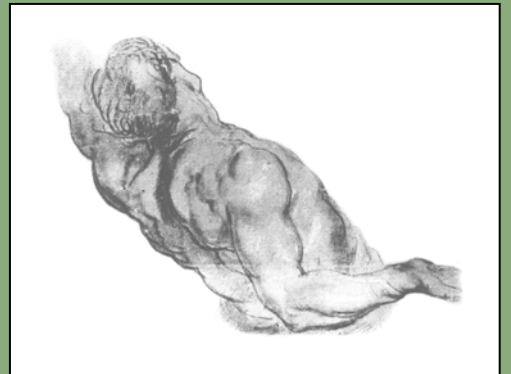


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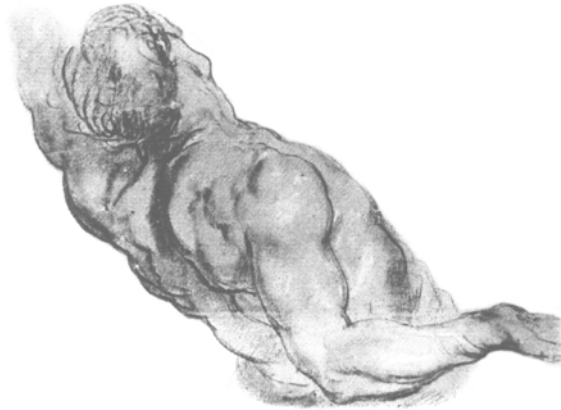


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USABP Mission Statement

The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999)

The USA Body Psychotherapy Journal **Editorial, Vol. 1, No. 2, Oct. 2002**

When we launched the Journal last spring after months of planning and hard work by members of the USABP Board of Directors, I said that it would be a “work in progress,” and so it is. Two important changes are already underway. First, we are working to constitute a formal Editorial Board that will work with me to establish policy and guide our progress and direction as a professional journal. In addition, a separate Peer Review Committee will conduct blind reviews of all articles submitted for publication and turn in their written comments and recommendations to the editor for help in planning future issues. These immediate changes, which we hope will meet with your approval, are reflected in the masthead in this issue. If you are interested in serving the USABP Journal in either of these capacities, please contact me at JACARLETON@aol.com.

That said, I am delighted to offer you in this FALL 2002 issue of the Journal an impressive variety of articles that reflect the depth and breadth of our field. Whether grounded in research or offered in the context of personal healing and professional practice, I believe you will see and appreciate how we are expanding as a body.

Christa Ventling leads off with a report on the research that won this year’s research award at the USABP Conference in Baltimore in June. An elegant research design investigated the efficacy of bioenergetic therapy as well as the stability of therapeutic results among patients of Swiss Bioenergetic therapists. Former patients were asked to fill out self-evaluative questionnaires and return them anonymously. An impressive 49% response rate netted a sample of 149. Questions covered psychic and physical condition, interpersonal and psychosomatic problems and the effect of body work on physical consciousness, cognitive insights and changes in the quality of life. But even more important than the results is her sophisticated discussion of the methodology of this type of research that will hopefully inspire continuing efforts in this direction.

Patrizia Pallaro and Angela Fischlein-Rupp, by contrast, explore the theoretical basis and practical application of dance-movement therapy within a psychiatric day treatment facility. Employing a case presentation, they illustrate the importance of an integrative approach allowing room for synthesis of various treatment modalities. They show how dance/movement therapy facilitates a process of physical, emotional and psychological integration by providing a safe container in which emotional issues can be addressed through movement, imagery, symbol and metaphor.

In an article entitled “Therapist’s Body Awareness and Strength of the Therapeutic Alliance” Douglas Radandt discusses data collected from practicing therapists in a pilot study in which they assess the relationship between body awareness of therapist and therapist’s assessment of the strength of the therapeutic alliance. This preliminary research raises several important questions about these relationships as well as other possible factors affecting the strength of the therapeutic alliance which are suggested for further study.

Following Kerstin White’s article in the first number of this journal on the ethical and clinical implications of the use of touch in psychotherapy, Jaffy Phillips outlines for the practicing clinician the factors which need to be considered when employing touch. In addition to discussing relevant ethical considerations, she provides an empowering manual for how to assess those factors under three headings: client factors, therapist factors and relationship factors. She then defines a technique she calls “somatic tracking” and illustrates how it can be used to assess subjective aspects of the client’s experience, the therapist’s experience, and of the therapeutic relationship which needs ongoing evaluation when touch is employed.

