

# INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

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T. Marks-Tarlow 11.09

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United States Association  
for Body Psychotherapy

**International Body Psychotherapy Journal**  
*The Art and Science of Somatic Praxis*  
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## Editorial

### volume 13 • number 1 • spring 2014

The last two years, as we completed the transition from the *USABPJ* to the *IBPJ*, have indeed been a time of tremendous movement, change, and transformation. And more changes are on the way, in this issue and the next. The *USABPJ* was basically a two-person operation; I edited it and Robyn Burns produced it. Today, we have peer reviewers and advisors from virtually every continent, along with an editorial committee that assists the editor on an ongoing basis as issues arise. We have instituted a system of tracking peer reviews and reviewers (the work of Associate Editor Diane Cai, recently assisted by Joshua Wright). We have set up a working system that flows quite well, but hope that soon the enormous peer-reviewing and proofreading work now done manually will be taken over by appropriate programs.

We have initiated our own website, [www.ibpj.org](http://www.ibpj.org). Abstracts of articles are posted on the *IBPJ* website in as many languages as we can find translators for. We have a German language editor, Elizabeth Marshall, who heads a whole peer review process in that language and then translates selected articles into English for the Journal. Honoring the growth, expansion, and constant change in our field, we are pleased that we have been able to keep the *Journal* open access online, charging a minimal fee for print subscriptions. So far, we have been able to do this without a charge to authors (as is becoming customary in open access online journals).

With this issue, we initiate a new cover design for the *IBPJ*. Joop Valstar, collaborating with Chiel Veffer, provided both the design and Eugene Brands' artwork for the initial two years of our transition from being the *USA Body Psychotherapy Journal* to our sponsorship by both the USABP and EABP, and a new title, *International Body Psychotherapy Journal, The Art and Science of Somatic Praxis*. The image on the cover was an oil painting by Brands, entitled *Everything Streams*, referring to 'Panta Rei', the principle (found in the philosophies of Heraclitus, Plato, Aristotle) that everything moves, changes, and transforms all the time. And so it does. Our new cover has been designed by Diana Houghton-Whiting, somatic psychotherapist, who authored an article in our last issue on her treatment of military personnel with PTSD. Diana has patiently responded to myriad requests for large and small changes. The cover art for this issue is from Terry Marks-Tarlow, a California psychotherapist and artist. She generously allowed the editors to choose an image for this issue from the vast array of her artwork on her website and then agreed to write an introduction to our choice. In her "Self-Reflections" she narrates her journey from a primarily "left-brain" approach to psychology to a more embodied stance through the lens of her artwork. Dr. Marks-Tarlow has also curated a wonderful collection of therapists' artwork, some of which we expect will adorn future covers.

The Fall 2014 issue will also see the inauguration of a new feature edited by Asaf Rolef Ben-Shahar. He has asked Nick Totton to write an article, which is then commented on by four other prominent body psychotherapists, each of whom is briefly responded to by the original author. It is our hope that both Nick Totten's contribution along with those of David Boadella, Stanley Keleman, Will Davis, and Akira Ikemi will inspire our readers to think and write about these and other issues, which, as always, we welcome as letters to the editor and dialogue with the community at large.

The marriage of art and science is of the utmost importance to the Journal. That includes more than the "art and science of somatic praxis" that hopefully describes our clinical work. As whole human beings, we must, as Dr. Marks-Tarlow reflects in her brief piece in this issue,

enlarge our own creative capacities both in and outside of our work. Art, music, poetry, drama — these must be reflected in the selves we bring to our consulting rooms, our research endeavors, and the rest of our lives. Whether we are consumers or producers, participants or spectators, we must be involved. We might in fact think of our work as embodying the art of science.

At our request, body psychotherapist Jeanne Denney, an early contributor to the USABPJ (in the Archives on the IBPJ website, see volume 7#8, 2008), has contributed two poems to this issue, one from the point of view of herself as patient and the other from the vantage point of that same person now as therapist. Ms. Denney exemplifies the union of art and science in her study of the effects of compassionate presence on hospice patients and the hospice workers who offer this compassionate presence, utilizing measures of heart rate variability supplemented by interviews with caregivers and family members. She brings a background in engineering, childbirth coaching, and body psychotherapy training to her work. And, she writes poems.

Courtney Young, past President of EABP, and Gill Westland, Director of the Cambridge Body Psychotherapy Center, in "Shadows in the History of Body Psychotherapy: Part I", take a penetrating, sometimes provocative, look at Jung's concept of the Shadow as it has appeared to them in the history of body psychotherapy from its inception up to the present. Moving chronologically, they highlight issues such as the historical lack of academic affiliation and all that has brought, including an anti-intellectual stance on the part of many. They point to the Freud-Reich split and its continuing effects on attention to the pre-verbal and non-verbal as well as attitudes toward touch in the larger psychotherapy community as well as that of body psychotherapy. The role of charismatic leaders and competition rather than cooperation among their followers is explored. Controversies involving boundary violations are mentioned and the relationship of body psychotherapy to humanistic psychology is traced. It is the editor's hope that this article and its sequel in our next issue will engender some lively discussion, especially among those who have participated in many of the events mentioned.

Will Davis's wide-ranging article, "The Endo Self: A Self Model for Body-Oriented Psychotherapy," calls upon physics, biology, and systems theory, making an argument for the existence of what he has chosen to call an "endo" self, a coherent subjectivity pre-existent to the relational self. The endo self, he poses, is the organizing agent of its own experiences, and the obverse of the object relational self. Positing that there has been an overemphasis on the role of the other in self-development, he describes three themes current in the re-evaluation of the self as developed through relationship: the existence of a pre-cortical self, the existence of a unified organismic self preceding the body/mind split, and the need for a non-deficit model of human development. He then goes on to elaborate the characteristics of the endo self: a primary source, self-referential, abhorrent of splitting, autopoietic, self-regulating, immutable, possessing a sense of security and well-being, profoundly self-knowing, non-judgmental but reality oriented, preverbal and nonverbal, spontaneously and continuously reorganizing, and outside of time. Brief clinical examples illuminate the theoretical material as he draws upon multiple sources to buttress his argument.

While Davis emphasizes differentiation, attempting to extricate a pre-existent, self-organizing, ultimately immutable self from its later elaboration in relationship, Homayoun Shahri, in an article entitled "Toward an Integrative Model for Developmental Trauma" has championed theoretical integration. Shahri, taking the existence of a self as a given, goes on to trace its vicissitudes as illuminated by selected theories from the realms of psychodynamics (ego psychology, drive-conflict theory, object relations, and self psychology) in addition to polyvagal theory, complex self-organizing systems theory, and both Reichian and Bioenergetic writings from somatic psychology. He then presents an extended clinical case to illustrate the enmeshing of these perspectives. Shahri and Davis present complementary overviews. Davis

defends a primal, what he terms “endo”, self, and Shahri addresses its possible developmental course as that self faces chronic developmental trauma in the form of existential threats or contact deprivation. But both Davis and Shahri bring together complex dynamic systems theory with neuroscientific models of the autonomic nervous system, such as Porges’s polyvagal theory, and various psychodynamic models, including object relations and Reichian and neo-Reichian theories.

Christian Gottwald makes a foray into the area of mindfulness which, as he points out, has recently entered mainstream psychotherapy, but which has been practiced by body psychotherapy schools such as Hakomi for quite some time. An extended transcript of an initial session provides an illuminating example of initiation and supervision of consciousness processes with bodily interventions. By simultaneously calling the patient’s awareness to his thoughts and bodily sensations and introducing some simple movements, the therapist is able to help the patient shift from his past and future orientations into the immediate present and alleviate his presenting symptoms. Awareness and mindfulness are fundamental to change process. Furthermore, he argues, “a mindful state of consciousness can often become a gateway for spontaneous spiritual experiences”.

Dyana Reisen, author of “Helping the Body Grieve: A Body Psychotherapy Approach to Supporting the Creation of Continuing Bonds After a Death Loss”, brings more than six years of experience in bereavement counseling, research, and hospice work, combined with her Master’s level work in Somatic Psychology at Naropa University, to this article on how and when to employ techniques of body psychotherapy to facilitate the grief process. Before outlining some embodied interventions, she gives us a brief introduction to a number of areas, whose somatic aspects she highlights, of grief and bereavement, including some controversy over whether people benefit from continuing bonds with the departed or should be encouraged to sever them. Focusing on uncomplicated grief, she paves the way for further investigations of somatic interventions in complicated grief as well. Her clear definitions of many aspects of grief counseling constitute a very useful primer.

Olga Brani and her colleagues at the University of East London report an intriguing pilot study of the impact of body awareness on subjective wellbeing. After a brief introduction to the mind-body problem as it has been conceived of within psychological literature along with wellbeing and positive psychology, they focus on definitions and possible applications of body awareness and body awareness therapy to the subjective experience of wellbeing. Upon conducting an online survey of 119 individuals from the general population, they find a small but statistically significant relationship between body awareness and subjective wellbeing.

In tandem with this issue of the *IBPJ*, the Spring 2014 issue of *Somatic Psychotherapy Today* will feature a number of articles, interviews, and book reviews on the burgeoning field of eating psychology. Given what seems to be a worldwide epidemic of obesity along with the prevalence of life-threatening cases of anorexia nervosa and bulimia, this is an important topic. According to Nancy Eichhorn, editor of *SPT*, the field of eating psychology “shines a spotlight on the dynamic psychological relationship we have with food and its impact on our health and emotional wellbeing. Advances in holistic and functional nutritional health are changing the way we understand the role our diet plays in obtaining and/or maintaining optimal health”. In this issue of the *IBPJ*, Stephanie Pollock, in “The Enteric Nervous System and Body Psychotherapy: Cultivating a Relationship with the Gut Brain”, explores the role of the enteric nervous system, or “gut brain” in healthy mindbody functioning. In the course of work for her Master’s degree in somatic counseling psychology at Naropa University, she devised a system of working with clients’ enteric nervous systems (ENS), which she handily called the E.N.S. System. Adapting material from the Institute for Integrative Nutrition, the

Institute for the Psychology of Eating, her yoga teacher trainings, seven years of work with private clients, as well as her own body, and incorporating the body psychotherapy theories and techniques of Gerda Boyesen, Stanley Keleman, and others, she suggests that paying attention to how a person’s eating, needing, and sensing (what she designates as the E.N.S. system) are digested in the gut brain can foster consciousness of the ENS. And, ENS awareness in turn can increase emotional self-regulation and the ability to respond to the “gut brain” in the moment.

Naropa University in Boulder, Colorado, requires Master’s candidates in somatic counseling psychology as a condition of their degree to write a publishable article. The two articles in this issue have come out of that provision, as have several we have published previously. Christine Caldwell, the director of the program there, has been a leading force in propelling our field forward into academic respectability. Students from Naropa’s program and those from other universities represent the wave of the future in somatic psychotherapy. They are seeking academic degrees for basic knowledge and licensure, and will hopefully continue post-graduate training in one or more body psychotherapy modalities. Earlier on, as Young and Westland point out in this issue, academic degrees were in psychology only, neglecting the complimentary somatic aspect. It is wonderful that today’s graduates have at least been introduced to mind-body work, sometimes in a course or two, and, sometimes, as at Naropa, as the focus of their degrees.

Jacqueline A. Carleton  
New York City  
March, 2014



## Self-Reflections on Art and Psychotherapy By Terry Marks-Tarlow, PhD

As a kid, I loved to draw. My mother envisioned a future career for me as a medical illustrator. During college, I played with the idea and attended Rhode Island School of Design for a summer to choose between art and psychology. In the end, I rejected the life of an artist. First, I believed I wasn't talented enough. Second, it seemed too lonely a life. And third, I feared I couldn't support a family. I became a clinical psychologist instead, yet never shook my desire to be immersed in the arts.

Following psychology graduate school at UCLA, I developed a specialty in creativity and its various blocks. My first book was a creativity curriculum for educators. After it was done, I had a sobering realization. I had written about creativity partly because I hadn't been ready to embrace my own. Meanwhile, ever leading with my head, I began exploring the neurobiology of talent. This literature seeded an important idea—that expertise in any field is more related to persistence than talent.

Heartened by this research, in the mid-1980s, alongside dance and yoga classes, I returned to drawing. Initially, I tricked myself back in after receiving an invitation by the sculptor Tom Van Sant. Tom held weekly drawing sessions at his home in the Hollywood Hills. Here, the Nobel Prize winning physicist, Richard Feynman, regularly attended. I recognized the privilege of hanging out with such an illustrious character. This thrilling prospect provided my initial impetus to produce art again. Meanwhile, I started feverishly reading up on science, especially of the nonlinear variety, in hopes of picking the brain of the reputedly smartest man in the world, after Einstein.

Although I returned to drawing under false pretenses, I remained for better reasons. My art became a right-brain mode of communication. I perceived images to carry the power of cutting through where words often couldn't. I started "seeing" how I could illustrate the myriad of ideas now springing forth from my newfound fascination with complexity sciences. My second book, *Psyche's Veil: Psychotherapy, Fractals and Complexity* (2008, Routledge; foreword by Daniel Siegel), took twelve years and three drafts to write, illustrate, and publish—but I persisted.

Having played with abstract ideas for decades, I next longed for a more embodied, grounded focus. I landed on clinical intuition, along with its somatic and brain aspects. Happily, this topic integrates nearly all of my previous pursuits—creativity, nonlinearity, embodied practices, implicit processes, and nonconscious sources of inspiration and change. As I lead with my body instead of my head, my writing has picked up speed. *Clinical Intuition in Psychotherapy: The Neurobiology of Embodied Response* (2012, Norton; foreword by Allan Schore) took a little over a year to research, produce, and illustrate. Its recently released companion, *Awakening Clinical Intuition: An Experiential Workbook for Psychotherapists* (2014, Norton; foreword by Allan Schore) flew out of my unconscious in a matter of months.

I find that intuition, as expressed through multi-modal channels, is a lovely bridge between soma and soul. The more I dance, draw, and do yoga, the more I develop an embodied awareness of how my art cross-fertilizes not only with my writing, but also with my primary calling as a clinical psychologist. Whereas dance invokes space through time, drawing invokes time through space, and yoga aligns the body both in space and in time. All engage intuition nonverbally, through entrained body rhythms.

About ten years after Richard Feynman died and Tom Van Sant's drawing sessions fizzled, I started holding my own life drawing sessions. Ever so slowly, I have developed a unique

figurative style by putting multiple poses on the same page. This innovative technique allows me to represent in spatial terms changes in the model's positions over time. Occasionally, various poses on one page interact with one another in interesting ways. I noticed a new kind of visual synchronicity when a single line served the double purpose (or portmanteau) of simultaneously representing the edges of two different poses. Clearly, it is no coincidence that I discovered this phenomenon through drawing at the very same time as I was working on a chapter about synchronicity!

The image that appears on the cover of this journal, *Mother and Child*, is very simple, produced with a single continuous line. My aim was to distill the earliest maternal/infant bond to its bare essence. A portmanteau occurs in this drawing as well—this time between people rather than between poses. The line that depicts the mother's upper torso simultaneously depicts the child's swaddled form. Psychologically, the merged figures represent intertwined subjectivities. I strived to make visible nonconscious streams of mutual attunement, such that mother and infant remain physiologically yoked, despite the severed umbilical cord.

I experience art as an incredibly powerful, healing, and transformative mode of expression. Over the past two years, this conviction has only increased with my latest professional journey. Past President and fellow Board member of the Los Angeles County Psychological Association, Pamela McCrory, PhD and I have co-conceived and manifested two rounds of an art exhibition called, "Mirrors of the Mind: The Psychotherapist as Artist." I had the great honor to curate the show as well as to edit the exhibition art book (go to: [tinyurl.com/http-MirrorsArtBook-com](http://tinyurl.com/http-MirrorsArtBook-com)). The outpouring of paintings, sculptures, photographs and other forms of visual art from clinicians of all disciplines and theoretical orientations has been astounding. Along with their powerful artist statements, the body of work reveals how psychotherapists use their creativity to cross-fertilize, heal, rail against, and renew through self-expression. This provides a rare opportunity for colleagues and the community at large to peer into the normally veiled, private spaces of the psychotherapist.

Not only does art carry the power to change those who dabble in it, but I believe it also carries the power to change the world. Another of my many hats is to sit on the Advisory Board of the Global Alliance for Transformational Entertainment (GATE). This nonprofit organization (founded by John Raatz, alongside honorary founders Jim Carrey and Eckhart Tolle) sports the mission of empowering media and entertainment professionals to produce and distribute content that inspires new awareness-based worldviews for global audiences. Whether as personal growth, during psychotherapy, or through professional organizations, I offer up art everywhere in hopes of creating a better world.

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## Two Poems

### Jeanne Denney, BS, MA

Because I am a sometime poet as well as body psychotherapist, I was asked if I would like to contribute a poem or two to the journal. I was honored with this challenge. It provoked me in the best kind of way to be more honestly outward with the inward, exposing a closet self. I immediately thought of old writing from the first years of my own therapy. As a young mother struggling to both find and hold onto a self in the tsunami of four young children, writing opened a means of unearthing the voice and self that was threatened by that experience.

My therapists of that time were profound and loving men who brought both blessings and sorrows. Therapy itself raised questions. Like, what was this near mystical "I-thou" relationship I was a part of? Who was this other? Why did therapy work on such different rules than the ones for the care I was giving to children? While I struggled, the poetic was the language I found to express my experience and the realms of the unseen that I was becoming aware of.

Re-reading these I am so strongly reminded of the great vulnerability and puzzlement that clients can experience in the presence of their helpers as well as the preciousness of that passage into new understandings of self. The first poem below gives a sense of this raw passage.

Later, of course, I became a therapist myself. I have written little to none about this until now. The second, recent poem was written from the point of view of a therapist, holding both sides of the mystery.

1.

All of the little things that I would tell you  
cluster like so many stars becoming constellations  
So many turning stars!  
My job is to hold myself  
so that they appear to be still  
so that we can find forms in them  
Look! There is an archer in the field!

When I come to sit with you, the constellations vanish  
Then there is only their after-image  
and I am stunned by the flutter of voices  
left in the chair where others have been  
I add my negative constellations to theirs  
to yours!  
A confusion the cricket knows all about.

I don't know how the astronomer looks so long at the night sky  
or if he is a lunatic  
If the apple falls because of these movements  
or where the car engines are going  
Why the sun has always been terrifying  
or why I have asked you into this night meadow

full of faint sound and faint light  
where you hold your tired eye to the looking glass.

2.

You who walk across the threshold  
bearing arms and thistles  
alms and roses  
wearing corsets and  
chewing tobacco  
That howl in your bones is older than you know.

It has chased you across generations in and out of strange places  
farmhouses, huts  
castles, fields  
like a sleuth  
like a sniper  
and here you bring it, weary traveler, looking for mate or a remedy.

Commissioners of spice,  
you remind me of  
soldiers heavy with burden  
or refugees  
going from village to village  
mothers looking for food and infants.

Your songs don't usually scare me  
the grim parade trailing behind you  
the tune of the fife in the distance.  
You pay me mainly for my suffering  
for soup, rose, fire and staff  
I accept, amazed. In celebration.

I won't be so grandiose  
as to say  
Let me carry your banner  
or Save your village  
because  
I can't save your village.

Instead, let's  
cut a hole in the ice floor,  
and peer at moving fishes  
count  
the dead  
Weep for them together.

I (no hero here) will not save you, only say  
 go ahead, die  
 (at least a little)  
 Do It  
 See

What happens.

Friend, the howl in your bones? I have it too.  
 Play me a song on that little flute  
 I will make a small harmony so that  
 we can plant trees of forgiveness  
 in lands of milk and honey

Together  
 whistling,  
 walking home.

### BIOGRAPHY

Jeanne Denney is a psychotherapist, healer, teacher and death (and life) educator who maintains a private practice in somatic psychology and energetic bodywork in Haverstraw, NY, and New York City. She has been a teacher and mentor at Ramapo College of New Jersey, The Institute for Transpersonal Psychology (Now Sophia University). She currently leads workshops and teaches at Nyack Living Core Program (Core Energetics). She has spent years as a doula for death and birth and has raised four children.

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## Shadows in the History of Body Psychotherapy: Part I<sup>i</sup> Courtenay Young and Gill Westland

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### Abstract

This article is intended to open up a discussion and to begin to name, reflect on, and gradually start healing some of the wounds that arose throughout the development of body psychotherapy, particularly during the 1960-2000 period.<sup>ii</sup> It highlights several problems inherent in individuals single-handedly pioneering new methods, and several systemic difficulties in the organization of the original training courses. These Shadows are not unique to body psychotherapy and similar examples of such issues can be found in many other modalities of psychotherapy and in many other communities. They have implications for the wider professional field and also the future development of the field of body psychotherapy that, once named and owned, can be utilized more positively. Because of its length, the article has been split into 2 parts. Part II will be published in Volume 13, Number 2, fall.

*Keywords:* body psychotherapy, shadow, history, abuse, healing, ethics

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### Introduction

#### Acknowledging the Shadow

Individuals, organisations, countries, and, of course, the profession of body psychotherapy, all carry their Shadow aspects. Jung saw the Shadow as a merging of unconscious personal elements with various archetypal contents of the collective unconscious. The Shadow also contains the repressed parts of ourselves that we cannot accept and “the less it is embodied in the individual’s conscious life, the blacker and denser it is” (as cited in Samuels, Shorter & Plaut, 1986, p. 138). The Shadow can further contain elements that have not yet emerged into consciousness and thus this part can only be inferred, often in the form of unconscious or subconscious projections. These projections can become stronger and more irrational, individually and collectively, as the contents of the Shadow move towards consciousness. The Shadow cannot be eradicated, but it is possible to learn to live with it, and even use it constructively (Samuels, Shorter & Plaut, 1986). The Shadow and its corollary, the Light, in Jung’s terminology, **both** have dangerous and constructive characteristics. Only when we “own” the good and bad aspects (of each) can we move beyond these polarities into a more integrated Self. While I use the terminology of the Shadow, I also indicate a process towards higher levels of consciousness (viz., Thich Nhat Hahn’s poem, “Call Me By My True Names”<sup>iii</sup>).

Jung also believed that, “in spite of its function as a reservoir for human darkness — or perhaps because of this — the shadow is the seat of creativity” so that for some, it may be that “the dark side of his being, his sinister shadow... represents the true spirit of life, as against the

arid scholar” (Jung, 1983, p. 262). Since the emergence of psychoanalysis, there has been a: ...vast outpouring of research, speculation, theorising, analysis, and controversy, resulting in a broad spectrum of schools and movements, all holding high the banners of their own truths and hostile to others (Jacoby, 1990, p. ix).

### The Founding Fathers of Body Psychotherapy

#### Pierre Janet

Whilst Janet was almost certainly one of the founding fathers of body psychotherapy (Boadella, 1997; Janet, 1925; Kimble & Wertheimer, 1998), being an elder established pupil of Charcot’s, and a contemporary of Freud’s during Freud’s 3-month study visit to Paris, it is somewhat remarkable that Janet had very little influence on the subsequent development of body psychotherapy. His work has only relatively recently been re-discovered by body psychotherapists, and so the impact of his Shadow on it has been relatively benign or obscure (except, perhaps, in the refusal or disdain of other continental body psychotherapists to publish widely in English).

#### Freud

Those familiar with the history of body psychotherapy (Young, 2006b, 2011) will also be aware that, whilst Freud originally acknowledged the importance of the body within psychotherapy, he later came to reject it, and eventually excluded those colleagues who supported it, such as Reich and Fenichel (Heller, 2012), both of whom supported a bodily oriented way of working. Freud had also previously rejected the totality of Pierre Janet’s work; and, with all these exclusions and later denials (including Jung and others), Freud then started to cast something of his own Shadow especially with respect to the body.

Furthermore, at first he believed his patients who had reported sexual abuse, but later on, he revised his thinking and saw these reports instead as normal childhood longings and fantasy, developing a whole (Oedipal) theory to support this essential denial. When Masson (1985) revisited this territory, using the Freud archives, he postulated that Freud had covered up actual sexual abuse and was not surprisingly met with considerable criticism from supporters of Freud, who did not like the small boy saying, “The Emperor has no clothes.”

We have recently been presented with a further theory that Freud was an unacknowledged cocaine addict (Cohen, 2011) and that possibly a substantial part of *The Interpretation of Dreams* was influenced by this.

Finally, there is reasonably strong evidence that, within psychoanalytical circles, there was an appalling degree of complicity with the rising power of National Socialism, especially in Germany from the mid-1930s (Nitzschke, 2003). Given our theme, these are some of the possible Shadow aspects of Freud and thus of psychoanalysis; there may well be others.

#### Reich

Reich was one of Freud’s most talented students, yet he was expelled from the International Psychoanalytic Association in 1934, about 18 months after he had first published *The Mass Psychology of Fascism* (Reich, 1933). Whether this expulsion was because of his previous involvement with socialist or communist ideals, or whether this was because of his increasing interest in the body in psychotherapy, or whether this was a (necessary) separation of psychoanalysis from Reich’s views about National Socialism, is difficult now to say. Even

Anna Freud (who chaired the committee that expelled him), later acknowledged that his expulsion was “unjust” (Boadella, 1973, p. 114). One result of this is that, for psychoanalysis, the body became part of its Shadow side. Again, I reiterate, the Shadow is only negative when denied or rejected; it becomes more positive and useful when owned and accepted. This denial is also a large part of our psychotherapeutic philosophy, and can be found in several religions as well.

Reich then became a refugee, first to Denmark, then to Sweden (each on a visitor’s visa for six months), and then to Norway, and finally emigrated to the USA in 1939, a short time before the Second World War, where he came under surveillance by the FBI (Bennett, 2010, 2014; FBI, 1999; Turner, 2011). He eventually died in prison in 1957. It seems, from the accounts of the newspaper campaigns against him and the investigations by the FBI and the Food & Drug Administration (FDA), who eventually took him to court, that he carried a large part of his Shadow with him. To an extent, he became his own worst enemy as he sowed, like Oedipus, the seeds of his own downfall. His books were burnt in both Nazi Germany and the USA in the 1950s (Young, 2006b, 2008, 2010) and body psychotherapy, such as it was then, had to distance itself from him, evidenced especially by Lowen (1958) hardly mentioning him in his first book, *The Language of the Body*. Later, his work was recognised and revived, and became influential within humanistic psychology (Clarkson, 1994). Body psychotherapy then re-recognised him in the 1970s, significantly with the publication of Boadella’s books (1973, 1976) and his journal, *Energy & Character*.

Reich’s life had had several severe traumatic experiences in it, some with a distinct sexual Shadow. He himself wrote of his early childhood sexual experiences (Reich, 1988) with a sense of self-agency, and Sharaf claimed (in a keynote lecture at the European Association for Body Psychotherapy conference, Vienna/Pamhagen, 1997) that Reich was probably sexually abused as a child, though this point is less clear in his book (Sharaf, 1983). There were definitely huge issues with his mother as well as subsequent female partners and wives that indicated he had not resolved any of these issues; and there were less obvious issues regarding ‘father-figures’ as well. Reich was certainly an iconic and controversial figure and it is therefore quite hard to come to any sort of balanced view about him. Many people have claimed that his work supported this, or that, films have been made, and his work has become the subject of pop songs, all of which he probably would never have condoned.<sup>iv</sup> It is very easy to get attached to one or more of the many facets of this iconic character, and thus hail him as a genius; it is equally easy to dismiss him out of hand. Both of these are aspects of the human Shadow that he graphically illustrated so well in *Listen, Little Man* (Reich, 1948/1972).

These are some of the very early foundations of body psychotherapy. Hopefully by recognising these creative and sometimes traumatic foundations, a potentially helpful and healing dialogue about the Shadow can be re-opened. Freud and Reich’s disavowal of religion (and, to an extent, spirituality) is another aspect of the Shadow that needs to be examined — more on that later.

#### Childhood Sexual Abuse

Irrespective of Freud’s reluctance to admit to the obvious, it has also, incidentally, taken a very long time for mainstream society to acknowledge that childhood sexual abuse happens a lot more frequently than was previously imagined. So, there is a huge parallel Shadow side here.



As therapists, we are — perhaps — slightly more aware of this topic now, after the mid-1980s when the topic came out of the “closet”. It was also reacted to strongly by the ‘false memory syndrome’ whereby therapists were accused of influencing their clients in the “recovery” of traumatic memories of childhood sexual abuse. This created a huge uncertainty that has possibly allowed several prosecutions of childhood sexual abuse (long after the event) to fail. Psychotherapy has had to face this Shadow side: as a therapist who has had clients who have recovered such memories when under a spontaneous form of regression — rather than hypnosis, sedatives or probing questions — I am convinced of their veracity, especially as these memories are received with horror and shock. However, the jury is still out on this topic.

Recently, many more incidents of childhood sexual abuse are being discovered (viz: the Catholic church “allowing” priests and nuns to continue abusing people within its congregation and under its protection; and the ramifications of the Jimmy Savile affair in the UK, with similar incidences of pop stars and TV personalities abusing their charisma.

### Risks Within Body Psychotherapy

In this article, we are not talking about any specific risks inherent within the modality of body psychotherapy or within body psychotherapeutic practice. This topic has been reasonably well-covered elsewhere (Young, 2006a). The specific risks of any particular psychotherapeutic method obviously need to be acknowledged, and therapists therefore need to be trained in any possible contraindications and in circumstances under which their various techniques or methods can be possibly inappropriate. Any such inherent risks:

... can be added to by unethical practice, power-trips, pervasive theories and doctrines that do not support the empowerment of the individual, lack of awareness, too hurried forms of working, goal-oriented therapy, and insufficient time for integration. (Young, 2006a, p. 7)

The four main risks, easily identified with respect to body psychotherapy, have been identified as being those around, “Re-traumatisation; Abusive Touch; the Breaking-Down of Defences; and Inappropriate or ‘Malign’ Regression” (Young, 2006a, p. 1). But these are fairly well known and also fairly easily identified and therefore do not really fall within the remit of this article about the (more unidentified) Shadows within body psychotherapy.

In dealing with the contentious topic of touch and the reactions of those adverse to the concept of legitimate touch in psychotherapy, we may carry our own Shadow when simply dismissing these opponents as either being uneducated or blinded by cultural mores around touch: this form of dismissal would allow us not to examine our own practices properly. Thankfully, there is a lot more healthy self-examination, especially around this topic, now within the field of body psychotherapy.

I deal with the risk that we carry about not doing any proper research into the effectiveness and efficacy of body psychotherapy in more detail elsewhere in this article, however, in more general terms — as with any practice, or treatment or methodology — there should be a healthy attitude towards exploring and assessing potential improvements and modifications. I have my doubts that this attitude is properly built into our professional training courses and, as far as I am aware, we have not properly considered this aspect as a professional concern until very recently. Hopefully the EABP<sup>v</sup> Science and Research Committee, working jointly with USABP<sup>vi</sup>, which was established only recently and just starting to work, will over time be given sufficient resources and influence that it will need to make the necessary

changes within our culture. There is still a basic attitude of, “Research? What research? Why do we need research? We know it works.”

So, as we progress in the establishment of body psychotherapy as a legitimate mainstream within psychotherapy, all the sorts of criticisms that are carried about other mainstreams — they are “too this” or “not enough that” — will also be applied to body psychotherapy; and some of these may have a legitimacy. We must try to guard against them. We will inevitably have our blind spots and our limitations, our areas of arrogance and complicity. As we carry the “specialness” of our particular way of working, we will always carry with it the inevitable risk of hubris.

### The Post-War Shadows of Body Psychotherapy

#### Cooperation & collaboration

As post-World War II psychotherapy developed, particularly from the 1960s onwards, body psychotherapies, far from being marginalised as they had been, began to proliferate, often emerging around a talented, charismatic founding individual. John Rowan writes about bodywork in his 1976 book on humanistic psychology, but unfortunately he muddles together body therapies and body psychotherapies, but observes that ... “with the exception of Boadella (1987)”:

One of the problems with the body therapies is that they seem to lead to a proliferation of individual practitioners each with a method about which he or she is completely dogmatic. For some reason, this seems to be much more the case in the body therapies than in any other approaches (Rowan, 2001, p. 91).

If we accept this comment about proliferation of dogmatic methodologies as semi-factual information, perhaps we can use the rest of the quote for reflection: it really may be the “dogmatic” aspect that has subsequently haunted us as a Shadow within body psychotherapy.

For a long time, until about the mid-1990s, the various different body psychotherapy schools often saw themselves as competing with, rather than complementing, each other and thus *their* particular method as being implicitly “better than” another’s or any others: a factor (perhaps) of the egotism of some of the founders of those particular methods. There was a fairly constant background of consistent critical reflection and comparison between different body psychotherapy methods that was not particularly healthy or supportive. And thus, what Petruska Clarkson (1999) described as schoolism would seem to have been very prevalent within body psychotherapy as well (Westland, 2010).

The situation has improved with the strengthening of the two main professional associations (USABP & EABP) over the last 10-15 years and the founding of some other similar associations in Australia and South America, but there is a long way to go to get any degree of real cooperation, coherence, and collegiality: there are, within Europe, the inevitable “cultural” North-South divides, where people from the Northern (Germanic) countries are seen as much too concerned with rules and regulations, and those from the Southern countries claim a more relaxed and laid-back attitude to organisational issues, as well as the historic East-West divide, reinforced by the post-war Iron Curtain, where the Western countries seemingly flourished and grew and those from the Eastern countries felt somewhat resentful and impoverished. Some of these Shadows still haunt us, especially at conference times, and with the fee structures. However, there are ways of working with this and the EABP has begun to grapple with these ways.

Now, at this point, we need to take a slightly deeper look at some of the factors or trends that went into creating some of the various Shadows within the different body psychotherapy modalities (and among their founders), but for obvious reasons we do not wish to “name names”, nor report salaciously or from rumour or speculation.

