (one client was a translator and the other a graphic designer).
- Finally, it was suggested that the Association start working on a pro bono policy.

Group 2, Question 3: *What topics do you bring to supervision? Are you in a position to realize when you step into therapeutic “grey zones”? How and when do you understand it? How do you cope with it?*

A score of 10. Members graded this question in terms of interest and relevance, and everyone could relate to it.

The main question was: “How do we define grey zones?” The final unanimous answer was that a grey zone is defined as a conflict between the therapist’s values and the client’s values, and a non-clearly defined violation of the therapeutic contract. This was seen as a definite topic about which to seek supervision.

Once the questions were answered, the group agreed on the following points:

- Areas that raise alarms and for which it is important to seek supervision are sexual transference, boundary issues, touch, therapist abuse, countertransference issues, and when therapists feel a threat to their life.
- All participants commented that the Ethics Code protects clients, but there is no clear reference or provision for how therapists can be protected from abuse from a client or colleague.
- All participants reported that when ambiguous topics are brought to supervision, the therapeutic relation usually ends, either by the therapist’s action or the client’s action.

Group 3, Question 2: *A client comes with a request for restitution for trauma caused by a previous therapist, who is no longer a member of the Association. This therapist purportedly exploited the transference and maintained an ongoing relationship with her, parallel to her therapy. How would you deal with this case?*

A score of 10. All members commented that since, according to the Ethics Code, the therapist receiving the complaint is no longer a member of the Association, the Ethics committee could not examine the case.

Thus, the ensuing question was: “How could the client be supported?”

Once the questions were answered, the group agreed on the following points:

- All members emphasized the need to investigate the validity of the case in relation with the client’s perception.
- The next level was to create a safe frame to prevent retraumatization and move towards the healing process.

For a case to be examined by the Ethics Committee, the following conditions must be fulfilled. The person towards which the complaint has been filed must be a member of the Association, and the incident must have taken place within the past five years. A year after this presentation, the EABP Ethics Committee proposed a change to the period for cases of sexual abuse: regardless of the time when the sexual incident took place, the Ethics Committee would examine the complaint. This change was approved by the EABP General Assembly.

3. Discussion

After finishing the workshop, members unanimously proposed:

- To continue having periodical discussions and continuing education on ethics topics and be able to exchange viewpoints and opinions.
- To post ethical dilemmas on the PESOPS site for discussion.

Questionnaire Results

The results of the questionnaire were presented at the last meeting of the Ethics Committee. Unfortunately, only 18 of the attending members completed the questionnaire. This small number of participants allows for only a descriptive analysis.

The results were shared with the participants in written form. They were then uploaded to a Google questionnaire for the descriptive analysis. The slides of the analysis could not be translated into English, thus, only the responses without graphics are presented.

Question 1: Gender

Gender: 89% women, 11% men.

Question 2: Age

76.5% of the members were above the age of 46 years old.

Question 3: Education level and number of years

The majority of people present were experienced therapists with more than 11 years of professional experience (second group). There were also supervisors (third group) and Trainers (fourth group). Trainees were fewer (first group).

Question 4: Are you aware of the EABP Ethics code that frames the practice of body psychotherapy in Greece?

89% were aware of the Ethics code. 11% were not.

Question 5: If yes, how did you learn about the Ethics Code?

60% learned about the Ethics Code from the PESOPS site, and 13.3% from the EABP site. The rest learned about the Ethics Code from other sources.

Question 6: Have you read or studied the Ethics Code?

69% said they had just read it, while 31% said they had studied it in depth.

Question 7: Do you use the Ethics Code during your daily practice?

87.5% used the code during their daily practice, and 12.5% did not.

Question 8: Do you mention the Ethics Code to your clients?

76.5% mentioned the Ethics Code to their clients and 23.5% did not.

Question 9: Do you consider the contribution of the Ethics Code important to the practice and legitimacy of our profession, and for what reason?

It creates a frame; it protects both therapist and patient. It is a prerequisite for professionalism.

Yes, for the safety that it provides.

Very important for safety and reliability.

It establishes the general frame of cooperation. It structures the relationship of patient and therapist.

It offers knowledge, basis, institutional frame, evaluation.

It is related with the life ethos.

It can be our flag.

It is proof of our seriousness and our trustworthiness.

It enhances the status of our profession.

Question 10: Are you aware of the existence of the Ethics Committee?

