Your addiction was your attempt to solve a problem. That problem was that of emotional pain, and hence my mantra...
Ask not why the addiction, ask why the pain.

—Gabor Maté

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IBPJ CALL FOR PAPERS

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In the past few months, we have repeatedly heard a disturbing point of view that merits close attention. It is echoed in Kathrin Stauffer’s observation about being a body psychotherapist in Britain: “…it may be that Body Psychotherapy is “mined” for tricks that create quick and effective change in traumatized individuals, and that as a result, body psychotherapy does not continue as a whole and inviolate Gestalt, but is dismembered into fragments…”

Although being mined can be seen as a form of acknowledgment, Kathrin’s speculation carries a warning sign. Echoed by others, the concern being voiced is that the practice of body psychotherapy and somatic psychology, which is the result of a long and established tradition, is being appropriated by other disciplines without true understanding or acknowledgement.

Great artists and designers know it is inevitable that their creations will turn up as knockoffs. Appropriation is expected, which is why ongoing innovation is critical to the growth and vitality of a profession, and essential to its sustainability. As a profession, we are now challenged on many fronts to embrace our fast-moving, turbulent time and meet it with creative engagement.

Every day – surrounded as we are by ongoing war and gun violence – there is opportunity to witness trauma in the making. These are times when empathy is stretched to its limit, and over-exposure to real and vicarious trauma is at our fingertips with a simple click. Confronted with heartbreaking tragedies, we are challenged to bring embodiment to those who may not see the value of living in bodies, to those who are on the frontline of personal, cultural, political, and national injustice. We champion the body in a world where the ability to say yes to life is fraught with complexity.

Trauma and chaos are not new to body psychotherapy and somatic psychology. In his autobiography, Wilhelm Reich describes how he spent four years – between the ages of 18 to 21 – in the trenches, enlisted in the Austro-Hungarian army fighting the Russian invasion of his homeland. When Reich arrived in Vienna and met Freud, he was already intimately familiar with the effects of trauma and war, knowing the craving for life as one is “inwardly laid waste, no longer capable of taking anything in.”

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Reich’s personal traumatic experiences surely guided him toward the development of body psychotherapy. Given contemporary research advances, it is our challenge to update this longstanding tradition to meet today’s unsettled times, as well as protect and keep our legacy current.

It is our goal, in upcoming issues, to bring you articles that support embodiment in turbulent times. We hope to continue putting together special sections, and are open to suggestions as to topics that may best serve the needs of our community. We have identified several directions we feel are important: war and social justice (upcoming), prolonged exposure to loss and grief, and how to tend to our children in times of chaos.

We hope you will send us your research, and share your professional wisdom and clinical cases, so that we can remain vital in this time when our bodies, which are built for connection and cooperation, feel assaulted by experiencing or witnessing bewildering violations.

Human beings are evolutionary survivors. We invite you to draw on your resiliency, on your adaptive creativity, and call in your biological intelligence to bring forth growth solutions that reflect our unique somatic perspective.

Let us know how you are working to keep body psychotherapy and somatic psychology relevant to the needs of our changing times.

The Editorial Team
We open with a special section on Addiction and Trauma curated by Jan Winhall as guest editor. Jan, who lives and works in Toronto, is the author of Treating Trauma and Addiction with the Felt Sense Polyvagal Model™ and a leader in charting an embodied direction for addiction treatment. In alignment with Gabor Maté who introduces the section, she invited colleague Steven Porges to discuss how his Polyvagal Theory points us toward an embodied direction in the treatment of addiction. She also invited Nancy Falls and Dawn Flynn to share the importance of emotional/relational presence in addiction treatment. Finally, informed by the evolving knowledge of our biology, Steve Hoskinson and Bach Ho come full circle to meet the wisdom of Reich’s initial formulations, as they argue for a fundamental clinical shift from negative to positive reinforcement that enables a client’s biology to break free of the dominance of the ubiquitous negativity bias, and align with the primary, organismic impulse that orients toward pleasure.

In the Research section, Aaron Freedman, Theresa Silow, Steuart Gold, Thomas Hope, and Denise Saint Arnault present their new instrument, The Somatic Post–Encounter Clinical Summary (SPECS), to help practitioners and researchers track and measure the process, interventions, and qualitative outcomes of somatic psychotherapy, and allow somatic psychotherapists to structure session data collection. For those less familiar with the field of research, Kolbjørn Vårdal’s article, Developing Relational Trauma Therapy, is a lesson in professional integrity from which we can all learn. He takes us step–by–step on his journey in assessing a body psychotherapy technique that was not performing as expected.

Seasoned master therapists Genovino Ferri and Luisa Barbato invite us into their Clinical Practice with a case presentation that deepens the developmental attachment understanding of Borderline Disorder in Contemporary Reichian Analysis.

The Interdisciplinary Approach section offers a challenging but rewarding paper by Homayoun Shahri. Life, Entropy, Information, Emotion, and Trauma is a complex but important exploration that anchors clinical interventions in biology, chemistry, thermodynamics, and information theory to derive a unified theory on how life is sustained within living organisms.

Getting To Know Reich continues our partnership with the Wilhelm Reich Museum in Rangeley, Maine. Håvard Friis Nilsen offers a fascinating article on how, at its roots, the development of our somatic field is intertwined with psychoanalysis. The Origins of Body Psychotherapy brings to light aspects of our somatic “childhood” that reveal how the concept of character emerged from interactions between Freud and Reich.

In our travels with Body Psychotherapy Around the World, Kathrin Stauffer reflects on Being a Body Psychotherapist in Britain. She talks about the advantages and disadvantages of cross–fertilization among therapies, and the trend among younger practitioners to make psychotherapy more available – preferably within the National Health Service.
Antigone, our managing editor, has long wanted to open a space in the journal for personal collegial sharing. In **Personal Viewpoints**, Vladimir Pozharashki offers a moving and inspirational personal account of his life-threatening *Encounter with Covid-19: Mobilizing the Will to Live*. We can all learn from this brave encounter, which engaged a clear-headed decision to use his medical knowledge together with his inner relationship to his body to insure his survival.

We close the issue with three **Book Reviews** that give the reader further insight into the current embodied direction of trauma and addiction treatment: Raja Selvam’s long-awaited *The Practice of Embodying Emotions*, reviewed by Ian McNaughton; Jan Winhall’s *Treating Trauma and Addiction with the Felt Sense Polyvagal Model: A Bottom Up Approach*, reviewed by Michael Ostolenk; and our beloved Serge Prengel’s *The Proactive Twelve Steps: A Mindful Program for Lasting Change*, reviewed by Jan Winhall.
If there was ever a time to welcome fresh ideas into addiction treatment, it is now. The pandemic has brought with it a growing epidemic of people struggling with anxiety and depression who are turning to addictive substances and behaviors for relief. These individuals are showing us that the current brain disease model of addiction is failing.

Nowhere is safe, and no one is safe, until we are all safe enough.

This is where Polyvagal Theory has much to offer. Safety is the backbone of the theory, and the precondition for health, growth, and restoration. Safety is the foundation of life. In safety, we develop the capacity to regulate our moods. From this perspective, addictions develop in the absence of, and as a result of the search for, enough safety. Whether in the struggle to calm down or seek aliveness, addictions help us in the short term, only to profoundly hurt us in the long term.

Too many of us live in dissociated states, having forgotten we live in bodies. Top-down, cognitive-centric culture views addiction as a malfunction of our computer-like brains – the result of a deeply imbued mind/body split that denigrates embodied awareness – and views bodies as inanimate objects devoid of value, except for carrying the brain around.

We may have forgotten our bodies, yet our bodies have not forgotten us. Gendlin, father of the term felt sense, taught that when we pause to listen to the body from the inside, this listening connects us to the trust we have lost – trust in our embodied intelligence. Gendlin’s interoceptive process of felt sensing returns us to the experience of our bodies as living organisms in continuous interaction with our environment. When we listen deeply, felt sensing reveals an implicit intuitive knowing – as Gendlin would say, “the right next step to carry forward.”
In the face of threat without escape, addiction makes sense. But in the context of enough safety, addiction seems bizarre – even masochistic. Addiction helps us endure painful and frightening experience through the powerful process of neuroception, Porges’ word for the unconscious way our autonomic nervous system evaluates and seeks to adjust our physiological state to ensure survival. When we tap into the continuous interaction of body and environment, we appreciate how context tells the story.

Each of the authors in this section offers an embodied and non-pathologizing way forward in understanding and treating addiction. In my paper with Steven Porges, we explore the adaptive nature of addiction through the lens of Polyvagal Theory and Gendlin’s concept of felt sense.

Nancy Falls delves into the healing power of embodied presence as an essential part of the therapeutic journey. Dawn Flynn takes us into the world of Chinese medicine and the energetic function of the heart with regard to women and addiction. Steven Hoskinson and Bach Ho shift from the pathologizing paradigm to a positive reinforcement framework for treating addiction, which is based on Organic Intelligence®.

Opening this special section, we have included Dr. Gabor Maté’s presentation at the Forum on Integrating Trauma and Addiction Treatment hosted by USABP and IBPJ in February. Maté’s trailblazing work reveals his passionate and steadfast commitment to challenging the current brain disease model of addiction. He demands that we address the root causes, the systems of oppression that continue to traumatize our culture. Maté joins us in our mission to bring embodied awareness into the healing journey of addiction.

We hope you will find this special section on addiction intriguing, and look forward to hearing your thoughts and experiences on the developing process of embodying addiction treatment.
“Your addiction was your attempt to solve a problem. That problem was that of emotional pain, and hence my mantra... Ask not why the addiction, ask why the pain.”

Gabor Maté

Gabor Maté is a retired physician who after 20 years of family practice and palliative care experience worked for over a decade in Vancouver’s Downtown Eastside with patients challenged by drug addiction and mental illness. The best-selling author of four books published in 30 languages, Gabor Maté is an internationally renowned speaker, highly sought after for his expertise on addiction, trauma, childhood development, and the relationship of stress and illness. His book on addiction, In the Realm of Hungry Ghosts, received the Hubert Evans prize for literary nonfiction. For his groundbreaking medical work and writing, he has been awarded the Order of Canada, his country’s highest civilian distinction, and the Civic America Award from his hometown of Vancouver.

I’ve worked in Vancouver’s Downtown Eastside in British Columbia. In the few square blocks of Downtown Eastside, North America’s most concentrated area of drug use, we have more people injecting, inhaling, ingesting substances of all kinds than anywhere in the Western world. I was the physician at North America’s first supervised injection site here in Vancouver. My patients were afflicted with mental illness, HIV, hepatitis, all the complications of addiction. 30% of them were Indigenous Canadians. Indigenous Canadians make up 5% of the general population but 30% of our jail population and 30% of the
population in the Downtown Eastside, which already tells you that addiction isn’t simply an accidental random event. It has to do with history, personal history, and the history of a culture.

Now, why is it that Indigenous people in Canada suffer so much? Because they happen to be the most traumatized segment of the Canadian population. For hundreds of years, they were subjugated, their culture was extinguished, their children were abducted from them, forced to be in residential schools under church guidance where they were beaten, sexually abused, emotionally abused, starved. Thousands died. They’re just discovering the bodies right now. In those communities, there are high rates of suicide, high rates of addiction, high rates of mental illness, high rates of physical illness, and high rates of sexual abuse of children. And again, high rates of addiction.

In other words, historical and personal trauma has everything to do with addiction.

What is addiction?

I define addiction as a complex psycho-physiological process manifested in any behavior in which a person finds pleasure and relief and therefore craves, but suffers negative consequences without being able to give it up. So: craving, pleasure and relief in the short term, negative consequences in the long-term, and the inability or refusal to desist, that’s what addiction is. Note I have said nothing about substances, because clearly people can be addicted to drugs, nicotine, caffeine, crystal meth, heroin, alcohol, but also of course, to sex, pornography, work, power, profit, gambling, the internet, cell phones, and everything else you can think about. The issue is not the external target or the behavior – the issue is one’s internal relationship to it. If there’s craving, pleasure and relief in the short term, harm and inability to give it up, that’s what addiction is.

And now I simply ask all those of you who recognize that at some time or another, you had some kind of an addictive pattern in your life to please raise your hands. Thank you. Hardly anybody leaves their hand down if they’re honest with themselves.

Now, this is where the whole cultural bias about what addiction is shown to be totally false. People make two assumptions about addictions. Number one is that it’s a choice people make, a failure of will, a character flaw, a deficiency of moral power. That’s one assumption. In fact, that’s the assumption that drives the legal system. The assumption is that people are consciously choosing to use certain substances illegally and therefore they deserve to be punished. Complete and utter scientific nonsense. I won’t spend a moment trying to refute it. (I would if I had time.)

The second assumption is a little bit more interesting, a little bit more accurate, but still misleading. It’s that addiction is a disease of the brain that somehow is generated significantly by genetic factors. That’s what the
medical belief is. There are some elements of truth to it, but it’s fundamentally inaccurate. Addiction is not a process that begins in the brain and there are no addiction genes, never have been, nobody’s ever found one. Nobody will ever find any either, contrary to what you’re told.

So, what is the source of addiction then? For those of you who raised your hands, I’ll ask you a question: Whatever your addiction process was focused on, behaviors, shopping, gambling, eating, drugs, whatever it was, the question is not what was wrong with it. You already know that. The question is: What was right about it? I’m going to ask you to put into the chat what that addiction temporarily gave you that you were looking for. What did you like about it?

So, let’s just see some of these answers. What did the addiction provide for you that you appreciated? Okay. Numbness, relief, distraction. Thank you. Relief, escape, avoidance, sedation. Thank you. That’s good enough.

When do people need to be numb? When they’re in pain.

What do people need distraction from? Painful internal body states, vagal states, and emotional states.

What do people need to escape from? Distress.

In other words, it gave you self-soothing. It gave you pleasure. The addiction wasn’t your primary problem. Your addiction was your attempt to solve a problem – the problem was of emotional pain. And hence my mantra: Ask not why the addiction, ask why the pain.

Of course, that pain is not just mental or emotional, it’s also an embodied thing. You can feel it, the tension in your neck, in your shoulders, in your belly, in your intestines, in your throat. And of course, in your mind. So, again, not why the addiction, but why the pain. Now, if you want to understand why the pain, you can’t look at people’s genes or choices. You have to look at their lives.

And this is where trauma comes in. I don’t think I need to review for you the voluminous literature that has linked addictions to trauma, the Adverse Childhood Experiences Study, and so on. What we know without a shadow of a doubt is that addiction is rooted in childhood trauma. I don’t have time to go into it, but childhood trauma not only gives you emotional pain, it also affects the body as this group would know. And it also shapes and programs the circuits of the brain that then become more prone to addiction, the natural opiate circuits, the dopamine circuits, the stress regulation circuits, the impulse regulation circuits.

So, to bring this to a close, I’ll sum up. Addiction is a desperate and forlorn but totally understandable attempt to deal with the impact of trauma. Addictions are far more common in this toxic culture than most of us realize. Therefore, the treatment of addiction needs to be not simply stopping the behavior, which is only a symptom, but dealing with the underlying embodied trauma. And for those of you who would like to read more about this, my book on addiction is called In the Realm of Hungry Ghosts: Close Encounters with Addiction. And the same subject is also taken up in the book to be published this fall, The Myth of Normal.

With that, I will stop. Thank you.

Revolutionizing Addiction Treatment with The Felt Sense Polyvagal Model™

Jan Winhall, Stephen W. Porges

ABSTRACT

This two-part paper begins with a discussion by Stephen Porges, whose pioneering work revolutionized our understanding of the autonomic nervous system. In part one, Porges applies his Polyvagal Theory to understanding addiction. In part two, Jan Winhall, a seasoned trauma therapist, lays out her Felt Sense Polyvagal Model™ of understanding and treating addiction that integrates Polyvagal Theory’s safety-based neuroception with Eugene Gendlin’s felt sense interoception. This paper provides a generic framework that complements and can vastly strengthen any therapeutic modality. This non-stigmatizing, embodied, strength-based model departs from the current top-down, disease-based understanding of addiction that dominates current clinical practice.

Keywords: Addiction, felt sense, polyvagal

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PART I

Addiction

A Polyvagal Perspective

Stephen W. Porges

The development of Polyvagal Theory was not targeted towards explaining or treating addiction. Rather, the theory provided a more general explanation of how the mammalian autonomic nervous system adaptively adjusts in complex environments to support survival. This perspective emphasizes two important points relevant to addiction: 1) context functionally defines what is appropriately adaptive; and 2) behaviors are emergent properties of a neural platform mediated by autonomic states. Thus, the adaptive characteristics are dependent on the appropriateness of the behaviors within a specific context. Conceptualizing behavior (addiction) in these terms could change our understanding of behavioral pathologies. We might end up interpreting a behavioral pathology as a behavior that might have been adaptive in one setting, and is now being elicited in a setting where it is maladaptive. For example, trauma survivors, who may be dissociating or shutting down through the use of addictive substances and behaviors, might be expressing a reaction that would be adaptive during a past traumatic event, but maladaptive in a current social setting.
As the principles of the theory as a science of feeling safe and sociality are outlined ahead, consider the quality of feelings and sociality of those who are addicted. Does addiction disrupt feelings of safety and sociality? Note that within the theory, autonomic state functions as an intervening variable biasing reactions to context. Reflecting on this latter point, consider addictive behavior as a valiant and yet failed strategy in regulating autonomic state, and as a poor substitute for the potent co-regulatory influences on calming autonomic state attributed to social behavior. As you read the sections on calming mechanisms and sociality, consider the limitations of the self-regulatory and co-regulatory repertoire of those who are addicted.

Polyvagal Theory emerged from the identification of the phylogeny of the vertebrate autonomic nervous system. The phylogenetic transition from asocial reptiles to social mammals required a repurposing of the neural regulation function of the autonomic nervous system, which had efficiently supported asocial reptiles. The repurposed system provided mammals with new pathways to downregulate defensive states, and to signal cues of safety. The title of the initial presentation of the theory (Porges, 1995) succinctly summarized its essence: Orienting in a defensive world: Mammalian modifications of our evolutionary heritage. A polyvagal theory. The theory provided a neurophysiological understanding of how mammals were capable of sufficiently downregulating the autonomic pathways that support defense in order to promote proximity, establish social bonds, and serve supportive roles in caring for their offspring and select others. This process of downregulating defensive states provides insight into understanding the link between sociality and health, as well as the negative consequences of addictive behavior on relationships (i.e., co-regulation) and self-regulation. Consistent with this theme, Polyvagal Theory focuses on the evolved neural circuits that enabled mammals to downregulate the sympathetic activation that could support mobilization to fight or flee, to reduce psychological and physical distance with conspecifics, and to functionally co-regulate physiological and behavioral states.

The core of the theory emerged through the identification of a phylogenetic transition in the regulation of vertebrate autonomic nervous systems that provided the neural resources for mammals to become social and to cooperate. The theory provides an innovative scientific-based perspective that incorporates an understanding of phylogenetic shifts in vertebrate neuroanatomy and neurophysiology. This perspective identifies neural circuits that downregulate neural regulation of threat reactions, and functionally neutralize defensive strategies via neural circuits communicating cues of safety. The theory proposes that feelings of safety are operationally the product of cues of safety via neuroception (see below), downregulating autonomic states that support threat reactions, and upregulating autonomic states that support interpersonal accessibility and homeostatic functions. Basically, when a human feels safe, their nervous system supports the homeostatic functions of health, growth, and restoration, while they simultaneously become accessible to others without feelings of threat and vulnerability. In the optimal social context of humans, social interactions serve as the prominent mechanism to calm the autonomic nervous system. However, in the world of addiction, we learn that social interactions are displaced by drugs and behaviors to regulate the autonomic nervous system, and these strategies result in poor outcomes, disrupting homeostatic functions and potentially compromising mental and physical health.

The theory focuses on the transition from reptiles to mammals, and emphasizes the neural adaptations that enable cues of safety to downregulate states of defense. Within Polyvagal Theory, the evolutionary trend has led to a conceptualization of an emergent and uniquely mammalian social engagement system, in which a modified branch of the vagus is integral. Neuroanatomically, this system is dependent on a brainstem area known as the ventral vagal complex. This area not only regulates the mammalian ventral cardio-inhibitory vagal pathway, but also regulates the special visceral efferent pathways controlling the striated muscles of the face and head. This does not preclude other structures being involved in mammalian social engagement behaviors, or homologous structures in other vertebrates who do not share our phylogenetic history having social engagement behaviors.

Polyvagal Theory proposes that the neural evaluation of risk and safety reflexively triggers shifts in autonomic state without requiring conscious awareness. Thus, the term neuroception was introduced to emphasize a neural process, distinct from perception, capable of distinguishing environmental and visceral features that are safe, dangerous, or life-threatening (Porges, 2003, 2004). A form of neuroception can be found in virtually all living organisms, regardless of the development of the nervous system. In fact, it could be argued that single-celled organisms and even plants have a primordial nervous system that responds to threat. As mammals, we are familiar with reactions to pain, a type of neuroception. We react to pain prior to our ability to identify the source of the stimulus, or even to be aware of the injury. Similarly, the detection of threat appears to be common across all vertebrate species. However, mammals have an expanded capacity for neuroception in which they not only react instantaneously to threat, but also respond instantaneously to cues of safety. It is this latter feature that enables mammals to downregulate defensive strategies to promote sociality by enabling psychological and physical proximity without anticipation of potential injury. It is this calming mechanism that adaptively adjusts the central regulation of autonomic function to dampen the metabolically costly fight/flight reactions dependent on sympathetic activation, and to protect the oxygen-dependent central nervous system, especially the cortex, from the metabolically conservative defensive reactions of the dorsal vagal complex (e.g., fainting, death feigning).
“Humans, as social mammals, are on an enduring lifelong quest to feel safe. This quest appears to be embedded in our DNA, and serves as a profound motivator throughout our life.”

Is it possible that those most vulnerable to addiction are in an autonomic state that promotes feelings of threat, and biases neuroception to detect cues of danger and adaptively be less sensitive to social cues of safety? Are those with addictions more likely to misinterpret positive social engagements via prosodic vocalizations, facial expressions, and gestures? If the addicted individual is chronically in an autonomic state that supports threat reactions and biases the detection of cues of threat, then these features would limit opportunities to co-regulate through the ventral vagal pathways and to successfully engage the social engagement system. The consequence of supporting an autonomic nervous system tuned for defense is to limit the functional neuromodulation benefit we derive from sociality, and become more reliant on the use of addictive substances and behaviors to modulate state. Ironically, this strategy of state modulation will not produce the physiological calmness that supports homeostatic processes, although it might numb bodily feelings of distress and physical pain.

Polyvagal Theory suggests a hierarchical conceptualization of feelings, as higher brain structures interpret the neural signals conveying information from visceral organs (e.g., heart, gut, etc.) to the brainstem. This psychophysiological perspective emphasizes the foundational function of autonomic state in the subjective experience of global feelings and emotions. Within this hierarchical conceptualization, feelings of safety are preeminent, and form the core of an enduring motivational system that shifts autonomic state, which in turn drives behavior, emotion, and thought. The resulting model suggests that feelings of safety reflect the foundational autonomic state supporting maturation, health, and sociality.

Feeling safe functions as a subjective index of a neural platform that supports both sociality and the homeostatic processes optimizing health, growth, and restoration. Operationally, feeling safe is our subjective interpretation of internal bodily feelings that are being conveyed via bidirectional neural pathways between our bodily organs and our brain. Feelings of safety are not equivalent to objective measurements of safety, which could pragmatically be defined as the removal of threat. Feeling safe is more akin to the felt sense described by Eugene Gendlin (2018). Although Gendlin, as a philosopher and psychologist, was not physiologically oriented, he described a “felt sense/shift” as not just a mental experience, but also a physical one.

Polyvagal Theory provides the science to understand the profound role of feelings of safety in the expression of sociality. The theory leads to a re-examination of the roles that feelings of safety and social behavior play in understanding addiction, and vulnerabilities to become addicted. Polyvagal Theory provides a perspective to understand addiction as a disruptor of the autonomic state that would support sociality and promote feelings of safety.

Humans, as social mammals, are on an enduring lifelong quest to feel safe. This quest appears to be embedded in our DNA, and serves as a profound motivator throughout our life. The need to feel safe is functionally our body speaking through our autonomic nervous system – influencing our mental and physical health, social relationships, cognitive processes, behavioral repertoire, and serving as a neurophysiological substrate upon which societal institutions dependent on cooperation and trust are based. While the optimal outcome occurs through fulfilling our biological imperative of connectedness, this is the product of individuals feeling safe through the co-regulatory properties of interactive social engagement systems. While the motivation to feel safe can be intense, the opportunity to feel safe may be difficult to achieve.

This may occur due to work schedule and location, in which proximity might limit availability of individuals who broadcast and are receptive to cues of safety. In addition, marginalized individuals experience barriers to the establishment of safe trusting relationships, even in their own community. Being marginalized through being identified by race, sex, ethnicity, religion, or disability frequently places an individual in a state of chronic threat, and greatly limits opportunities to co-regulate in work, school, and community settings in which those who are not marginalized can feel safe and co-regulated. However, in those experiencing limited access to positive cues of safety, the motivation to feel safe remains high, although the availability of appropriate individuals with whom to feel safe is low.

Although co-regulation and the use of sociality as a neuromodulator to regulate autonomic state is the neurobiological norm for our species to downregulate threat reactions, the norm is predicated on safe relationships. At times, opportunities to co-regulate with a trusted other are not available, and feelings of safety are not easily accessible. This may occur through either physical or social isolation. It also can involve an inability to feel safe with others. For example, individuals with severe adversity histories often experience feelings of threat in the proximity of others, and are unable to use sociality as a neuromodulator to calm autonomic state. Without
Addiction, from a polyvagal perspective, reflects an unsuccessful strategy to reduce the impact of threat by numbing or mobilizing. Addiction can appear to successfully mask, distort, or numb feelings of threat. Interestingly, the strategy of numbing and masking seems to follow implicit strategies frequently employed to foster a dissociation between feelings and actions, and frequent valiant attempts to prevent bodily feelings from disrupting intentional behaviors. However, unlike the neurobiological potency of sociality in generating feelings of safety, these strategies fail, and over time exacerbate feelings of threat.

A polyvagal perspective of addiction focuses on the attempted use of addictive substances or behaviors to damp underlying feelings of threat. This perspective frames the client’s behavior within a quest to feel safe. Unfortunately, feeling safe is dependent on an autonomic state that can only efficiently be reached through sociality, while recruiting ancient neurobiologically-based survival strategies that are insensitive to the intentions of higher brain circuits will fail.

If the therapist’s intention is to enable clients to feel safe, then it is important not to use evaluative phrases suggesting that their behavior is wrong or bad. By moving outside the moral veneer of societal norms, we need to explain to the client how their body responded. Interestingly, the strategy of numbing and masking seems mistaken to assume that numbing feelings of threat will lead to sociality.

The use of addictive substances and behaviors are effective in changing autonomic state, although the autonomic changes do not reliably support co-regulation, and frequently lead to poor outcomes. Two important factors contribute to these changes in state disrupting both feelings of safety and sociality. First, addictive substances and behaviors often downregulate the bi-directional feedback loops through which our nervous system communicates and regulates visceral organs. This numbing process may have short-term benefits, such as reduction of physical pain and mental distress, but it does not promote feelings of safety or spontaneous social engagement behaviors. Moreover, by dampening the neural regulation of visceral organs, it might lead to end organ damage. Second, addictive substance and behaviors often recruit an autonomic state that supports defensive threat reactions, which may result in abusive and aggressive behaviors.

On the surface, addiction is related to difficulties in feeling safe and maintaining trusting relationships. Addiction, from a polyvagal perspective, reflects an unsuccessful strategy to reduce the impact of threat by numbing or mobilizing. Addiction can appear to successfully mask, distort, or numb feelings of threat. Interestingly, the strategy of numbing and masking seems to follow implicit strategies frequently employed to foster a dissociation between feelings and actions, and frequent valiant attempts to prevent bodily feelings from disrupting intentional behaviors. However, unlike the neurobiological potency of sociality in generating feelings of safety, these strategies fail, and over time exacerbate feelings of threat.

The literature confirms the strong link between trauma history and addiction. A survey conducted by SAM-MA confirmed that approximately 75 percent of women and men in substance abuse treatment report histories of abuse and trauma (see samhsa.gov). From a polyvagal perspective, this link reflects an attempt to regulate autonomic state by numbing feelings of threat. This supports the proposed consequence of trauma history, especially in abuse experienced during childhood, as retuning the autonomic nervous system to be locked in to states of defense that would lead to mental health vulnerabilities, and attempts to ameliorate feelings of threat via addictive behavior (e.g., Carliner, Keyes, McLaughlin, Meyers, Dunn & Martins, 2016; En och, 2011; Felitti, 2006). Unfortunately, these strategies mistakenly assume that numbing feelings of threat will lead to sociality.

The client needs to appreciate this adaptive feature, and to understand that this adaptive feature is flexible, and can change in different contexts. The first step is to replace an evaluative focus with a curiosity about the adaptive survival prioritized repertoire of the nervous system. This curiosity leads to an appreciation of the emergent behaviors, which are dependent on the flexibility of autonomic state regulation while adapting to the challenges of complex contexts. A product of this journey is the development of alternative perspectives and personal narratives that would lead to greater bodily awareness, and an understanding of the difference between primitive neural pathways that support survival, and higher brain structures detailing intentions. With this rich information, the client can develop a narrative that treats atypical behaviors not as bad, but as understandable in terms of adaptive functions that may often be heroic.
The Felt Sense Polyvagal Model™ (FSPM) is a healing paradigm that integrates Porges’ Polyvagal Theory, and Gendlin’s felt sense. While the model can be applied to any aspect of wellbeing, this paper focuses on the field of trauma/addiction. The two embodied processes of neuroception and interoception form the foundation of the model. Resting on that foundation are five theories that build the conceptual framework: 1) feminist trauma-informed theory; 2) focusing-oriented therapy/the felt sense; 3) interpersonal neurobiology; 4) learning model of addiction; and 5) Polyvagal Theory.

1. The Roots of the FSPM – A Feminist/Trauma Theory Framework

Over forty years ago, I began practicing as a somatic trauma therapist. My first job was leading groups for young women who were survivors of incest. I started reading feminist therapists, such as Judith Herman’s Trauma and Recovery (Herman, 1992) and Sandra Butler’s Conspiracy of Silence (Butler, 1978). They helped me to validate what I knew intuitively, that the top-down pathologizing model I was surrounded by was harming my clients. Feminist therapists understood how trauma and addiction happen in the body, and that we must help our clients to reclaim their embodied knowing. It was common knowledge in the feminist community that addictions were very effective and adaptive ways to attempt to regulate numbing and flooding responses. We see this clearly in the binging and purging cycles that occur with dysregulated eating. Herman understood the function of addictions in the context of trauma as state regulation strategies. She described a continuum from intrusion, the sympathetic response, to constriction, the freeze response. She included the calm, dissociated state as part of constriction in the body. Back then, our understanding of dissociation was limited by the traditional model of the ANS. We now understand this “calm” state as descriptive of the collapsed, shutdown dorsal state that Porges integrated into the new understanding of the ANS. Porges’ contribution matched our clinical observations, and provided us with the missing piece. The state of collapse that appears to follow constriction explains the calm relief that our clients feel with profound dissociation and sleep. This is the place of relief that the body seeks when other forms of safety and comfort are unavailable.

Van der Kolk was curious about self-harming behavior (Van der Kolk, 2014). He asked, “Why are so many people attracted to dangerous or painful situations?” He conducted research with eight war veterans, who agreed to watch violent scenes from the movie Platoon (1986) while they took a standard pain test. They measured the length of time the veterans could keep their hands submerged in a bucket of ice water. They were then exposed to calm and peaceful scenes. They found that seven of the eight veterans kept their hands submerged in cold water thirty percent longer during the violent scenes. Van der Kolk states, “We then calculated that the amount of analgesia produced by watching fifteen minutes of a combat movie was equivalent to that produced by being injected with eight milligrams of morphine, about the same dose a person would receive in an emergency room for crush- ing chest pain”. (Van der Kolk, 2014, p. 33)

This research was profound in helping us make sense of our clients’ often-misinterpreted self-harming and...
addictive behaviors. Instead of assuming masochistic or attention-seeking explanations, we appreciate the role of the autonomic nervous system in shifting states to survive. We see how our clients re-enact their trauma stories by unconsciously returning to threatening situations that activate the release of endogenous opioids, creating a shift into a dorsal state of shutdown, and the calm relief that Herman spoke about.

Herman and Van der Kolk’s work in unravelling the mysteries of self-harm and addiction are wonderful examples of the integration of top-down and bottom-up approaches.

They listened to survivors with curiosity and compassion. By conducting qualitative and quantitative research, they contributed to unravelling the mysteries of the body and mind as they seek to survive unrelenting pain.

Feminist therapists also understood that establishing moment by moment safety was the most important part of the healing journey. I learned that creating a “safe nest” for our clients is essential for healing to begin. Safety is our North Star; it invites us, igniting a path and keeping us company as it points the way to connection. Without it, we are lost. Herman provided a three-stage model that created a safe container for the healing journey: establishing safety, remembering and mourning, and reconnection (Herman, 1992). Her work guided feminist therapists to create more structure and containment at the beginning of treatment, particularly in group therapy with survivors of sexual abuse.

Herman’s anti-oppressive lens provided a framework in which to understand the systemic nature of abuse on a personal and political level. This broad view of societal trauma provided a deeper, more sophisticated understanding of the challenges in creating safety for our clients, and in society.

2. Gendlin’s Focusing and Felt Sense

In developing the FSPM™, I searched for a therapy that would help my clients reclaim their connection to body wisdom. In the mid-1980s, I found Gendlin’s book Focusing (1978). His contribution to the FSPM™ is found in the breadth and depth of his teachings. His philosophy of the implicit (Gendlin, 1997) offers a fresh way of integrating science and first-person experiencing. It teaches us that the body’s implicit knowing is beyond our conscious awareness. Gendlin discovered that clients who did well in therapy were connected to their body and its implicit knowing through what he called the felt sense. This knowing is at first vague. Turning attention inwards and noticing feelings and body sensations allows a felt sense, a whole sense of a situation, to form in the body. The felt shift arises as the body makes meaning from the felt sense. Embodied knowing is implied in the next step towards growth. Gendlin called this deep listening process Focusing. While it is a natural process, many people find it hard to do at first, perhaps because we live in such a disembodied culture. He made six steps to teach it to people.

Gendlin created the Experiencing Scale, (EXP; 1986) that provides clinicians with a validated seven-point scale to assess the level of emotional and cognitive awareness of one’s ongoing experience. This interoceptive tool aids clinicians in tracking clients’ ongoing progress in deepening their capacity to integrate traumatic experience and strengthen their ventral presence. It is an essential part of the FSPM™.

Gendlin encouraged the creation of Focusing partnerships. He believed that people were more often able to go deeper in their practice if they were accompanied by another person. Focusing is very much about listening to your partner in a way that honors their deep process. In this way, he created a powerful partnership practice based on the polyvagal concept of co-regulation. We help each other to connect and settle in our ANS as we deepen our Focusing practice.

Thoughts, feelings, physical sensations, and memories are avenues into the felt sense. In asking questions about these avenues, we help clients deepen their embodied knowing of an issue. As the felt sense forms, we pause and stay with the fullness of experiencing. Sometimes a felt shift, a physical release, happens as the client integrates new knowing. This relieving shift is the body’s way of pointing us in the direction of safety and healing. These shifts are what Gendlin called “the motor of change” (Gendlin, 1964) that carries us forward in life.

As I learned about felt shifts, it helped me to understand what I was observing in my clients’ bodies. As we worked through the trauma, I could see the physical shifts as their bodies opened and they became more present and socially engaged. With this presence comes a sense of meaning and purpose in life. This is vitally important, because trauma and addiction diminish and often shatter one’s sense of meaning and purpose.

When I began to read about Polyvagal Theory, I could see the interconnection between the subjective experience of a felt shift and the neurophysiological shift in autonomic states. My FSPM™ incorporated this theory, and posits that these felt shifts are, in fact, shifts in

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...brain changes, a process called neuroplasticity, that occur in addiction are the same as those that happen when we are in love, or absorbed in a sport.
Thus, addiction is not a chronic disease, but a learned response...

3. Interpersonal Neurobiology

Dan Siegel’s work in helping us to understand the nature of mind-body interaction forms another layer of the FSPM™. Siegel takes us into the world of interpersonal neurobiology (IPNB), an integration of subjective experiencing and traditional science. He deconstructs the pathologizing paradigm, creating a new way of understanding mental health. His model emphasizes the regulation of emotional states on a continuum from hyper-aroused to hypo-aroused. This work compliments Polyvagal Theory. Siegel understands wellbeing as a state of integration where clients learn how to regulate through mindfulness practices.

4. Lewis Learning Model of Addiction

In developing the FSPM™ I incorporated Marc Lewis’ (Lewis, 2015) learning model of addiction. The disease model argues that addiction changes brain chemistry. Lewis points out that brain changes, a process called neuroplasticity, that occur in addiction are the same as those that happen when we are in love, or absorbed in a sport. Thus, addiction is not a chronic disease, but a learned response – one that becomes habituated over time. This habituated response can also change as new neural exercises are learned, offering the addicted person hope in achieving a stable and healthy life. This de-pathologizing model of addiction provides a vital part of the FSPM™.

5. Polyvagal Theory

When I discovered Polyvagal Theory, I knew I had found the missing piece for my evolving model. I was now able to clearly see the functional role of addiction as activating a blended state of both the sympathetic and dorsal branches of the ANS. The theory resonated with me in three powerful ways: 1) Porges’ emphasis on safety as the precursor for healing; 2) his identification of both the dorsal branch of the ANS and the social engagement system; 3) the concept of autonomic state as the intervening variable in the traditional stimulus-response model.
Safety as the Precursor of Healing

Understanding addiction within the context of both an absence of and a quest for safety is a powerful framework. It challenges us to examine our understanding of what constitutes safety, and how lack of experiences of safety relate to trauma and the prevalence of addictive behaviors. Indeed, the research that links trauma and addiction is impressive, as emphasized by Porges, above (e.g., Carliner, Keyes, McLaughlin, Meyers, Dunn & Martins, 2016; Enoch, 2011; Felitti, 2006).

So, what is safety? The answer to this question differs greatly depending on what framework you employ. Our culture’s current top–down approach typically understands safety as the absence of physical threat (Porges, 2017). We concentrate on making environments safe by building walls, fences, security systems, and jails. Our actions are driven by fear. We often fail to address our very real need to actively create cues of safety. When our needs for “enough safety” are not met, we are often traumatized by a culture that blames individuals instead of examining societal systems of oppression. Many of our clients live in chronic states of dysregulation, having learned to deal with traumatizing conditions by using substances and behaviors to alleviate overwhelming feelings of isolation. In terms of addiction, we create a “war on drugs,” and then criminalize those suffering from addiction. In our current dissociated state, we fail to see the systemic causes of trauma and addiction.

From a bottom–up perspective, we view safety quite differently. While physical safety is important, it remains one dimension of our experience. Porges notes that feeling safe is akin to a felt sense. When we tap into our felt sense of safety, we become aware of thoughts, feelings, physical sensations, and memories. We have an embodied sense of connection with our emotional and physical needs. When we are connected to embodied knowing, we realize the importance of creating safe spaces that address all our needs: physical, emotional, sensory. When we nourish these parts of ourselves, we become interconnected as a species. We appreciate the inequalities that exist in our world, and how those inequalities create trauma and addiction. And, we understand the importance of repair instead of punishment.

From a polyvagal perspective, we must consider not only our clients’ need for safety, but also our own. We understand that we co-regulate each other’s ANS, and therefore need to create the conditions upon which we will both feel safe enough to grow together.

Unfortunately, our professional boundaries reflect the top–down methodologies that are currently dominating our therapeutic work. Forty years ago, the field of trauma was very underdeveloped. As we began to address issues of abuse and neglect, we were told that we should stop asking clients if they were abused, for fear of implanting “false memories” (Loftus, 1996). We were instructed not to touch our clients, as that could trigger them. We were told that they couldn’t distinguish between safe touch and sexually abusive touch. Many of us were afraid of being sued or sanctioned by our colleagues, and an appalling sense of fear silenced us. I would argue that this fear is still shaping our professional standards. As therapists, we must feel safe enough to foster a warm, deeply intimate space in which to hold our clients. We must have the courage to move beyond fear, and share our own authentic self. When we share our own vulnerability in a carefully bounded way, we model what it is to be human in all its rich and various forms. As humans, wired to connect, we need to feel free to acknowledge our enjoyment of each other, and to relax into being ourselves. After all, we are engaging with our clients in an arduous and lengthy journey. Our commitment is fed by our enjoyment of the relationship.

Our job as therapists is like no other. We need to be able to create moment by moment experiences of enough safety so that healing can begin. From a polyvagal perspective, this requires much from us. We are our own instruments in the work. We cultivate, as much as possible, a grounded awareness and embodied connection with our clients. We do not have to be fully grounded, but we do need to be grounded. We gently and steadfastly coax the person we are accompanying into “eyes wide open” presence. This is facilitated by much patience, and often love, for our clients. It requires us to be firm in holding them accountable when facing the truth about their lives. As we build the safe nest, they will lean into us. We have to stand tall, like the oak tree. It bends in the wind, but it must stay standing.

Identification of the Dorsal Vagus and Social Engagement System

Porges’ identification of the unique functions of the dorsal branch of the vagus nerve as part of the ANS facilitated a huge shift in the trauma world. It provided a clear understanding of the powerful numbing and shutting down experiences that we see in our clients’ responses. We now appreciate the immobilizing effect of the dorsal state when the body is under great threat. Polyvagal Theory provides a top–down and bottom–up theory that explains the full range of options in the ANS, from sympathetic to dorsal responses. The shutdown, numbing function of the ANS can now clearly be identified as separate from the commonly called freeze state.

The freeze state is now understood as a blending of sympathetic mobilization and dorsal immobilization, resulting in a stuck process in the ANS. The body contracts with the sympathetic surge, but it is simultaneously immobilized with dorsal activation, creating a stopped process. This identification of the freeze state leads us to a deeper understanding of the role of addictions as state regulation strategies in the ANS. This stuck process is a powerful feature of addiction. From
a polyvagal perspective, it makes sense that addictions act as propellers that shift the body along this continuum in a quest for safety. Sadly, as Porges points out, even if these behaviors bring temporary relief, they create an endless feedback loop that results in unsuccessful attempts to regulate.

Norman Doidge describes this state as the “plastic paradox” (Doidge, 2017). The process of neuroplasticity – the way in which our brains are always changing – paves the way for healing from trauma and addiction. However, herein lies the paradox: if behavior is repeated too often, as in addiction, the neural pathways become rigid and unchanging. Then, the addicted person is literally in a rut – spinning their wheels and going nowhere.

The social engagement system is a term coined by Porges that describes the cluster of neural pathways that interact in the ventral vagal complex to support sociability, while simultaneously supporting health, growth, and restoration (Porges, 1998). The ventral vagal complex is a brainstem area that regulates the ventral vagal pathways and the striated muscles of the head and face. The ventral vagus communicates with organs above the diaphragm, and facilitates bidirectional neural communication between the face and the heart. This demonstrates how we are wired to connect through our facial expressions and prosody of voice.