### Humanistic Psychology

Reich's views were first taken up in his lifetime, often by small groupings of psychiatrists interested in his ideas in Scandinavia and then in the U.S., which he tended to influence and control (especially in the U.S.), setting rules that still exist to this day (e.g. that only medical doctors should become proper Orgonomists). Whilst there are some good reasons for this, it creates an exclusivity or hierarchy, which often covers a Shadow. It may (or may not) be significant that, since his death, the Orgonomists have kept themselves very much to themselves and, “ploughed the same furrow: over and over again”.

He became much more popular, particularly in the 1960's, 70s, and then the 80s. These post-Reichian developers of body psychotherapy in the U.S. (such as Alexander Lowen, John Pierrakos, Chuck Kelley, Malcolm Brown, Stanley Keleman, Ilana Rubinfeld, etc.) and Europe (Ola Raknes, Jay Stattmann, David Boadella, Lisbeth Marcher and Gerda Boyesen) were all bold and creative innovators (Young, 2008, 2010 & 2011). These innovators all caught the spirit of the times, and the growth wave of humanistic psychology, but, apart from the first two body psychotherapists listed, none really knew Reich and all of them had borrowed (or diluted) some of his ideas. They were all also quite risk-taking pioneers, but, with their creativity and challenging of the cultural norms, they also sometimes brought about ways of working and organising trainings that had some problematic elements, especially when viewed through later contemporary eyes. Reich's daughter Eva was the only one of his children to follow in his footsteps and she softened his work with her form of “Gentle Bioenergetics”<sup>vii</sup>, strongly influenced by her work as a paediatrician. However, her father might not have agreed with her if he had still been alive. She may have also used the term ‘Bioenergetics’ in the title of her work as an implicit criticism of Lowen's “harsh” form of Bioenergetics.

Much of this period of development in body psychotherapy was within the context of, or as a result of, the Human Potential Movement (Marlock, 1996), and the 1960's hippie movement. Major structural changes were happening in society, where previously repressed elements were finding freer expression, and overly restrictive structures were being overthrown. Many of Reich's ideas were eagerly taken up by Fritz Perls' Gestalt therapy (though not ever properly attributed to Reich), the Beat Generation (Turner, 2011), and even passed into the counter-culture. Humanistic psychology at this time had its “mavericks, innovators, charlatans, and would-be-gurus” (Smith, 1990) and body psychotherapy was also developing within this context and therefore carried (or was labelled with) some of these components as well. Again, the incredible cultural changes of this era led to certain permissive attitudes in psychotherapy, as well as outside it, that are now considered unwise, inappropriate, or totally unprofessional.

There were, for example, several instances of trainers and therapists sleeping with group members, or patients/clients. This was not at all confined to body psychotherapy; it was part of the “scene”. There were also several more specific instances of encounter with group processes that became abusive or even violent (Boadella, 1980), and whilst most of these were not necessarily directly connected with body psychotherapy, it took a body psychotherapist to be one of the first to condemn them.

### Anti-Intellectualism

Within humanistic psychology, there was also a fairly strong anti-intellectual component and this was also evident within several of the developing body psychotherapies in those days. It was one component of balancing an over-intellectualised view of human beings within psychology (and especially psychoanalysis) at the time. Humanistic psychology valued highly subjective experiences, wanted to find much more of a place for people's feelings and the senses, and thus put great emphasis on these. Whilst the psychodynamic theory of childhood trauma and repression was intellectually accepted, now — with the developing techniques of regression and abreaction — it could actually become experienced.

Unfortunately, sometimes the regressions, often in the form of re-birthing, could be done excessively without the necessary integration of the experiences or in some cases the regressed person might have been left in a fairly regressed and deconstructed state, which would now be considered bad therapy. Some of the abreactions that were encouraged took a person so far out of the person's normal “comfort zone” that great difficulty would be experienced with re-integrating.

Within body psychotherapy itself, there was still an emphasis on “breaking through” the (identified) body armouring and the character structure, to a (supposedly) core aspect of the person, who had never really been able to develop this core. Many of the therapists of the time saw the key to body psychotherapy as being in the catharsis: the “breakdown” or the “breakthrough”, and not — as is now much more generally acknowledged — in the “softening of” the ‘armour’ so that the fragile or undeveloped core may grow and expand, using the therapeutic relationship as a medium.

The Californian growth centre, Esalen, was founded in 1962 to explore “unrealized human capacities” (Esalen, 1996) and generally blended Eastern and Western perspectives, mostly experientially, as did many body psychotherapy trainings, some of which still happen there. Yet there was absolutely no place for this sort of study within any of the universities at that time. So, a body of humanistically based, body-centred, experiential, and often hands-on competencies and therapeutic skills emerged and flourished, with less attention paid to any sort of conventional academic intellectual rigour or investigational research parameters. There were often statements made such as: “Get out of your head and into your body”, and a cultural form of anti-intellectualism arose. This was evident in that virtually no written work was ever demanded of us in our particular body psychotherapy training in the late 1970s and early 1980s — and we were not unique. The relationship of body psychotherapy to academia and universities still carries some of this aversion. This is another aspect of our Shadow that we are now being asked, and required, to address.

If body psychotherapy becomes more university-based, with Master's degree-level trainings, it may well have to lose some of its experiential expertise and richness, and instead favour a bit more academic discipline, critical thinking, scientific testing, and proof of efficacy — none of which has really been done properly, yet. As a result, we may find that many of our favoured body psychotherapy theories over the years just do not stand up to any sort of appropriate scientific testing, and therefore have (perhaps) as much relevance as the long-held theories that the sun moves around the Earth, or that the Earth is flat or sits on the back of a giant turtle.

However, in contrast, many of the university-based trainings are dry, flat, and predominantly academic — their own Shadow — and so the formation of links whereby accreditation is afforded to training schools by recognised universities is probably a more favourable route.

But this demands the training school have some academics attached to it, with at least someone with a PhD prepared to do a lot of hard work to get the accreditation process set up. However, it would be worthwhile and there would be many valuable spin-offs, including the publishing of theses and dissertations, and involvement in research programmes.

Nowadays, most humanistic psychotherapy courses in the UK are being validated by universities at Master's degree level and yet have managed to retain their experiential component (for example, Gestalt psychotherapy at the London Gestalt Centre, Metanoia, another psychotherapy training school in London, and Karuna, a Buddhist-oriented psychotherapy training school in Devon). There are also several UK university-based Dance Movement Psychotherapy training courses.<sup>viii</sup> All of these arts therapy Master's programmes have substantial experiential learning as part of their training; and so, if these, why not also body psychotherapy? Mainly because we are not putting in the effort: there is a resistance, or an "edge", which could well be part of our Shadow.

Finally, as a part of this anti-intellectualism, the appalling paucity of any proper research (until very recently) into the efficacy and effectiveness of body psychotherapy cannot really be excused. This is definitely part of our Shadow, in that we may not want to think about the possibility that proper research might demonstrate that body psychotherapy is no more effective than any other psychotherapy, and we may also not be very well prepared to do the actual research as there are few "proper" academics amongst us.

It is true that these points can apply to other psychotherapies as well: much of the research actually shows that they are all equally effective (the Dodo Bird hypothesis: "All should have prizes", according to Luborsky et al., 1975), and it is also true that randomised controlled trials and other accepted methods of scientific research are not the most suitable for assessing the "natural" science of psychotherapy and body psychotherapy (Young, 2012a). But there is no excusing the fact that, until recently, no one really attempted to do proper research into body psychotherapy. We may soon be forced to change.

### The Anti-Psychiatry Movement

In Europe, in the 1970's, there were the remnants of the pre-war Reichian school in Norway: Jay Stattmann was working in Amsterdam; David Boadella was working in England; and Gerda Boyesen had moved from Norway to "swinging" London to teach her Biodynamic Psychology (Southwell, 1988). London was very fertile ground then for psychotherapeutic experimentation: R.D. Laing (Laing & Esterson, 1964), Joseph Berke, Morton Schatzmann and others were working in Kingsley Hall and later established the Arbours Association. There were other therapeutic communities starting up, like the Philadelphia Association and the Richmond Fellowship, as well as the more radical "People, Not Psychiatry" movement. Also present were a host of cutting-edge spiritual and psychological opportunities.

There was a wide cross-fertilisation of ideas and experimentation amongst these people. For example, Jerome Liss, the Harvard-trained psychiatrist and body psychotherapist worked with Laing before going to Italy, and Jenny James (Ward, 1982) worked first with David Boadella, then for "People, not Psychiatry", and then founded Atlantis, an experimental therapeutic community in Ireland.

Meanwhile, body psychotherapy effectively stood on the side-lines and ducked many of the anti-psychiatry or radical psychotherapy issues; this, despite the fact that we possibly had much greater insight into what was actually happening within people when they went out of their heads and their bodies sometimes took over. It took people like Stan Grof (Grof & Grof,

1990), who founded the Holotropic Breathwork form of body-oriented therapy technique (incidentally, not a form of body psychotherapy), to envisage and include Kundalini-types of experiences into the different forms of 'spiritual emergencies' that he described coming out of his work with LSD and at Esalen.

### Boundary Issues

The opening up to greater sexual freedom and individual sexuality (with the almost simultaneous development of the contraceptive pill) in the 1960's, liberated some of the more sexually repressive elements in society, but without sufficient thinking-through of all its implications. Within many humanistic psychology and also body psychotherapy trainings in the 1970's, there was more emphasis on catharsis and in-depth experience, and sexual boundaries were often quite fluid. However, by the 1980's, various people were beginning to question some of the methods being employed in the name of body psychotherapy.

Boadella (1980) had already questioned the sometimes extreme levels of violence that existed in some encounter groups, as well as humanistic psychotherapy and body psychotherapy groups, and he quotes Eva Reich commenting that her father, Wilhelm Reich, never hurt people and was "against drastic manipulations and heavy muscle-pushing" (Boadella, 1980, p. 9).

Greater thinking about appropriate sexual boundaries occurred throughout the 1980's and this led to several articles, such as Southwell's (1991) article, "The Sexual Boundary in Therapy".

During the 1990's, some more, or deeper, reflection was beginning to be given to ethics and practice in body psychotherapy, for example, the work of MacNaughton, Bentzen & Jarlmae (1993). Other books were also being written like *Touch in Psychotherapy* (Smith, Clance & Imes, 1998) and *The Ethical Use of Touch in Psychotherapy* (Hunter & Struve, 1998), which were trying to establish proper boundaries in a (now) fairly de-regulated field and regarding a very contentious issue.

There was also some implicit questioning of the style of teaching in some body psychotherapy trainings, where a guest trainer (with considerable charisma) might fly in from abroad bringing huge expectations of powerful new methodologies. Sometimes these expectations would be fulfilled, sometimes they were disappointing, yet there would never be anything considered essentially "wrong" with the charismatic, international trainer, him or herself. There was also little opportunity for feedback, open discussion, or debate. Sometimes, the quite powerful interventions, methods, or techniques used by these trainers would be quite provocative; yet this was — in the *métier* of the times, still considered "good therapy" — and so people came back for more.

This form of idealisation could carry forward into the group member(s) having enormously powerful, individually reactive experiences, but afterwards it would be the local or resident therapists, who would have to help pick up some of the pieces, or help the trainee or group member re-integrate. Occasionally, the person would have a psychotic episode, and the trainer would often take very little of the responsibility, preferring to blame the person rather than examine the method.

Yet, it was not all extroversion and catharsis; some of the theorists, like Boadella (1986) and Davis (1984), were also beginning to recognise the value of the 'in-stroke', as well as the 'out-stroke', and that containment and expression of feelings each had its place and value. In her trainings, Gerda Boyesen also said frequently, "Less is More", and spoke of a

“subtle approach” to body psychotherapy; and yet, there were still instances of people having (seemingly) psychotic episodes after Biodynamic therapy sessions, or experiences in training groups, which were often put down to the “powerful effects of Kundalini rising” in addition to the person having “insufficient ego strength to cope with the powerful forces of the id”. This is a disavowal of responsibility for the technique, and might also indicate a lack of consideration for contra-indications, or even of doing a risk assessment of the appropriateness of that technique for that person.

Most of these types of uses or abuses within body psychotherapy (as well as in other psychotherapies) happily got “ironed out” in the 1990’s. However, some therapists, who may have initially trained in those earlier unbounded periods, did not curtail their abusive practices and continued to give therapy in what became increasingly unacceptable ways.

One such (dare we say it, body-oriented) psychologist and psychotherapist ended up in court, with a three-year sentence, two in prison and one year on probation, and an eight-year limitation on practicing, with fairly substantial damages being paid to the four complainants, although there were possibly at least another 160-180 people that he had “treated” in this so-called “scientific” method. He had called it “experimental embryonic skin contact work”, but this included both participants being naked, and the client or trainee’s clitoral and vaginal areas being stimulated. In his formative years as a therapist, it was not the custom to take notes or keep medical records, so his defence that this was “scientific” was ignored. One judge asked, appropriately, whether the therapy worked only for women, and then only for women of a certain age. Apparently, he “has taken little notice of frontiers” and imagined that he was “a pioneer” and was giving these people “the warmth and security” that they had had to do without.<sup>ix</sup> A lot of the so-called theory behind this particular form of abuse was wrapped up in pseudo-scientific work to do with pre-natal and peri-natal psychotherapy about risk factors in the womb (Krens & Krens, 2006).

Unfortunately, this one publicized example might be just the tip of the iceberg. We may, in due course, need to track this back to the charismatic therapist(s) who trained him; and we may also need to track this forward to the therapists and trainers that he trained or inspired. This sort of Shadow is (unfortunately) quite pervasive and pernicious as it links into several politico-social stereotypes and it is also very difficult to eradicate, as — even after investigation — a lot of in-depth re-education is necessary.

It is worth noting that, by all accounts, this sort of behaviour has also been ascribed to people from other modalities: there are salacious stories about Ferenczi, Jung, Perls, and Kahn, though none of these were ever taken to court or successfully prosecuted. There are similar prosecutions today of eminent psychiatrists, psychologists, and psychotherapists — as well as doctors, dentists, etc. — being prosecuted for long-term sexual abuse of clients.

### The Loss of Values and Spirit

The catastrophic wars and social upheavals of the early 20th century, the loss of established conventions, the widening of the industrial revolution into a technological and materialistic tsunami, population explosions, ever increasing numbers of refugees, youth unemployment alongside increasing materialism, have all helped to create a degree of rootlessness, a senselessness that not only prompted the primacy of conscience and greater religious freedom epitomised in the Second Vatican Council (1962-65), but that also made various religious and spiritual cults and sects — set up by those people who said that they knew the answers — much more attractive, especially to the young.

The trouble is not so much that we have totally lost touch with the little that is left of our Christian traditions but that we have lost or thrown overboard all of our traditional values.

The modern world is bored; and because it is bored, it is in anguish; and because it is in anguish, it is mad. But the root of our madness is our boredom, and the root of our boredom is the fact that we have lost all sense of spiritual values. (Zaehner, 1974, p. 24-25).

In the post-WW2 era, the Maharishi Mahesh Yogi influenced the Beatles; Bagwan Shree Rajneesh had an enormous following from the mid-1960s onwards (Mann, 1987); Charles Manson founded his “Family” in California in 1968; Jim Jones set up the catastrophic Jonestown in Guyana in 1973; Sun Myung Moon started the more successful Moonies (Unification Church) in the mid-1950s, which now has over five million members; and the Scientologists were started by L. Ron Hubbard in about 1953. There were many other smaller sects and cults.<sup>x</sup>

Many of these movements were not all bad, but many of them were also a little crazy (Singer & Lalich, 1996). In a world where almost “anything goes”, anything that gives someone a better sense of direction, an internal focus, a sense of self, and a new method to get inside the body-mind (rather than the head) can seem very attractive. But these new ways often seem attractive as they offer a different value system.

Some people, in some aspects of body psychotherapy, also capitalised on some of these trends with the proliferation of competing methods, all with their unique answers, sense of finding deeper values and getting back to the “core”, often under the guidance of a charismatic founder. Thus, it has to be said, some trainings, schools, or institutions within body psychotherapy became a little bit more like sects than professional trainings.

At the same time, with the easing of morality, and the changes in value systems, especially after the 1960s, there were many values that now seemed to be old-hat: hard work, professionalism, research, discipline, thrift, etc. Some of these new trends seemed to ally themselves with the new materialism, the “let-it-all-out” and the “have-it-now” cultural trends. We may have thrown the baby out with the bath water. The pendulum certainly swung; it may have started to swing back a bit, but we shall see. It is still too early to look back in retrospect.

Michael Heller, in his (2012) encyclopaedic work on body psychotherapy, points to some of these long-term changes in trends and attitudes, especially when he writes about “Starting with the Certitudes of the Soul and ending with the Ambivalences of the Mind” and “The Limits of Dividing Reality into Distinct Realms of Knowledge”.

### Closed Communities

Much of this experimentation was, out of necessity outside the mainstream of psychotherapy. But body psychotherapy also functioned without much recognition and operated almost as an underground movement (Boadella, 1991). It was hard to get articles and books published by international publishing houses, and therefore much material was self-published, un-edited, not peer-reviewed, and very self-referential. The trainings were organised as private businesses, sometimes owned by an individual or family, and each taught its own versions of *its* methods and theory. Many smaller trainings or encounter groups happened within private spaces, or larger rented centres, or in association with other centres (like Quaesitor or the Open Centre in London) and/or communities like (or in association



with) centres run by (something like) Bagwan ‘sanyasins’ (disciples) — and thus could (perhaps unconsciously) hide themselves away a little. The trainings tended to be small and quite cliquy. This did not change significantly in Europe until about the 1990s (Westland, 2002; Young, 2011).

In the U.S., in the 1960’s and 1970’s, the main body psychotherapy trainings were essentially Lowen’s Bioenergetic Analysis and John Pirrakos’s Core Energetics, with possibly Chuck Kelley’s Radix work in third place. The Orgonomists, the inheritors of Reich’s way or working, kept themselves very much to themselves, with quite exclusive criteria, even though their journals were more widely available.

The other body psychotherapy trainings all tended to be quite small and very individual prior to the 1990’s: Stanley Keleman and a few others worked quite individually, and as the 1980’s progressed into the 1990’s, Ron Kurtz’s Hakomi work started to grow and Ilana Rubinfeld started training small groups in her form of body psychotherapy, Rubinfeld Synergy, in New York. People in these trainings did not communicate much with other psychologists, psychotherapists, or even with other body psychotherapists. Most of the interface was done, if at all, through the main trainers, or through the founders visiting other centres, which meant a less reflective form of communication. We took their word that “this” was good or that “that” was not — and often these views were quite pejorative.

Larger workshop centres, like the Esalen Institute in Big Sur, California, or the Omega Institute in Rhinebeck, up-state New York, were often used to host such trainings and also to lend a degree of respectability to these otherwise quite small and obscure training courses. There were very few conferences where wider views could be disseminated, a relatively small number of journal articles often disseminated new concepts and methods only to the adherents, and there were virtually no research projects. This form of closed community has been another part of our Shadow.

It wasn’t until the 1990s that some educational centres expanded into universities, and the whole academic side began to get much more involved. One of the first was at Naropa, in Boulder, Colorado. Then came JFK University in Berkeley, CA, the California Institute of Integral Studies (CIIS) in San Francisco, and later the Santa Barbara Graduate Institute, which unfortunately was recently bought out by the University of Chicago. All of these were running accredited Masters (and some Doctorate) programs in Somatic Psychology.

By the 2000s, there were also a plethora of body-oriented training courses: Lomi, Rubinfeld Synergy, Bodydynamics, Rosenberg’s Integrative Body Psychotherapy, Keleman’s Formative Psychology, and Malcolm Brown’s Organismic Psychotherapy, etc. (see Young, 2010), and some of them were now more solidly based within psychotherapy, rather than just in a psychologically-oriented body therapy. This form of differentiation was apparent between the first US Body Psychotherapy conference in Beverley MA, in 1996 — which was very open and included many forms of body therapy, dance therapy, etc. — and the first USABP conference in Boulder, CA, in 1998, which was only for body psychotherapists. Ironically, by “closing the door” and defining body psychotherapy more precisely, a greater clarity and subsequently an improvement in standards and ethics has occurred.

In Europe, up to the 1980s, there were the remnants of the “golden age” of body psychotherapy in Scandinavia, the Character-Analytic Vegetotherapists, with a few spin-offs, like Lillemor Johnson, Lisbeth Marcher’s Bodydynamics, and eventually Gerda Boyesen’s Biodynamic Psychology. Jay Stattman was developing his Unitive Psychotherapy; David Boadella was developing his form of Biosynthesis; and there were a few transatlantic

influences, with Lowen and Pierrakos coming over and doing training workshops. Some Europeans made the journey across and trained in the USA and then brought the method back over. But all of these trainings and methods were — up to then — relatively closed.

Any closed community, such as a religious order, cult, sect, prison, or residential facility, has certain vulnerabilities because of its inward organisation. These communities can provide a protective space for the development of new ideas, or for focusing on a particular outcome (like rehabilitation), but closed communities are also characterised by embedded ways of being and working together, without the natural checks and balances that come from dialoguing with different perspectives or conforming to external standards and regulations. Through their closure, they can also hide abuses.

Open communities are more expansive and welcoming, can be evangelistic, and may seem very successful, but may lose out on quality and depth. There is clear evidence of this in the wide-ranging spate of fairly open alternative communities that developed, especially in the 1960’s and 1970’s period for example, Findhorn (Scotland), Esalen and The Farm (USA), Auroville (India), as well as many others especially when contrasted with the more closed sects or trainings. One community called Damanhur (in Italy) opened up after being very closed at first, which is rare.

Such communities may have been founded by charismatic leaders, who were sometimes credited with quasi-religious status, being considered something like a guru or messiah, but such leaders actually inhibited the survival of these communities (Brumann, 2000).

The recognition of potential difficulties within closed communities is significant because between 1960 and 1980, within body psychotherapy and in several other forms of psychotherapy, there was a tendency for relatively more closed systems of organisation, especially within the actual body psychotherapy training schools. This allowed the fairly charismatic leaders essentially quite a free reign to do what they liked, charge what they liked, structure the training how they liked, and also determine who succeeded in the training, and/or who should leave. There were few checks and balances, little internal democracy, and no external regulating forces. Inevitably, there were also some abuses.

Again, we reiterate that we do not wish to “name names”, nor to report salaciously, or from rumour. However, a number of body psychotherapy communities, like that within Radix and also, to an extent, the Hakomi community, did split, and by all accounts the splits were quite emotionally painful for those involved. In London, the Boyesen Biodynamic Psychology community also split in the early 1990s, and whilst one branch flourished, turning into the Chiron Centre and later with another spin-off into the Cambridge Body Psychotherapy Centre, the original branch (containing the founder, Gerda Boyesen) diminished and eventually had to be totally re-founded as the London Biodynamic School. All have now embraced wider horizons and are also moderated externally through their status as member organisations of the UKCP<sup>xi</sup>, which, interestingly, did not exist until the early 1990s. Similar splits have happened with other schools and within other modalities of psychotherapy (viz. psychoanalysis and also Psychosynthesis).

By all accounts, the transition within Bioenergetic Analysis, from being almost totally controlled by Lowen, to becoming an independent professional and international association and training organisation, was also not without its own severe difficulties, tensions, and cliques. That it has survived and is still flourishing is greatly to its credit, but it has also done so by having relatively little contact with other body psychotherapy organisations (like USABP & EABP) and so can be considered still somewhat closed in this context.

The transition from a small closed school, centred around an often gifted or charismatic founder or leader, to a wider, more open community, with perhaps several centres and differing parameters, is a difficult one. Where these transitions have not happened easily or been managed well, there is often long-lasting pain and hurt. This is therefore also part of the Shadow side of body psychotherapy.

One of the reviewers of this article commented: “Similarly, the intolerance for deviance among pupils is a well-known phenomenon in most psychotherapeutic modalities. For psychoanalysis, excellent references are Makari, G. (2008) and Haynal, A. (1987).” There are also similar examples in various religious sects and cults.

### Psychotherapy Regulation

Meanwhile, the Church of Scientology, founded by L. Ron Hubbard in 1953, had groups and offices in many cities internationally and offered personality questionnaires and a new way of being called “getting clear”. There was, and still is, great concern about this organisation and whether it is a cult or whether, as it has stated, it is a new type of psychotherapy (Miller, 1987). When Scientology started actively attacking psychiatry and psychology, a British government inquiry was set up, chaired by Sir John Foster. With perspicacity, Foster recognised the inherent problem of psychotherapy, namely dependency and pioneering of methods. He reported:

...I have become convinced that it is high time that the practice of psychotherapy for reward should be restricted to members of a profession properly qualified in its techniques, and trained — as all organised professions are trained — to use the patient’s dependence which flows from the inherent inequality of the relationship only for the good of the patient himself, and never for the exploitation of his weakness to the therapist’s profit (1. para. 258).

Since then, the debate on psychotherapy regulation in the UK and Europe has rumbled on. The stated motivation for regulation was the raising of training standards, the protection of patients, and the establishment of a new profession, which would also enable the employment of lay psychotherapists in the UK National Health Service (Royal College of Psychiatrists, 1983). However, the largely unacknowledged (Shadow) reasons seem to be an irrational fear of sects and cults.<sup>xii</sup>

There are also, it must be stated, some very valid fears and worries about over-regulation, unnecessary controls and structures, a distancing of client and therapist, abuse of organisational power, and the lack of any real evidence that regulation produces better therapists or outcomes (Postle, 2000). Some of these views are also held strongly by some body psychotherapists.

There are also strong views held that having trained as a different psychotherapist (say, in a gestalt or psychodynamic training course), one cannot then just do a “conversion course” or 2-year additional training in the essence of body psychotherapy. On the one hand, this sort of facility is available in nearly every profession and would apply in reverse; an already trained body psychotherapist can do a 2-year gestalt conversion course: on the other hand, it is claimed that – as body psychotherapy is essentially done from a felt experience – it is necessary to have an extensive (4-year) grounding in that experience. So, we may have to look at the Shadow of this sort of exclusivity.

These criticisms are some of the Shadows of increased professionalism within psychotherapy and body psychotherapy.

### BIOGRAPHIES

Courtenay Young trained in body psychotherapy over 30 years ago, with Gerda Boyesen, David Boadella, and with significant inputs from John Pierrakos, and later Stan Grof and Arnold Mindell, amongst others. He is now an accredited psychotherapist, working within humanistic, transpersonal and body-oriented modalities and also working as a counsellor and psychotherapist in the National Health Service in Scotland. He has served on the Boards of the United Kingdom Council for Psychotherapy (UKCP), the European Association of Body Psychotherapists (EABP), and the European Association for Psychotherapy (EAP). He has recently been heavily involved in a project to establish the Professional Competencies of a European Psychotherapist for the EAP ([www.psychotherapy-competency.eu](http://www.psychotherapy-competency.eu)). He has written a number of articles for the EAP’s *International Journal of Psychotherapy*, for the *USABP Journal*, the *Journal of Body, Dance & Movement in Psychotherapy*, and *Energy & Character*, and has also written other articles in other journals as well as chapters in books. He has had one book published, *Help Yourself Towards Mental Health* (Karnac Books, 2010) and has published another, *First Contacts with People in Crisis and Spiritual Emergencies* (AuthorHouse, 2011). He also publishes a series of collections of body psychotherapy articles on various topics, as a director of Body Psychotherapy Publications. He is currently editing the English-American version of the *Handbook of Body Psychotherapy and Somatic Psychotherapy* with Gustl Marlock & Halko Weiss, due to be published by North Atlantic Books in 2015.

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Gill Westland is Director of Cambridge Body Psychotherapy Centre (CBPC) and a UKCP registered body psychotherapist, trainer, supervisor, consultant and writer. She has worked as a body psychotherapist for many years and has been training body psychotherapists for the past 30 years. She worked originally as an occupational therapist in the National Health Service in Mental Health at the Maudsley Hospital, London, and then at Fulbourn Hospital, Cambridge, as a clinician and then as a manager, clinical supervisor and teacher. She is a full member of the European Association for Body Psychotherapy (EABP); an External Examiner for the Karuna International Institute in Devon, U.K. and the London School of Biodynamic Psychotherapy, London, U.K; and a supervisor on the M.A. Body Psychotherapy programme at Anglia Ruskin University, Cambridge, UK. She is also co-editor of the journal, *Body, Movement and Dance in Psychotherapy* (Taylor and Francis). The Body Psychotherapy training offered at CBPC is rooted in a psycho-spiritual perspective.

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**Editor’s Note: Because of its length, this article has been split into two parts.  
The References and Endnotes are located at the end of each part.**

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## ENDNOTES:

- <sup>i</sup> The original version of this article: "The History & Development of Body psychotherapy: Part 5: 'Qui custodiet ipsos custodes?' [Latin: Who guards the guardians themselves?] was written by Courtenay Young as part of the series in the *Journal of Body, Movement and Dance in Psychotherapy*. The original version was then published in "The Historical Basis of Body Psychotherapy (Young, 2011). It was also extensively rewritten and developed in conjunction with Gill Westland and this present article is a subsequent development of that revised version.
- <sup>ii</sup> Being an editor myself, I don't often like disagreeing with other editors, who have their own styles, etc. and that there are different editorial conventions from different sides of the Atlantic, but I have to register a slight personal protest at the de-capitisation of Body Psychotherapy throughout this article.
- <sup>iii</sup> Thich Nhat Hahn's poem: 'Call Me By My True Names' [www.quietspaces.com/poemHanh.html](http://www.quietspaces.com/poemHanh.html)
- <sup>iv</sup> However, Philip W. Bennet (2010, 2014) is currently running a campaign (in his own iconic manner) to show that Reich was a victim of the FBI and a form of McCarthyism; and there is also a new film about Reich by Antonin Svoboda (2012).
- <sup>v</sup> EABP: European Association of Body Psychotherapy: [www.eabp.org](http://www.eabp.org)
- <sup>vi</sup> USABP: United States Association of Body Psychotherapy: [www.usabp.org](http://www.usabp.org)
- <sup>vii</sup> Gentle Bioenergetics – essentially developed from a form of massage for premature babies – developed by Dr. Eva Reich: [www.gentlebio-energetics.com](http://www.gentlebio-energetics.com)
- <sup>viii</sup> Masters degree Dance Movement Psychotherapy trainings currently exist at Goldsmiths (U. of London), Roehampton University, Derby University, Canterbury Christchurch University, and Queen Margaret University (Edinburgh).
- <sup>ix</sup> From an account of the Roermond (Netherlands) court records in the prosecution of Hans Krens (14/02/2007) on 4 counts of repeated statutory rape under Article 249.2.3 of the Dutch Penal Code §174 (Criminal Code) concerning sexual abuse by taking advantage of a consulting, treatment, or equivalent care relationship. Two of the victims spoke of long-term abuse (about 8 years); the other 2 for shorter periods.
- <sup>x</sup> Sects and cults: this is a descriptive use of these words, rather than a pejorative use of these words. These terms usually refer to a small religious or philosophical group; but more recently the pejorative usage has crept in. The early Christians and the Essenes were sects (in their time). In the USA, the FBI (1999) analysis focused on apocalyptic religious groups, doomsday cults and (New World Order) conspiracy theories.
- <sup>xi</sup> UKCP: United Kingdom Council for Psychotherapy.
- <sup>xii</sup> In France, this fear of sects is much more openly acknowledged and the recently proposed new French law on psychotherapy is based on legislation from the 16th century against witches (Oakley, 2004).

## The Endo Self: A self Model for Body-oriented Psychotherapy? Will Davis

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### Abstract

I present two major self-models: self as subject and self as object. My position is that in development and psychotherapy, there is an overemphasis on the role of the other, resulting in the over-reliance on the self-as-object model. I argue for an endo self (ES), a term that I have created to indicate a unified body/mind state with a coherent subjectivity existing a priori to contact with others; this relationship is necessary to elaborate this pre-existent self. I discuss three themes basic to this re-evaluation of the self, which I follow with a discussion of the characteristics of the ES.

*Keywords:* agency, self-to-self relations, self-referential, embodiment, Reich

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### Introduction

This article addresses an overemphasis on the role of the other in theories of development and therapy, and elaborates the role of the self in development: the self as the organizing agent of its own experiences. Humans are not fulfilled without relation; it's essential for the development of the self. The formative role of the other is not to be denied, merely re-defined. In this conception, relation is not the creator of the self, but an essential enabler on the developmental trajectory of a pre-existing subjectivity to its fulfillment through such relation. There is a difference between existence and development. The self is revealed in relationship, but the initial sense of self is not created *by* relationship. Subjectivity exists *a priori* to relationship. The most important relationship is the self-to-self relationship, which is the basis for all later relationships.

The elaboration of the concept of an endo self (ES), a term I created to emphasize the inner origins of this self, is the first part of a larger work: the creation of a self-to-self theory as the obverse of objects relations theory. An "obverse" answer is offered here as a counterpart that does not need to invalidate the other to be true. Obverse also implies turning towards; in the sense used here, it is a turning towards the self.

### Self Models

The following quotation from Snygg (1941) represents the two main theories of self:

For behavior to be studied, it must be observed from two distinct points of view. It may be studied objectively, as by an outside observer, or it may be studied phenomenologically, from the point of view of the behaving organism itself.