88.2% were aware of the existence of the Ethics Committee. 11.8% were not.

Question 11: What is the value of the Ethics Committee?

To research, provide knowledge, and share this knowledge with PESOPS members.

To establish awareness and appreciation of the ethics topics.

It helps to structure the psychotherapy profession, updates it relative to topics that occupy psychotherapists, and functions as a foundation for legal, ethical, and other issues.

It has the role of updating, advising, and exchanging reflections about boundaries and values.

Defends our profession.

Supports and offers safety to our members.

Updates and gives birth to dialogues.

Correct use of services, safety of therapist and patient.

Update and awareness of both therapists and clients.

Spirit of solidarity and teamwork, enhancement of principles and values.

Support for the therapist. Safety for the client.

Protection of rights for both sides.

Question 12: Are your clients aware of their rights in relation to the Ethics Code and the Ethics Committee?

43.7% responded yes; 37.5% responded no; 18.8% responded I do not know/did not answer.

This questionnaire is currently posted, with small variations, on Google forms to compare the answers over a time span of four years.

Meeting Evaluation

At the end of the meeting, participants were handed an evaluation form regarding the meeting. Once again, only a fraction of the members present filled the evaluation.

The meeting was evaluated as follows.

On a scale of 1 to 5, how would you grade today's meeting in the following areas?

1. Needs serious improvement
2. Mediocre
3. Satisfying
4. Very good
5. Extraordinary

	1	2	3	4	5
<i>Meeting organization</i>				1	16
<i>Structure of the meeting</i>			1	2	15
<i>Structure and topics</i>				2	16
<i>Preparation of main speaker</i>				2	16
<i>Presentation of the main speaker</i>				2	16
<i>Topics for each group</i>			1	1	16
<i>Organization of groups</i>				5	13

Please answer the following question:

What topics regarding the Ethics Code and Ethics Committee are of interest to you?

- Ethics Code and Social Media 10
- Updating your clients about the Ethics Code and the Ethics Committee 4
- Discussion regarding interpreting the Ethics Code 7
- Discussion regarding ethical dilemmas 10

Other: **Philosophy and Ethos**

Based on this evaluation, the next PESOPS meeting was organized by the PR and Public Relations Committee on the topic “How to Use Social Media Professionally.” It was presented by the Committee’s Coordinator, and the Ethics Committee Chair supported this presentation by discussing the ethical point of view regarding social media.

Conclusion

The main points emphasized in these meetings created a frame for further discussion and action.

- All members present felt that discussion and analysis of the Ethics Code on a more frequent basis would be supportive, needed, and helpful. It would help more experienced members to exchange views, and less experienced members to be mentored regarding Ethics issues.
- The use of hypothetical cases and examples as a tool to discuss ethics was defined as a practical, useful, and pragmatic approach.
- The need to share everyday ethical dilemmas that are not described in the Ethics Code was noted.

- The Ethics Code is focused on the body psychotherapist’s professional conduct. All members present emphasized the need to discuss and expand the principles regarding therapists’ rights, and to develop a client code of ethics.
- The members present emphasized the conflict between individuality and universality – how therapists maintain their individuality in the universality of ethics – and also felt that more discussion on that area was needed.
- The need to have discussions connecting the Ethics Code with life philosophy and with the ideas of ancient Greek philosophers.
- The Ethics Committee urged the members to print the Code of Ethics, have it in their offices, show it to their clients, and explain to clients their ethical rights.

Both the PESOPS Board and the Ethics Committee considered that the meeting reached its goals:

- To refresh knowledge regarding the Ethics Code and the Ethics Committee.
- To offer connection and support to members.
- To create a platform for discussion and exchange of opinion regarding professional issues that colleagues encounter in their everyday professional life.
- To create a mentoring environment for younger colleagues who found this encounter useful and enlightening.

In addition, the results of the questionnaire offered valuable insight in terms of demographics related to the Code, leading to further courses of action.

The PESOPS Board remains vigilant about continuing to organize these meetings that have been accepted with enthusiasm by its members, even during the pandemic.