Our final article, Margot S. Biestman’s “Exploring Healing with the Experience of Breath: My Story,” chronicles the author’s own healing journey after a severe spinal trauma at the age of 70. Working with the body therapy modality she practices and teaches Margot shares intimately the healing

of a healer. This inaugurates what I hope will be an ongoing feature of this journal: a personal account of one of the intersections of our personal and professional lives.

Articles such as these are establishing a firm foundation for the USABP Journal. In future issues, we would like to include case studies that illustrate practice and inform readers of the context/research that supports that practice. Please consider offering your practical work and submitting a case study to the journal for peer review. Overwhelmed by the plethora of new books that pique your interest and tease your checkbook? We are in the process of gathering advance copies of books from publishers for our members to read and review. Let us know if you would like to offer your services as a critical reviewer.

Please know that your enthusiastic response and support for the USABP Journal has fired our commitment to producing a credible publication that will reflect, define and validate the growing field of bodywork psychotherapy. That said, as a body, let us go forward!

Jacqueline Carleton, Ph.D.
Editor
New York City
Fall 2002

Efficacy of Bioenergetic Therapies and Stability of the Therapeutic Result: A Retrospective Investigation

Christa D. Ventling

Abstract

This article reports on a retrospective investigation of the efficacy of bioenergetic therapy with adults in a private practice setting as well as on the stability of the therapeutic results achieved over time. Sixteen certified bioenergetic therapists of the Swiss Society of Bioenergetic Therapists (SGBAT), provided data on 319 former patients who had terminated their therapies after a minimum of 20 sessions 6 months to 6 years earlier. They were then sent an evaluation questionnaire to be answered anonymously; 290 of them could be reached and 149 (49%) returned it. The questions dealt with the psychic and physical condition, interpersonal and psychosomatic problems and the effect of body work on physical consciousness, cognitive insights and changes in quality of life. Statistical analysis showed significant positive changes in all areas questioned and supports the efficacy of the method. Regarding the stability of the therapeutic result, 107 (75%) patients indicated a stable or even improved condition.

Keywords

Bioenergetics – Consciousness – Efficacy – Efficacy of Bioenergetic therapies – Psychosomatic - Stability

Introduction

The question, "how effective is a certain psychotherapy method ?" is an urgent one. Not only do our patients have a right to know what they are “buying”, the politicians dealing with health insurance issues also have a right to know who we are and what we are “selling”. The efficacy of psychotherapy is based on the sum of several items, which include, to name but a few, on the therapist’s¹ side his formative background, his professional and personal way of bringing into the sessions empathy, knowledge, art and wisdom; and on the patient’s side his motivation to want to change things, his ability to make insights and to apply these in everyday life and last but not least as a key issue the relationship between therapist and patient.

As to the question “how does one measure efficacy?” there are basically two approaches possible depending on whether one is interested in the final result of the therapy (outcome quality) or in the quality of the therapy while it is going on (process quality). By means of suitable questionnaires in both cases, one can question the therapist, the patient, or both. There are advantages and disadvantages to each approach and they need careful consideration.

For this study, we were investigating one aspect: the outcome quality of the therapies and the stability of the result obtained. For such an investigation we had to decide, basically, whether we wanted to have our questions answered by former patients or by present patients starting their therapies now. Again, advantages and disadvantages played a role in the decision making, for in any case a large number of patients was required for a good scientific and statistical evaluation. Former patients may be difficult to locate, but the stability of the findings are more reliable. For new patients beginning therapy, the outcome of the therapy is unpredictable, and the question of stability is even more so and may not be answerable for many years. We chose to locate and question former patients.

Let us return for a moment to the above mentioned quality of the therapist. An investigation of the state of well-being of former patients comes originally from many different therapists and raises the question of whether the background and training of these therapists are of matching quality. They must

¹The terms therapist and patient include both genders.

have similar training to form a consistent basis. Bioenergetic therapists undergo a training prescribed and overseen by international trainers recruited from the staff of the International Institute of Bioenergetic Analysis (IIBA) in New York and trainees graduate with a certification (Certified Bioenergetic Therapist = CBT).

In Switzerland the title “psychotherapist” became legally accepted and protected in 1992, when the CHARTA, an organization composed of a number of psychotherapy schools was created to establish uniform standards for the formation of psychotherapists. As a prerequisite for becoming a psychotherapist in any of the accredited member schools, a University degree in psychology (Masters) or medicine must be obtained followed by a uniform training period of five years with CHARTA-prescribed hours of theory, practice, personal therapy, supervision etc. In this way the CHARTA became the guaranteeing body for quality psychotherapy training. The Swiss Society for Bioenergetic Analysis and Therapy (SGBAT) is a founding member of the CHARTA. SGBAT members have an academic background and a more intensive training than the one offered before through the IIBA.