The facts derived from these two points of view are non-identical and are often completely contradictory. (p. 406)

The objective, self-concept theory noted above is also called self as object, a thing that can be observed and studied. This is also what William James (Ryan, 1991) called “self as known”. Another term used in this context is “reflected self” (Ryan, 1991), which emphasizes the importance of mirrored social interactions in creating the self. According to Harter,

One uses significant others as a social mirror. One gets one’s opinion about oneself from the response of the other and these adopted opinions form self-definition. It is the “me” rather than the “I”. Relationship is based on one as an object for the other. This results in internalized heteronomy: subjecting oneself to an external law, social norms, which is the opposite of autonomy, an internally based sense of right and wrong in a contingent status. (as cited in Ryan, 2003, p.227)

The self as object is a *cognitive* concept based on language wherein, “[t]he individual”, Mead argued, “cannot experience himself directly, but only through the public medium of language. This linguistic monopoly has become axiomatic” (Pagis, 2009 p. 266). In contrast, the phenomenological view of the self is based on the experience of the organism, the “self as knower” or “self as subject” wherein the actor and the perceiver are the same, and the focus changes from the content of the self to *how it is organized*. As Loevinger & Blasi (1991) point out, an important characteristic of the self as subject is that it is difficult to quantify. “The fact that the self as subject must be the self as lived, not the self as known or conceptualized, renders it elusive” (Loevinger & Blasi, 1991 p.161). As a result, most studies of the self are based on the external, observable social self.

A more recent model is the dialectic self whereby the two aspects of self and other modify each other. This relational model is co-evolutionary because how the self is perceived shapes development, and those changes in turn shape and create the external observations.

### **An Overemphasis on the Role of the Other**

An overemphasis on the formative role of the other is reflected in various theories. Margaret Mahler (Buckley, 1986) described the baby as moving towards and away from the object as the orientation point but does not mention the baby turning back to itself, an important dynamic that has been recognized in recent infant research. Winnicott’s (Buckley, 1986) position is that the baby doesn’t exist without relationship, and this view was reiterated at a Bioenergetic Congress by Tonella (1999) when he said, “Existence is found in relationship with the therapist.” The body psychotherapist Inge Krens (1999) writes, “The self is inconceivable without the object” (p. 35). Fairbairn (in Buckley, 1986), after hearing a patient declare, “I want a father”, concluded that the aim of the drive is the object. I argue the obverse conclusion, that the aim of the drive is the self. In contrast to Fairbairn’s position, it is not the “father” that is the main theme, but the experience of “I want...” The patient didn’t ask for her father, but rather expressed the unfulfilled, immutable desire to be “fathered”. The psychoanalyst Peter Fonagy (2002) concluded from twin studies, “It is probably true that we have exaggerated the importance of parents for development: adoption studies show that much of parental influence is illusory” and “...precious little in a child’s development is directly attributable to characteristics of the parents” (p. 5).

### **Three Themes**

There is a movement within psychology towards a re-evaluation of an earlier sense of self within the infant (Cozolino, 2002, 2006; Hepner, 2002; Kouider, 2013; Mitchell, 2000; Schore, 1999; Stern 1998.) Outlined below are three themes involved with this re-evaluation of the self and its development through relationship: an endo self, a unified state, and positive psychology as first conceptualized by Maslow.

#### **An Endo Self**

The endo self (ES) is an early, self-organizing, unified, embodied, coherent sense of self whose unique quality is that it exists *a priori* to contact with the “other”. The ES is based within the phenomenological and organismic theories of self: self as subject/knower. It is what initially comes into relationship with objects/others. It can be contacted and worked with on the functional level. I will refer to various fields — psychoanalysis, biology, psychotherapy, cognitive and social psychology, psychiatry, mindfulness, and physics — to show that there is indeed much support for a formulation of an endo self.

For example, Buckley (1986) quotes Melanie Klein: “...the experiences of the child’s object relations in real life are of secondary importance” (p. xvii) and comments that her description of the infant’s world is almost “hermetic” (p. xvii). Saying that “object relations are secondary” incites the question, secondary to what? The conclusion proposed here is that object relations are secondary to the primary relationship to the self. Along these lines, Hinshelwood (1989) argues that what are commonly called fantasies by Kleinians are body, not cognitive, states experienced as object relations.

Guntrip’s (in Buckley, 1986) “inner core of selfhood” (p.466) implies that there is something deeper than the usual sense of self which is similar to Winnicott’s (in Buckley, 1986) incommunicado core. The concept of an endo self calls for communication with that core, the source of the desire for relationships.

In biology, Maturana and Varela’s books *Autopoiesis and Cognition* (1972) and *The Tree of Knowledge* (1998) describe the nervous system as characterized by “operational closure”, the hermetic quality mentioned earlier (1998, p.135). Using the image of a submarine, Maturana and Varela (1998) contend that inside such a vessel, a person will have experiences but will never know what is going on outside. The environment only exists for the observer. One can observe the submarine and make certain conclusions about it: the submarine has to be careful to avoid a reef or going too deep, etc. The internal experiences within the submarine and the behaviors of the submarine that are observed from the outside, as Syngg (1941) noted, are usually not the same thing. Syngg (1941) said of the submarine analogy: “The determining locus of action is the behavior’s phenomenological field” (p. 413), which is the same approach to the self that is taken in the gestalt formulation of a figure/ground; the background is the phenomenological field and the loci of actions are what the behavior *chooses* to create as figure from this field. For Syngg (1941), the loci of actions of the behavior are “not open to outside observation” (p. 413).

Abraham Maslow’s (1968) “being state” continues this description of a profound, internal subjectivity and is a useful description of an ES state:

Being states are a whole, detached from relations, from usefulness, expediency, and from purpose. As if that were all there was in the universe; there is a sense of complete absorption. A figure becomes all figure and the ground disappears. (p. 74-75)

Loewald's agrees: "...the primary unit of experience might 'best be described as being'" (Mitchell, 2000, p. 42). As a result, the endo self is the object of its own subjectivity, both a participant and an observer in its own experience.

The ES and "being states" are related to signs of high oxytocin levels. At an EABP Congress, Uvnäs-Moberg (2004), described the state of high levels of oxytocin: smooth muscle activation in labor and breastfeeding, increased digestion, more movement, better learning, a higher pain threshold, and lowered heart rate and cortisol levels. These measurable physiological responses translate to being deeply relaxed, within oneself, secure, and self-accepting, all of which reflect Maslow's (1968) description.

An early sense of self is in contrast with cognitive and social psychology's concept of the self as known, which develops from language, discourse, and discussion with others and oneself. Mead (in Pagis, 2009) wrote, "One inevitably seeks an audience, has to pour himself out to somebody" (p. 277). This recalls Winnicott: without the other the self doesn't exist; there is no such thing as a baby without the mother. But this model is beginning to shift. Similar to the ES concept, Pagis (2009) has reached the conclusion that "[t]he actual representation of the self is no longer seen as being dependent on direct social interaction" (p. 277). Also representing this shift is the cognitive psychologist Ryan (1991) who refers to the basic drives as intrinsic motivation that "...is present from infancy evidenced by activity to get environmental responses. This suggests from infancy a nascent core of self" (p. 214). A nascent core of self supports the idea that there is a subjectivity revealed by the fact that it is seeking contact with an external environment before the experience of language and interpersonal discourse. Stern (1998) points out that infants "seek stimulation" (p. 41) and are "...predesigned to seek out and engage in learning opportunities" (p. 46).

Similarly, the embodiment concept in psychiatry distinguishes between mind and brain, and speaks of a brain that "matures" into a "relational organ". Fuchs (2009) writes:

From birth, it is mainly through our embodied interaction with the world and others that the brain matures and develops into a 'relational organ.' The relationships and meanings experienced in these interactions come to be sedimented in the organism in the form of neuronal circuits and excitation patterns. *Once developed* [emphasis added], these organic dispositions may then be *actualized* [emphasis added] in accordance with the present situation, thus functionally connecting organism and environment. However, it is only as a part of embodied interactions that the patterns of brain activity can serve as carrier processes of conscious experience. (p. 573)

This speaks of a "mind" before the brain is involved; before the realization of relationship, there must exist an organizing agent functioning *in order to be* in relationship.

Marcus Raichle (2010) offers support for this state of an organizing agent preparing for relationship: "A great deal of meaningful activity is occurring in the brain when a person is sitting back and doing nothing" (p. 28). What was originally thought to be "background noise" is in actuality the brain networking with itself and consuming 20 times more energy than is utilized when the brain responds consciously. Engaging in conscious activity increases energy consumption only 5%, while "60 to 80% of all energy used by the brain occurs in circuits unrelated to any external event" (Raichle, 2010 p. 31). Raichle (2010) suggests that it may be the way the brain organizes memories and internal systems. Raichle (2010) points out that little external sensory input reaches the central nervous system: "Of 10 billion bits per second that arrive on the retina... only 10,000 bits per second make it to the visual cortex... The findings suggested that the brain probably makes constant predictions about the environment in anticipation of paltry sensory

inputs reaching it from the outside world" (p. 31).

In the body psychotherapy branch of Functional Analysis, the development of the pulsatory concept of the "instroke" has resulted in a systematic way to elicit a deep self-state (Davis, 1984; 1989; 1999a; 1999b; 2000). Reich's (1967) concept of pulsation describes the movement out to the periphery and back again. He referred to it as expansion in pleasure and contraction in fear, and used the disturbance of this natural rhythm as indication of dysfunction. Instead of expansion and contraction, I have taken Kelley's (2004) model of outstroke and instroke, and elaborated his instroke concept. It is true that the organism does contract in fear and pain away from a negative experience. But the instroke is differentiated from contraction because not all movements inward are avoidant or contractive (Davis, 1999a & b). Deep spiritual experiences, reflective moments, the states described with high oxytocin levels, sleeping, or Maslow's (1967) being state are examples of non-contractive inward movements *towards* something deeper: the endo self. The instroke is a gathering, a centripetal movement inward that creates experience rather than interfering with it. It is exergonic, energy-freeing, and results in a movement towards the self. The instroke creates distance and differentiation but not, as contraction does, isolation and separation. One patient's instroke experience was: "I had an appointment with myself". Another commented: "I don't get older; I want to dance; I am untouchable, not influenced by others, solid".

Surprisingly, research in physics supports the concept of the ES. In *The Self-Organizing Universe*, Jantsch (1979) comes directly to the point about what I call an endo self when he suggests that with existence comes consciousness (p.10, p. 40). For humans, there is the possibility of subjectivity from the moment of conception. This idea is echoed by Sir Stafford Beers (1972) in his introduction to *Autopoiesis and Cognition*: "They define cognition as a biological phenomena; the very nature of living systems. They are saying that if you are living, you have consciousness" (p.v). Fritz Perls (1972) suggested that awareness was a property of matter.

Additionally, in 2012, the Cambridge Conference on Consciousness issued a declaration emphasizing that fetal and infant affect states and consciousness arise much earlier than thought.

The neural substrates of emotions do not appear to be confined to cortical structures. Systems associated with affect are concentrated in subcortical regions where neural homologies abound. Young human and nonhuman animals without neocortices retain these brain-mind functions. Furthermore, neural circuits that support behavioral/electrophysiological states of attentiveness, sleep, and decision-making appear to have arisen in evolution as early as the invertebrate radiation, being evident in insects and cephalopod mollusks (e.g., octopus). At the Cambridge Conference on Consciousness, we declared the following: "The absence of a neocortex does not appear to preclude an organism from experiencing affective states. Convergent evidence indicates that non-human animals have the neuroanatomical, neurochemical, and neurophysiological substrates of conscious states along with the capacity to exhibit intentional behaviors. Consequently, the weight of evidence indicates that humans are not unique in possessing the neurological substrates that generate consciousness. Nonhuman animals, including all mammals and birds, and many other creatures, including octopuses, also possess these neurological substrates."<sup>1</sup>

This is to claim that there is subjectivity before cortical activity. A magpie bird has no cortex, and yet it still has a sense of self.

<sup>1</sup> The Cambridge Declaration on Consciousness was written by Philip Low and edited by Jaak Panksepp, Diana Reiss, David Edelman, Bruno Van Swinderen, Philip Low and Christof Koch. The Declaration It was publicly proclaimed in Cambridge, UK, on July 7, 2012, at the Francis Crick Memorial Conference on Consciousness in Human and non-Human Animals, at Churchill College, University of Cambridge, by Low, Edelman and Koch. The Declaration was signed by the conference participants, in the presence of Stephen Hawking.

### A Unified State

This elaboration of early states of consciousness brings us to our next theme: the endo self exists *before* the development of psyche and soma. It is an organismic self, preceding the body/mind split. The two realms of psyche and soma emerge from this early, unified state of body/mind, differentiated but indivisible. Descartes referred to this as the *conarium*. All of the later, more differentiated and articulated psychic structures and functions develop out of this earliest sense of subjectivity. The concept of a “dual/unity”, to use Mahler’s (in Buckley, 1986) phrase, can be modeled by our understanding of ice, steam, and water. They seem like three different things, but we know that on a molecular level they are three forms of the same thing, H<sup>2</sup>O. Depending on its energetic state, it can function in different manifestations, but underlying all three is the unchanging, unified source of the molecular arrangement. A patient referred to this more primary state when he said that what he was feeling was in the body but not in the “physical body; it is in the ‘archaic body’”.

Similar to the experience of an archaic body, the psychoanalyst Hans Loewald describes a primal density where: “...experience begins in an undifferentiated state; there are no objects, no drives, no self, no others, no now, no then, no external, no internal. Everything is experienced in terms of...a primal density. All distinctions and boundaries which we are familiar with are superimposed upon this primal density” (as cited in Mitchell, 2000, p. 39). (By “self”, Loewald here is referring to the traditional psychological concept of a social self.) This “primal density” is the original subjective state. The distinctions and boundaries are the later psychic differentiations and structures that develop through interaction with the environment.

There is a shifting paradigm towards a unified body/mind state in cognitive and social psychology, where typically the self is rooted in social interaction, cognition, and language. Schubert & Koole (2009) write “...social concepts are processed in close interaction with the sensory-motor systems and are grounded in their physical context. There is ‘embodied cognition’” (p. 828). Further, Pagis (2009) reports that certain types of experiences do not require conceptualization or verbalization to be meaningful. “Somatic self-consciousness is a symbolizing process that takes place through a *nonverbal, embodied medium*” (Pagis, 2009 p. 268). Somatic self-consciousness is somato-psychic, originating in both realms at the same time.

This shifting paradigm towards a unified body/mind state is also seen in psychiatry’s theme of embodiment with the convergence of phenomenology, cognitive science, and dynamic systems resulting in a “recorporalization of cognition” (Fuchs, 2009 p. 570).

On the one hand, the phenomenology of the lived body is able to overcome the dualistic concepts of the mind as an inner realm of representations that mirror the outside world. On the other hand, the neuro-cognitive system cannot be grasped separately; it exists only as enmeshed in the world in which we move, behave, and live with others through our bodily existence. So instead of representationalism, with its fixed inside-outside distinction, we need embodied and enactive concepts of cognitive neuroscience that are in correspondence with the lived body (p. 574). “A phenomenology of embodiment may be combined with enactive approaches to cognitive neuroscience in order to overcome the *dualist concepts of the mind as an inner representation that mirror the outside world* [emphasis added]” (Fuchs, 2009 p. 571).

I understand this discussion on the change from representationalism to the lived body as shifting the emphasis from the importance of the object and its representations to an emphasis on the determining, creative forces of the subjective self. It furthermore overturns the perception of a split between the body and mind.

From an entirely different perspective, the same is true for the development of the concept of embodiment in robotics (Anderson, 2003). The top-down view of development based on the model of the brain’s ability to symbolize necessarily poses a limitation to robotic development. Anderson (in Davis 2013) argues that the ability to symbolize developed out of earlier sensory-motor system experiences, what Reich called “man’s roots in nature”. Therefore, building robots should be more an “up hierarchy” whereby feelings, thoughts and beliefs are rooted in physiology with an aim at unified body/mind functioning (Totton, 2014 p.3).

### Maslow’s Positive Psychology

A third reason for the formulation of the endo self is the overuse of negative development terminology that emphasize the self’s deficits: *tabula rasa*, autistic, normal autism, narcissistic, in a state of primitive hallucinatory disorientation, primitive, pre-reflective, and the id as chaotic and destructive. This is what Maslow (1968) calls “deficiency psychology”, overemphasizing pathology, dysfunction, and lack. In turn, he emphasized the need for the development of a “positive psychology”. Shore’s (2006) implicit self, Ryan’s (2003) nascent self, Damasio’s (2000) proto self, Kohut’s (2001) fragmented self, Stern’s (1998) emergent self, and Lacan’s (1997) self not existing until the development of language, all continue this orientation of deficiency.

The formulation of a non-existent self or a deficiency state of the self has serious repercussions. Janus (1997) points out that until the 1980s, “...surgery was carried out on newborn babies without anesthetic because they were denied psychological life and pain sensitivity” (p.6). Cozolino (2002) writes that “into the 21st century 75% of circumcisions are performed without anesthesia” (p. 266). As Kouider (2013) points out, however, “...neural markers of consciousness found in adults can be generalized to infant populations...and [this] might help pediatricians confront issues of infant consciousness in relation to anesthesia, pain, and pathologies” (p. 380).

It is interesting that while deficiency model formulations indicate a lack of cohesion, consciousness, and coherency, at the same time many theorists argue for the concepts of primary identification and projective identification which describe an unconscious (for Schore(1999), body-oriented), emotional communication system between mother and baby. The question that arises from this is: whom is the mother communicating with and vice versa? Another example comes from Kohut (2001), who argues that in a fragmented state, the infant masters reality. It is easy from there to conceive that there must exist a developed, coherent, stable sense of agency/subjectivity with which to organize this difficult task.

This is the position of the body psychotherapist Michel Heller who wrote that it is classically understood that “...the infant’s early psychic structure is eventually replaced or superseded by a more reality-oriented self” (personal communication, November, 2009). For Heller, “Life is always reality-oriented” (Heller, 2009). Even Freud can be called upon for support. His position is that the id is chaotic, incoherent, and even destructive. Yet, out of this dangerous chaos arises the ego, a logical, social system oriented towards relationship and development. From disorder comes order, suggesting that within the infant there is self-organization and coherency.

As Ryan (1991) pointed out earlier, the “nascent core of self” is seeking environmental responses. It has subjectivity, knows what it wants, and is in contact with reality. He also comments on Piaget’s developmental stages and argues that the passage through “inherent structures” during development is always being done “by someone” (Ryan, 1991, p. 212). This paper argues for a shift from an overemphasis on lack, pathology, and dysfunction to a resource-based, positive psychology emphasizing the endo self’s subjective experience and its ability to self-organize and self-regulate.



### Characteristics of an Endo Self

The mind, whatever else it is, is a constant of everyone's experience, and, in more and other ways than we know, the creator of the reality that we live within, that we live by and for and despite, and that, often enough, we die from. Nothing is more essential to us. (Robinson, 2010 p. 1).

#### The Primary Source

The ES is the source of all drives, desires, dreams, motivations and movements. It is the origin of all interactions with the external environment as well as *interactions with itself*, and the deepest of these is the instroke, the return to the self. The classical literature is full of instroke-oriented developmental terminology: incorporation, introjection, assimilation, insight, internalization, etc. (For an additional listing, see Davis, 2006). All impulses, inward and outward, have their origin in this original, unified state of body/mind creating all relationships. In a paper presented at the 2nd European Bioenergetic Congress on embodied relations in 1999, I argued that the preconditions for relationship, a sense of self, well-developed borders, clear differentiation etc., are all instroke-oriented, endo-self functions. Therefore, the primary source for relationships is a clear self-to-self relationship.

#### Self-Referential in the First Line

I became interested in the endo self concept when my patients began to report more present moment, self-referential comments, and less about others and what had happened to them in the past. A patient said, "On the way here to see you I cried the whole hour in the car, but then I stopped crying because I realized I now have someone who cares for me." I asked, "Who is caring for you?" He replied, "Me."

For Jantsch, (1979) all systems are self-referential in the first line. This is easily understood in terms of approach/avoidance or attraction/repulsion. In psychological terms these are unconscious decisions, and brain scan research, as well as the Cambridge Declaration, shows that we are always making decisions on a pre-cortical level without awareness. According to Cozolino (2006), the vast majority of memories are unconscious (pre-cortical), and it is these memories that shape our emotional experiences, self-image, decisions, and relationships. He points out that the speed of the amygdala in processing information generates a physiological reaction before we are conscious of what is being processed. He calls this the "known and unremembered" (p. 130). We have decided if we like a person even before shaking hands or hearing a name. This follows with the conclusion, reached by Raichle (2010), that the brain makes constant predictions about the environment with "paltry" sensory input.

"Self-referential" may be a more useful expression for describing experience than the "hermetic" that was used earlier, which has a negative quality. Every system is in intermittent, pulsatory contact with its environment; it continually evaluates experience as positive or negative and then acts. In a training group I was explaining the concept of self-referentiality, with which one woman did not agree. After we went back and forth for a while she said, "I will have to think about it." I pointed out that what she was doing was self-referential behavior in the first line. She didn't automatically believe her trainer, she referred to herself first.

The social psychologists Loevinger and Blasi (1991) mirror Jantsch's (1979) self-referential model by describing the self as "...something accessible in the 1st instance only to itself. This is not the self concept. The self is not a collection of self schemas" (p.150). Syngg (1941) similarly

emphasizes the self as the originator of its own experience. "Behavior is completely determined by and pertinent to the phenomenological field of the behaving organism. More specifically, the direction and degree of differentiation are determined by the phenomenological needs of the behavior" (p. 411). Syngg (1941) goes on to point out the reader is probably "...selecting parts that substantiate one's own views" (p. 412).

The biologists Maturana and Varela (1972) take the same view using the terms "allo-referred" states (in self theory terms, self as object) and "self-referred" states (in self theory terms, self as subject). They prefer the "self-referred" model. In his introduction to *Autopoiesis and Cognition*, Beers (1972) emphasizes that:

Theirs is a systematic theoretical biology which attempts to define living systems not as they are objects of observation and description, nor even as interacting systems, but self-contained unities whose only reference is to themselves. ...they are autonomous, self-referring and self-constructing closed systems – in short autopoietic systems...more radically still, one which from 'the point of view' of the system itself, is entirely self-referential and has no 'outside'. (p. v)

#### All Systems Abhor Splitting

A correlate of the idea of self-referentiality is the principle that like all other systems, the ES will do whatever is necessary to stay in existence. The hope of psychotherapy is based on this will to survive; despite all dysfunction, the person wants to stay in the world.

Defense is a functional attempt, no matter how "illogical", to keep the organism in existence. Paradoxically, people split off to stay whole. The following incomplete list of defenses illustrates the desperate behaviors the organism will engage in to avoid danger: schizoid splitting, disassociation, fragmenting, decomposition, repression, armoring, avoidance, denial, resistances, compensations, adapting, projection, projective identification, intellectualizing, disassociation, merging, fusion, symbiosis, psychosis, fractionation, splitting of mentalizations, multiple personality disorders, and active expulsion. All are an attempt by the self to separate from a state that cannot be integrated and which threatens the integrity of the organism. Cozolino calls it "the need to escape an unbearable self", "...a self as something to avoid at all costs" (2006, p. 206).

More specifically, Kernberg (1984, as cited in Schore, 1991) points out that "primitive splitting" is normal and healthy in children because, for example, they cognitively cannot yet integrate the "good mother" and the "bad mother". In the adult state, an inability to integrate manifests most evidently in the splitting off behaviors of the borderline personality disorder case and in projective identification. The contents cannot be tolerated within the poorly developed sense of the self, so they must be split off by "jumping out" behaviors or being projected onto another being in order to survive. Insightfully, the biologist Voeikov (1991) states, "...a living system cannot violate the principle of its existence" (p. 21).

In *Developmental Defects Versus Dynamic Conflict*, Morris Eagle (1987) emphasizes that whichever of the two major developmental theories one may adhere to — defects/deficits/lack or drive/conflict — one still works with the same problem because functionally both theories are based on the splitting process. In the deficits model, disassociation as a strategy serves the individual by excluding threats by dangerous content. In the classical drive/conflict model, unacceptable mental contents are repressed, relegated to other "selves" or the impersonal "it". Eagle's analogy is to say that it is as if the person has a piece of plastic embedded within. At the same time, there is a "me" and a not "me" (Eagle, 1991, p.55). For Eagle (1991),



intellectualizing is a form of splitting: psychonoetism, the transference of personal conflicts to the intellectual sphere. He points out that simply making unconscious material conscious is usually not enough. It remains split off, placed *alongside* of the acceptable content. Eagle refers to the writings of Gedo & Klein to elaborate his point "...the integrity and continuity of self organization is a supraordinate aim for all people independent of their diagnosis" (1991, p. 6).

No matter what theoretical stance one takes, the first task for the organism is "sheer intactness of the self" (Eagle, 1987, p. 9), a maintenance of its existence. Taking a deficits position, Eagle argues that even though disassociation leads to self-diminishing, the main theme is not the diminished self, but a loss of self-cohesion. He points out that the same is true for the conflict model. Not only does unresolved conflict result in failure to experience satisfaction, but more importantly, the "all-important" aim of integrity and unity is frustrated (Eagle, 1991 p. 7).

Surprisingly, Syngg's (1941) phenomenological view is the same as Eagle's: "Fundamental needs in a phenomenological system are the preservation of the organization & integrity of the phenomenological field and the phenomenological self — thus our tendency to remain unaware of or reject, with emotion, data inconsistent with our own beliefs" (p. 413). Consistent with an inherent sense of self-integrity, Mahler (Buckley 1986) pointed out that within the first month of life, there is an "ego instinct towards self-preservation" (p. 201).

In terms of trying to come to grips with the earliest sense of existence, of consciousness, it is necessary to understand some of the basic laws of nature, especially those governing the life process. For this reason, I find research in physics and biology relevant to delineating an endo self. For example, the view of self-preservation as the primary process of life has been extended into the inanimate realm by the works of the physicists Eigen (in Jantsch, 1979), Prigogine (1977), Jantsch (1979) and the biologist Voeikov (1999). Self-preservation is not just a living system dynamic but a law of nature. Eigen (in Jantsch, 1979) has modeled the "hyper-cycle" showing how non-living energy systems, such as chemical reactions, will "search" the environment for more input in order to keep reacting in order not to "die" (p. 7). Prigogine (1977) points out that even chemical reactions have "more than one solution" (p. 3). This is a physicist's representation of Ryan's nascent self that will "seek environmental responses" in order to get what it wants. Infant research supports this understanding, going so far as to say that the baby will manipulate the mother to see that its needs are met.

Voeikov (1999) makes a similar observation from a biological perspective and furthers it. Metabolism in non-living systems usually results in the "death" of the system. In the living, metabolism is necessary for the preservation of the system. The living system *actively* consumes matter and energy, whereas the inanimate is a passive participant in a similar process. Energy is "pumped into" the inanimate system.

While it is true that usually the animate object is "triggered" by an external stimuli or impulse, as a rule, the amount of energy released as a result of an external stimulus or impulse *greatly exceeds the energy of the impulse/input* [emphasis added]. A fire may be triggered by a spark but it destroys the structures it touches and never creates new ones. A fire dies but a living system seldom burns out the fuel extracted from the environment. Rather it builds up its energy stock to *prolong its existence* [emphasis added]. (Voeikov, 1999 p. 19)

This is an excellent modeling of both relationship and the gathering force of the instroke. If we incorporate into this Jantsch's (1979) model of co-evolution between interacting systems whereby both systems are altered by the contact, we can then model the dialectic position of development and therapy.

Prigogine's (1979) revolutionary development of dissipative structures shows how the second law of thermodynamics is overcome by self-starting and self-regulating, non-equilibrium, non-linear structures — that is to say, living systems. They are entropy-negative. Boltzmann's Law states that entropy is a measure of disorder (p. 4). Life is a movement away from disorder to order: structuralization over time.

Voeikov, (1999) states that living systems do whatever is necessary not to "slide" into entropy that will result in inertia or system "death" (p. 21). "Stable non-equilibrium that characterizes the living system belies the reductionist view" (p. 21). He leads us beyond the Second Law of Thermodynamics when he points out that "[n]o living system is ever at equilibrium. It continually performs work against equilibrium..." (Voeikov, 1999 p.17) It is "born" in a non-equilibrium state. A living system is out of balance with its environment in that it does not move from a higher order of organization to a lower one, as the Second Law of Thermodynamics demands. Vernadsky calls this "the main law of life" (Voeikov, p. 20). The point of this discussion is that there are now recognized and at least partially understood laws of nature supporting the idea that a living system's bottom line, the self's "supraordinate aim", is to stay in existence and does this by the self-centered, centripetal, gathering force of the instroke.

Based on physicists' understanding of the laws of living systems, but in the language of therapy, the Operationalized Psychodynamic Diagnostics system sees that psychic "...structure constitute a set of information that in turn organizes experiences and processes them. This resembles a system stressing dynamics of homeostatic balance in terms of recursive rules and the start of non-linear process" (OPD Task Force, 2001, p. 41). The "dynamics of homeostatic balance" are the same as the non-equilibrium and non-linear "survival" models of Eigen (in Jantsch, 1999), Prigogine (1977), Jantsch (1979), and Voeikov (1999).

Earlier I offered a list of splitting-off behaviors. Taylor, Kemeny, Reed, Aspinwall (1989) take splitting in an opposite direction. They point out the paradoxical positive effects that threatening events can have by creating "positive illusions" within the person (p. 239). Typically, splitting is seen as a manifestation of a deeper problem. These authors conclude that the splitting off in "creative illusions" is necessary for good mental health in the face of threat. In their work with cancer and AIDS patients, they concluded that "[p]ositive illusions tempered by realism are critically important in maintaining the integrity of the self in the face of threat" (p. 252), and that "...people with no illusions are just as maladaptive as those with over developed illusions" (Taylor, et al, p .11).

The theme of splitting refers to two of Reich's (1950) energy concepts. The first is that once a system is formed, it "abhors" splitting, and will do whatever it can to stay whole. The second is that orgone energy moves from lower to higher concentrations; it is negatively entropic and therefore overcomes the Second Law of Thermodynamics as Prigogine (1977) and Voeikov (1999) have pointed out.

### Autopoietic

A fourth characteristic of the ES is an extension of the negative entropic discussion. The ES is autopoietic: self-starting and self-organizing. Carl Rogers (1978) postulated "a formative directional tendency" towards development in the universe. This is also a basic Reichian energetic concept that is mirrored in Maturana and Varela's (1998) "proposition that living beings ...are continually self-producing", defining them as "...an *autopoietic organization*" (p. 43). The social psychologist Ryan (1991) sees the developmental need for autonomy and competence as autopoiesis (p. 209).

### Self-Regulation

Self-regulation is closely tied to autopoiesis and themes of self-organization. In this context, the ES is seen as teleorganic, capable of serving the necessary life needs of the organism. Ryan (1991) states:

The locus of initiation and of spontaneous engagement with the surround is, from an organismic perspective, the self. The self is both the agent that integrates and the structure to which new functions, values, and propensities are integrated. In addition, to the extent that action becomes regulated through the self organization, then it is described as self-regulated or autonomous. (p. 212)

In the context of the ES, autonomy is seen as an innate characteristic. It is not used in the classical sense of autonomy arising from the separation/individualization process. The infant is autonomous in the sense of agency; it is self-starting, self-organizing, and self-regulating. It learns attachment and bonding and later goes through a separation/individualization process to learn to be autonomous *within* the state of relatedness.

Kohut (2001) inappropriately refers to self-regulation from a deficiency model wherein the infant must master reality. In Kohut's conception, the narcissistic state of the infant cannot bear the existence of anything outside itself and is too weak to destroy or flee the object, so it masters its environment by incorporating and merging the parent imago into its narcissistic sense of itself. These self-referential, self-organizing, and self-regulating behaviors arise spontaneously from *within* the infant's psyche in the face of perceived threats. The infant knows it is threatened by the other and does whatever it can to stay unified.

Self as organizing agent is also a theme for Daniel Stern (1998). He describes the "... sense of self as a primary developmental organizing principle" (p. 26) and this agency as having as its starting point the infant's inferred subjective experience.

Certainly Mahler and Klein and the other object relations school have focused on the experience of the self-and-other, but mainly as the fall out of, or secondary to, libidinal or ego development. Those theorists never considered the sense of self as the primary organizing principle. This account, centering on the sense of the self-and-other, has as its starting place the infant's inferred subjective experience. It is unique in that respect. (p. 26)

Stern is not unique in this view. However, while the principle is the same, the theory of the ES formulates agency much earlier than Stern.

### Immutability

Buckley (1986) suggests, "In some sense, Klein's is the ultimate depth psychology within the internal mental world of the infant. This internal world has an inexorable development" (p. xvii). The concept of the ES is built on the infant's inexorable development. As Reich's (1950) energy concepts formulate, you can interfere with development, but you cannot stop it from trying to move forward towards completion and satisfaction. Freud's sublimation has the same root.

Schore's (1999) projective identification emphasizes this immutability. "Embedded within the patient's often vociferous communication of the deregulated state is also a definite, seemingly inaudible, urgent appeal for interactive regulation. This is a "lifelong phenomenon" (Schore, 1999 p. 14). Interactive regulation is the basis of development: a right brain-based emotional contact with the environment. He is pointing out that desire

for contact can be interfered with, resulting in "the deregulated state" and becoming barely "audible" (p. 14). But embedded within those distorted and distorting behaviors remains the original, inexorable push for satisfying developmental relationships throughout life.

All transference behaviors are based on this immutability and is represented in Guntrip's dual nature of transference (Buckley, 1986). For Guntrip, a good object is the basis of mental health (Buckley, 1986, p. 447). In its absence, the patient finds a good object in the analyst in both the transference relationship and real life. He points out that the continual seeking of satisfaction is in all relationships.