Appendix A

Case examples proposed for discussion during the workshop

1. You have a good client who is punctual and pays well, but as a therapist, you start becoming bored. What do you do in this case?
2. You have a client that you like as a person, although not sexually. You would like to have him as a friend and not a client. How would you deal with this issue?
3. A client brings a topic to a session that is similar to one that occupies your own thoughts. How would you deal with that?
4. You are currently going through a period of exhaustion in your life. You have concluded that this exhaustion affects your professional performance. However, you need the money. What would you do in that situation?
5. Because of the current financial crisis, some clients request an exchange of services. How would you cope with this request?
6. A client comes with a request for restitution for trauma caused by a previous therapist, who is no longer a member of the Association. This therapist purportedly exploited the transference and maintained an ongoing relationship with her, parallel to her therapy. How would you deal with this case?
7. Your client is desperately looking to rent an apartment in an area you have an apartment to let. The apartment is ideal for their needs. Would you offer to let them rent your apartment?
8. What are the topics that you bring to supervision? Are you in position to realize when you step into “grey zones” of therapy? How and when do you understand it? How do you cope with it?

Appendix B

Questionnaire Format

Gender

Male Female

Age

20-25 26-30 31-35 36-40 41-45 45>

Level of Training and Years

Training 1 2 3 4 5

Psychotherapist 0-3 4-5 6-10 11-15 15>

Supervisor 0-3 4-5 6-10 11-15 15>

Trainer 0-3 4-5 6-10 11-15 15>

Are you aware of the EABP Code of Ethics which frames the practice of body psychotherapy in Greece?

Yes No

If yes, how did you learn about the Code of Ethics?

EABP site PESOPS site Other (describe)

You have:

Read the Code of Ethics Studied it in depth It is not a concern of yours

Do you use it in relation to your everyday practice?

Yes No

Do you mention it to your clients/trainees?

Yes No

Do you find its contribution important to the practice and legitimacy of your profession? For what reasons?

Explain your answer.

Are you aware of the PESOPS Ethics Committee?

Yes No

In what capacity could this Committee be most useful?

Are your clients aware of their rights in relation to the Code of Ethics and Ethics Committee? *Explain your answer.*

Appendix C

Meeting Evaluation Form

On a scale from 1 to 5, how would you grade today's meeting in the following areas?

[1: Needs serious improvement; 2: Mediocre; 3: Satisfactory; 4: Very good; 5: Extraordinary]

	1	2	3	4	5
<i>Organization of the meeting</i>					
<i>Structure of the meeting</i>					
<i>Structure and topics of the presentation</i>					
<i>Preparation of the main speaker</i>					
<i>Presentation of the main speaker</i>					
<i>Topics for each group</i>					
<i>Organization of groups</i>					

Answer the following question:

What topics regarding the Code of Ethics and Ethics Committee are of interest to you?

- Ethics Code and Social Media
- Updating your clients about the Ethics Code and the Ethics Committee
- Discussion about interpretation of the Ethics Code
- Discussion of ethical dilemmas
- Other

Appendix D

Presentation Slides

Code of Ethics and
the **Ethics Committee**

**What we need to know
for our everyday practice**


A presentation by
PESOPS Ethics Committee



**What is an
Ethics
Committee
and an
Ethics
Code?**




**Why an
Ethics
Committee?**



- Complaints from a client to a professional
- Complaints from one professional to another professional
- Supporting a client who feels too weak to submit a complaint

**Why an
Ethics
Committee?**



Training on...

- Ethics Deontology
- Issues that we have to cope in our professional everyday life.
- Update regarding the actions of EABP

What else can an Ethics Committee offer?



- Deontology and Ethics are not distant concepts
- We must often cope with ethic dilemmas in our professional life

Why do we need an Ethics Code?



The Ethics Code is the frame that establishes the...

- Principles
- Professionalism
- Safety for therapists and clients
- Safety in the relationships among professionals

Ethics Committee aims



- To inform you in regularly regarding developments in EABP Code of Ethics
- To update and connect the Code of Ethics with institutional and legal issues

Ethics Committee aims



- To start educational meetings and discussions regarding the understanding and effective use of the Code of Ethics

Why Ethical Code?



Clients feel secure when they are aware of the existence of both the Ethics Committee and the Code of Ethics and how they can use them

Because in the end...



The Code of Ethics is the common denominator regarding the frame of practice of our profession.

This practice has an impact on all professionals.

Please remember!



If you have any question, please feel free to communicate with us.

And urge your clients to communicate with us as well.