The social engagement system is activated when we feel safe enough to be grounded and present. We have the capacity to connect with others, and think through how we want to respond to situations, especially those that require empathy and good judgment. When we lose this connection due to activation of defensive states, our capacity to think clearly and respond with empathy is debilitated. In the state of addiction, the ventral vagal complex is compromised. We lose our clear-headed and compassionate selves. This is how good people can find themselves doing bad things. People who are addicted are compelled by a neurophysiological drive to acquire whatever it takes to self-soothe. The body is wired to survive, and in a desperate state the social engagement system is severely compromised.

This understanding is key to revolutionizing addiction treatment. Rather than invoking addictive metaphors of devils or greedy monsters that must be defeated, we describe the process in our autonomic nervous system that shifts the body into states of defense to survive. In chronic defensive states – the addictive loop – we lose our capacity to think clearly. Illegal and immoral acts then become options in our repertoire of behaviors. Appreciating the body’s attempt to keep us alive enables us to befriend the body, rather than treating it as a war zone. In my experience, explaining this to clients is life-changing. It creates what I call “moments of liberation” from endless shame and despair. It sheds light on the profound confusion that clients have in understanding how they could have behaved in ways that they often abhor. These moments are the treatment! This understanding brings powerful felt shifts into ventral states of repair as clients learn to hold their addicted parts with love and kindness.

Knowing that our clients will want to avoid social engagement helps us to understand why the treatment of choice, group therapy, will be a scary proposition for most. I start with individual sessions, building co-regulation over time. As we establish some safety and connection, most clients will take a risk with group, especially knowing that I will be there to lead.

**Autonomic State as Intervening Variable**

Polyvagal Theory suggests that our autonomic state determines how we will experience the world. Our ANS is the intervening variable in the traditional stimulus-response model. Simply put, when we are stimulated by an experience, our present autonomic state will determine our response. I will give an example.

As I write this today, large numbers of people are demonstrating against vaccine mandates and other Covid measures in a movement for “freedom.” They are gathering in mounting numbers by foot, and driving large trucks into the center of the city. As they approach, a few miles from my home, they are chanting and honking horns incessantly. I listen to the news, and hear about police presence, and the concern that these trucks will attempt to block access to hospitals. I sense the momentum building, and feel a surge of sympathetic energy flow through my body. I am moving into a state of defense.

As I respond from this sympathetic state, I feel scared and angry. My body is mobilizing, and I want to hide or fight back. I feel judgment and despair about this behavior. If I invite my body to settle and engage in ventral energy, a felt sense of enough safety forms in my body. The story that follows from this ventral state is different. I understand that these folks are upset, and perhaps feel helpless and frightened by the very prolonged Covid measures that they are enduring. They too are surging into sympathetic flight/fight responses without much ventral capacity.

I understand that in order to move into social engagement and co-regulation, our officials will have to facilitate a way forward by listening to each other. As I breathe and stabilize, I feel much less judgment and much more capacity to empathize.
Anti-Oppressive Theory

The FSPM™ is held by and accountable to anti-oppressive theory. From this lens, we understand the root causes of addiction and their role in the autonomic nervous system. Our culturally conditioned systems of oppression lead to trauma, and trauma is the underbelly of addiction. Consequently, marginalized groups are much more vulnerable. Staci Haines, author of *The Politics of Trauma* (2019), puts it so well when she says that trauma robs us of safety, belonging, and dignity. Without these basic needs being met, we seek out twisted ways of soothing to help us survive.

Introduction of the Graphic Model

Clinician and Client Versions

The graphic models help clients become familiar with the ANS using imagery. By visualizing images, we engage a bottom-up process that helps clients embody the concepts and pathways to healing through activating the right hemisphere. The use of these models early on in treatment accelerates the ability to befriend the body by harnessing the ANS and the felt sense as powerful vehicles for change.

To support the FSPM™, I created two graphic models—one for clinicians and one for clients. My clients helped me create a simple version where each state starts with the letter F to make it easy to remember. They keep track of their state by putting a picture of the model on their phone and/or their refrigerator. We call it orienting to the Six F’s when we discuss the model. Together, we track states, tracing the pathways, as a way of describing the healing journey. The graphic images help clients see very clearly how addictions function as propellers between flight/flight and fold. The top half of the model shows the trauma pathways where the ventral social engagement system is compromised. The bottom half follows the ventral pathways, the states that support a fulfilling life.

Looking at the graphic depiction of the FSPM™ clinician version, we can see the three circuits of the ANS, connected via a solid-lined, inverted triangle.

1. For color images and downloads of the models, go to janwinhall.com

Focusing Practice

*I invite you to take time to pause, to breathe into your response.*

*Notice how your ANS is carried in your body, and how the state impacts your felt experience.*

A. The ventral vagus is in yellow at the bottom of the page,

B. The sympathetic in red is on the right, and

C. The dorsal vagus is in grey on the left.

Next are blended states, connected by the dotted-line triangle. Blended states in the system utilize two pathways. The ANS has the capacity to blend states, creating a greater range of experiences. The blended states are represented in the model in mixed colors:

A. Play is on the bottom right in yellow/red.

B. Stillness is on the bottom left in yellow/grey.

C. The FSPM™ also proposes a third blended state of addiction, which is at the top of the model in red/grey. Addiction is a blending of sympathetic and dorsal states. Substances and behaviors then serve as state regulation strategies.

The client version uses what I call the Six F’s to define the states of the autonomic nervous system: Fight/Flight, Fixate/Freeze, Fold, Flow, Flock, Fun/Fired Up. As we work with the model, we discover other blended states.

1. **Fight/Flight** – sympathetic response. Flight is a state of fear and anxiety. In this state, the body mobilizes to run and escape. Fight is a mobilizing state of anger.
2. **Fold** – dorsal response. Fold is a collapse of the ANS into a dissociative state when the sympathetic response is ineffective.
3. **Fixate** (Fight/Flight and Fold) – blended state. It is the blended state of addiction that acts as a propeller between Flight/Fight and Fold.
4. **Flow** – ventral and dorsal response. Flow is a blended state between ventral and dorsal. It is a state of safety with stillness.
5. **Fun/Fired Up** – ventral and sympathetic response. Fun is the blended state between ventral and sympathetic, a state of playfulness. Fired Up, an impassioned, activated state, is another blending of ventral and sympathetic.
6. **Flock** – ventral state of grounding and safety. This state promotes health, growth, and restoration.
THE FELT SENSE / POLYVAGAL MODEL™ OF TRAUMA AND ADDICTION

CLINICIAN VERSION

TRAuma

ADdiction

IMMOBILIZED

DORSAL / SYMPATHETIC

Self-Harm, Process Skipping

MOBILIZED

Hypo-Arousal
Numbing, Dissociative

Hyper-Arousal
Flooding, Activated

INSECURE

ATTACHMENT

SECURE

STILLNESS

DORSAL VAGUS
Parasympathetic

VENTRAL / DORSAL
Parasympathetic

Ventral Vagus
Parasympathetic

Intimacy, Awe,
Meditation, Focusing

Enjoy and Create /
Impassioned

Health, Growth, Restoration
Carrying Forward

THE AUTONOMIC
NERVOUS SYSTEM

THREE BRANCHES
BLENDed STATES

SAFEty

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Revolutionizing Addiction Treatment with The Felt Sense Polyvagal Model™

THE FELT SENSE POLYVAGAL MODEL™ OF TRAUMA AND ADDICTION

CLIENT VERSION 6 F’s (3/3)

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Applying the Felt Sense Polyvagal Model™ Embodied Assessment and Treatment Tool (EATT)™

When I began working with the FSPM™ I realized that I would need to create an assessment tool that captured the experiential process of the work and the somatic history of the client. The traditional bio–psycho–social assessment is completed in the first or second session. It focuses on taking a detailed assessment of the client’s history, with no reference to embodied processes. There are many problems with this approach. For example, clients are required to share detailed traumatic experiences and addictive behaviors all at once, and at the beginning of treatment, when a sense of safety is just beginning to be explored. At the very least, this is uncomfortable for clients, and at worst it is retraumatizing.

In sharp contrast, the Embodied Assessment and Treatment Tool (EATT)™ slowly integrates assessment and treatment over time. In keeping with the experiential nature of our work, and the attention to body process, the client’s history unfolds as the body reveals its wounded places. By tracking neuroception (polyvagal theory) and interoception (focusing) as our framework, we develop a comprehensive assessment package that documents ongoing progress, and provides the client with therapeutic tools and practices they can use as resources in their healing journey.

The Importance of Asking

If your early assessment with a client indicates a lack of ventral presence for significant periods of time, it is important to consider that they may be using self–harming and potentially addictive substances and behaviors to manage neurophysiological state changes. It then becomes essential, from a polyvagal perspective, to explicitly ask about self–harm and addiction. We need to bring the body on board, to recruit the ANS as a collaborator in helping us unlock the addictive pathways, by shifting neuroception. When we work with the body, we invite all the parts of a person to embrace the idea of reducing harm. Otherwise, we engage in an unspoken power struggle: the mind wants to stop addiction, but the body is stuck in an ANS trauma loop.

With the FSPM™ as our guide, we begin to track the client’s autonomic state and capacity for embodied experiencing. The tool has eight components that include the following:

1. The Felt Sense Polyvagal Model™
2. The Experiencing Scale (EXP,1986)
3. The Felt Sense Polyvagal Dialogue™
4. The Three Circles (Carnes, 2001)
5. The Trauma Egg (Murray, 2012)
6. The Nine Domains of Integration (Siegel, 2012b)
7. The Privilege Wheel, (https://www.oise.utoronto.ca/edactivism/Activist_Resources/The_Power_Flower.html)
8. Specific Concerns

In a top–down approach, we would use each of these in order. I start by tracking neuroception with the FSPM™ and interoception, using Gendlin’s Experiencing Scale. Then I use the rest when, and if, they become helpful in our experiential journey. For the sake of brevity in this article, I will give a case example using the FSPM™ and the Three Circles practice by Patrick Carnes. For a detailed description of the Felt Sense Polyvagal Dialogue™ that I used in this case, see Chapters 13 and 14 in my book Treating Trauma and Addiction with the Felt Sense Polyvagal Model (Routledge, 2021).

A Case Example
Lily and Lucas

Lily, a hip young woman in her mid 30s, came to see me five years ago. She and her partner Lucas met at a ballroom dancing course. They fell into a routine of going for drinks after class. Over time, they moved in together, and the drinking became a nightly routine. It was never enough to prevent either of them from performing well at work, but Lily was feeling more and more uneasy about it.

During our time together Lily and I explored the feelings that surrounded this behavior. She learned how to connect with her felt sense of the problem. It came quite naturally to her, since she was a trained dancer. She became adept at understanding her calmed and smoothed the jagged edges of her anxious state. Together we traced the addictive pathways from Fight/Flight (sympathetic) to Fold (dorsal) with alcohol and sugar planted firmly in Fixate(sympathetic/dorsal). She resonated with the understanding of addictions as propellers that shifted her from one extreme to the other. She appreciated how the addictive neural pathways were in the top half of the FSPM™, limiting her capacity for social engagement and a feeling of safety. We used Carnes’ Three Circle Practice to help Lily make a harm reduction plan and be accountable.

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2. For a detailed example of the EATT, including the Process Recording Form, a copy of the Three Circle Practice, and the Body Cards, downloads are available on my website janwinhall.com and further elaborated in my book Treating Trauma and Addiction with the Felt Sense Polyvagal Model (Routledge, 2021).
to herself. This practice, called a neural exercise in polyvagal language, helped Lily create new ways of finding grounding energy that moved her into Flock, Flow, Fun (ventral).

**Body Cards**

In keeping with the enhancement of bottom-up processes in working with the FSPM™, we use Body Cards to invite the client to draw the felt sense of a neurophysiological state. The imagery helps to explicate the implicit experience, and in the case of ventral states, the cards can be used as resources. Here is an example of a Fight/Flight sympathetic state Body Card.

**The Three Circles**

The Three Circle practice is a tool that was developed by Patrick Carnes (2001) in his work with sex addiction. The three concentric circles provide a map for clients to document their management of addictive behaviors. I integrated the ANS states into the three circles.

**The Inner Circle: Fixate**

The inner circle represents addictive behaviors that clients are ready to change. We work with the process by using the FSPM™ as our guide.

By explaining the model, we are recruiting the person’s nervous system to collaborate in the healing process. We invite the body to consider letting go of addictive behaviors. When clients are ready, we place the behaviors inside the circle. The behaviors must be quantifiable for clear accountability. Clients agree to check in with their therapist to build accountability on a daily or weekly basis, and/or they can check in with their focusing partner. If they want to change the boundaries around the behaviors, they agree to negotiate with their therapist first.

Lily’s inner circle contains no alcohol, and two desserts per week.

**The Middle Circle: Fight/Flight, Fixate/Freeze, Fold**

The middle circle represents the stressors, the experiences that lead to the activation of the addictive behaviors. These can be current-day stresses like job problems, conflicts in relationships, systems of oppression, poverty, and early abuse histories. We trace the ANS states on the FSPM™ to help clients begin to understand how these soothing behaviors ease anxiety and rage. They begin to appreciate how addictions act as state regulation strategies, propelling them often from flight/fight to fixate to fold. They appreciate the adaptive nature of their very bad habits when flock was not available.

Lily’s middle circle contains stress at work, loneliness, anxiety, and feelings of shame that are profound and confusing.
The Outer Circle: Flock, Fun/Fired Up, Flow

The outer circle is the sweet spot where bodies feel safe enough to engage in social interaction, to rest, to digest, to trust. It is the place of health, growth, and restoration in the body. The felt sense experience of life is engaged, and purpose and meaning carry us forward in a productive life. Addictions are not active in this state of social engagement.

Lily’s outer circle contains:

- doing daily practices including checking Three Circles and FSPM™
- spending time with friends and family, and with Lucas
- teaching dance, yoga
- attending weekly therapy sessions
- Focusing weekly with her partner

Lucas Joins Us

Lily was making some progress with the use of the Three Circles and the FSPM™, but she was finding it difficult without Lucas’ participation. When we invited him to join us, he was eager to begin his own journey. Lucas did his Three Circle Practice so they could work together on a plan. They both agreed to stop drinking alcohol, placing “no alcohol” in the inner circle. They cultivated their outer circle behaviors, and their relationship began to settle into a flock, flow, and fun rhythm. We said goodbye for now, and I didn’t see them again until I got a call from Lily about a year later.

The Call

I opened my office door to tall, elegant Lily, dressed in gorgeous colors and delicate silver earrings. My body remembered beautiful, vulnerable Lily with a loving feeling of delight. But something was terribly wrong. Lily sat down and collapsed into our warm space. She had discovered that her handsome, safe, and loving Lucas, the man she trusted as kind and honest, was hooking up with men for sex.

As she shared this with me, Lily fell into a dorsal state of shock, her body folding into the couch, eyes sinking into oblivion. I felt alarmed, and leaned in. I whispered to the Lily that I know, coaxing her back to breath, back to me and to life. She began to surface, breathing more deeply as she returned to the room, but her eyes held mine with a despairing gaze. It was hard to greet her here, in such a painful, dark place. But that is our job, to be present and hold these places with love and care. This is the arduous work of co-regulation. I gently extended my hand, and she reached over, hungry for the anchoring warmth of touch. We paused and breathed, feeling our feet on the ground.

The Healing Journey

Lily, Lucas and I met over several years. Together, we explored their embodied stories through the relational felt sense, the body’s way of co-regulating. We started by building a safe nest together. They revisited the Three Circle Practice and Lucas agreed to add “no use of pornography” and “sexual activity only with
Lily" to the inner circle. We checked in at the begin-
ing of each weekly session to help them be account-
able to each other as the therapy progressed. Over
time more of their trauma stories were revealed as we
moved deeper into the wounded places. This work is
the heart of the journey, excavating the trauma that
forms the underbelly of the addictive behaviors.

As Lucas connected with his felt sense, deepening his
capacity for experiencing, he was able to share more
of his struggle with obsessive use of pornography, and
unsafe sexual encounters with men. He was confused
and frightened by this behavior describing it as an
‘out of body, mechanical’ feeling that came over him.
It seemed clear that this behavior was addictive. He
wanted to stop but was struggling to stay grounded.

As they established safe boundaries in their rela-
tionship, we worked through the trauma using the
FSPM™ to help them understand their ANS pathways.
They became familiar with their default autonomic
states. Lucas was aware that he lived much of his life
in a somewhat dorsal state – seeking aloneness and
shutting down intense emotion. Lily recognized her
general tendency towards sympathetic activation,
often feeling the full range of fight/flight feelings.
She acknowledged that she flew into raging at Lucas
when she was angry, which activated his shutdown
response. Lucas began to cry as he heard Lily’s ac-
knowledgement of her anger. To hear her capacity
to give to him now, after he had hurt her so deeply,
was overwhelming for him. He was as confused by
his acting out behavior as Lily was, but he knew his
confusion was not an excuse. He was responsible for
hurting her. I saw him slowly peek at Lily, as he tried
to find his voice.

“It feels really good to hear you acknowledge your
rage. When you yell, I die inside… In fact, right now
my heart is racing.” Lily asks Lucas to check down
into the center of his body and see what is happening
now. “It feels shaky, like butterflies in my stomach. I
can see that red ball, like the fight/flight place on the
model, in my gut. It feels good though to talk openly
with you, and for you to hear me.”

Lily mirrors back, and I see a moment of connection
deepen between them for the first time since this all
happened. Together, we pause and help Lucas explore
more of his felt sense. He checks in with the but-
terflies in his stomach, the red ball in his gut. He shares
that it feels calmer in there now, more relaxed, and
expansive. I tell him that we call this the felt shift
when the body changes neurophysiological states.
“Like going from flight to flock,” he says.

“Yes!,” I say, and we all laugh (Winhall, p. 203).

From time to time they both slipped in their efforts to
not drink alcohol. Lily did well with her two desserts
a week. Lucas was able to stop hookups with men,
but did occasionally slip into watching pornography
when Lily was traveling for work. This caused a lot of
reexperiencing of the trauma. I decided to refer Lucas
to a Focusing-oriented sex addiction group for men,
and Lily to a women’s group.

During their separate therapy sessions, Lily and Lu-
cas both awakened early memories of sexual abuse.
While these memories were never completely dis-
sociated, they lay dormant in the body. As the body
healed, more of the story emerged. They eventually
revealed to each other, with heart-wrenching ten-
derness, their shared histories of child sexual abuse.
Lily shared a history of being abused as a little girl
by her uncle and his friend. Her body takes her back
to the felt experience of the abuse, and her soothing
with food. This connection is powerful, and creates a
felt shift for Lily. Fragments of feelings and behaviors
start to fall into a cohesive narrative about her life.
Lucas and I can see the physical release in her body as
she settles into a ventral state of relaxation.

Through his work in the group, Lucas began to make
deep connections with past and present behaviors. He
was able to share memories of being sexually abused
by an older male neighbor, and a teacher. By tracking
his felt sense of these memories, he began to connect
his hookups with the same feelings that originated
in these early experiences – a deeply confusing mix-
ture of sexual excitement and repulsion. While he still
wasn’t clear about it all, he was beginning to under-
stand that his body was taking him back to wounded
places that he needed to make sense of. He realized
how the acting out was followed by a deep dorsal
state of numbing, bringing him relief from anxiety
and depression. Now it became clear to both of them
how the abuse activated the middle circle dysregulat-
ed trigger states, subsequently leading to their inner
circle addictive behaviors. They both recognized how
their addictive behaviors told a deeper story about
their lived experiences.

The couple still struggled in their relationship. While
Lucas no longer identified as being sexually addicted,
he challenged the relationship in his need to explore
his sexual orientation. While unclear, he was very
committed to Lily, not wanting to lose the deep inti-
macy they had created. Lily grew to accept that Lucas
was attracted to many kinds of sexual expression, but
for now she needed him to be monogamous. For now,
he agreed.

Moments of Liberation
and Couple Felt Shifts

“So, we have little Lily and little Lucas, child parts
that learned about sexuality in a scary way. A way
that was confusing and robbed them both of the right
to decide how and when to share that part of them-
selves. As I say this, we all start to cry. I try to honour
my tears and at the same time, tuck them inside so I
can be here for this wonderful moment of liberation
for Lily and Lucas. As we unravel the triggered places, I invite us all to notice the felt shifts as we sense into this exquisite moment” (Winhall, p. 210).

The Five R’s for Addiction Treatment

I have adapted Deb Dana’s four R’s as they apply to the Felt Sense Polyvagal Model™ for addiction. They summarize Lily and Lucas’ healing journey. They are as follows:

◼ Reframe addictions as state regulation strategies
◼ Recognize and explore the autonomic state/felt sense
◼ Respect the adaptive survival response
◼ Regulate or co-regulate into a ventral vagal state
◼ Re-story [Adapted from Deb Dana] (Dana, 2018, p. 7)

Lily and Lucas were able to re-story the rupture in their relationship by working through their early abuse histories. The Felt Sense Polyvagal Model™ helped them reframe their addictive behaviors and respect them as state regulation strategies that were adaptive survival responses. By recognizing and exploring their ANS and their relational felt sense, they were able to co-regulate into a ventral vagal state.

Conclusion

Polyvagal theory and the work of Stephen Porges makes a major contribution to our understanding of addictive behaviors. In the language of Polyvagal Theory, we understand that behaviors are emergent properties of a neural platform mediated by autonomic state. A behavior viewed as pathological in one setting can be adaptive in another setting. Addiction disrupts feelings of safety and sociality through changes in autonomic state that function as an intervening variable, biasing reactions to context. Although addiction strategies are an attempt to dampen underlying feelings of threat, the strategies frequently downregulate the bidirectional feedback loops, resulting in a numbing process that may have short-term benefits in relation to physical pain and mental distress, but in the long term, dampened neural regulation of visceral organs may lead to organ damage.

In the optimal social context of humans, social interactions serve as the prominent mechanism to calm the autonomic nervous system. In contrast, in the world of addiction, social interactions are displaced by drugs and behavior to regulate the autonomic nervous system, thus disrupting homeostatic functions and potentially compromising mental and physical health.

The Felt Sense Polyvagal Model™ is grounded in Polyvagal Theory, and integrates the work of Eugene Gendlin’s Focusing Oriented Psychotherapy, as well as Marc Lewis’ learning model of addiction. It is a generic framework that provides an embodied, comprehensive, non-pathologizing model for understanding and treating trauma and addiction. The model brings addiction treatment into the world of somatics, and can provide the psychotherapist with a framework for any treatment modality that they are currently using.

This paper offers a new and deeply embodied way of understanding and treating addiction. Bringing attention to the body’s autonomic nervous system, our safety monitor, reveals the protective qualities of addiction when faced with prolonged feelings of isolation and lack of enough safety. By recruiting our nervous system as a collaborator in the healing process, we tap into the key to successful treatment, establishing safe enough spaces for healing to begin. We know that addiction is created and prolonged by states of vulnerability. Embodied psychotherapists see the trauma of addiction every day. We see how the addicted person is stigmatized. “The drug addict is today’s scapegoat,” says Gabor Maté (2008, p. 58).

It is easier to offer brain disease models than to address the source of the problem by dismantling systems of oppression that undermine safe spaces. But there is a growing social movement that seeks embodied approaches — a movement that longs for connection, cooperation, and dignity for all. While we may appear to have lost our way, it is only in our heads. Our bodies know the answer.
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Stephen W. Porges, PhD, is a distinguished university scientist at Indiana University, where he is the founding director of the Traumatic Stress Research Consortium. He is professor of psychiatry at the University of North Carolina and professor emeritus at the University of Illinois at Chicago and the University of Maryland. He has published more than 400 peer-reviewed scientific papers. He is the creator of the Polyvagal Theory and a music-based intervention, the Safe and Sound Protocol™, currently used by more than 2000 therapists to reduce hearing sensitivities, improve language processing, and increase spontaneous social engagement. He is a co-founder of the Polyvagal Institute. He is the author of The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation, The Pocket Guide to the Polyvagal Theory: The Transformative Power of Feeling Safe, and Polyvagal Safety: Attachment, Communication, Self-Regulation, and co-editor of Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies.

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Embodied Presence

The Essential Therapeutic Stance in Working with Addictive Behaviors

Nancy Falls

ABSTRACT

The focus of this article is the embodied presence of the therapist. An embodied presence is a core ingredient to work with those who engage in addictive behaviors or have experienced trauma. An overview provides the theoretical framework that informs the understanding of embodied therapeutic presence. Using the polyvagal concepts of co-regulation, social engagement, and neuroception, practical applications and specific strategies for the embodied presence are presented in three areas: creating the brave space, preparing for an encounter, and the five essential qualities of an embodied therapist.

Keywords: Embodied presence, addictive behaviors, co-regulation

The therapist’s embodied presence is the essential ingredient that creates a safe environment for healing and recovery. The focus is on the therapist and the use of embodied presence – how to be in the work, rather than in the knowledge and skills of how to do the work. The fields of therapeutic presence, trauma, and addiction form the theoretical framework for this paper.

Self-awareness is a critical skill for therapists in general, but having an awareness of what is happening in the body while with clients is central to embodied presence. Therapists must be able to connect to what is happening within themselves as well as in the relational space, and help their clients connect to their body (Winhall, 2021). This requires a willingness to be vulnerable, and an ability to regulate one’s own autonomic nervous system. Working with those who have experienced trauma or engaged in addictive behavior should be a free and informed choice, as the work has profound consequences.

Practical applications for the therapist’s embodied presence are presented in three areas: creating the brave space, preparing for an encounter, and the five essential qualities of an embodied therapist. Specifically, these five essential qualities are described, along with strategies to assist therapists in maintaining an embodied presence. The five qualities include being invitational, intentional, integrative, insightful, and inspirational. From the state of embodied presence, therapists can coregulate their clients through the creation of a brave and safe space. Once clients can internalize a sense of safety, they can slowly begin to access the wisdom of their own bodies to heal and recover.

The Foundational Framework

The following overview provides the theoretical framework that informs an understanding of an embodied therapeutic presence.
Understanding the various fields and foundational theories related to trauma, attachment, child development, neuroscience, therapeutic presence, and addiction is essential to inform the work with those who engage in addictive behavior. We are here but for a moment in time— with our attempt to provide the best possible care, using the most effective practices available. Our understanding of working with those who have experienced trauma and engaged in addictive behavior has and will continue to evolve.

**Therapeutic Presence**

“The essence of working with another person is to be present as a living being. And that is lucky, because if we had to be smart, or good, or mature, or wise, then we would probably be in trouble.”

Eugene Gendlin, 1990

Therapeutic presence has long been identified as foundational in psychotherapy, regardless of the theoretical approach. “Therapeutic presence is the state of having one’s whole self in the encounter with a client, by being completely in the moment on a multiplicity of levels—physically, emotionally, cognitively and spiritually” (Geller & Greenberg, 2012, p. 7). In his early work, Carl Rogers identified the qualities of congruence, empathy, and unconditional positive regard as the necessary and sufficient preconditions for therapists to assist change (Rogers, 1957). Eugene Gendlin, who studied under Rogers, developed Focusing, an experiential approach that helps access bodily felt knowing and wisdom. Gendlin described the body’s felt sense as experienced somatically—the sense of the “whole” experience of a situation, problem, or aspect of one’s life. Paying attention to an experience with acceptance, welcome, and curiosity moves it step by step until a forward movement emerges (Gendlin, 1996). Gendlin asserted that when two people interact, there is only one interaction. Embodied presence refers to the felt sense of being embodied, with an awareness of “the whole” of what is happening in the moment, in and between two individuals. The relational felt sense is the felt experiencing of an interaction between focuser and listener (Winhall, 2014).

Neuroscience has provided language and understanding for what is neurophysiologically happening in the body. Polyvagal Theory is an important development, allowing for a more comprehensive understanding of our autonomic nervous system. Porges (2011), developer of Polyvagal Theory, identified three organizing principles:

1. **Neuroception**, our body’s unconscious quest for safety in relationship. Observing another’s body posture, prosody, and nonverbal facial and eye muscles cues, our body determines whether we are safe, or activates a fight/flight response.

2. **Coregulation**. Biologically, we are hardwired to connect with others. Through mirror neurons, when two people interact, the same neural structures are activated in their brains. We are unconsciously predisposed to imitate those around us (Siegel, 2010). Therapists who are connected to their social engagement system maintain attunement to themselves, their client, and the relational space. An individual with a regulated brain and body can regulate another person’s brain and body. Therapists are most effective when fully attuned and in a state of embodied presence. Since a calm embodied presence can unconsciously help clients reach a similar state, repeated encounters with embodied presence create neural pathways of safety and promote positive social engagement (Geller & Porges, 2014).

3. **Hierarchy**. Deb Dana (2018) describes Polyvagal Theory in lay language understandable to clients and therapists alike. She describes the arousal hierarchy as a ladder. When we are at the top of the ladder, we are in the parasympathetic ventral vagal branch, or safe state. This social engagement system occurs when the body feels safe, and when we can fully connect to our prefrontal cortex, the thinking part of our brain. This is where health, growth, healing, and emotional and relational regulation occur.

If our system feels under threat, we move down the ladder to the sympathetic nervous system where fight/flight responses are activated. If this state is not sufficient to keep us safe, the body responds through the dorsal vagal branch of the parasympathetic nervous system, which brings about a shutdown or immobilization response that results in states of disconnection, fainting, or fawning. Babette Rothschild (2017) has created a scaled chart to describe what to look for in various states within the autonomic nervous system—for example, how might arousal, bodily functions, emotional regulation, and connection to the prefrontal cortex manifest when a person is in the parasympathetic branch of their ANS (lethargic, dorsal vagal, or ventral vagal response), as compared to when they are in the sympathetic branch of their ANS (active/alert, fight/flight, or freeze). In addition, Bruce Perry’s Neurosequential Model of Therapeutics (NMT) integrates developmental theory and neurobiology to clarify the impact of early maltreatment on function. Of particular importance is state-dependent function, describing how developmental age, time, cognition, and arousal operate differently when the body is aroused or experiences alarm states (Perry, 2013). For example, if individuals are in a state of fear, or, from a polyvagal perspective, in parasympathetic shutdown, they will act younger than their chronological age, function at a
lower IQ level, experience a loss of time, and may experience dissociative symptoms. Thus, interventions must target the state of functioning; in this example, the targeted intervention will involve strategies that are patterned, repetitive, and rhythmic, as clients will not be able to utilize their cognitive capacities (Perry, 2013).

Neuroscience provides information critical to our understanding of embodied presence. As therapists, we need to understand what is happening in our brain and nervous system when with our clients. When we move out of the ventral vagal branch of the parasympathetic nervous system, we need to identify our state, and target our strategies to address the specific parts of our brain and nervous system as we work to return into social engagement—for example, identify strategies and develop tools that address fight/flight states versus fixed or shutdown states. Understanding our nervous system responses, and planning strategies to return to a ventral state, prepares us to maintain a socially engaged embodied presence.

Trauma

The word trauma has become part of our everyday lexicon. People use it in many different contexts, and it seems to have become synonymous with adversity. From a psychological perspective, “trauma is an inescapable stressful experience that overwhelms an individual’s existing coping mechanisms” (Van der Kolk, 1995). Three key features have been identified to further explain the concept of trauma: the event(s), the experience of the event(s), and the effects of the event(s) (Substance Abuse and Mental Health Services Administration, 2014). Lenore Terr (1992) was the first to describe distinct types of traumatic events:

1. Acute trauma of a single event—unexpected, dangerous, and overwhelming, the event appears “frozen in time.” Memories may be more complete, and are more likely to lead to typical symptoms of post-traumatic stress disorder.

2. Multiple events that are chronic and longstanding—the expectation and fear of recurrence becomes anticipated. This type of trauma is more likely to be of human design, such as physical, sexual, emotional abuse, neglect, torture, and war. Traumatic events that are experienced repeatedly can lead to complex trauma (Herman, 1992).

3. Intergenerational trauma and cultural genocide—trauma to entire populations, or to generations, as in the colonization of Indigenous peoples. Environmental trauma is becoming more prevalent with massive wildfires, tornadoes, typhoons, floods, and landslides, to name a few. When traumatic events are experienced by entire communities and cultures, individuals as well as families, communities, and cultures are impacted—impacts that require additional ways of healing.

How an individual experiences an event depends upon a multitude of internal and external factors. Not everyone who experiences a traumatic event will be traumatized. Our unique internal and external resources determine our resiliency—our ability to cope—when traumatic events are experienced. Trauma can impact every area of functioning: social, emotional, physical, psychological, and spiritual, as well as negatively impact a person’s worldview (Van der Kolk, 1996; Janoff-Bulman, 1992). How trauma impacts functioning is unique to each individual, and points to the importance of conducting a comprehensive assessment to determine the unique effects of traumatic experiences (NCTSN, 2022). Janoff-Bulman (1992) identified a number of core beliefs or assumptions about the self and the world that are affected by trauma. Trauma can change core beliefs so that a client then views the world as unsafe and unpredictable, and views the self as unworthy and deserving of what has happened.

In summary, experiencing a traumatic event—one that overwhelms our body’s ability to cope—can impact a person’s function on many levels, as well as how they view themselves and the world. Understanding trauma (the event), its impact (the experience of the event), and its effect (the meaning assigned to the event) is necessary when working with those who are traumatized. While not all those who have experienced trauma will engage in addictive behavior, the connection between trauma and addiction is well documented (Nathoo, Poole, & Schmidt, 2018; Yafit et al., 2021). Therefore, knowing how to help people heal from trauma is essential when working with those who have engaged in addictive behavior.

Addictions

Addiction is a large, complex, and multidisciplinary field. The use and description of such terms as substance use disorder, substance abuse, and addiction are vague and often used interchangeably; however, there are differences. “Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving” (Savage et al., 2003 in Herie, Godden, Shenfeld & Kelly, 2010). Another way addiction or the problematic use of a substance has been described uses 4 Cs: Craving, loss of Control, Compulsion to use, and use despite Consequences (CAMH, 2022 website). Most current definitions of addiction reflect a disease or medical problem perspective.

I was thrilled to learn of the Felt Sense Polyvagal Model (FSPM™) developed by Jan Winhall (2020). It is a
Non-pathologizing and embodied approach that views addiction as a learning process, and as a means to cope. Winhall’s FSPM integrates Polyvagal Theory and Gendlin’s focusing-oriented therapy.

She identifies six autonomic states in her client version of the model:
- Flock – the ventral vagal branch of the ANS
- Fight/Flight – the sympathetic branch of the ANS
- Fold – the dorsal vagal branch of the ANS
- Fun/Fired-up – the intertwining of the ventral vagal branch and the sympathetic nervous system
- Flow – the intertwining of the ventral and dorsal branches of the ANS
- Fixated or addicted – the intertwining of the sympathetic and dorsal branches of the ANS

This view describes addiction as state regulation strategies in a quest for safety – strategies seen as natural embodied responses in which the social engagement system is inaccessible. As a result, the individuals are left in dysregulated states, using a substance or behavior to avoid intense emotional states or to shut down completely (Winhall, 2021). This perspective shifts our concept of recovery, and highlights how people who engage in addictive behavior do so to manage and cope, rather than due to some inherent disease that leaves them prone to relapse. Addictions help us when there is not enough safety. The function of addictions as protective strategies is contrary to the view of addiction in medical or disease models. This instills hope. Our bodies hold the wisdom needed to heal (Winhall, 2021). This model supports the values of a recovery-oriented approach that is person-centered, honors empowerment, and is strength-based, focusing on a person’s overall health and well-being (Gagne, White, and Anthony, 2007). The reader is referred to Winhall’s book, Treating Trauma and Addiction with the Felt Sense Polyvagal Model (2021). “The model provides a graphic representation of the integration of felt sense experiencing, and the neurophysiology of the autonomic nervous system (Winhall, 2021, 8).” To cultivate an embodied presence, the therapist needs to be in their social engagement system during an encounter. This is often easier said than done. We are all human, and we will respond to our clients’ experience through the activation of our own autonomic nervous system. Having awareness of our own ANS allows us to identify and use targeted strategies to return to our social engagement system. Through personal awareness, we can coregulate with our clients, and help them be more aware of their own internal state so that they can maintain ventral vagal presence. It is empowering for a client to be able to identify and manage their nervous system through targeted interventions, and develop a toolbox of alternative coping strategies.

Becoming an Addiction and Trauma Therapist

To become a professional in the field of addiction and trauma requires a foundation of knowledge and skills. Professional associations such as SAMSHA (Substance Abuse and Mental Health Services Administration) and NCTSN (National Child Traumatic Stress Network) have outlined specific essential competencies that provide a framework for standards of practice, identifying the knowledge, skills, and attitudes essential for professional practice in this field. Readers engaged in working with addiction would do well to follow their professional guidelines and ethical practices.

Self-awareness

As therapists, it is important to understand our own theoretical orientations and approaches. The lineage of influential people, approaches, and theoretical understanding is unique to each therapist. Who we are reflects the learning paths we have chosen, and the professionals who have influenced us along the way. My understanding of embodied presence comes from Focusing. I had the honor to work with Eugene Gendlin, and to experience firsthand the power of his presence. The ability to identify a felt sense, to accompany the inward journey with welcoming compassion and curiosity, to allow the bodily process to unfold in a forward direction requires time and practice. Focusing is a natural process in which our bodies have the wisdom and knowing to move our lives forward if we know how to listen. One of Gendlin’s sayings that most moves me is that “every bad feeling is potential energy to a more right way of being, if you give it space to move toward rightness” (1981, 76). At the heart of this approach is the belief that each of us has within the knowing we need to move our lives forward, and that the body is biased towards moving towards health and well-being (Gendlin, 1996).

The motivation and reasons for choosing this field and work with those who have experienced trauma and addiction are also unique and multilayered. Some may have had firsthand experiences of trauma or addiction themselves or within their family. Others may have fallen into it through a job opportunity. Whatever the reason, the choice must be conscious. Since self-awareness and reflection are essential qualities, you are invited to explore the history of the field, and of those who were influential in your development as a helping professional. Consider the following questions:

- What theoretical frameworks have informed your practice?
- Who clinically has influenced you as a professional?
- What five books on your bookshelf have you read that have personally touched you?
- How have your history and life experiences influenced who you are as a therapist, and your choice to enter the field of addiction and trauma?
What is your learning style? Personality style? Temperament?

What are your strengths, skills, and knowledge gaps related to embodied presence?

Having a broad understanding of the development of our field, of its approaches, of its theoretical underpinnings, and of those who have gone before us, locates us in the work. Knowing who you are, where you come from, and how your lived experience influences your being with another on their journey is essential. This understanding of self, the field, and the commitment to be a lifelong learner will assist you in being the captain of your own career.

Self-awareness has long been recognized as an essential skill in the helping profession, especially for cultivating an embodied presence. Indeed, there is a body of research that provides a comprehensive understanding of self-awareness and its benefits to health, mental health, and well-being. For the purposes of this article, I refer to self-awareness as one’s ability to observe what is happening internally – being able to observe your thoughts, emotional states, and physical sensations, and being conscious of your memories and behaviors. Dan Siegel (2013) refers to this as “mindsight,” and describes it as “the ability to truly ‘see’ or know the mind … and is at the core of both emotional and social intelligence” (p. 39–41). You are not your thoughts, feelings, behaviors, and body sensations; there is you, and you have them. This differentiation or disidentification allows the observing part of the brain to be separate, and not merge or become overwhelmed by emotional states (Cornell, 2013). Cornell refers to this state as self-in-presence, an optimal stance to observe and explore one’s inner process with curiosity and compassion. Being able to pay attention to what is happening inside your body is an essential skill for an embodied presence. In witnessing your embodied state, your client’s mirror neurons learn to connect with their body, develop their sense of self, differentiate from what has happened or what they have done, and redefine their sense of purpose and meaning in their lives (Siegel, 2010).

**Let’s Practice**

**A Focusing Clearing Space Exercise**

- Get in a comfortable position.
  
  *Sometimes it helps to sit upright with your feet on the floor, allowing your strong back and the furniture to provide the support to go inside.*

- Notice your observing self.
  
  *Having a relaxed body and an alert mind helps to notice what is happening in you.*

- Notice your breathing.
  
  *You do not have to change it or “do it right,” just notice with curiosity and acceptance.*

- Begin to bring your awareness into the center of your body.
  
  *Somewhere between your throat and lower abdomen, say a friendly hello to whatever is there for you.*

- Ask inside: Is there anything coming between me and feeling fully present in this moment?
  
  *Pause and notice what comes. An alternative question, if nothing comes, might be a statement like “Everything in my life is well, and I am fully present in this moment.” Perhaps something may come, for example, “All that about work,” or “All that about family.”*

- Notice how your body carries “all that.” Where is it physically?
  
  *The language of the body is not complex. Is there a word or image that captures how you experience the sensation physically?*

- Don’t fall into it.
  
  *You are not it; there is you and then there is this physical sensation. Using your observing mind, get the “right distance” from the felt sense.*
Body Awareness

Body awareness has its origins in Eastern practices, particularly meditation and yoga. “Body awareness implies the precise, subjective consciousness of body sensations arising from stimuli that originate both outside and inside the body” (Rothschild, 2000, p. 101). From the outside, we take in information that comes through our senses (touch, taste, smell, sounds, and sight). The brain then unconsciously determines possible threat, and the ANS responds accordingly. From the inside, the body perceives through its connective tissue, muscles, and viscera, sending signals to the brain. The vagus nerve connects many internal organs to the brain, with 80 percent of its fibers being afferent – meaning they go from the body to the brain (Van der Kolk, 2014).

Trauma happens in the body; it alters our brain and nervous system. Somatic memory can also be carried in the body (Rothschild, 2000). For those who have experienced trauma or engaged in addictive behavior, the body then becomes an essential resource with which to work. The therapist’s own embodied presence is required to help traumatized individuals reconnect with their body.

Embodied presence creates a safe container for the client to explore their bodily awareness. Helping clients to befriend their body, notice and tolerate emotions and sensations, restore executive function through developing self-awareness, and experience the state of social engagement all become essential tasks in recovery.

Choice

The last important feature to consider in becoming a therapist working with those who have experienced trauma or engaged in addictive behavior is choice. The work is demanding, and complex. Walking with someone on their journey has its own responsibilities – above all, do no harm. Choosing this work requires the capacity to explore possible barriers to our own embodied presence:

- Take a moment to consider your experience with those who have experienced trauma or engaged in addictive behavior.
- Imagine sitting across from someone who caused significant harm as a result of their addictive behavior.
What arises in you? How do you maintain compassion for yourself and your client when something arises?

Engaging as a therapist with an embodied presence requires the choice to be vulnerable. In Brené Brown’s wonderful book, Daring Greatly (2012), she describes vulnerability as uncertainty, risk, and emotional exposure. Being an embodied therapist requires taking the risk to be wholly connected, uncertain of how our lived experiences may get triggered, and the ability to sustain the potential result of being in an activated and uncomfortable state. It is the willingness to be seen, genuine, and real that allows deep connection with clients. We need not be perfect, because none of us is—we need to be present, knowing that we have the skills to return to an embodied presence. We need to be in our social engagement system, as the need arises.

Lastly, before choosing to do this work, we must be aware that the work has consequences. “The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet” (Naomi Rachel Remen, 2006). Working with those who have experienced trauma or engaged in addictive behavior will have an impact! It is not only a matter of developing the skills or knowledge that prevents us from being affected by the work; it is a matter of recognizing when and how the work impacts our thoughts, feelings, behaviors, physical sensations, and worldview. This is why a free and informed choice is necessary.

Practical Applications

Specific to becoming an addictions or trauma therapist, this section presents practical applications in three areas: creating the brave space, preparing for an encounter, and important qualities a therapist must have to do this work.