While the quality of bioenergetic therapists in Switzerland is not questioned anymore, there is, considerable scientific and political pressure to provide evidence of the efficacy of the psychotherapeutic method used. The pressure came from the cognitive-behavioral therapists (Lambert & Bergin 1994; Grawe & Braun 1994, Laireiter 1995), and from Grawe et al. 1994. Grawe (Grawe 1990, Grawe, Caspar und Ambühl 1990a-d) had previously published a very extensive study comparing the efficacies of interactional behavioral therapy (IVT), enlarged-spectrum behavioral therapy (BVT) and client-centered therapy (GT), in individual and group setting. They had gathered an impressive amount of data on the efficacy of each form of therapy relative to the diagnosis of the client. They retested results six months and twelve months after ending the therapy. Their study is probably the first one to take into consideration the stability of the therapeutic result achieved. It has, however, serious drawbacks: clients could neither choose the form of therapy nor the therapist but were randomly assigned, which caused many drop-outs. Statistical comparisons were made with only 15 clients per group, therapy was limited to weekly sessions for less than a year and psychology students in training for cognitive-behavioral psychotherapy were used as therapists albeit under supervision.

Bioenergetic therapists, like the therapists from many other schools, notably the analytical ones, showed their concern and interest in quality evidence first by publishing case reports and vignettes and like most others felt that this was sufficient. In Switzerland, Ehrensperger (1991) demonstrated by presenting individual case vignettes, that Bioenergetic Analysis and Therapy (in the following abbreviated as BAT) is an efficient form of therapy with patients suffering from certain psychosomatic problems (tension headaches, rheumatism, irritable colon). In contrast to Ehrensperger, Amstutz (1992) compared three groups: a BAT group, a group having client centered therapies and a third group learning autosuggestive relaxation techniques (AT). The groups were given a standardized questionnaire before and after therapy (VEV questionnaire by Zielke and Kopf-Mehnert, 1978). Highest and statistically significant positive changes were obtained by the BAT group (49 neurotic patients in therapy for 3-4 years), followed by the GT group (45 patients of undescribed diagnosis in therapy for 9 weeks) and last by the group in AT treatment (32 mostly psychosomatic patients having had 10-35 sessions). Again, this study is deficient in that the groups are not truly comparable. However, it represents a first serious concern about the quality of BAT. One thing became clear in the studies of both Ehrensperger and Amstutz: Bioenergetic therapy is not a short-term therapy.

The first large-scale scientific investigation of the application and efficacy of BAT was carried out by Gudat (1995, 1997) in Germany. His retrospective study was done with 309 patients from private practices. He used the VEV questionnaire as an instrument to measure and statistically evaluate changes between the beginning and the end of therapy, which was approximately 2 years. Data were also correlated with the DMS-III diagnosis. BAT proved to be especially successful for the treatment of neurotic problems, such as anxiety and depression as well as for psychosomatic disorders. A comparison

of the VEV data from BAT with those from cognitive-behavioral therapy (VT), client-centered therapy (GT) or even psychoanalysis showed that BAT was just as efficacious as the other forms of therapy, and this in spite of the fact that differing forms of psychotherapy were applied for very different lengths of therapy. BAT patients were in therapy on the average for 75 hours while those in VT or GT were in treatment for much less time and those in psychoanalysis for much longer.

As to the question, "for how long does the result of the therapy last?" the literature provides practically no answers, yet this question ought to be of utmost concern to therapists. Besides the study of Grawe et al. (1990a-d) mentioned above we found only one article where the question of stability of the therapeutic result achieved was studied: the Jungian Society of Switzerland found that the variable, the ability to work, was stable over a period of six years after the end of therapy (Keller et al. 1997).

In the investigation documented here we provide conclusive evidence that Bioenergetic analysis and therapy is an efficacious form of therapy for patients with mostly neurotic and psychosomatic problems. Furthermore we show that the result achieved is stable for a period of at least 6 months to 6 years after the therapy ended.