The current Ethics Committee



Pepi Mazaraki



Sofia Petridou



Antigone Oreopoulou



Reserve Member
Alkiviadis Terstetis



Antigone Oreopoulou studied Biology at the University of Thessaloniki, Greece, and continued her graduate studies in Nutrition (MSc, University of Toronto), Psychology (MA, University of Indianapolis), and PR Strategy and Communication (MA, American College of Greece). She is trained in Biosynthesis therapy and supervision, hypnotherapy, trauma therapy, EMDR, and Crisis Intervention. She holds a European Certificate of Psychotherapy. She has been elected to various administrative positions in professional associations, including PESOPS Board member, Chair of the PESOPS Ethics Committee, and a member of the EABP Ethics Committee.

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She loves reading, drawing, dancing, walking in nature, swimming, animals, sunrises, and sunsets, and travel, and feels grateful for the experiences life has offered her and all the wonderful people she has met and connected with.

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BOOK REVIEW

The Elusive SELF

Reflections of an Internal Family Systems Therapist

by Marcel Duclos

Independently published, 2019

Adam Bambury

A

ppropriately for an Internal Family Systems (IFS) therapist, Marcel Duclos' book is made up of many different parts. It references people and topics as diverse as William James, Antonio Damasio, Sigmund Freud, Carl Jung, the Chiron body psychotherapy school, and the Kabbalah of Jewish mysticism. It looks at advanced old age, affect regulation, and alchemy.

This diversity has a central idea at its core: the self. The self is one of the key concepts in IFS, alongside the need to welcome all "parts" (equivalent to subpersonalities, aspects, etc.) of the client. To better understand and connect with our many parts, IFS encourages access to our "Self" – a coordinating center that brings healing and "can and should lead the individual's internal system (IFS Institute, n.d.)."

Duclos wants to go a step further with this concept. His search for the elusive Self divides it into three interrelated aspects with differing quantities of capitalization: the self, the Self, and the SELF.

If you read this book, you'll see a lot of these varying capitalizations, and quite a few definitions of them, too. They serve as ways into something that is necessarily difficult to define in any concrete way. But, for Duclos, this trinity is worth looking for, or drawing out, as it adds a new level of insight beyond the use of the singular self.

So, what do the three terms mean? One of his more straightforward explanations is:

- self = "the me, the ego, the I"
- Self = "the self that functions through the wisdom-qualities of the SELF"
- SELF = "the archetypal Imago Dei, the Other, the Source, that transcends the multiplicity manifest in the trinity of mind, brain, and body" (p. 201).

Or, following a discussion of Jung and mystical Judaism, there's:

"Through awareness, the self consciously transforms into a Self, existing through and by the SELF's energies. It is the person's life's task to effect a separation from the self's original unconscious identification to an eventual conscious relationship with the SELF that creates a third entity, the Self. A trinity within" (p. 65).

Or the more esoteric:

"As the SELF gives birth to the self, the self enters the crucible of transformation and becomes the Self who incarnates the SELF into the post-paradisiacal world, thus giving the ALL, the IT, God, an opportunity to heal the broken and burdened by experiencing the cost of healing the IT's OWN CREATION." (p. 126).

Like the IFS practitioner, you can perhaps get a flavor of some of Duclos' other parts from these explanations. They include the young New England theology graduate student enthused by the work of Jung, the professor of psychology and philosophy, and the Core Energetics-trained prac-

tioner working with soma as well as psyche. Looking back at over fifty years of study and practice, Duclos' aim in this book is to examine how his three-self model, and IFS itself, can be seen to connect with, be informed by, or further inform, the work and concepts of practitioners and theorists, past and present. He also reflects on own work and life, with autobiographical asides on some of the at times painful learning experiences that have informed who he is today.

Both these shared experiences and the range of thought and subject matter covered help give this book a wider audience than just IFS practitioners. Those without an IFS background might do well to brush up on some of the basic terminology of the practice, as we're quite quickly dropped into a fairly deep end. But, while Duclos obviously sees IFS as something of a pinnacle in terms of current therapeutic modalities, he also notes it as one of many, and his insights have relevance to other practitioners working in a similarly aligned way.

While some of the territory and nature of this inquiry felt new to me, my reading soon settled into its own rhythm. I found myself interestedly following down the many paths presented, encountering some fascinating books and new angles on established thinkers. These are quoted frequently alongside Duclos' comments in a form of exegesis or critical interpretation, and many times I found myself highlighting authors, and wanting to take my own extended journeys into some of the works he mentions. The way individual sections fit together occasionally felt confusing or fragmented, but the bigger picture, the felt sense of the work, seemed cohesive, led by the warm spirit of Duclos' generous, inclusive inquiry.