The Brave Space

Creating a safe space is a key component of all therapies. Creating a safe environment includes all realms: physical, emotional, mental, spiritual, and relational (Geller, 2017). Therapists can create a safe environment, and offer an embodied presence that is calm, open, accepting, non-judgmental, compassionate—however this does not mean clients will feel safe. Clients have their own internal systems, unique brains and autonomic nervous systems that decide, consciously and unconsciously, if they feel safe. Those who engage in addictive behavior have experienced or caused harm, and often enter therapy with significant levels of mistrust, denial, minimization, shame, and activated arousal. Building trust and creating safety takes time. We need to join clients where they are in their process, and walk with them from there. One of my colleagues, Heather Barbour, introduced me to a definition of trust I find helpful to share with clients. Trust is “saying-doing over time”. Creating a structured, consistent, and welcoming environment, and being compassionate and embodied as a therapist will eventually help create the safe container for the client to do their inner work. Honesty is essential in the therapeutic relationship. Denying and minimizing are common coping mechanisms, especially with those who have caused harm to self and others. Shame can interfere with truth-telling.

What is it like for you as therapist or helper when a client tells a bold-faced lie during a session?

How do you confront?

How do you repair ruptures in the relationship as a result of lies?

I invite you to sit with the felt sense of what it is like in you when a client lies in a session. Notice what forms in your body as the whole of this experience. Notice if your nervous system is activated, and what is like. What does the felt sense need from you in this moment? What strategies work for you to return to a sense of calm? I invite you to think about some of these challenging issues in advance, so that when they arise in a session, your body has a sense of what it needs to return to and maintain a regulated state.

Arao and Clemens (2013) popularized the notion of creating brave spaces. Creating a brave space in a therapy environment allows for safe self-reflection, challenging with compassion, taking responsibility, and relationship repair. Being transparent and discussing the creation of a brave therapy space is the first step. In addition, normalizing that shame is a common and human experience can help clients acknowledge their behavior. When the groundwork is set, challenging with compassion from an embodied presence is possible. For example, “I feel a tightness in my chest, as I have information to the contrary. I am wondering what comes between you and being able to tell the whole or more accurate experience?” Another example might be, “I noticed your body appeared to tighten when you were talking about... I wonder what that is like for you physically in your body, and would it be okay to spend some time with that felt sense?” Within this brave therapeutic space, we can challenge with curiosity and compassion.

Preparing for an Encounter

In preparation for a session, I pause and connect with my felt sense of embodied presence. As a therapist, I need to distinguish what is happening in my body as I listen and hold space for the experiences of my clients. Early in my career, Mary Armstrong, my Focusing mentor, taught me to create a container to hold the other person’s experience. I continue to use a precious container to hold someone’s experience with respect, acceptance, and non-judgment. I use the image of an ironwood bowl, and found an image of a bowl that matched my felt sense on the internet.
I invite you to create a special and precious container:

- What would it look like?
- What size, shape, texture, and material would make it special for you?

Before a session, I imagine this container in a felt way; for me it is in my abdomen – solid, open, and inviting. With this container, I can hold the other’s whole experience, no matter what the trauma or behavior, because it is not mine and it is not in me. Of course, from time to time, it spills over. In those times, I pause to acknowledge my own felt sense and my nervous system’s response. I mark it so that I make time to come back to it later, asking what it needs so that I can keep it separate from my client’s experience. Sometimes it is only through reflective practice that I can identify and manage my response. But at the close of a session, I imagine giving clients their experience back, because it belongs to them. I was given the opportunity to enter their world, but in the end, it is their experience.

Qualities of the Embodied Therapist

As a trauma and addiction therapist, it is important not only to be an authentic and attuned presence: how you are in session is also important. I have identified five qualities I believe to be essential for an embodied therapist. The qualities all begin with the letter I: Invitational, Intentional, Integrative, Insightful, and Inspirational. The following provides the rationale for each of these qualities as they relate to being an embodied therapist working with those who have experienced trauma or engaged in addictive behavior:

**Invitational.** Trauma robs a person of their sense of control, particularly in complex trauma when the body anticipates re-experiencing trauma, and the unpredictability of when the next trauma may occur (Herman, 1982). Therefore, as a compassionate therapist with an embodied presence, it is essential to support our clients’ autonomy and sense of control by inviting them to participate, and allowing them to have input whenever possible. Choices can help clients maintain a sense of control. For example, “What feels right to do first?” or “It sounds like there is a lot going on for you, check inside to see if anything needs your attention now,” or “Check inside and see what comes between you and choosing to…” It may not sound that significant, but language matters, especially when you are seen as a person in authority. When clients are desperate and just want to have you tell them how to fix their life, it can be tempting to save the day. However, telling someone what to do, or trying to fix another person not only robs them of an opportunity for control, it is also unlikely to result in lasting change. We must empower clients to take charge of their life and their process; they have to make the choice to heal, and they have to heal themselves.

**Intentional.** Intentionality refers to being resourceful and directive so that there is a purpose to everything we do. Best practice promotes an assessment-driven process with a phased approach to treatment. Herman (1982) suggested a three-phase approach that involves safety and stabilization, resolving the trauma, and moving on. Other therapeutic approaches have a number of phases or steps that all tend to include similar content. With respect to addiction, there are a number of competencies and approaches that facilitate recovery. Knowledge is empowering, and so psychoeducation is an important part of the healing process. Therefore, those who help people recover from addiction need to understand the theories and concepts, and offer psychoeducation in language that is understandable and helpful to their clients.

Therapists with embodied presence have knowledge of the issues to address, and through intentionality, bring them up in session at appropriate times. By being in their social engagement system, they help clients stay in that state with them as they take in information. Thus, clients develop more ability and readiness to succeed. Clients who have substance use disorders or have engaged in addictive behavior often will not voluntarily express the desire to work on shame or other emotionally painful topics. Therapy with intentionality provides the avenue to bring these difficult topics into the session.

**Integrative.** Integration means living a connected life. As we experience life, we are connected to our thoughts, feelings, memories, behaviors, and physical sensations. In treatment, some of the tasks that promote the integration of experience include helping to identify and address cognitive distortions, teaching emotional language and expression, understanding how emotions, memories, and experience are carried in the body, resolving traumatic memories, and helping clients connect with their felt sense and body wisdom. During the assessment, I attempt to determine the extent to which clients are able to integrate and connect to their thoughts, feelings, memories, behaviors, and physical sensations. This becomes the starting point towards helping them live a connected life. Telling the story about an event does not guarantee that its memory will be integrated and laid to rest. When clients first describe their experience, they are often immersed in it. They are in a dysregulated state, often reliving the emotions, smells, sounds, memories, and body sensations of the past. Helping clients coregulate and drop into the parasympathetic ventral branch of their nervous system allows them to engage the parts of their brain that supplies a sense of time and perspective – being in the now, and not the past – as well as to integrate their trauma in a coherent narrative (Van der Kolk, 2014). Trauma results in disconnection, in splitting memories, emotions, somatic sensations, and behaviors. Healing requires linking all the aspects of an event; both the implicit and explicit aspects and memories need to be bridged in or-
we can observe what is happening in a bodily felt way. Instilling hope must be real in building a hopeful future, but also internalize their victory so that they not only develop a cognitive sense of bodies (Van der Kolk, 2014). As embodied therapists, we have an undefined sense of self, and feel unsafe in their a loss of the sense of purpose. Traumatized individuals \( \text{ies. This is important to understand, as trauma causes} \) allows us to notice what is happening inside is an essential component in mindfulness. I like to refer to it as \text{insight in the moment} – we can observe what is happening inside from \text{just the right distance}, so as not to fall in and become overwhelmed.

Insight also refers to the ability to make connections from the present to the past. Identifying triggers or reminders of traumatic experiences, or acknowledging the need to disconnect from uncomfortable and overwhelming emotional states, is part of developing insight. Being conscious and aware of the triggers allows us to engage with the experience differently. Recognizing, “Oh yes, that is what it felt like when...” allows compassion and understanding. Our ability to observe the state then allows us to take action – for example, saying to ourselves, “That was then, and it is not happening now,” or “What does this place need right now?” or “It makes sense that I was reminded about what happened.” Insight is necessary to integrate experience, make meaning, and allow trauma to be held in the past.

\text{Inspirational.} Inspiration is about holding and instilling the hope for a better future. It is well known in positive psychology that hope and optimism are related, and both contribute to positive outcomes physically, mentally, and emotionally. The hope theory of Charles Snyder, an early pioneer in positive psychology, identified three elements: goals, paths, and freedom of choice (Mulder, 2019). When clients initially enter therapy, they have often lost hope and their personal sense of agency. As embodied therapists, we need to hold the hope and belief that the person has the ability to heal until they are ready to internalize their own sense of hope, meaning, and purpose. Neurologically, the midline structures of the brain are involved in creating our sense of self. Specifically, the medial prefrontal cortex allows us to notice what is happening inside our bodies. This is important to understand, as trauma causes a loss of the sense of purpose. Traumatized individuals have an undefined sense of self, and feel unsafe in their bodies (Van der Kolk, 2014). As embodied therapists, we help clients connect with their social engagement system so that they not only develop a cognitive sense of building a hopeful future, but also internalize their vision in a bodily felt way. Instilling hope must be real-istic. It is important not to offer false hopes over which neither therapist or client have control. For example, it would not be fair to suggest that relationships will return to what they once were. The only person clients can control is themselves. Thus, hope must focus on the belief that they will recover from their trauma and addiction with a renewed sense of agency, make meaning of their experience, and develop a sense of purpose for themselves.

\text{Conclusion}

The embodied presence of the therapist is central to helping clients heal from addiction and trauma. Having an embodied presence is based on the ability to connect to our felt sense and attune to what is happening physically in our body, and in our felt sense awareness of an integrated experience – in our thoughts, feelings, behaviors, memories, and physical sensations. Not only is it important for therapists to understand the ever-evolving knowledge in the fields of neuroscience, addiction, and trauma (and more), it is also essential to provide psychoeducation to help clients connect to their body, regulate their nervous systems, and thus take control and make meaning of their experiences. As therapists with an embodied presence, maintaining presence in our social engagement system and holding the brave space creates a sense of safety. Through the polyvagal lens of coregulation, clients develop new neural pathways of safety within their bodies. The therapist’s embodied presence allows clients to become attuned, and able to regulate their own internal nervous systems (Porges, 2011). Healing and recovery occur through connection. When embodied therapists and clients are grounded in their social engagement systems, clients can access their prefrontal cortex so that they can integrate and make sense of their experiences.

We examined five qualities that contribute to a therapist’s embodied presence while working with those who have experienced trauma or engaged in addictive behavior. Being invitational helps clients maintain a sense of choice, and invites them into their body. Intentionality brings purpose to sessions, addresses difficult issues, and ensures that the timing of interventions matches clients’ nervous system state. Integration, or connection to thoughts, feelings, memories, behavior, and physical sensations, is a necessary condition for healing. A neurophysiological sense of safety allows for meaning-making of lived experience, and helps people live connected lives. Insight encourages self-awareness, allowing clients to be aware of what is happening in their nervous system, and determine what their body needs in order to return to a regulated state and connect to their social engagement system. Inspiration is the ability to hold and instill hope for a different future, and contributes to successful outcomes in therapy. The felt sense of hope becomes an embodied experience promoting lasting change.
This article focused on the therapist’s embodied presence as the central or core component required to heal from addictions and trauma. Embodied presence, self-awareness, and self-reflection are essential qualities for therapists to access the wisdom of their body. In these uncertain times of COVID–19 pandemic, having an embodied presence and being able to regulate our nervous systems supports resilience. Our embodied presence can create safety for others, as we strive to help them live a calm and connected life.

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Treating the Heart of Addiction in Women with Focusing and Chinese Medicine

Dawn Flynn

ABSTRACT
This article discusses the unique needs of women who have experienced trauma and engaged in addiction. Using a Chinese medicine model, the energetic functions of the Heart, Pericardium, and Blood are seen as developing protective mechanisms used by the body to manage the emotional and physical impact of trauma. These adaptations often result in a sense of isolation and difficulty forming bonds that can lead to addictions. Together with the practice of Focusing and the shared field created between patient and practitioner, this integrated approach helps women connect to their innate body wisdom, heal the wounds of the Heart, and support the recovery from addiction.

Keywords: Addiction, Focusing, Chinese medicine, trauma, women

Feeling connected to a larger living process is a natural need deeply rooted in the heart of human beings. Feeling included in a community or family gives us a sense of belonging and an essential inner knowing that we matter. To share a connection in a committed relationship with the one we love offers a bodily sense of safety and trust. To find ourselves alienated from this larger living process, feeling separate from our human tribe, disconnected from loved ones and the aliveness within ourselves, is perhaps the most significant source of our suffering.

For women who have experienced emotional, physical, or sexual trauma, the interpretations and beliefs created around these experiences can be more painful than the experiences themselves. The natural flow of belonging and connectedness can feel distant and unattainable, and contribute to ongoing difficulties in their relationship with self and others, leading to depression, anxiety, and struggles with addiction.

“We are faced with a conundrum; What needs to be healed is self-alienation, but we need receptive self-responding for such a healing process. The resolution of this conundrum is the understanding that since we are interaction, a new kind of relating with another person will constitute a new living, a new system, a new self.” (Preston, n.d.)

This article explores the challenges that are unique to women based on their gender, which is biologically, socially and psychologically constructed. Chinese medicine and Focusing offer body-based methods for listening, understanding, and treating the grandmothers, mothers, daughters, and sisters who find themselves lost in the addictive process.

Wholebody Focusing is a body-based practice that brings balance to a chronically overstimulated nervous system, helps one have
treating difficult emotions: Compared to men, women may perceive themselves as “weak” when they cannot function as independently as others require of them. We can better help women with addiction by viewing them within the context of their larger relational system (Greenfield, 2010). As health professionals, we must examine the quality of their friendships (Crawford, 2004). Girls who do not have close friendships may have difficulty befriending themselves, and experience feelings of anxiety, depression, low self-esteem, and isolation, and will often put aside their own values, interests, and passions in order to feel a sense of belonging. These girls are at much higher risk for substance use and other addictive behaviors later in life (Briggs & Pepperell, 2014).

Young girls have difficulty balancing being who they are with being who they think they need to be. Social roles are very complicated for adolescent girls. They receive repeated and conflicting messages regarding how their bodies should look, how sexually active they should or should not be, and are encouraged to be smart, but not too smart. They are often striving for a level of perfection that can never be attained. Helping girls and women cultivate healthy relationships with people who reflect their talents, gifts, and unique qualities, and express love and care, will support them in their feelings of connection with themselves.

The interdependence of women: As independence is traditionally more valued than interdependence, women may perceive themselves as “weak” when they cannot function as independently as others require of them. We can better help women with addictions by viewing them within the context of their larger relational system (Greenfield, 2010). As health care providers, we can validate their innate need and want of support from friends and family, and we can help them recognize their gracious ability to be of service to others.

Addressing the specific needs of women for successful treatment outcomes

Drug and alcohol treatment has among the highest recidivism rates of any counseling treatment in the field, partly because treatment is often not sufficiently geared toward individual client needs, especially regarding cultural differences, including gender. Over the years, research has demonstrated that women are underserved by the addiction counseling community (Briggs, 2014; Marsh, 2000).

Using drug and alcohol treatment modalities that do address the specific needs of women, such as treatment for commonly co-occurring depression and anxiety, as well as experiences of trauma, accommodation for childcare, family therapy, and other family services, as compared to mixed-gender alternatives, showed much greater success in treatment outcomes even in the face of more severe substance use and psychiatric morbidity (Mazuro, 2020). Such success stresses the importance of addressing the unique needs of women.

Addiction is a complex mixture of biological, psychological, and social influences. Here, we look at some of the differences between men and women addressed in Focusing and Chinese medicine.

- **Being with difficult emotions**: Compared to men, women are more likely to have a diagnosis of depression, PTSD, phobias, and eating disorders, and to engage in substance abuse to cope with or suppress difficult emotions (Landheim, 2003). It appears that, in general, alcoholism precedes depression for men, while depression and anxiety precede alcoholism for women (Lynch, 2002). Helping women be with difficult emotions such as depression, anxiety, and stress, and not impulsively react to them, will help increase the likelihood of abstinence from drug and alcohol use, and decrease the chances of relapse.

- **Culturally, women are seen as the guardians of morality and wholesome home life.** When women engage in addictive substances or behaviors, or seek help in treating them, they are likely to receive criticism and judgment from family, friends, and society. Women tend not to respond well to confrontation regarding their addictive substance use or behavior, but instead will be more likely to respond to receiving support and nurturance. Harsh confrontation regarding their addiction or their “resistance” is not helpful, and is likely to cause more anxiety, shame, and fear, and contribute to avoiding treatment (Briggs & Pepperell, 2014).

- **Development of self in adolescence**: The development of self in connection with others is a lifetime exploration for all of us, and is especially central to the lives of adolescent girls. A significant difference between men and women is in the formation of identity (Pipher, 2005). Girls begin individuating from their families of origin and finding connections with peer groups earlier than boys (Crawford, 2004). Also, more than boys, girls place great value on, and receive a sense of their own value from, peer groups. Friends are crucial to girls. Girls bond and join others to find their voice, goals, value system, and purpose.

Girls’ self-esteem tends to correlate positively with the quality of their friendships (Crawford, 2004). Girls who do not have close friendships may have difficulty befriending themselves, and experience feelings of anxiety, depression, low self-esteem, and isolation, and will often put aside their own values, interests, and passions in order to feel a sense of belonging. These girls are at much higher risk for substance use and other addictive behaviors later in life (Briggs & Pepperell, 2014).
The struggle for power: For some people who feel they have control and power over their addiction, even when life around them is falling apart, admitting they are powerless can be a much-needed surrender, and bring the clarity that help is needed.

However, an unrealistic sense of power is not typically the problem for most women. Women with addiction often struggle to feel any level of power in their lives, which worsens addictive behaviors. Issues of powerlessness become even more significant for women of color, lesbian and transgender women, women with disabilities, and women in their senior years. Often, alcohol, drugs, or addictive behaviors are coping mechanisms for dealing with the effects of oppression (Briggs, 2014). Asking women to admit their powerlessness could be unnecessary and detrimental, and promote further feelings of oppression. Being “resistant” to treatment or leaving treatment could be evidence of body wisdom, growing empowerment, and a healthy expression of defiance to a system that is not supporting their needs – rather than a sign of being unmotivated or noncompliant.

Trauma: Research shows that traumatic stress in childhood is the leading cause of alcohol drug abuse in children, with a high percentage of women in recovery for alcoholism reporting a history of trauma (Felitti, 2019). Girls who were sexually abused were also more likely to have suicidal thoughts, use substances, engage in more risky sexual behaviors, and have generalized feelings of sadness and hopelessness (Howard, 2005). Working or attending school in an environment of sexual harassment – even when there is no specific threat or physical touch – tends to lead to chronic stress, fear, confusion, and anxiety, appears to produce some of the same symptoms as a sexual assault, and is associated with drug and alcohol use and compulsive behaviors (Ross, 2003).

Women often enter into treatment with histories of sexual and physical violence, unsupportive family structures, and socioeconomic problems. Many treatment options do not address the trauma and violence that many women addicts faced in their past. Addiction itself can also be traumatizing, and leave women more susceptible to domestic violence, sexual assault, and emotional and physical abuse in the present.

Research demonstrates that addressing the individual needs of our patients will enable them to let go of their addictions more easily. For successful outcomes, it is essential to respectfully help women with addiction and their trauma, their underlying feelings of depression and anxiety, and to address the relational aspect of their addiction. Supporting their sense of empowerment and identity, and working with them to create healthy affirming relationships, are essential for long-term recovery. Focusing and Chinese medicine are practices that help women connect to their inner life force in connection with another, unwind from the stresses, traumas, and pain of life, and move forward to a new, integrated, and embodied way of living in the world.

A non-pathological approach to working with the addictive process

“From conception, an inherent intelligence ceaselessly engages and adapts our innate terrain to life’s stresses, shocks, and trauma. We can only learn from this intelligence (and rarely improve on it) if we recognize and respond quickly to its messages. Respect the symptom, respect your nature; don’t kill the messenger.” (Hammer, 2010)

From a relational perspective, we can view women as being drawn to their addiction in ways that help them make connections and feel loved, energized, or supported. Women and girls often use substances or food for solace and relief from the pain of their traumas. They often feel isolated, lonely, and unloved. Addictions relieve difficult emotions such as depression, anxiety, and stress, but, over time, contribute to maladaptive coping mechanisms that arise due to trauma can point toward healing. “Each moment, every bit of experience, no matter how dark it is, has within it an implied way ahead” (Preston, n.d.). Healing can come from recognizing the sense of separateness, and addressing the deep emotional wounds through careful attention.

The field of relational neuroscience and its clinical implications has brought forth new understanding. While many have contributed to this field of research, the work of Bessel van der Kolk, Peter Levine, and Allan Schore is recognized as foundational in developmental neuroscience, trauma, and body-based therapies. Others, including Stephen Porges, Gabor Maté, Dan Siegel, Jan Winhall, and Deb Dana, have brought this work into the clinical setting with compassion, kindness, and care for those who have experienced trauma.

Although practitioners have their individual experiences, methods, and processes for helping others caught in the struggle of addiction, we all have in common that we are human, and we can be with another human, listening with our ears, hearts, and whole bodies. Our heartfelt connection can provide a new way of relating that might not be available to our patients in their other relationships. “The intention of patients is to survive and heal, to stay intact while they stay in contact. Mal-adaptive contact is their life history, the reason they are coming for help...” (Hammer, 2017)
Focusing, the body-centered practice brought by Eugene Gendlin, and Wholebody Focusing and Relational Wholebody Focusing, developed and taught by Kevin McEvenue, Karen Whalen, and Roberto Larios, as well as the work of Chinese medicine practitioner Leon Hammer, acknowledge and emphasize that the connection formed between patient and practitioner is one of the most necessary ingredients in revealing the unexpected and unpredictable steps toward healing.

The science of Chinese medicine

Much like Gendlin’s philosophy and his Focusing approach, the science of Chinese medicine focuses on change, processes, and relationships between objects, rather than on the objects themselves. The ancient Chinese studied life with its complexities and interrelationships, and welcomed chance occurrences and unknown variables. They opened the field to include unexpected and surprising events over time. When something did not work, they set it aside. What is included in current practice are the principles that contemporary Chinese medicine practitioners depend on, and continue to elaborate for effective treatment planning.

Chinese philosophy and medicine show us that all of life functions as a single force called qi. Existence is a manifestation of this one unifying force. Qi moves through different states of complexity, and passes through varying levels of physical substance. As it slows down, it coalesces into physical forms, such as planets, stars, trees, seashells, and the human body. The human body, and every aspect of human health and illness, exist as complex combinations of tangible and intangible patterns emerging from this invisible force that circulates within nature and the greater cosmos. All of life begins as this force; therefore, true healing must include therapies that address this underlying force (Neal, 2021; Hammer, 2010).

For at least 3,000 years, Chinese medicine has been evaluated, tested, and practiced with billions of patients. The study of Chinese medicine texts, the refinement of the practitioner’s senses to perceive patterns occurring in the patient and in nature, the intuition and experiences held within the practitioner, and the connection between patient and practitioner are all valued and considered essential for successful therapeutic outcomes.

The central Chinese medicine concept of Spirit – Shen – appearing in early Chinese texts can be defined most simply as “that which is subtle and invisible, yet commands everything.” Chinese medical diagnosis and therapy work to treat qi and Spirit and the physical body. While ancient Chinese philosophy considered emotional sensibility our greatest asset in fulfilling human destiny, it also regarded emotional instability as our greatest liability due to its vast pathogenic potential (Fruehauf, 2006).

Leon Hammer, who practiced psychiatry for several years before finding his way to Chinese medicine, worked with Fritz Perls and Alexander Lowen for eight years, and was influenced by Reich, Gestalt, Rolfing, and bioenergetics. He says, “Chinese medicine has been for me the fulfillment of a search for a congenial system of healing that embodies the inseparability of body and mind, spirit and matter, nature and man, philosophy and reality…it allows me to be close to the essence – to the life force – both my own and that of others”. (Hammer, 2010, p.xv) His work, along with that of John Shen, has contributed much to the current field of Chinese medicine and the understanding of trauma and the therapeutic relationship. His work continues to live forward through his students.

The heart of addiction

Heartshock, a term coined by Dr. Hammer and Dr. Shen, refers to the multitude of effects trauma has on the body’s various systems. When a person sustains a trauma, a protective measure will be employed by the Heart. These protective measures, which affect circulation and other body systems, can have a lasting impact depending on a person’s areas of vulnerability and their perceptions and interpretations of the trauma. Symptoms of heartshock include emotional liability, feeling flustered, depression, anxiety, panic disorder, hypervigilance, insomnia, nightmares, fatigue, mental confusion, worry, and wandering joint pain (Rosen, 2018). More pronounced effects will be seen on the nervous system. Most significantly, the Heart is interrelated with every other organ system in the body, and its stability is required for sustained health in these systems. It is essential to address the Heart and circulation of Blood and Qi to reach the underlying insults to the body, and help relieve symptoms effectively. Chinese medicine practitioners may do this with acupuncture and herbs, but all practitioners can offer themselves as human beings to influence the Heart’s functions.

The meaning of any experience one goes through will be unique to the experiencer, depending on areas of vulnerability within the body, age at the time of trauma, and the constitution and resources available to help them through the experience. There are, however, types of early childhood traumas that have a more direct effect on the Heart, and will have a lasting impact on how a woman forms her sense of self and connects with others and her larger environment throughout her lifespan. These are discussed below.

Although all body systems can be affected by trauma, the energetic functions of the Heart, Pericardium, and Blood play significant roles in how the body responds and recovers. Because these systems include their energetic and functional aspect, not just the physical, they are capitalized to distinguish them from their reference in Western medicine.
The Heart

“Under the direction of the Heart, the rhythm of Blood and breath allows the flow and circulation of life. From the deepest interior, the Heart communicates with the rest of the body without ever being disturbed, even though its effect, animation of the entire being, is felt everywhere.” (Larre and Rochat, 1995)

The Heart is said to be the Emperor or Empress of the human body, as all other systems will sacrifice themselves to sustain the health and wellbeing of the Heart. It is that organ network that opens our connection to Spirit (Fruehauf, 2021). The Heart’s function is to find unity, and keep that line open so no separation occurs. The well–functioning Heart is present in all of our life experiences without being affected by the mind’s interpretation of those experiences. When working at its best, it allows us to be present and meet life situations, people, and events freshly, spontaneously unaffected by the conditioning of the past. Like a fire reaching out for wood to keep its flame alive, the Heart longs for connection and relationship. It allows us to be feeling beings and have a “heartfelt” connection with another, with ourselves, and with the living environment in which we live.

The Pericardium

The Pericardium is responsible for that full–body urge, experience, and yearning to be in love. It knows how to create closeness in relationships through appropriate vulnerability. The Pericardium allows us to feel romantic love and open the Heart’s function: to be in love with everything. When the Pericardium is not functioning well, a person will often be engaged in abusing addictive substances that provide a temporary experience of ecstasy, such as food, sex, drugs, and falling in love again and again. These can leave emotional scars on the Pericardium, which prevent it from opening fully to the Heart, the Hearts of others, and Spirit (Fruehauf, 2021).

Blood

Blood and its movement through the body are considered one of the most critical physiological manifestations of what is occurring and what has occurred within the emotional, physical, and mental aspects of the human being (Johnson and Welch, 2014). Chinese medicine practitioners can access this information through the connection of their fingertips to the radial pulses. According to the ancient Chinese, the Blood is imbued with consciousness through the Heart. From this perspective, Blood becomes more than the fluid circulating in the blood vessels containing iron, hormones, and vitamins; it is where awareness resides. Our ideas and perceptions work within the Blood. Blood stores our lived experience as memories. When blood flow becomes blocked due to physical or emotional trauma, loss of memory of painful events, difficulty with intimacy, and pain may then ensue.

Trauma’s effect on the Heart, Pericardium, and Blood

Trauma calls on the protective role of the Pericardium. When the Pericardium goes into action, it shunts Blood from the periphery of the body toward the interior in order to maintain blood circulation where it is needed more urgently for survival. This helps keep the pain from consciousness and allows one to function more easily in life (Fruehauf, 2021).

Falling in love completely with the whole self is governed by the Pericardium. When this innocent process and healthy vulnerability are betrayed, the closing of the Pericardium begins. It has the potential to get stuck closed, and prevent the Heart from doing its job effectively. A woman will feel closed off and unable to connect with herself and her partners. A woman may go from one partner to the next, but not allow for a true union of hearts.

The loss of a parent or caretaker, or loss of a loved one through death or separation can affect the Heart so significantly that to adapt, the Pericardium will close. It can leave challenges with interpersonal relationships throughout life (Rosen, 2018).

The crossing of boundaries by someone known or unknown in rape shatters the boundary of the Heart and the body with force. This is an emotional trauma in a most vulnerable area. The younger the person, the more challenging the recovery will be, as boundaries and experiences in love have not yet been established (Jarrett, 1995).

For a young girl, experiencing her boundaries being crossed by one she loves and trusts, such as a family member or friend, can be painfully confusing and lead to feelings of shame and misplaced responsibility. The fuzzy boundary between anger and love for her abuser has the potential to lead to intimacy problems in future relationships (Jarrett, 1995).

Implying the way forward

“Energy is the essential factor in life and, therefore, the prime consideration in sickness and health. Whatever other forces may be at work in a given instance, the distinction between health and illness is predominantly determined by the vicissitudes of that energy in the body it inhabits. This is a unifying concept, emphasizing the powerful single tie that binds us rather than the less significant forces which divide us. The energy that causes the disease is the one that cures it.” (Hammer, 2010)

The wounds of the Heart call on us to heal the wounds through the Heart. Through the safe inter–relational
Love and harm are difficult to distinguish for those men. “Sure, I was harassed,” she said. “But back then, ful and, at times, painful history of relationships with the height of the #metoo movement about her color (Gendlin, in press). 

Coming from the philosophical tradition of Dilthey, Dewey, and Merleau-Ponty, Gendlin developed a philosophy of the implicit and applied it to the work Carl Rogers was doing in the 1970s at the University of Chicago (Hendricks, 2001). In his research, Gendlin discovered that the people who were more successful in changing their life situations naturally sensed inwardly and referred to their direct experience. Gendlin developed the process of Focusing as a specific way to teach people how to refer to their experience inwardly, and come into relationship with what he called the felt sense (Gendlin, 1996). By felt sense, he meant a bodily sensation that carried meaning. The more vague, unknown, and hard to describe, the more likely the felt sense could lead the focuser to a fresh, new experiencing. 

Focusing is typically done seated and begins by bringing awareness inward to bodily sensations in the torso. A listener (practitioner) and focuser (client) slow down and turn their attention inward to create a welcoming space for a felt sense to emerge within the focuser. The practice of Wholebody Focusing and Relational Wholebody Focusing invites the focuser to bring their attention to the rest of the physical and energetic body, often while standing. Listener and focuser take time to connect to their environment and feel the connection forming between them. When they bring awareness to these connections and experience attuned presence, the living process in continual interaction with its environment becomes free to move forward from places that were previously blocked. 

At the core of Gendlin’s philosophy of the implicit is that the living body is always sensing and living its next bit of living. He calls this bodily implying. The whole body implies its implicit understanding of what is needed to carry forward its living in a situation (Gendlin, in press). Gendlin states, “When something implied doesn’t occur, the body continues to imply it. Until something meets that implication — carries it forward — the body continues to imply what was implied and didn’t occur” (Gendlin, in press). 

I recall a conversation with one of my patients during the height of the #metoo movement about her colorful and, at times, painful history of relationships with men. “Sure, I was harassed,” she said. “But back then, I didn’t look at it as harassment; I looked at it as love — and I wanted more of it!” 

Love and harm are difficult to distinguish for those whose Pericardium has scarred and does not open and close appropriately. They may find it challenging to love others, recognize true love when offered, and they may not recognize love within themselves. However, “every living creature has the conditions for its living built into it, organically” (Gendlin, 1996). When her boundaries were crossed abusively as a young girl, an implied process stopped. In all its wisdom, her body did what it needed to continue to imply what did not occur at that vulnerable stage of her emotional growth. Eventually, as an adult, she was able to receive help and have this implying met with new interaction, with a person she trusted who encouraged her to be her full self in the world. This led her to form other caring, loving, life-affirming relationships. 

Wholebody Focusing invites us to bring our awareness to the living body and feel the process of life emerging, unfolding, and changing in its right way, informing us of the next right steps. The shared field created between focuser and listener, and their connection to the larger environment amplifies and informs the whole bodily implying of the situation in a way that benefits both (Whalen, 2020). 

Clinical Vignette 

A 38-year-old patient named Amber had been trying to get pregnant for years, and wanted help improving her fertility. She described herself as “ADD” and struggled with anxiety. She drank two to three glasses of wine per night, more on the weekends, and wanted to stop drinking but found she could not. I suggested that in addition to the acupuncture, nutritional changes, and herbs she was taking, perhaps she would like to spend time doing a Focusing process, and she agreed. The following is a summary of one of our visits, with commentary to illustrate the process of Wholebody Focusing. 

Bringing awareness into the body 

We begin by bringing awareness into the body, into the structure and physical form in which the life force moves. I invite her to feel the earth beneath her feet, to feel Grounded Presence, keeping her anchored and yet free to move if her body would like to. I invite her to feel her spine, saying hello to what would like more attention — a sore spot, a tense area. We feel the hips, the pelvis, the muscles, the length of the neck, the hips in the chair if we are sitting, or sometimes standing. This begins the sensing of the body, of textures, of the qualities of whatever sensations may arise. 

When we bring awareness into the body, it comes more alive. The light of our human consciousness changes the living body and its experiencing, activating the implicit energy to open to its healing direction. “Whenever we invite the bodily life processes to become aware of themselves, our neutral conscious observer — Self activates the quantum firing of the cells of the various parts of the body—mind” (Whalen & Fleisch, 2017).
Bringing awareness into the environment

We bring our awareness to the earth, to the sky, we keep our eyes open and take in our surroundings. Perhaps something in the office calls to her. Maybe she wants to bring something from the outside into our awareness—a favorite stream or tree, a four-legged friend, or we can listen to the birdsong coming from outside the window. I invite the directions to orient us to the space we occupy, I might invite time into our environment as well—the moon’s phase, the darkness of mid-winter, the early sunrise, the end of a workday, all of this giving orientation to our place in the space/time rhythms of the earth and cosmos, perhaps feeling these shifts and their effect on our bodies.

In the Process Model (Gendlin, 2018), the body is described as an ongoing interaction with, and inseparable from, the environment. In its formation from its very beginning, the body is body-environment interaction. The self-aware living body is always in relationship with the knowing of the living environment. By bringing awareness to the environment, its space/time movements, and motions, we invite this knowing in our patients that might otherwise be cut off from this source of connection.

“Everyone agrees that the body is made of environmental stuff, but it was assumed to be separate from the environment, merely perceiving and moving in it. But if we consider the body’s formation as a body process, then the body is environmental interaction from the start. The body is identical with its environment in one body-constituting process.” (Gendlin, in press)

Bringing awareness into the energetic body, sensations, emotions, and feelings

I invite more inner sensations and feelings and allow for inner-directed movements. She lets me know that she feels a lot of energy in her pelvic area. It feels good at first as it flows around the inside of the bowl of her pelvis and is warm. Then it feels stuck like there is too much energy for the small space. There is pressure.

As we become more aware of the physical body and the body aware of itself, we more easily feel the movement of qi. We may feel muscles twitch, or the body may sway. We allow all of this if it feels right to do so. We allow room for the body’s wisdom to express itself through inner-directed movement. Spontaneous and energetic shifts and gestures are the body’s way of releasing itself from imposed and habitual postures, and finding its more natural way of being.

“The movement seems to be an expression of our whole selves acted out and connected directly to Who We Are. It is expressed as a truth in us that needs no further validation because it is a universal truth. The inner-directed movement in Wholebody Focusing is a way to move towards this deeper sense of a bodily knowing self that feels true for all times, shared with all others, and seems to connect us with life itself.” (McEvenue, 2002)

Bringing awareness to our shared connection

I am part of the environment, a living, breathing human sitting with her. The same force that moves through her moves through me. We make eye contact, then close our eyes, open them again. She smiles; I reflect her smile. I feel her in a wholebody way. She knows I am here, willing to go where she goes. As she describes her sensations, I experience the movement in my own body, and feel the pressure. I am aware of the energy wanting to move down, but not. I invite her to stay with this pressure in the pelvis.

She says, “It wants to move down my legs, but my knees are locked shut. It is like a door has been slammed shut and locked.” I ask if it is okay that we sit together with the slammed door that’s locked.

“The body is an energetic and physical storehouse of all of my relational life experiences and holds unconscious patterns of feeling, thinking, acting, and inter-relating, some of which negatively impacts my wellbeing. Relational Wholebody Focusing facilitates bringing these held patterns to consciousness, enabling reorganization and healing, opening me up to new relational possibilities.” (Whalen, 2020)

The shared field created in relationship allows something new and alive and palpable to emerge—more than what could be created by each person alone. The core of Wholebody Focusing is tending to the shared experience between two living beings. We bring acceptance, care, and patience to the relationship. Places in us often did not get this support in relationship to others, and shut down. With this intimate connection now felt deeply, they can emerge and become more fully integrated.

The transpersonal space

After some steps, Amber recognizes that her knees don’t feel safe. She brings her attention to their feeling of wanting to be safe. She provides her attention in a way that feels good. She gently rubs her hands along her thighs. She acknowledges their strength. She brings her awareness within her knees, and senses how good it feels to them to have her attention, touch, and presence. Her legs naturally and visibly relax and fall open. She describes the stuck energy moving from her pelvis through her legs, down to her toes like water moving through a dam that has been opened. I see the color come into her face. Her breath deepens. Her eyes shine. These are all signs of qi moving and transforming. We spend time here, feeling this new way of being.

Our senses are open, our living animal bodies responding to the surroundings and our inner bodily intelligence, our skin feeling the subtle sensations of the air. “It sometimes happens that our body becomes part of
the larger body of the land — that our sensate flesh is taken up within the wider Flesh of the breathing Earth" (Abram, 2017). We have tuned our whole bodies to ourselves, one another, and the larger breathing Body. Its edges and boundaries soften, and we are body–environment–interaction.

We trust the deep wisdom of the body to find its way forward. We welcome the places in the living body that want to come alive, and we trust that each of these places has its wisdom. We create a welcoming and trustworthy environment where the new life unfolds.

After

After this visit, Amber shared her story more openly. She explained that she had been drinking more alcohol to relax as she and her husband were engaged in more sexual activity. She was aware that she dissociated during lovemaking. She said that her husband often commented that she tightly held her legs together even when the rest of her appeared relaxed, like when they were cuddling on the couch or engaged in foreplay. Even though she remembers his saying this, she said it didn’t sink in. Now, with the loving support of her husband, she makes it a regular practice to bring attention to her knees and legs while being intimate, and finds this helps her stay more present and connected to herself and her husband. She recognized that her body didn’t feel safe when her mind was elsewhere, and she wasn’t present.

When we observe this emerging life information and energy and invite it to explore itself in a bodily way while staying at the edge of what wants to happen or needs attention, the whole organism moves forward in its right way (McEvenue 2017). Rather than saying that the tension in her legs is at fault and the source of the problem, or telling her to just relax, we give space and the grounding of her whole body to let her legs reveal more about their tension, and how it lives in and serves her.

When her husband described his observations about her legs, it did not “sink in,” but when her own body showed her this new information, it had a much different impact. This holding pattern transformed and led to a new body–environment interaction. With the support of the whole living body in grounded presence, aware of itself and the shared field, a new way of receiving support and connecting to another emerges, and she can “stay intact while making contact.”

Conclusion

One of my first patients was a young 23-year-old woman who had a history of sexual trauma, and had been in treatment for heroin dependence for two years. She exuded sweetness and bashfully kept her eyes down, now and then peeking up to look at me. She requested that her sister be in the room with us. After listening to her story and connecting, she asked that I not leave the room during her acupuncture treatment. When the needles were in, she breathed deeply, smiled, and said, “Wow, I feel sooooo good.” Then, very seriously, “Is it okay that I feel this good?”

My whole body resonated with the place her words came from. Feeling so good usually means there will be a price to pay – in financial security, with the law, in relationships, and in our bodies. Many women sacrifice so much for these moments of feeling good because the short-term benefit feels impossible to resist. For some, it blasts away their walls and boundaries so that they might fleetingly come close to feeling true intimacy. They want to be freed from their cage, feel their profound, wild woman nature, connect to the force that moves through the water, the wind, and circulates through their veins.

Some women may find that addiction provides the one thing that is holding them together enough to tolerate the dangers of affection, close connection, and touch. They want to quiet the fear that cripples them, numb the shame that comes with the carnage left by substance use or destructive behaviors.

It can feel like a revelation that it is okay to feel good and that there will be no negative consequences. With patience, persistence, and help, we can all be free of the struggle, and enjoy trustworthy, committed, passionate relationships. We can connect with an intelligence much larger than ourselves. We can listen to the voice of our Hearts, naturally as we did when we came into being. We can calmly breathe in a world that loves us.

When two people come together in presence and attuned connection with a shared intention to connect as fully as possible, that relational space becomes a womb of fertile life–giving possibilities. What makes me “me” and you “you” fades. What arises is a shared field with one life force growing and opening through us, guiding the way toward healing, gracing us with an embodied connection to the natural flow of life.
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Treating the Heart of Addiction in Women with Focusing and Chinese Medicine


A Non-Directive Positive Reinforcement Framework for Trauma and Addiction Treatment

Steven Hoskinson, Bach Ho

ABSTRACT

People grow and heal through support. This paper argues that mainstream addiction treatment is prone to reinforcing states of negative affect and negative urgency in the client. These states, especially the latter, keep the client’s biology stuck in negative reinforcement – in oscillations of negative affect followed by relief of negative affect, which then potentiates the next cycle of negative affect, and so on. This is the addiction dynamic, broadly considered. This paper outlines a protocol, within a shaping paradigm, to create a positive reinforcement framework for addiction and trauma treatment. This Organic Intelligence® (OI) framework establishes natural relational conditions that are guided by a free association conversation. Therapeutic attunement and a specific reinforcement process amplify the client’s eventual pleasurable and meaningful reflections in the here-and-now, gradually enabling the client’s biology to break free of the dominance of the ubiquitous negativity bias. OI proposes this fundamental clinical shift from negative to positive reinforcement because it aligns with the primary, organic impulse – not to process trauma or the past, but to enhance processing capacity.

Keywords: Addiction, trauma, organic intelligence

The cost of addiction to individuals and society is staggering. Not surprisingly, global health, governmental, and commercial responses proliferate, with seeming aims ranging from education/amelioration to profiteering. As the co-occurrence of addiction and trauma has become more recognized, high-profile treatment centers in the U.S. – such as The Meadows, Sierra Tucson, etc. – recruited high-profile trauma professionals to affiliate with their brands. Trauma methods like EMDR® and SE® were soon incorporated at numerous addiction centers. However, questions of efficacy and negative outcomes have emerged, and there is limited incentive to assess negative outcomes of somatic intervention protocols, including in commercial treatment environments.