Methodology

Data collection

In the spring of 1997 all certified bioenergetic therapists of the Swiss Society of Bioenergetic Therapists who had been working with adult patients in private practices since 1990 or earlier were requested to list all patients they had treated from January 1991 until December 1996 and supply age, gender, number of therapy hours, form of payment, diagnosis according to the ICD-10 and main character structure according to Lowen² for each patient. This documentation provided us with the total number of patients seen and their socio-demographic data. In August 1997 the same therapists were asked to send a specially designed questionnaire (see at the end of this article) to only those patients who had terminated their therapy after a minimum of 20 hours during the time period of 1991 to 1996.

The Questionnaire

As criteria of the efficacy of a therapy we consider the positive change observed for a number of disturbing or painful parameters in the individual or social surrounding of a patient, as measured between the beginning and the end of the therapy. For criteria of stability we consider the lasting effect of the therapeutic result achieved between the end of the therapy and the present time of questioning. As we wished to measure both criteria at the same time, we needed a suitable questionnaire which would take into account the three time-points needed: 1. before therapy, 2. at the end of therapy, 3. at the time of questioning, which was within the time period of 6 months to 6 years after termination of the therapy. Thus, a comparison of the data from the first two time points gives an indication of the changes achieved during therapy, e.g. the efficacy of the therapy, while a comparison of the data from the last two time points tells us something about the stability of the result achieved.

The most widely used questionnaire within German-speaking Europe, the VEV mentioned above, was not suitable because a) it measures the changes between two time-points only and we did not want to confuse the ex-patients by asking them to fill out the same questionnaire twice, and b) it contains no questions about working with the body which we assumed to be crucial. Thus we resorted to designing our own questionnaire. We took into account the advice of Seligman (1995): to place all questions on a single sheet of paper, to ask for anonymous responses, to add a letter of explanation and a stamped return envelope pre-addressed to a neutral place. According to Seligman, this procedure should assure a reasonable return of at least 25%. We used 5 different colors for the questionnaire in relation to

² The data obtained relating to the character structures of Lowen will be published in a separate paper.

the 5 character structures of Lowen (e.g. blue for schizoid, pink for oral etc.). The therapists were to mail them to their former patients in accordance with their dominant character structure.

Statistics.

The relative frequency was calculated for items which could be answered “yes” or “no”. For questions to be answered with “poor”, “satisfactory”, “good” etc. we rated an improvement by one grade with a + and a drop to a lower grade with a -. Thereafter the statistical significance was calculated with the sign test (two-sided questioning, 5% error limitation). For more complex comparisons, the Chi-Square test for dependent samples was used. All statistical programs were available as software “CSS, Statistical for personal computers”.

Results

Patient Data

All patient data in this investigation were collected by 16 SGBAT therapists, 7 of them male, 9 female, and 6 of them were psychiatrists (e.g. medical doctors) and 10 were psychologists (e.g. with a Master degree). All of them worked with adults in private practices in the German-speaking section of Switzerland. From January 1991 until December 1996 they treated a total of 1399 patients in single therapy sessions. Of all these patients 319 terminated their therapies after at least 20 sessions. These 319 ex-patients satisfied the requirements for our study; the questionnaire, to be answered anonymously, was received by 290 (90.9%) and returned by 144. Two questionnaires could not be evaluated. The 142 correctly filled out ones correspond to a return of 49%.

Sociodemographic Data

The age distribution of the 319 patients shows 64% between 30 and 50 years, 6% were younger and 16% older. Altogether 14% did not indicate their age. The mean age was 41.6 years, with a minimum of 20 and a maximum of 62.

The distribution of the number of therapy sessions (at one session per week) shows that about half of all the patients required up to 75 sessions, a fourth up to 150 hours and another fourth more than 150 hours. (Mean = 91 hours, Modal= 26-50 hours).

All 319 patients were diagnosed according to the F categories (to the second decimal point) of the ICD-10. However this precision could not be maintained when calculating the frequencies due to very small numbers in some of the categories. Therefore, we resorted to using only F1 - F9. The F4 group (neurotic, stress and somatic symptoms) was the largest represented (58%), followed by the patients of the F6 group (13.5%, personality and behavior disturbances) and those of the F3 group (12.3%, affective disorders). In the F9 group were only 7.5% of the patients (behavioral and emotional disturbances originating during childhood). The remaining 8.6% represented the other F categories. As the questionnaire was answered anonymously an ICD-10 diagnosis was not possible anymore for the 142 returned forms.

The gender distribution of the 290 patients showed 203 women (64%) and 116 men (36%); the same gender distribution of the 142 answering patients was with 77 women (52%) and 55 men (39%) very similar, whereby 10 persons (9%) did not indicate their sex.