The sheer number of different topics covered and quoted makes this a difficult work to summarize, but readers of this journal may be particularly interested in what Duclos has to say about body psychotherapy. In Chapter 12, "Somatic Psychotherapy and the Self," he selects a few of his many influences to discuss in this context.

He sees an "amicable, creative relationship" between IFS and body psychotherapy, something that is being made more explicit by the Somatic IFS of Susan McConnell, which is concerned with the embodiment of self as part of the healing process.

He discusses John Pierrakos and his concept of the Core: "the source of our being... our divine connection to universal forces," which gives access to our "higher self" (p. 156). There is a commentary (p.164) on some of the more "enigmatic" statements from Stanley Keleman's book *Your Body Speaks Its Mind: Expanding Our Selves* (1975), praising his "anti-dualistic" understanding of human nature, musing on pulsation, and considering connections with religious experience as explored by William James.

A brief look at Linda Hartley's writing in *Contemporary Body Psychotherapy: The Chiron Approach* (2009) connects Reich's trust of the organism's inherent capacity for self-regulation and wellbeing with the IFS trust in the regulatory nature of the Self, and the inherent positive intent of our various parts.

Particularly resonant was an analysis of John Conger's book, *The Body in Recovery: Somatic Psychotherapy and the Self* (1994). Conger is a Jungian analyst and body psychotherapist, and this book helped Duclos "bridge the psychosomatic world" in his personal and professional life while in Core Energetics training (p. 178).

For Conger, embodiment means "not perfect health but rather a consciousness of wholeness and relatedness, a standing in the center of many polarities as an inventive curious presence in a state of spontaneous play." In response to the "psychic injury" of interpersonal trauma (essentially a "crushed rebellion, a voice of protest reduced to silence"), therapists need to foster the client's "embodiment, [that] capacity to bring diverse internal and external elements into an organization called the Self" (Conger, 1994, p. 199). This sense of Self becomes something that can be trusted to endure, no matter the difficulties of the present, which knows that it is related to others, and knows that it is part of nature and life itself.

In Conger's writing, Duclos says that he can hear "the strains of Jamesian music, Jung's symphonic elegance, the Jazz of body-psychotherapy modalities, the IFS sonatas." It's an apt description of Duclos' book as a whole, too. It contains many different styles of music perhaps, but music all the same.





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BOOK REVIEW

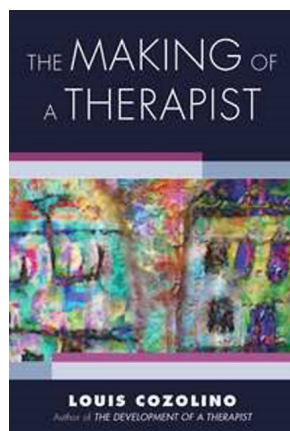
The Evolution of a Therapist

*Louis Cozolino's Companion Guides for the Journey of
Becoming a Therapist and Building a Satisfying Career*

by Louis Cozolino

W. W. Norton, 2021

Antigone Oreopoulou



The Making of a Therapist

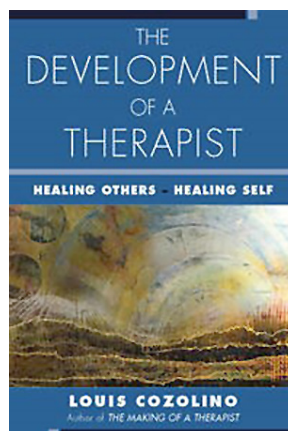
Louis Cozolino

Paperback

ISBN 9780393713947

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Norton 2021



The Development of a Therapist

Louis Cozolino

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Both books, published by Norton in their Interpersonal Neurobiology Series, abide by the goal of the series to “*advance our understanding of human experience by finding the unity of knowledge, or consilience, that emerges with the translation of findings from numerous domains of study into a common language and conceptual framework. The series integrates the best of modern science with the healing art of psychotherapy.*”

Louis Cozolino, the series editor, is a writer, teacher, and psychologist practicing in Los Angeles. A professor at Pepperdine University since 1986, he lectures worldwide on psychotherapy, neuroscience, trauma, and attachment¹.

Cozolino's primary focus is on connection, attunement, and interaction. Working principally from a psychodynamic model, he employs strategies and techniques from other modalities, including CBT, family systems, and a humanistic/existential approach.