Kohut (2001) refers to the immutability as the "narcissistic stream". A disturbance in the finalization of the idealization process results in the fact that "the person will forever search for external ideal figures" (Kohut, 2001 p. 62), and "...the narcissistic stream of the infant continues throughout life and is the basis of creativity, wisdom and self esteem" (Kohut, 2001, p. 40). "The original narcissism is the precursor of object love" (p. 107) and "[o]ur ultimate goals and purpose and our self esteem...betray that an *unaltered* [emphasis added] piece of the old, limitless narcissism functions actively alongside the new, tamed and realistic structures" (Kohut, 2001, p. 109). Kohut's position is that the narcissistic stream seeks satisfaction, and even when satisfied, it inexorably continues to flow through life in the form of love, creativity, wisdom, and self-value.

The Eagle (1987) joins this chorus when he criticizes the deficits model; "...it is unlikely that a particular set of early experiences — whether consisting of failures of empathetic experiences or (failures of) opportunities for idealization — would have a determinative and decisive influence on something as complex as integrative capacity" (p. 16). He takes Reich's energetic model assertion that one can interfere with integrative capacity but never stop the organism from trying to be integrated.

When the developmental task is unsatisfied, it spontaneously transforms itself and continues to seek satisfaction within the duality of the transformation in order to stay in existence. This functioning represents the combined themes of immutability, self-referentiality, self-organization, self-regulation, and the desire to stay in existence. The duality of the transformed state — in the form of sublimation, substitute objects, transitory objects, idealized objects, transference, and all splitting behaviors — is a result of the immutable quality of existence. As Kohut's narcissistic stream showed, even when satisfied, this innate, immutable push towards development and satisfaction will spontaneously continue to transform into the next phase of development; it is embedded in health and dysfunction. After an experience of an endo self state, a patient summed this up: "I realize now that I always wanted to be somebody".

In the conflict model, the person has mental content and emotions that are *by their nature* repugnant to him/her and must be dealt with by repression, sublimation, active expulsion, etc. If not, there will be deep, unresolved conflicts that will, as Eagle (1987) points out, cause dysregulation and disorganization in the system and disrupt the "supraordinate aim" of unity. The ES theory holds that embedded within the dysfunctional states of repression, sublimations and expulsions is the undamaged desire for contact, regulation and relationship: the desire to both give and get love. For Perls (1972), transference is not about what happened, but what did not happen and what is missing that is still being sought. It is a psychodynamic model of the ice, steam and water analogy. Below the transformed, distorted and distorting behaviors is an unaltered, immutable stream flowing towards health. This is the hope of psychotherapy.

### Security and Well-Being

Immutability is reflected in the next characteristic which is reminiscent of Maslow's (1969) being state. When one returns to the deeper self, there is always a sense of security and well-being. The immutable quality, while interfered with, does not change. The ES exists before and is untouched by disturbance, trauma, lack, and conflict; it is what the Bioenergetic therapist Olaf Trapp calls the "undamaged self" (personal communication, June, 2013). In this state, there are only desires, not needs. As Rogers suggested, "All the facts are friendly" (as cited in Ryan, 2003, p. 75).

Working with schizophrenics, Fuchs' (2009) embodiment represents another facet of security whereby "mental disorders are not to be considered as mere brain dysfunction" (p. 573). Rather, they are disturbances of a person's "being-in-the-world" state (p. 571). Fuchs distinguishes between the pre-reflective, unperceived subject body (Leib) and the physical body (Körper) which is perceived by the self and others. The subject body is a medium or background requiring no explicit attention.

Thus the lived body also corresponds to the bedrock of *unquestioned certainties...as a pre-reflective know-how* [emphasis added]. Radcliff has argued recently that basic bodily feelings are at the same time feelings of bodily states and ways of experiencing the world. This applies in particular to 'existential feelings' such as *feeling at home, belonging to the world* [emphasis added]. (p. 574)

It provides a fluid, automatic and context sensitive pre-understanding of everyday situations, thus connecting the self and the world ...'intercorporality'... Recently, a patient facing a potentially dangerous situation reported having had "...in the background, a thought/feeling of being empowered — sure of myself and it was not linked to what happens outside." (p. 572)

When aiding patients to experience the ES, it is possible to work before the onset of a trauma with the undamaged self in which, the system is still functioning well. In a training group, I did a demonstration session with a trainee who had had a traumatic experience at 12 years old. She was tied to a dangerous machine; the machine would be turned on if she struggled and she would be sexually assaulted. Luckily she escaped, but it was still a traumatic experience. I did not go into her personal history before the demonstration session so I had no awareness of her episode of trauma. I worked with the gentle touch technique used in Functional Analysis. Nothing happened. At the end of the session, she reported she had "re-lived" the trauma memory, but this time it was completely different than any other time in her therapy. She "saw" the whole scene and went through it as usual. Yet this time there was no traumatic mental images or vegetative signs: hands sweating, dizziness or heart palpitations. She "watched it" but was not split off from it. It was happening to her, but she had no panic. She was the object of her subjectivity, a participant observer. She commented that she felt that this time it was "finished". I was in contact with her for a few more years and heard nothing to indicate that it was not finally finished. This is an example of the security and well being one has when in the endo self state. Because she felt safe and secure, she could experience the trauma from the undamaged self state without feeling threatened. (See also the case in Davis, 2013.)

Fuchs (2009) points out the same quality in schizophrenia. "With growing alienation, even acts of perceiving itself may come to awareness. Then the patients are like the spectators of their own perceptive process: "I saw everything I did like a film camera" (Fuchs, 2009, p. 572). There is a "...pathological explication of implicit bodily functions

which means that normally tacit sensory/motor processes (the pre-reflective lived body) become available for conscious introspection" (Fuchs, 2009, p. 572). I think the key words here are "growing alienation". To say it simply, in the case of schizophrenia, the person is experiencing the "implicit body" in an already split off state, which is thus disorienting and dangerous. This is Reich's view on schizophrenia; a lot of the strange experiences inherent in schizophrenia are misinterpretations or distortions of natural states.

### Familiarity: Knowing the Knower

Security and well-being are rooted in the fact that the ES state is always familiar. Maslow (1968) writes, "The peak experience is felt as a self-validating, self-justifying moment which carries its own intrinsic value with it. That is to say, it is an end in itself. It is felt to be so valuable an experience, so great a revelation, that even to attempt to justify it takes away from its dignity" (p. 79). Because it is familiar, there is security and therefore there is no need to justify or explain. Pagis (2009) has pointed out that in these states there is no need for discourse. In Functional Analysis we call this the "Haiku effect". The patient has a "new", known, profound experience and yet has little to say about it. It is self-evident. At the end of a session, one patient couldn't find the words to describe how he felt. Finally he said: "It doesn't matter. It is more important to me than it is to you."

It is valuable to note that this quality of familiarity is reflected in three disparate disciplines: philosophy, psychology, and biology. The philosopher Merleau-Ponty (in Pagis, 2009) writes, "At the root of our experiences, we find a being which immediately recognizes itself" (p. 267). Experiences are not sublimated; they arise "with content" (Pagis, 2009). Earlier, Syngg (1941) had written the same in different terminology: "A phenomenological system is anthropomorphic. Its data is stated in terms of immediate experience and requires no translation to make it meaningful" (p. 421). The biologist Maturana (1998) writes, "Knowing is the action of the knower...rooted in the living being as a whole" (p. 34). A patient of mine expressed this clear knowing as "an extreme presence in the absence of myself". The usual self-concept was seen for what it was: distraction. Once she got past the distraction, she recognized her self.

### Nonjudgmental but Reality-Oriented

The next characteristic of the endo self experience is a nonjudgmental state. A patient once said to me, "I love myself beyond the good and the bad." It is clear that within the context of the social self, she sees herself as both "good" and "bad". She is suggesting there is a more important sense of self, rooted in the lived body, beyond judgment. In the endo self there is no comparing, judging cognition — but there is evaluation. She differentiates between different levels or manifestations of her self. This is not the "creative illusion" mentioned earlier; she knows that if we are not able to realistically evaluate ourselves, as Willie Nelson sings, "Your dreams will be dreaming you."

Maslow echoes this sentiment with: "The peak experience is only good and desirable, and is never experienced as evil or undesirable" (1968, p. 81). The same is true for Ryan: "In true self determination, there is no fixed concept of self to protect or enhance" (2003, p. 75).

In mindfulness, Shapiro, Carlson, Astin and Freeman (2006) refer to an "orientation to experience, which involves curiosity, nonstriving and acceptance" (p. 5). They suggest the term "reperceiving" (2006, p. 5) as a fundamental "*shift in perspective*". In a recent

article in the IBPJ, Greene calls it “self observation”, “spectating rather than participating” (2013, p. 69).

Rather than being immersed in the drama of our personal narrative or life story, we are able to stand back and simply witness it. As Goleman suggests, “The first realization in meditation is that the phenomena contemplated are distinct from the mind contemplating them. Reperceiving is akin to the Western psychological concepts of *decentering* (Safran & Segal, 1990), *deautomatization* (Deikman et al., 1990) and *detachment* (Bohart, 1983)” (as cited in Shapiro et al., 2006, p.5).

Shapiro et al. go on to point out that reperceiving is a rotation in consciousness in which what was previously subject becomes object. What they call mindfulness and I am referring to as an endo psychic state is “...simply a continuation of the naturally occurring development process whereby one gains an increasing capacity for objectivity about one’s own internal experience” (Shapiro et al., p. 6). There is a contactful distance between the self and its troubles. “If we are able to see it, then we are no longer merely it; we must be more than that” (Shapiro et al., p. 6). There is no problem about the problem. A patient said it this way: “I don’t suffer from my sufferings.”

### Preverbal and Nonverbal

Mitchell elaborates the classical view on language and its development:

Most philosophers and psychologists of language regard early human development as bifurcated by a fundamental and perhaps unbridgeable divide between the preverbal and the verbal. Increasingly over the course of the 20th century, language has become understood as the material out of which adult mentation is generated, the very stuff of the mind... [F]ollowing Lacan, many understand the unconscious itself in terms of linguistic structures. A divide has opened up between the early months of life, before the child is inducted into the linguistic-semiotic system through which he will become a person, and his later psychological self. (2000, p. 5)

Yet, this classical view can be challenged. Loewald writes: “...the primary process is unhampered by laws of contradiction, causality, time and subject/object” (as cited in Mitchell, 2000, p. 37). Cozolino supports this:

Despite the fact that the vast majority of the information we acquire and encode is both outside of conscious awareness and processed prior to conscious awareness we feel and act as if we have all the necessary information and have made a conscious choice. In truth, we have little or no conscious access to the information or the logic on which most of our decisions are based. (2002, p. 158)

This applies to any early experience. According to Schore (2006) the logical left-brain does not come “online” until about 18 months and does not dominate until about five years old. Until then the right brain processes all emotional experiences. Schore argues that unconscious right brain emotional regulation is more significant in the adult state than conscious “logical” decisions.

Loewald takes this theme further: there is language within the womb, where there is no separation between preverbal and verbal.

The mother speaks with or to the infant, not with the expectation that he will grasp the words, but as if speaking to herself with the infant included... [H]e is immersed, embedded in a flow of speech that is part and parcel of a global experience

within the mother-child field. While the mother utters words, the infant does not perceive words, but is bathed in sound, rhythm, etc., as accentuating ingredients of a uniform experience. (as cited in Mitchell, 2000, p. 8)

A study by deCasper and Fifer (in Mitchell, 2000) proved this. Babies preferred to listen to recorded stories read to them by their mother *in utero* than to recorded stories by the same author read to them after birth. Beebe et al. note that these babies are able to “distinguish intonation, frequency, variation, and phonetic components of speech” (Mitchell, 2000, p. 8). For Cozolino, “Systems of implicit memory are active even before birth, as evidenced by the newborn baby’s instinct to orient to the sound of her mother’s voice” (2002, p. 88). Hepner (2002) reports cognitive changes *in utero*; the fetus has cognition and can learn. Mitchell then asks us to consider this “...astounding finding. Words are salient feature of babies’ experience, not after birth, but *in utero*” (2000, p. 8). This research supports two points: one is the importance of nonverbal experiences, and the second is that “someone” is registering these experiences.

An advantage of working functionally is that it is possible to work on the verbal, the pre-verbal, and the non-verbal level through embodied cognition, the lived body, where there are no words but experiences are nonetheless registered and remembered. Bollas (1987) called it the “unthought known”. Pagis sees that certain types of experiences do not require conceptualization or verbalization to be meaningful: “Somatic self-consciousness is a symbolizing process that takes place through a *nonverbal, embodied medium*” (2009, p. 268).

### Spontaneous, continuous re-organization

The OPD’s (2001) description of a healthy psychic structure is a fundament of the ES. “Structure lies at the basis of long term personal style in that individuals time and again restore their intrapsychic and interpersonal equilibria. A highly integrative structure is flexible and has creative functions that regulate and adapt within and between individuals” (p.41). The physicist Jantsch (1979) says it more succinctly in a wonderful piece of jargon: optimal, temporal structuralization. The OPD and Jantsch are describing the same phenomena: the ability of an organism to continually reorganize itself in changing circumstances. Prigogine refers to “order through fluctuations (changes in the internal and external environment) in non-equilibrium structures” (1997, p. 5). This ability to adapt to changing circumstances, to create order out of fluctuations/disorder, is rooted in the aforementioned undamaged, secure, known state of the endo self, which is founded in the living process itself. Without an innate, restorative resource, deficiency-oriented psychology/psychotherapy cannot answer the question of how a system can do what the OPD claims: continually restructure itself to heal or overcome deficits or unresolved conflicts. As well, according to the biologist Vernadsky, “...the process of development is impossible from a physics and chemistry point of view. The process of the lower to the higher from uniform and incoherent to differentiated but indivisible, is the main natural process. Yet, the main law of life, the steady increase of organization, is not yet comprehended” (Voeikov, 1999, p. 20).

### Outside of Time

Time is an important theme in psychotherapy. Psychotherapists typically focus on the patient’s historical past. In addition, they deal with the past and the present in terms of



transference, projective identification, projection, and regression. As well, the patient's sense of his future is a good diagnostic indicator of his present state and the progress and prognosis of the therapy. Despite this, a unique quality of the endo self is that time is not relevant.

Loewald describes the primary process as "unhampered by...time" (as cited in Mitchell, 2000). The same is true for Maslow's being state, about which he says, "It is as if they had some place in another world in which time simultaneously stood still and passed rapidly" (1968, p. 80). In osteopathy, it is called the "still point". In Functional Analysis, patients experience themselves as slowly drifting, floating, or in a hypnagogic state and comment at the end of the session how they lost the sense of time. Furthermore, I have witnessed patients stop breathing, with no sense of holding their breaths, for frighteningly long periods.

Brain research is now showing us that traumatic events are stored in the more primitive regions of the reptilian and limbic brain with little cortical and left brain involvement, resulting in the absence of localization of the memory in time. Cozolino (2002) concludes flashbacks are always in the present and total system experiences (pp. 272-273), which is also true for positive, life-supporting experiences (Schore, 1999), reflecting the position taken in the Cambridge Declaration: "The neural substrates of emotions ...are therefore 'out of time'" (2012).

In the 1940's, Reich (1967) wrote:

There is no antithesis between the historical and the contemporaneous. *The whole experiential world of the past was alive in the presenting form of the character attitudes. The make-up of the person is the functional sum total of all his past experiences.* (p. 121)

The schizophrenic does not 'regress to childhood'. Regression is merely a psychological term describing the actual, present day effectiveness of certain historical events. The schizophrenic does not 'go back to the mother's womb'; what he actually does is to become a victim of *exactly the same split in coordination of his organism which he suffered when he was in the deadened mother's womb*; and he has maintained that split his entire life. *We are dealing here with actual, present day functions of the organism AND NOT WITH HISTORICAL EVENTS.* (p. 492)

The physicist Callender supports Reich when he writes that Einstein's theories of relativity suggest that there is "...no special present, and that all moments are equal. The rift between the time of physics and the time of experience is reaching its logical conclusion, for many theoretical physicists have come to believe that time fundamentally does not exist" (2011, p. 41).

### Summary

My view is that, while essential, the role of the other is overemphasized both in developmental theory and therapy. I have argued for an early state of subjectivity that is a coherent, sometimes cognitive sense of self-existing before relation to others. Arising autopoietically, this self is what is brought to initial relationships, leading in turn to its own development. The endo self is the source of all drives and desires both outward and inward. It is also the source of all latter differentiated psychic structures and continues to underlie the behaviors of these structures throughout all relationships in later life. This being state

is self-starting, self-organizing, and self-regulating. The resource, competency orientation of this approach seeks: "...to see how the mind describes itself" (Robinson, 2011, p. 16).

### BIOGRAPHY

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## Toward an Integrative Model for Developmental Trauma

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#### Abstract

In this paper, an integrative model for developmental trauma is presented that attempts to integrate ego psychology, drive-conflict theory, somatic psychology, object relations, and self psychology. The latest neuroscientific findings are presented to support the proposed integrative model. Formal definitions of emotions, feelings, and affects based on the theory of complex dynamical systems and energy exchange are presented. The importance of shame in the formation of developmental trauma is also discussed, for which supporting material from neuroscience is also provided. The complementary nature of conflict psychology and psychology of the self within the proposed integrative model is discussed with implications for body psychotherapy.

*Keywords:* character structure, complex dynamical systems, developmental trauma, drive theory, emotions, neuroscience, object relations, polyvagal theory, self psychology, somatic psychology.

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#### Introduction

The developmental model discussed in this paper is the chronic traumatic experience of a child during his various developmental stages. As needs are frustrated, the child faces perceived existential threats or suffers from contact deprivation, not being seen for who he or she is, or being seen as an object for the satisfaction of the parents' narcissistic needs, etc. Chronic developmental trauma changes the way an individual interacts with the environment, flow of information, and flexibility of response to the surrounding. Chronic developmental trauma may change the body (boundary) of the individual, making it rigid at times or flaccid at other times, resulting in a loss of motility and limiting the individual's life and aliveness. It may also change the shape and functioning of the internal organs. Chronic developmental trauma may change the individual's metabolism of energy, and exchange of energy with the environment. This paper is organized as follows: First, a definition is presented for complex dynamical systems. Formal definitions for emotions, feelings, and affects are then. This is followed by a short introduction to polyvagal theory based on the work of Porges (2001 & 2001). An integrative model is then proposed which brings together ego psychology, drive-conflict theory, somatic based therapies, object relations, and self psychology. Lastly, a case history is illustrated, followed by concluding remarks.

In order to understand the effects of developmental trauma, it is helpful to start from the basics, that is, from the definition of systems, since all living organisms can be considered

as dynamical systems in the most general sense of the term. A system can be viewed as a group of interacting, interrelated, and interdependent elements and bounded processes. Systems transform inputs that are consumed into outputs that are produced. Systems are characterized by their boundaries, which separate them from their surroundings (Gros, 2013). This boundary may be real or notional but it defines a finite volume, within which the system operates and exchanges energy or matter with its surrounding. Systems are also characterized by their internal laws of functioning. A general system model is shown in Figure 1. Systems can be open or closed.

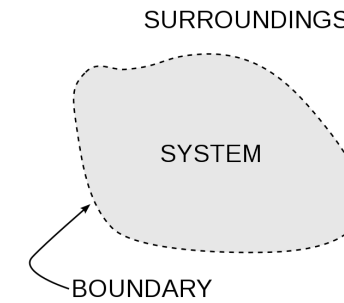


Figure 1. Basic System Model

The dynamical system concept is a formalization in which the behavior of the system is said to be 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 a system interacts and forms new relationships with its environment and surroundings. Complex systems are open and dynamical, 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 an external entity or element that's affecting it. This structure or pattern forms from the interaction of elements that make up the system and result in self-organization (Gros, 2013).

Living systems are considered subsets of all systems. Living systems are by definition complex and self-organizing, have the special characteristic of life, and interact with their environments (they're open). This interaction with the environment takes place by means of information (entropy) and material-energy exchanges. Living systems can be as simple as a single cell or as complex as humans. Living systems, aside from basic energy and matter exchange with environment, interact with their surroundings via their emotion, feelings, and affects (all of which contain energy and information).

#### Emotions, Feelings, and Affects

All living organisms, from single cell amoebae to humans, are born with innate abilities evolved to handle the basic challenges of life. These challenges include: finding sources of energy; incorporating, consuming, and transforming energy and matter; maintaining a chemical balance of the interior compatible with the processes of life; maintaining the organism's structure by repairing damage; and defending against external treats (Damasio, 2003). Living complex systems tend to move toward homeostasis, that is, self-regulation and stability.

At the top of the processes that promote homeostasis are emotions and feelings (Damasio, 2003). Emotions in their simplest form correspond to the energetic states of the body. “Emotions are actions or movements, many of them public, visible to others as they occur in the face, in the voice, in specific behaviors” (Damasio, 2003, p. 28). Emotions are primarily communicated by nonverbal behavior, such as facial expression, eye contact and gaze, tone of voice, body posture and motion, and timing of response (Siegel, 1999). “Emotions represent dynamic processes created within the socially influenced, value appraising processes of the brain” (Siegel, 1999, p. 123). Siegel also states, “Emotional processing prepares the brain and the rest of the body for action” (1999, p. 125).

Feelings in their most basic form are perception of emotions or body states (Siegel, 1999). Damasio (2003) provides the following definition: “[...] a feeling is the perception of a certain body state of the body along with the perception of a certain mode of thinking and of thoughts with certain themes” (p. 86). As an example consider the sight of beautiful scenery, which may change our body state, perhaps to a state of relaxation, resulting in the emotion of joy. This emotion may then be perceived as the feeling state of happiness.

Siegel (1999) defines “affective expression” or simply “affect” as the external revelation of internal emotional states (body states). Conscious awareness of affects also results in feelings. It is also important to note that feeling emotional states, that is being conscious of emotions, offers a flexibility of response based on past experiences of and history with interacting with the environment. However, innate drives are needed to start the process. It should be noted that the limbic system participates in the enactment of drives and instincts and has an important role in emotions and feelings (Damasio, 1994). In summary, we can think of feelings as mental sensors of the organism’s interior; that is, mental sensors of the energetic states (emotions) of the body, as life is experienced moment-to-moment.

I will now discuss the process by which our organism mobilizes for action (energetically), or in other words, the expression or enactment of drives and instincts. This mobilization for action is described by Porges in polyvagal theory (2001 & 2011).

### **Polyvagal Theory**

The human nervous system is divided into two branches: the peripheral nervous system and the central nervous system (spinal cord). The peripheral nervous system is further divided into somatic-sensory nervous system and the autonomic nervous system. The somatic nervous system is further divided into motor (efferents) and sensory (afferent) nerves. The autonomic nervous system, on the other hand, is divided into the parasympathetic nervous system and the sympathetic nervous system.

The parasympathetic nervous system has two main components: The first branch is controlled by the dorsal vagus nerve, “...characterized by a primitive unmyelinated visceral vagus that controls digestion, and responds to threats by depressing metabolic activities and is behaviorally associated with immobilization and freeze behavior” (Porges, 2001, p. 123). The second branch is controlled by the ventral vagal nerve and is unique to mammals. According to Porges:

The ventral vagal complex (VVC) has primary control of supradiaphragmatic visceral organs including the larynx, pharynx, bronchi, esophagus, and heart. [...] In mammals, visceromotor fibers of the heart express high levels of tonic control and are capable of rapid shifts in cardioinhibitory tone to provide dynamic changes in metabolic output to match environmental challenges. (2011, p. 160)

The other branch of the autonomic nervous system is the sympathetic nervous system (SNS). The sympathetic nervous system is capable of increasing metabolic output and inhibiting the dorsal vagus nerve, thus increasing mobilization behaviors necessary for fight and flight (Porges, 2001).

The more primitive life forms use the unmyelinated dorsal vagal complex (DVC) and the sympathetic nervous system to modulate cardiac output and mobilization, and freeze responses. Mammals on the other hand, in order to survive, had to distinguish friend from foe, determine and evaluate the safety of the environment, and communicate with the community. The ventral vagus complex (VVC) is the response to these evolutionary needs. The myelinated ventral vagus complex characterizes the human social engagement system, which is responsible for facial muscles (emotional), eyelid opening (looking), middle ear muscles (differentiating a human voice from background noise), muscles of ingestion, muscles of vocalization and language, and muscles for head-turning (Porges, 2001).

In more primitive life forms (pre-mammals), the dorsal vagal complex and the sympathetic nervous system have the opposing functions of decreasing and increasing cardiac output respectively, and thus modulate mobilization. In mammals, with the evolution of the ventral vagal complex, the cardiac output is modulated without the engagement of the former more primitive systems. Thus, activation of the myelinated vagal system can result in temporary mobilization and expression of the sympathetic tone without requiring actual activation of the sympathetic or adrenal system (Porges, 2011). The ventral vagal complex, therefore, acts as a break on cardiac output and is capable of rapid changes in heart rate, resulting in mobilizing or calming effects. Polyvagal Theory (Porges, 2011) proposes a hierarchical organization of the autonomic nervous system. When a system higher in hierarchy fails, then a more primitive branch of the autonomic system engages. The following can thus be observed: At the top of the hierarchy is the ventral vagal complex (VVC), a mammalian signaling system for motion, emotion, and communication. The second complex in the hierarchy is the sympathetic nervous system (SNS), which is an adaptive mobilization system engaged during fight or flight behaviors. Finally, the dorsal vagal complex (DVC) is the immobilization system (Porges, 2011).

Figure 2, adapted from Ogden and Minton (2000), shows the three zones of arousal and the window of tolerance within which the social engagement system (ventral vagal complex) is activated. When an individual is hyper-aroused, the person experiences too much arousal to process information effectively and is usually overwhelmed and disturbed by intrusive images, feelings, affects, and body sensations. When an individual is hypo-aroused, on the other hand, something different is experienced, namely, a downward modulation of emotions and sensations — a numbing, a sense of deadness or emptiness, passivity, and possibly paralysis. On the other hand, people with a narrow window of tolerance (the middle region in Figure 2), experience fluctuations in emotions and feelings as unmanageable and dysregulating. Most traumatized people have a narrow window of tolerance and can easily shift into hypo/hyper-arousal states by normal fluctuations in arousal (Ogden, Minton, & Pain, 2006). It is also very important to mention that the states depicted in Figure 2 are not mutually exclusive, in that one can simultaneously be both hyper-aroused and hypo-aroused, which would be experienced as being highly aroused (ready for action) but unable to move. It is also possible to be in the optimal zone of arousal (activation of the social engagement system) yet experience elements of hypo/hyper-arousal. Also of note is that the boundaries between these zones are not very rigid and depend on, among other things, the emotional state (energetic state) of the mind- body.



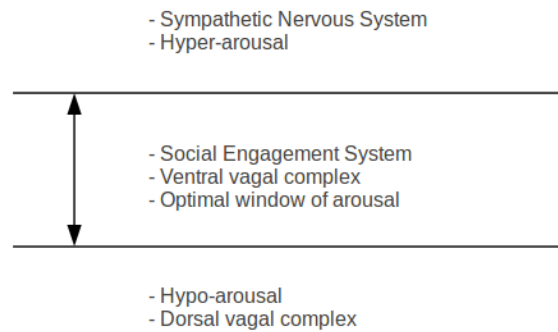


Figure 2 *Optimal Window of Arousal*. Adapted from “Sensorymotor Psychotherapy Institute,” by P. Ogden, & K. Minton, 2000, Retrieved from <http://www.sensorimotorpsychotherapy.org/articles.html>

**An Integrative Model for Developmental Trauma**

I will start by briefly describing drives, which are the biological core of motivations and actions. The term “drive” refers to and is based on the principle that organisms have certain physiological needs that when not satisfied lead to a negative state of tension. When a need is satisfied however, the organism returns to a state of homeostasis and relaxation, and the energy of the drive is reduced.

According to the theory, the energy of the drive tends to increase over time and needs to be expressed to avoid the state of negative tension. Drives can also be considered as the psychic quality that cannot be further analyzed by introspection (Kohut, 1978).

A model, based on the work of Wilhelm Reich, seems to clarify the means by which developmental trauma takes shape. This model is based on drive theory (or conflict theory, and can also point to therapeutic strategies. With that in mind is the following diagram, taken and adopted from Reich (1980). This model, in a slightly modified form, has also been discussed by Hilton (2008) in great detail.

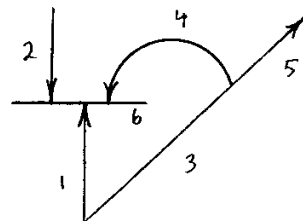


Figure 3. *Drive, repression, and identification*

This diagram (Figure 3) depicts a drive which seeks expression by moving toward external objects (segment 1), which then comes into conflict with a frustrating force from the outside world (segment 2). This counter-force may include parents, school, society, and other authoritarian forces. It can be seen that the content of the prohibition of the

drive comes from the outside world, but the cathexis (energy) with which prohibition is maintained comes from the energy reservoir of the individual himself. Under the influence of the pressure exerted from the outer world, an antithesis develops within the person, a dissociation or cleavage of a unitary direction of the drive (expression) that causes one drive to turn against another (segments 3 and 4). The drive splits in two directions, one that goes toward the world and seeks expression in an alternative way, and one that turns against itself (segments 3 and 5, and 4) (Reich, 1980).

A question arises, namely, in the absence of the repressive force from the outside world (segment 2): how is the repression maintained by the drive that turns against itself? The answer seems to be the armor (segment 6). Where the two meet (drive and environmental frustration), there is the formation of the armor in the form of muscular blocks, and physical tensions that keep the drive from expressing itself. The energy that maintains this block comes from the drive itself, which now has turned against its original goal. This is a simplification, as in reality the armor is layered, and a warded-off drive wards off more deeply repressed impulses and drives. Thus the armor develops as muscular blocks and tensions in accordance with the portion of the drive that has turned against itself. One could then postulate that the stronger the defense (segment 4), the thicker the armor will be (segment 6).

A different question that arises is: how does the splitting of the redirected drive happen and how is it experienced? The point at which the split takes place Reich (1980) named ‘psychic contactlessness’, which he defined as the point in which the therapy seems to reach a point where nothing moves anymore. Subjectively, Reich (1980) stated that an “inner deadness” is experienced by the individual at this point, or a state of “no contact” and isolation.

In his book *Character Analysis*, Wilhelm Reich writes:

Originally, character analysis conceived of psychic armor as the sum total of all repressing defense forces; it could be dynamically broken down through the analysis of the formal modes of behavior. Later it was shown that this concept did not embrace the psychic armor in its totality; indeed that it probably overlooked the most important factor. We gradually came to see that even after the formal modes of behavior had been completely broken down, even after far-reaching breakthroughs of vegetative energy were achieved, an un-definable residue always remained, seemingly beyond reach. One had the feeling that the patient refused to part with the last reserves of his narcissistic position and that he was extremely clever in concealing it from himself and from the analyst. (1980, p. 310-311)

Reich believed that the origin of this psychic contactlessness stemmed from childhood experiences, and he further said, “In order to heal the patient’s psychic contactlessness, the patient needs to be understood, and he needs to feel understood” (1980, p. 319).

This psychic contactlessness occurred in a relationship with a caretaker early in life, and it thus needs to be resolved in a therapeutic relationship. Hilton says, “It has been my experience that this psychic contactlessness, the result of the client’s narcissistic position, can only be dissolved within a healing therapeutic relationship” (2008, p. 94).

Thus it can be concluded that simply reducing the strength of the armor (segment 6) and some release of the impulse is not enough, as a residue will remain that still maintains the armor. One must simultaneously work on this residue which, Reich’s psychic contactlessness, to achieve full healing. Reich mentioned that the patient needs to be understood, and he also needs to feel that he is understood. This is what Hilton (2008 &

personal communications, February 2009) calls the “healing therapeutic relationship”. And what is the neuroscientific basis for the assertion that the healing therapeutic relationship can heal psychic contactlessness?

A drive (impulse) is formed in the organism resulting in increasing arousal mediated by the ventral vagal complex (VVC, or social engagement system) which increases cardiac output, thus increasing the individual’s energy to act and resulting in a different energetic state (emotion) and its perception which may be a good feeling (feelings). This drive may then be frustrated by the environment (caretaker, etc). The organism will then block the expression of the drive by mobilizing the dorsal vagal complex (DVC) to immobilize the action that is in the process of taking place. This process is shown pictorially in Figure 3. The perception of this shift from activation of the social engagement system (VVC) to the freeze system (DVC) is experienced as shame. Siegel points out:

Shame is thought to be based on the activation of parasympathetic system (to an external NO!) in the face of highly charged sympathetic system (an internal Let’s go!). It’s as if the accelerator pedal (the sympathetic branch) is pressed down and then the brake (the parasympathetic branch) is applied (1999, p. 279).

Although experience of shame is evidently inevitable and perhaps necessary for socialization of children, parents do not need to use shame intentionally as a strategic form of parenting (Siegel, 1999). In my opinion, parents and society must undo the damaging and malignant long-lasting effects of shame through re-establishment of the empathic contact and relationship. I will return to this toward the end of this article.

Schore (1994) writes, “Shame is experienced as an interruption, and it functions to impede further affective resonance and communication” (p. 206). Shame in general is associated with elevated parasympathetic system activation following the activation of sympathetic system (Schore, 1994). Recent research in Polyvagal Theory (Porges, 2011) points to activation of the DVC (the freeze system) branch of the parasympathetic nervous system (PNS) following the activation of VVC (the social engagement system) branch of PNS, as the cause of the experience of shame. However, the reader should understand and be clear regarding the process and perception of shame. Schore elaborates on the state of shame:

This misattuned relational transaction triggers gaze aversion, a response of hiding the face — to escape from this being seen or from the one who sees — and a state of withdrawal. Under the lens of “shame microscope” which amplifies and expands this negative affect, visible defects, narcissistically charged undesirable aspects of the self are exposed. It is as though something we were hiding from everyone is suddenly under a burning light in public view. Shame throws a “flooding light” upon the individual who then experiences — a sense of displeasure plus the compelling desire to disappear from view, and an impulse to bury one’s face or to sink, right then and there, into ground, which impels him to crawl into a hole and culminates in feeling as if he could die. The sudden shock-induced deflation of positive affect which supports grandiose omnipotence has been phenomenologically characterized as a whirlpool — a visual representation of a spiral and as a flowing off or leakage through a drain hole in the middle of one’s being. The individual’s subjective conscious experience of this affect is thus a sudden, unexpected, and rapid transition from what Freud called “primary narcissism” to what Sartre described as a shame triggered “crack in my universe” (1994, p 208).