For somatic treatment, as with psychotherapy generally, the assessment of harmful outcomes is mostly lacking. There is cause for concern regarding unwanted outcomes, since the field of somatic trauma therapy, still in its infancy, mostly lacks research-based guidance for treatment protocols. However, the field of interpersonal neurobiology stands with a unique opportunity at this early stage of its development to reconsider traditional concepts of therapy that are incorporated into somatic treatment. Furthermore, care for risk management is especially important, given the vulnerability of those struggling with addiction. The authors hope to inspire interventions with a greater eye toward harm assessment and reduction. The reconsideration of somatic trauma treatment protocols is seen as an opportunity to advance the field.
of treatment frameworks and basic assumptions as they relate to addiction here serves to highlight the most salient considerations for therapeutic success generally, and especially for treatments aiming to be somatically and trauma-informed.

“The problem of adverse effects of psychotherapy has been recognized for decades, yet research on causes and prevention of harm has failed to progress.” Here, Parry, et al. (2016) join a small chorus in the indictment of unwanted effects in therapy. Challenges to merely assessing prevalence are numerous and daunting. While estimates of the prevalence of negative effects are sobering (cf. Strauss et al., 2021), still more concerning is the fact that such assessments themselves likely undercount prevalence. They are confounded by well-known biases in survey methodology. Cognitive dissonance, for instance, would say that paying a price, in this case monetary or emotional, for something lends value to whatever is acquired. Negative reinforcement suggests that cessation of an adverse process actually reinforces that process. And the repeated suggestion in the culture of therapy that pain is a necessary part of growth — rising even to the nadir of a healing crisis — surely skews clients’ perspective post-process.

Trauma therapy arises almost exclusively from within this feel-the-distress framework, as it relies on exposure, anti-repression, and processing models founded in the earliest Freudian and Reichian notions of therapy. It seems to strain credulity: How can we process trauma if we avoid it? However, these basic assumptions are misleading. Therapists and their clients do not process trauma; they experience neurobiological states in the here and now. To work therapeutically with such states, it is necessary to first understand the dimensions most relevant to how they function in the biology, and how they maintain and change — including how states that shift from moment to moment can change to enduring traits.

The most salient characteristics must be understood within a framework of complexity science. Such a framework highlights how our biological systems organize, maintain the status quo, or disorganize. Ahead, we will discuss how positively valenced intensity can catalyze organization in human dynamical systems. The key dimensions for a dynamic systems understanding are:

1. Overall intensity level
2. Valence — positive or negative
3. Acceleration/deceleration as a function of inhibitory and disinhibitory biologic conditions

Every system has a threshold where intensity will fragment or disorder that system. Negative intensity, however, largely keeps the system’s status quo by reiterating negative intensity states through negative reinforcement and the negativity bias. Addiction treatment is largely ensconced in reiterating negative states — thus maintaining the system’s status quo through that negative reinforcement.

The hazardous role of negative affect in addiction is well known. Measelle et al. (2006) demonstrated that negative affect is a prospective correlate of substance use. However, even more discriminative than negative affect alone is “negative urgency” (see Kaiser et al., 2012) — the habits or impulsive strategies — like substance use, for instance — for lessening negative intensity. We propose to:

- Explicate these dynamics with an alternate framework that relies on the understanding of complex systems, such as allostasis and large-scale brain networks.
- Outline Ol’s relationally attuned therapeutic work with clients’ spontaneously occurring (and recurring states), which can increasingly be shaped within a positive reinforcement paradigm.

This new paradigm notwithstanding, addiction and trauma are serious, even life-threatening conditions that often require multidisciplinary treatment approaches. Thus, there are numerous evidence-based approaches to treating addiction and trauma, including CBT, exposure protocols, introspective and interoceptive excavation of traumas, assignments of self-care practices, and joining community. However, we believe that harm will be reduced when we reexamine what underlies most therapy: the process of creating and maintaining an aversive level of intensity in the client. This uncomfortable intensity is the source of a severely under-recognized form of harm. One reason that it is under-recognized is that most people – including therapists and clients – believe, explicitly or implicitly, that harm is good: “No pain, no gain.” “It may get worse before it gets better.” “To heal and grow, we need to get out of our comfort zone.” Thus, both therapists and clients are liable to interpret suffering in therapy as positive — as signs of healing and growth.

We propose a radically different model: working at a lower and even pleasant level of intensity. This enables the addicted person to gradually move away from top-down efforting, from managing their system, to something much more easeful and beneficial. Our biologies have the capacity to heal and grow on their own, and a comfortable level of intensity is fundamental to enabling this innate process.

A therapeutic program that focuses as much as possible on sustainable comfort and minimizing swings to discomfort operates on a framework of positive reinforcement: a framework that teaches the client’s physiology that it’s possible to feel better by feeling better. This contrasts with negative reinforcement, a framework that reinforces in the client’s physiology that feeling better must always in some way be attached to feeling worse, e.g., I felt better after that unpleasant session in which I had to feel my uncomfortable feelings, or after I did...
practice X (e.g., exercise, journaling, socializing), even though it was uncomfortable to do.

A positive reinforcement framework is the essence of Organic Intelligence® (OI), a therapeutic approach that has been taught and used with anecdotal success by hundreds of OI students internationally. While processing negative intensity associated with trauma is the current norm, one of the main discoveries in OI is that humans can increase processing capacity through increasing intensity of positive valence. In this way, the physiology can increase its capacity to handle intensity effortlessly, automatically, and autonomically. This frees up time and energy for people to pursue meaningful lives – as opposed to spending so much time, energy, and attentional focus on managing their systems.

Positive reinforcement is especially indicated for the treatment of addiction and trauma because these conditions are fundamentally disorders in the biology’s processing capacity. In this paper:

1) We make a case for understanding addiction and trauma as disorders in biological processing, including information processing.

2) We introduce OI theory and its scientific background: OI offers a way to increase the capacity to process intensity autonomically. The key to catalyzing this increase in capacity is a positive reinforcement framework for therapy in a here-and-now context.

3) We explain how OI can be used to create a positive reinforcement framework for the treatment of addiction and trauma.

**Addiction and Trauma as Disorders in the Biological Processing of Intensity**

Koob and Moal (2000) have argued that addiction is a disorder in the biological processing of intensity, i.e., of the biology’s capacity to process intensity automatically and easily, without requiring effortful management by the person. Trauma, we suggest, is a similar disorder. Many are familiar with the ACEs study (Felitti et al., 1989), which demonstrated that trauma had been an under-recognized factor in substance abuse, as well as a host of other disease conditions. The profound and under-appreciated import of this study, bolstered by subsequent confirming research (Centers for Disease Control and Prevention, 2021), is that the effects of trauma land firstly in the biology, the soma, before manifesting visibly in the psyche. Interventions for both addiction and trauma, we therefore suggest, must somehow have a coherent strategy for change at the biological level. In this section, we elaborate on how addiction and trauma are disorders in the biological processing of intensity. This lays the groundwork for the next section, in which we introduce a theory of how change can be catalyzed at the biological level.

Addiction and trauma manifest in the biology through various forms of uncomfortable intensity, or stress, e.g., unpleasant emotions, sensations, images, and thoughts. Some might think that adopting a perspective on addiction and trauma as being forms of stress down-plays their seriousness. This thought, however, under-estimates the seriousness of stress itself. We would like therefore to elucidate on stress, its seriousness, and its relation to trauma and addiction.

Stress is a biological state, with associated effects on lived experience, in which the demands on one’s physiology exceed the physiology’s ability to easily process those demands. In this systems processing definition, stress is known as allostatic overload, which is the total load of demands on the physiology. The demands for processing can arise internally or externally. If there is too much demand, too much intensity from within our physiology and/or from environmental demands, our physiology is stressed, and we may feel stressed.

The four general conditions for stress, or allostatic overload, are (“a) repeated ‘hits’ from multiple stressors, (b) a lack of adaptation or habituation, (c) prolonged response due to delayed shutdown, and (d) inadequate response that leads to compensatory hyperactivity of other mediators” (McEwen & Gianaros, 2011, p. 3).

Stress has been demonstrated to be so integral to addiction that addiction has been conceptualized not fundamentally as a brain disease, but as a stress disorder (Ruisoto & Contador, 2019). Ruisoto and Contador link brain and stress with brain-change inclusive concepts, including addiction as a learning/social learning disorder, a reward deficit disorder (an anti-reward excess disorder), an executive function disorder, and a brain stress disorder:

...[S]tress exposure and drug abuse result in the progressive up-regulation or excess of the brain stress system (till now referred to as the “anti-reward” brain system), which is the key to understanding the stress-like state of the negative emotion/withdrawal stage, driving drug-seeking and taking through negative reinforcement. This up-regulation results from the increase in the reactivity of the HPA axis and amygdala, also increasing hypersensitivity to stress. It is, therefore, involved in the relief-craving. Furthermore, repeated exposure to drugs and withdrawal from drugs can be considered, in themselves, as stressors, inducing the same brain changes, increasing the risk of relapse, a hallmark of addiction. (p. 64)

Clearly, to understand stress, including traumatic stress and addiction, it is crucial to have frameworks that encompass the physiology from the standpoint of interacting complex systems. Two such inclusive frameworks are (1) alldynamics and (2) large-scale brain networks. Alldynamics refers to the process of organismic resources being allocated to meet demands. We are alldynamic systems: systems that continually deal with physiological demands. An alldynamic under-
standing of addiction sees addiction fundamentally as a dysregulation of the optimal processes of organismic resource allocation. At their optimum, these processes allocate resources in ways that enable the organism to sustain itself organically, i.e., without stress or overload.

Large-scale brain networks implicated by research in stress and addiction include the salience network (SN), the executive control network (ECN), and the default mode network (DMN) – the so-called triple network. A simplified understanding of these networks, with an eye toward their clinical relevance, upon which we will elaborate later in this paper, is as follows. The SN determines what directs our attention – e.g., whether our attention is directed towards threat (real or perceived), the immediate environment, or healthy pleasure. The ECN is active during goal-directed action – e.g., decision making, problem solving, or acting on one’s own behalf. The DMN is active during states of rest, autopilot, and freeze. The triple network model of psychopathology posits that aberrant functional organization of, and interaction between, these networks underlie a wide range of psychopathologies (Menon, 2018, p. 236).

The triple network model sheds light on how stress and addiction hijack attention, which is arguably the most important organismic resource. Attention is directed, or filtered, primarily in a hierarchy of neural pathways comprising the brain’s salience network, which determines relevance (Menon, 2015). Menon describes the salience network anchored in the anterior insula, dorsal anterior cingulate cortex, and subcortical structures – including the amygdala, ventral striatum, and the substantia nigra/ventral tegmental area. Collectively, these contribute to complex brain functions including communication, social behavior, and integration of sensory, emotional, and cognitive information.

Lerman et al. (2014) examined the relationships among the triple network using correlational measures that comprise a resource allocation index (RAI) using FMRI data. Their conclusions include observations of likely links between triple network dysregulation and psychiatric disorders, as well as the dysregulation that comprises addiction. Of particular clinical relevance to the OI therapeutic protocols related to trauma and addiction (to be elaborated later), it was stated that in a nicotine-deprived stress state, the salience network (SN) seemed to draw attentional resources to the inner experience of craving. Additionally, there was a weakening of the link between the SN and the executive control network (ECN) – with a corresponding, enhanced DMN hyperactivity. These neurological network images describe the potentially ruminative cascade of the attention drawn inward by the negativity bias toward interoceptive states of lesser goal-directed agency and executive control. Stress is disorientation, and interoception of negative states decreases executive control. Importantly, Lerman et al. connect the dots between these dynamics and other patient symptoms, such as depression and dysthymia.

By definition, a system affected by addiction and trauma has learned a host of maladaptive processing tasks and salience habits. These habits include the preference of attention to what’s wrong: Threat may be seen where none exists, and threat missed where it actually exists. This priming reiterates signals that reinforce a system in stress, and is a reflection of what has been well documented as the negativity bias, or what OI calls simply, “The What’s Wrong Attention” (WWA) (Hoskinson, 2022; Ohman et al., 2001; Soroka et al., 2019; Vaish et al., 2008). These neural habits add extra processing demands, resulting in stress and allostatic overload, where traumatic stress circuits fail to reliably dampen or habituate too soon. In these conditions, attention seeks non-relevant or non-existent stimuli, aided by perceptual and response biases, particularly the negativity bias (Leong et al., 2019). As a reminder, the negativity bias is one of the most powerful forces in human neurobiology, even in infants and children (Vaish et al., 2008), and with therapies focused on addiction, trauma, and their sources, it compounds stress upon stress (Tyborowska et al., 2018). In early development, its remodeling of brain architecture is well known by ACEs, attachment, and a host of other relational, psychological and physical effects (McEwen, 2006). The neural links between the negative reinforcement cycles of stress and addiction are well established, and articulated in a review by Ruisotto and Contador (2019) in the alldynamic framework. In other words, addiction is impossible without negative reinforcement.

Based on this convergence of neural states and their conditions (including ADHD, cf. Cai et al., 2021; Um et al., 2019), it is clear that the increased ability to deal with systemic stress is crucial to addiction recovery and for general human functioning, adaptation, and performance on a global scale. Toward this end, many therapies are increasingly focusing on what they claim would enhance executive function: helping people focus and manage stress; teaching skills to cope with and reduce external stressors, and prescribing drugs that help manage stress. In addiction, stress management is of course crucial, especially in early recovery. And, since negative emotion and negative urgency (Kaiser et al., 2012) predict addiction and relapse, it seems that the work of inhibiting such negative affective states would be a primary therapeutic goal. Paradoxically – yet affirming of OI strategies, however – there is evidence that inhibitory management involves the overuse of executive control (Chester, 2016).

There is an alternative and complementary approach, implied by this literature, and – as we will show in the next section – explicitly developed into a comprehensive therapeutic framework in Organic Intelligence. The alternative to the overuse of inhibition is to increase the capacity to process intensity natively and effortlessly. Consequently, we will feel more ease, and have less negative urgency (thus requiring less inhibition). The idea that we can increase our capacity to process
intensity organically – to increase our bandwidth – is underrepresented in the scientific literature. While the notion of brain plasticity allows for increased adaptation to a changing variety of stressors (such as the four mentioned earlier in this section), the possibility of qualitative increase in plasticity itself has received little attention. As a result, most therapy remains within the confines of this status quo, and strays from an organic path that would facilitate this increase – instead, focusing on management.

The conditions for understanding dynamical systems and the qualitative increase in processing capacity, however, are gaining interest, but a comprehensive clinical model has been lacking until this point. To glean the current clinically relevant pointers from allodynamics and dynamical systems, and their pathways for a qualitative growth in alldynamic range, we must understand some of the nuance of these systems frameworks. From Sterling’s research (2012), we learn that the framework of allostasis facilitates the understanding of interactions among large-scale brain networks. Both of these systems’ (i.e., interactionist) constructs have received increased research attention as the limitations of simpler homeostatic and linear models of management, and mechanical compensation models, have become apparent.

Therapeutically, what is this important difference between the homeostatic and the more organic allostatic lens? The term “allostasis” was coined in 1988; its Greek roots mean, essentially, coherence through variability. This coincides with our more current understanding that the brain increases selective advantage not only by adapting to the current moment, but also by making micro-predictions of needs for adaptation to the future. Allostasis references this predictive process of adjusting the internal milieu to promote survival and reproduction, and contrasts against homeostasis, which is the organismic process of maintaining the same internal milieu (Sterling, 2012, p. 5). The earliest theorists of alldynamics speak eloquently to valence, processing demands, and the role of positively reinforcing experience. Peter Sterling, who, with J. Ayer, coined the term allostasis and defined its construct, describes its difference from homeostasis – vis-à-vis addiction – with a poetic style rare for neuroscience articles, saying allostasis allows

...innumerable activities and experiences to each provide non-adapting anxieties and brief pleasures, their reward values depending partly on the effort expended. But modern life narrows the variety of small pleasures and reduces effort, thereby reducing their reward value and requiring larger portions for equivalent satisfaction – a cycle that generates addictive behaviors.

Homeostasis and allostasis locate pathology at different levels. Homeostasis identifies proximate causes; for example, it attributes essential hypertension to excess salt water in too small a vascular reservoir. Thus, it directs pharmacotherapy toward reducing salt and water, expanding the reservoir, and blocking feedbacks that would counteract these measures. Allostasis attributes essential hypertension to the brain. Chronically anticipating a need for higher pressure, the brain mobilizes all the low-level mechanisms in concert: kidney to retain salt and water, vascular system to tighten, and salt appetite to rise. Correspondingly, allostasis would direct therapy toward higher levels – to reduce demand and increase sense of control – so that the brain can down-shift its prediction and relax all the low-level mechanisms in concert.

For disorders of addiction homeostasis pursues pharmacological treatments: drugs to treat drug addiction, obesity, and other compulsive behaviors. Allostasis suggests broader approaches – such as re-expanding the range of possible pleasures and providing opportunities to expend effort in their pursuit (Sterling, 2012, p. 5).

As a way to treat addiction, Sterling suggests expanding the range of pleasures and the opportunities to pursue them. Similarly, Menon (2015) identifies the potential for expanding the range of pleasure. He identifies a higher order network that is paralimbic–limbic, and selectively targets for the “spotlight of attention” domains relevant for goal-directed behavior. These include such events as “…deviants embedded in a constant stream, surprising stimuli, and stimuli that are pleasurable and rewarding, self-relevant, or emotionally engaging” (Menon, 2015, p. 597). We shall see how each of these events are emphasized in the OI therapeutic protocol, as OI trains practitioners to see subtle signs of such – mostly unconscious – salience recognition in their clients. Over time and with proper reinforcement, this recognition can find signs of a system quietly advocating for its own auto-organization.

Let us summarize, then, the understanding of addiction we have proposed, and its implications for treatment. The proposal is to understand addiction fundamentally as an allostatic disorder: a disorder in an organism’s capacity to natively process load, or intensity. Addiction hijacks the normal functioning of large-scale brain networks. Most clearly implicated in the research on how addiction hijacks our biology are the dopaminergic pathways of the brain’s reward system. The effects are system-wide, affecting overall inhibitory structures, salience determination, motivation, and other executive functioning (Volkow et al., 2011). Attention is thus repeatedly directed toward pain and threat – even nonexistent threat – rather than toward the environment or healthy pleasure. The compulsive, addictive force is reiterated and reinforced by this process of negative reinforcement, which is the bane of today’s approaches to therapy, trauma, and addiction recovery. Negative reinforcement adds stress, which by definition is the com-
promise of vital allodynamic balance, by dysregulating brain network inter-functioning (Raz et al., 2016).

Given the complexity of these conditions, optimal treatment approaches must incorporate large-scale and comprehensive multi-system frameworks to guide unique relational and biologically-based interventions, attuned to and tailored for each person in the moment. In the next section, we introduce such an approach, one that we believe constitutes a paradigm shift in therapy and the treatment of addiction: the addicted person, and any person, has the potential not only to learn coping strategies for stress, but also to increase their capacity to process intensity easily, naturally, and pleasurably, without requiring the undue demand for management. In other words, a person’s biology has the potential not only to learn and practice skills that facilitate pleasant homeostasis, but also to collaborate with their allostatic system. Physiological reorganization and change can develop that strengthen the organism’s ability to learn and process information and intensity more efficiently and effectively. While management may be crucial in early recovery, ultimately, the optimal treatment is to grow bandwidth. This idea lies at the heart of Organic Intelligence and its application to treatment, to which we now turn.

**Organic Intelligence Theory**

A key feature of existing treatment approaches to addiction and trauma is the importance placed on efforting: active doing, willpower, discipline, achieving goals, commitment, sticking to an action plan, taking the bull by the horns.

While efforting is crucial, especially in early recovery, according to OI, there is another possibility that we ultimately want to help clients realize – a path of ease and comfort, a recovery of pleasure, in which steps that promote wellbeing are more easily, pleasantly, and naturally taken. To take these steps, we need to tap our physiology’s capacity to undergo fundamental changes that increase our inherent resilience and capacity to process intensity, and adapt to environments automatically and easefully.

OI refers to this process of the physiology’s increased processing capacity, or inherent resilience, as auto-organization. To elucidate the notion of auto-organization, it is necessary to consider some of the scientific theories underpinning OI, which is grounded in a clinically-operationalized understanding of dynamical systems, including brain network theory (Bressler, 2010). The field of complexity science studies dynamical or complex systems, which are systems that are capable – when in apt conditions, i.e., initial conditions – of undergoing fundamental changes in their nature that increase their strength, stability, and resilience. In complexity science, this process is called self-organization. OI calls it auto-organization, in order to emphasize that the change happens automatically in the system; it is not directed by conscious doing.

Human physiologies, according to OI, are complex systems. And, importantly, we are the kind of organic systems that can be self-organizing. Under certain initial conditions, our biological systems are capable of reorganizing in a way that produces stronger, more stable states. In human beings, this state corresponds to an increased capacity to process intensity. The initial conditions that enable human auto-organization in human beings are (1) orientation, which OI defines as connection to the environment through the senses, and (2) orientation to pleasure, which refers to seeking and feeling pleasure that is healthy, not too intense, and non-addictive.

Orientation is a natural impulse of our physiologies, which seek to map the environment as a vital component of allostatic prediction. When oriented, we typically feel safe and comfortable, if the immediate environment is not life-threatening. A state of orientation and of pleasantness – pleasantness within the base of orientation – is the proper, healthy baseline for a human being. When oriented, modulation of intensity is easy, and typically trends toward pleasant and more sustainable states. These initial conditions of orientation, and orientation to pleasure, constitute the essence of a positive reinforcement framework.

Both conditions are crucial, not just one or the other. There are therapeutic approaches that rightly focus on the second: on pleasure, on the enjoyment of life as important for healing. Such approaches often provide many in-depth practical exercises for pursuing and feeling pleasure. See, for example, Resnick (1997). In OI, however, we’re ultimately looking for pleasure that emerges organically within the physiology due to the stabilization of the trait of orientation. For auto-organization, there is a world of difference between efforting at pleasure – e.g., using willpower to do something we enjoy – and pleasure that emerges effortlessly within, due to being oriented and in the here-and-now. The former reinforces negative reinforcement; the latter puts us on a positive reinforcement path.

Given how fundamental orientation is to enabling auto-organization, let us elaborate on the science behind its function. Salience means what matters to the biology, as well as what may subjectively be felt as meaningful for an individual. According to Menon (2021), the salience network maps salient external stimuli and internal mental events, and facilitates the engagement or disengagement of brain systems for goal-relevant behaviors. In therapeutic work, OI practitioners learn – within relational attunement constraints – to preference clinically observable, biologically, and evolutionarily selected states and behaviors. Orientation is the first of these states, because it forms the bridge between salient internal and external events. It is also a vital part of the process of making cognitive maps:
how we navigate in space, form motor plans, create memory retrieval cues, and locate interesting people. In other words, orientation is vital to what the biology really wants and needs to do. In evolutionary terms, its success would have clear selective value. Behaviors that are especially good at providing selective advantage are often more quickly learned, incorporated, and retained. As expected, learning and looking out for danger are quickly learned. However, salience is also relevant for positively valenced learning of behaviors that bestow outsized selective advantage: how and to what shall we orient that is beneficial.

Orientation and orientation to pleasure bestow such important selective advantages that the physiology is readily prepared to incorporate them. This readiness is known as “prepared learning,” a concept coined and articulated by Martin Seligman (Seligman, 1970; Seligman, 1971; Dunlap & Stephens, 2014). We find that orientation is prepared learning, and can be appropriated into automaticity. With practice and priming, orientation maps us in the environment through our senses, and integrates as a seamless part of the fabric of consciousness. However, it often takes more practice than we might expect, given its readiness as a prepared learning. In the West, there is of course the culture of therapy, and some mindfulness traditions that emphasize internal awareness, self-referencing, and examination of feelings, sensations, thoughts, and images. Thus, there is an emphasis on locating ourselves in our inner cognitive-emotional milieu, or psychological “self.” This cultural predisposition of self-referencing iatrogenically disrupts what would help form a more stable and continuous baseline of affective states.

Biologically, with the discovery of grid cells, place cells, and border cells, we know that self-mapping happens first in relation to the environment, and is primarily located in the hippocampus (Moser, et al., 2015). However, recent research into cognitive mapping has expanded the notion of hippocampal mapping to include more senses than just visual, and with important representations in the somatosensory cortex. This reinforces the fact that autobiographical and body representation (i.e., embodiment) are functionally related to connecting to the environment through the senses (Long and Zhang, 2021) – OI’s orientation, rather than self-referencing. In fact, as we have seen above, it is the negativity bias that often reinforces attention away from the executive control network and towards internal experience, internal intensity, and states that are more disorganized, disoriented, disempowering, and that increase the negative effects of DMN dominance.

Indeed, DMN hyperactivity can be quite aversive, to the degree that it is associated with states that arose with the fear of death. This includes the survival response of freeze, or immobility (Porges, 2001). Naturally, the amygdala is implicated in arousal around survival and trauma, and is a key component of the salience network’s assessment of relevance of both external stimuli and internal mental events (Menon, 2021). Under stress, the link between reduced contribution from the network pairs of salience and executive control, compared to the default mode and executive control, has been affirmed by current research. (Chand et al., 2020). In other words, chronically reiterated states of stress draw attention inward and away from executive control, where integrated, coherent decision-making happens. The issue of physiological coherence is also described by Porges (2007) through its relationship with heart rate variability (HRV), including measures of respiratory sinus arrhythmia (RSA) and vagal tone as indicators of organismic coherence. This is little more than emphasis on the longstanding awareness in the neuroscience of trauma that more stress means less executive control. The clinical importance in OI of RSA as an organizer of physiological resilience can hardly be overstated. Learning to actually see and recognize the subtle behavioral correlates of this modulation takes time and training.

At the opposite clinical pole is the association of DMN with immobility states (cf. Porges’ dorsal vagal network, 2007). This freeze-y aspect of stress, in which there is the suggested hyperactivity of the DMN, points to the clinical presentation of dissociation that we believe to be an important contributor in dysregulating the efficient relationships among brain networks. Thus, the importance of OI’s notion of orientation is that the salience network, through effortless experience, may recruit states of DMN in their normal function, and thus down-regulate intensity and help rebalance the DMN–SN to ECN–SN relationship. The normal function of orientation as a salience driven, effortless and automatic state is a re-sourcing aspect of DMN.

This is, in fact, the most common clinical report of those practicing even 45 seconds of orientation. People typically report feeling state shifts to more relaxation, more settled, and present. Additionally, orientation 1) can naturally be learned and incorporated (cf. “prepared learning” above); 2) quickly becomes an effortless, background aspect of consciousness; and 3) is externally directed attention that circumvents the likelihood of reinforcing the attractor of negative internal intensity states. When orientation is effortless and non-self-conscious, it potentially offers a more integrative non-specific awareness, and an even restful state that can participate in a neutral to positive balanced experience, including with the DMN – and not overtaxing the modulatory abilities of the ECN.

Now to the main point: the OI tenet that orientation, and orientation to pleasure, are initial conditions for auto-organization. When a system attains these initial conditions, the brain network balance supports intensity in the system so that it oscillates toward pleasurable increase and aims toward discrete, biologically determined, and clinically perceptible intensity thresholds. In fact, a system is largely organized around, and defined by, the precise amount of arousal that the system (the biology) can process easily. If a system can reach these precise
thresholds and then rest, or de-arouse, afterward, it will auto-organize, thus increasing that intensity threshold. When this example of prepared learning occurs, when the system itself picks up the pattern of precise, largely pleasurable intensity, that is auto-organization. The OI clinical result is that a person will have greater capacity to process intensity: to experience pleasurable intensity, to problem solve, to increase resiliency, and to handle complexity.

The concept of increasing biological thresholds is distinctively OI, and has significant implications for the treatment of addiction. Koob and Moal (2000) suggest that addiction involves a compromise of biological thresholds, or “set points.” “[D]rug addiction is hypothesized to involve a change in reward set point and reflects an allostatic . . . adaptation (i.e., outside the normal set point)” (Koob & Moal, 2000, p. 102).

Auto-organization can happen automatically for people whose systems are well-organized, with trait access to orientation, and orientation to pleasure, and an overall positive social environment. For those who have a compromised capacity to process intensity and who don’t auto-organize, OI sessions can help. An OI clinician helps a client restore and build access to initial conditions by engaging in free association conversation with the client, tracking myriad aspects of their physiology and conscious experience, and reinforcing any movement in the direction of initial conditions. This process is multifaceted, sometimes looking like a normal conversation between friends, sometimes like a psychotherapy talk session, and sometimes like a somatic session in which one helps the client track sensation. To elucidate further, let us now turn to explain the essentials of OI session work.

OI sessions are free association conversations in a warm relationship of attuned unconditional positive regard (cf. Carl Rogers). The OI clinician invites the client to talk about anything on their mind and to speak as freely as they like, rather than having to be linear or focus on a certain problem, goal, or therapy topic. Free association conversation creates a non-self-conscious, low-demand, and low-stress context in which a client can feel relaxed, comfortable, and safe. This context supports the client’s spontaneous, uninhibited conscious experience to emerge. The OI clinician tracks five aspects, or channels, of the client’s conscious experience: image, sensation, orientation (sensory connection to the environment), meaning (thought), and affect (emotion). The acronym for these five channels is ISOMA. While attuning to the entirety of the client’s experience, OI clinicians selectively reinforce, often subtly, orientation and less negatively valenced ISOMAs. And when the client is stabilized in orientation, rising intensity increasingly manifests through positively valenced ISMA, i.e., neutral to pleasant, comfortable ISMA.

The OI clinician observes the rate of modulation and intensification, as different ISOMA channels have characteristics of inhibition or excitation. Supporting clients’ ideal amplitudes of arousal–dearousal levels occurs with in-the-moment exchanges, verbal and nonverbal, in the conversation. OI clinicians learn how to tap the brakes or press the accelerator (or both) so that clients’ positive intensities reach their organic threshold peak – that thermostat-like level that catalyzes auto-organization.

There is a learning curve for clients and their biology to shift from the extant therapy milieu and negative reinforcement to positive. When people’s systems move into a mode of auto-organization, therapeutically, intensity is processed in positive valence. However, what is gained is that intensity that was formerly too much – such as a certain level of grief, sadness, irritation or anger – can become sub-threshold as intensity thresholds grow. This is what is meant by growing bandwidth. Remarkably, however, in the OI clinical process, we find that the states associated with traumatic memories arise, but they arise contextualized within a positive associative frame. It becomes possible for the client to undergo reconsolidation of their traumatic memory states in ways that are positively valenced, i.e., pleasurable.

The explicit content of such memories has cues, nodes of the “original” event and its accompanying intensity level – but in an alternate, positive valence. In other words, traumatic memory reconsolidation can happen organically where the explicit content is fully – even unconsciously – present and resonant, but positively valenced. The negative or traumatic narrative remains unexpressed, and, if present, is often unconscious. It seems it is intensity that is most salient in evoking states for reconsolidation, not valence. In fact, therapeutically, a positively valenced reconsolidation is what seems to be especially empowering, and avoids the precise pitfalls of stressful recall – including the risk of retraumatization. This is inevitable when we understand that explicit memory and its expression are a function of, and never separate from, the biological agenda. So, when a system is organizing around organic thresholds, it presents narrative content with that agenda.

An example of positively valenced reconsolidation can be seen in a recorded OI demonstration session, when a student was talking about an earthquake experience. Some minutes later, the student recalled a different, (similarly) intensely positive memory in the same location, with the same accompanying gestures and other associates of the original experience, including some tears, and the whole house was shaking! There was no conscious connection at the time, nor need there have been, that the spontaneous positive recall was related to the traumatic memory of the earthquake. The student’s system was able to reconsolidate the memory without

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focusing on or even being conscious of the trauma, and was instead simply engaged in a pleasant, free association conversation (with a skilled OI clinician who understands how to work with the system to catalyze auto-organization).

In sum, auto-organization is the allostatic process that underlies what we recognize as the deepest healing and growth, including healing from addiction, trauma, and developmentally-originating and relational states. It limits the potential harm inherent in therapies that work without a positive reinforcement framework. With systemic auto-organization comes more comfort, pleasure, ease, interest, curiosity, and interest in the next appropriate level of challenge and increased complexity. Time and energy are freed up for people to pursue what is meaningful in life, rather than continually expending life energy unnecessarily on hypervigilance, hyperactive self-care, or white-knuckled sobriety.

The key to catalyzing auto-organization is a positive reinforcement framework: providing positive reinforcement for attention that spontaneously orient to the environment and to wholesome pleasure — to what is rewarding, meaningful, positively surprising, interesting, and emotionally engaging. We now turn briefly to how to create a positive reinforcement framework for trauma and addiction treatment.

Creating a Non-Directive Positive Reinforcement Framework for Trauma and Addiction Treatment

A positive reinforcement framework assumes the ultimate goal of auto-organization by promoting the two initial conditions of orientation, and orientation to pleasure, as defined in the prior section. Here, we give brief, practical guidance on creating a positive reinforcement framework for trauma and addiction treatment. We will focus primarily on creating such a framework in a one-on-one session. At the end of this section, we will indicate how the framework can be created for other aspects of a multidisciplinary treatment program.

One might think that OI recommends simply directly telling people to practice orientation and pursuit pleasure, as two additional things for a client to do, on top of whatever else they must do as part of their treatment program. In fact, however, in the insistence on attunement and joining, we often do not directly command clients to orient, or orient to pleasure — whether in session or in life. One reason for this is that clients simply may not be able to do so, and in such cases, being directive will just add stress, pressure to follow commands, and guilt, shame, and hopelessness when clients are not able to follow these directives. A second reason that directives are generally contraindicated is that even if clients are able to comply, it is the client’s own initiative and self-organizing tendency that are valued, i.e., empowerment. Furthermore, inorganic shifts of state or attention may create such a different intensity level or valence that it creates a discontinuity of states. OI’s clinical process and auto-organization are integrative, meaning that states are comfortably and increasingly connected and interconnected. If someone is in a certain state, whatever it is — e.g., sadness, anger, happiness, neutrality, fight, flight, freeze, talking about topic X or Y, trying to problem solve, etc. — being suddenly told to look around the room, or talk about something pleasant, or hunt for and feel pleasant sensations in the body, can be jarring, misattuned, and come at the opportunity cost of working within the weave of the client’s state continuity.

Instead, the bulk of creating a positive reinforcement framework consists in setting conditions that make spontaneous orientation, and orientation to pleasure, increasingly more likely, and in subtly — often very subtly — reinforcing orientation, and orientation to pleasure, when they do emerge.

Four practices that increase the chances of orientation, and orientation to pleasure, are:

1. Facilitating a free association conversation
2. Deep, empathic attunement to the client
3. Support and engagement becoming more interesting to the client than the intensity of their pain
4. Priming and amplifying certain ISMA channels

First, the free association conversation often looks like a casual, everyday human conversation. Even for analysts, it may be challenging for a clinician to get used to the strategic reinforcement process in the OI free association conversation. Such conversations may feel unproductive, because they are not consciously and linearly connected to any specific, concrete, measurable progress marker, such as, for example, filling in one’s gratitude journal five days this week, or confronting a specific painful trauma in therapy. However, the structured, interpersonal free association conversation, and the accompanying easing of intensity and pressure to set and meet specific goals, are exactly the point. The more interactions that feel like casual, every day, low-pressure conversations, the more likely orientation and pleasure will emerge for supportive interaction.

This interaction is founded fundamentally within a Rogerian attunement context, our second practice. This includes training in being with the client exactly where they are in the moment, and tracking and joining with the client’s state, as opposed to trying to change it. If the client is in fight or flight, we often find what is acceptable, even pleasurable intensity. If the client is in freeze, likewise, we support the client’s own perception in lack of affect, in immobility, and in cognition at a pace and intensity that helps them feel accompanied. If the client is talking about what’s positive and going well, we join there. If the client is talking about deep trauma and pain, we join there.
A second suggestion is to train the various people that require attentional effort on the client’s part is a potent way to prime orientation and to draw the client’s attention to the environment. The therapist counts as part of the environment; thus, if a client finds what the therapist is saying interesting, their attention will reside more in the environment than in their interior painful intensity. This is orientation.

The fourth practice, that of priming and amplifying certain ISMA channels, is more advanced and requires more formal training in OI. Let us offer a general explanation of the practice. Over-threshold intensity will generally manifest in particular channels, and different people will be prone to becoming over threshold (i.e., over the organic threshold for catalyzing auto-organization) in different channels. For some people, intensity in affect tends to become over threshold very easily; they are easily overwhelmed by intense emotion. For others, it’s intensity in thought; they are stuck in constant mental intensity; thought after thought without reprieve. To lower intensity, and thus make spontaneous orientation and pleasure more likely, a therapist can prime and amplify a less intense channel. For clients who tend to become over-threshold in affect, priming and amplifying the meaning channel will help lower intensity. For clients who tend to become over threshold in thought, priming and amplifying the affect channel may lower intensity. Furthermore, the reality is that clients generally are cycling between under- and over-threshold experience. There is an art to the process of reinforcing the client’s auto-organizational trend because it involves sometimes simultaneous amplification of inhibitory and disinhibitory ISOMA states.

It is beyond the scope of this paper to go into technical detail about the fourth practice, but one important feature deserves emphasis. Trying to prime and amplify ISMA channels must be done within the context of attunement and state continuity. If a person is dominated by uncomfortable emotion, we fully join them, and may prime another channel, e.g., thinking or orientation (say, by becoming more interesting). We do not simply tell a person who is uncomfortably emotional to think about something else, or to orient.

These four practices, again, make spontaneous orientation and pleasure more likely to occur. When they do occur, it can be subtle and very brief, requiring the therapist to be very oriented to the client. A client may orient for a split second, e.g., glance out the window. A client may feel relief of pain or a pleasant affect or thought for a split second. If the therapist can spot these moments, they can subtly reinforce these initial conditions by a micromovement, such as nodding the head or smiling, or brief verbal confirmations, e.g., “yes,” “mmhmm.” Reinforcing too intensely can be counterproductive, as it may drive the client’s intensity over threshold, and knock them out of the very initial condition that the therapist is trying to reinforce (orientation and pleasure). Pouncing on a client’s mention of something positive and asking them to elaborate on it may be jarring, especially if the positivity emerged briefly and delicately within a wider context of mostly negative and painful content. If the client reacts negatively to our reinforcement efforts, we recalibrate from that feedback about the clinician’s misattunement. We re-establish attunement, which is always prerequisite, before attempting to reinforce initial conditions.

The above four practices are intended primarily for one-on-one therapy sessions. It is also desirable to create a positive reinforcement framework outside this context for as many aspects of a multidisciplinary treatment program as possible. We end this section with a few practical suggestions in that direction.

- One suggestion is to make environments as orientation-friendly as possible, e.g., decorating a facility with plants and objects that are likely to receive clients’ attention, including objects that clients can smell and touch, as well as see.

- A second suggestion is to train the various people who will regularly interact with clients – e.g., medical professionals, group facilitators, and any staff, broadly construed – in the value of orientation, free association conversation, attunement, positivity, and promoting comfort and ease as much as possible. The more the overall treatment program can be infused with these values, the better.

- A third suggestion is to allow for as many options as possible for clients to reduce uncomfortable intensity that are programmatically installed in any aspect of the treatment program. Recall that positive reinforcement is defined as what makes a state or behavior more likely to recur, or to increase its intensity or duration. It’s not necessarily what the program or therapeutic model defines as positive. For instance, it is increasingly thought that social engagement is a therapeutic goal. The definition of addiction as a loss of community or as relationship proxy, especially with the now 40-year old “Rat Park” research, has galvanized some in the recovery community to take new steps in examining social and environmental facets of addiction (Alexander et al., 1981; Gage & Sumnall, 2019). However, with regard to treatments that emphasize social engagement on the grounds of understanding addiction as relationship proxy, we must guard against categorical or linear conclusions about the origins or treatment of stress and trauma. State and biological readiness for social engagement must be clinically assessed, lest we risk misattunement and add to allostatic load by prematurely in-
sisting on socially engaged treatment protocols. For addiction, there are notable exceptions and negative findings related to the effects of socially enriched environments. Furthermore, the causes of addiction are complex, and cannot be boiled down to the loss of one thing or another. Many factors influence addiction (and stress). For instance, genotype, strains, age, and other factors all affect and interact with social and environmental conditions (Khoo, 2020).

**Conclusion**

OI work is complex because humans and their biologies are complex. The OI clinician must track myriad nuanced aspects of the client’s physiology and conscious experience, in order to prime, in every single moment, the optimal intensity level for the client’s auto-organization. Taking a step back from the complexity and technical details of OI, we want to close by emphasizing a simple, fundamental idea that we hope will increasingly support outcomes and reduce harm in the field of therapy, and especially in the treatment of addiction and trauma: the idea of not doing too much at once.

Everyone has a sense of the importance of not doing too much at once. We do not want to overload ourselves, creating stress, panic, burnout, etc. This life tip applies as much to therapy as to daily living: we do not want to (allostatically) overload our clients.

The challenge is that what actually counts as too much, according to OI, is far less than what most people – clients and therapists alike – think. The slightest discomfort, even if titrated, is already a sign that negative reinforcement is likely. Even working within “the window of tolerance,” what is regarded by the mainstream as “tolerable” arousal may already be over threshold – in part because it is discomfort that, explicitly or implicitly, this framework recommends tolerating. By contrast, OI focuses on tolerating comfort.

For persons who suffer from addiction and trauma, it is all the more important not to do too much at once. In addiction, reclaiming and reassociating pleasure pathways is necessary, and will require careful supervision in supporting a lifestyle change to sobriety. However, the value of recruiting brain functions, such as executive control functions by using lower stress protocols is profound (Smith et al., 2011). The OI treatment protocol has developed clearly defined milestones where the overall organizational level of the organism is assessed, and clinical interventions are tuned (and attuned) to that level so as to ensure reconsolidation without retraumatization or over-threshold intensity.

We suggest working as much as possible in a “window of enjoyment” — the capacity of the client’s system to experience pleasure within positive reinforcement; a capacity that can grow indefinitely through auto-organization. Training in OI enables therapists to precisely recognize and support the optimal amount of intensity that facilitates auto-organization in the client. Whether one trains in OI, we recommend that every helping professional draws on their skills, knowledge, and experience in order to minimize their client’s discomfort and to work in positive reinforcement as much as possible. Follow-up assessment on unwanted negative results, and further empirical research are needed for this recommended course correction.

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The Somatic Post-Encounter Clinical Summary (SPECS)
A New Instrument for Practitioners and Researchers
to Measure the Wisdom of Somatic Intelligence

Aaron Freedman*, Theresa Silow*, Steuart Gold, Thomas Pope, Denise Saint Arnault
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ABSTRACT
In creating a research project to examine the effects of somatic psychotherapy, the authors needed a measure to gather somatic data to be filled out by therapists. After multiple iterations, and balancing clinician experience with research efficacy, we created the Somatic Post-Encounter Clinical Summary (SPECS). SPECS is a one-page tool to track and measure the process, interventions, and qualitative outcomes of somatic psychotherapy, to train somatic psychotherapists, and to structure data collection of their sessions. This paper explains the development, methodology, and usage of SPECS for clinicians as well as researchers. SPECS helps clinicians reflect on their practice and improve their skills, as well as providing a simple uniform structure for many different specialists to report on the process of somatic psychotherapy. SPECS also can be used in larger research projects for gathering data about the process and efficacy of somatic psychotherapy. We hope that it will be widely used and improved by practitioners and researchers in our field as well as adjacent and related fields.