1. See Louis Cozolino website <https://www.drloucozolino.com/about>

These books ask essential questions:

- Do you believe therapists should give priority to their rational, trained, professional voice? Should their inner self, body sensations, feelings, thoughts, and doubts – regardless of whether they whisper or shout – remain in the passenger seat?
- If you are a teacher or supervisor, what might you say to new and future therapists?
- What is the most precious advice you could offer?
- What are the key elements that transform a student from a good to an excellent therapist?
- If you are a new therapist, what are the dominant anxieties, fears, and issues you will need to come to terms with?

Cozolino's companion books offer refreshing answers to these and many other questions. *The Making of a Therapist* is a gentle guide for beginning therapists, describing the journey from its first steps all the way to a fully established practice. *The Development of a Therapist* copes with the everyday personal and professional challenges therapists encounter.

The answers Cozolino provides are based on a vital axiom: therapists are human beings with their own demons (*The Development of a Therapist*, p. 146) who have "to learn to learn" (p. 157), and merge opposing worlds by developing the "... ability to be simultaneously thoughtful and emotional, to mix the poetry of human connection with a scientific mind, is the essence of a good psychotherapist" (*The Making of a Therapist*, p. 2).

In both books, the presentation is flowing, comprehensive, and simple – though far from simplistic. Each page is packed with useful information and fresh perspectives about the core and serious issues of our profession – transference, countertransference, resistance, defenses – and the challenges both new and seasoned therapists encounter. Cozolino's writing style conveys the experience of being with him in a relaxed setting, engaged in authentic conversation about what preoccupies our mind as therapists. His language is calming, the results are fruitful, and the witty headings reflect his ability to transform and translate scientific knowledge into comprehensive and familiar everyday images. Each chapter offers an inspiring quote – from Plato and Ovid to Oscar Wilde and Anais Nin, among others – in perfect harmony with the chapter's content. Thus, each challenge presented is transformed into a manageable, inspiring task.

The books present usual, and unusual, challenges and case vignettes that both new and seasoned therapists will face over the course of their careers. Cozolino offers insights and fresh coping perspectives for every challenge. He connects the dots between what may seem to be unrelated facts, offering a better view into the client's world. Nonetheless, he never loses sight that his most important offering is bringing therapists into the therapeutic relationship as human beings, not only as experts.

"... therapy is not a set of techniques; it also requires you to be aware of your own fears and needs. It is a challenge to give others what we may never have received ourselves." (*The Development of a Therapist*, p. 5)

The underlying dictum is "know yourself," which Cozolino considers to be the wise road of action, before, during, and after every therapy session.

The Making of a Therapist

In *The Making of a Therapist*, Cozolino anchors his insights, experience, suggestions, and questions in his own journey as therapist. The book opens with the description of his own first session, and the five points his supervisor had told him to remember during his first therapeutic hour. He starts by exploring the inner thoughts of the therapist, and how to handle them through centering and learning to listen. He offers practical suggestions on centering and listening, on the details of eye contact, chair position, and the importance of communication styles.

His advice regarding practical issues, though often familiar, also offers not so expected advice regarding the therapist's feelings, thoughts, and inner world. He reminds us that the world of therapists is intrinsically connected to that of their clients.

The following chapters offer valuable information regarding the therapeutic experience itself – what to say, what to do, how to conceptualize cases and plan treatments, how to face pathology,

deal with the unexpected, and use crises as a communication tool. He devotes a full chapter to the dangers of cultural and religious assumptions and prejudice. In the chapter “Challenges and Strategies,” he offers valuable advice on how to use mistakes, silence, and transference along with the kind of questions therapists should ask themselves in these situations. He focuses on the therapeutic power of confusion and of *good* mistakes. A most interesting chapter deals with the therapist’s feelings, their power, the importance of bringing them to the surface, and if necessary, to supervision. He gives special attention to impatience, sexual attraction, and regression, all the while emphasizing the constant need for therapists to heal themselves. He offers ways to manage client resistance as it presents in the form of cancellations, rejection of the therapist, premature termination, fee issues, and interpretation challenges.

After dealing with these practical matters, Cozolino moves on to focus on the person of the therapist. He describes the therapist’s challenges during sessions, including the oscillation between the therapist’s world and that of the client, and oscillations between the mind and the body. He addresses the challenge of feeling difficult emotions, such as distraction, boredom, and fatigue, once more offering questions that help therapists clarify situations and find solutions.