The source of the feeling of contactlessness, the inner deadness, the illusive psychic energy, then becomes clear. It is shame, which has also been discussed in detail by Haelfaer (2006). Thus, following the shame state, coming out of DVC activation, the individual creates a positive self-image to reactivate its energy or arousal (segment 5 in Figure 3) while simultaneously creating a mental image (body map) of the drive and ensuing frustration of it that resulted in the shame state, in an effort to avoid its repetition (segment 4 in Figure 3), thus identifying with the environmental frustration. This mental image is eventually saved in the orbitofrontal cortex. When later in life the circuits of posterior sensory cortices and temporal and parietal regions are activated due to an emotionally competent stimulus (ECS) that created shame in the past, the prefrontal circuits that hold records pertinent to the same category of events become active (Damasio, 2003).

It is noteworthy at this point to distinguish between the states of shame and humiliation. The latter occurs when an elevated parasympathetic (DVC in this case) system is accompanied by a heightened sympathetic system (Schore, 1994). When the environmental frustration involves contempt and angry rejection, humiliation results. Kohut (1978) refers to this as narcissistic rage. Schore writes:

...[T]here is now strong clinical evidence that shame-humiliation dynamics always accompany child abuse. Narcissistic personality disorders who have difficulty modulating rage typically present a background with a parent who humiliates the child by harsh, continuous, or massive exposure (1994, p. 207).

Shame, however, as discussed above, results when the nervous system shifts from arousal (VVC, i.e., social engagement) to hypo-arousal (DVC, i.e., freeze). Thus, the dorsal vagal branch of the parasympathetic nervous system is always involved in shame and humiliation. Humiliation is particularly important to study and pay close attention to, since it involves both branches of the autonomic nervous system. One can draw an analogy to driving a car. It is as if one foot is on the gas pedal, and the other is on the brake simultaneously. The danger is that if the ego strength is not sufficient, rage (aimless, disconnected, ungrounded anger) could break through the armor and result in destruction, devastation, and even murder — that is, if the individual is not grounded, does not have strong boundaries, or does not possess a strong enough containment for impulses and emotions. Another important feature of shame is avoidance of mutual facial gaze due to deactivation of the VVC (social engagement system). Shore (1994) writes: “...visually-induced, shame-mediated neurohormonal signals are registered in the orbitofrontal cortex, known to contain neurons with the unique feature of having receptive fields that specifically include the central area of the visual field” (p. 214).

A further insight can be gained from the school of object relations, a psychodynamic theory within psychoanalytic theory. The theory describes the dynamic process of development and growth in relation to real others (external objects). The term “objects” refers to both real external others in the world, as well as internalized images of others. Object relationships are formed during developmental phases through interactions with the primary caregivers. These early patterns can be changed and altered with experience, but frequently continue to have a strong influence on one’s interactions with others throughout life. The term “object relations theory” was formally introduced by Fairbairn in 1952. In contrast to Freud, who saw instincts as pleasure-seeking, Fairbairn believed that instincts are primarily object-seeking. The infant internalizes the object (as well as the object relations), and splits in two the object toward which both love and hate are

directed. The good object (idealized) representations are important and are necessary to go on in life. The bad (frustrating, repressing) object is further split into two, namely the repressive object and the exciting object. The ego identifies with the repressive object (anti-libidinal self) and keeps the original object-seeking drive in check. The ego also identifies with the exciting object (libidinal self) and seeks exciting objects in the world. From this description it can be readily deduced that the anti-libidinal ego is Segment 4 in Figure 3, and the libidinal ego is Segment 5 in the same Figure (Guntrip, 1971).

Fairbairn states:

At this point an important consideration arises. Unlike the satisfying object, the unsatisfying object has, so to speak, two facets. On the one hand, it frustrates; and on the other hand, it tempts and allures. Indeed its essential 'badness' consists precisely in the fact that it combines allurements with frustration... In his attempt to control the unsatisfying object, he [the infant] has introduced into the inner economy of his mind an object which not only continues to frustrate his need, but also continues to whet it. He thus finds himself confronted with another intolerable situation — this time an internal one. How does he seek to deal with it?... He splits the internal bad object into two objects — (a) the needed or exiting object and (b) the frustrating or rejecting object; and then he represses both these objects. (1952, p. 111)

This process is shown in Figure 4 below. Note that in the absence of environmental frustration (Segment 2, shown with dashed line), the individual identifies with the frustrating force, introjects it, and acts it out as shown in Segment 7.

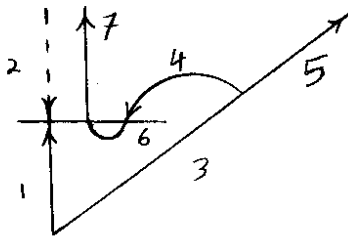


Figure 4. Acting out - old object relations, and introjects

Let us consider what happens when the expression of a drive faces environmental negativity in more detail. The immediate response of the young human is to go into a shame response — that is, experience a shift from social engagement system (VVC) activation to the freeze system (DVC). If a young human has a relatively cohesive and intact self, then he or she readily identifies with the source of environmental negativity. If the self is, however, not cohesive, then how does the young human rise up from the shame (and create a positive self image) when empathic responses from the environment are absent? Self psychology (Kohut, 1971; Kohut, 1977; Kohut, 1974; Kohut, 1984) provides the answer. The young human seeks merger with archaic selfobjects (inner perception and experience of objects that are not part of physical reality but of psychological reality (Kohut, 1984)), which can mirror the young human, those who are the source of idealized power and strength, or finally those who are essentially like the young human (mirroring, idealizing, or twinship selfobjects). This is what Segment 5 in Figure 3 represents. This is the aspect of the drive

that seeks expression in an alternative way, according to Reich (1980), which is the same as the libidinal ego according to Fairbairn (1957), or the false self, or finally the narcissistic self. The result of course is defects, disturbances, or distortions of the self, which is posited by self psychology to be the cause of nearly all forms of psychopathology in that all flaws of self are due to disturbances within self-selfobject relationships in childhood (Kohut, 1984). Self psychology further posits that in the presence of a healthy self, drives are not experienced in isolation, but as an integrated part of the healthy self (Kohut, 1984). Kohut (1971) argues that narcissistic disturbances of the self are due to failure of empathy by the childhood selfobjects. When the child's self is not cohesive, then frustration and repression of drives result in seeking archaic selfobjects in life. These archaic selfobjects are sought to either mirror the individual (resulting in grandiosity), or as idealizing sources of strength and power, or essentially as replicas of the individual. Narcissism is thus the complementary aspect of early childhood conflicts. Kohut (1971) argues that narcissism has its own line of development. This was also implicitly argued by Lowen (1985).

Kohut (1977) argues that depth psychology requires two complementary approaches: that of conflict-drive psychology and that of self-psychology. He sees man's functioning in two different directions, the direction of activity of his drives and the direction of fulfillment of his self. The man who lives his life within the pleasure principle and his drive activities, Kohut (1977) names the guilty man. And the one who seeks to express the pattern of his nuclear self and who strives beyond the pleasure principle, Kohut (1977) names the tragic man. These two men represent the two poles of the structure of the self. These two poles of the structure of the self can be seen in Figure 3. If the self is relatively cohesive, then the child's response to environmental frustration and repression of drives results in formation and internalization of parental introjects (identification with frustrating object), and later the child becomes the guilty man who lives within the conflicts of expressing and taming of drives. If the self, however, is not cohesive (due to severe failure of empathic selfobjects), the environmental negativity results not so much in the formation of a strong punishing superego in the form of internalized parental introjects, but in the child seeking archaic selfobjects with whom to merge so as to be reaffirmed. This child, thus, becomes the tragic man, who is in search of the self. The complementary nature of the guilty man and the tragic man indicates that both are present in an individual simultaneously, albeit in different degrees. This points to a complementarity between the narcissistic line of development and the drive-conflict based line of development.

Lowen, in the introductory section of his book "Narcissism" (1985, p.x), argues that the patients he is seeing do not manifest the neurosis of earlier times. Instead, he is seeing problems associated with inner emptiness, frustrations, unfulfillment, and lack of feelings. In other words, he is seeing individuals affected by defects of the self. Kohut (1978, p.681) also indicates that he is not seeing patients whose complaints are about unresolvable inner conflicts. He argues that his patients are suffering from the deprivation of a give and take (optimal frustration) with an environment that is empathic and understanding of their needs which would help them get rid of their infantile grandiosity and help them to become more self-confident, active participants in the adult world. It is important to view developmental trauma in light of these changes in the presenting issues of patients and clients. If, indeed, this shift from conflicts to disorders of the self has taken place in recent times, what are the corresponding changes in the body? This is a question that I do not claim to be able to fully answer. I can however, theorize that one would not expect character armor, in the form of muscular contractions or flaccidity (Marcher & Fitch, 2010), to be as strong. One may expect that the character armor might have shifted somewhat to a disconnection from the body and its sensations. No longer is the client,



afflicted with disorders of the self, as aware of feelings and sensations as the conflicted client of older times. This client with disorders of the self, instead of being haunted by a punitive and punishing superego, may be more haunted by a sense of emptiness which motivates him or her to seek ever-continuing excitement in order to avoid depression. This client's senses, feelings, and emotions may not be integrated within the totality of his or her personality. Thus this client is prone to acting out, helped by weakening of muscular armor. Kohut (1977) points out that in the absence of a cohesive self, drives become isolated and thus powerful entities of their own. One can also perhaps theorize that our psychotherapeutic work needs to be more centered around integration of feelings and sensations than release of repressed drives. The self needs to become more cohesive and integrated, which in turn necessitates a more relational and empathic approach in our work than ever before, as elaborated in great detail by Hilton (2008). Tonella (2011) also discusses the importance of restoration of expression of the self through the therapeutic relationship, and Clauer (2011) suggests that in the presence of an insecure sense of self, there is a need to develop the basic self functions.

Of course, one cannot expect only one drive to be frustrated. In reality, many drives are frustrated and blocked in various degrees. Thus, when studied closely and carefully, one observes patterns of behavior resulting from the sum total of frustration of drives and their adaptations. One can think of this sum total as the developmental trauma, which is also known as "character structure" (Reich, 1980; Lowen, 1971; Lowen, 1994). Character structure functions as a filter that together with its neural correlates, filters the behavior of the individual in response to external or internal emotionally competent stimuli. The individual, thus, is not free to respond to the environment in a way that is most advantageous to the organism, but motility and expression are limited by the functioning and operation of this filter. The body proper has imprints of all the traumas that the individual has endured. In most somatic therapies in general and bioenergetic analysis in particular, it is well known that posture, shape of the body proper, expression of eyes, facial expression, tone of voice, interpersonal interactions such as handshakes, as well as viscera, all speak to and of the past history of the individual who might have suffered trauma(s). I must again emphasize that most clients, these days, do manifest significant disorders of the self that need to be considered accordingly. In other words, our traditional model of character structure may need to be augmented with disorders of the self.

The imprints on the body resulting from developmental trauma can be studied to gain an understanding into the nature of trauma itself, as well as to point to treatment strategies. These imprints are also indicators of the way the individual's energy system filters impulses and drives. Thus, they also indicate the way the individual metabolizes energy. Similar to amoeba, the body of a human child contracts if chronically and harshly frustrated or traumatized, and maintains a shape that is indicative of the trauma suffered, or loses contact with the body entirely. Trauma leaves its imprint on the young human body.

In the following case history, I will discuss the application of the proposed integrative model of developmental trauma and supportive neuroscience findings, especially shame, in analysis. This case also illustrates the complementary nature of conflict and self-psychologies.

### The Case of Sean

Sean is a 22-year old man who was born to an affluent family and referred to me by a colleague about a year ago. He has a brother who is about four years older than he is. He and his family immigrated to the United States about twelve years ago. Sean's father is

a businessman and travels quite often. He has been away from his family, sometimes for months at a time, for as long as Sean remembers. His mother stays home and is described by Sean as being depressed, which is concerning to him. Sean is a tall and handsome man with a rigid structure. When he first came to my office, he spoke very softly and quietly, almost whispering, and at times he covered his mouth with his hand as he spoke and avoided eye contact. Sean has a very set jaw, which is slightly forward, as if he is in a constant state of defiance. Sean's presenting issues were lack of motivation, having no sense of direction in life, and not knowing what his passions are. He was also mildly depressed, but did not have much anxiety. He was spending most of the day sleeping and smoking marijuana at night. At times he attended college, but never did well, and never was serious about his studies, despite the fact that he is a very bright man. Sean has had quite a few relationships but indicates that he has never loved any of his partners. Sean had about one and half years of cognitive behavioral therapy before coming to my office.

Therapy with Sean started slow. Almost from the very beginning I started working with Sean on the body level. Initially he could not feel much in his body, and he was not feeling much at all. He could only, and barely, identify if something felt good or bad. Our work started by getting Sean to feel his body and become aware of his sensations and deepen his breathing as his breathing was very shallow. We also worked on grounding, as Sean was very much in his head. We also had to work on setting boundaries, and saying "NO". Sean found out later in therapy that saying "NO", to him, meant possible loss of contact and love. As the work progressed, Sean began to show up late to our sessions, and at times did not show up at all without calling to inform me of his absence. This behavior was highly correlated with the building of the therapeutic relationship. In other words, any time that a strong bond was developing between Sean and me, he would behave in the ways that I mentioned, as if he wanted to disappoint and frustrate me so that I would reject him (just like his former therapist did). Interestingly, as he felt my frustration, he would take on a pleasing role, only to follow it with more disappointment. I brought up his behavior in a session to process and analyze it, and it became apparent to Sean that this is what he does with his parents, friends, and even college professors who were kind to him. He did not know why he engaged in this behavior of disappointing others who were nice to him.

I worked very intensely with Sean's sensations and feelings. He became aware of a deep sense of shame that he carried with himself from not living up to his parents' expectations. But his odd behavior of frustrating and disappointing others continued. He found a job and was terminated because of this behavior, even though his manager was fond of him. A few months ago, he excitedly came to a session after about a month of absence and mentioned that he had found a job several weeks ago, and that he has become friends with a few people in the company. He realized that he was repeating his pattern of disappointing them, which nearly got him fired again. Having worked on his sensations and feelings for many months, I felt he was ready to go deeper. I asked Sean what sensations he was aware of when someone was deeply fond of him. He said that he felt a strange sensation similar to anxiety in his stomach and his chest. I asked Sean to stay with those sensations and see what he felt was going to happen. His response was quite interesting. He said he felt he would merge with people who liked him, and that he would not exist as himself anymore! The meaning of his odd behavior thus became clear to him. He would disappoint and frustrate those who cared for him, in order to maintain some sense of self. Over several sessions he became aware of early childhood memories in which he had to lift his mother's mood by

cheering her up and pleasing her. But then she would not let go of him. All he could do was disappoint and frustrate her in order to get away from her, so that he could have some sense of self. He was stuck in a major dilemma. He had to cheer up his mother to receive contact and love from her, only to have to push her away to maintain some sense of self and thus lose contact. This was not acceptable to the young boy, and therefore he pleased her again to receive contact... He was stuck in a loop! Our work still continues, but Sean has been able to maintain his job for several months, has fallen in love for the first time in his life, and plans to go back to college when he discovers his passions. He no longer disappoints and frustrates those who are close to him and/or fond of him, and has become much more responsible in his life. My work with Sean was mostly concentrated on his sensations and feelings in order to strengthen his sense of self. Interestingly Sean's Oedipal conflicts are now beginning to surface, which we are currently working on. This case clearly indicated the need to engage in both psychology of the self and conflict psychology, but the body and the relationship were always at the center. The work with the body, through breathing exercises, grounding, and working on integrating sensation and feelings, were instrumental in this client's progress in therapy. Of equal importance was building the therapeutic relationship in which Sean could feel that I, the therapist, would not abandon him. And he tried hard, as he mentioned in one of his recent sessions. It was the containing of his feelings and emotions within the therapeutic relationship and the consistent work on his body that allowed Sean to slowly dissolve his defenses and develop a deeper sense of self. What was also crucial in his therapy was his idealization of me along with optimal frustration on my part within the therapeutic relationship in that I did not push him away when he frustrated me, but stayed with him, helping him to finally separate from his mom.

### Summary and Conclusion

In this paper, an integrative model for developmental trauma was presented which attempted to integrate ego psychology, drive-conflict theory, somatic psychology, object relations, and self- psychology. The intention was to present a model that brought together the aforementioned schools of psychology. The intention was not to synthesize a new model based on existing ones. Specifically, it was argued that when a drive/impulse is formed (pleasure seeking or object seeking) in the child, and meets with parental frustration and negativity (frustrating object), it splits in two parts. Simultaneously, the frustrating object is also split in two: a good object and a bad object. The child idealizes the good object in order to survive. The child then internalizes the bad object, which goes through further splitting into frustrating and exciting aspects. The child identifies with frustrating aspect of the bad object, resulting in repression of the original drive/impulse and leading to parental introjects (origin of the formation of superego), having antilibidinal characteristic, and serving as internal saboteur. The second part of the split impulse/drive, corresponding to the exciting aspects of the bad object (libidinal ego), seeks the needed selfobjects which are meant to affirm the child's self and serve the mirroring, idealizing, or twinship needs of the child. Somatic aspects of the defensive mechanism for maintaining the repression of drives, in the form of muscular armor, were also discussed. The latest findings of neuroscience were presented to support the proposed integrative model, and it was shown that, based on this model, character structure could be viewed as developmental trauma. The importance of shame in the formation of developmental trauma was also discussed,

and supporting material from neuroscience was provided. The complementary nature of conflict psychology and psychology of the self, within the proposed integrative model, was presented with implications for body psychotherapy.

### BIOGRAPHY

Homayoun Shahri, Ph.D., M.A., received his PhD in electrical engineering from Lehigh University in 1990, and his master of arts in clinical and somatic psychology from Santa Barbara Graduate Institute (now part of The Chicago School of Professional Psychology) in 2012. He is a marriage and family therapist and intern, and currently practices in Irvine, CA, USA. Homayoun is a Bioenergetic analyst and completed the Bioenergetic training program in the Florida Society for Bioenergetic Analysis, in 2009. He is a member of the Southern California Institute for Bioenergetic Analysis (SCIBA), where he is working toward the completion of his certification requirements. Homayoun is a member of the United States Association of Body Psychotherapy (USABP), International Institute for Bioenergetic Analysis (IIBA), and California Association for Marriage and Family Therapists (CAMFT).

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## Awareness and Mindfulness in Consciousness-Centred Body Psychotherapy Christian Gottwald, MD

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### Abstract

It is extremely valuable from a clinical perspective to make use of the processes of consciousness in a differentiated manner in body psychotherapy. The integration of a basic spiritual training with the therapeutic process can lead to sustained and meaningful change in established patterns of experience and behaviour. It also offers opportunity for the development of consciousness depending on the structure of the patient and the particular phase of therapy. To demonstrate this, a transcript is included of the first session of therapy with a psychosomatic patient who, with the help of body psychotherapy interventions, decisively achieves an awareness for the here and now. The holistic approach described here is a method in which therapy and the process of individuation are linked together. Plausible explanations from cultural history and from neuroscience, psychotherapy, and infant research are integrated. This way of working is based on an attitude of mindfulness and its related process — awareness — which are to accompany the patient's therapy. This attitude was borrowed pragmatically from the Eastern (especially Buddhist) schooling in consciousness and introduced into the non-religious context of change processes. In the later stages of individuation therapy, 'awareness' can develop with altered perceptive and experiential qualities through which one's own existence newly can be directly perceived and experienced. This condition transcends the customary patterns of experience.

*Keywords:* mindfulness, awareness, development of consciousness, unity of body, soul and spirit, consciousness-centred body psychotherapy.

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### Background

With the third wave of behavioural therapy and developments such as Marsha Linehan's Dialectical Behaviour Therapy (1996) and John Kabat-Zinn's mindfulness-based stress reduction (2011), the inclusion of mindfulness as an essential factor in the healing process is becoming increasingly widespread in various psychotherapy methods. In humanistic psychology and body psychotherapy in particular, the use of mindfulness has a certain tradition. On the basis of his experiences with Zen, Fritz Perls played a leading role in



introducing “awareness” into Gestalt therapy (Perls, 1976). By the same token, Ron Kurtz (2000) eclectically and pragmatically adopted the “mindfulness” practice as seen in Taoist meditation to support the therapy process of his Hakomi method. Gendlin focussed on the relationship of mindfulness to the body with his “felt sense” (1992, 1997). There are many more therapy forms that centre on mindfulness, for example, mindfulness-based cognitive therapy (MBCT) and Acceptance and Commitment Therapy (Halko Weiss & Michael Harrer, 2010). In the consciousness-centred body psychotherapy approach to supporting change in therapy and individuation work described here, mindfulness and, significantly, awareness as a continuing quality of existence and consciousness, are encouraged and facilitated. This contribution is meant to stimulate discussion around a differentiated initiation and supervision of consciousness processes in body psychotherapy. For each of the stages of therapy, consciousness of the here and now, as well as mindfulness and awareness, can be introduced and practiced. The approach to these states of consciousness that is espoused in this paper will be illustrated through a case study later.

Vital insights of neurobiological research will be taken into consideration when dealing specifically with consciousness processes in the framework of body psychotherapy (Damasio, 1996, 1999; Davidson et al. 2003; Hüther, 2003; LeDoux, 1996, 2001, 2003; Beutel, 2003, 2008; Singer & Ricard, 2005).

- 1) Mindfulness is very beneficial for change and learning. Mindfulness and awareness are variations of the state of consciousness known as attention. Ott (2008, 2010) provides a comprehensive literature on the scientific research into mindfulness and meditation.
- 2) Only in the present can one access and influence the experience and behaviour patterns of our body/soul/spirit, which are established in the nervous system. A plausible consequence of this is that consciousness of the here and now is essential for change processes and should be the focus of therapy from the beginning.
- 3) The world we experience is a subjective reality, created in each moment by the nervous system. Signals from the outside world are transformed in the neurons into electro-chemical signals and in the synapses into neurotransmitter signals. From this abundance of signals one develops the impression of oneself and the world, which one then experiences as objective truth. The patterns of these perceptions, experiences, and behaviours occur automatically and without voluntary participation. They have a fixed, repetitive structure and thus ensure the continuity of self-experience but thereby determine a limited perception of present reality.

The fact that self-experience is imprinted by history and is subjective and not directly in contact with external reality can unfortunately lead to extremely painful consequences. It is common to have no spontaneous awareness of or distance from this process and to believe that one’s experience of reality is the truth. This subjective impression of oneself and of the world can be perceived and experienced in a more differentiated way through appropriate consciousness training and through experiencing the body and body contact.

A holistic understanding of healing that is based on the scientifically proven unity of body, soul, and spirit (summary in Niedenthal, 2005) strongly suggests incorporating cultural, historical, and philosophical motifs from antiquity. In the Greek asclepeia, for example, the unity of body, soul, and spirit was taken for granted in the collaboration between priests and physicians. Buddhism has, as well shown in countless cases over 2500 years, the value of offering consciousness training for laypersons. With a holistic understanding of healing enriched by elements of this basic training, we can find a connection to our own Western mystical tradition (for example, in the German language sphere, Meister Eckhart, Nikolaus

von Kues, Johannes Tauler). The background and various aspects of what I am describing here as a scientifically plausible, methodically integrated approach to working with change processes in therapy and individuation have been comprehensively described elsewhere (Barrat, 2012; Gottwald, 2004a, 2004b, 2007a, 2007b, 2010a, 2010b; Kurtz, 2002; Pessa & Perquin, 2008).

### Arriving in the Here and Now

As we see in the following case study with a completely inexperienced psychosomatic patient, clients must first become aware of the present moment. This is why they are invited, preferably right from the start, to experience the present in full awareness of all that their consciousnesses can perceive. The focus is on the body as the incarnated mind-soul, which is in contact with the environment that is perceived through the body.

In consciousness-oriented body psychotherapy, by now there are a host of interventions that help patients, clients, and students become aware of the elements of their experiences of both the body and the emotional sphere in its entirety. In the initial phases of therapy, it can be possible in some cases through body psychotherapy interventions to actively help patients become aware of the present moment and gradually perceive their own bodies (ensouled bodies) more consciously. This can be facilitated by intensifying the strength of the stimulus of the internal signals (somatic markers), through, for example, bio-energetic stress positions, an increase in generated breathing, and the use of voice.

### Case Study: Mr. A

Mr. A is an intelligent, 57-year-old man who comes from a simple background and suffers from depressive moods and neuropathic paraesthesia of the hands and feet, which he experiences as extremely threatening and which tends him towards hypochondria. After an initial interview and a brief overview of his history, he comes in for his first session. Having broken off several previous treatments, he is very sceptical; it seems particularly important in his case that he should have a different experience in this first session, so the therapist decides to take a very active approach.

### Transcript of the First Body Psychotherapy Session

(The figures represent the minutes and seconds of the session. Explanations and comments are in italics and parentheses. Pauses are indicated by ellipses.)

1:01 Therapist: How have you been since our first meeting?

A: What should I say, doctor? I still don’t know whether I’m in good hands with you. I tell you this quite honestly. I’ve trusted other therapists so often and none of it has really helped. I’m ambitious and I want to achieve things. I always wanted to get on and, really, I wanted to study, but circumstances always put obstacles in my path.

1:31 Therapist (*who has already taken a detailed history, tries a very active intervention*): Would it be all right if I challenge you a bit? (*A agrees*.) I’m convinced that it wouldn’t help you much if you just repeat these stories, which you know so well anyway, and which you’ve already at least told me in part.

1:37 A (*cleverly interrupting the therapist*): So it would be better to plan for the future! (*Evidently, he has been asked to do this in earlier treatments.*)

1:44 Therapist: No, that’s not what I mean. First and foremost, what would help you most in my opinion would be to arrive in the present! Therefore my first question would be: **what do you notice at the moment... here and now?**

2:00 A: What do I notice at the moment? I feel these symptoms.  
 2:10 Therapist: **What do you feel and where do you feel it exactly?**  
 2:10 A: It feels as if my shoes are making my feet numb. And my feet are very cold.  
 2:20 Therapist: According to the diagnoses you brought with you, you do in fact experience both paraesthesia and cold feet, both of which could be due to the diabetes mellitus you have. (*It is important to acknowledge the somatic and neuropathic dysesthesia from the start.*) But the rest of the problem could depend on how you deal with these sensations, how you cope with them.  
 2:56 A: Possibly!  
 3:02 Therapist: Thousands of people have the same physical condition, but everyone reacts differently to it. We should try to find out what is exactly happening in the present that unsettles you so much. (A agrees.)  
 3:12 Therapist: **What do you notice is happening just now?**  
 3:15 A: What's happening now? I already told you that before...  
 3:17 Therapist (*actively confronting A again*): **But you're going back into the past again! The question is what's happening to you now.**  
 3:25 A: It was a great shock for me when my wife died so suddenly.  
 3:30 Therapist: But again you're back in the past! What's happening here and now in the present?  
 3:36 A: In the present, I've just met a nice woman.  
 3:42 Therapist: That's the recent past... (*Further explanation is required.*) I'm trying to make you aware of the absolute, exact, present situation here in this room, in your body, do you see? This is the only moment we live in and which we can influence directly. The past, including the recent past, is gone, we can't change it any more. And the future isn't here yet. May I continue insisting on calling your attention to the precise present moment? (*A nods.*)  
 4:00 A: What do I notice now?  
 4:03 Therapist: Yes, exactly — what do you notice, or what do you feel in your body and where, or what are you aware of through your senses?  
 4:08 A: You mean what's bothering me?  
 4:13 Therapist: No, I mean something quite simple: do you notice that you are alive and that you are living in the moment in your body?  
 4:15 A: Yes, I notice... that I'm alive.  
 4:17 Therapist: **How do you notice that?**  
 4:20 A: Yes... I'm breathing. (*This sounds more cognitive.*)  
 4:21 Therapist: **Do you notice how you're breathing just now?**  
 4:24 A: Maybe not.  
 4:28 Therapist: It seems quite possible that this simple experience of breathing as well as the many other functions of your body may go on with you hardly noticing.  
 4:31 A: Yes, actually, that's true. I notice what's not working, but I don't take any notice of what works well. (*A becomes thoughtful.*)  
 4:45 Therapist: That's possibly it. So what do you notice spontaneously in your body now and also through the senses... beyond the sensations in the foot? Try to be open about what's going on in your body apart from that.  
 4:56 A: Yes, exactly, for example my digestive system is functioning well...but... (*Again, this is cognition, not experience.*)  
 5:08 Therapist: Notice what's just happening: you mention something that functions well and in the next moment, with much more emphasis, you say "but"! Do you notice

this tendency?  
 5:22 A: Yes, I do!  
 5:29 Therapist: Can I just explain a little about some basic neurobiological principles? (*A nods.*) What we focus our attention on becomes larger and what we withdraw our attention from becomes smaller. This means that you are repeatedly less aware of what works well in your body and that instead you focus on what is not so pleasant, what doesn't work so well. (*The therapist emphasises the psychological explanation with gestures, showing how these aspects grow ever larger.*)  
 6:02 A: You're right there! My brain directs my attention towards something unpleasant, something negative. But you know... sometimes I have a good moment, but then it starts up again!  
 6:35 Therapist: And it goes on so that by force of habit you're virtually drawn to the unpleasant signals, for example, the painful sensations in the feet... Could this be the case?  
 6:47 A: Yes it could. I'm afraid that it could be something really organically wrong.  
 6:57 Therapist (*using his authority as a specialist*): There is probably some organic malfunction, such as tiny changes in the nerves caused by your diabetes. Something like that could trigger painful sensations. But these sensations are always psychosomatic: that means a part is organic, connected to the body, and another part is connected to the soul, with how that deals with the experience. But you can influence how you deal with these things. And of course at 57 you're not as young and in as good a condition as you were as a teenager.  
 7:40 A: Yes, that's true.  
 7:43 Therapist: But we can influence this at any age. I can help you to do this. That would be the beginning of the therapy, when you notice more clearly how little you participate in your life in the present moment. Then, I could help you to pay more attention to what you can perceive here and now. Would you agree to this? (*A agrees.*) Now I will ask you some questions that you might not be able to answer easily or quickly. I'll start by asking you again: How are you feeling now? But the question is really: **How are you feeling exactly in the here and now? What do you notice in the body?**  
 7:58 A: How am I feeling now? Yes, I notice that I'm feeling better. (*The responsiveness of the therapist has of course calmed A down a bit.*)  
 8:03 Therapist: **How do you notice this?**  
 8:10 A: Yes... my thoughts have gone somewhere else. I'm not thinking about my legs at the moment.  
 8:20 Therapist: Isn't that interesting? **What else do you notice? How do you notice if something is better? What is going on now in your body, while you're not following your thoughts in their usual direction?**  
 8:39 A: I notice that I'm more relaxed.  
 8:41 Therapist: **How do you notice that you're more relaxed? Where do you notice that in the body?**  
 8:46 A: Perhaps the heartbeat?  
 8:48 Therapist: But that's probably again something you're thinking about! **What I'm asking is what you perceive directly. How and where in the body do you notice that you're maybe a little more relaxed?**  
 9:03 A: What should I say? What I notice now? (*A is at a loss.*)  
 9:07 Therapist (*A needs perhaps more help and guidance in his bewilderment*): I can understand that you're perhaps not used to paying attention directly to the body. Until now, you've really only been aware of the body through bad sensations. Maybe you need more help in noticing

and becoming aware of yourself in your body. Then you could perhaps realise that you have a life beyond these bad sensations. Up until now, it's probably been very difficult to really feel this vital life of the body through the bad sensations.

9:40 A: I do notice somehow that I'm alive, but how?! ... *(A is becoming increasingly quieter and more thoughtful.)* Up until now I've been concentrating on the negative aspects!!!!

10:15 Therapist: Shall we continue practising this perception of the body in the present moment? *(A nods slightly.)*

10:40 A: If I pay attention to it, I notice that I'm breathing.

10:53 Therapist: Very good, **would you like to stay with this experience of breathing?**

11:02 A: But you know....

11:04 Therapist *(in view of the good working alliance, interrupting A before he can fall back into his usual cognitive mode)*: Do you notice how you're just about to move away from direct experience now?

11:07 A: Oh, yes...exactly! ...

11:12 Therapist: Could it be that you find this simple experience of the living breath in the here and now dull? Most people do.

11:59 A: But why is that? ... Does it all have to do with my past and all that? ... I had some very bad experiences! *(A refers to general knowledge of depth psychology he has garnered from earlier therapies.)*

12:08 Therapist: Yes, in the course of our lives we do in fact learn these habits of guiding our attention to certain things. It's good to be aware of this. But it's not really helping you in the present, when you have such pain, to concentrate on it and worry about it so much.

12:35 A: But I had too many negative experiences in the past... That's why I always expect negative things to happen. *(A slaps his thigh.)*

12:48 Therapist: Then it can easily happen that you leap from this difficult past into the future and expect similar experiences there. *(The therapist demonstrates and underscores this with the left hand symbolising the past underneath and the right hand symbolising the future high above).* But the only moment in which we are alive is here and now! *(The therapist demonstrates this through body language with the arms crossed at the centre.)* But many patients, just like you, find it difficult to be conscious of most of the aspects of the present.