Keywords: somatic psychotherapy, somatic countertransference, training tool, trauma, body awareness, somatic intervention, mindfulness

omantic psychotherapy has been practiced in various forms for over a century, and references to body-focused forms of healing exist throughout the ages. Despite this strong historical foundation, it is still an emerging specialization that has not fully made inroads into the wider field of general psychotherapy. One reason is that research substantiating the unique contributions of somatic psychotherapy is still sparse (Rohricht, 2009 and Young, 2010). Further, there is a tendency in the field to focus on and separate practice from research (Johnson, R., 2014). Another reason may be a continued focus on disparate approaches, rather than overarching principles (Johnson, D.H., 1995, p. xii). Due to the disparate modalities and schools of thought that make up the spectrum of somatic psychotherapeutic approaches, a large part of research in the field has been siloed and underdeveloped (Johnson, D.H., 1995; Young & Grassman, 2019).

The authors are excited to contribute to the development of the field by presenting a new measure, the Somatic Post-Encounter Clinical Summary (SPECS). SPECS seeks to support clinicians and researchers in clarifying somatic interventions applied in clinical sessions, the intentions behind these interventions, and
their observed outcomes. We will describe the context in which the measure was created, discuss how it relates to other measures, introduce its components, describe how somatically-trained clinicians received and improved it, and consider its strengths and limitations. We begin by offering a context for its development, and what led to its inception.

The Context for Development of SPECS – Somatic Psychotherapy Study

In the fall of 2015, Theresa Silow, in her role as Chair of the Somatic Psychology Program at California Institute of Integral Studies (CIIS) in San Francisco, was approached by Denise Saint Arnault, a researcher at the University of Michigan School of Nursing, and at that time Chair of the Research Committee of the United States Association of Body Psychotherapy (USABP), regarding a possible joint research project. Several phone discussions between the two ignited interest to explore the possibility of clinicians, students, and faculty collaboratively designing a research project to examine the unique contributions of somatic psychotherapy on patient health outcomes – potentially with clients with trauma histories. They initially discussed the possibility of a somatic psychotherapy research project with CIIS faculty, and then expanded to include representatives of the two somatic psychotherapy clinics in the Bay Area. It was particularly exciting to find out that both center directors were interested in such a project. Thomas Pope of the Lomi Psychotherapy Clinic (LPC) in Santa Rosa and Steuart Gold of CIIS’s Center for Somatic Psychotherapy (CSP) in San Francisco signed on to the project. Lastly, when the USABP put out a call for researchers to participate, Aaron Freedman, a CIIS graduate and research assistant at the Osher Center for Integrative Medicine, joined. The authors of this paper have come together and formed an ongoing research group. For this particular paper, the senior author, Denise Saint Arnault, contributed to the science and development of SPECS, and then stepped back from the authorship and specifics. We hope that the next phase will cover the completion of the full study, explained below.

Overview of the Study

The study aims to gather detailed information about what clients and therapists regard as somatic psychotherapy interventions, and how they evaluate their impact. We intend to collect data about somatic psychotherapy clients’ experiences during the course of therapy, their presenting problems, and overall lifestyle improvement. At the same time, we want to hear from their assigned clinicians about their view on what happened in the sessions. We anticipate somatic psychology concepts overlapping since most somatic psychotherapy models have similar general aims (body awareness, emotional self-regulation, identity and agency formation, relational and attachment capacities, trauma resolution, relief of mind-body symptomatology, etc.). What emerged is a quantitative and qualitative mixed methods project that examines somatic psychotherapy as a conceptual and clinical model, and its impact on patient health.

The research proposal outlined three specific aims:

1. Examine the therapeutic effect of somatic psychotherapy on clients’ health, symptoms, bodily awareness, and emotional regulation, while controlling for demographics and treatment expectancy

2. Describe the therapists’ post-encounter analyses of their therapeutic encounters, including the type of body-oriented techniques, rationale for their use, and perception of their outcomes.

3. Examine the clients’ and therapists’ individual experiences with the somatic approach, therapeutic engagement, and emerging self-understanding.

To collect data from both sides of the clinical dyad, incoming clients and clinicians from both LPC and CSP are invited to participate in the research. Both centers are well established somatic psychotherapy training sites for marriage and family therapists (MFT), professional clinical counselors (PCC), and clinical psychologist trainees, associates, and interns on the licensure track. A battery of pre- and post-quantitative surveys are administered to clients, demographic and experience surveys to the clinicians, and post-treatment interviews to clients and clinicians. For example, the pre-treatment quantitative survey is administered to clients with questions about demographics; previous psychotherapy treatment and satisfaction, health and wellness (pain, vitality, social functions); depression (PHQ-9); anxiety (GAD-7); somatization (PHQ-15); and interoceptive awareness (MAIA). These questionnaires are useful in gathering information about a client’s subjective experience of themselves and their therapy over time. Additionally, our goal is to track what treatments clinicians are using to address which problems, and whether they seem to work.

The study was launched at both clinics, and we have already collected a fair amount of data. Unfortunately, the project was halted by COVID-19. In March 2020, the

1. PHQ-9: Patient Health Questionnaire is a 9-item depression severity measure. See Kroenke, Spitzer, and Williams (2001).
2. GAD-7: Generalized Anxiety Disorder is a 7-item anxiety measure. See Spitzer, Kroenke, Williams, and Lowe (2006).
3. PHQ-15: Patient Health Questionnaire is a 15-item measure of the severity of somatic symptoms. See Spitzer, Kroenke, and Williams (2002).
4. MAIA: Multidimensional Assessment of Interceptive Awareness.
clinics quickly had to shift their in-person sessions to online platforms. To add the task of ongoing data collection for the research project on top of this monumental change was too much for the clinics to manage. The plan is to re-institute data collection once psychotherapy work can return to face-to-face settings. It is now spring 2022, five years after our initial discussions, and we are still under the impact of the pandemic. Needless to say, reaching this point required commitment and dedication.

The newly developed measure, SPECS, aids practitioners and researchers by structuring the collection of clinical data after individual somatic psychotherapy sessions, and functions as a valuable training and teaching tool for therapists, supervisors, and students.

The Need for SPECS

While we developed our research methodology, we realized that we needed a more specific instrument to track interventions employed in sessions. We needed to know which interventions clinicians used, why they used them, how well they were perceived to have worked, and what they planned to try in the next session. We wanted the instrument to be a mix between a progress note and treatment plan, with more specific attention paid to somatic interventions.

Many somatic psychotherapy interventions are intuitive and felt responses to clients’ somatic presentation, and their engagement in the therapeutic dyad and environment. It seemed necessary to devise an instrument that would make some of these implicit processes more explicit. We wanted to clarify the therapeutic aims, the somatic interventions, and the healing mechanisms inspired in clients. Most psychotherapeutic measures look at outcomes; however, we wanted to create a measure used by clinicians to evaluate their sessions, and to describe their most common practices. Additionally, it was essential that the instrument be brief so that it wouldn’t add much time to the normal session documentation.

A particularly important criterion was that the instrument should be useful to the clinicians as well as the researchers. This valuation of research participant experience is in alignment with a more collaborative and social justice-oriented framework of research (Caldwell & Johnson, 2012), as opposed to mining the data of clinicians or clients with minimal improvement of their own experience. The prioritization of clinician experience was ultimately essential for encouraging participation from the clinicians.

We briefly reviewed some existing literature and instruments available to address our aims. If an existing instrument could be found that closely approximated our goals, it would be preferable to fold our data into the context of other similar research with psychometric validity and functionality. Unfortunately, none of the existing options were able to fully fit our needs. In the following section, we will present some of the existing literature on somatic instruments.

Evaluation of Existing Research Tools

Our need for instruments that particularly addressed somatic interventions and somatic work focused our search. Our initial exploration included the European Association of Body Psychotherapy’s Bibliography. A cursory search there provided helpful meta reviews, such as The Effectiveness of Body Psychotherapy by Bloch-Atefi and Smith (2015), May (2005), and Rohricht (2009). Mehling et al. (2009) reviewed 39 body awareness instruments, and found two with high reliability and four with validity. Many of these studies were focused on client outcomes, and were difficult to adapt for a training clinic model. On the shoulders of that review, we continued to look for more nuanced instruments that could capture the wholeness of a therapy session in a brief and usable instrument.

Another criterion for inclusion was an instrument that touched on somatic countertransference. This is a core aspect that separates somatic psychotherapists from other psychotherapists; the unique attunement to the physical experience of being with a specific client. There are various case studies and theoretical approaches to somatic countertransference that highlight its importance, but they haven’t yet led to creating validated measures. Vulcan (2009) provides an excellent overview in this area, but no somatic countertransference measures are mentioned. A few studies that explore the clinical experience of somatic countertransference include Gubb (2014), Forester (2007), and Stone (2006). These all explore the qualitative therapeutic experience, but do not translate into qualitative research. A key concern for our research to plug this gap would therefore be to use mixed methods. For that purpose, we focused our continued search on somatic tools with mixed methods capabilities.

The best tool we found was Egan and Carr’s (2005) Body-Centered Countertransference Scale (see Booth et al., 2010), which does specifically address somatic countertransference in session with clients on a quantitative scale. However, the timeline was limited to “the past six months.” For our purposes, we wanted clinicians to reflect right after a session on that immediate session, and to use those reflections on the interventions and content of this session to inform future treatment planning.

The most in-depth, somatically-oriented instrument is the Multidimensional Assessment of InterceptiveAwareness (MAIA) (Mehling et al., 2012). This is a thoroughly scientifically validated instrument for dealing with the somatic concept of interception and bodily awareness. This instrument helps users assess themselves for concepts such as self-regulation, emotional awareness, and body listening, among others. The instrument is thoroughly psychometrically validated, and has been
translated into over 20 languages (Mehling et al., 2012, p. 8). Unfortunately, the MAIA does not capture clinicians’ experiences during sessions, and is neither specific enough to inquire into the therapeutic relationship, nor broad enough to integrate multiple types of somatic interventions and therapeutic goals.

After this brief review of the options available, we realized that none of the existing instruments fully met our needs. It became apparent that creating our own tool for our research, with an eye on the possibility of it being generalizable for others in the future, was necessary. Thus, we decided to create a new, user-friendly measure for somatic psychotherapy interventions (SPECS).

**Intention and Development of SPECS**

SPECS seeks to clarify somatic interventions applied in clinical sessions, the intentions behind these interventions, and their observed outcomes. SPECS’ wider purpose is to support researchers and clinicians in understanding, integrating, and advancing the practical efficacy and unique contributions of somatic psychotherapeutic approaches in encouraging client health. Therefore, the data collection – and especially how the data are collected – needs to be palpably felt as one link in a chain of helping and healing. In the spirit of congruence, the motivating and ongoing evaluative prompts during creation were: How does a clinician’s relationship with SPECS contribute to the learning and service of healing? And are the questions we are asking, as well as how we are asking these questions, inviting the clinician into the very somatic realm we are studying?

In order to center clinicians’ experience, and harmonize with the project’s valuing of collaboration, when it came time to test SPECS in the field as an instrument in the larger research project, MFTs, PCCs, and clinical psychologist trainees, interns, and associates at both LPC and CSP participated in two pilot studies inspired by the following inquiries:

- What are your experiences of the instrument’s ease of efficiency (design, flow, organization)?
- In what ways has using SPECS benefited both your clinical understanding and your treatment formulation of your case–work?
- In what ways have you noticed clients’ therapeutic process benefiting by using SPECS?

Each pilot study occurred over a two-week period, and included the participation of approximately ten MFT/PCC and clinical psychologist trainees, interns, and associates from both clinic sites. The following is a summation of the clinicians’ experience of completing SPECS after every session.

Clinicians responded positively to SPECS’ ease of use and practical flow, while also suggesting a consistent format of “Check all that apply,” as well as a layout that provided more space for narrative write-ins. This was crucial for having quantifiable data as well as narrative, qualitative data. Additionally, there was, and continues to be, an energetically voiced desire to integrate SPECS into the required standard clinical case progress notes.

The clinicians found the instrument’s content helpful for providing options and reasoning when considering somatic psychotherapeutic interventions. They also found it supported their self-observation, as well as articulation of explicit and implicit clinical dynamics, and it helped them create a thread from one session to the next. The instrument’s fields that were most influenced by the clinicians’ reflections were the “Interventions Used,” its immediately related “To Promote” section, and the area focused on the “Therapist’s Experience in the Session.” (See SPECS below for reference.)

The “Somatic Resonance/Countertransference” and “Self-Care” categories were fleshed out to underscore their clinical value, and to encourage clinicians’ mindful consideration of their own subjective presence. Recognizing the profound clinical significance of multiculturalism and intersectionality embodied by both client and practitioner, “Embodiment of Culture” was emphasized to explicitly promote clinicians’ careful awareness of and active attention to the central presence of self-identities within therapeutic relationship dynamics.

The following is a list of specific themes and feedback that emerged:

- The language of SPECS helped clinicians clarify their intentions to themselves, their colleagues, and their clients, and created an increased sense of safety in the therapeutic process.
- The long list of somatic interventions encouraged clinicians to reflect on the modalities they routinely use, and stimulated novel approaches.
- The connection of recent client outcomes to future session planning helped maintain the arc of treatment continuity.
- The opportunity to consider clients’ somatic states with a deepened level of regular detail enhanced the potential of appreciating substantial shifts happening slowly, and helped clinicians maintain awareness of all that happens nonverbally and intuitively.
- The steady invitation for clinician self-reflection increased therapist/client attunement and awareness of somatic countertransference, and further emphasized and contextualized the beneficial influences of the clinician’s somatic bearing and actions within each session and throughout the course of treatment.

We appreciatively took this feedback and continued to revise and fine-tune the sections until we came up with the final one-page instrument. The following is a comprehensive look at each section, and is offered as an informal user guide with general definitions and suggestions.
Somatic Post-Encounter Clinical Summary: 

Therapist Code: _____  
Client Code: _____  
Session Date: _____  
Session #: _____

1. Presenting PROBLEMS or areas of exploration this session: (check all that apply)

- Anxiety
- Depression
- Trauma
- Grief
- Sexuality
- Gender Identity
- Other: _________________________

   □ Medical Issues/Physical Pain
   □ Employment/Economic/Housing Issues
   □ Relationship Issues
   □ Family Issues
   □ Drug/Alcohol Use
   □ Socio-Cultural Issues/Oppression

2a. Somatically-oriented INTERVENTIONS used this session:  

- Somatic Psychoeducation
- Focus on Breathing
- Body Sensation Tracking
- Focus on Gesture/Posture/Muscular Tone
- Spatial Proximity
- Gaze/Orienting
- Vocal Tone/Volume/Prosody
- Use of Therapist’s Own Body (Posture, Tone, Gaze)
- Mindfulness/Meditation
- Props
- Touch (Client–Self Touch or Therapist Hands On): (specify) __________________
- Movement: (specify) __________________
- Other: _________________________

2b. To PROMOTE: (check all that apply)

- Awareness/Insight of
  - Inner Landscape
  - External Environment
- Emotional Regulation
  - Up-regulating: Enhancing/Opening/Express
  - Down-regulating: Calming/Soothe/Contain
  - Centering/Grounding
- Relationship Skills
  - Communication
  - Intimacy/Connection
  - Boundary Articulation/Individuation
- Other: _________________________

3. OUTCOME of the session (include both client’s words and somatic clinical observations):

_________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

4. THERAPIST’S Experience in session: (check all that apply)

a. General Sensation:  □ Comfort  □ Discomfort  □ Neutral/Numb
   
b. Bodily Awareness:  □ Shallow Breaths  □ Deep Breaths  □ Hypotonic  □ Hypertonic  □ Energized  □ Lethargic
   
c. Somatic Resonance/Counter Transference:  □ Ease  □ Engaged  □ Off Balance  □ Overwhelmed
   
d. Self Care:  □ Grounding  □ Centering  □ Orienting  □ Posture  □ Breath  □ Other: _________________
   
e. Embodiment of Culture:  □ Similarities to Client  □ Differences  □ Other: _________________

   General Description: _______________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

5. Somatic GOALS for next session:

A. 

B. 

6. Planned Somatic INTERVENTIONS to address these Goals (see “INTERVENTIONS” above for suggestions):

A. 

B. 

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**SPECS Specifics**

SPECS was designed using a distillation process. The authors identified broad categories of interventions and the intentions for their use. Also included is the subjective experience of clinicians that informs the process of somatic psychotherapy. This distillation allows to aim clinicians from a variety of different schools of training to be able to document broad categories of interventions and methods. The following is a more in-depth look at the anatomy of each section.

At the top, SPECS has space for the therapist’s and client’s code for identification and for confidentiality. The session date and session number help situate the data in the larger course of treatment.

Here are descriptions of each section:

**Section 1. Presenting Problems:** This section shows the client’s issues being addressed in the specific session and in the therapy. A wide variety of common clinical issues are listed. This information is important to show that specific interventions are used to target particular problems.

**Section 2a. Interventions:** This section captures which interventions are being used. While many non-somatic interventions are used in most therapies, this list attempts to focus on the broad types of somatically-focused interventions used in the field.

- **Somatic Psychoeducation:** Explanation to clients about the process of somatic psychotherapy and the benefit or purpose of specific interventions in addressing the relevant issues and problems.
- **Focus on Breathing:** Increased awareness or active engagement of the client’s experience of breathing.
- **Body Sensation Tracking:** Tracking the moment-to-moment flow of sensations of the ongoing felt-body experience.
- **Focus on Gesture/Posture/Tone:** Identifying and exploring gestures and postural stances, patterns of formation, as well as momentary bodily expressions. Identifying and exploring tone, ranging from hypotonic to hypertonic.
- **Spatial Proximity:** Exploring the physical distance in the room between client and therapist, and the associations and ramifications that emerge in the contact process.
- **Gaze/Orienting:** This may include therapist/client eye contact, the client’s use of their eyes to orient in the moment, or any other conscious use of visual perception.
- **Vocal Tone/Volume/Prosody:** Shifting volume, tone, patterns, and rhythms of speech and voice, implicitly without comment, or as an explicit invitation for client exploration.
- **Use of Therapist’s Own Body (Posture, Tone, Gaze):** Conscious or unconscious shifts of posture, muscular tonicity, use of gaze, gesture, stance, etc., of the therapist.
- **Mindfulness/Meditation:** Use of client’s attention to the range of experience in the moment, especially of sensations and feelings, and associated thoughts. Training clients to pay attention and tend to themselves, in the moment.
- **Props:** Pillows, blankets, toys, chairs, clay, baseball bats, exercise equipment etc. used to aid the therapeutic exploration.
- **Touch:** Use of touch in the therapeutic process, including client’s self-touch or the clinician’s use of touch.
- **Movement:** Any type of guided movement when sitting, lying down, or standing, either subtle or large movements, internal or external.
- **Other:** There is room for the clinician to add any other interventions not mentioned above.

**Section 2b. To Promote:** This section tracks purposes for which the interventions are used. It encourages clinicians to make the connection between the interventions they are using, and why they are using them. It is used to reflect on which interventions work best for which outcomes with each client. (We considered using lines to connect the interventions and reasons, but ultimately decided that would be too time-consuming for clinicians, and speculative from a research perspective.)

- **Awareness/Insight** is aiming primarily at a client’s conscious awareness of their internal landscape or external environment, and is a primary focus of many therapies.
- **Emotional Regulation** consists of 1) “Up-regulating,” which increases healthy psychophysically sympathetic nervous system state activity and emotional expression, with the ability to open up and enhance experience; 2) “Down-regulating” increases the parasympathetic nervous system functioning and helps reduce overstimulating or hyperarousal states; and 3) “Centering/Grounding” helps a client connect to a solid base, and bring them back to being in the present moment. Together, these create emotional functionality, flexibility, and range.
- **Relationship Skills** include 1) “Communication,” both verbal and nonverbal; 2) “Intimacy/Connection,” which includes physical or emotional vulnerability and feeling close to others; and 3) “Boundary Articulation/Individuation,” which allows one to maintain a sense of self within relationships. Together these skills address relational wounds, repair relational ruptures, and open to an embodied sense of vitality in connection.

**Section 3. Outcome:** How did the session go? What were the effects of the interventions, and did they achieve the goals intended? This is the clinician’s perspective on the main takeaways, including the client’s reported experience.
Section 4. Therapist’s Experience: The therapist’s subjective experience is part of the therapeutic process, and informs the treatment. We break this down to five categories, which are generally self-explanatory. The goal is for the therapist to reflect on what was unique about this session, and to differentiate this from their personal state before they started the session. “General Description” allows a more qualitative and creative way to reflect on the clinician’s intersubjective experience of being with the client.

Section 5. Somatic Goals: This section is an aid in developing the overarching goals of the therapy, and in connecting one session to the next. It helps keep the larger somatic treatment plan in mind, encouraging ongoing conceptualization of the course of treatment from the somatic lens.

Section 6. Planned Somatic Interventions: Clinicians consider specific interventions from the list in 2a., or their own, specifically to address the goals outlined in number 5 above. This encourages them to make a specific plan that they could revisit before the next session. In the future, researchers or clinicians could track how many of these interventions were actually used in the next session. Pilot feedback has been that these last two sections have been very helpful in thinking about what needs addressing in the therapy, and how to achieve the goals that the client and therapist collaboratively have set. These sections can help bridge from the current session to future ones in a coherent fashion.

In the spirit of collaboration, SPECS is a living and adaptable document. We hope it will change as it is used, and as the field develops. We encourage modifications, and we request notice by emailing specs@ciis.edu if you intend to use it or tailor it for your work, so that we can track and continue developing the tool.

Future Developments

We acknowledge that SPECS has limitations, and we hope that it can be improved with input from the researchers and clinicians who use it. The instrument is limited to the subjectivity of the user, and would benefit from wider acceptance and agreement of terms. SPECS includes the biases that clinicians have toward their own sessions, and encourages them to reflect on their patterns and habits. It is currently in paper form. We are currently working on a digital version for future use for large-scale research, and a standardized process for implementing adaptations and changes, which we intend to publish through IBPJ. In the meantime, please email any feedback to specs@ciis.edu. Further, we need to test SPECS’ cultural relativity.

There are inherent biases within the concepts of SPECS that come from the social, cultural, and racial context from which it originates (Freedman et al., 2020). The authors are all white, and practice in the Bay Area of California, which is steeped in a particular therapeutic culture. Regional and international feedback will help improve the tool, and can bring the field into dialogue across cultural differences.

SPECS highlights the relational experience of therapy, and validates subjective and objective observation. A future adaptation of SPECS could be a client-centered instrument, which could be used for research and also to encourage clients to review each session, and note important insights and experiential learning. There are many other potential versions of SPECS, but beginning with the clinician’s perspective seems the most fruitful for coalescing the interventions and gathering larger data.

We hope that our work over these past years will provide the reader with an opportunity to review their own practice, and inspire them to use SPECS to dialogue with other clinicians and researchers. SPECS is intentionally generic and simple so it can be used in many settings and adapted at will, with notice to the authors. Every participant will help contribute to developing the field of research, as long as there is dialogue. This growth is vital for our field to thrive. Cruz and Koch (2015) have noted that quantitative and evidence-based research may be difficult to engage, but serves to strengthen the foundation of the field, and vastly improves client care.

Conclusion

Our intention is that SPECS contributes to the growing body of research in somatic psychology. For that to happen, it must be used widely, improved upon, and debated by researchers and practitioners alike. The techniques that it describes are often more art than science, and as such are difficult to operationalize. By beginning with a measure that casts a wide net and integrates descriptive data, we hope to provide a starting point for further clarifying and codifying terms and techniques across various modalities within the somatic specialization (Mehling et al., 2011). We want to help address the difficulties that disparate limbs of specialized modalities have in communicating with each other. As Dr. Barnaby Barratt notes: “The only way to transcend this problem is for us to have articulate research by which we can compare and appreciate our different theories and methodologies, thus empowering us to communicate better with each other” (2019, p.17).

SPECS can function as a therapist training tool, a research instrument, and as an addition to clinical documentation. It can be applied by brand new and experienced clinicians, as well as mixed methods researchers. We acknowledge that SPECS is not intended to become psychometrically validated or to prove efficacy. But it can help move the field of somatic practice towards becoming evidence-based. This instrument adds a tool to somatic psychotherapy so that researchers can further the knowledge base in the field. We must train clinicians to be able to reflect on and explain their work — wheth-
er those colleagues apply the same somatic discipline, come from a different somatic perspective, or are general practitioners without somatic training.

Having researchers and clinicians who are more embodied, reflective, and able to evaluate the benefits of somatic psychotherapy will improve client experiences. We need ongoing financial support and collaboration between member organizations such as the USABP, EABP, universities, and training organizations to create research that validates the benefits and mechanisms of all interventions being used. This can be done only as a collective effort, and is more and more important as dominant cultural trends continue to drag us toward dissociation and disembodiment (Leder, 1990; Van Wolputte, 2004). SPECS is a roadmap toward the ongoing goal of illuminating somatic psychotherapy and its integrating and healing contribution to the world.

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ABSTRACT

This article describes Merete Holm Brantbjerg and Kolbjørn Vårdal’s professional journey to create the Relational Trauma Therapy method. Its development is described through the lens of Alvesson and Kärreman’s five methodological principles for qualitative research and focuses on the challenges encountered using the “running technique” which originated in the Bodynamic shock trauma methodology and eventually led to a breakdown. A breakdown is determined to have taken place when empirical observations show a lack of fit between theoretical expectations and actual experience. Brantbjerg and Vårdal saw two breakdowns: first, a collapse trauma reaction in clients using the running technique, and second, some clients developed a very strong attachment to the therapist while using the running technique, and strengthened a pattern of needing the therapist to regulate high arousal. Through defragmentation, defamiliarization, and working through the problems posed by these breakdowns, Brantbjerg and Vårdal created new methodologies, such as the principle of dosing, and designating different stages in the trauma resolution process. This article informs the reader of Brantbjerg and Vårdal’s broad scholarship, and how they integrated reflexive critique into developing Relational Trauma Therapy.

Keywords: Trauma, theory development, PTSD, hypoarousal

The main goal of this article is to present a key aspect in the development of the theory and method of Relational Trauma Therapy. We also aim to start a discussion in our professional field on how we, as body psychotherapists, can describe how we develop our theory within a scientific framework.

The article describes findings connected to the development of our theory. The purpose of the article is not to argue about our findings, but to foreground our reflections about the use of a specific methodology – and with that, stimulate this kind of method reflection. The development of our theory about the hypoarousal/collapse state is described in Merete Holm Brantbjerg’s article, Sitting on the edge of an abyss together: A methodology for working with hypoarousal as part of trauma therapy. The methodology is taught in our online course on hypoarousal. A future article is in progress is about hypoarousal and attachment in connection with submission and dominance.

In this article, Alvesson and Kärreman’s methodological principles are applied to a qualitative research process for theory development. In creating the methodology of Relational Trauma Therapy, the problems posed by the running technique, as taught in the Bodydynamic shock trauma therapy training, have been a major driving force for the development of a new theory. Merete Holm Brantbjerg and Kolbjørn Vårdal have both been deeply embedded
in the Bodynamic culture, and this article describes essential aspects of their professional journey in creating Relational Trauma Therapy.

Background

The original Bodynamic group, with Lisbeth Marcher as a visionary leader, consists of two generations. Merete Holm Brantbjerg was part of the younger generation, with Marianne Bentzen and Ditte Marcher. The older generation of the Bodynamic group – Lisbeth Marcher, Lennart Ollars, Ellen Ollars, Steen Jørgensen, and Erik Jarlnæs – formulated methodology for working with trauma beginning in 1969, and with increasing focus from 1975 onwards. In 1993, the Bodynamic group published a book about their trauma therapy method (Jørgensen 1993).

The book was called Releasing Shock Trauma. It described their methodology which took inspiration from the work of Carl Kirsch, Joel Dweck Isaacs, Al Pesso, Frank Lake, and later Peter Levine (Jørgensen 1993). A significant part of this methodology involved a method called the running technique.

In this technique, the client lies down supine on a mattress, with the therapist seated at the client’s side. The client imagines the beginning point of the trauma history chronologically, while the therapist tracks the client’s body. In this context, tracking means that the therapist visually looks at the client for signs of reactions, and then the therapist senses reactions in his/her body, and asks the client what he/she senses in their body. When the client starts to feel panic or freeze, the client “runs on the mattress” by pushing their feet and elbows to the ground, just as if they were running in a standing position. At the same time, the client imagines moving from the site of the trauma to a safe place. The safe place is a physically accessible place, either at home, at work, or even in a dream world. If the client lacks access to a memory of a safe place, the therapy room would be the place to imagine running towards. When the client arrives at the safe place, emotional reactions would often arise, and the therapist would support processing them. The goal of the therapy was to release instinctual impulses that had been repressed or blocked, and then facilitate a healing process.

Kolbjørn learned to use this technique at a training with Erik Jarlnæs, and later became an assistant to him, and later to Merete. In 2003, Merete left the Bodynamic Institute, and started her own trainings under the visionary name Moaiku. At that time, Kolbjørn was teaching at the Bodynamic International practitioner training in Denmark along with Erik Jarlnæs, and continued to do so until 2010, when he also left Bodynamic International.

In 2008, Kolbjørn became a co-teacher with Merete. Together with Steen Jørgensen, they began to develop a theory and method based in the Bodynamic shock trauma training and character theory. Steen Jørgensen was part of the group until 2011, when he retired. The primary focus at the start of developing the theory was to limit the running technique, and integrate knowledge from different trauma therapy methods and Systems-Centered Therapy.

Challenges with the running technique created a mystery

In working with the technique, we saw that it didn’t always end with a trauma release that was functional for the client. Two problems were most common. First, the technique itself could be overwhelming for the client, who would then partially enter a collapsed state. The technique didn’t help clients out of the collapsed state; in fact, it risked pushing them further into it. The second problem was that clients often developed a very strong attachment to the therapist, and strengthened a pattern of needing the therapist to regulate their high arousal for them. Both problems led us to develop new techniques for arousal regulation, authority issues, and attachment dynamics.

From the point of view of qualitative research, focusing on the challenges of using the running technique can be seen as a breakdown that created a process of theoretical problematisation (Alvesson and Kärreman, 2011). A breakdown is determined to have taken place when empirical observations show a lack of fit between theoretical expectations and actual experience.

The running technique method did not always work as its theory predicted. This stimulated our curiosity and we began a systematic learning process to develop a more functional method. This learning is best described as a research process driven by a critical dialogue between theory and empirical data.

It was particularly the collapse reaction that was a mystery to us – a mystery that created repeated breakdowns in our work with clients, and for which there was little research support in the curriculum of our trauma training. In hindsight, I see that we used Alvesson and Kärreman’s five methodological principles for a qualitative research process in theory development. These principles are 1) (de)fragmentation, 2) defamiliarization, 3) problematization, 4) broad scholarship, and 5) reflexive critique.

1. (De)fragmentation

(De)fragmentation involves working with patterns and fragmentation, and looking for deeper meanings behind the incidences of incoherence in the empirical data. In this context, the empirical data are primarily the experiences and feedback our students reported in our trainings and supervisions, and secondarily, our clinical work with clients. These are documented in notes taken during trainings, as well as notes from supervision sessions and journals from clinical practice.
The collapse reaction was a fragment that did not fit into the desired success of the running technique. Merete, Steen, and I looked at our empirical data, started a literature search, and concluded that the fight/flight responses were only two of many survival reactions, and were not the only ways out of a traumatic freeze response. Paradoxically, we saw that the more severely traumatized participants and clients who were in great need of running to a safe place often collapsed in the arms of the therapist.

Although the running technique focuses on the trauma story to be healed by releasing the unresolved fight/flight reflex, the collapse response revealed a deeper underlying pattern. Instead of focusing on finishing and healing the trauma story in a specific prescribed sequence, we turned our focus on trauma reaction patterns. We noticed from our empirical material that traumatized individuals used the same trauma reactions again and again, independently of their narrative.

In 2006, when we first introduced the principle of systematic dosing with a focus on hyperresponsive muscles in psychomotor skill training, survival reflexes and implicit trauma memories became apparent. We define dosing as (Brantbjerg, 2019, p. 5) "a principle available in all aspects of psychotherapeutic process. Cognitive, emotional, bodily and relational methodologies can be dosed differently. The question becomes: Is there a way to do this movement or that exercise which would open access to resources, and which would give access to a part of us that is normally avoided or protected against through not sensing it?"

The principle of dosing was then used on the different elements of the running technique to prevent clients from falling into the collapse reaction. In this process, three patterns became evident. We categorized the different elements of the running technique, and sequenced them into what happened before, during, and after the trauma. The next step was to realize that it is not necessary to work with the elements in a linear sequence. In fact, for some clients, it is best to begin working with the time and lack of resources after the traumatic incident, whereas for other clients, it is best to begin at the time before the trauma, and work with the orienting reflex and skills.

Furthermore, for some clients, it was too much to work with one of their more central traumas, so dosing the central trauma work by first working with a small trauma – or even with just an episode where the client was scared – was better. Our experience was that the potency of traumatization often did not matter. The patterns of the trauma defense mechanisms became visible with the right dosing, and that dose was often low. The consequence of dosing the stressor was that very few participants spontaneously regressed into the collapse state.

This allowed the second pattern to emerge. Paradoxically, the technique of dosing the different elements made space for more hypo states: reactions like numbing, sensing cold all the way into the bones, feeling very tired in the body with a shallow breathing pattern, feeling dead in the body, and sensing paralysis in body parts or in the whole body. Often, people used metaphors to describe their experiences – such as feeling as if they were falling into an abyss, sensing a space of dissolution, or losing connection with other people and the world. Our focus on dosing revealed that it created a boundary for the hypoarousal state, and participants could relate to that state instead of being over-identified with it, or scared/angry in relation to it. We also focused on dosing the emotional contact between the trainer/therapist and participant/client while using, and dosing, the different techniques for trauma therapy.

Dosing the technique and the contact created a specific balance between self-regulation and mutual regulation that made it possible to sit on the edge of the abyss and relate to the hypoarousal state. How successful this was for the participant/client was related to their specific self-regulation and mutual regulation skills. This is the third pattern that became evident while using the dosing principle.

Based on our experience, we concluded that, by taking the negative side effects of participants/clients going into collapse and fragmentation seriously when using the running technique, a lower dose could become a magnifying glass that revealed significant and differing patterns for trauma therapy. The dosing principle as a technique created space for studying the hypo states and, in the end, revealed a pattern of skills necessary to create the ability to relate to and process the hypoarousal states – it supported a process of (de)fragmentation.

Using the dosing principle on the running technique led to a research journey to understand the differences between PTSD, and PTSD with dissociation. It became clear to us that the running technique in its original form is a trauma technique, which, from our perspective, is used mainly for a few specific simple PTSD traumas.

In fact, these days, we do not teach the running technique in its original form at all. We teach the elements with the new tools we created on our research journey, in a sequence that works best for each group. Working with the dosing principle while teaching also made it clear to us that it works better to process some trauma themes before others. The sequence we found most functional is to start with working with arousal regulation, secondly with authority issues, and lastly, with trauma-related attachment dynamics.

2. Defamiliarisation

The element of defamiliarisation is connected to observing and interpreting social phenomena in such a way that our viewpoint is professionally distant, and not distorted by private prejudices. This is more difficult when studying one’s own culture where a lot of phenomena are taken for granted, rather than being a stranger in an...
unfamiliar culture. At the start of our research journey, Merete was deeply embedded in the Bodynamic culture, and I came in as a promising therapist and teacher asking a lot of questions.

When Merete, and later I, left the Bodynamic group, we both found new groups to learn from and new ways to relate to others. Merete began Systems–Centered Therapy training, and entered a group culture where the focus was more on authority issues than on the trauma dynamics involved in arousal regulation. I began part-time university studies, first in educational science, then in psychosocial work specializing in violence and traumatic stress. Both of these areas of study helped me ask good questions, integrate research methods, and relate to authority issues in my own professional culture. In the past three years, I have been studying neucentric training for health and fitness professionals at Z–health University. Here, I experience a professional knowledge culture based on nervous system principles similar to neurologically-informed trauma therapies, but with a greater physical approach that creates better movement.

These cultures helped us increase distance from our techniques, and as Alvesson and Kärreman recommend in their book, we implemented choosing “one or a few dominant categories in the field one is working in, and then start to investigate its (problematic) restrictive impact, and in the process perhaps indicate challenging ways to approach the subject matter” to confront the taken-for-granted assumptions and ways of thinking. We chose the running technique as one of the primary categories. Being involved in other professional cultures became an important way to defamiliarize ourselves from our original professional culture, and problematize the way we worked.

3. Problematization

Problematization involves systematic questioning of some aspect of the dominant perspectives and theories, while at the same time offering a positive or constructive formulation of interesting research questions. As described earlier, this article refers primarily to the problematization connected to the use of the running technique in trauma therapy.

A major problematization process has been how we, as professionals, use our authority in the therapy process. In the running technique, the therapist is very direct and active. For example, if the client doesn’t start running when the therapist thinks it is time to run, the therapist has the authority to demand that the client start running. The theory is, in short, that it is good to release the flight reflex, and that it will heal the trauma. However, what if the issue is not the flight reflex, but another reflex, or what if the client has a major problem with direct authority that leads to their collapse? This example also shows a potential conflict between strictly following the method, or relating to the client.

In addition to this example, we problematized the running technique in detail. Examples include the following:

- How to support the client’s orientation skills through sensory rehabilitation of proprioception, the vestibular system, and visual system
- How early in the process should the client start to move (run) to a safe place
- Different styles of moving to a safe place, instead of running
- How the context at the time of trauma influences the technique
- How conflicts between the protective and flight instincts affect the outcome
- How the technique impacts the attachment system
- How different attachment styles are challenged

This problematization led us to formulate hypotheses connected to dosing, sensory rehabilitation of trauma, hypo responses, authority issues, the relational aspect of skill training, disgust, memory processes in trauma, hypoaousal, as well as which elements are more significant in trauma therapy, and in what sequence they benefit being worked on. Our journey toward broad scholarship is fundamental for this process.

4. Broad scholarship

Our interpretive repertoire for the research process in creating Relational Trauma Therapy can be categorized into shallow (lay) and deep (scholarly) repertoires. The deep repertoire includes the theories and practices in which we are educated at a high level. Both of us have been teachers and supervisors in Bodydynamic Analysis. After leaving the Bodydynamic system, Merete committed to learn Systems–Centered Therapy (Agazarian and Gant), and intensively engaged in the Intermediate training level. I started part-time at the university, writing my bachelor’s thesis on post-traumatic growth (Calhoun and Tedeshi) and an exam paper on disgust (Nussbaum, Rozin, and Herz). My master’s thesis was on how to communicate with traumatized youths, with a focus on a care ethical perspective (Tove Pettersen) in the memory retrieval process (Chris Brewin, Anke Ehlers, Emily Holmes, Åse Langballe, and Asbjørn Rachlew). The thesis was grounded in police interviews of traumatized youths from the Utøya terrorist attack. During the last three years, I have been studying pain and performance neurological training (Z–Health). Currently, we are integrating neurologically-informed interventions into Relational Trauma Therapy.

At the same time, though not at a deep level, our shallow repertoire allows us to use the theories and practices we know when their research improves our interventions. The shallow repertoire is brought into our research if the empirical material is in line with this research, and if it becomes more interesting when in the new framework. The most important contributions have come through
reading the works of Ruth Lanius, Jaak Panksepp, Stephen Forges, Allan Schore, and Ellert Niejenhuis. Merete has been in dialogue with Babette Rothschild, Eric Wolterstorff, David Baldwin, Yvonne Agazarian, Tom Wannecke, Kathrin Stauffer, Flemming Kærøeby, and Mari-anne Bentzen. We have integrated theories and practices from these authors that are now part of our curriculum. Since 2012, Merete has also written four articles that have been accepted in scientific peer-reviewed journals, in which we presented our new trauma methods to the professional community and began a dialogue with the professional field.

Our broad scholarship has allowed us to develop significant parts of our interpretive tools, and made it possible for us to conduct a more complex investigation of the use of the running technique. At the same time, it has provided the foundation from which to develop the Relational Trauma Therapy method. Engaging a dialogue between our shallow and deep repertoires has been an important part of developing a self-critical use of theory in theory development.

5. Reflexive critique

Reflexive critique, as seen from Alvesson and Kärreman’s perspective, is when the researcher takes great care in constructing the data, and moves to new positions to unlock and disembed from the previous position. The point of using multiple perspectives is that each new perspective should add greater value to the theory’s development.

Merete’s and my research journey has been guided by curiosity and pragmatism. Our goal has been to develop methods that help the professional trauma field get one step further in creating functional methods for clinical treatment, and for developing resilient therapists. We have had ongoing doubts about our vocabulary, and offer our perspective as one of many. Our frame of interpretation has evolved over many years, typically with Merete being overly optimistic about a new theory or method’s possibilities, and myself dissecting it and looking at all the problems. At the same time, I have rapidly integrated new perspectives and exercises into our training, and Merete has sometimes slowed down my tempo so that in my enthusiasm, I do not introduce too much complexity.

Every new theoretical piece or practical exercise has been scrutinized from many angles. An important tool for this is Merete’s meticulous notes from our training. These notes describe the exercises we used, the group’s main process, every new process we had not seen before, and ideas and critiques that came to us during the training. Every time we begin a new training, we take some time to go through all the notes, and look at the structure of the training, with the new perspectives we have gained since the previous training. Every year, we also set aside time for theory development based upon the notes and new theories that we have encountered.

Since 2008 we have been dissecting different parts of the running technique, adding new elements and creating new methodology. Along the way, we have been each other’s critics and support in the integration of new knowledge. The ideal of reflexive critique has at times, been time-consuming and resulted in a lot of re-reading. Integrating new knowledge is often fruitful, but also creates hypotheses that can lead to dead ends. At the same time, this process has deeply inspired us to teach and try new hypotheses in our trainings.

Concluding comments

Using as background Alvesson and Kärreman’s five methodological principles for a qualitative research process in theory development, I have presented a problematization of the running technique used in the Bodinm shock trauma method. The problematization revealed the (problematic) restrictive impact the technique had on trauma clients. This led us to create new theory and methods.

In a critical dialogue between theory and empirical data, it became evident through (de)fragmentation that the collapse reaction in clients was a mystery. A mystery is a finding that lacks documentation in theory and earlier research. Through problematization, many aspects of the technique were highlighted and solved through dialogue with theories and methods from different trauma therapies.

Merete’s and my broad scholarship is the basis for the reflexive critique of our findings and creation of a new methodology. The methods used in Relational Trauma Therapy have been subjected to years of scrutiny, and are refined with each new training. In constructing a new methodology, therapist interventions are classified into three categories – the interventions aim to support arousal regulation, and resolve authority issues and attachment dynamics connected to unresolved trauma states. Our experience and hypothesis show that these three categories of interventions work best in that sequence. Developing a methodology for this is a possible next step.

The breakdown of the running technique served as a theory and method-generating tool for many years. The process has in many ways resembled the discussion comparing methods for working with simple PTSD issues to methods for working with complex PTSD problems. The strength of Relational Trauma Therapy is its pragmatic and practical use. Based upon years of experience, these methods can be tailor-made for different trauma states, but remain at an experimental level.
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ABSTRACT

Tea is a young Italian woman with borderline personality disorder. After taking her clinical history, we use Character-Analytic Vegetotherapy to summarize her therapeutic process and how it manifests as activation in her body. We review the theory of borderline disorder in contemporary Reichian analysis. Character-Analytic Vegetotherapy is presented as an embodied therapeutic technique with remarkable complexity and methodological articulation.

Keywords: Reichian psychotherapy, borderline disorder, body psychotherapy activations, primary object relations, therapeutic relationship, Character-Analytic Vegetotherapy

Tea’s Clinical History

Request for treatment

Tea, a 23-year-old woman was referred about three years ago by a colleague who was her mother’s psychotherapist. A very beautiful girl, she is tall, slender, with long brown hair, deep dark eyes, and a manner simultaneously resolute and fragile.