Next, he delves further into “knowing yourself” in terms of countertransference, offering exercises on uncovering it, and accepting the healer’s innate vulnerability. He looks at the effects of the therapist’s childhood and past struggles, and how their character structure might play out in the therapy room. Finally, he offers valuable advice on building a “*satisfying and sane career*” (p. 72) by following four principles and asking reasonable questions.

Though training institutions present the same knowledge, this book offers all that a therapist needs to know, in a compact and easily searchable format.

The Development of a Therapist

In his second book, Cozolino traces the deepening evolution of the therapist-client relationship. He explores how therapist and client are interconnected, and how healing is an evolving, intertwined parallel process within a deeply interwoven connection affecting both therapist and client.

Cozolino deepens our understanding of therapy by delving into more abstract definitions and concepts. He explores the many approaches therapists can use to relate to clients, and brings together a range of therapeutic tools, approaches, and results, along with the latest research on neural networks and systems knowledge.

Cozolino calls the therapist who regulates anxiety an *amygdala whisperer* (p. 5). Based on this definition, he underlines basic traits an amygdala whisperer must develop – the ability to see multiple truths simultaneously (p. 13), and the ability to take responsibility for helping clients find the safety they lack, regardless of their defenses (p. 15). Here, his guidance centers on how to “*venture beyond the rational*,” and how to practice “*relaxed curiosity and shuttling*,” which he defines as “*an open exploration, a journey of free-floating attention through the many dimensions of self and other within the therapeutic relationship* (p. 21).” Other issues explored include the “*navigation of the therapeutic space*,” the secret of redirecting clients to “*say more in the therapy and focus on here and now*,” respect for “*the circular awareness*” offered by the right cortical hemisphere, and the use of “*free-floating attention*” as a precious ally. He employs the “*paradox of resistance*” and “*listening with the third ear*” as useful therapeutic allies.

Using case vignettes, he also talks about the origins of intergenerational trauma, how to recognize clues that deepen client narratives and the therapist’s need for reflection when they must cope with the challenge to “*stay in role, when our bodies and personal histories are making us want to run or steer our clients away from what we find difficult to tolerate* (p. 62).”

At this point, he takes a deep dive into the mind of the therapist (p. 63), the mind of the client (p. 88), and the mind of the body (p. 102), describing and connecting their interaction and influence on the therapeutic evolution.

Next, under the challenging titles “What do zombies do for fun?” and “From terror to safety,” Cozolino describes client cases. He skillfully interweaves case descriptions with neuroscience principles and his own reflections. He deals with internet and screen addiction and its effects on relationships, in particular parent-child relationships.

The book ends by exposing what he sees as the fallacies of therapy trainings. He points out that current trainings involve “*nothing about protecting the public or how we need to uphold higher standards* (p. 194).” He suggests that all new students take control of their training and ends the book by saying that “*if you are to build a meaningful career as a psychotherapist, you have to learn, first and foremost, how to silence your mind, listen to your heart and pursue knowledge* (p. 198).”

Conclusion

Regardless of where you find yourself on the therapy continuum – trainee, intern, novice therapist, experienced therapist, supervisor, or trainer – these two books are desktop material offering tools, ideas, explanations, perceptions, and critical questions that clarify challenges and issues on personal, relational, and professional levels. Their most important contribution, however, lies in the questions Cozolino believes therapists should ask themselves – questions that lead to looking deep inside our humanity in order to look deep inside our clients, connect with them authentically, and help them reach their therapeutic goals.



Antigone Oreopoulou is a psychotherapist who focuses on eating disorders, pre- and perinatal psychology, and effective communication in relationships. She lives in Athens, Greece.



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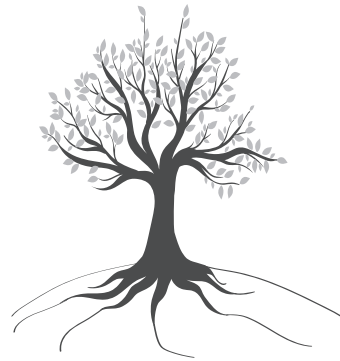
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The Earth's eco-social situation, at this moment, is one of intense transformation. Ecosystems are being attacked as never before in millions of years. Much has been destroyed, much is being transformed. It is not yet known which path will prevail.

—Rubens Kignel