13:15 A: So I have to learn to live now today?!

13:18 Therapist: Absolutely! In any case, it would be good if you became more aware of sensations and experiences in the present. Otherwise, you could very easily be so absorbed in the pain in your feet that you leap into the future with all the fears and or fall back into thoughts and worries from the past... *(A seems more present and nods his head).*

13:46 Therapist *(thinking that as A has had great difficulty in becoming conscious of himself in his body, a body psychotherapy intervention could reinforce the strength of the physiological signals)*: **We could now try to strengthen the signals from your body with a little body exercise. It would probably make it easier for you to feel more clearly what else is going on in the body apart from the pain in your feet.** Would you like to try it? *(A agrees.)*

14:01 *(The therapist stands up and invites A to do the same. The therapist moves the chairs away. Then he squats down low with legs apart and invites A again to take up the same position, which he does willingly.)*

14:21 Therapist *(while he and A are squatting, motioning that sooner or later the thighs will start to hurt)*: When the pain comes just let it be there. *(The patient breathes very shallowly at first).* Try to relax as much as you can. And if possible try to make a sound with the breathing, perhaps with an audible sigh on the out-breath. Do you notice the shallowness of your

breathing? Now I'd like to invite you to squat down lower, let the breathing gradually become deeper, and allow the voice to join in as a sigh. *(Including the voice tends to make breathing easier and deeper).*

15:01 Therapist: I'll show you how to do it. *(The therapist demonstrates an audible sigh.)* In this way your breathing could become deeper and deeper if you will let it.

15:02 A: *(Slowly A begins to breathe more deeply and to make his breathing audible.)* Ah, yes!... *(In the end he can't keep up the low squat position and stands up straight. The therapist does the same as it seems that there is adequate stimulation of the patient's breathing.)*

16:03 Therapist: Let yourself notice what is happening now that you've done that.

16:15 A: I feel as if I'm heavier now.

16:17 Therapist: Exactly! Now you can notice how heavy your body is!

16:20 A: That's it!... I feel heavier. And I notice that I'm standing more... firmly on the ground.

16:25 Therapist *(marking the changes)*: You notice that your contact with the ground has improved?!

16:33 Therapist *(deciding to reinforce the perceptible changes in this first session, so as to bring A more strongly into contact with his breath power, "chi", his aggressive potential)*: If you like, I could show you a second exercise from a martial arts school, which trains the breath power and which should be challenging for us both. *(A agrees. The therapist stretches his arms out in front of him and offers his hands to A at about shoulder height. Then he invites A to stretch his arms out at shoulder height and to grasp the hands of the therapist.)* Now I'll try to push you towards the wall behind you. You resist me as strongly as possible, so that I can't move you. *(The therapist pushes A, who is very strong but who resists only slightly, backwards. Afterward he invites A to push him back in the other direction.)*

16:54 *(A stops breathing while trying to push the therapist backwards, which prevents him from doing so effectively.)*

17:02 Therapist *(drawing A's attention to the constriction in his breathing and showing him how much more difficult it would be for the therapist to push A back without breathing. Then he shows A what happens when he uses his imagination to send the breath through his arms and breathes freely. In this way, he can push the patient backwards with no effort at all)*: In the course of the psychotherapy you can learn and improve this skill of expanding and extending the breath. Shall we try it again now? *(A agrees.)*

17:30 Therapist: Now push me back to the wall with your breath, your life energy.

17:35 *(By utilising his breath and his voice, A actually manages to push the therapist to the wall and is obviously enjoying himself.)*

17:41 *(As A is breathing deeply, this is a good moment to let him feel what's happening.)* Therapist: **Now feel again what you're experiencing in the body at the present moment after we did this experiment together.**

17:48 A: My breathing is deeper!... Yes, it's really an improvement... Yes, the breathing is much deeper. *(A is astonished and obviously very relieved and happy.)*

17:57 Therapist: How is it for you to feel yourself in the body like that?

18:05 A *(laughing)*: Oh, so this is what it's like to breathe properly!!

18:14 Therapist: Maybe now you can be more aware of what a strong man you are... How is this quality for you just now?

18:35 A: Yes... When I move vigorously ... *(Through the experiences A just made, he is having insights which have real meaning for him.)*

18:46 A *(very thoughtfully)*: ... Yes, it's true... Yes, funny when I do yoga — sometimes I do



yoga — when I breathe more deeply, I calm down!

*(These spontaneous insights are related to resources that the patient has already developed. Therefore the therapist decides to provide some more information. He explains the Eastern concept of “prana” and points out that the Hebrew word “ruach” also means the breath of life that God has breathed into the human being. A listens, intrigued. Finally, the therapist demonstrates what further possibilities there are in body psychotherapy for becoming more aware of the present condition of the body, feeling more at ease in the body, and experiencing one’s own energy flow. He shows A, for example, that he is not standing in the centre line and that he is over-extending his knees when he stands.)*

23:37 Therapist: **Shall we arrive again in this new present moment?** *(A agrees.)* **What do you notice now?**

23:39 A: Very good... I notice that now I really do have more energy.

23:46 Therapist *(despite the fact that that was a relatively diffuse perception, still feeling that it should be marked):* Exactly, you notice now how much more energy you have.

23:52 A *(very thoughtfully):* Yes, yes. That’s true. *(He laughs and his face is glowing.)*

*(In the rest of the session, A asks about a diagram, the so-called growth-energy-spiral, which hangs in the offices. It illustrates the cyclic interaction between two people. With the help of this energy-growth-spiral, A reflects on the process he has just experienced and relates it to his life. He also talks to the therapist about what consequences these ideas and experiences could have for his life. Subsequently he mentions that after he has participated in a sport, he tends to return to concentrating on the pain in his feet. The therapist and A then go through the possibilities of guided attention once more.)*

39:05 A: Yes, I understand that now... Super! When can we have another session?

### Deepening Mindfulness in Later Phases of the Change Process

As patients gradually achieve an awareness of the here and now, we can help them to become more conscious of their own bodies by asking again and again about the basis in the body of each pattern of experience. (“Where do you notice that in the body? Where do you get the information from the body for this feeling? How does that feel in the body?”)

Later, therapists can reduce their activity and explanations. The patients can achieve a deeper awareness of the present and learn mindfulness more independently. This state of consciousness means maintaining a conscious, attentive, accepting attitude towards all that arises in the mind moment by moment.

Basically, mindfulness can be practised in two ways: as a one-off exercise, and as an attitude of mind that is practised and encouraged in the ongoing therapeutic process. The Hakomi method has integrated such a concomitant form of inner mindfulness into the field of psychotherapy. In this process, the patients, clients, and students learn to consciously experience the present as an experiment and also to create experiments themselves, which they then follow attentively, expressing their present experiences as they are had in a mindful way. They perceive themselves in all their various, multifaceted aspects and speak at the same time from this experience without losing the connection to the present moment. This allows the therapist to participate directly in the events of this inner life, communicating simultaneously, and so support the process appropriately. Therapists can encourage patients and students to slow down the spontaneously emerging pattern of experience and behaviour, or to stop for a moment. Patients increasingly become the experts on their own worlds. Supporting the process becomes increasingly subtle. Such processes sometimes feel like a joint meditation.

Since basically every present event is considered to be an embodied experiment on a mutual playing field, experienced in all its ramifications, this experiment can be corrected at any time. According to the situation, therapist and client can consciously create new experiences together. This experimental (and therefore in principle, scientific) understanding allows for a highly creative and custom-fitted approach to interactions.

Sessions of consciousness-oriented body psychotherapy seem at first glance very different from each other, although the basic principles could be named at any time. All the options from the previous experiences of patients, clients, students, and of the therapist (including various methodical backgrounds, especially from body therapy and body psychotherapy) can be included, tested, and integrated. For a clinical, psychosomatic (body psychotherapy) practice, the use of mindfulness in such an experimental manner can become a fundamental component of an integrated, structural way of working that utilises various methods and which allows the inner space of the psyche to be expanded and experienced in a more differentiated way. In this respect, we could speak of a psycho-soma-noetic practice (the Greek word “nous” meaning mind-consciousness).

Such change processes become obvious in the mindful awareness of the psychodynamic, historical background of previous patterns of experiencing and behaviour and the corresponding representations of self and object. Together we can create corrective responses, experiences, and (of course bodily and otherwise) interactions for traumatic or deprived states of self and early deficits. Through inclusion of the body in therapy, historical experiences can be worked through in a healing manner. These new holistic experiences can be internalised and may later help patients support themselves adequately. Additionally, clients are introduced to the royal road to change in life and in consciousness.

### Direct Experience: Awareness as the Training of Consciousness With a Direct Potential for Change in Body Psychotherapy

In the therapy phase (even before individuation work), patients can be encouraged in a suitable moment not only to stop the unfolding of a pattern, but also to let go of all activity in that moment of awareness. The corresponding state of embodied perception, which is connected to a certain quality of existence, can be best termed “awareness”. It signifies the opening of an inner, embodied “room of experience” in which we accept all that appears, change nothing, and simply marvel. When individuation reaches an advanced stage, states of self arise, which different therapeutic approaches name and describe in various ways. Winnicott, (1983) for example, speaks of the “true self”, Dürckheim (1975) in the line of Husserl (1913) and Medard Boss (1975) of “being”, and Assagioli (1965) of the “higher self”.

In such states, we can succeed in dis-identifying ourselves with those historically determined automatisms that are spontaneously invoked by the brain. If patterns that are deeply embedded in the body start to change or dissolve, existential experiences sometimes develop that fundamentally transcend the historically determined personality. Such transformations can be experienced as extremely impressive and surprising events in the evolution and development of the personality, and, beyond all previous expectations and perspectives, even as a miracle. Similar states of experience are described in spiritual systems: in mysticism as “awareness”, in yoga as “samadhi” (Zimmer, 1973), and in Tibetan Buddhism as “rigpa” (Dalai Lama, 2001). In these cases, they happen spontaneously but usually after long meditation. We can systematically increase the probability of such transformations in the non-religious context of body psychotherapy change processes through the appropriate

support. Our experience as therapists leads us to advocate the training of consciousness and an existential mindset not only in spiritual schools and systems, but also in therapy and individuation work. We can take the responsibility for such a step, as in a consciousness-oriented body psychotherapy such as the Hakomi method (Ron Kurtz, 2002), which also understood simultaneously as an experiment, and the effects can be noticed and corrected at any point.

Patients with no previous knowledge may find it trivial to directly experience and be aware of the present moment beyond the usual patterns of perception. But awareness requires a subtle reorientation not only of perception but also of the fundamental attitude toward the phenomena of the experienced world, which can be more and more differentiated. At first, it is easiest to understand only theoretically that the separation between subject and object disappears in pure awareness and that there is a non-dual form of perception and existence. We can comprehend that there are different qualities of awareness: the quality of the awareness can vary, as well as the quantity of the processes of which we are aware. In this way, we can have a high level of awareness of cognitive processes but at the same time a low awareness of body sensations or feelings.

In the therapy stage of the change process, with the help of consciousness-centred body psychotherapy, a mindful state of consciousness can often become a gateway for spontaneous spiritual experiences. This observation reinforces the idea of Fritz Perls (1976) and later Ron Kurtz (2002) of adopting and pragmatically integrating, from Buddhist spiritual training and meditation, the development of awareness and mindfulness as a fundamental education in change processes. Apart from the “felt sense” of Focusing (Gendlin, 1997), it seems wise to include other impulses, especially the fundamental attitude, from Eastern consciousness training, to differentiate mindfulness even further and to initiate systematic changes in perceptive and being qualities. In individuation work, which is inspired by this, it can become clearer how in everyday consciousness, cognitive processes and thought chains usually play a part in and affect how we are feeling. Thus, we teach patients, clients, and students, as a first step, how to become aware of their thoughts as such, then how to stop them, and later how to distance themselves subtly from these chains of thought without either repressing them or being absorbed by them.

Increasingly they learn to notice the quality of their thoughts and simultaneously their basis in the body with all the senses and thus to become directly aware of all the elements of these cognitively interwoven experience patterns. In the process, impressions automatically rise up out of the body cells, metaphorically speaking. We can embrace these qualities and learn to linger in them, to swim in them, while marvelling at the experience without wanting to influence or change anything. Just being able to stay with an experience creates a significant difference in the quality of the world we live in, which means direct participation in the experience and a subtle distancing from it at the same time. In this process we notice in an increasingly differentiated way how the experience changes from moment to moment. New creative ideas can come up intuitively, which can be extremely inspiring. Such states of self transcend the historically determined patterns of experience and behaviour. In a spiritual context, they would be characterised as ego-transcending experiences because they make one aware of one’s connection to the immediate environment and even to what one may experience as the cosmic or divine whole. Strictly speaking, however, it is the systematic development of the consciousness of a personality. Such an experience is usually only possible after a longer preparation in therapy and individuation work. (For a relevant detailed case history with transcript see Gottwald, 2012.)

## BIOGRAPHY

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## Helping the Body Grieve: A Body Psychotherapy Approach to Supporting the Creation of Continuing Bonds After a Death Loss Dyana Reisen, MA, CT

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### Abstract

This article attempts to bridge the gap between thanatology and body psychotherapy. More specifically, the focus is on why and how bereaved individuals can use their body memories of deceased loved ones to form continuing bonds. Historically, there has been a prevailing view among clinicians in Western society that breaking attachments with the deceased is essential to the mourning process and that remaining connected is pathological (Freud, 1917/1957; Rando, 1984; Worden, 2009). But over the years, evidence has shown that many survivors actually continue their relationships with the people who have died (Klass, 1993a, 1993b; Rosenblatt, 1983). Because grief is a somatic process, a theoretical framework is proposed for using body memories by those experiencing uncomplicated grief to aid in the creation of continuing bonds with the deceased.

*Keywords:* grief, death, continuing bonds, body psychotherapy, body memory

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### Introduction

Most people will experience death and grief at some point in their lives. Anyone who loves or forms an attachment with another runs the risk of losing that person and suffering the consequences of that loss. In that light, the only way then to avoid the pain of loss would be to live a life without attachments so there is nothing to lose. Grief is the usual, natural response to a loss (Hooyman & Kramer, 2006; Rando, 1984). It “allows us to let go of that which was and be ready for that which is to come” (Rando, 1984, p. 17). Grief is also a life-long journey. This, however, does not mean that people need always suffer. Instead, individuals can create a life that supports the grief process.

Loss results from an event that is perceived to be negative and that creates long-term changes to a person’s life (Hooyman & Kramer, 2006). Thanatology, the study of dying, death, and bereavement, defines grief as the personal reaction to loss (Worden, 2009; Rando, 1984; Corr, Nabe, & Corr, 2009). Mourning, though sometimes used interchangeably with grief, is the intrapsychic and interpsychic process used to cope with loss. Bereavement describes the situation of having experienced a loss. In this article, grief, mourning, and bereavement will be used in accordance with these definitions.

Many survivors are able to endure the distress of loss without disruption in their daily lives; these people seem to experience new challenges with ease (Bonanno, 2004). People

who are able to adapt to loss are considered by thanatologists to have uncomplicated or normal grief (Rando, 1984; Worden, 2009; Zisook & Shear, 2009). The term uncomplicated grief will be used in this article because normal grief implies that some grief is abnormal, which the literature increasingly indicates is not true. On the other hand, those who grieve without moving through the mourning process towards reorganization and adaptation, thus potentially impairing their functioning, are said to have complicated grief (Howarth, & Leaman, 2001; Horowitz, Wilner, Marmar, & Krupnick, 1980; Worden, 2009). Worden (2009) differentiates between supporting an individual experiencing uncomplicated grief and supporting an individual with complicated grief. Grief counseling is for mourners who are experiencing uncomplicated grief and are seeking added support as they adapt to the changes precipitated by the loss. Grief therapy is appropriate for survivors with complicated mourning who need to resolve conflicts with regard to separation from the deceased. It is difficult to make distinctions between normal and complicated grief (Stroebe, Hansson, Stroebe, & Schut, 2001) and when to use grief therapy versus counseling (Worden, 2009). These distinctions are being noted in order to give context for why certain terms are used in this article.

Grieving is an individual experience and even if two people experience the same loss, they do not grieve in the same way. Nevertheless, there are common elements that are evident in the grief response (Bauman, 2008). Normal grief is comprised of a variety of feelings, physical sensations, cognitions, and behaviors that are common after a loss (Rando, 1984; Worden, 2009). Although grief is usually viewed as a psychological reaction, there are somatic reactions as well (Rando, 1984). Some of the more common physiological manifestations of grief are gastrointestinal disturbances, physical exhaustion, crying, shortness of breath, inability to sleep, tightness in throat or chest, or restlessness (Rando, 1984; Worden, 2009). Somatic reactions are often the main reason that individuals with complicated grief are referred to therapy (Rando, 1984). Furthermore, physiological factors are said to influence a person’s grief reaction, and grief interventions should be tailored to take into account these factors. “To ignore the somatic aspects of grief in favor of the psychological ones is to incompletely address the needs of the griever” (Rando, 1984, pp. 85-86).

Since grief is a somatic experience, body psychotherapy may be a useful approach to working with the mourning process. This form of therapy takes into account the interactions of the body and the mind (Caldwell, 1997; European Association for Body Psychotherapy, n.d.; Totton, 2003, 2005). In body psychotherapy, embodiment, the connection of body and mind, is an important part of being human; when working with the body, one is also working with the mind, and vice versa (Totton, 2003). “[A] person’s beliefs and feelings manifest in their body and, conversely, changes in the body can and do facilitate changes in belief and feeling” (Totton, p. 24). Emotions are therefore able to bridge the mind and body in that they are experienced in both (Caldwell, 1997; Damasio, 1999; Pert, 1997; Schore, 1994). In addition, the human body does not exist in isolation (Totton, 2003). We form our relationships through and as our bodies. Because of the focus on emotion and relationship formation in body psychotherapy, it seems fundamental to use such an approach when working with someone who has had a loved one die.

This article will serve to bridge the gap between thanatology and body psychotherapy by presenting a theory of why and how individuals experiencing uncomplicated grief can use their bodies to create lasting relationships with those who have died. Using the concept of body memory, this article will address how body psychotherapists can support mourners in using their bodies to get in touch with their memories of the deceased and create continuing

bonds that involve their bodies. Body memory refers to implicit memory that is inherent to the body and includes how we experience and remember life through the body (Casey, 2000; Koch, Fuchs, Summa, & Müller, 2012). Continuing bonds pertains to how “survivors construct a sense of the deceased and develop an inner representation of that person” (Silverman & Klass, 1996, p. 19).

### Grief Theories

The study of grief began with Freud and his work on mourning and melancholia (Freud, 1917/1957). Freud proposed that a person needed to work through the loss of a loved one who had died. He stated that mourning’s “function is to detach the survivor’s hopes and memories from the dead” (Freud, 1917/1957, p. 257). Freud’s theoretical framework was later reinforced by Lindemann’s (1944) study that included people who had experienced the death of a loved one in the Coconut Grove fire in Boston. From his research, Lindemann (1944) concluded that grief work, the process of coping with a significant loss, required the bereaved person to confront the reality of the loss and detach from the deceased in order to build new relationships.

One theory that became well known and accepted was Elisabeth Kübler-Ross’ grief theory. In her book, *On Death and Dying* (1969), Kübler-Ross introduced the five stages of dying. These stages were presented as a normal response to one’s own death. The process, which is familiar to many people, starts with denial and progresses to anger, bargaining, depression, and acceptance. Even though Kübler-Ross’ stages were based on people who were dying, they have been applied to mourning survivors as well. Rando (1993) also contributed to the stage theory of grief. Rando’s model, the six “R” processes of mourning, suggested that mourning has six phases: recognize, react, recollect, readjust, relinquish, and reinvent. This model is rooted in Lindemann’s (1944) concept of grief work. Thus, Rando (1993) theorized that a bereaved person needed to sever ties with the person who died by relinquishing old attachments to the deceased and readjusting to the new world and creating new relationships.

Despite its popularity, limited empirical research has been done on the stage theory of grief. The studies of stage theory show mixed support for Kübler-Ross’s model. One study did not find any support for the stage model (Barrett & Schneweis, 1981), whereas other research found limited supporting evidence (Holland & Neimeyer, 2010; Maciejewski, Zhang, Block, & Prigerson, 2007; Meuser & Marwit, 2001). In addition to the lack of research that supports the existence of stages in the grief process, there is also no agreement among thanatologists on what the stages of grief actually are (see Dillenburger & Keenan, 2005).

Breaking away from grief stages, Worden (1982) adopted a different approach to loss by developing a task model of mourning. He stated that stages or “phases imply a certain passivity” (p. 38) and the tasks concept implies that the mourner can and needs to do something to actively adapt to the death of their loved one. In other words, the bereaved person is given some control over their grief process. Although these tasks do not have to be done in order, there is some sequencing in their definitions. Worden’s (2009) current tasks are the following:

- To accept the reality of the loss
- To process the pain of grief
- To adjust to a world without the deceased
- To find an enduring connection with the deceased in the midst of embarking on a new life.

Notably, Worden’s (1982) final task was originally to withdraw emotional energy from the deceased and reinvest it in another relationship. Worden (1991) later changed this task due to further research that showed a large number of survivors stay connected with the loved one who died.

The shift in Worden’s (1982, 1991) grief model illustrates how new theoretical perspectives rejected the concept of breaking bonds with the deceased as a part of the resolution of grief. This came about because researchers began to discover that mourners were continuing their relationships with those who had died long after their deaths. Numerous studies revealed that survivors often feel a sense of presence of the deceased (Rosenblatt, 1983; Silverman & Worden, 1993; Stroebe, Stroebe, & Domittner, 1988). Some studies found that bereaved parents maintain a continuing interaction with their deceased children by creating inner representations of them (Klass, 1988, 1993a, 1993b). Fairbairn (1952) defined inner representation as “aspects of the self that are actualized in the interaction with the deceased person; characterizations or thematic memories of the deceased; and emotional states connected with those parts of the self and with those characterizations and memories” (as cited in Klass, 1993a, p. 344). In addition, other researchers discovered that many widows maintain an active connection with their spouses through a sense of presence of the deceased (Glick, Weiss, & Parkes, 1974; Shuchter, 1986). Because the modern Western world has moved toward a more individualistic view of the self, it is difficult for grievers to feel supported in creating lasting connections with those who die (Stroebe, Gergen, Gergen, & Stroebe, 1992). Many other cultures believe that the deceased continue to live on in some form after death and create rituals that sustain relationships with the dead (Silverman & Silverman, 1979). Therefore, it is important for therapists working with bereaved individuals to be knowledgeable about and sensitive to how different cultures and religions may impact a person’s grief journey.

### Somatic Components of Grief

As mentioned earlier, there are various components of a grief reaction: physical sensations, behaviors, cognitions and emotions. Of importance to this article in particular are the physical or somatic manifestations that are associated with grief. Many researchers have studied the reactions of grief and found that bereaved individuals report experiencing physical manifestations, such as changes in sleep or appetite, after their loved ones’ deaths (Kowalski & Bondmass, 2008; Lindemann, 1944; Parkes, 1964; Parkes & Brown, 1972; Zisook, DeVaul, & Click, 1982). Other studies on the somatic impact of bereavement have used biochemical measures to determine what happens to an individual’s body while undergoing grief. Some researchers have found that people who have experienced the death of a loved one have impaired endocrine functioning (Hofer, Wolff, Friedman, & Mason, 1972a; Hofer, Wolff, Friedman, & Mason, 1972b). Furthermore, research has shown that survivors may experience dysfunction in their immune systems (Schleifer, Keller, Camerino, Thornton, & Stein, 1983; Spratt & Denney, 1991; Zisook et al., 1994).

Despite studies that indicate there are physiological changes that occur when someone is grieving, the physical sensations that accompany grief are often overlooked (Worden, 2009). None of the aforementioned studies on the somatic components of grief suggested ways to address such concerns. In grief literature, the physical issues are usually addressed only as a means to rule out any physical disease the grieving person may have (Rando, 1984; Worden, 2009).

### Body Psychotherapy and Grief

Because grief is such a somatic experience, somatic psychology can be a useful modality when working with someone who is bereaved. However, there is minimal literature on body psychotherapy and grief. Some of the major authors in somatic psychology do not do anything more than mention grief in a list of emotions or in passing (Heller, 2012; Lowen, 1972; Totton, 2003, 2005). Even when grief is discussed at length, the information is more anecdotal and does not present theory or research to support the claims that are made (Keleman, 1975; Romanyshyn, 1998).

Many times when grief is discussed in the body psychotherapy literature, it is combined with trauma (Minton, Ogden, & Pain, 2006; Ogden & Minton, 2000; Rothschild, 2000; van der Kolk, 1987). Grief is viewed as a response to a traumatic event and researchers often focus on unresolved grief. It is, however, important to separate grief and trauma. According to Stroebe, Schut, and Stroebe (1998), “it is possible to experience trauma without bereavement...and bereavement without trauma” (p. 83). The focus of this article will be grief in the context of body psychotherapy without connecting it to trauma. However, it is important to note that when trauma is a part of an individual’s grief experience, the trauma needs to be worked through before the process of grief can begin (Lindemann, 1944).

### Body Memory

Body memory is a rather newly explored field. The concept of body memory emerged from cognitive research on explicit and implicit memory (Summa, Koch, Fuchs, & Müller, 2012). Schacter (1987) stated that explicit memory stores experiences that can be consciously recollected, whereas implicit memory stores experiences and the emotional behavior connected to those experiences and is unavailable to conscious awareness. Body memory has been studied in cognitive science as implicit memory (Caldwell, 2012; Fuchs, 2012). Phenomenology has also explored the concept of body memory (Casey, 2000; Fuchs, 2012; Sheets-Johnstone, 2012). Fuchs (2003) declares, “What we have acquired as skills, habits and experience, has become what we are today; implicit knowing is our lived past” (p.2). Some phenomenologists have also differentiated various forms of body memory (see Casey, 2000; Fuchs, 2012). Koch (2012) empirically tested Fuchs’ divisions of body memory by doing a content analysis of interviews about differentiation of body memory. Results indicated that Fuchs’ categories were included by interviewees and were further sub-divided as well.

Trauma researchers have also investigated how somatic memory and the body play a role in trauma and post-traumatic stress disorder (Minton, Ogden, & Pain, 2006; Rothschild, 2000; van der Kolk, 1987). van der Kolk (1987) first talked about somatic memory in terms of trauma and asserted that unconscious memories of trauma are expressed as somatic symptoms. Despite body or somatic memory being supported in these fields, there is a gap between body memory theory and research.

In addition to there being little research on body memory, the research on body memory and grief is even more limited. Hentz (2002, 2012) is the only person to have investigated body memory following the death of a loved one. Hentz (2002) discovered in her interviews that the body experience around the anniversary of the death was relived as it had been experienced at the time of the loss. In her second study, Hentz (2012) analyzed a case that again expanded on the grief process and revealed that body memory can be a part of a survivor’s grief experience.

### Theory: How Body Memory Can Inform Continuing Bonds

Grief is a somatic process — people experience it through their bodies. Researchers have shown that survivors may exhibit numerous physical manifestations following a loss (Kowalski & Bondmass, 2008; Lindemann, 1944; Parkes, 1964; Parkes & Brown, 1972; Zisook, DeVaul, & Click, 1982). Furthermore, emotions are experienced in both the brain and the body (Caldwell, 1997; Damasio, 1999; Pert, 1997; Schore, 1994). It therefore seems apparent that the body can serve as a resource for mourners as they process their grief. One of the ways that this can be done is by using a person’s body memory of the deceased to create continuing bonds with the loved one who has died.

### Continuing Bonds

Continuing bonds reflect the efforts of the bereaved to preserve ongoing relationships with the deceased and construct internal representations of them (Klass et al., 1996). This theoretical approach proposes that it is normative for a person to maintain a connection with the deceased. Instead of letting go, the emphasis is on creating and recreating the meaning of loss over time. Continuing bonds are not about living in the past or a failure to acknowledge the death. They are actually a recognition of the bonds that, though formed in the past, can still influence a person’s present and future.

Creating continuing bonds with the deceased is a complex task that changes as the griever reconciles the loss. There are various ways in which people may maintain a relationship with the person who has died. These include dreaming, keeping belongings, talking with the deceased, feeling a sense of presence of the deceased, visiting the grave, and frequently thinking of the person (Parkes, 1972; Shuchter, 1986). Certain expressions of continuing bonds are found to be adaptive, whereas others seem to create more distress for survivors. Field, Gao, and Paderna (2005) propose that an important factor in determining if a continuing bond is adaptive is whether the given expression reflects a survivor’s attempt to create a more internalized and symbolically based connection that demonstrates an acceptance of the loss. Individuals who maintained a more concrete tie and were not able to give up physical proximity to the deceased were believed to have more maladaptive relationships with the person who died. Furthermore, other researchers found that preserving a relationship with the deceased through their belongings was correlated with more distress over time, whereas creating a continuing bond through fond memories was not (Field, Nichols, Holen, & Horowitz, 1999). Nevertheless, Klass (1993a, 1993b) discovered that linking objects provided solace to parents of the deceased, as well as validation that the children live on even though they have died. Linking objects and linking phenomena are external objects or experiences that connect a person to the deceased, and include examples such as a watch or a smell (Volkan, 1981).

### Body Memory

Body memory is viewed as how people experience the world around them through their bodies (Caldwell, 2012; Fuchs, 2012; Koch, 2012). It is dynamic in that it changes over time. As Fuchs notes, “body memory is our lived past” (2012, p. 11) because it does not represent the past but rather reenacts it in the present through the body. Many researchers argue that memories are tied to sensory systems and that experiences start with senses (Caldwell, 2012; Fuchs, 2012; Rothschild, 2000). The way that the brain constructs representations of a situation and the movements that result from that situation depend on interactions between the brain and the rest of the body (Damasio, 1994). Furthermore, emotional memories are



said to be stored subcortically, which Totton (2003) states is equivalent to being stored bodily, since this region of the brain is strongly connected with the body.

Some researchers propose that body memory is a long-term or life-long representation of sensations, perceptions, and actions that result from and form individual understanding of internal and external worlds (Glenberg, 1997; Kruithoff, 2012). Keleman (1987) adds that muscular movement patterns can also be a source of memory. “We recall an actual past muscle pattern together with its emotional associations. By re-experiencing those patterns and associations, we make internal images to represent the event” (p. 28). Implicit memory, when referring to the whole individual and not one or more systems in the brain, is sometimes used to refer to body memory (Caldwell, 2012; Fuchs, 2012; Jansen, 2012). Therefore, Summa, Koch, Fuchs, and Müller (2012) argue that body memory is “a form of lived experience, which is constantly reactualized and implicitly lived through by a bodily subject” (p. 425).

### Continuing Bonds Through the Body

The goal of continuing bonds is to create an internal connection with the loved deceased, since the external relationship is no longer possible. This internal relationship must be established in the body. In addition, this new relationship that is formed with the deceased is based on memories. Because of the somatic aspect of the relationship and the use of memories to create it, body memory can support the creation of continuing bonds. A bereaved individual's body memory is a way to discover how the body remembers the person who died, as well as to experience memories of the deceased in a new way. This process can also help mourners uncover aspects of the memories that they were not aware of before because body memories are a culmination of sensations, emotions, and cognitions.

Body memory is not simply a remembering of the past, it is a connection to the past from the present. Gendlin (2012) remarks that body memory should not be considered exclusively in the past because “the past reshapes itself in the course of the body's present performance” (p. 73) and allows people to create something new. As a result, a mourner can use their body to recover memories of the deceased loved one and reshape the relationship that once existed. For instance, the former external relationship can be recreated into one that resides in the bereaved individual's body; survivors can change how they relate to the memories of the deceased, namely, from only cognitively to both cognitively and somatically. The survivor can achieve this by linking objects or phenomena in the present moment and/or becoming aware of how the body responds to the memories of the person who died. This ability to reshape the past can allow the bereaved individual to create an internal representation of the person who died, which is the foundation of continuing bonds.

There are many ways in which one can use the body to encode, store, and retrieve memories of the deceased loved one. Body memory is comprised of sensations, movements, postures, gestures, thoughts, and images (Koch et al., 2012). By working with these components that are associated with the person who has died, a survivor can retrieve more embodied, and therefore possibly more substantial, memories. The act of embodying those experiences is the closest a mourner can get to once again being with the person who died. The individual no longer has access to the physical person who has died but can still have the physical experience of that loved one. People's bodies and body memories give them the opportunity to create new relationships with the deceased.

In order for a body psychotherapist to help a mourner retrieve and successfully work with body memories of the deceased, some time needs to pass to allow the initial, intense pain of the loss to lessen. Reminders of the loved one are often considerably more emotionally painful in

closer proximity to the death rather than later on (Parkes, 1998; Field & Friedrichs, 2004). The positive memories, the ones that the bereaved most likely wants to hold on to, can even be very painful soon after the death. As a result, the therapist's role is to help the person come to terms with the death and process some of the pain of grief before embarking on extensive work with memories (Worden, 2009). Those who are not able to process their pain may avoid feelings or things that remind them of the deceased loved one, thus inhibiting any work with body memory and continuing bonds.

Before a therapist can make use of a client's body memory in the formation of continuing bonds, the therapist must first ensure that the survivor's experience of memories about the deceased is positive. This does not mean that all of the survivor's memories are, or will be, pleasant. Relationships have both positive and negative aspects to them. The goal here is to help the person process both the pleasant and unpleasant memories. This can allow bereaved individuals to hold onto the memories they want as well as work through any pain that arises. By supporting the griever in working through the pain, the therapist can help the individual find comfort in the pleasant memories.