Her request for analysis is motivated by the insecurity she feels. She lives with her mother, who has been separated from her father for many years. Tea struggled to obtain her secondary diploma, does not like to study, and works in civil service, which gives her a small income. She would like to leave home, but cannot afford it. She takes courses in juggling, and hopes to become a professional juggler and travel the world as part of a circus.

When she needs money, she goes “to the traffic light” – in other words, she puts on a juggling show in front of cars stopped at red lights. She reports good earnings, up to 100 euros a day. The problem is that the smog she breathes all day gives her severe headaches and causes breathing difficulties. She is highly guarded and not very trusting.

As Tea slowly becomes more communicative in our relationship, she begins to talk about her deep distress, her unruly adolescence when she ran away from home several times, and her use of all types of drugs – including heroin, for which she prostituted herself. She attended rave parties, took drugs, and went missing from home and school for several days until the police, alerted by her parents, found her. She was promiscuous, had sexual dysfunction, and mentions being sexually assaulted when she was 18. As she matured, she outgrew and is now ashamed of her wild and impulsive adolescent phase. She would like to settle down in a quieter lifestyle through which she could fulfill her desires, but is not sure what they are.
Anamnesis

Her father and mother met in a care cooperative where they did volunteer work. Her father works at a public institution, but is also a well-known musician who plays tenor sax and transverse flute, teaches music, and performs with his band. Tea holds her father in high esteem, and describes him as impulsive, strict, and authoritarian. Her mother, in contrast, comes from a small town in southern Italy, settled in Rome to study psychology, and, although she has a degree, does not practice as a psychologist but works in a training center. She is socially active in volunteer work, was a staunch feminist, and tries hard to find Tea work opportunities. Tea describes her as joyful, independent and strong – the woman she would like to be. Her mother’s two sisters both fell ill with breast cancer and died. This happened during Tea’s childhood, and touched her deeply.

Shortly after they met, her parents moved in together and later married. Tea was wanted and the pregnancy went well, but two negative events happened during gestation. Her mother learned that one of her sisters had cancer, and then realized she had been betrayed by her husband after she accidentally discovered a letter sent to him by another woman. Her mother cried for days, and a marital crisis ensued. Eventually, the parents made up and her mother forgave her father. Tea’s birth was induced, as the pregnancy was over a week late. She was breastfed.

Of her childhood, Tea remembers mostly the fights between her parents, and the day they told her that they wanted to separate. Soon afterwards, her father left home. She recounts that when they told her about their decision, somewhat embarrassed, she found them “ridiculous” because although she was only eight years old, she had already figured it all out. She had a good relationship with her father; when he left, she remembers suffering greatly from abandonment. “I grew up without a father,” she says, and “my mother was both father and mother.” Now, she still feels somewhat angry with her father, who she continues to see, and who continues to pay a portion of her living expenses.

Since childhood, Tea has always been unconventional, and rebelled against the rules. At 15, she began using drugs to inhabit a different reality because the reality she knew was full of problems. There was no communication at school, and she could relate only to the “outliers.” At one point, her dream world and the real world became merged. Methadone helped her get off heroin, and later married. Tea was wanted and the pregnancy went well, but two negative events happened during gestation. Her mother learned that one of her sisters had cancer, and then realized she had been betrayed by her husband after she accidentally discovered a letter sent to him by another woman. Her mother cried for days, and a marital crisis ensued. Eventually, the parents made up and her mother forgave her father. Tea’s birth was induced, as the pregnancy was over a week late. She was breastfed.

The therapeutic relationship

The setting with Tea is difficult; she requires great acceptance “with inclusion at a fair distance” and great care “with reasonable and intelligent challenge.” Tea has established a good relationship with the analyst, but she struggles to be consistent, and the therapeutic path is infused with her fickleness and impulsivity. She comes consistently for months, then disappears for weeks. When the analyst thinks he has lost her, she suddenly calls back to schedule a session as if nothing happened. The analyst tries to be firm and set clear boundaries, and asks her to pay for sessions missed without warning. Tea returns repentant, admits to behaving “badly,” and says she is wrong. Sometimes she comes to the session and curls up in the corner of the room, wanting to talk from there. Other times, she refuses to use the waiting room and waits on the stairs of the building.

Slowly, she becomes more stable in life, finishes her civil service, does various odd jobs, and drops the juggling course. For weeks she works, attends a yoga class, tries to go out less at night. Then she again feels the need to transgress, goes out and hangs out all night, gets drunk, and sleeps with the first man she meets. Then she comes to therapy and cries, saying she can’t stand it when she does that. She has relationships with men with whom she promptly falls in love, but her impulsive behavior and unpredictability drive them away. She feels rejected, excluded, and in pain. When calmer, she says she is afraid of therapy because analysis “makes her normal,” and she does not want to be normal and lead a mediocre life. Periodically, she comes to therapy angry, shows all his distrust, says that the analyst is taking away her creative, lively side and wants her to become like everyone else in a squalid world, only in the end, to be abandoned by the analyst as well. At another time, she confesses that she has been meeting with another psychotherapist with whom she feels very comfortable. However, when she told him that she was already in analysis, the colleague correctly suggested that she must first clarify her therapeutic situation with the analyst, and she stops seeing him.

She begins to cultivate various interests; she is passionate about ecology, meditation, and yogic and shamanic practices. She enrolls in a course to become a yoga teacher. She then systematically looks for work and becomes a model, posing for various art academies even though she confesses being ashamed to stand naked for hours in front of strangers. But they pay her well, and the overall situation is much better than waitressing. Finally, her desire to study psychology emerges; she wants to devote herself to her passion for interiority in a professional manner. In recent months she has been studying quite steadily to pass the faculty entrance exam.

During the three years of therapy, Tea’s impulsiveness and anger have greatly diminished, her relationships have become more stable, and she has learned to trust and become more of a planner. The theme of addiction
lingers “like an undercurrent,” she says, but her suffering over her father’s abandonment has been explored, as has her love–hate relationship with her mother. Her negative introjects have become less threatening, as has the threat she felt from the outside world that led her to flee or be vulnerable to manipulation by others.

Body psychotherapy activations

Character-Analytic Vegetotherapy was a very important aspect of Tea’s therapeutic journey. From the earliest analytic stages, bodywork with her eyes (using still point with light) allowed her to establish boundaries and a more appropriate sense of reality – crucial elements with a borderline, in addition to giving her appropriate countertransferenceal mirroring contact.

Therapy was a gradual process in which it was essential to reestablish, through breath awareness and eye mobility, contact with her body, its boundaries and a firmer sense of the ego and its subjectivity. Given the fragility of her structure, body psychotherapy was geared toward defining boundaries, feeling more stable, and processing her high reactivity. After deeper self-awareness was established, it became possible to process her fear and sense of abandonment, and she felt the emotions resonate in her chest. The work was gentle, respectful of her limits, and gradually confronted her fear of the terrifying emotions she felt dwelling inside – “her monsters,” as she liked to call them.

Finally, only recently has she been able to talk about the sexual violence she suffered at age 18 – an assault perpetrated by multiple boys at the end of an evening when she was completely drunk and drugged. She remembers almost nothing. It is like a dream, but a dream that comes back in the form of flashbacks that continue to haunt her even now.

The Borderline Disorder

As we see from Tea’s clinical case, borderline is among the disorders that used to be grouped under marginally defined categories. According to Kernberg’s terminology, the psychopathological manifestations that lie between neurosis and psychosis; something uncertain, insufficiently characterized that cannot be included in clearly defined categories.

If we consider the DSM–5, Tea’s diagnosis might be borderline personality disorder. In particular, of the nine prognostic criteria given by the DSM–5, some appear particularly fitting:

- Unstable and intense interpersonal relationships characterized by alternating extremes of hyper–idealization and devaluation
- Altered identity, markedly and persistently unstable self–image and self–perception
- Impulsivity in at least two areas that are potentially harmful to the subject, such as spending, sex, substance abuse, reckless driving, binge drinking
- Affective instability due to marked mood reactivity, such as episodic intense dysphoria, irritability or anxiety, usually lasting a few hours, and only rarely more than a few days
- Unmotivated and intense anger, or difficulty controlling anger

For Reichian analysts, borderline disorder is etiologically defined by an insufficient and unsatisfactory self and other-than-self circuit originating before birth, as early as in the maternal fetal relationship. We thus define an old etiology, speak of an unsatisfied intrauterine block, considering the borderline disorder as tracing back to a defective primary object relationship, already insufficient at the dawn of life.

This implies a necessarily low energetic density with a low relational exchange, having consequent effects on the resilience of the primary maternal object relationship. We then have a low dynamic, ambivalent, borderline relationship with objects that will pick up maternal projections in the future. There is never a true separation, but there are attempts through constant approaches and departures, often with explosions due to unsustainable energy field interactions. In fact, borderline individuals always move on the boundary of relationships, at an energetic safe distance. They are forced to oscillate between getting closer, but not too close, because the other’s greater attractive self-density becomes threatening and annihilating and moving away, but not too far, for fear of being abandoned and unable to survive and sustain the chronic feelings of emptiness of the self. If they get too close, they risk disappearing into the relationship – that is, not existing, not having an identity – or, if they move too far away, they experience an unbearable emptiness. They are thus forced to oscillate on either side of the relational edge.

On this first dynamic of primary ancestral object relationship which demands implicit and impossible satisfaction, a second one is layered which carries short-circuited impulsivity. This is the implicit demand for a phallic–narcissistic recognition from an anguished mother. The child comes forward as the phallic candi-
date who wants to make the parent of the opposite sex “smile,” but shows an unbearable disappointment at this vulnerability.

Borderline disorder, in our negentropic systemic reading, is a personality structure with low primary density and resilience. It is a weak, light, almost rarefied, highly permeable, unstable and variable structure, deeply frightened and easily bewildered. It is a structure on the edge, on the border, and at the limit between medium and very low density, between neurosis and psychosis. The symptoms become clearly psychotic the moment the self is subjected to further lowering of energy, and result in decompensation. In other words, in the border structure, there is a mild compensation of successive fixations of more evolved non-prevalent genito-ocular traits. Because an energetic lowering, in the here and now, can eliminate the coverings and establish a consequent decompensation, it would be more clinically accurate to call it “a depression masquerading as psychosis.”

**Character-Analytic Vegetotherapy in Contemporary Reichian Analysis**

In 1935, Reich identified the main modality of body psychotherapy to be Character-Analytic Vegetotherapy, a structured and intelligent set of body expressive modalities, enriched by refinements produced by four generations of direct and successive students of Reichian analysts, such as Raknes, Navarro, and Ferri.

These psychocorporeal activations, also called actings, are experienced by the patient in relation to the history and therapeutic relationship present in the analytic setting. These actings are identified according to a psycho-emotional reading of the patient's body, its muscular and neuro-vegetative blocks, and are related to different childhood developmental stages and therefore specific relational and attachment history.

The blocks are layered in seven body levels that express not only the patient’s history and imprints, but also the architecture of trait patterns. Actings – or psychotherapy activations – are a complex system; they are progressive and specific, related to developmental stages, trait patterns, and connected body levels. They represent internal time in dual directionality (top down and bottom up) leading to the various planes, more or less ancient, of our life stages. Through bodily expressions, they re-actualize partial object relations as they were marked at the body levels, and constitute fundamental energetic-emotional and psychodynamic insights.

If we conceive borderline disorder and its low-density architecture to be established early in intrauterine life, we might consider the body segments. With Tea, we selected the bodywork on the eyes that allows the analyst, from the earliest analytic stages, to build boundaries and formulate a more appropriate sense of reality – crucial elements in a borderline, as well as in appropriate mirroring contact.

For each patient, and for each body segment, we wonder what emotional intelligence is implied. In the specifics of Tea’s case, where do her eyes rest on the arrow of internal time? What relational story do they tell? Do these eyes no longer see? Are they empty, distant, elsewhere? Are they stunned and panicked? Are they avoidant, aimed at infinity, unable to converge on a point? But also: is this gaze demanding, suspicious, furtive, icy, moist, luminous, or enthusiastic?

All these observations tell us about Tea’s ocular development and the primary relationship with her mother that is structured in the visual relationship of the earliest stages of breastfeeding. With Tea, the experience of vegetotherapy through the initial work on the ocular segment was instrumental in helping her find a more stable sense of ego, and restructuring, in a way that was not only cognitive, but above all bodily-emotional, the initial attachment relationship she experienced with her mother in the earliest stages of life and breastfeeding.

The bodily levels, still present in the here and now, with their relational engrained patterns, thus constitute the gateway for therapeutic embodied activation, the peripheral afferent from which to access the central areas and intelligently harmonize the personality. They propose a new prototype of object relations in the here and now, new in patterns, new in the renewed energy circuit.

The actings of Character-Analytic Vegetotherapy connect there-and-then with the here-and-now, depth with surface, unconscious with conscious, implicit with explicit memory, corporeality with subjectivity. They create new sensory channels, form new brain maps, activate possible receptors of pleasure, and free internal time sequestered in body blocks. They enable the transformation of the embodied mind, increasing cognition and feeling, resulting in greater intelligence of mind and subjectivity of Self.
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ABSTRACT

In this article, I will introduce concepts from biology, chemistry, thermodynamics, and information theory to derive a unified theory on how life is sustained, based on the reduction of entropy (disorder) within living organisms. I will use information theoretic neuroscience to show how the concept of entropy can be applied to psychology, and to suggest that emotions represent entropy within the unitary psychosomatic structure. I will discuss the relationship between emotions and feelings, and the role that each plays within the psyche. Based on these roles, I will present a technique to discharge excess emotional energy. I will also introduce a simplified theory of object relations and self-psychology based on the reduction of entropy, and a technique to speed up the treatment of relational trauma. On that basis, I will discuss memory reconsolidation theory, and show how traumatic memories can be revised during the reconsolidation phase. Two techniques, based on memory reconsolidation theory and information theoretic neuroscience, will then be introduced that can be highly effective in treating shock trauma and erasing the emotional content of traumatic memories.

The Beginning of Life

Earth was formed about 4.5 billion years ago, and life began here about a billion years later. The oldest fossilized microbes provide evidence that life on Earth might have appeared 3.8 billion years ago. But how did life begin on our planet? This is an old question that many have attempted to answer, yet no fully satisfactory response has yet been offered.

In 1924, the Soviet chemist Alexander Oparin (1965) and, independently in 1929, the British biologist John Haldane hypothesized that Earth’s early atmosphere was very reducing – in other words, limited in oxygen (Tirard, 2017). Under these conditions, in the primordial soup of oceans filled with organic molecules and powered by the sun, Oparin and Haldane both hypothesized that organic molecules could have gone through a series of reactions resulting in the formation of more complex organic molecules and compounds. Oparin (1965) further hypothesized that organic molecules could have gone through a series of reactions resulting in the formation of more complex organic molecules and compounds. Oparin (1965) further hypothesized that early protocells formed in this manner might have been coacervates (Figure 1). In water, organic materials do not disperse uniformly, but instead lump together and may form droplets (as when oil is added to water). If these droplets form in an aqueous environment as colloids (a homogeneous substance consisting of large molecules) tightly surrounded by a semipermeable boundary of water containing complex organic compounds and molecules, they are then known as coacervates.

Coacervates have the interesting property in that they allow absorption of simpler organic compounds from their environment – a process that Oparin believed was similar to metabolism (Oparin, 1965). Oparin found that, under certain conditions, coacervates can be stabilized in water for weeks if they can me-
To metabolize energy, Oparin added enzymes and glucose to the water. Coacervates absorbed the enzymes and glucose, and the enzymes caused them to combine the glucose with carbohydrates already present in the coacervate. This caused the coacervates to grow in size. Waste products from the reaction with glucose were expelled. Once the coacervates became sufficiently large, they began to spontaneously break up into smaller coacervates (Oparin, 1965, p. 250–252), and the process continued. It is noteworthy that by absorbing matter and energy, a structure as simple as a coacervate can maintain some semblance of order within its boundary. Interested readers must note that coacervates are not cells, and lack the conditions of life. However, coacervates have boundaries, exchange energy with their environments, and can grow in size (Oparin, 1965, p. 250–252). They can thus be considered simple systems capable of maintaining a certain degree of order within their boundaries. The Oparin–Haldane hypothesis has recently received renewed interest, and coacervation theory, and coacervates as early protocells, are topics of active research (Lazcano, 2015).

**Systems**

A system can be viewed as a group of interacting, interrelated, and interdependent elements, as well as bounded processes. Systems transform inputs that are consumed into outputs that are produced. A system is characterized by its boundary, which separates it from its environment or surroundings. This boundary may be real or notional, but it defines a finite volume within which the system operates, and exchanges energy and/or matter with its surroundings. Systems are also characterized by their internal laws of function. A general system model is shown in Figure 2. Systems can be open or closed.

The dynamical system concept describes the behavior of the system as dependent on the time and position of the system in space. Complexity in a system indicates how relationships between parts give rise to new behaviors, and how the system interacts and forms new relationships with its environment. Complex systems are open and dynamic, and tend to be self-organizing. Self-organization is the process by which the system may form a structure or pattern in its behavior without imposition by an external entity or element. This structure or pattern forms from the interaction of elements that make up the system, and results in self-organization.

Living organisms can be considered as dynamic systems in the most general sense of the term, and are considered subsets of all systems. By definition, living systems are complex and self-organizing, with the special characteristics of life, and interact with their environments (open). Interaction with the environment generally takes place by means of material–energy exchanges that are governed by the laws of thermodynamics, which I will discuss next. Living systems can be as simple as a single cell, or as complex as human beings.

**Life and Entropy**

Readers may skip the mathematical concepts and formulas; they are included in this article for rigor, accuracy, and thoroughness, but they are not necessary to fully understand this work. Readers may simply focus on how these concepts are interpreted.

Thermodynamics is a branch of physics that explores the relationship between heat and other forms of energy. Most of us are familiar with the first law of thermodynamics, which essentially states that energy cannot be created or destroyed (the law of energy conservation). Of interest here is the second law of thermodynamics, which states that during energy exchanges between systems (or transfer of energy within a system),thermodynamics is a branch of physics that explores the relationship between heat and other forms of energy. Most of us are familiar with the first law of thermodynamics, which essentially states that energy cannot be created or destroyed (the law of energy conservation). Of interest here is the second law of thermodynamics, which states that during energy exchanges between systems (or transfer of energy within a system),
more and more energy is wasted, and systems move more and more toward disorder (greater entropy). Entropy, “S” in thermodynamics, is defined as the ratio of energy supplied over the absolute temperature at which it is supplied (Van Ness, 1969). That is, \( S = Q / T \). \( Q \) is the energy measured in joules, and \( T \) is the absolute temperature measured in degrees Kelvin. For example, suppose that 5,000 joules of energy are transferred from a hot reservoir at 500 °K to a cold reservoir at 200 °K, assuming no change in temperature and no loss of energy due to work. The change in entropy is \( \Delta S_{\text{net}} = S_h + S_c = -5,000 / 500 + 5,000 / 200 = 15 \). The ‘-’ sign indicates the negative transfer of energy from the hot reservoir, and \( \Delta \) denotes difference. The entropy of the system of hot and cold reservoirs increases as energy is transferred from one reservoir to another. The second law of thermodynamics indicates that the change in entropy is always positive. Furthermore, the increase in entropy results in a certain amount of energy not being available for work after the transfer. The wasted energy is \( \Delta S \times T \), which in the above example is \( 15 \times 200 = 3,000 \) joules. As mentioned, an increase in entropy is related to increased disorder. This can be seen by considering a melting ice cube. Energy transferred to the ice results in melting, and transforms ice into water. It is clear that molecules in water move more randomly (with greater disorder) than do molecules in ice, and are thus more disordered. This process is depicted in Figure 3.

In summary, the second law of thermodynamics implies that anything that occurs in any part of the world increases entropy in that part of the world.

In statistical mechanics, entropy is defined as \( S = k \log(D) \); “\( \log \)” is the logarithm (for example, \( \log(100) = 2 \) since \( 10^2 = 100 \)), and \( k \) is the Boltzmann constant, which is \( 1.380649 \times 10^{-23} \text{ J/K} \) (joules/degrees Kelvin), and \( D \) is related to disorder in the system (Van Ness, 1969). This equation can also be written as \( S = k \sum -p_i \log(p_i) \), where \( \sum \) denotes the sum, and \( p_i \) is the probability that a system with countable energetic microstates has \( n \) particles in state \( i \) (position and momentum of particles) ‘i’, or simply the number of particles in state \( i \) over the total number of particles \( (p_i = n_i / n) \).

For example, consider water molecules and their position and momentum within liquid. The definitions of entropy described above are equivalent, but its proof is beyond the scope of this article. For proof, see Van Ness (1969, p. 94). Of interest here, however, are two boundary conditions: minimum and maximum entropy in systems. Entropy is zero in a crystal, as the particles are arranged in a fixed pattern, and only one state exists, which can be determined by \( p_i = 1 \). Note that \( \log(1) = 0 \) \( (10^0 = 1) \), and thus the sum above will equal zero. On the other hand, entropy is at its maximum when the system approaches thermodynamic equilibrium – that is, when all the energy in the system has been exhausted, and the temperature in the system is uniform. The system is then left in a completely unpredictable state, with state probabilities all being equal – that is, every state is equally likely resulting in maximum entropy. The sum is maximized when all probabilities are equal. In other words, entropy reaches its maximum when the system decays and no longer has enough energy to produce work, resulting in thermodynamic death. Throughout this article, the word entropy can be understood to mean disorder, chaos, uncertainty, unpredictability, and uncountability.

In his 1944 publication What is Life?, Erwin Schrödinger (1967), the Nobel prize laureate in physics, introduced the concept of negative entropy and declared that life feeds on negative entropy (or negentropy). As discussed above, entropy is not negative, and this is guaranteed by the second law of thermodynamics. In other words, entropy always increases in isolated systems. If entropy is reduced in a system, it must increase somewhere else, and the net result is always positive. Schrödinger was referring to order when he wrote about negative entropy. Thus, if entropy is a measure of disorder, then negative entropy is a measure of order (Schrödinger, 1967). Mathematically, we can write \( -S = k \log(1 / D) \), since \( \log(D) = -\log(1 / D) \). Therefore, if “\( D \)” is the measure of disorder, then “\( 1 / D \)” is the measure of order. Thus, in an open system that is not isolated, it is possible for entropy to decrease via the exchange of energy and matter. This reduction of entropy within the system results in an increase of entropy outside the system. Thus, according to Schrödinger, life is based on reducing entropy within the living organism.

Schrödinger argued that by exchanging energy and matter, and through the process of assimilation, the living organism (an open, dynamic, and complex system) can decrease its internal entropy. Excess entropy is discharged from the living organism through heat, work, and the expulsion of waste after energy has been absorbed. The organism can then continue to thrive as long as it can maintain the condition of negative entropy (decreasing entropy relative to the surrounding environment). In other words, the living organism avoids increasing entropy (disorder) by continuously absorb-
ing order (negative entropy) from its environment (Schrödinger, 1967). However, nothing escapes the second law of thermodynamics, which will eventually take over as the organism decays, reaches thermodynamic equilibrium, and dies (see del Castillo and Vera-Cruz, 2011). Recently, there has also been renewed interest in Schrödinger’s controversial theory within the field of somatic psychotherapy (Ferri & Cimini, 2021).

In biology, the conditions for life described above are associated with biological homeostasis – the ability of an organism to maintain internal equilibrium. It can also refer to the organism’s ability to remain within its optimal range of function despite changing environmental conditions. Here, I will focus only on the thermodynamic view of life for reasons that will become apparent below – namely, if the soma thrives on feeding negative entropy (reducing entropy within the organism), so should the psyche! From this point on, the word entropy should be understood to connote disorder, uncertainty, and unpredictability.

In two recent books that have very recently come to my attention, I was interested to see Damasio (2021) and Solms (2021) also discuss, respectively, homeostasis and the free energy principle. The free energy principle is closely related to the concepts presented in this paper, which I independently developed. According to Solms, he and Damasio had a heated discussion about their somewhat differing ideas about consciousness in Damasio’s office (Solms, 2021, p. 154), which might have provided the impetus for their books on the subject.

**Entropy and Information**

In the late 1940s, Claude Shannon, the father of information theory, was working at Bell Laboratories (where I also worked early in my career). There, he investigated the loss of information (energy) in telephone lines. He formulated and modeled information loss, and referred to it as the “uncertainty function.” Later, John von Neumann, the mathematician and father of modern computer architecture, correlated Shannon’s uncertainty function to the thermodynamic concept of entropy, and encouraged Shannon to call his uncertainty function entropy. In “A Mathematical Theory of Communication,” published in Bell Systems Technical Journal, Shannon formally introduced the concept of information theory (Shannon, 1948).

According to information theory, the information contained in an event’s occurrence is inversely proportional to its probability of occurrence, \( p \) (a number between 0 and 1). Thus, the more likely the occurrence of an event, the less information the event contains. Conversely, the less likely the occurrence of an event, the more information it contains. For instance, the sentence “There is at least one rainy day in a year” contains very little information, since the assertion is very likely to be valid. But “It will rain tomorrow” carries much more information, as it is less likely that it will rain tomorrow than that there will be one rainy day in a year. In other words, events that are predictable contain less information, while unpredictable events contain more information. Interested readers may already discern the connection between thermodynamic entropy and Shannon’s notion of entropy.

Shannon (1948) quantified the information ‘I’ contained in an event with probability ‘p’ (a number between 0 and 1), according to this formula:

\[
I = \log (1/p)
\]

Where ‘\( \log \)’ is logarithm in base 2 (a quantity representing the power to which a fixed number – the base – must be raised to produce a given number; for example, \( \log (8) \) in base 2 is 3, since 2 to the power of 3 is 8). The information ‘I’ is measured in bits. Shannon (1948) formally introduced the concept of entropy, which measures the information content of an event, \( E \), that contains \( n \) outcomes. Entropy is simply the statistical average of information ‘I’ contained in the occurrence of each outcome of event \( E \). Entropy, \( H \) is defined as:

\[
H = \sum p_i \log (1/p_i)
\]

where \( \sum \) is the summation over all values of \( i \). Shannon (1948) also introduced the concept of mutual information \( I(X; Y) \), which is a measure that indicates how much uncertainty is reduced relative to the occurrence of event \( X \), given that a related event \( Y \) has occurred. Or, \( I(X; Y) \) indicates how much information \( Y \) provides about \( X \) (Pierce, 1980).

\[
I(X; Y) = H(X) - H(X | Y)
\]

\( H(X | Y) \) is the conditional entropy (uncertainty) of event \( X \), given that event \( Y \) has occurred. Mutual information is also measured in bits.

Shannon (1948) computed the channel capacity \( C \) as the maximum amount of information that can be transmitted through a channel. An implication of channel capacity, as applied to the brain’s sensory information processing, is that sensory information encoding must be efficient, and that neurons must be expressing their full output capacity in order to encode sensory information (with little loss), subject to the limits imposed by channel capacity. In the field of neuroscience and information theory, this is known as the efficient coding hypothesis. Loh and Bartulovic (2014, p. 1) write: “The Efficient Coding Hypothesis, suggests that sensory relays re-code sensory messages, so that their redundancy is reduced, but little information is lost. Coding to reduce redundancy eliminates wasteful neural activity, and also organizes sensory information such that an internal model of the environment causing the past sensory inputs to built up, while the current sensory situation is
represented in a way that simplifies the task of the part of the nervous system which is responsible for learning and conditioning.9

The efficient coding hypothesis, also known as the redundancy reducing hypothesis, was introduced by Horace Barlow (1961).9 If biological systems must minimize their entropy, and entropy is the average information, then it follows that they must keep the flow of information they process to a minimum" (Solms, 2021, p 172). Solms (2021, p. 172) writes further: “Self-organizing systems must minimize information flow, because increasing information demand implies increasing uncertainty in the predictive model. Uncertainty yields surprises, which are bad for us biological systems because they can be dangerous."9

Barlow (1961) argued that laws of nature bring order and simplicity to our complex sensory experiences (lower entropy). He further argued that the brain’s communication and coding of information should be fast, precise, and minimally redundant (efficient), and should work regardless of interference in the communication channel. The associativity of memories can be considered a direct corollary of Barlow’s hypothesis, since by encoding associated (correlated) information together, redundancy is reduced, as memories are not encoded in separate and redundant parts. Another corollary of Barlow’s hypothesis is that when a memory is recalled, all associated previously encoded memories are also primed for recall, and thus the constituent neural networks have a higher probability of becoming activated. Redundancy in information theory is defined as (Pierce, 1980):

\[
R = 1 - \frac{I}{C}
\]

Where ‘R’ is a measure of redundancy, ‘I’ is mutual information, and ‘C’ is the channel capacity, which is fixed and depends on the nature and characteristics of the channel. In this formula, it is clear that redundancy is minimized when mutual information is maximized – which essentially means that the goal of the nervous system is to maximize information about the environment (more predictable; lower entropy). We can readily observe that mutual information, \(I(X; Y)\), is maximized when conditional entropy \(H(X | Y)\) is minimized. \(H(X | Y)\) is minimized when our uncertainty about the occurrence of event \(X\) is minimized, given that event \(Y\) has occurred in the past. Conditional entropy \(H(X | Y)\) is reduced when event \(X\) in the present bears some resemblance to event \(Y\) in the past, which exists in memory – in other words, when events \(X\) and \(Y\) are highly correlated. It is also important to note that the brain does not simply compute the correlation between sensory inputs corresponding to event \(X\) and events \(Y\) that occurred in the past. It begins the computation with events that have higher information content (higher entropy) that are more significant. Not only do neuroscience and information theory prove this assertion, but it is also important to note that this would have had significant evolutionary advantages, in that previously encoded events with high information content were generally more important and more relevant to the survival of our species.

A corollary of Barlow’s hypothesis is that our nervous system moves toward predictability, and avoids "high entropy" and unpredictability. Thus, the nervous system feeds on negative entropy, in the information theoretic sense. Viewed rather simplistically, our brain can be thought of as an information processing machine constantly trying to reduce unpredictability by correlating and comparing sensory input to encoded past events with high information content (entropy), and finding the closest match for a response – thus increasing mutual information and reducing redundancy in encoding sensory input. Pfaff (2006) relates brain arousal and emotion to information and entropy, thus indicating that by their very nature, emotionally significant events contain more information and are more unpredictable.

The efficient coding hypothesis can thus be seen as in complete accord with my hypothesis that if the soma feeds on negative entropy, so does the psyche. In other words, the psyche feeds on the reduction of information (negative entropy).

Information and Emotions

What are emotions? All living organisms, from single-celled amoebea to humans, are born with innate abilities that evolved to solve the basic challenges of life (lower entropy – increase order). These challenges include finding sources of energy; incorporating, consuming, and transforming energy and matter; maintaining internal biochemical balance; repairing damage to maintain structure; and defending against external threats (Damasio, 2000). Complex living systems tend to move toward homeostasis (lower entropy); that is, toward self-regulation and stability (Avery, 2012).

At the very bottom of the evolutionary ladder, we find single-celled organisms with simple processes that promote homeostasis – including approaching or withdrawing from an object, assimilating nutrients, and discharging waste. As we move up the ladder to multicellular organisms, we find more complicated processes leading organisms to homeostasis. From primitive to complex, these processes include metabolic regulation, basic reflexes, immune responses, pain and pleasure behavior, drive and motivation, emotion, and feeling (Damasio, 2000). Note that these processes leading to biological homeostasis also reduce the organism’s entropy. For the purposes of this article, I am primarily concerned with drive, motivation, emotion, and feeling.
Drive and Motivation

Drive and motivation propel the organism to exchange matter and energy with its environment, to assimilate nutrients, to reduce inner tension, to explore the environment in order to avoid danger and overcome obstacles, and (in humans and other mammals) to seek objects for connection and contact. Thus, the goal of drives is not solely achieving satisfaction or seeking objects, but reducing entropy within the organism. Solms (2021, p. 177) writes: “The fundamental driving force behind the volitional behavior of all life forms is that they are obligated to minimize their own free energy. This principle governs everything they do.” Minimizing free energy (Solms, 2021; Friston, 2009) is equivalent to maximizing mutual information between sensory input and the organism’s internal states (stimulus and response). Interested readers can thus readily see the relationship between the free energy concept and the efficient coding hypothesis (Barlow, 1961), as discussed above.

In evolution, older systems are never replaced; they are simply modified and/or augmented with new systems. Emotions sit atop processes that promote homeostasis. We can thus say that emotions are biologically determined, and use the body as their vessel. Emotions play a regulatory role in the body, and are crucial in helping higher organisms maintain life (Damasio, 2000). In summary, emotions are part of an array of biological tools that higher organisms (humans and other mammals) use to regulate life. They play a fundamental role in steering higher organisms toward homeostasis (Damasio, 2000). In their simplest form, emotions correspond to energetic states of the body. They occur in the body as autonomic responses to external stimuli. However, bodily states (emotions) can also be created through the recall of memories, which Damasio (2000) calls the “as if” loops.

Based on the hypotheses presented in this article, emotions are fundamentally autonomic bodily responses to high entropy (unpredictable – novel) external environmental stimuli. As such, they represent increased entropy within the unitary psychosomatic structure; emotions are thus equivalent to entropy. In order for an organism to return to homeostasis, excess entropy (emotion) needs to be reduced and processed. In mammals, this reduction is primarily achieved through the body. Emotion (entropy) is processed and discharged predominantly through expression and by taking action. Mammals typically discharge residual energy related to emotion (entropy) by vibration, or other bodily mechanisms. Homo sapiens are endowed with the ability to block the expression of emotions to a certain extent (thus increasing entropy within the psychosomatic structure). How do these blocked emotions get released? The short answer is feelings!

Panksepp (1998), Damasio (2000, 1994), and LeDoux (2015) all agree that emotions are different from feelings. Feelings require conscious awareness, while emotions occur outside conscious control. The authors differ on the mechanisms of emotion and feeling, but agree that feelings require cognitive awareness, and are essentially limited to Homo sapiens. During the course of evolution, feelings resulted in enhanced emotional processing and perception within the human brain.

However, I posit that feelings serve another very important purpose: when accompanied by intention and full conscious awareness, they result in the discharge of residual emotion. As practitioners of mindfulness know, if we become mindful of an emotion (consciously aware), it will fade away and a state of temporary homeostasis may result. Siegel (2015) also indicates that emotions will weaken after 90 seconds if observed (felt). The role of feelings in processing and discharging emotion thus becomes clear. However, if emotion rises above a certain threshold (very high entropy), then the brain’s cognitive structures are no longer fully available to process and discharge emotion. In that case, some degree of emotion may need to be discharged through the body via expression, vibration, or other means before we can become consciously fully aware (feel) – which can then result in further discharge. Thus, an important role of feelings is to bring the organism back to homeostasis by discharging residual emotion and lowering entropy within the body. “After all, one of the foundations of consciousness is feeling, whose purpose it is to assist with the governance of life in line with homeostatic requirements” (Damasio, 2021, p. 131).

This assertion is valid for positive as well as negative emotions. In their most general sense, pain and pleasure are not emotions (LeDoux, 2015). They correspond to conditions of high and low entropy within the body. When the organism cannot efficiently manage its internal entropy, entropy will increase, which causes the body to react (possibly by contraction), which in turn causes pain and discomfort. On the other hand, pleasure is related to lower entropy and to expansion of the body (Reich, 1980, & Lowen, 1994). “The overall profiles and ease and relaxation contribute to feelings that we designate by such terms as well-being and pleasure; the contraction and strangulation patterns produce what we call discomfort and malaise... and the extreme discomfort that we designate as pain” (Damasio, 2021, p. 90).

Of course, practitioners of somatic psychotherapy have always implicitly known the importance of self-regulation (Reich, 1980), which is equivalent to lowering entropy, and maintaining low entropy, within the unitary psychosomatic structure. They also know that without emotional regulation (the ability to reduce entropy), self-regulation is not really possible. Somatic psychotherapists know that self-regulation occurs when the body is motile and relaxed, when breathing is full, when the musculoskeletal structure is aligned, when the eyes shine, when skin color and hue reflect full blood flow to the surface of body, and when emotions are felt (Lowen, 1994). On the psyche’s side, the sense of self is strong, the voice is resonant, and spoken words and thoughts are embodied and connected to feelings (Lowen, 1994).
A Technique

This hypothesis immediately lends itself to a technique to discharge excess emotion (entropy). Its effectiveness is based on clients having proprioception — the ability to sense their body — as well as a strong sense of self. When clients experience a strong emotion related to a lingering stimulus, I first ask where they sense the emotion in their body. Once they can successfully identify the emotion’s location, I ask them to imagine a container that encapsulates the emotion in their body, and extends a little beyond, so they can observe the inside of the container in front of them. I then ask them to place their awareness on that container (to feel it) and not think about anything. After a few minutes, clients generally feel the container becoming smaller, while its content also becomes smaller and more distant. I then ask them to imagine that the container has a small, capped hole at the bottom. I ask them to remove the cap from the hole, and let the residual energy (emotion) discharge down through their legs and toes, and into the ground. This exercise usually results in the successful discharge of residual emotions (entropy). I have used it many times with good results. Interested readers will note the similarity between this technique and a simplified version of Gendlin’s focusing (Gendlin, 1982). The theory I propose here thus also explains why focusing is effective, and how it works in situations where emotions are not too overwhelming.

Case Study

Sue has been seeing me for about a year. One day, she came in and complained about an argument she had with her mother. She was just feeling “bad,” and this bad feeling was lingering and not going away. I inquired about her sense of feeling “bad.” After a bit of analysis, she realized she was feeling a mix of anger, guilt, anxiety, as well as sadness. I asked Sue to tell me where in her body she felt these emotions, and she indicated they were centered around her chest. I then asked her to imagine a container that fully encompassed these emotions, and was large enough that she could look inside. I asked her to just observe the interior of the container with awareness, and let thoughts come and go without dwelling on them. After a few minutes, I sensed that something had shifted, and asked her about the container and its content. She indicated that the container seemed smaller, and so did the content. I then asked her to imagine that the container was capped at the bottom, and to open the cap and let the rest of the content discharge through her body down to the ground. After doing so, she felt the “bad” feeling was gone, and she was no longer carrying that emotional load. Once Sue was relatively free of the excess emotion related to her argument with her mother, we were able to explore their relational conflicts.

Relational Trauma

At birth, infants begin their life journey. This is the first period in the life of the neonate, referred to as normal autism (Mahler, 1975), the autoerotic phase prior to primary narcissism (Freud, 2012), or the schizoid stage (Lowen, 1994). In terms of object relations, this stage is objectless; infants’ drives are focused on themselves (autoeroticism). This lasts for about a month. At the end of this period, infants, if safe, have formed a relatively integrated image of their body. For example, they know that their limbs belong to them.

At the beginning of the second month, which corresponds to the symbiotic stage (Mahler, 1975) or the first half of the oral stage (Lowen, 1994), infants face existential anxiety and fear. In object relations terms, this period is pre-object. Infants’ drives are mostly focused on the need for satisfying part-objects (such as the breast), and infants experience their mother’s functioning as part of themselves (the symbiotic stage). Disorders related to these periods are beyond the current scope of this article, and will not be discussed.

Full object relations begin at the end of the symbiotic phase, which ends at around five months of age. Infants begin to differentiate themselves from their mother, and begin to distance by pushing her away when being held in her arms. This is Mahler’s differentiation sub-phase (Mahler, 1975) or the second half of the oral period (Lowen, 1994). At this point, infants fear not having the object (mother) in their vicinity, and at the same time want to differentiate from her. Drives during this and subsequent periods are focused on the object for support and safety, as well as on exploring the environment. In either case, and as previously discussed, drives serve to reduce infants’ internal entropy by seeking proximity, and their external entropy by exploring their environment. Infants’ needs are partially met and partially frustrated. The frustration of their needs results in higher tension (entropy) within. In order to gain some control over their environment and be able to predict it (to reduce entropy), infants must adapt to this situation. They consequently form neural pathways that resemble those of their mother (the unsatisfying object) in order to predict and conform to their environment. They thus internalize the “bad” mother in order to reduce uncertainty (anxiety) within their environment, and in so doing, their immediate needs for the mother are reduced as well. The “bad” internalized mother has two facets; on the one hand, it allures but does not satisfy, and on the other, it frustrates and rejects!

This is an intolerable situation, and to manage it, infants split the internalized “bad” mother into the needed or exciting object that allures but does not satisfy, and the frustrating or rejecting object. Infants will seek the exciting object (EO) throughout their life by seeking fuller human connection, thus reducing entropy within their unitary psychosomatic structure. The ego maintains a libidinal attachment to this internalized excit-
I suggest that these newly developed neural networks also represent a form of internalization, as they resemble those of the good object. We know that the brain wires through experience, and this phenomenon is observed in therapy, as clients have good experiences with the therapist and form new neural pathways similar to those of the therapist. These newly formed pathways support new coping mechanisms and new effective approaches to life’s challenges, thus reducing entropy.

However, residues of the original drives still remain as the “I” that relates to the environment and to people in the outside world. Fairbairn (1952) called this endopsychic structure the central ego (CE), which forms as drives are shaped by the reality principle. The ego is mostly conscious, but may also contain unconscious elements and aspects of original drives. It is, however, weak and ungrounded, as some of its energy has been consumed, limited, and shaped by the libidinal and anti-libidinal egos. Its approach to its environment and objects may be tentative and cautious. Increased entropy, which can be experienced as a partial loss of the sense of self due to weakness and lack of grounding, can be somewhat ameliorated by mirroring self-objects, idealizing self-objects, or twinship self-objects (Kohut, 1971). A self-object is the experience of an object (person) as part of the self. This represents the narcissistic line of development, the focus of self-psychology (Kohut, 1971).

The tentativeness and caution of the central ego are related to perceived higher entropy and uncertainty within the environment, and the ego’s relative inability to approach and withdraw effectively. Individuals can reduce entropy by finding objects that mirror them and reflect a sense of self-worth and self-value (mirroring self-objects), by finding people who help calm and comfort them (idealizing self-objects), or by finding those who give them a sense of alikeness – twinship self-objects (Kohut, 1971).

In Figure 4, I depict the process of relational trauma in a model adopted from Wilhelm Reich (1980). A simpler form of this diagram was discussed in detail by Hilton (2008). Here, segment 1 represents the unitary drive, as previously defined. The drive may face frustration, rejection, or environmental negativity, as represented by segment 2. Segment 3 represents the new direction taken by the drive. Identification with the rejecting aspects of the object is represented in segment 4 (anti-libidinal ego), and seeking the needed and exciting aspects of the object is represented in segment 5 (libidinal ego). Segment 6 represents the central ego (CE). The muscular armor, which keeps the original drive in check, is represented by segment 7.

For the most part, the strategy used in childhood to reduce psychic entropy has the opposite effect during adulthood. Fairbairn (1952) contended that in order for clients to risk releasing bad objects from their unconscious, they need to feel safe in the therapy setting, and
see their therapists as good objects before they can become vulnerable and function beneath their defenses as their brain forms new neural pathways. They can then overcome their resistance to releasing bad objects from their unconscious. Releasing the bad objects and internalizing the good objects support the true self (related to segment 1 in Figure 4). The true self (segment 1 in Figure 4) may replace the endopsychic structures, although residues always remain. Recall that Wilhelm Reich (1980) asserted that psychoanalysis is about consistent analysis of transference and resistance. Transference and resistance are simply the persistent activation of old neural networks. Consistent analysis of transference and resistance is necessary to successfully release and dissolve endopsychic structures, since formation of new neural pathways is based on new experience with the therapist. Once bad objects are released from the unconscious, the conflict (high entropy) between the true self (segment 1 in Figure 4) and its internalized bad objects is diminished, thus reducing entropy.