There are various ways in which a therapist can support a mourner through this initial part of the grief process. Body psychotherapists can guide the person to use the body as a way to work through pain. It is important to help survivors understand that their reactions do not always need to hurt and can become something pleasant. Some interventions that may be useful at this point in the grief process, as well as throughout, are ones that help the individual tolerate painful emotions and self-regulate. For instance, the therapist can guide the person to follow the breath while talking about the memories that elicit intense emotions. By moving through the emotional pain of something linked to the deceased, the bereaved person can then discuss positive experiences that are tied to the memory. There is an ebb and flow to the grief process. Therefore, some days may be more painful than others, even years after the death. Body psychotherapy can be used in work with bereaved individuals to help them learn how these waves of grief come and go and how they react to and work through them.

### Application: Using the Body to Create Continuing Bonds

The following are proposed body psychotherapy interventions for bereaved individuals who are in grief counseling and experiencing uncomplicated grief. Working with memories and supporting the formation of continuing bonds is only one part of grief counseling. These techniques can be used in one session or they can span several sessions. It depends on the particular client and how that client moves through the memory of the deceased or if that client wishes to work on multiple memories or death losses. The work is client-driven, which is to say the client has an active role in determining how these interventions are used. Furthermore, some of the linking objects or phenomena in these exercises may still bring up unpleasant reactions for the mourner. It is the individual's choice to decide whether to turn the negative charge associated with those objects or phenomena into a more pleasurable experience. Some negative experiences, however, cannot be changed into positive ones. Nonetheless, by working through the pain that arises from these occurrences, as well as working with the person's body memory of the deceased, the client can reshape the experience of the past and have the opportunity to discover what really gives the individual enjoyment.

Continuing with Worden's (2009) concept of tasks, these interventions are intended to be action-oriented in that they provide bereaved individuals with tools to facilitate their own



creation of positive connections with the deceased through their bodies. Body psychotherapy can support these tasks by providing techniques that allow clients to become more familiar with their bodies and internal experiences. Grief is a unique experience for everyone. By building a bereaved individual's awareness through breath and techniques to help tune into their body, such as a body scan, a body psychotherapist can potentially help that person discover what their grief looks like and how it shows up in their body. The following interventions are ways in which body memory can inform continuing bonds for survivors. They are based on the author's experiences working with people who have experienced the death of a loved one.

### Senses

Exercises that incorporate the five senses use the client's body to help in remembering the person who died. These sensory experiences can facilitate the creation of continuing bonds that are formed not only from memories, but through the mourner's body as well. The different senses can evoke various memories, emotions, and bodily sensations. With all of these techniques, the therapist can start by having the person settle into the body by using deep breathing or having the client notice how the body feels in the moment. Additionally, the therapist can support the client by facilitating a body scan during the exercises so that the client can learn more about how their body responds to the different sensory experiences.

**Smell.** A client can bring in something that has a smell that is tied to a memory of the deceased. An example of this is a woman who keeps bottles of a lotion she frequently used when she and her husband dated. The woman would smell the lotion in order to evoke memories of her husband from that time.

Another way to use scents to create continuing bonds is by tying a new scent with the memory. The therapist can have the client think about positive memories that are connected to a photo or object, as well as how the body feels during the recall of that memory. The person then smells an enjoyable scent, one that is not necessarily tied to the memory. Later on, the person can smell that scent, and now can bring up those positive memories and body sensations. This intervention may be useful when a mourner is having difficulty reconfiguring negative reactions to memories into more positive ones.

**Sight.** Bereaved individuals may have a memory of seeing something with the person who died or have pictures with the deceased that can be used. A survivor who spent summers with their grandpa at the shore has memories of sitting with him on the beach watching the sunrise as dolphins swam in the ocean. The individual can bring in pictures of dolphins or sunrises over the ocean to help in connecting with these memories of their grandpa. As the person talks about memories of the shore, the therapist can support them in noticing how their body remembers those memories as well.

**Sound.** There are numerous ways in which sound can link a survivor to the loved one who died. For instance, people often listen to music that reminds them of the deceased. The music may also elicit associations the client had not thought about before. Sometimes hearing a certain noise, such as laughter, can make a mourner think of the person who died. Therefore, a client can use sounds that are somehow linked to the loved one to connect to the memories that are associated with those sounds.

**Taste.** Bereaved individuals may have certain tastes that are tied to memories of the deceased. A person who often ate spaghetti with their spouse can use that taste to bring up memories of their loved one. Or someone who drank coffee in the mornings while their child ate breakfast can use that same brand of coffee to connect back to those mornings. These are examples of how

clients can use something that they ate or drank with the deceased in order to remember those times with them.

**Touch.** Sometimes a client was touched in a certain way by their loved one. If someone touches them in a similar manner, this can evoke memories of when the person who has died used to touch them. Touch however is still a controversial topic in therapy sessions (Strozier, Krizek, & Sale, 2003). Therefore, the therapist could encourage clients to have people they feel close with touch them in ways the deceased used to, such as hugs or back scratches. In addition, the feel or touch of a particular linking object can be used. For example, a bereaved individual can feel a flannel shirt to access memories associated with their loved one who once wore it

### Movement

Movement is another way for a survivor to use their body to connect to memories of the deceased. One way individuals can accomplish this is by doing an activity they used to do with the loved one who died. This could include performing a dance the client did with the person who died or gardening as the individual used to do with the deceased.

Authentic movement is another way in which a person can get in touch with memories of the deceased. This technique is a form of free association in movement (Payne, 2006 as cited in Konopatsch & Payne, 2012). During authentic movement, the client can trigger memories through certain movements, body postures, or gestures (Konopatsch & Payne, 2012). In other instances, the memory of the deceased can create the impulse to move. A mourner may move freely and then suddenly think of a time they were playing a board game with their mother before she died. The memory of the board game was generated from a certain posture the person had assumed.

These ways of creating ties to the deceased are different than moving like the deceased moved. Researchers have found that people who imitate the deceased through movements or by taking on their somatic symptoms are most likely experiencing complicated grief (Lindemann, 1944; Worden, 2009). This can be explained as the bereaved individual over-identifying with the person who died, which can result from an inability to accept or adapt to the loss. Due to the nature of the therapeutic relationship, the therapist should rely on the griever to share examples of symptoms or movements of the loved one in order to assess whether the bereaved individual is taking on the persona of the deceased.

### Memories

All of the above techniques have a bottom-up approach in that they use the body to produce different memories of the loved one who has died. It can be just as important to start with the memories and explore the body sensations that arise. As mentioned before, this can be useful when first working with memories during the grief journey in that it can help a bereaved individual process pain. By focusing on the body when accessing memories of the deceased, the client can create a richer experience of the memories, one filled with sensations and emotions, rather than only thoughts. For instance, a person may have gone on numerous camping trips with the deceased person. When recalling these trips, the individual can think of the events that occurred as well as experience how the body remembers the events.

### Conclusion

Research has shown that grief is an individual process and that grieving is a natural response to loss (Hooyman & Kramer, 2006; Rando, 1984). The grieving process is a somatic

experience (e.g., Kowalski & Bondmass, 2008; Lindemann, 1944; Rando, 1984) and as such, it only seems natural to use a therapeutic approach that incorporates the body when working with bereaved individuals. Mourners store numerous memories within their bodies, many of which are unconscious, that wait to be accessed and integrated in a way that helps in reconciling grief. Body psychotherapy can thus be used to work with a person's body memories to connect to the deceased. In doing this, the mourner's relationship with their loved one can become anchored in their body, which can then facilitate the creation of an internal relationship or continuing bond. A therapist can support this process by using interventions that incorporate the sense experiences, movements, and body sensations that are associated with memories of a deceased loved one.

The proposed framework assumes that clients have some level of body awareness. More work may need to be done in sessions to help the bereaved individual learn about their body and bodily sensations. Furthermore, some people may believe that their bodies are foreign and unsafe. The therapist must therefore assess whether or not body interventions are right for the client or at that time. It should also be noted again that this therapeutic approach is meant for those experiencing uncomplicated grief. There are many complex factors that can result in a person having complicated grief. As a result, these survivors may require different or supplementary therapeutic interventions as compared to those presented in this framework.

There are many ways in which the body can be integrated into grief counseling and grief therapy. This article illustrates only one way to work with the body in grief counseling, using body memories to create or enrich continuing bonds. More research is needed to understand how to work with the grief process somatically. One of the next steps could be to empirically study how people use their bodies to create continuing bonds, as well as their experiences of doing so. Future work incorporating thanatology and body psychotherapy could also include research on how to use body interventions to support those who are experiencing complicated grief and are unable to move through it. No matter the direction of potential research, therapists must view griever as whole entities, comprised of body and mind, in order to better serve them. The body would need to be used explicitly in the process.

## BIOGRAPHY

Dyana Reisen, MA, CT, received her master's degree in somatic counseling psychology at Naropa University in 2013 with a concentration in body psychotherapy. Dyana has over six years of experience in thanatology through research, volunteer work at hospices, and facilitation of bereavement support groups and individual grief counseling. She recently received her Certification in Thanatology through the Association for Death Education and Counseling. Dyana would like to thank Elizabeth Collier, retired grief counselor and instructor at The College of New Jersey, for introducing her to the field of thanatology and continually supporting Dyana throughout the development of her career. Dyana would also like to thank Dr. Christine Caldwell, Dean of Graduate Education and founder of the Somatic Psychology program at Naropa, for teaching her about body psychotherapy and body memory, concepts that now inform Dyana's work with bereaved individuals.

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## The Impact of Body Awareness on Subjective Wellbeing: The Role of Mindfulness

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### Abstract

Positive psychology has been criticized for the lack of research on the role of the body in wellbeing. As the research into the many variables that influence subjective wellbeing (SWB) continues, the important role of body awareness (BA) on SWB has been neglected. It was hypothesised that there would be a significant predictive relationship between BA and SWB, and moreover that this relationship would be moderated by mindfulness. One hundred and nineteen participants from the general population completed relevant self-report scales through an online survey. BA had a positive relationship with SWB, but this relationship was not moderated by mindfulness. These findings have implications for positive psychology that reinforce the argument for more body-based interventions and overall embodiment within the discipline.

*Keywords:* body awareness, subjective wellbeing, mindfulness, positive psychology

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### Introduction

#### The Mind-Body Problem

The nature of the connection between the physical body and the subjective psyche has been of great interest to the field of psychology for many years (Hefferon, 2013). Indeed, this 'mind-body problem' has occupied thinkers throughout the centuries, giving rise to a range of philosophical positions on the subject. For example, materialistic monism grants primacy to the physical body while the subjective mind is regarded as an illusion or epiphenomenon. Conversely, transcendental monism (or idealism) gives ontological primacy to the mind while the material body is viewed as an aspect of mind (e.g., a mental construct). Finally, a number of perspectives acknowledge the reality of both material body and subjective mind, with different positions on the nature of their interaction. For instance, in Chalmers's (1995) dual-aspect theory, the fundamental 'reality' underlying both mind and body is information; this information is then manifested both physically (as the body and brain) and experienced subjectively (as the mind).

Amidst debates around the mind-body problem, further confusion is generated by the ambiguous semantics of the word 'body'. In the philosophical positions above, 'body' refers to the physiological organism — which includes the brain — in contrast with the subjective mind. However, subjectivity also includes the felt experience of our own bodies, a construct

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referred to as ‘embodiment’ (Riva et al., 2003). Thus, there are two ways of conceptualizing and approaching the mind-body question: the relationship between the material body (including the brain) and subjective mind; and the relationship between somatic aspects of conscious experience (e.g., embodied sensations) and mental aspects of conscious experience (e.g., thoughts). Examining the mind-body connection has become a prominent point of concern in psychology, particularly in consciousness studies under the rubric of the ‘neural correlates of consciousness’ paradigm (Fell, 2004). However, in many areas of psychology, the relevance of the body is under-researched and under-theorised. One such deficiency pertains to our understanding of wellbeing.

### Wellbeing and Positive Psychology

The notion of wellbeing is of interest to many areas of psychology (e.g., health psychology) as well as other disciplines more broadly (e.g., economics). Recent years have seen the emergence of ‘positive psychology’, a term uniting scholars interested in issues of happiness and wellbeing (Seligman & Csikszentmihalyi, 2000). Among the concepts articulated and explored in positive psychology is ‘subjective wellbeing’ (SWB). SWB is viewed as comprising a cognitive and an affective component (Diener, Suh, Lucas, & Smith, 1999). The cognitive component refers to satisfaction with life. The affective component pertains to the balance or “ratio” of positive and negative affect. Thus, broadly speaking, SWB reflects how people think and feel about their lives (Ozmete, 2011).

SWB is viewed as a substantive good, desirable on its own terms. However, researchers have also investigated the extent to which it is an instrumental good, that is, associated with other positive outcomes. Lyubomirsky, King, and Diener (2005) have identified beneficial consequences of SWB in four areas of life. First, SWB is correlated with increased sociality. Second, SWB is linked to greater work enjoyment and higher levels of remuneration (Diener, Nickerson, Lucas, & Sandvik, 2002). Third, SWB has been causally associated with greater health and indeed longevity (Roysamb, Tambs, Reichborn-Kjennerud, Neale, & Harris, 2003). Fourth, not only does SWB have a positive impact on an individual level, but also on societies as a whole (Tov & Diener, 2008). For example, individuals with high SWB tend to be less prejudiced, more trusting, and show higher levels of cooperation.

In addition to the concept of SWB, related constructs have been proposed to account for other dimensions of wellbeing. For example, the importance of purpose and meaning in life have been recognized and incorporated within the idea of psychological wellbeing (PWB), which is also referred to as ‘eudaimonic wellbeing’ (Ryff, 1989). Eudaimonia — from the Greek term meaning ‘true self’ — is used within positive psychology to refer to flourishing in life.

However, positive psychology has received criticism for not having sufficiently engaged with the body and its relevance to wellbeing (Hefferon & Boniwell, 2011; Hefferon, 2013). Recent efforts have been made to redress this lacuna. For instance, the concept of a ‘positive body’ has been proposed, featuring five components thought to promote SWB and PWB (Hefferon & Boniwell, 2011). These five components include: “human touch, positive sexual behavior, physical activity, nutrition, and even physical pain” (Hefferon & Boniwell, 2011, p.176). More recently, bringing together diverse disciplines, Hefferon (2013) has explored anthropological, sociological, neurological, biological, and phenomenological perspectives on the role of the body on wellbeing and flourishing. This paper continues this emergent focus on the body in positive psychology, with body awareness being a

potentially useful area that has hitherto not been investigated.

### Body Awareness

The notion of body awareness (BA) is an “overall concept for experience and use of the body, representing body consciousness, body management and deepened body experience” (Roxendal, 1985, p.10). Although there are many definitions of BA (Bekker et al., 2008), Mehling et al. (2009) usefully conceptualise it as attention to and awareness of internal body sensation. In the early 1990s, BA was predominantly studied in relation to anxiety or panic disorder, where it was believed that over-attention to symptoms or body reactions had adverse consequences (Cioffi, 1991). For example, high BA was associated with somatosensory amplification — a tendency to experience somatic qualia in an intense and often noxious way — leading to hypochondriasis, anxiety, and somatization (Cioffi, 1991). However, opposing this negative appraisal of BA, recent studies indicate that attending to inner sensations can have beneficial physiological and psychological consequences (Mehling et al., 2009). For example, studies involving patients with chronic back pain found that patients who focused on the ‘sensory components’ of their physical pain experienced reduced subjective pain compared to patients who tried to suppress their pain (Burns, 2006). There have also been intriguing studies exploring the impact of BA on symptomology in those recovering from physiological or psychological trauma (Price & Thompson, 2007) and people suffering from eating disorders and substance abuse (Burns, 2006).

Findings on the benefits of BA have led to the emergence of various therapies, referred to collectively as body awareness therapies (BAT), centered on increasing BA (Gard, 2005). BATs include Basic Body Awareness Therapy (BBAT; Gyllensten, 2001), Feldenkrais therapy (Feldenkrais, 1977), and the Mensendieck system (Gard, 2005). These BAT therapies, especially BBAT, are becoming increasingly utilized in treating psychiatric disorders, particularly in Nordic countries such as Sweden (Archer, 2005). The main components of BBAT are massage, breathing regulation, presence in the situation, and a focus on the experience of the individual’s own movement<sup>2</sup> (Johnsen & Raheim, 2010).

A number of studies have shown the impact of BATs on wellbeing, particularly in clinical populations. For example, Skateboe, Friis, Hope and Vaglum (1989) suggest that personality disorders are associated with issues around BA, such as distortions of body image, limited BA, and disturbed emotional awareness and psychomotor functioning. Exploring the use of BBAT with this population, Skateboe et al. found that BBAT promoted psychological growth and personal development through the “harmonizing” of movements (measured with the Global Physiotherapy Muscle Examination, observations, and self reports). Similarly, a study with female patients with severe personality disorder found that patients who undertook BBAT showed greater improvement than those given psychodynamic group therapy, and also reported greater satisfaction with their treatment (Leirvag, Pedersen & Karterud, 2010). Furthermore, a pilot study with patients suffering from eating disorders found that BBAT improved symptomology (Catalan-Matamoros, Helvik-Skjaerven, Labajos-Manzanares, Martinez-de-Salazar-Arboleas, & Sanchez-Guerrero, 2011). Finally, Johnsen & Raheim (2010) studied patients with a range of psychiatric disorders, reporting that BBAT had a positive impact on sleep and rest patterns, ability to overcome demanding situations, and overall physiological and psychological balance.

The studies above indicate that BATs can have a beneficial impact in clinical

<sup>2</sup> Some of these components are very similar to the theories of mindfulness and its practices, and this will be discussed later.

populations, with patients already suffering from pain, illness, or stress. However, Anderson (2006) suggests that it may be easier for people to proactively develop BA when they are in a healthy state, rather than waiting until a physical or mental health issue arises. Anderson thus proposes that BA training should begin early in life, in the same period of childhood as language acquisition.

What motivation would a person in good health — with no stress, pain or illness — have to train in BA? A possible answer from positive psychology is that BA may be linked to SWB. As such, as individuals come to experience incrementally greater BA, they might enjoy corresponding rises in SWB, thus motivating them to increase BA still further. This link between BA and SWB is as yet untested — reflecting the lack of focus on the body in positive psychology as noted above — a deficiency the current study seeks to remedy. However, studies have made a connection between SWB and a concept that shares conceptual kinship with BA, namely, mindfulness.

### Mindfulness

Academic and clinical interest in mindfulness, a construct derived from Buddhism, has significantly grown in recent years (Brown et al., 2007). Questions around how to conceptualize, define, operationalize, and measure mindfulness are a source of much debate in the field of psychology (Hart, Ivtzan, & Hart, in press). However, Jon Kabat-Zinn (2003, p.145) offers a widely cited “operational working definition” of mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment”. Beyond orienting definitions, efforts have also been made to construct more detailed theoretical models of mindfulness. For example, Bishop et al. (2004) have proposed a two-component model: The first component concerns self-regulation of attention, such that “it is maintained on immediate experience thereby allowing for increased recognition of mental events in the present moment” (p.232). The second component involves the adoption of a particular attitudinal orientation to experiences, characterized by “curiosity, openness and acceptance” (p.232).

A large body of work has consistently linked mindfulness to wellbeing, both in terms of the alleviation of distress and mental health issues as well as the promotion of positive outcomes like SWB (Ivtzan et al, 2011; see Mars & Abbey, 2010, for a recent review). There are various explanations for this positive impact. Ryan and Deci (2000) suggest that mindfulness helps individuals disengage from automatic actions and thoughts, such as unhealthy behaviors and habits, and thus plays a role in promoting behavioral regulation. Additionally, Brown and Ryan (2003) hold that mindfulness promotes wellbeing by increasing the “moment to moment” intensity of a person’s life. In terms of accounting for the beneficial impact of mindfulness on wellbeing, of particular interest in the context of the present study are explanations focusing on the parallels between mindfulness and BA. Mehling et al. (2009) have highlighted the close conceptual kinship between the two constructs. They argue that mindfulness encompasses awareness of inner sensations (as well as thoughts), which overlaps with the concept of BA. Similarly, in terms of the development of mindfulness and BA, skills required in order to achieve mindfulness (e.g. attention, non-judging, concentration) are also of importance in developing BA. Lastly, and perhaps most relevantly, Mehling et al. (2011) report that one motivation for people in the West to practice mindfulness is as a means of getting “closer” to their bodies, with the aim of enhancing wellbeing.

This last finding pertains to the as-yet untested possibility, noted above, of people seeking to develop BA as a route to greater SWB.

Thus, we have a nexus of three interrelated constructs: mindfulness, BA, and SWB. This study seeks to examine the relationship that might exist between these, as it has not hitherto been researched. More specifically, we broke this question down into a number of sub-questions. First, we investigated whether mindfulness and BA both predicted SWB (and if so, which had the greater impact). Second, we observed whether mindfulness mediated the relationship between BA and SWB. There were two main hypotheses:

H1: There will be a significant predictive relationship between BA and SWB, and also a significant predictive relationship between mindfulness and SWB.

H2: The relationship between BA and SWB will be moderated by mindfulness.

### Methods

#### Participants

The research sample consisted of 119 males (42.9%) and females (57.1%) who undertook an online survey. Participants were all adults from the general population. Participants were contacted with an email, which included a description of the research purpose and procedure as well as a link to the online survey. Inclusion criteria were that individuals had to be over 18 years old and have a good knowledge of the English language. Demographic variables, including age, country of origin, and gender, were also collected at the start of the online survey. The first author’s nationality is Greek, so consequently the largest percentage of participants was of Greek nationality (67%). Participants’ ages ranged from 18 to 69 with a mean age of 32.3 (SD=13.41).

#### Design

Data were gathered through an online survey featuring three questionnaires measuring the three variables of interest: SWB, BA and mindfulness. Firstly, SWB was assessed using the Satisfaction with Life Scale (Diener et al., 1985). This scale is a well-validated self-report tool that allows respondents to assess their lives as a whole according to their own chosen criteria (Diener & Pavot, 1993). The scale features five statements that participants are asked to rate on a 7-point Likert scale, ranging from (1) strongly disagree to (7) strongly agree (Diener et al., 1985). The scale has strong reliability and stability (with an alpha coefficient of 0.87, and a 2-month test-retest stability coefficient of 0.82) (Pavot & Diener, 1993).

Secondly, BA was assessed using the Body Awareness Questionnaire (Shields et al., 1989). This is a self-report measurement tool that assesses the level of attention given by respondents to normal ‘non-emotive’ body processes. The questionnaire has 18 items (e.g. ‘I notice differences in the way my body reacts to various foods.’) which are rated on a 7-point Likert scale ranging from (1) not at all true of me to (7) very true of me. This questionnaire is reliable for men (alpha coefficient = .82) and women (alpha coefficient = .80), has good test-retest reliability ( $r = .80$ ), and has discriminant validity and stability in factor structure (Shields et al., 1989).

Finally, mindfulness was measured by the Mindful Awareness and Attention Scale (Brown & Ryan, 2003). This assesses an individual’s frequency of mindful states, and focuses on attention on and awareness of what is happening in the present (Brown & Ryan, 2003). It includes 15 items (e.g. ‘I could be experiencing some emotion and not



be conscious of it until sometime later.’), rated on a 6-point Likert scale ranging from (1) almost always to (6) almost never. The scale has been validated for diverse groups and has a test-retest reliability of .81 (Brown & Ryan, 2003).

### Procedure

This study was designed and conducted according to the guidelines of the British Psychology Society (BPS) Code of Ethics and Conduct as well as in accordance with the guidelines of the University of East London (UEL) Code of Good Practice. Initially, participants were contacted by email to invite them to participate. Prior to the study, participants were informed of the procedure through an information sheet and asked to sign an informed consent form. After completion of the surveys, participants were fully debriefed about the purpose of the study and given the contact details of the researchers should any questions or problems occur. Anonymity and confidentiality were protected, and data collected were stored in a password-protected computer. This study received ethical approval from the ethics committee of the University of East London.

## Analysis and Results

### Hypothesis 1

In order to examine whether there was a predictive relationship between BA and SWB, or between mindfulness and SWB, a multiple regression analysis was conducted. BA and mindfulness were the predictor variables, and SWB was the DV. The results of the standard multiple regression are detailed in Table 1 below.

Table 1. *Standard Multiple Regression results for BA and Mindfulness as the predictor variables and SWB as the DV.*

	B	Std.Error	Beta	Sig.
BA	.087	.041	.184	.034
Mindfulness	.212	.049	.374	.000

R Squared=.182, Adj. R Squared=.167

A significant predictive relationship was observed between BA and SWB, and between mindfulness and SWB. However, mindfulness had greater predictive power, accounting for 14% of the variance in SWB, against 3% for BA.

### Hypothesis 2

A moderation analysis was conducted with BA as the main effect, mindfulness as the mediator, and SWB as the dependent variable. BA was entered into the analysis first, followed by mindfulness and then the interaction term (it must be noted that the predictor variables were centered prior to the analysis). The results, shown in Table 2, indicate that the relationship between BA and SWB is not moderated through mindfulness.

Table 2. *Results of the Moderation Analysis between BA and Mindfulness*

	B	Std.Error	Beta	Sig.
Step1 ba	.098	.044	.207	.027
Step2 ba	.087	.041	.184	.034
mind	.212	.049	.374	.000
Step3 ba	.103	.044	.218	.021
mind	.219	.049	.387	.000
ba x mind	-.003	.334	-.091	.334

Step 1: R Square= .043 , Adj. R Square=.034

Step 2: R Square=.182, Adj. R Square=.167

Step 3: R Square=.189, Adj. R Square=.167

## Discussion

The data analysis produced a set of intriguing findings that both confirmed and also challenged our expectations. Firstly, we observed a predictive relationship between BA and SWB. While this was in line with our hypothesis, this is the first study to confirm an explicit statistical link between these two constructs. There was also a strong predictive relationship between mindfulness and SWB. This too confirmed our hypothesis, since the connection between these constructs has been well-established in the literature (Mars & Abbey, 2010). However, it was striking to see the extent to which the predictive power of mindfulness on SWB (14%) exceeded that of BA (3%). Evidently, these two constructs are not interchangeable, but can influence SWB in different ways. Secondly, corroborating this last point, we were surprised to observe that the impact of BA on SWB was not moderated by mindfulness. Again, this tends to indicate that BA and mindfulness, while conceptually similar constructs, both have their own contributions to make vis-à-vis individual wellbeing.

The predicted finding that BA has a positive predictive relationship with SWB is notable for many reasons. First of all, participants were drawn from the general population. To our knowledge, all the research studies in the current literature have been conducted on a targeted sample of physiologically or psychologically unhealthy participants, or with people who had undertaken a form of BAT. These previous studies have shown that BAT has the potential to reduce mental health issues and improve symptomology in clinical populations (Johnsen & Raheim, 2010). However, the present study indicates a link between BA and SWB in a nonclinical population. The implication here is that BAT has the potential to be used with “healthy” populations as a way of promoting SWB. Indeed, as Anderson (2006) suggests, it may be desirable to factor BA training into the early-years education of children, thus engendering BA from a young age. Moreover, these findings are one answer to Anderson’s question of what might motivate healthy individuals to undergo BAT training: one inducement would be experiencing increments in SWB as a result of improving BA.

A predictive relationship was also observed between mindfulness and SWB. This finding adds to the ever-increasing body of work linking mindfulness to various outcomes of wellbeing. Studies indicate that interventions to train and develop mindfulness, like Mindfulness-Based

Stress Reduction, can serve to elevate levels of SWB (Carmody & Baer, 2008). Moreover, so-called 'trait' mindfulness — relatively stable levels of mindful awareness conceptualized as a personality characteristic, indexed by the Mindful Awareness and Attention Scale used in the present study (Brown & Ryan, 2003) — has been linked with higher levels of SWB (Carlson & Brown, 2005). Although this particular finding in the current study simply serves to corroborate these previous studies, the unique angle offered here concerns the interrelationship of mindfulness, BA, and SWB. The 3% predictive power offered by BA constitutes a further discriminant predictive power over and above the 14% given by mindfulness. This indicates that both mindfulness and BA make unique contributions to wellbeing and that conceptually one cannot be reduced to or subsumed within the other.

This latter point is also supported by the rejection of the second hypothesis in the analysis, namely the prediction that the link between BA and SWB would be moderated by mindfulness. This prediction was informed by literature that indicated that many aspects of BA, such as somatic awareness and attention-focusing techniques, were perhaps captured more directly by the concept of mindfulness (Mehling et al., 2011). Indeed, Mehling et al. (2009) suggest that many people who practice mindfulness use it as a means to develop BA, thus directly implicating mindfulness as a key process within the development of BA. However, the independent predictive powers of mindfulness and BA, and the regression analysis indicating that mindfulness was not a mediating factor in the BA-SWB link, show that mindfulness and BA are distinct, albeit related, concepts. One explanation for the greater predictive power of mindfulness can perhaps be found in Bishop et al.'s (2004) two-component model. This holds that the efficacy of mindfulness does not reside in people simply becoming more aware of subjective qualia, but imbuing this awareness with particular qualities such as kindness and compassion (Shapiro et al., 2006). While mindfulness and BA both share a common emphasis on internal awareness, only mindfulness implies a particular attitudinal stance. This stance may well itself play a crucial role in SWB, thus giving mindfulness "the edge" over BA. However, it is also notable that in our study BA offered predictive power not accounted for by mindfulness, indicating that BA does not completely overlap or fall within the concept of mindfulness. Indeed, while some adaptations of mindfulness do focus specifically on the body (Ditto, Eclache, & Goldman, 2006), mindfulness practices arguably focus more on cognitions rather than somatic qualia (Teasdale, Segal, & Williams, 2003). In this sense then, it appears that mindfulness practices may be able to learn from BA practices, like BAT, in terms of engaging more with the body. Indeed, this last comment could equally apply to positive psychology more generally, as noted above.

However, the limitations of the study mean that caution should be exercised with these interpretations of the findings, and show the need for future research in this area. One key limitation is that participants were not screened for previous knowledge or experience with the concept or practice of mindfulness, or the concept or practice of BATs. Issues around relying on self-report scales assessing 'trait' levels of mindfulness, such as the Mindful Attention and Awareness Scale, have been raised by Grossman (2011). It is argued that such scales lack content validity and overlook external referents that would determine the validity of the construct. Grossman (2011) queries whether the self-reported mindfulness "skills" of an individual are reflective of actual behavior. Further issues include response biases influenced by each respondent's level of knowledge and practice of mindfulness, and variations in the semantic interpretations of each item. There are further limitations around the data-gathering techniques in the present study. Using an online survey makes it hard to control

the participatory environment: participants may have different software, equipment, and even Internet connectivity. Thus, it cannot be assured that all received the information and measurement tools correctly (Riva et al., 2003). Another limitation to online data collection is that it may exclude particular sections of the population from participating (i.e., those with less access to or familiarity with the Internet, such as older populations) and skew the sample towards those from the higher ends of the socioeconomic and educational spectra (Riva et al., 2003).

Recognition of these limitations illuminates the way ahead for further research. The current research has indicated that there may be complex links between mindfulness, BA, and SWB. Responding to the first limitation raised above, future studies will ideally screen participants in terms of previous mindfulness experience, to shed further light on whether mindfulness plays a moderating role between BA and SWB. Issues around online data collection methods skewing the sample in particular directions means greater efforts should be made to recruit from harder-to-reach populations as well as to explore alternative methods of data collection. In addition, it would be interesting to explore the intersections of mindfulness, BA, and SWB with people from different cultural backgrounds. Mindfulness as presented in the West tends to be generally decontextualized from its antecedent Buddhist origins (Kabat-Zinn, 2003). However, people from Asian cultures may have a more contextualized appreciation and understanding of mindfulness (i.e., awareness of the broader religious context in which it was developed), which may alter the way in which their experience of mindfulness intersects with BA and SWB. Such cross-cultural research will help to refine and develop the connections revealed in the current study.

### Conclusion

The study found a predictive relationship between BA and SWB. This finding is valuable as it suggests that individuals could benefit from becoming more bodily aware as a potential route to increased SWB. Further research on whether healthy individuals from the general population could be trained to increase levels of BA would be a fruitful line of inquiry. In addition, a predictive relationship was found between mindfulness and SWB. Compared to the BA-SWB relationship, mindfulness had greater predictive power. However, it was notable that BA still had an impact independent of mindfulness. Similarly, it was striking that mindfulness was not found to mediate the relationship between BA and SWB. This indicates that BA and mindfulness are not isomorphic constructs, but that each impact upon SWB in subtly different ways. Future research will be able to further tease out the subtle connections among these three constructs.

### BIOGRAPHIES

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## The Enteric Nervous System and Body Psychotherapy: Cultivating a Relationship with the Gut Brain

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### Abstract

The Eating, Needing, Sensing (E.N.S.) system is a somatic insight-based therapy for working with clients in a session as well as across time. This system proposes the inclusion of the enteric nervous system (ENS), the brain in the gut, into body psychotherapy (BP). A system is proposed for how to cultivate awareness of the ENS, utilizing scientific research, psycho-peristalsis, and theories of the body. This E.N.S. system includes paying attention to how a person's eating, needing, and sensing is digested in the gut brain. Examples and questions are presented to foster consciousness of the ENS. ENS awareness is intended to inform a person of the gut's messages in order to increase emotional self-regulation by appropriately listening and responding to the gut in the moment.