Guntrip (1973) posited that the client’s primary nature (segment 1 in Figure 4), which was repressed and arrested in development, needed to be strengthened—not the central ego. At this point, the real self, for the most part, replaces the central ego, which in the past needed the self-objects to maintain a weak sense of self. The release of bad objects is a lengthy process. We must analyze and work through the transference and resistance while new neural networks form, based on new experiences in relationship with the therapist. As previously noted, once clients internalize the therapist as the good object, they can risk releasing internalized bad objects. Internalizing contact with the good object will occur over time. Once the contact with the good object is internalized, clients do not need the presence of the therapist (good object) any longer. During stressful times, however, contact with good objects may be necessary for self-regulation and reduction of entropy within the unitary psychosomatic structure. Interested readers should note that my description of object relations differs slightly from Fairbairn’s original formulation (1952).

To shorten the process, and for clients to experience how it feels to temporarily let go of internal bad objects, I designed the following technique.

The Technique

Before describing the technique, I must mention that it 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 not retraumatizing. This exercise is contraindicated for clients who cannot connect with and feel their body, and/or have a diminished sense of self. Clients must first be able to connect with their body for this exercise to be effective.

In Figure 5, I show the process of working with relational trauma. Throughout the process, I invite clients to release thoughts. I pull my chair a bit closer to them and ask them to remain aware of their body (from their neck down, to avoid staying in their heads) and breathe normally. I may have to coach clients in staying 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 remain in contact with me. Frequently, I have to coach clients how to stay in contact with me. I maintain gentle eye contact with them and look at their left eye, and ask them to gently look at my left eye so we can make a right-brain to right-brain connection (the left eye is connected to the right brain, and the right eye is connected to the left brain). I also ask them to be aware of the space (distance) between us (to feel the connection), and I do the same (become aware of the space between them and me). Feeling and awareness of the space between us can be perceived 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 simultaneously maintaining contact with me. After a bit of practice, clients can follow these steps. Throughout the exercise, clients remain silent and simply stay in contact with themselves and with me. For this step to be effective, clients must have reached a certain level of ego strength, and a certain degree of trust within the therapeutic relationship in order to become vulnerable, and drop their defenses and resistance.

After a minute or two, or when I feel it is appropriate to go to the next phase, I ask them 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. I then ask them to stay with their sensations and feelings for about a minute or two, until I sense that they feel their contact with me in their body. I suggest this last step is the somatic correlate of internalization.

Through this energetic and somatic exercise, clients first connect with themselves, then to the therapist, and finally they internalize the contact. Afterwards, cli-
ents typically feel much calmer and feel a deeper connection with me and their bodies. They report that they are able to self-soothe between sessions when they feel emotionally overwhelmed. Again, connecting with and internalizing the good object is a lengthy process. This exercise may shorten it by creating a psychological imprint, through the new neural networks (initially weak) that form during the exercise. Future therapeutic work is then built upon strengthening these newly-formed neural networks.

Case Study – Nancy

Nancy, a woman in her thirties, had been working with me for nearly two years. She came to see me because of anxiety. She felt estranged from her husband, whom she described as cold and narcissistic. She believed that her husband was having an affair. Nancy had no support system, and felt lonely. She said that even the thought of leaving her husband would dramatically increase her anxiety. In terms of relational trauma, her libidinal ego could not give up the needed object (the exciting object, her husband). Over time, she developed a strong therapeutic connection with me, but the connection with herself was not very strong, and she thus felt powerless.

About a year into our work, I decided to do the aforementioned exercise with her. I asked her to not think throughout the exercise, and to close her eyes and feel her own body from her neck down to her toes. When she was ready, I asked her to open her eyes and connect with me by simultaneously looking at my left eye and also putting her awareness on the space between us. After a few minutes, when I felt that she was connected with herself and with me, and that she was calmer, I asked her to close her eyes and imagine that I was getting closer to her, and to bring me as close to her as she felt comfortable, so that she could feel my energetic presence and stay with that. After a few minutes, I asked her to slowly open her eyes and stay in contact with herself (to feel her body). Then I asked how she felt. She said she felt calm. I asked if she still felt lonely and anxious. She immediately said “no”. I explained the purpose of the exercise. In a calm tone, Nancy said she wanted to feel this way “all the time.” I told her this was our therapeutic goal, and that she now knew this place, and that her limbic system and frontal cortex had an imprint of how she felt when she was connected to herself and to me. We did the exercise several times over the course of her work. She made significant progress over time. Recently, Nancy mentioned that she felt very empowered, that her anxiety had lessened, and that she felt she had many choices and was no longer a prisoner of her fear.

Shock Trauma

When the brain’s information processing ability cannot keep up with high entropy external stimuli (events), the result is shock trauma. The memory of the traumatic event will not be consolidated in cohesive form, but will likely be fragmented, with missing parts. I previously discussed that according to the efficient coding hypothesis, the brain maximizes mutual information between stimulus and response. Recall that mutual information is \( I(X; Y) = H(X) - H(X | Y) \), and that mutual information between \( X \) and \( Y \) is how much information \( Y \) provides about \( X \), or how much the uncertainty about \( X \) is reduced, given that \( Y \) has occurred.

Let \( X \) be the response to a stimulus correlated to a traumatic event that resulted in response \( Y \) in the past. \( H(X | Y) \) is the conditional entropy of response \( X \), given the event with response \( Y \). Mutual information is maximized when \( H(X | Y) \) is minimized. \( H(X | Y) \) is minimized when response \( X \) is highly correlated to \( Y \). In other words, the efficient coding hypothesis implies that response \( X \) to a present event will be similar to response \( Y \) to a correlated past traumatic event (the repetition compulsion). We can successfully treat trauma if we can minimize mutual information – in which case, response \( Y \) to a traumatic event in the past will not result in a similar response in the present. That is, the present event will be treated as novel, resulting in a different response.

In information theory, conditional mutual information is defined as \( I(X; Y | Z) = H(X | Z) - H(X | Y, Z) \) (Pierce, 1980). The interpretation of conditional mutual information is how much information \( Y \) provides about \( X \), given that \( Z \) has occurred, or how much \( Y \) reduces uncertainty about \( X \), given that \( Z \) has occurred. Let \( X \) and \( Y \) be defined as indicated above; let \( Z \) be a new event that has occurred. If event \( Z \) results in minimizing conditional mutual information, then response \( Y \) will clearly not lower the entropy of response \( X \), and the individual will thus have a range of response choices that may not be correlated to \( Y \). We can make the notation more precise by writing the equation in this form:

\[
I(X; Y | Z = z) = H(X | Z = z) - H(X | Y = y, Z = z)
\]

Here, ‘\( y \)’ is the specific traumatic response to an event in the past, and ‘\( z \)’ is the specific added event in the ensemble (set) ‘\( Z \)’. Thus, mathematically speaking, the treatment of trauma could be framed as an optimization problem of choosing the “right” event ‘\( z \)’ that occurred in the past, which minimizes conditional mutual information.

Consider the following example. Every year, Bob, a middle-aged man, vacations at a remote island. He sometimes goes fishing during his stay. He needs to know what the weather is like before going fishing, but the only weather report for the island is provided by a local man who can predict the weather with 90% (0.9 probability) certainty. Bob trusts his prediction, and plans accordingly. When he returns to the island the following year and looks for the local weather forecaster, he is told the man had a stroke, and is 50% (0.5 probability) cognitively impaired. Can Bob continue to plan his fishing excursions? It is easy to see that the answer is NO!
Let $X$ be Bob’s uncertainty about the weather (clear or stormy), let $Y$ be the local forecaster’s response, and let $Z = z$ be the new information: the local forecaster has had a stroke. It is clear that before the forecaster’s stroke, $Y$ maximized mutual information between $X$ and $Y$. $I(X; Y) = H(X) - H(X | Y)$. Note that $H(X)$ is the uncertainty about $X$ (clear or stormy). And $H(X | Y)$ is very small, as $Y$ with probability 0.9 (90%) predicts $X$. Thus, conditional entropy is close to zero, which means that mutual information is maximized. Note that if $X$ has a probability of 0.5, the forecaster’s weather prediction is similar to tossing a coin. If the forecaster can predict the weather with a probability of 1 (100%), then $Y$ provides 1 bit of information about $X$ (clear or stormy – 0 or 1 requiring only one bit), since $H(X) = 1$, and $H(X | Y) = 0$ ($Y$ completely determines $X$).

Let us now consider the added information that the local forecaster had a stroke. Recall that conditional mutual information is $I(X; Y | Z = z) = H(X | Z = z) - H(X | Y, Z = z)$. Since the local forecaster’s cognitive impairment is 50% (probability 0.5), then $H(X | Z = z) = H(X)$. In other words, Bob’s uncertainty about the weather does not change, given that the local forecaster had a stroke. On the other hand, $H(X | Y, Z = z)$ is maximized, since Bob’s uncertainty about the weather does not change very much – given that the forecaster predicted the weather, and given that he had a stroke resulting in 50% cognitive decline. That is, his prediction is as good as tossing a coin! Therefore $H(X | Y, Z = z)$ is very close to $H(X)$. We thus see that in this case conditional mutual information is minimized. Also note that since the probabilities are known in this example, mutual information and conditional mutual information can be computed.

My interest in the nature of traumatic memories began in 2012. In particular, I was curious about the controversy within the somatic psychotherapy community related to Janet’s (van der Kolk, 1994) and Freud’s (1952) views regarding the nature of traumatic memories, and whether traumatic memories were dissociated (Janet) or repressed (Freud). Although van der Kolk had initially sided with Janet in this old debate, he later revised his views (van der Kolk, 2014). Using information theoretic neuroscience results, Shahri (2017) showed that traumatic memories were neither fully repressed nor fully dissociated. When processing the information associated with the traumatic event was beyond the brain’s capacity (very high entropy), the result was dissociation. Otherwise, these aversive memories were repressed, and encoded as implicit memories that dominated the individual’s behavior in more subtle ways (Shahri, 2017).

In 2016, I became inspired by the recent works of LeDoux (1996, 2002), who posited that it should be possible to alter traumatic memories during the reconsolidation phase. In 2017, while continuing my research on revising traumatic memory, I came across the latest findings from LeDoux’s laboratory. Late in 2017, while working with my former therapist Dr. Robert Hilton, I stumbled upon a way of modifying traumatic memories, which later evolved into a technique based on information theoretic neuroscience and research results from LeDoux’s lab (Shahri, 2018). Below, I present more advanced versions of the technique, which can erase the emotional content of traumatic memories. Independently, Ecker, Ticic, & Hulley (2012) discussed the application of the findings from LeDoux’s lab in modifying traumatic memories, which I discuss next.

Daniela Schiller et al. (2009), researchers at LeDoux’s lab, found that during reconsolidation, memories go through a period of instability after being recalled. They also introduced a behavioral technique to target reconsolidation of fearful memories in humans. They demonstrated that traumatic memories can be associated with benign information provided during the reconsolidation window. They showed that, as a consequence of this association, fearful responses to traumatic memories were no longer expressed. They indicated that this effect lasted at least a year, and affected only the reactivated relevant memories. In a separate study at LeDoux’s lab (Diaz-Mataix, et al., 2013), researchers indicated that while in the labile (unstable) state, which lasts about five hours (Ecker, 2015a, 2015b), the emotional content of traumatic memories can be modifed by introducing new information during the reconsolidation window, while leaving autobiographical memories essentially unchanged (Ecker, 2015a, 2015b).

To reiterate, LeDoux’s lab research indicates that the emotional content of traumatic memories can be altered by introducing additional information that contradicts or augments the original memory while it is labile (unstable), a phase that lasts about five hours, and takes place before reconsolidation is complete. The new information can erase the emotional content of the traumatic memory, while leaving its autobiographical aspects fairly intact (Ecker, 2015a, 2015b). To be fully effective, however, the new information needs to minimize conditional mutual information, as stated above.

Recall that the emotional aspects of traumatic memories are, for the most part, implicit and encoded in the limbic system (LeDoux, 2015). There is thus no direct way to access implicit traumatic emotional memories verbally; they cannot be processed through introspection. Therefore, alternative interventions may be necessary. Note that the autobiographical aspects of traumatic memories are formed by the hippocampus, and encoded mostly in the prefrontal cortex (Makin, 2017); the amygdala attaches emotional significance (entropy) to autobiographical memories (LeDoux, 2015). Traumatic memories can change when the link between autobiographical memory and its emotional aspects are established, as memories change when they are recalled (LeDoux, 2002) due to association. It is then that the addition of new information can modify the aversive memories during the reconsolidation phase.
Reconsolidation occurs in everyday life

Alice, a woman in her thirties, dined each week at her favorite restaurant. A few months ago, she ended up with food poisoning, which she attributed to the seafood she ate there. Her symptoms began minutes after she finished her food. After this traumatic experience, whenever she drove by the restaurant or saw/smelled the same food that had made her sick, she became triggered, and her body reacted to her past traumatic experience. At the suggestion of a close and trusted friend, she decided to go to the same restaurant to possibly overcome her aversive reactions. Upon entering the restaurant, she again became triggered. Her trusted friend ordered and ate the same food that had made Alice sick, and did not end up with food poisoning minutes later. It was then that Alice recovered from her aversive reactions to the food and the restaurant.

This example shows that when Alice’s memory of the past traumatic experience was activated (autobiographical and emotional), and new information was added, within the reconsolidation window, that contradicted her original memory (expectation) – her trusted friend not getting sick eating the same food – the emotional aspects of Alice’s traumatic memory were erased, and she was then free of her aversive traumatic reactions. Had Alice needed to wait for more than five hours before knowing whether her friend would end up with the same fate, her traumatic memory might not have changed, as this would have been outside the reconsolidation window.

The theory presented in this article fully predicts the results from LeDoux’s lab. I discussed earlier that the living organism must constantly reduce and maintain entropy to continue its existence and reach biological homeostasis. I also noted that in the case of Homo sapiens, the psychological system must also reduce entropy to reach psychological homeostasis. Earlier, I discussed how emotions (which form spontaneously in response to high entropy stimuli) correspond to increased entropy within the psychosomatic system. The psychosomatic system constantly strives to reduce entropy (psychosomatic homeostasis). However, in the case of consolidated traumatic memories, due to fragmented memories of traumatic events or the high emotional charge (entropy) of these events, entropy cannot be easily reduced, as high emotional charge is associated with the traumatic memories.

However, when a memory is recalled while it is labile, if an alternative “low entropy” (benign or predictable) story is introduced that either contradicts the original story or augments it, the psychological system chooses it over the old highly charged (high entropy) memory in order to reduce entropy, and consolidates the new memory during the reconsolidation phase – leaving the original traumatic memory relatively unchanged while erasing its emotional content. After recall, memories are unstable and can change, and the brain chooses an alternative with lower entropy during the reconsolidation process.

High entropy events like traumatic memories require more resources to encode and consolidate, which means that more neural networks are consumed to encode and consolidate them. Recall that memories are associative, and can associate, if correlated, when the constituent neural networks are activated (when recall has occurred). Thus, when a traumatic memory is recalled and alternative partially correlated (lower entropy) new information is added that contradicts or augments it, the brain associates the two stories, but gives higher credence to the new (low entropy) story. It effectively decouples the original traumatic memory from its emotional content (which is essentially erased), and reconsolidates the new story while maintaining knowledge of the original memory (episodic memory). In my experience, the emotional content (energy) of the traumatic memory is usually discharged through a deep breath, soft tears, or some other somatic response.

Next, I present two techniques to alter the emotional content of traumatic memories. The first is mostly applicable to situations in which the memory of the traumatic event is relatively intact, but recalling it is overwhelming and triggering. In the second, I discuss situations in which the memory of the traumatic event is fragmented and disjointed.

The Technique – I

I sit directly across from clients, and invite them to bring the traumatic memory to their attention (recall), as if they are watching someone else going through the trauma. I ask clients to imagine they are safe with me, so that they do not become overwhelmed or activated. I then ask them to stay in contact with their body and with me in the manner described earlier. While remaining aware of our connection, I ask them to look to the left at their imagined self (to access their emotions) by simply turning their eyes, not their head, for perhaps a second; the stronger the emotions related to intro-
sive memories, the shorter the duration of staying with them. This is done in order to activate their right hemisphere (Figure 6).

By observing the emotional states of their imagined self on the left, clients effectively decouple the emotional aspect of the traumatic memory from the autobiographical (episodic) memory, increasing the efficacy of this technique and the erasure of the aversive emotional memory. I then ask clients to see if an alternative story emerges that contradicts the original story. We continue the exercise until a more benign and empowering story has arisen. At times, I may need to guide clients through creating the new story during the exercise or before they begin.

Throughout the exercise, I ask clients to avoid thinking and stay with their body. Once the new story has taken hold, the emotional state of their imagined self (to their left) also changes, and the emotional aspect of the traumatic memory is erased. Clients always still remember their traumatic memories (autobiographical), but no longer seem to be triggered by them, since their emotional contents are erased, and a more benign (low entropy) alternative story becomes dominant in their memory.

The new story ‘z,’ is created in a way that minimizes conditional mutual information. Interestingly, the story chosen can subjectively be seen to minimize conditional mutual information. If not, I usually make suggestions, and guide clients to choose a different story, one that lowers conditional mutual information. The exercise usually lasts only a few minutes. Over the past several years, I have worked with many clients; in every case to date, we have been able to successfully rewrite intrusive traumatic memories, and they have not returned.

Case Study – Mary

Mary, a woman in her late thirties, came to see me a few years ago. Her presenting issue was anxiety. She reported she was using drugs to self-medicate. Her anxiety was largely hidden, but manifested visibly as twitches in her stomach area. Our work proceeded slowly, yet positive transference was established fairly quickly. Six months into her therapy, she mentioned that when she was a teenager, she had been raped by a man who owned a gas station where she worked. It seemed that many of her symptoms were the result of this trauma.

I asked Mary if she was willing to do an exercise, and she affirmed that she was. I asked her to not think during the exercise, but to feel her body, then connect with me, so that she could feel both herself and me simultaneously. I then asked her to picture the traumatic incident at her left, as if she were watching a somewhat foggy and unclear movie (to reduce her emotional arousal) for half a second, and to then come back and connect with me. After about thirty seconds, I asked Mary to allow an alternative story to emerge, one that was safe. She continued the exercise for another minute or so, and I then noticed a change in her emotion that was apparent on her face. I asked her to stop the exercise and connect with me for a little while, which she did. I then asked if an alternative story had emerged. “Yes,” she said, and proceeded to tell me that her parents had unexpectedly showed up as the perpetrator was about to attack her. They then called the police, and the man was arrested. I asked her to look at the incident for just a moment to see which story came to mind. She said, “the alternative story.” I asked her not to think about the story (old or new) for at least five hours. I checked during our next session to make sure that the new story had reconsolidated, and the result was affirmative. Two years after the intervention, the new story still persisted, and many of Mary’s symptoms had diminished.

The second technique is related to situations in which the memory of the traumatic event is fragmented and disjointed. In this case, my approach to rewriting the emotional content of traumatic memories is based on adding new information at the time of recalling the traumatic memory so as to fill the gaps in the fragmented memories (augmentation), which then results in its re-encoding during reconsolidation. Re-encoding emotionally charged memories converts these aversive memories, through elaborative repression (Erdelyi, 2006), to more predictable, benign, and less emotionally charged memories. The efficacy of this technique is predicated on a strong therapeutic relationship, which functions as a predictable holding environment and safe container.

To illustrate the next technique, consider Figure 7, where A and B represent two different people. Look at A, then B, and repeat. Since the two pictures are very different, you might notice slight activation within your nervous system (higher entropy) due to the difference between them. Now observe the sequences of pictures at the bottom of Figure 7, one at a time, from left to right, and see if the arousal lessens. The bottom images simply morph picture A into picture B.

The Technique – II

I sit across from the client (Figure 5) and ask them to recall the traumatic memory and observe themselves at their left, as if their imagined self were going through the fragmented traumatic event. However, I ask them to recall it very slowly – one frame at a time (in slow motion). I also ask them to connect with me as needed if the recalled material is overwhelming, and they need to feel my presence and support.

Recalling traumatic memories in this way will be less overwhelming; the brain can process the high information (emotion) content of these memories and add extra information through elaborative repression (Erdelyi, 2006), which fills in the gaps and makes sense of the traumatic memory, thus resulting in integration. My presence with clients and their connection with me
serves to reduce arousal so the brain can process the re-called memory, and the added information can fill in the gaps in that memory.

When the change has occurred, I can usually observe it on a client’s face. When these early memories – the blueprint for much future behavior – are re-encoded and rewritten, clients generally feel freer, and do not function from their early traumas as often and as intensely. With this technique, conditional mutual information is minimized by filling in the gaps. Even though the new and the original story are correlated, the new story has lower entropy. It augments the original story in a way that contradicts the outcome, thus reducing conditional mutual information. It also erases the emotional content of the original traumatic memory.

Case Study – Karen

Karen, a woman in her late forties, had been working with me for a number of years. Her connection with her body was not very strong, and her therapy had progressed very slowly – in general, it was not very successful. She mentioned that she was very afraid of water, and would become anxious when she was even close to a swimming pool. She would also get triggered by the smell of chlorine, a substance often added to swimming pools. I asked how long she had had this symptom. She indicated she had been afraid of water for most of her life. I asked if she remembered anything in her childhood related to water. She indicated she had been afraid of water for most of her life. I asked if she remembered anything in her childhood related to water. She recalled that when she was about five, she nearly drowned in a swimming pool at a resort where she and her family were vacationing. She and a few other children were playing in the pool when an older child pushed Karen underwater; she could not breathe and almost drowned. Fortunately, an adult saw that Karen was being held underwater by the older child, and came to her rescue. Her recounting of this story was based mostly on what she had been told by her parents, except for bits and pieces that she remembered. The whole incident had happened very quickly, and she could not remember very much of it. I suspected this was the main cause of her symptoms and her fear of water.

I asked Karen if she was willing to do an exercise, and she responded “yes.” I asked her to feel her body to the extent that she could, and to also connect with me, as described above. These were not easy tasks for her, but she was able to do both to some extent. I then proceeded with the exercise, and asked her to watch what happened toward her left, and to come back to her connection with me when she needed to feel safe. I instructed her to slow down her recollection of what happened to “one frame per second.” She initially had a hard time with this, as she had no detailed recollection of what had happened. I asked her to just imagine what had happened, and to simply make it amusing and playful by filling in the gaps in her memory.

After a few minutes, I felt she had created an alternative story! She said she imagined that, in a fun way, she was playing with other children, and they would push each other underwater, and then they would push with their feet against the bottom of the pool to come up. She was smiling as she recounted the new story, and felt that it could have been a lot of fun to play that game. This new story persisted when I checked with her during our next session. She indicated that her anxiety about water was essentially gone, and she no longer felt afraid of water – although there were still some knee-jerk reactions, which went away quickly.
Complex trauma

Complex trauma is different from shock trauma, and is characterized by the occurrence of many traumatic events and/or prolonged exposure to traumatic stimuli. Complex trauma can be distinguished from developmental trauma, which is the result of suboptimal childhood experience during different developmental phases.

Complex trauma can affect an individual in many different ways. They might have uncomfortable physical sensations, a constant feeling of sadness, anxiety, shame, fear, confusion, lack of trust, or self-hate. These feelings usually persist in the body, and are not consciously attached to specific events. They are, however, triggered by stimuli with some similarity to past traumatic events. The efficient coding hypothesis (maximum mutual information) nearly guarantees that the response to the present stimulus will be similar to the response to the original traumatic events. In the case of complex trauma, there may not be any recall of past traumatic events that triggers the present-day response.

It is possible to modify emotional memories related to complex trauma during reconsolidation, as presented above. Recall that emotions related to complex trauma represent high entropy states in the body. The approach is very similar to what I presented in the intervention for shock trauma, as briefly described below.

The Technique

As noted, I sit directly across from clients, and ask them to stay in contact with their body and with me. While aware of our connection, I ask them to look toward the left at their traumatized self (their emotional/body state) by turning only their eyes, not their head for perhaps a second, in order to activate their right hemisphere (Figure 6). By observing the emotional states of their imagined self at the left, clients effectively isolate the emotional aspect of the complex trauma. I then ask if they observe any changes in the emotional states of their imagined self. We continue the exercise until such a change occurs. At times, I may need to guide them through the process, and if I feel they need support, I might suggest they imagine I am there as a source of support. Throughout the exercise, I ask clients to avoid thinking, and to stay with their body. Once the emotional states of their imagined selves have changed, the emotional memories related to their complex trauma are erased. The new emotional body state ‘z’ that the client creates minimizes conditional mutual information related to complex trauma. The exercise usually lasts only a few minutes.

Case Study – Harry

Harry was a long-term client who had worked with me for several years. He indicated that he would become anxious in the morning, and experience contractions and tightness in his lower back. He thought this might have been related to getting ready to go to work, and dealing with his difficulties there. He was probably right! There was not a single incident that was responsible for Harry’s present day reactions, but rather prolonged exposure to traumatic events in his life. This was deemed to be complex trauma. I asked Harry about his earliest memory of these reactions. Around age six, he remembered feeling similarly in the morning before going to school. He felt anxious, and remembered that he contracted his lower back, presumably to be ready for some kind of “impact.”

I asked Harry to imagine himself at that age in that contracted posture and emotional state. I also asked him not to think, to remain in contact with himself and with me, and to look at his imagined self on his left (Figure 6) for one second, and to then connect with me by looking into my left eye and being aware of the space between us for two seconds. I invited him to repeat this sequence until the posture and emotional state of his imagined self had changed. He followed my instructions for a few minutes. He then reported that the posture of his imagined young self had changed. The young boy (age six) was now standing tall with his chest out, knees relaxed, and his lower back no longer contracted. At this point, his intrusive emotional memory had changed. I checked with him to make sure that the change had taken hold. During our next session, I confirmed with him that the change had been sustained. Harry reported that he was no longer anxious in the mornings, and that his lower back did not contract as much. His attitude toward his work responsibilities had also changed.

After any of these interventions, I ask clients if the new memory has taken hold. If not, then I repeat the process. I also ask in their next session if the new memory still persists, and if not, I repeat the exercise. I tell clients that after we do the technique, they should not think about the process since the new memories will be labile for about five hours (Ecker, 2015a, 2015b).

These techniques, which minimize conditional mutual information, are not unique. Based on this theory, I hope that other techniques, perhaps more efficient, can be found by other researchers.

The steps in modifying traumatic memories by erasing their emotional content can be summarized in the following steps. These bear some similarities to those described by Ecker (2015a, 2015b), but are based on the techniques described in this article.

1. Identify the past traumatic event responsible for the current symptoms.
2. Ask the client to recall (as per the above techniques) the traumatic events.
3. Create an alternative story that either contradicts or augments the traumatic memories, while subjectively minimizing conditional mutual information.
4. Check to see if the new memory has taken hold; if not, return to step 2 and repeat.

In closing, I would like to paraphrase Schrödinger’s statement that life feeds on negative entropy. I have shown that if the soma feeds on negative entropy, then so should the psyche. An implication of Schrödinger’s theory, as presented here, is that thriving societies also feed on negative entropy; otherwise the entropy of individual members of society will increase and lifespan will shorten. Economic systems that put profit ahead of human needs increase social and environmental entropy, as do wars, overpopulation, and pollution. Human activity in general increases planetary entropy, as promised by the second law of thermodynamics, but reckless human behavior resulting in global warming substantially increases the planet’s entropy, and consequently increases social entropy and therefore entropy within living organisms, including *Homo sapiens*.

**Conclusion**

Using concepts from biology, chemistry, thermodynamics, information theory, and psychology, I have discussed how life might have formed, and how living organisms are sustained by the reduction of entropy (Schrödinger, 1967). I also showed how the thermodynamic notion of entropy within living organisms is related to the information theoretic notion of entropy within the psyche. I considered the roles of emotions and feelings in biological and psychological homeostasis. I presented a simple technique to potentially discharge excess emotional energy. On that basis, I formulated a simplified form of object relations theory and self-psychology, and presented a technique that may speed up the process of healing relational trauma. Using memory reconsolidation theory and information theoretic neuroscience, I presented two very effective techniques for modifying the emotional content of traumatic memories.

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In 1925, Wilhelm Reich published his first psychoanalytic monograph, Der triebhafte Character (The impulsive character). Surely one of the most important psychoanalytic that year, Reich’s clinical portrait of the impulsive character was a path-breaking study of what we today call the borderline personality, and laid the conceptual foundation for his later venture into character analysis of body postures and eventually the emotional expressions of the body. Today, the original Freudian theoretical understanding of character is usually forgotten or overlooked, and replaced by a simpler presentation of expression through the body. This paper revisits the original development of the concept of character from Freud to Reich.

At the organizational as well as theoretical level, psychoanalysis had a golden age in the mid-twenties. By 1925, it was no longer battling for recognition, but was a firmly established professional community, organized as an international association with branches in five different countries (Austria, Germany, Hungary, Britain, and the Netherlands). Freud’s scientific and psychiatric project now had its own publishing house, its own journals in German and English, and its own clinics in Berlin and Vienna. It attracted pupils and patients from many countries in Europe and the United States. Lectures, courses, and seminars were held on the premises of the Vienna Psychoanalytic Society (Der Wiener Psychoanalytischen Vereinigung), at Pelikangasse 18, and the Vienna Outpatient Polyclinic, which was established May 22, 1922 and led by Eduard Hitschmann and Wilhelm Reich, where medical treatment was provided for poor and destitute people. Advice on sexual hygiene, contraception, and birth control, as well as immediate psychological counseling and assistance, were provided free of charge for the poor. Normally, analysts would devote two to three hours every week to work in the clinic. Reich would also occasionally collect contributions from colleagues to support its operation.

Freud turns from symptom to character

Two major theoretical developments emerged in the psychoanalytic community in the early to mid-twenties. First, Freud’s formulation...
of the faculties of mind into the realms of the ego (das Ich), the superego (das Über-Ich), and the id (das Es), transformed a lot of psychoanalytic theory and general discourse. The second trend, connected to the first, were the attempts at extending psychoanalytic therapy into an analysis of resistance, the sum total of which was seen as a person’s character. In his autobiography, Richard Sterba (1982) recalled how this transition took place at the beginning of the 1920s in the psychoanalytic community. The older generation of analysts were used to Freud’s topographic model of the mind: consciousness as the tip of the iceberg, with most of the ice being like the subconscious. Beginning with Beyond the Pleasure Principle (1921), Freud introduced the model of the mind as the ego, super-ego, and id. This new model encompassed not only the tension between a rational ego and an irrational unconscious, but aimed at understanding the dynamic tension within the rational domain itself: the Ich (ego) and its moral censor, the Über-Ich (clumsily translated as the superego). From here on, the ego would be seen as a battleground between desire and resistance.

In his seminal work The Ego and the Id, Freud elaborated upon a point made in an earlier paper, where he explained the painful condition of melancholia by supposing that

...in those suffering from it, an object which was lost has been reinstated within the ego; that is, that an object—cathexis has been replaced by an identification. When this explanation was first proposed, however, we did not appreciate the full significance of the process and did not know how common and typical it is. Since then, we have come to understand that this kind of substitution has a great share in determining the form taken on by the ego, and that it contributes materially towards building up what is called character. 3

This important passage shows how Freud opened an entirely new vista of possible new revelations to psychoanalytic research. Freud now zoomed in on the process of establishing object relations, from the very first bonds between child and parents, and the ambivalence and dynamic tensions connected with this process, aiming at showing how these early object—relations formed adult character. This was Freud’s first mention of character as part of the psychoanalytic realm; it would lead to a new direction in psychoanalysis, furthered by Karl Abraham, Sandor Ferenczi, Otto Rank, Edward Glover, and eventually, perhaps above all, Wilhelm Reich. 4

### Object relations and character formation

The starting point for understanding character was typically to explore the love objects and object relations. A typical resolution of the Oedipus complex was that the boy broke with the father to secure the bond with the mother, but thereby compensated for the loss of the father as a love object by incorporating his masculine traits and identifying with him; the girl likewise became more feminine in the process of breaking with the mother in order to approach the father as a love object. But these typical patterns were only two of a myriad of possible specific outcomes of early object relations. A woman breaking with her father as a love object could compensate for the loss by interjecting and identifying with his masculine traits, thus becoming both more father-like and masculine as a consequence of feeling rejected by him and breaking with him as a love-object. 5 And vice versa: a man breaking with his mother as a love object could compensate by adopting a feminine attitude. Wilhelm Reich would later formulate this process in grammatical terms: “We tend to identify with the most frustrating parent.” 6

The study of tension between the ego and the superego thus fundamentally changed the work of psychoanalysts — a change that had only just begun to take hold when Reich published his first monograph in 1925. While the first generation of analysts had been taught to be “libido detectives,” as Sterba put it, adhering to Freud’s dictum that “the analyst has to follow the libido into its hideouts,” the new generation, in contrast, had to accept that the ego itself was part of the repressive mechanism, and this innovation led to increased awareness of transference dynamics and resistance.

In comparing all the different aspects of psychoanalytic training open to a young candidate in the early 1920s and 30s, Sterba concluded: “The most instructive part of the curriculum for me remained the biweekly seminar of continuous case presentations conducted by Wilhelm Reich.” 7 According to Sterba (who later dissociated

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from Reich), Reich was “an impressive personality full of youthful intensity. His manner of speaking was forceful; he expressed himself well and decisively. He had an unusual flair for psychic dynamics. His clinical astuteness and technical skill made him an excellent teacher, and his technical seminar was so instructive that many of the older members of the society attended it regularly.” This differed from the Kinderseminar gathering of the “second generation” of younger analysts (Kinder), a seminar the older members avoided. The old-guard analyst Eduard Hitschmann forbade Sterba from attending the Kinderseminar.

In her biography of Anna Freud, Elisabeth Young-Bruehl acknowledges Wilhelm Reich’s rise to prominence in the Vienna Society as “the most swift” in his generation. Through his work as vice-director at the Psychoanalytic Clinic and the Wagner-Jauregg-Clinic, Reich acquired strong authority in the clinical therapeutic field, and reported case studies of a nature rarely before seen among analysts. Reich focused his energy on gathering clinical material from the psychiatric ward at the Wagner-Jauregg clinic, combined with innovative theoretical contributions that resulted in one of the most important psychoanalytic publications in 1925, namely *The Impulsive Character. A Psychoanalytic Study of Ego Pathology* (Der triebhafte Charakter).

Reich expressed an early wish to write a treatise on psychoanalytic technique, which was lacking in the early twenties. He had proposed this idea to Freud in 1924, who responded in a letter dated June 26, 1924. Freud advised Reich against embarking on such a project at the present time:

I respect your motive, and I also do not doubt your capacity to carry out your undertaking. But I see the following difficulties which I cannot conceal from you.

a) Psychoanalytic therapy has just now been set in motion by the innovations of Ferenczi and Rank. It would not be the right time to attempt a somewhat rounded presentation.

b) No other realm of psychoanalysis places such high demands on the experience of the analyst if he wishes to say more than what is usual.

c) A text on psychoanalytic technique, probably similar to what you have in mind, by Dr. H. Sachs is now being published, consisting of the lectures which he delivered before the Congress.

Mit herzlichen Grüßen, Ihr Freud

Approaching its centennial, *The Impulsive Character* is a remarkably fascinating read today, exploring what we today speak of as “borderline cases” or latent schizophrenics. Providing both an overview of the psychoanalytic literature on character analysis and character disorders, as well as an outline of several case studies Reich had treated in therapy, it broke new ground. Significantly, Reich wanted to enlarge the scope of psychoanalysis to include schizophrenic patients and narcissistic disorders, normally thought unfit for analytic treatment, as narcissism would preclude a beneficial transference situation. Many of the cases described in this monograph were quite seriously disturbed individuals who Reich had treated through his work at the Wagner-Jauregg clinic, which were far more severe than the general neurotics encountered in private practice:

A twenty-six year old single female came to the psychoanalytic clinic because of continual sexual excitation. She longed for satisfaction but could feel nothing during intercourse. She would lie there ‘tense’ and ‘listening for the satisfaction to come.’ The slightest bodily movement would dispel every upcoming pleasure sensation. She also suffered from insomnia, anxiety states, and compulsive masturbation. She would masturbate with a knife handle up to ten times a day, reach a high pitch of excitement, then stop the friction in order to avoid con-

8. Ibid.

Dr. Wilhelm Reich
Der triebhafte Charakter

Neue Arbeiten zur Erlichen Psychoanalyse
Herausgegeben von Prof. Dr. Sig. Reich
N. IV.
summation. She would do this to exhaustion, until, finally, she would have no climax at all, or she would deliberately make her vagina bleed and derive satisfaction from the accompanying sadistic fantasies. 11

The woman spoke with her vagina during masturbation, letting the vagina be a little girl “Lotte,” and herself adopting the role of the strict mother. Through the analysis, Reich revealed a “fantasy (or dark memory)” of her being raped by two tenants in her fourth year of life. The upsetting nature of such a violent assault had disturbed her sexual life altogether, and she was tormented by insatiable sexual desires, combined with guilt feelings and self–disgust. Her mother had once thrown a knife after her when she found her daughter masturbating; this had in turn created the obsessive use of the knife as masturbatory instrument. She was masturbating and at the same acting as the mother, punishing herself for her lewdness.

Reich provided clinical examples of two main types of psychiatric cases: compulsive neurotics, and what he termed impulsive characters. Although seemingly completely different types – the former being obsessively tidy, meticulous, and overly conscientious, the latter consisting of borderline cases prone to criminal behavior, sadism or masochism, juvenile delinquency, etc. – they shared a basic similarity, according to Reich. The two types both started with ambivalent feelings toward their parents or primary nurturing relations.

Their main difference was found in the solution to the ambivalence: whereas the compulsive neurotic reacted against the ambivalence (e.g., turning a hateful impulse into its opposite, into love), the impulsive character would have regularly kept the original ambivalent feelings, or hate would predominate. Whereas the compulsive neurotic in turn developed a very strict superego, a severe moral censor releasing guilt feelings whenever the hateful impulses threatened to break through, the impulsive character had, as it were, isolated the super–ego, Reich claimed – or managed to neutralize it and dissociate from it. Thus, whereas the compulsive neurotic struggled with sadistic impulses accompanied by guilt, the impulsive character experienced sadistic impulses with no guilt. Similarly, the impulsive character developed an unscrupulous character, while the compulsive neurotic became overly conscientious, often with ascetic ideals.

Reich was thrilled with the book, especially the clinical portion. Clinical work formed an important source of Reich’s authority; few other analysts could point to such wide–ranging clinical experience, which he had acquired both through his work at the Wagner–Jauregg clinic, and above all at the Psychoanalytic Polyclinic. As the cases in these clinics were often far more serious than those seen in private practice, Reich’s material consisted of many striking examples of psychotic illness – cases previously rare in the psychoanalytic literature. Freud sent an enthusiastic letter after reading the manuscript:

Vienna 14/12/24

Dear Doctor!

I have read without delay the manuscript sent to me and am glad to inform you that nothing stands in the way of its acceptance and publication. Regarding the first sections, I have to criticize the fact that they lack clearness and contain an excess of formulations of problems. We know indeed all that is still unknown to us, and it is of little help if we gather together these problems as long as we cannot solve them. The two last sections, on the other hand, contain very valuable material, are clear, and, I hope, also correct. You confirm the expectation which I once expressed, that the relationships between Ego and Super– ego will be a realm of research for us similar to that hitherto studied alone between the person (Ego + Super– ego) and the object. I leave unanswered the questions of whether the terms “triebhafter Charakter” (impulsive character) and “Isolated Super– Ego” will prove useful in the final analysis. In any case, your work signifies an important step forward in the knowledge of the forms of illness which perhaps reach their culmination in moral insanity.

Mit herzlichen Grüßen, Ihr
Freud

As a very early study of borderline cases in psychiatric literature, central objects of Reich’s later research focus are already to be found in this work: the development of character through defensive reactions between the ego and superego, and an attempt at broadening psychoanalytic therapy into the realm of narcissistic disorders. Among the very few psychoanalysts who in recent decades have emphasized the importance and neglected influence of Reich’s first publication, David Livingstone Smith points to the impulsive character as a work that broke new ground in psychoanalytic theory on what would later be called the borderline personality disorder. 13 Smith also points to a significant convergence in this work between Reich and Melanie Klein, who would later have a profound impact on British psychoanalysis. Klein attended a lecture Reich delivered in Berlin in 1925, where he claimed that impulsive characters

12. Sigmund Freud in letter to Wilhelm Reich, December 14, 1924, Archives of the British Psychoanalytic Society, CFE/F20/02b
struggle with a savage, “merely organ” or part-object superego formed shortly after birth – a notion that would be central to Klein’s later reformulations of Freudian theory. Although neither Reich nor his close friend Otto Fenichel had strong ties with Melanie Klein and her school (they were not particularly impressed with Klein’s work, as is clear from Fenichel’s Rundbriefe), it is clear that many aspects of Reich’s work are echoed in Klein’s writings, just as his influence on his generation of analysts in general is underrated. During the seven years from 1920 to 1927, Wilhelm Reich was a clear, rising star in the psychoanalytic movement, and Sigmund Freud regarded him as one of the very best in his generation. In 1927, he wrote to Mira Oberholzer that he considered Reich one of the most skillful, eager, and diligent analysts in Vienna [einer der tüchtigsten, eifrigsten und strebsamsten Analytiker in Wien]. According to Reich, Freud nodded towards the audience at the Seventh Psychoanalytic Congress in Berlin and said to Reich in a low voice: “You see all these people? How many do you think can analyze, can really analyze?” There were 122 present in the audience. Freud smiled and held up five fingers.

Reich’s leadership of the Vienna Technical Seminar from 1924 to 1930 led to the first systematic case presentations, and the first clinical seminar and supervision group. In these meetings, Reich’s focus on character and resistance clarified a coherent and structural approach to clinical procedure. His work on the impulsive character attacks many of the problems that would pervade his later writings; the development of character was due partly to a resolution of Oedipal tensions and conflicts, partly as a defense pattern, and all forms of defenses could eventually stiffen into a permanent behavioral pattern, which Reich later termed character armor [Charakterpanzer], and which made him focus on muscle tension and rigidity as defence. Long forgotten today, this discussion on ego relations and object relations formed the theoretical origins of many later schools of body psychotherapy.

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I have been invited to give an overview of the state of Body Psychotherapy in the UK. I have lived in this country for over 30 years and trained as a body psychotherapist at the Chiron Centre for Body Psychotherapy in the 1990s.

For anyone looking to train in Body Psychotherapy, I should perhaps say that the Chiron Centre, which trained several hundred body psychotherapists during its approximately 30-year lifespan, is now closed. There are currently two Body Psychotherapy trainings in the UK that lead to accreditation, and several that run shorter training courses. All these trainings have smaller student numbers than the Chiron Centre; the gap left by the Chiron Centre in the UK Body Psychotherapy training landscape remains.