*Keywords:* body psychotherapy, enteric nervous system, second brain, gut brain, nutritional counseling

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### Introduction

Most people believe that intelligence comes from the brain in our heads. However, each individual actually carries two brains within the body: one in the head and one in the gut. The brain in the gut is called the enteric nervous system (ENS). Several researchers have proposed that the ENS, the nervous system in our viscera, is a second brain within the body and has the ability to think for itself (Boyesen, 2001; Gershon, 1998; Mayer, 2011). Gershon (1981) stated that the ENS is “the intrinsic innervation of the gastrointestinal tract” (p. 227). The ENS consists of the esophagus, stomach, small intestines, and large intestines, and contains 100 million neurons (more than either the spinal cord or peripheral nervous system) within its walls, which, from esophagus to anus, measures about nine meters (Gershon, 1998). The enteric nervous system generates a copious amount of information from the millions of neurons it contains. Therapists may miss vital information within a session that could facilitate a client's awareness and understanding of self if only communicating with the head brain and not tapping into the messages of the gut brain.

Body psychotherapy (BP) is a distinct branch of psychotherapy involving an “explicit theory of mind-body functioning that takes into account the complexity of the intersections of and interactions between the body and the mind, with the common underlying assumption being that a functional unity exists between mind and body” (United States Association for Body

Psychotherapy, 2013). BP claims that listening to the body is important for client well-being. Yet, BP has not historically attended to the gut and its nervous system, which have been found to operate separately from the central nervous system (CNS) (Gershon, 1998). This paper explores the unique way in which attention to the ENS can support body psychotherapists in clinical practice.

The theory proposed here is a system in which therapists can facilitate awareness of the ENS within each client, inspired by body psychotherapy interventions. This system uses the acronym E.N.S., where E stands for Eating, N stands for Needing, and S stands for Sensing, to help clients become aware of their enteric nervous systems.<sup>1</sup> When speaking of the Eating, Needing, Sensing system, E.N.S. will be used, while ENS without periods will refer to the enteric nervous system. The Bodying Practice (Keleman, 2004), Psycho-Peristalsis (Boyesen, 1974), the Focusing Technique (Cornell, 1996), and the use of breath for relaxation are the BP interventions that will be used in conjunction with the Eating, Needing, Sensing (E.N.S.) system. The goals of working with the E.N.S. system are to: cultivate awareness of how the gut brain processes eating, needing, and sensing; increase emotional self-regulation (managing and monitoring responses to emotions) through internal listening to one's unique bodily needs; and moment-to-moment body attentiveness.

It is important to note that the CNS (which includes the brain and the spinal cord) and its messages will not be discounted in this paper. The brain and the gut brain are in constant communication via the vagus nerve (Gershon, 1998). Still, messages from the gut brain might be repressed, ignored, or drowned out by the head brain. As clients become aware of gut messages, they can use the tools in the E.N.S. system as a means to release repressed emotion and facilitate proper digestion of food. “System” is defined as an organized or established procedure (Heuristic, n.d.). Additionally, “ENS”, “gut brain”, and “second brain” will be used interchangeably to refer to the enteric nervous system, and “head brain” will refer to the brain in the head. In order to understand the value and function of the ENS, we turn to some prominent research in the field.

### Literature Review

The ENS was first popularized as a second brain by Michael Gershon (1998). Gershon (1998) asserted that a multitude of neurotransmitters in the gut, such as serotonin and acetylcholine, make the ENS function much like the brain in the head. The gut brain has been found to operate separately from the head brain, making it possible that the ENS could have “neuroses” of its own and experience an inability to process input from the head brain (Gershon, 1998; Mayer, 2011). It is estimated that 95% of serotonin is located within the gastrointestinal (GI) tract, consisting of the stomach and intestines (Kim & Camilleri, 2000). The gut has over seven different serotonin receptors (Gershon, 1998). Serotonin is a neurotransmitter relevant to depression, migraines, and other neuropsychiatric illnesses (Kim & Camilleri, 2000). Additionally, serotonin aids in signaling peristaltic action and communication from the gut to the head brain (Gershon, 1998; Baker, 2005). Peristalsis helps with absorption of food and propelling food forward, and functions as a cleansing tool that removes potentially harmful colonies of bacteria, thus maintaining optimal health (Peristalsis, 2013).

<sup>1</sup> The author devised this system working with clients as well as her own body from 2006 to 2013. She learned that what was relevant was not just what her clients were eating but how, when, and why they were eating food. Eating psychology and body psychotherapy illuminated the relationship between how clients approached food and how they related to other aspects of life. The author adapted and integrated material from the Institute for Integrative Nutrition, the Institute for the Psychology of Eating, her yoga teacher trainings, and studies in body psychotherapy.

Mayer (2011) claims that 70-80% of the body's immune cells are in the tissues of the gut. Some research has found a connection between a healthy immune system and mental health (Leonard, 2007; Esch, 2002). In addition, 50% of endorphins, which are endogenous opiates, are made in the ENS and influence the immune system (Gershon, 1998). Endorphins play a role in the defensive response to stress (Amir et al., 1980). Tension in the gut brain may block the production of endorphins, diminishing the ability of the immune system to function (Gershon, 1998).

The formation of a healthy gut is initiated in the womb. Various researchers posit that new cells within the ENS continue to be created post-natally (Gershon, 1998; Pham et al., 2004), when the ENS is plastic (adaptable) and still developing (Boyen, et al., 2002). The first completely developed system in the body of a fetus is its digestive system (Love & Sterling, 2011). Early experiences, such as an infant's interactions with their parents, may affect the personality and development of the ENS (Gershon, 1998; Love & Sterling, 2011). Mayer (2011) theorizes that a newborn's first experience of pain (hunger and abdominal discomfort) and pleasure (related to the experience of ingestion) are held within the gut, affecting the homeostasis of the ENS. The infant's experiences with food intake, satiation, and gut responses provide the newborn with its first value-based map of the world based on positive and negative experiences with food (Mayer, 2011).

O'Mahony et al. (2011) assert that early-life stress induces alterations in many systems throughout the body including the GI tract. The effects of stress and trauma on the gut have been found to alter the ability of the ENS to function properly (Gui, 1998; Mayer, 2000; Mayer et al., 2001; Stam et al., 1997). O'Mahony et al. (2011) found that stress from maternal separation causes alterations in the hypothalamic-pituitary adrenal (HPA) axis (involved in the stress response) that increase hyperactivity, decrease pain modulation, and change gut flora. Research on probiotics, a type of beneficial bacteria, has shown its ability to reduce anxiety, decrease cortisol production, and to have other beneficial psychological effects (Carpenter, 2012; Cryan & O'Mahony, 2011).

Healthy gut flora also influences neural development, brain chemistry, emotional behavior, pain perception, and how the stress system responds in adulthood (Carpenter, 2012; Cryan & O'Mahony, 2011; O'Mahony et al., 2011). The alterations in the gut that affect its functioning correlate with the onset of Irritable Bowel Syndrome (IBS), including pain in the abdomen, gas, bloating, constipation, or diarrhea (O'Mahoney et al., 2011). Many researchers have found that IBS is connected to stress and its ability to alter the gut's capacity to function (Gui, 1998; Mayer, 2000; Mayer et al., 2001; Stam et al., 1997). The idea that alterations in the gut precede IBS is only one view.

The opposite perspective has also been observed, demonstrating how disturbances in the GI tract correlate with neurological and psychiatric features (McMillin et al., 1999; Mertz, 2005; Scaer, 2013). It is difficult to find any research indicating that the ENS has cognitive capabilities similar to the CNS. Numerous researchers have linked IBS with disruptions and alterations in the head brain (Drossman, 2005; Mertz, 2005; Sykes et al., 2003). It is not a common view that the enteric nervous system can function as a separate nervous system and that a change in the ENS can be just as detrimental to mental health as issues within other nervous systems in the body.

### The Enteric Nervous System and Body Psychotherapy

Body psychotherapist Gerda Boyesen created Biodynamic Psychology in the 1970's, claiming that the gut stores emotional energy to be released and integrated (Boyesen, 1980). Boyesen (2001) believed that the digestive tract is the most primitive and instinctual part of the body. She focused her therapeutic work on the gut for releasing undigested emotions. She named the digestion of life experience "psycho-peristalsis", which is the healing mechanism in the body that provides a connection between psyche and soma and is tracked via sounds in the gut (Boyesen, 1974).

Boyesen (1974) contended that sounds from the gut can be heard in a Biodynamic Massage session at times of insight or after a moment of expression and resolution. Da Silva (1990) and King (2011) found similar results in their research on stomach rumblings, called *borborygmi*. The findings detailed the use of *borborygmi* as a way to process therapeutic content during sessions. For example, a therapist spoke of experiencing a sinking sensation in their gut and a loud groan from his stomach while a client was talking of unresolved issues (King, 2011). In response to the therapist's stomach noises, the client began to listen to his own body and feel their emotions. The client then verbalized their perception of why the therapist's stomach groaned. When one is able to be aware of and express one's gut messages, relaxation is most likely to occur within the ENS.

When one experiences negative emotions, the intestines naturally cramp and digestion becomes physically and emotionally impaired (Boyesen, 2001; Vianna et al., 2006). Physical relaxation allows the intestines to settle and digestion to function (Boyesen, 2001). Boyesen (2001) listened to the intestines via a stethoscope in Biodynamic Massage. This kind of massage is meant to break down habitual ways of being that shape muscle tone and posture, and thus affect the body's ability to function (Schaible, 2009). Internal organs can become stiff and armored, which is likely to cause tissue changes and loss of peristalsis, making it difficult to process food, emotional energy, and stress (Schaible, 2009). Psycho-peristalsis is meant to bring awareness, integrate repressed energy, and empty suppressed content from the guts (Boyesen, 2001).

Many researchers believe feelings may be held in the gut and that reflection on gut sensations can help an individual consciously release past wounds via the ENS (Da Silva, 1990; King, 2011; Love & Sterling, 2011). Love & Sterling (2011) state that from the time of birth there is awareness of and an aversion to emptiness, and a striving for both physical and emotional fullness in the body. They speculate that from an early age, children lose touch with their gut feelings and are shaped by the external world which they rely on to survive; ENS information is drowned out by the head brain as children are externally influenced (Love & Sterling, 2011). A child's ability to listen to internal hunger and fullness cues can be affected by the environment and external factors. When feelings of full and empty were first felt can potentially be revealed by explorations of the past in order to integrate those experiences into the present (Love & Sterling, 2011).

A person listening only to the head brain can ignore messages from the gut brain until it is under duress. It is theorized that when the ENS stays in a stress response for long enough it will eventually send signals to overwhelm the head brain and make an individual listen to the gut's messages. Gut reflection is believed to then dislodge the external thinking that causes distress to an individual (Love & Sterling, 2011). It is noteworthy that Love & Sterling's data are speculative due to the fact that reflections on past gut sensations are based on the client's subjective memories. Additionally, some research would argue that emotions cannot be held in the digestive tract and are created from processes in the head brain (Damasio, 1999; Scaer, 2013).



### The Enteric Nervous System and the Body

Somatic patterns like posture can, according to Keleman (2003), shape the way one experiences the world and affect every tissue, muscle, organ, cell, thought, and feeling. Stanley Keleman, creator of Formative Psychology, explains that the shape a body takes is an anatomical organization and that the shape of any body is a behavior (Keleman, 2008). Keleman (2004) uses a methodology called the Bodying Practice, which involves becoming aware of how one is living in one's body, intensifying this bodily experience, and then collapsing the intensification to re-organize new patterns of being. When there is anatomical change, there is behavioral change and vice versa (Keleman, 2008). For example, posture while eating affects how the ENS digests input (David, 1991; Hirota et al., 2002). Slouching can cause peristaltic waves to be irregular and may even lock food in one place (David, 1991). Alignment of the spine may be a precursor to experiencing biological and psychological fullness (David, 1991). Thus, the form of the body affects all muscles and organs, including the ENS, and in turn the proper functioning of the ENS, comprising moving, processing, and digesting, may affect the form of the body.

The body is constantly pulsating, but it can be interrupted, deadening satisfaction within the body (Caldwell, 1997; Keleman, 1975). Yet, with each new experience, the body re-forms (Hartman & Zimberoff, 2004; Keleman, 1975). Noticing posture and tension may allow one to tap into thoughts and emotions that correlate with the formation of one's physical structure (Keleman, 1975; Young, 2005). Disintegration of current body alignment can then occur, leading to the re-organization of a new body structure (Keleman, 1975; Young, 2005). This could be as simple as a person learning to sit up with an erect spine and thereby invoking new internal emotions. Another way to tap into these emotions and sensations in the ENS is through the food one is digesting.

Marc David (1991), founder of the Institute for the Psychology of Eating, and Gershon (1998) support that we eat what we are. When eating under stress, one has less saliva in the mouth, which produces fewer enzymes, and interrupts one's ability to digest food properly (David, 1991). An individual may choose certain foods depending on a need to perpetuate or stop a feeling. Oudenhove et al. (2011) found that experiencing the emotion of sadness will increase the urge to eat. Without awareness of the emotional processing of the ENS, humans can reach for what would fill a physical hunger to satiate emotional hunger (Locher, Yoels, Maurer, & Ells, 2005; Wardle, 1990).

Joshua Rosenthal (2008), founder of the Institute for Integrative Nutrition, considers primary food (the food that nourishes the body first) to be how one is filled by one's relationships, physical activity, career, and spiritual practice. An individual who forgets to eat lunch from being caught up with having fun in the snow is being filled by primary food. Letting go of substitutes, such as food and drugs, to quench emotional hunger can bring about painful physical manifestations of the emotional suffering that was covered up by those substitutes (David, 1991). One's experience of food can be an experience of one's self (David, 1991). As food is digested within the ENS, it is feasible that food choices affect how bodies and actions are shaped from the inside out.

### Theory

As seen in the works of Boyesen (2001), David (1991), Gershon (1998), Keleman (2008), Love & Sterling (2011), and Mayer (2001), there seems to be a strong relationship between the gut, head brain, and behavior. Research supports the correlation between the head brain and behavior in therapy (Damasio, 1999; Schall, 2004), but the third underexplored element is the gut. Attention to how the ENS digests food, sensations, and needs could facilitate the processing of new and old input from the gut. Digestion typically involves stripping food of what is needed and disposing of

what is not. Digestion of sensations and needs can work the same way. An individual can engage with sensations and needs and use the information that is useful from the exploration and release what is not. The individual can then respond differently to ENS messages through new gut insight.

The Eating, Needing, Sensing (E.N.S.) system includes psycho-education about food and how it affects the body, discovering the meaning of cravings and needs, and paying attention to sensations in the gut. The gut brain may contain all sorts of information about emotions, past experiences, proper digestion of food, and current states. Explorations by Boyesen (2001), Da Silva (1990), King (2011), and Love & Sterling (2011), show that digestion in the gut can include how emotions, events, trauma, and life experiences are processed within the gut, in addition to how food is broken down. Nourishment can come from the food one puts into one's body and how one is fed by one's life. Therefore, the definitions of digestion and nourishment can expand to include how the body processes information physically, emotionally, and cognitively.

### Eating

Attending to the type of food ingested and how it is put into the body are ways of cultivating a relationship with the ENS. Noticing how food is digested in the gut can lead to a discovery of the information held within the ENS. A person who eats lots of cakes and cookies can explore if they are stress and trying to find comfort through sweet food. Eating these types of foods will most likely keep an individual feeling stressed due to the low-nutrient and high-sugar contents. When physical hunger is present and the body is fed with high-quality, nutrient-dense food, nourishment is most likely occurring in a way that will optimally keep down stress levels, tension, and inflammation.

One way to alter the ENS is to change the food one eats. Food is responsible for tissue repair, growth, hormones, and immune function (Rojek, 2003). Food can affect the neurotransmitters in the gut that influence feelings, thoughts, and behaviors (Rojek, 2003). For example, a high protein diet can promote dopamine production and provide a sense of calm (Kruse, 2011). Pert (1997) discovered several bio-chemicals, such as endorphins, involved with emotions, and Rojek (2003) holds the notion that food is the material needed to produce bio-chemicals in the body. Thus, there is a probable correlation between eating foods that support digestion and the ability to manage difficult emotions. Healthy gut bacteria have been shown to play a role in manufacturing the body's supply of serotonin, which influences mood and GI activity (Carpenter, 2012). It is possible to eat in a way that reduces inflammation, stress, food cravings, and nutritional deficiencies in the gut by consuming whole, unprocessed foods, which in turn supports the growth of healthy bacteria (Blaut, M, 2002; Gibson & Roberfroid, 1995; Jacobs et al., 2009; Rojek, 2003). Undigested food in the GI tract promotes parasitic growth and creates less space in the gut for healthy bacteria, which may also affect mood (Rojek, 2003).

Food can encourage one to feel clear and grounded or to pollute the body and make it difficult to listen for gut brain messages. Careful attention to the digestion of food may facilitate awareness of the difference between eating preserved and processed foods vs. whole, unprocessed foods (Kweon et al., 2001; Mateljan, 2013). Eating whole, unprocessed foods will typically provide energy and clarity, thus assisting the therapeutic process through one's ability to think clearly from both brains. Additionally, how one is eating is just as important as what one is eating. How nourishment is consumed includes the speed of eating and the rhythm and timing of eating throughout the day. Eating quickly can cause a stress response in the body, which will inhibit digestion (David, 2005) and negate the benefits of eating whole, unprocessed foods. Eating consistently throughout the day can cultivate a trusting relationship with the gut brain.

Before a baby can communicate verbally, food is often used to meet every physical and

emotional need. For the rest of life, food can be connected to love. Food experiences can trigger memories in the ENS correlated with the love received in childhood, current self-love, and survival needs. For instance, fostering awareness of the speed of eating at each meal and the cues of satiation could help one to explore how food is being used to fill an emotional emptiness. Insight and different responses to the information held in the ENS could release stagnant feelings in the gut.

### Needing

Noticing what one needs is another part of fostering awareness of the ENS. This is done by learning the difference between physical and emotional hunger. Physical hunger refers to what is felt within the body as a biological need for the energy to function. Physical hunger feels different for each individual. Some people experience stomach gurgles, light-headedness, or a decrease in the ability to think from either brain. Emotional hunger is defined as feelings of emptiness when one does not need food. When trying to fill an emotional hunger with food, people tend to have precise cravings and choose specific foods (Konowitch, 2012). For example, one may reach for ice cream to bring sweetness and comfort into a moment of feeling lonely and not wanting to deal with emotions. Learning the difference between emotional and physical hunger can facilitate awareness of what the ENS needs, whether that is physical (hunger) or emotional (loneliness, fear, anxiety). Inflammation, stress, and cravings may decrease while the ability to regulate emotions increases as one learns to relax and trust in how one chooses to nourish the ENS.

Excessive external stimulation can make it difficult to appropriately assess suitable food intake, needs, and senses within the ENS. The continuous stimulation from the environment (television, music, tables, and cell phones) can be experienced as a charge within the body from an overload of input (Farjon, 2013). Each charge without a discharge (a bodily or emotional release including stomach gurgles, relaxation, crying, gas) can make it increasingly difficult to tune in to the gut brain. Boyesen (2001) used touch to facilitate a discharge within the gut. However, attention to eating, needing, and sensing might initiate a bodily or emotional release within the gut through one's deeper understanding of oneself and different responses to ENS messages. For example, not allowing nourishment to be felt might lead to an exploration of the past and how one parent might have withheld love and support. This new insight may facilitate the realization that holding onto these past experiences and feelings of unworthiness is unnecessary in the present. Finding positive, loving relationships and eating foods that feel satiating may now be explored as new options in one's life.

Nourishment can come from positive food experiences or surroundings and social situations which feel satiating. One can nourish the gut physically and emotionally based on the discovery of what actually feels to be internally satiating, instead of what one is told externally. Awareness of ENS messages and needs might aid people in discovering who they are separate from how they have constructed themselves socially. The ENS can then be a guide in learning about one's unique desires through what digests well by paying attention to the sounds and sensations of the gut.

### Sensing

The final component of working with the E.N.S. system is to develop awareness of sensations in the gut. Sensations in the gut can be signals of the state of the gut brain, and the condition of the gut can be an indicator of information and emotions held within the ENS (Boyesen, 2001). Cultivating a relationship with the gut's sensations can help digest past experiences that first shaped personality (Love & Sterling, 2011). This occurs by understanding sensations, interpreting the gut's messages in a way that feels useful and digestible, and using new insight to let go of old ways of being. Tracking

emotions held in the gut can bring about new forms of self-expression and alter one's interpersonal and intrapersonal interactions.

Boyesen (2001) asserts that the main healing mechanism in the body resides in the gut. The potentially quick-healing nature of the gut could lead to rapid therapeutic results. People can continuously discuss what they are upset about, but without the change in the body, the patterns that have been ingrained within the muscles may continue. Slowing down verbal communication to focus on sensations within the ENS can facilitate the arising of an emotional response. Feeling one's emotions can foster a bodily release (crying, screaming, gas, gurgles, bowel movements, and sweating) of what is no longer necessary to contain within the gut.

The ENS has the capability to regenerate over time as cells die and renew (Gibson & Burke, 1983; Vladimir & Dolmatov, 2011). Rapid cell turnover in the gut makes it structurally set up for change. Different choices made to nourish the gut, from fast food to home-cooked meals, can lead to a new gut forming as cells continually die and renew. By nourishing the gut with what digests well, one may alter the gut's ability to function. The relaxation felt in the gut from eating foods that digest well can transform the ENS by lessening tension held in the viscera. Thus, the development of a new gut can continue each time one pays attention to food that is being properly digesting. A subsequent feeling of relaxation in the gut brain also facilitates change in the form of the body, thus allowing one to stand up taller or present oneself differently.

The type of listening in the Eating, Needing, Sensing (E.N.S.) system uses the Focusing Technique as its foundation. Focusing was created by Gendlin in the 1960's and "is a process of listening to something inside you that wants to communicate with you" (Cornell, 1996, p. 15). Focusing is about noticing how you feel and having a conversation with your feelings (Cornell, 1996). In this system, one tunes in to the noises, gurgles, or lack of sound within the gut and listens to sensations of tension, ease, lightness, and heaviness. ENS listening is not just about listening to the sensations in the moment, but nourishing the gut in the way that individuals want their guts to feel. If one is feeling stressed and anxious and wants to feel grounded and relaxed, one may eat protein, which can facilitate a sense of calm. In cultivating a relationship with the ENS, one can potentially increase one's ability to self-regulate through having a clearer sense of what will feel physically and emotionally satiating in the present and in the future.

### Application

This E.N.S. system of working in a body psychotherapy session involves paying attention to these three areas/questions:

**Eating:** what is the client eating?

**Needing:** what is the client needing/craving?

**Sensing:** what is the client sensing/feeling?

These parts of the E.N.S. system interact with one another and are not separate. When cultivating awareness of how food affects oneself in the eating section, an individual is also tuning into needs and sensations. Additionally, noticing sensations in the gut brain relates back to foods and cravings. This E.N.S. system can be utilized in every session. The progression of cultivating awareness of the gut brain and its messages will be different for every individual.

Thus, there is no set amount of time to complete this system. It can be consciously touched upon and deepened through time. It could take months or years to foster awareness of the messages from the gut brain, depending upon the commitment of the individual to do this work. When there is no relationship with the ENS, it will take time to hear and understand its messages. Tracking

eating, needing, and sensing offers information about the level of awareness clients have of their gut brains. The therapist should notice what areas could use more attention in guiding the client towards what needs more focus and exploration. This is a process that each person can work on outside of therapy as well to facilitate new habits of listening to the enteric nervous system.

### Eating

The main question in this section of the E.N.S. system is “what is the client eating?” The therapist is learning what, when, and how the client consumes food. A client’s relationship with food can be indicative of how they relate to everything else in life. The therapist can begin with an eating assessment/history and ask questions such as: Does the client restrict intake of food? Does the client over or under eat every day? Does the client eat foods knowing they do not feel good in the ENS? Stuffing food in the gut can also make it difficult to feel what the ENS is trying to relay. In addition, constantly not eating enough can decrease one’s ability to concentrate on anything else but food as one is most likely in a continuous state of deprivation.

To cultivate awareness of how the client’s choice of nourishment affects them, the therapist can assign the homework of keeping an E.N.S. journal. The journal documents what the client is eating, how fast, and what the internal and external environments are like while having an eating experience. This will invite the client to notice how food is being digested in the body. Bloating, gas, and cramping can be signs that what one is eating does not sit well in the gut or that one is eating too fast. One could write down that one ate a salad quickly while completing tasks at work, noting in the journal feelings of being bloated after the meal and attributing this to the environment and pace of eating, as on a separate occasion, one had eaten that salad and it was digested fine when eaten slowly. This can help one explore the stress in one’s life and perhaps the feeling of rushing through everything. Making a treatment plan with a client involves practical changes in eating behavior.

Once clients notice how quickly or slowly they are eating, therapist and client can discuss the client’s experiences with feeling satisfied. Does one speed through a meal to ignore the fact that one is giving oneself nourishment? Does one extend the experience of eating, not wanting to let go and end the receiving of sustenance? The way one experiences emptiness and fullness within the ENS can be clues around one’s capacity to contain happiness and satiation in the body. How one relates to food can also be an indication of how one relates to others. Does one speed through engagements with friends and family or never want an event to end?

Rhythmic eating can encourage one to listen to one’s physical and emotional gut needs throughout a day. In the E.N.S. journal, one can write down when one eats. A therapist can inquire: Does the client skip breakfast? Does the client eat every two hours and under what circumstances? Does the client eat normally all day and then eat a large quantity of food at night? Does the client restrict nourishment and satiation on a regular basis? Rhythm with food can invite discussion about what clients believe they deserve in terms of nourishment and love. If one possesses the belief that one doesn’t deserve nourishment (in whatever form it comes in: food, love, affection), the body’s cortisol levels can increase because of the stress these negative beliefs induce (Eck et al., 1996). Beliefs around food can then affect the optimal functioning of digestion.

### Needing

The focusing questions in this section of the E.N.S. system pinpoint what the client needs/craves. In this part, a client learns the difference between physical and emotional hunger and the therapist may explore a client’s history with needs and cravings. This can occur at the same time as the evaluation of the client’s eating. The therapist can inquire: Does the client know the difference between physical

and emotional hunger? How does the client experience physical and emotional hunger? Keleman’s *Bodying Practice* (2004) can be utilized to intensify what the client is feeling in the gut to come to an understanding of how sensations of needs or cravings feel in the ENS. A client might discuss an intense craving for sugar. The therapist can ask the client to focus on the gut and feel the sensations of this craving. During intensification, the therapist can inquire about memories that may be arising for the client. In this discussion, the therapist can ask: When does the client first remember what fullness, emptiness, and having a need to be filled, felt like in the gut? What emotions arise from this reflection?

The therapist can guide the client to process experiences of needs and cravings, either for survival or from desire. Does the client know how to fill an emotional need without turning to what would feed a physical need? What does the client typically crave, physically and emotionally, when an emotional hunger arises? As Boyesen (2001) connected gut sounds as insights from the gut brain, cravings can be viewed the same way: as information about the current status of the ENS. Cravings can be a sign of nutritional deficiencies in the gut that affect the functioning of the body or contribute to a sense of lack in one’s life (Rosenthal, 2008).

Cravings can be distinctive to each individual depending upon what is going on internally and externally within the client’s body and life. A client with a specific craving for a particular food or activity can provide an opening for the therapist to delve into the meaning behind the craving. For example, every time a client gets sick, cravings for scrambled eggs and ginger ale may arise. The therapist can inquire about times when the client ate these kinds of food and possibly discuss how the client’s mother fed them to the client when sick as a child. Thus, eating those foods when sick as an adult is a way to re-experience the feeling of being taken care of by a parent.

The therapist can also investigate clients’ abilities to allow their cravings and needs to be satiated. Client and therapist can discuss emotions that arise when needs get met or when the charge of a need fails to find completion. One might speak about how one had always wanted hugs from one’s parents but never received them, so then turned to food to quench emotional hunger. In therapy, the client can dive into what it was like to not have that need met, cultivate acceptance of the need, and find other ways unrelated to food to find emotional satiation.

Lastly, the therapist can guide clients to sit with their feelings and sensations non-judgmentally without having to take action while experiencing a craving. This process utilizes the Focusing Technique (Cornell, 1996), which asks clients to describe sensations in the ENS and initiate conversations with their cravings. This could lead to insight as to how they allow or ignore their needs. Often, clients have not allowed the emotions that the cravings are masking to arise. When repressed emotions and unresolved needs begin to surface, it is important that the therapist support the client in titrating these emotions as they can be experienced quite intensely if a client has not tuned into the ENS before.

### Sensing

The main question here is “what is the client sensing/feeling?” Tuning into sensations within the gut brain has been happening throughout the E.N.S. system. Here, clients learn how to track how they feel before, during, and after certain meals or activities. The therapist can ask: What sensations in the gut does the client notice when nourishing the body? Does the client feel lighter, heavier, grounded, spacey, sad, or joyful? How did the client feel in the gut before filling the body?

The therapist instructs clients to listen for what resonates in their systems by how the gut responds to inputs. They may experience relaxation, softening, gurgles, gas, tension, bloating, heat, or pain. The therapist can teach clients to slow down and listen for these sensations in the gut using the breath as a tool to facilitate relaxation. Clients then learn to feel their sensations while not having to take action to immediately ameliorate them. Reflection on sensations within



the gut can be written in the E.N.S. journal before, during, and after a meal, event, or emotional experience. Clients can tune into their gut feelings throughout an eating or nourishing experience and observe their abilities to sit with feelings of being full, empty, or in-between. The quality with which sensations/rumblings move through the gut brain can serve as information about how a client is digesting food, emotions, events, and information. The therapist can ask: What does the client sense in the ENS when digestion is occurring? What emotions arise when the client feels stagnant in the gut? Does the client feel fluid movement and hear noises within the ENS? Are there emotions connected to the ease or difficulty of digestion?

The therapist can investigate what it feels like in clients' ENS's when they choose to physically and emotionally nourish themselves based on externally received messages. Client and therapist can also explore what sensations occur in the gut brain when the client chooses to feed the body in alignment with what is needed. For example, a therapist can inquire what a client senses in the gut when eating a piece of cake just because everyone else was having a slice and that was not actually pleasurable to eat. Reflecting upon sensations in the ENS can help clients individuate from the societal constructs that may have previously defined them.

### Appropriateness

As clients learn to be aware of the ENS, it is also important to rate the appropriateness of what they are eating, needing, and sensing in the moment. For example, a person might be at home alone not doing anything, feeling anxious, needing contact, and considering eating an entire chocolate pie. In that instant, this individual can take a pause and ask, on a scale of one to ten, how appropriate it is to have these sensations and needs and to be eating an entire chocolate pie. Furthermore, if the client is craving chocolate pie, is it congruent with a need to eat because the client feels true physical hunger? This process is entirely subjective. It could be appropriate to eat food to fill emotional hunger if mindfulness of senses and needs are present.

Craighead (2006) defines effective emotional eating as eating to fill an emotion only to the point that the emotion feels satisfied while not overfilling the physical body. Pausing to rate the appropriateness of eating, needing, and sensing, one can allow oneself time to reflect on what the ENS is trying to relay. This gives one the chance to integrate ENS information and take action that is in alignment with an inner knowing of what would best serve well-being. This part of the E.N.S. system can be utilized when one feels more grounded in one's skills of listening to the gut brain and its messages. It could be difficult to assess appropriateness at the beginning of a relationship with the ENS when an individual might be unclear about what the ENS is trying to relay.

### Conclusion

Becoming aware of eating, needing, and sensing will potentially foster a relationship with the enteric nervous system in which clients will be able to hear and understand its messages. This can lead to an increase in emotional self-regulation through internal listening and responding to unique bodily needs. More research on the ENS could prove very useful in incorporating the gut brain into body psychotherapy. Investigations need to be completed on the ENS in a therapeutic context that demonstrates how working with the second brain can affect the outcome of healing and transformation for clients. Additionally, further research needs to be initiated on whether the assertions made in this paper are accurate and effective. The limitations of this theory lie in that assumptions were made as to how the eating, needing, sensing (E.N.S.) system works.

It is yet to be documented how the head brain could be affected by awareness of the gut brain

and how ENS consciousness may facilitate a dialogue between both brains. The E.N.S. system outlined in this paper serves as a starting point for the process of incorporating the insight of the second brain into a session. Perhaps with knowledge and time, body psychotherapists will be able to integrate the gut brain into therapeutic work and provide clients with a new lens through which to understand their bodies and be able to live and interact from a place of congruency, authenticity, and genuineness in the world.

### BIOGRAPHY

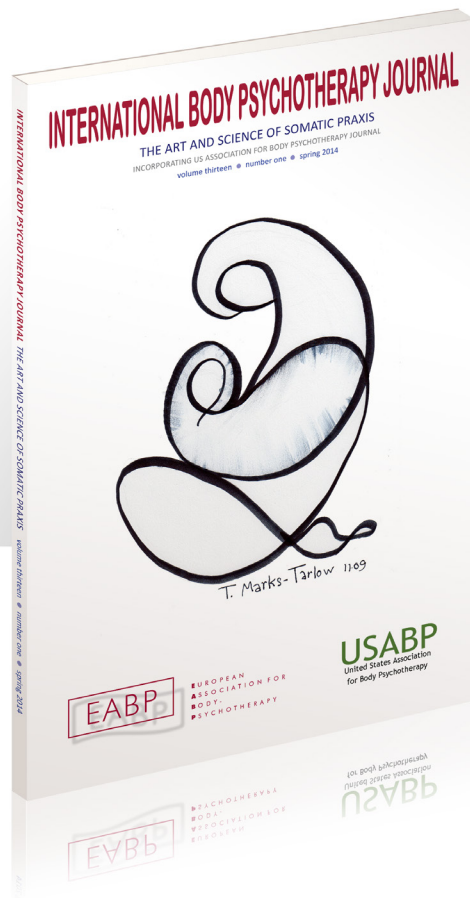
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