Blessings of Being a Body Psychotherapist in the UK

I have been blessed in many ways in my professional life. For one, it has been easy to be self-employed in the UK. The regulatory and taxation framework has been friendly to small businesses such as self-employed psychotherapists. A second advantage is that psychotherapy has not been regulated by law, but allowed to self-regulate under a number of professional associations that set standards and guarantee their maintenance to the general public. This has been of great benefit to body psychotherapists because several Body Psychotherapy training organizations have contributed to this self-regulatory process since its beginning in the 1980s. There was therefore never a doubt that Body Psychotherapy was one of the diverse modalities of psychotherapy recognized in the UK, and belonged firmly to psychotherapy as a field. A third blessing is that many trainers at the Chiron Centre were interested in the thinking and practices of other modalities, and created a process of integration between modalities. In turn, practitioners from other modalities developed an interest in Body Psychotherapy which has contributed to its good reputation in Britain. I am aware that for some colleagues, this process of engaging with other modalities has been painful and difficult, leaving them feeling alienated from their therapeutic tribe, and confused about how to work. Again, I have had the good luck to benefit more than suffer from this process.

Becoming Mainstream

I began working at the time when Body Psychotherapy ceased to be a somewhat eccentric fringe modality and took its place in...
mainstream psychotherapy. Indeed, I can boast having played a small part in this when the large umbrella to which we belong, the UK Council of Psychotherapy, organized a conference on the body in psychotherapy, and I was delegated by my professional association to participate in the organizing committee (*About a Body*, UKCP Conference, 2004). I helped create something of a showcase for Body Psychotherapy for a wide audience of psychotherapists from all modalities. This work taught me a lot about being mainstream or marginal: I realized that this is, to a surprisingly large extent, a characteristic that we confer upon ourselves rather than something that others give or deny us. In other words, those who take it for granted that they are part of the mainstream will likely be in the mainstream while those who expect to be marginalized will likely be on the margins. This is of course an oversimplification, and I do not want to deny that discrimination and exclusion of relatively less powerful sections of society by relatively more powerful sections is a reality. I have learned much more about this in recent years and find it interesting that exploring our own expectations and introjected power dynamics, and possibly our own fears of what it means to be in the mainstream or on the margins, is not only a political process but also a psychotherapeutic one. Following the 2004 conference, I wrote my thoughts on this topic in a contribution * to the Newsletter of the Chiron Association of Body Psychotherapists.

For most of my career, I have thus benefited from a professional landscape that was reasonably liberal, where it was easily possible to earn a living as a body psychotherapist in private practice, and where in addition, Body Psychotherapy had a good name among psychotherapists. More and more psychotherapists from other modalities have spoken of their interest in the body, have attended CPD events about some form of Body Psychotherapy, and have been especially keen to learn such body psychotherapy-derived trauma therapies as Somatic Experiencing, Somatic Trauma Therapy, or Sensorimotor Therapy – to name the best known. In the course of my career, I have particularly experienced increased interest from attachment-based psychoanalytic psychotherapists and anyone dealing with early material. As I stated a few years ago, we can tell that Body Psychotherapy has become mainstream by the fact that people are stealing our techniques.

**Advantages and Disadvantages of Voluntary Regulation**

So where are we going?

I worry that the future may not look as good as the recent past, and I will set out my reasons for this concern, which are connected to the way the profession as a whole has been developing.

The self-regulation of psychotherapy in Britain has advantages and disadvantages for both psychotherapists and their potential clients. Advantages for therapists include the existence of large multimodal umbrella bodies that have created a good tradition of talking to practitioners from other modalities, in addition to the connections between Body Psychotherapy submodalities. There is a cross-fertilization among therapies.

For clients, this cross-fertilization means they have a diversity of therapeutic approaches to choose from, and those who take the trouble to educate themselves about the available approaches have a good chance of finding one that works optimally for them. At the same time, these large umbrella bodies guarantee standards of training and practice, and clients can trust the quality of the therapy they are receiving. Therapists who belong to professional bodies usually subscribe to their codes of ethics, which include professional conduct processes that save clients from going to court when in dispute with their therapists. I view this as another advantage.

The disadvantages of the profession’s self-regulation have largely to do with money. The self-regulation model works because a majority of clients pay for their psychotherapy, and nearly all clients in long-term open-ended psychotherapy pay for their own sessions. Consequently, therapy fees are relatively low compared to the fees charged by therapists in countries where health insurance pays for therapy. So, therapy, especially long-term therapy, is a relatively expensive lifestyle choice for clients, and a financially relatively unrewarding profession for psychotherapists. After 25 years in the profession, with no other source of income, I can say that I have always been able to pay the bills, and mostly felt that I had enough money — but I have certainly not become wealthy.

To my mind, perhaps the worst disadvantage is that psychotherapy is a privilege and only accessible to those who are relatively well off, or at least those who work and/or have private savings. This creates a large social inequality, perhaps larger than we would find in countries where people can expect their health insurance to pay for some or all of the cost of psychotherapy. Many colleagues have given a lot of thought to this problem, and most offer some low-cost sessions or work for volunteer organizations that offer free therapy to those with particular issues – for example, complicated bereavement, childhood sexual abuse, or pregnancy losses, to name just a few neighborhood charities I am aware of.

* Article available from http://stauffer.co.uk/cinderella.html
Changes Now and In the Future

Together with social inequality and limited access for those unable to pay for psychotherapy, the issue of employment for psychotherapists is an important driver for change in the profession. When I began training in 1993, it was clear to me that I would be spending my professional life self-employed. No paid holidays, no money coming in unless I earned it myself, no security if I fell down the stairs and broke a leg, and so on. To begin with, I found this quite stressful, and well remember the pang of fear every time a client mentioned terminating therapy! It took me a number of years to develop the trust that new clients would come, that I was offering something that would always find a market, and that I would be able to earn a living for years to come. At the same time, I could see that for many of my colleagues, this path was not right. Some have continued to work part-time, typically in some other profession, while maintaining a part-time psychotherapy practice – often for years or decades. It has seemed difficult for them to take the leap into full-time self-employment. It seems that most of these colleagues have had to work hard and keep late hours; by comparison, my own life has been easier. Additionally, there have been those who never finished their training as psychotherapists because they could not envisage earning a living as self-employed practitioners. Clearly – and in contrast to the discourse we hear from our neoliberal politicians – self-employment is not a good, or even possible, lifestyle for everyone.

I think it is fair to say that in the past, our profession has consisted to a substantial extent of people in at least their thirties and forties, who had initially chosen the “wrong” profession and were retraining as psychotherapists (as I did). But more recently, we have a new generation of trainees who are often much younger, many choosing psychotherapy as a first profession. These colleagues are hoping to find employment as psychotherapists. Their desire for increased employment opportunities, as well as something resembling a proper career structure, follows a political movement aimed at making psychotherapy more available to everybody – preferably within the National Health Service, which is free to the user. This movement has gained substantial momentum since the pandemic, which has left huge numbers of people with burning mental health problems.

I assume this landscape is similar in other countries. The general outcry for psychological therapies is deafening in a time when so many people have suffered so much anxiety, stress, and contact deprivation for so long. Governments see a need to respond to the outcry, and may choose to respond in ways that are not determined as much by clinical considerations as by financial ones. Whatever services are set up must not be too expensive, and will be aimed at helping people get back “on the road” by patching up their functioning as quickly and cheaply as possible. As it happens, this political brief is best met by the reputation that short-term, solution-focused cognitive therapies have created for themselves – making sure that people think in a way that ensures their optimal function in the cogs of the economy. They will not involve anybody in messy and subversive feelings or human qualities. To underpin their cognitive narrative, cognitive therapies claim to be medically sound and evidence-based, because they have spent a lot of time and money creating and advertising an impressive-looking evidence base of randomized controlled trials.

Personally, I can understand that governments choose to make short-term solution-focused therapy part of healthcare provisions for the general public. I think it would be inappropriate for the state to fund more long-term depth psychological therapies. The reality seems to me that long-term therapy is a minority pursuit, even though the current tendency to reserve long-term therapy for the privileged middle classes is not right, and access for the less affluent needs improvement. What is missed by policymakers who know nothing about psychotherapy is that cognitive therapies have no monopoly on delivering good outcomes in a short time, and that manualization of psychotherapy is largely irrelevant to clinical outcome. In this context, I appreciate and praise my colleagues who have managed to “sneak” other modalities of therapy – including Body Psychotherapy – into employed positions. It may be that these colleagues will manage to convince the relevant commissioning bodies that Body Psychotherapy is a good modality for fulfilling the aims of the National Health Service. However, I fear they may not, and that the future of the psychotherapeutic profession lies in a division between the mostly cognitive or cognitive-behavioral solution-focused therapies delivered by therapists employed to see clients on a time-limited basis, and the in-depth open-ended psychotherapies of almost all other modalities. I see the future of the latter types of psychotherapy, including most Body Psychotherapy, to be in the private sector, delivered by self-employed therapists. Sadly, this may be the best we can currently hope for.

To make matters worse, the development of the profession in this direction does not look at all straightforward at this point. There are powerful forces at work who do not feel comfortable with the coexistence of different types of psychotherapy. Mostly, those who set up psychotherapeutic services in the statutory sector do not appear to be knowledgeable about the current diversity of psychological therapies in Britain, and find it easier to focus on one approach, imagining that it will suit everybody in the same way that aspirin works for everybody’s headache – in ignorance of the fact that aspirin does not, in fact, do that. This direction is in part pursued by professional bodies, who are presumably jostling for power. We have to fear that the result will be a great impoverishment of the spectrum of psychological therapies available.

This situation may even reach the private sector should our policymakers outlaw anything they do not endorse. It is easy for policymakers to spread narratives about
how untrustworthy, useless, and potentially harmful therapeutic approaches are that do not fit their ideas. The psychotherapeutic profession has modeled ways of discrediting each other for about a hundred years, so these are well-tested methods. Although we can throw our political weight behind efforts to preserve the rich diversity of our profession, if some psychotherapeutic modalities are outlawed, we can realistically expect that Body Psychotherapy will be among them.

**A Future in Being Assimilated Into Other Modalities?**

So how will Body Psychotherapy look in Britain in 10 or 50 years? It may be that somehow, by the unstinting work of colleagues with more energy than I, Body Psychotherapy remains as it is – a therapy largely for private clients who pay for their own sessions. It may be that it is formally outlawed, and therefore that therapists will have to find a way around this – perhaps by calling themselves healers, complementary therapists, or something else. And it may be that Body Psychotherapy is “mined” for tricks that create quick and effective change in traumatized individuals, and that as a result, Body Psychotherapy does not continue as a whole and inviolate Gestalt, but is dismembered into fragments – some which may disappear, and some which may be co-opted by the short-term solution-focused therapies in the statutory sector. It seems to me that the process of dismembering Body Psychotherapy and having its fragments spat out or co-opted by mainstream therapies is likely to happen, and is probably already taking place. If this is the end of the line for Body Psychotherapy in this country, it probably means that “real” embodiment, with all it entails for psychotherapists, as well as “real” Body Psychotherapy approaches, would die out.

But perhaps I am too pessimistic. Perhaps there will always be those who understand what it means to be “proper” body psychotherapists who inhabit their own body, work from a profoundly embodied and human place, and who will be able to keep Body Psychotherapy alive in the UK for future generations. It is worth mentioning that when EABP-UK was dissolved, its final general meeting set aside seed money for a new Body Psychotherapy training in the UK, as well as funds to set up a new national association, in the hope that, in the fullness of time, the phoenix might rise from the ashes. We are currently in a limbo state, and await new developments.

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My Encounter with Covid-19

Mobilizing the Will to Live

Vladimir Pozharashki

My encounter with the virus began in late October 2020 with a light cough. I tested positive, and immediately went to Tokuda Hospital for an examination. I then began the approved home treatment protocol. During the first few days, I had a cough, a temperature, weakness, muscle aches, and abdominal discomfort. On the third day, I felt some improvement, and thought: “There it goes; I’m getting better. That was it!” Unfortunately, on the fifth day, my existing symptoms worsened. The insidiousness of this disease is in its long-lasting effects, compared to other viruses I have encountered, and in its imperceptible pathological effect on various tissues and systems that leads to disintegration. It affects the lungs, mucous membranes, kidneys, the coagulation system, the nervous system – including the sensory organs of smell and taste – the psyche, and much more.

As a doctor, carefully observing my condition, I was quite concerned about one of my symptoms – the progressive loss of strength. When I got up and tried to move a bit, my weakness sent me back to bed. I preferred to sleep. I returned to the hospital for re-examination. My colleagues at the emergency room offered to admit me to the hospital. I had already developed pneumonia, and my saturation (blood oxygen level) was insufficient. One of my inflammatory markers was significantly elevated, which led me to wonder if my body was overreacting to a disease it could not overcome.

In the hospital, they put me on intravenous medical treatment, and immediately gave me an oxygen nasal cannula. They told me to use the oxygen at all times. This is when things became interesting. I noticed that with the oxygen, I would calm down within 30-45 minutes, but gradually, my breathing would become shallow, reaching respiratory distress and completely obstruction; for a minute, it would become difficult to inhale or exhale, and I would choke, which led me to cough to recover my breath. It would take minutes to recover my normal breathing rate. This, along with my observation of the extremely high level of inflammatory marker (CRP) in my blood, and my restricted breathing volume, gave me reason to suspect a secondary pathogenic mechanism in addition to the main inflammatory process in my lungs.
I am referring to the distress syndrome that presents as confusion, disruption, and blocking of the internal self-healing process. The healing process is always imperceptibly active within, and functions in the background to guarantee health. Self-healing is a dynamic constant process in the body and mind, providing the internal balance we call health. If it is disrupted or dis-oriented, as occurs when the stress of illness continues for long enough without successful healthy adaptation, the process turns from health-bearing and organizing to a disorganizing distress nucleus with a logic opposed to health. Based on my observations, I firmly believe that its nature is not only somatic, but also psychosomatic.

I think that medical treatment external to the body, as adequately as it may be delivered with considerable experience, sophisticated equipment, and complete care, is unfortunately often not sufficient for healing unless it is also supported by the internal self-healing process. In fact, external medical treatment is not specific enough, because it is aimed at the consequences and not at the direct cause of the illness. Targeting the direct cause can only be done by the body’s own capacity to build specific antibodies against the virus. Thus, the two healing processes must work hand in hand to adequately move towards recovery and health.

The Will to Live

When I experienced the obstructed breathing in my chest and felt my body’s distress reaction, and when I saw the decreasing blood saturation indicators, which surprised even me, I asked myself whether I wanted to live. The answer was YES. But along with my yes came the realization that to want to live meant taking action toward achieving my desire. The will to survive mobilized my strength to live and recuperate.

Based on the observations described so far, along with my knowledge of psychosomatics and body psychotherapy, I decided to start breathing as deeply and as intensely as possible—to breathe with the full knowledge that I needed oxygen if I wanted to live. Thus, for more than 24 hours, I breathed with my mouth open, most of the time near an open window. I was fighting for my oxygen, for my life. The general effect was interesting—soothing and relieving.

I believe breathing is important as a process, and not only because it is physiologically significant. Breathing not only “steals” from the environment the oxygen needed to release the energy of nutrients but at an impulse level, it also bears within itself the impulse of life. True life begins at birth with the first deep breath. Breathing is an automatic process, and we do not think about how important it is, precisely because we receive it ready-made. Our life ends with the last exhalation, and with it the impulse of life—it's flame—burns out. Life is in between these two bodily, and, why not, mental, movements. Life itself is movement. Thus, by consciously activating our breathing, we bring ourselves back to life, strengthening the flame, gathering its fuel, and with them, movement and balance. Otherwise, we are soon gone.

The Physiological Benefit of Deep Breathing

The lungs are affected to varying degrees by the infectious virus. The functional part of the lung’s parenchyma is a fine alveolar membrane which, when expanded, presents a huge area for exchange potential. I’m talking about the alveolar wall, the structural and functional elements of lung tissue. This thin wall allows oxygen from the air into the blood in one direction, and releases CO₂ in the opposite direction. When affected by a virus, the alveolar wall swells and thickens; hence its permeability decreases, which then reduces the exchange of oxygen and CO₂.

The lungs do not have their own motor activity. They passively spread as a result of the active unconscious breathing movements of the chest muscles. Automatically regulated based on the body’s moment-to-moment needs, active unconscious breathing movements regulate the breathing rhythm. A decrease in thoracic cavity movement leads to insufficient spread of the pulmonary tissue. If the pulmonary tissue does not spread, not only does its oxygen and CO₂ exchange function plummet, but its own blood supply decreases—leaving the lungs themselves neither well-fed nor energized. This automatically reduces their resistance at a tissue level, and in viral inflammation, increases the conditions for deepening the disease tumefaction. This, I believe, is a key moment in the disease making a negative turn.

The Inner Self-Healer

In my opinion, and especially based on pulmonary clinical findings, active breathing is of key importance in treating this disease in order to awaken the *inner self-healer* so that it can face the disease hand in hand with the medical treatment. However, this is something only patients can do, rather than those who are treating them. Those doing the treatment can only invite the ill person to actively participate. No one else can breathe for them.

The need for mechanical breathing in intensive care units is a sign of the lungs’ depleted ability to fight, of their inability to compensate for the inflammation. Indeed, this depends mainly on the underlying viral damage to the pulmonary tissue, but why not also on whether I have tried to actively support my own forces of resistance? In this situation, life needs rational, conscious support.
During the 16th hour of breathing, I meditated. Tears streamed down my cheeks. I asked myself why I was crying, and the answer came: fear. A vital fear had nestled itself inside. A fear for my life. Somewhere deep down, these days without improvement had frightened me. I feared my state was worsening – a fear I had not perceived until then. My body was scared. By this, I mean that my subconscious body and mental movements, which are part of the internal self-healer, were scared, and therefore blocked. When I say internal self-healer, I am not referring to anything esoteric. Very far from it. I am a doctor and body psychotherapist. I see the internal self-healer as the psycho-neuro-endocrine-immunological net (PNEI), which, at a higher level, coordinates and integrates the separate systems to balance the whole organism and maintain health. For years now, this phenomenon has been mentioned in some medical fields.

Once I perceived this fear, my body relaxed and warmed up. Breathing further eased. I continued to breathe stupidly, breathing against fear. I proceeded continued this way in the following days and weeks, gradually less intensively. Seeing my blood saturation at almost normal levels, my hospital colleagues removed the oxygen, and left me to breathe on my own and decide to give myself oxygen as needed. If I ever stopped deep breathing, my saturation immediately dropped. I realized I was fighting for my life. One thought remained in my mind: “I want to live.” A pretty good motive if you think about it.

Covid-19 – The Fear Virus

Fear indirectly, but insidiously, infects us, gradually and imperceptibly, through the virus’ intimate mechanism of obstructing breathing and confusing the psyche. I believe the media contributed its fair share to stoking public fear, while failing to give adequate logical explanations, and instead opting for chaos and sensationalism. I believe in the importance of individual adequate, rational understanding. I believe that actively supporting medical treatment is essential in order to stand strong together in the face of this 21st century plague, rather than becoming crushed by fear and its cause.

Recommendations Based on my Personal Experience

**Active breathing.** Breathe actively, as deeply as possible, but do not force yourself. Gradually bring your breathing into a rhythm that allows relaxation. Remain consciously in this rhythm for hours. Bend your knees if you feel more comfortable. If dizziness occurs, massage your head and take a brief rest.

**Relaxation.** General relaxation and relaxation of the rhythm of your breathing are signs of success. The process will become automatic, and could potentially continue at the same rhythm and depth while asleep at night, as happened in my case. To create more space, breathe lying on your right, on your left, on your belly with a pillow under your chest (despite the heaviness, which should release in about half an hour), or on your back – with or without a pillow between your shoulder blades, so that your shoulders fall back and your chest opens up.

**Do not do too much of anything!** Slowly, carefully, gradually, observe. From time to time, try to take a deep breath, and hold it one to two seconds in order to open your lungs. It could stimulate a cough, but if that cough is not too strong, it’s a bit of gymnastics for your lungs. Spit out the mucus!

**When you feel improvement.** Put on some music and breathe. You’ll gradually feel full of energy. Do not seek quick effects, simply an effect. This is the moment when, if you feel you have enough strength, stand up, and carefully move your body in the upright position. Move with the full awareness of your moment-to-moment energy. Move your legs, your hips, your back, your shoulders, and breathe. If you have the strength, dance. Why not? Breathing in an upright position opens the base of the lungs, which, when lying down, does not fully spread open and is the site where pneumonias form from lying in bed.

Breathing leads to unleashing your energy. Use it to move, which will further revitalize you. Remain wary of not crossing over the line toward fatigue. The strategy I propose is to slowly and carefully recultivate your energy.

**If you feel revitalized.** Lie down and rest for up to 30 minutes. Then continue your active breathing. The aim is to oxygenate your blood slowly and gradually, to carefully and gradually energize and soothe your body in order to regenerate the self-healing processes by shifting them out of distress. The process is slow, and requires constant care and self-observation. What I am describing worked out well for me, and I relatively quickly managed to make it out of the downwards spiral I had gone into, and out of the hospital – but unfortunately, not so quickly out of the disease itself. I consider my experience one of personal self-discipline.

**My message to the virus.** “I will live because I want to. I will not give in to fear. Because even if I die, and before I die, I will live with the feeling of being alive and fighting. I will not be dead in advance from fear or lack of a will to live. I face you with my entire personal resources and with the invaluable help that the treatment and care of those around me provide.” And to my caregivers, a deep and sincere “Thank you” for their care, their attention, and their dedicated work!

Follow Up Observations

Looking back, I no longer speak of my symptoms, but of their overall effect and of the correct attitude and relationship to have toward them. As a causative agent, this virus affects many tissues and body systems. The symp-
toms I described above were the basic ones, but there were all kinds, everywhere – including mental. I felt seriously confused, and I remember telling my wife, who was caring for me: “I need to meditate. It helps me pull myself together. It immediately has a beneficial effect.” It was mentioned in a clinical practice article that about 20% of cases showed an exacerbation of psychopathology. Such a multitargeted attack against the organism leads to confusion in the self-regulation system.

Life is a structure, and death is the loss of such. If I ask myself what the most integrating force in nature is, I can give no better answer than love. I believe it is important to be warm and caring in our attitude towards the ill, but also for those who are ill to realize how important it is at such times to take good care of themselves. To nurture their warm inner core as it becomes disoriented, to give it a lot of love and care to help it gradually reorganize itself in order to bring back the state of health. Meditation, prayer, deep and steady breathing, listening to soft or lively music as preferred, and rest. These activities reintegrate the systems, and anyone can do them for themselves.

Vladimir Pozharashki

Vladimir Pozharashki, MD, has been a Medical doctor since 1991. He now works as a body psychotherapist in private practice in Sofia, Bulgaria, specializing in obsessive-compulsive disorders. He is the author of the book OCD. Obsessive–compulsive disorder or the drama to be strange. His interests are early trauma bodywork, integrative body psychotherapy and the philosophy of life. He is married and lives with his family in Sofia.
Here comes a moment in each person’s life when a choice is made, consciously or not, to either jettison the past and create a positive future, or stay mired in self-defeating patterns that lead nowhere. Fortunately, Raja Selvam chose to orient toward the unknown, to move from a past bookmarked by a near-death experience at birth, abandonment, and life with an abusive father, to successfully transition into the expansive realm of emotional embodiment.

His journey traversed continents and human consciousness to leave behind what was, and immerse himself in multiple modalities of sophisticated body psychotherapy systems, mainstream psychologies of intersubjective psychoanalysis and Jungian psychology, and the spirituality of enlightenment. The depth and breadth of his studies and experiences with prominent pioneers in the field of somatic psychology affords Selvam and his latest publication, *The Practice of Embodying Emotions: A Method for Improving Cognitive, Emotional, and Behavioral Outcomes*, a lasting place in body psychotherapy.

After noting that there is often an intimate relationship between psychological systems and the personal histories of their founders, Selvam adds: “Looking back over my life and my choice of orientations in psychology, I find that my relationship with the work of emotional embodiment in Integral Somatic Psychology (ISP) is no exception. I developed ISP as a comprehensive psychological approach to the embodiment of all levels of the psyche, individual and collective, with emotional embodiment as its primary clinical strategy, to improve cognitive, emotional, and behavioral outcomes in all therapies” (p. 4).

*The Practice of Embodying Emotions* is a valuable guide for therapists and readers alike who are looking not just for help but also deep transformation. Selvam introduces new concepts, solid theory, and grounded practice to embody emotions in gentle and innovative ways. The reader will walk away with cutting-edge scientific knowledge on the physiology of emotions in the brain and the body, the extent to which cognition and behavior depend not just on the brain but also on the body, how the capacity to experience and tolerate emotions in as much of the body as possible is important for potentially improving cognitive, emotional, and behavioral outcomes in all therapies, and how to go about the process of embodying emotions, especially difficult ones, in a systematic manner in therapy and life.

His concept of sensorimotor emotions is a unique and much-needed contribution to the field of human consciousness. Also, his presentation on how to use interpersonal resonance, the innate ability our bodies have to exchange information with each other through electromagnetic and quantum mechanical means, will be of considerable help to therapists in somatically attuning to their clients to emotionally regulate them. Refreshing in its presentation, Selvam’s book offers a clear guide for readers on a path of discovery toward embracing their whole being.

Selvam writes from a place of intimate and intuitive knowing. His personal stories are shared in conjunction with illustrative case studies to teach the concepts he is presenting. The book is divided into three parts: Part I: Overview, Part II: Theory, and Part III: Practice: The Four Steps of
Emotional Embodiment. For people who may be in a hurry to read through the book or who want to get to the hands-on experience quickly, he recommends to read Part I and then skip to Part III, saving the more in-depth theoretical explanations in Part II for later. In light of this review, and limited space, I opted to follow Selvam’s guidance. As an aside, his theoretical presentations that form the rigorous scientific basis of his work are well worth going back to read if you, too, should jump from Part I to III.

**Part I: Overview**

The four chapters in Part I establish the foundation for understanding Selvam’s core thesis – “involving more of the body in emotional experience can create a greater capacity to tolerate emotion and stay with it for a longer period of time” (p.2).

Chapters 1 and 2 provide overviews of the concepts, methods, and outcomes of the practice of embodying emotions in the context of case studies of clients learning to embody their emotions with higher and lower levels of emotional intensity, from earlier and later phases of development of the work. Chapter 3 considers concepts, methods, and outcomes in clinical settings with clients who are dealing with individual, collective, and intergenerational traumas as they learn how to embody emotion. Chapter 4 presents the benefits that can be derived from emotional embodiment, as observed in different therapeutic modalities and clinical contexts in short-term as well as long-term treatment. Along the way, Selvam also introduces the major paradigm-shifting research findings from neuroscience, body psychotherapy, cognitive psychology, and general psychology to explain the range of benefits of the practice of embodying emotions that have been observed in diverse therapy settings.

According to Selvam, emotions ultimately enable us to assess the impact different situations have on the wellbeing of our whole organism, our whole body. When the impact is distributed throughout the body, there is more support to subjectively tolerate the feelings, versus slipping into patterned reactions. People who tend to lack coping skills often turn to defense mechanisms to protect themselves from unwanted and overwhelming emotions – constriction being one such defense, which in turn limit emotions to a few places in the body while increasing the level of stress and dysregulation throughout the organism. (Another unique contribution of this book is a detailed treatment of all kinds of physiological mechanisms involved in generating as well as defending against emotional experiences, in chapter seven of Part II).

In his work, Selvam defines “expanding the body” as a way to “undo such physical and energy defenses to improve all of these vital flows from one part of the body to another, to help distribute the emotional experiences to more places in the body to make it more bearable, and to improve the level of regulation throughout the brain and the body to resolve psychophysiological symptoms” (p. 22).

**Part III: Practice: The Four Steps of Emotional Embodiment**

Here, Selvam presents four concrete steps – The Situation, The Emotion, The Expansion, and The Integration – for embodying emotions, with demonstrative examples.

The Situation is the specific circumstance that is impacting the client emotionally, with one's reaction contingent on the concrete detail of the situation. Here, Selvam shows how to access the specific details of the situation – the perceptions, the meanings, and the feasible behaviors – that are of critical importance in evoking the emotional responses.

The Emotion step involves helping people grasp the impact the situation has on them as emotional reactions. It might involve educating clients about the different kinds of emotions that can arise, including sensorimotor emotions that could be as simple as feeling uncomfortable. Chapter 9 in Part II offers a detailed treatment on different kinds of possible emotions, including the always-present but often-overlooked sensorimotor emotions. It might also involve recognizing and working with various innate and psychological defenses against emotions.

One innovative and effective way in which he uses the specialized emotional physiology of the face and the throat to help clients get into their feelings is to have them imagine another person expressing uncomfortable feelings through vocalizations and facial expressions, and then actually
do the acts themselves. From here he invites clients to “embody the simple sensorimotor emotion of feeling distressed or painful to as much of the brain and body physiology as possible” (p. 237) in the Expansion step.

The section on the Expansion step includes numerous methods for expanding different areas of the body, and why specific areas are critical in certain situations. Being able to work with specific body areas can help clients undo their defenses against emotions in those areas. Although numerous tools are available to work with physiological and energetic defenses to expand the emotional experience locally or from one area to another, Selvam limits his discussion to awareness, intention, and self-touch to make it easier for the practice to be adopted across as many therapy modalities as possible.

The optional step of Integration involves the conscious use of the improvements in body, energy, cognition, emotion, and behavior that begin to accrue when a person starts to improve their capacity for tolerating an emotion as resources for further emotional capacity building. Selvam even offers a seven-step protocol involving all four steps to help people with low levels of affect tolerance, such as those with borderline tendencies.

**Emotional Embodiment Is Not for Every Body**

Selvam acknowledges the reality that all methods have limitations, and there are times when emotional embodiment may be ineffective or contraindicated. Instances where emotional embodiment is unlikely to work are with clients whose lack of emotional development is severe; clients who cannot sense into/feel their body; and with clients whose window of tolerance is easily breached when they sense their body.

**In Conclusion**

Dr. Selvam has provided us with an innovative and clearly articulated contribution to the field of somatic psychology, and to the larger field of all those seeking to manage human suffering and expand consciousness, especially in these troubled times. The clarity of his theory, and examples and protocols for the reader to experience his methodology firsthand, greatly facilitate experiential learning of the book’s contents.

He acknowledges the contributions of other researchers and practitioners on which his work is built. His synthesis brings a new dimension to the work at hand, that of emotion and the body, that has not previously been articulated in such a novel and complete way. This book is well worth the exploration, for oneself and for those working with or researching emotions in any field.

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BOOK REVIEW

Treating Trauma and Addiction with the Felt Sense Polyvagal Model

A Bottom-Up Approach

by Jan Winhall

Michael D. Ostrolenk

As we in the modern world transition from the industrial age to the information age, it is becoming clear that many, if not most, of the institutions that act as mediators between us and our lives, such as education, medical systems, financial services, and food no longer serve us well (if they ever did). Foundational to each one of these institutions are various models and maps that drive individual psychology and cultures. As those institutions show their weaknesses and limitations, the models and maps that underlie them are shown barren as well. Transitional times can be, and often are, very hard and challenging. The very ground on which we collectively stand for our own safety and security is unstable. Yet these times also offer an opportunity to create anew.

Jan Winhall has done just that in the field of psychology and counseling. In her new book, Treating Trauma and Addiction with the Felt Sense Polyvagal Model: A Bottom-Up Approach, she reveals the limitations of the model that has been the bedrock of modern psychology and psychiatry for the last 60 years – the biomedical model and its pathological orientation.

Of course, it is easy to critique the existing model, just as its twin in physical medicine has also been shown to be wanting through the latest research in epigenetics. The biomedical model is quite reductionistic, and does not see the human as a complex adaptive system with both interior and physicality contextualized in social and natural ecologies. Jan’s research, study and clinical experience offers us a new foundational model, which is that humans are complex adaptive systems who can and do adapt to life conditions. Not only does she take into account the human system with both interior and physical (physiological) domains, but she also contextualizes all this in the interpersonal space – that is, relationships matter (literally). She humanizes the human, and integrates various approaches such as Gendlin’s felt sense, interpersonal neurobiology, and Porges’ Polyvagal Theory, among others.

Jan’s work has been a deep exploration through observation and paradigm shift questioning, which first began when she ran an incest survivors’ group in her early days as a therapist. Although her formal training had taught her that the self-destructive behavior of the women in her group, such as cutting and unsafe sexual practices, were pathological, she chronicles how this explanation did not sit well with her. At the time, she did not have the background and understanding that she gained through studying the felt sense and polyvagal theory, but she had an intuition that the consensual model did not quite explain what she was seeing. Through continued observation, questioning, and study, she began to see that the self-destructive behaviors found in her clients who had suffered from various types of traumas were not pathological, but were rather quite adaptive – at least in the short run. Her clients were attempting as best they could to manage their affect and regulate their nervous systems. She began to see addiction in a similar vein. For instance, cutting or drug use or promiscuous unsafe sex were attempts by her clients to induce certain emotional and bodily states. This is where the latest research on the nervous system has proven so valuable, as it provides a physiological explanation for the behavior and subjective reporting she was noticing from her clients.
A continuum exists from emotional flooding and chaotic responses to numbing and rigidity. She could see that her clients were vacillating between extreme sympathetic activation (fight/flight) and extreme parasympathetic activation (shutdown and rigidity). Not only were they vacillating, but both extreme states could and did exist at the same time. Through their adaptive responses to these internal states, her clients were attempting to shift states. They were, in fact, self-medicating, whether through drugs, sex, or cutting. She could see that these were the best strategies her clients could create for themselves at a time when there was no sense of safety. Jan could see that her clients’ behaviors were their nervous systems’ natural and self-organizing attempt to self-regulate in order to survive. It was their attempt to offer themselves a respite when being present was too threatening and overwhelming. Instead of shaming her clients as does the pathological model, she saw their behavior as heroic reactions in the face of perceived unsafe environments (both interior and external).

As mentioned above, over time, research from Polyvagal Theory and interpersonal neurobiology, as well as more bottom-up approaches that integrate the body as a first-person phenomenon, began to emerge, and provided conceptual models as well as practices that gave Jan’s intuitions empirical and experiential grounding. As an integrator, she saw the value in these different approaches and wove them into her work. She saw that what her clients really needed was to develop the capacity to ground themselves, to feel safe, and to be able to find healthier ways to manage their affect in the context of human connection. With the help of a good therapist’s love, compassion, and skills, they basically needed to learn to move their system from dysregulated, i.e., chaos and/or rigidity, to states of integration, health, and restoration.

Not only does Jan offer a new model to explain the adaptive responses of humans to trauma, but she also presents ways of addressing trauma through a non-pathological, humane and relationship-centered approach. Before I touch upon the approach she articulates, which is to help her clients deal with their trauma in a healthier long-term manner, it is important to expand this conversation to the socio-cultural level, as it is reductionistic to see trauma and addiction as only individual issues.

Jan also addresses oppression as a cultural issue, and how certain cultural forces show up in individual body-mind systems. She discusses exploitation, marginalization, powerlessness, cultural imperialism, and violence. So, we can’t just “work” with the individual and their trauma, but must also take into consideration the socio-cultural forces that contribute to and cause the trauma in the first place. Otherwise, we will simply be doing social symptom management.

There are two basic approaches she integrates into her work to assist her clients to learn to self-regulate and create an internal sense of safety, autonomy, and health. One is through the therapeutic relationship itself. The love, care, and compassion of a therapist can and does go a long way in showing clients what is possible interpersonally. A safe container created by a trusted therapist can be a good first step in helping their client begin to co-regulate their internal states. Done concurrently, the second approach is to teach the client to deepen their awareness of their own internal states (as appropriate), and how to regulate them through awareness, breath, and various embodied practices.

Jan’s book Treating Trauma and Addiction with the Felt Sense Polyvagal Model: A Bottom-Up Approach is a paradigmatic game changer. It is not just a new and useful mental model; it is an embodied approach that, when enculturated in the modern world, will offer us an opportunity to really help people who suffer from trauma, as well as create the conditions that can lessen the likelihood of trauma occurring in the first place.
The Proactive Twelve Steps is a great resource for our clients who are dealing with addiction or other manifestations of trauma. It provides a user-friendly framework that helps clients practice, on their own, a mindful process of self-discovery that is consistent with what we do in therapy.

The book integrates trauma and addiction. You cannot separate them out; they are intimately intertwined. When seen through a polyvagal lens, addictions are neurophysiological state changers. They involve being stuck in a feedback loop of sympathetic and dorsal, shifting between one and the other in order to find some kind of regulation. Of course, it doesn’t work, but it is all that is available until the underlying trauma is addressed.

Serge’s premise is that there is something in the Twelve Steps that really resonates with people. So, instead of focusing on the limitations of the Twelve Step model, he embarked on a dialogue between his perspective as a trauma-informed therapist and the healing process outlined by the steps.

The outcome is a user-friendly guide to embodied self-inquiry. As we all know, you can’t just tell people that they should be “in their body,” especially when that is scary to them. This book leads readers, little by little, to be in touch with their embodied experience.

It starts, in Step Two, with a metaphor: the healing process is likened to disentangling a cord. You cannot disentangle it by pulling mindlessly. You have to engage with it. Serge does not need to tell the reader to be in their body. He conveys it through the powerful metaphor of disentangling. This has an embodied resonance with all of us who have ever dealt with that experience.

Step Three shows us a way to shift from mindless, automatic behavior by taking a mindful pause. Serge clearly explains that this kind of pause is not the same as pausing a video. It involves curiosity, sensing into inner experience, and inviting the potential for change.

And so, by the time we come to Step Four, looking for patterns in your life is not an abstract idea. It is clearly based on exploring inner experience.

While the process is parallel to the traditional Twelve Steps, the actual step-by-step experiencing reflects a trauma-informed understanding of how people can make difficult changes. Instead of using the language of “defects of character,” Serge shifts the paradigm by talking about “coping mechanisms.” He invites the reader to understand the wisdom of these survival strategies from inside the body. He introduces the notion of vulnerability: helping the addicted person to begin to touch into threatening experiences while slowly building a capacity to be with uncomfortable places.

As a reader, you begin to understand how fear compels you to avoid staying in a vulnerable place, and pushes you to bounce back into your coping mechanisms. Addictions are not scary demons lurking inside. This is the intensity of the fear which can be assuaged by creating safe, nourishing relationships.
The process described in these Proactive Twelve Steps is clear and practical. It involves finding and rehearsing alternative behaviors that become daily practices. If you are in the middle of the fire, you cannot improvise a new response. It takes rehearsing, while you are safe enough to think more clearly.

And so, these steps do not dwell on making apologies to people for the sake of apologizing. Apologies naturally come about as a result of having a deeper understanding of your coping mechanisms, of finding more effective ways to deal with your fears and manage your problems. The apology is all the more meaningful, as it comes after you have found a way to not repeat the offensive behavior. As the shame heals, the apology follows.

Unlike the original Twelve Steps, The Proactive Twelve Steps are not driven by the grace of God or a Higher Power. They describe a down-to-earth process of developing your ability to make an enduring connection with yourself and others. Finding acceptance need not require believing in the grace of God. Being listened to in a compassionate way helps you find the acceptance that makes it possible to change.

You can now experience your social engagement system as a compass. It can fulfill this role, as you are able to deal with the triggers that fueled your reactivity. It is empowering to understand that your reactivity was trauma-based, not a moral failing. This leads to moments of true liberation — liberation from fear and shame.

**In Summary**

The Proactive Twelve Steps is an unusual kind of self-help book. It describes a deep process in user-friendly terms. It gently draws you into an inner exploration that is mindful and embodied.

It is a great tool to help our clients keep practicing, on their own, the kind of mindful process that we foster in therapy. For our clients who are in traditional Twelve Step groups, this book provides a most useful bridge between what they do in these programs and what they do in therapy. For those who seek the support of the groups, but are looking for a different way to understand their addictions, this book is a welcome addition to the field.

While the book is a great resource, clients do not need to buy it to have access to The Proactive Twelve Steps. The steps themselves, commentaries on the steps, instructions, and FAQs are all available online at http://proactive12steps.com.

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Jan Winhall, M.S.W. F.O.T., is an author, teacher, and psychotherapist. She is an Adjunct lecturer in the Department of Social Work, University of Toronto. Jan is Director of Focusing on Borden, a psychotherapy and training center, and a Coordinator with the International Focusing Institute. She teaches internationally on trauma and addiction.
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War Trauma

Working with the effects of chronic conflict, warfare, and persecution

There is no justification for war and persecution – no matter how justifiable each side’s arguments might seem, and wherever it may happen on the planet. How can body psychotherapy and somatic psychology help overcome and heal the mental distress, PTSD, syndromes, anxiety, depression, and hopelessness that result from chronic conflict, warfare, and persecution?

Guest Editor  ▫ Christina Bogdanova  MA

Christina is a Neo-Reichian analytical body psychotherapist with an academic background that includes a BA in Journalism and Mass Communications and a MA in Psychology and Psychopathology of Development. She has a private practice in Sofia, Bulgaria – individual and group, as well as she is a trainer at the Bulgarian Institute of Neo-Reichian analytical body psychotherapy. Currently, she is specializing in Somatic Experiencing and Somatic Trauma Therapy.

Suggested paper topics should include but are not limited to:

□ How exposure to severe war-related trauma, both in conflict or post-conflict settings, impact mental health, interpersonal and social functioning among the different parties involved – soldiers from either side, civilians, and refugees.
□ The consequences of war-related trauma on intrapersonal and interpersonal levels in the short and long-run. What might be working strategies for coping from the realm of body psychotherapy and social psychology?
□ Multicultural aspects in working with refugees. Ethical aspects in working with soldiers.
□ Helping parents help their children. The prevention and healing of trauma in children affected by war.
□ Transgenerational trauma – how war and severe conflicts today will affect the next generation. How can we work in support of alleviating, bringing resilience, and healing the transmission of transgenerational war trauma?

Papers should be submitted by September 30th 2022
submissions@ibpj.org
Call For Papers

Spring ▪ Summer 2023

The IBPJ Editorial Team feels that now, more than ever, our field must bring forward body-centered methodologies that foster diversity, equity, inclusion, and belonging. This coming year, we will highlight how the science and practice of body psychotherapy and somatic psychology can inspire and energize integrated body-mind approaches in the fields of trauma and addiction, war trauma, and social justice.

Social Justice in Somatics

Guest Editor ▪ Karen Roller  PhD, MFT, FAAETS, DNCCM, CT, CFT, C-SCR, RYT

Karen is an Associate Professor of Counseling at Palo Alto University, and Clinical Coordinator at Family Connections, a parent-involvement preschool serving the low-resource migrant community along the San Francisco Peninsula. Karen is co-author of Lifespan Development: Cultural and Contextual Considerations (in press). She presents internationally on trauma-informed care for the underserved.

Suggested paper topics should reference anti-racist guidelines * and include but are not limited to:

- **BIPOC, LGBTQ+ Ability Leadership.** Outline how somatic practices show up in decolonizing ourselves. *Elevate the voices of the historically marginalized.* *Humbly engage in anti-oppression and liberatory work—in progress.*
- **Clinical Intersections.** Center the historically marginalized. *Share somatic practices that bring heartfelt healing and cohering ritual.*
- **Holistic Healing.** Integrate the unbroken lineage of indigenous ancestors. *Highlight how somatic practices that heal bodyminds and the Earth bring balance and right living, free of domination.*
- **Ethical Responsibilities.** Manage power and privilege dynamics in somatic practice. *Emphasize shared decision-making and participatory action in assessment, treatment, termination, and related research.*

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First consideration will be given to articles of original theory, qualitative and quantitative research, experiential data, case studies, as well as comparative and secondary analyses and literature reviews.

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- If it is a case study, is there a balance among the elements, i.e., background information, description and rationale for chosen interventions, and outcomes that add to our body of knowledge?
- If it is a reflective piece, does it tie together elements in the field to create a new perspective?
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Your addiction was your attempt to solve a problem. That problem was that of emotional pain, and hence my mantra... Ask not why the addiction, ask why the pain.

—Gabor Maté