Evaluation of the efficacy of Bioenergetic Analysis

A therapeutic goal as motivational aspect

Of the 142 patients asked 122 (86%) said that they had a goal in the beginning of the therapy and 44 (36%) of them indicated they reached it completely. Another 69 (57%) said they reached the goal only partially, and a mere 9 persons (7%) claimed not to have reached it at all.

State of psychological well-being and social competences

Tables 1a and 1b summarize psychological well-being and social competences before and after therapy. Before therapy about half of the patients indicated that their psychological well-being was poor (54%), their self-esteem low (52%) and their self-acceptance poor (49%). A third of all patients judged their assertiveness as poor. At the end of therapy all these variables were improved (highest significance $p < 0.001$). Only 2-5% of all patients declared no improvements.

Table 1a. General feeling and social competence at the beginning of BAT (n=142)

Variable	Poor		Satisfactory		Good	
	n	%	n	%	N	%
General feeling	77	(54.2)	57	(40.1)	6	(4.2)
Ability to make contact	27	(19.0)	71	(50.0)	41	(28.9)
Ability to work	22	(15.5)	45	(31.7)	72	(50.7)
Self-esteem	74	(52.1)	61	(43.0)	6	(4.2)
Self-acceptance	69	(48.6)	63	(44.4)	8	(5.6)
Assertiveness	49	(34.5)	72	(50.7)	18	(12.7)

Table 1b. General feeling and social competence at the end of BAT (n=142). The sign test relates to changes since the beginning of therapy (Table 1a).

Variable	Poor		Satisfactory		Good		Sign-test
	n	%	n	%	n	%	
General feeling	3	(2.1)	44	(31.0)	94	(66.2)	0.001
Ability to make contact	3	(2.1)	45	(31.7)	91	(64.1)	0.001
Ability to work	5	(3.5)	27	(19.0)	108	(76.1)	0.001
Self-esteem	5	(3.5)	72	(50.7)	64	(45.1)	0.001
Self-acceptance	6	(4.2)	64	(45.1)	70	(49.3)	0.001
Assertiveness	8	(5.6)	57	(40.1)	73	(51.4)	0.001

Problems of relationships

The most frequent relationship problem encountered among patients was that of partnership. Two thirds of our patients (66%) suffered from these at the beginning of the therapy, another 42.3% indicated problems with parents and another 27.5% had problems with their superiors. After the therapy 41% of the patients indicated an improvement in their partnerships, 21% had better relationships with their parents and even the problems with superiors were improved by 14%. All these changes are statistically highly significant.

Physical sufferings

A relatively high percentage of patients indicated at the beginning of therapy that they suffered physically. Predominant complaints concerned the neck and shoulder area with headaches (40%), followed by sleep disorders (36%). About half of all the patients showed highest significant improvements ($p < 0.001$) by the end of therapy with the exception of those complaining of circulatory problems. Of the 20% of all patients requiring a medication at the beginning of the therapy, only 13% did so at the end of the therapy (statistical significance $p < 0.04$).

Quality of life

We defined quality of life in accordance with Seligman (1995) as the total of feeling alive, being creative, having friends, living a satisfactory sexual life, loving and respecting oneself by following healthy nutrition and hygiene, being active physically and enjoying hobbies. All these variables (Table 2) improved during the therapy significantly ($p < 0.001$). The improvement in the feeling of aliveness was 76%, followed with 44% for creativity and 40% for sexuality. The least change was in personal hygiene (22%).

Table 2. Changes in quality of life during the therapy (n=142)

Variable	Unchanged		Better		Worse		Sign-test P<
	n	%	n	%	n	%	
Vitality	34	(23.9)	108	(76.0)	0	0	0.001
Personal Hygiene	111	(78.2)	31	(21.8)	0	0	0.001
Creativity	79	(55.6)	62	(43.6)	1	(0.7)	0.001
Eating Habits	97	(68.3)	44	(30.9)	1	(0.7)	0.001
Sexuality	81	(57.0)	57	(40.1)	4	(2.8)	0.001
Circle of friends	87	(61.3)	44	(30.9)	11	(7.7)	0.001
Physical Activities	86	(60.5)	46	(32.4)	10	(7.0)	0.001
Hobbies	100	(70.4)	40	(28.2)	2	(1.4)	0.001

About the effect of body work

We wanted to know whether our Certified Bioenergetic Therapists actually do body work and if so how the patients reacted to it. 125 (88%) patients acknowledged the body work, but only 70 (56%) of them said that the body work was the reason for gaining new insights; 58 (46%) linked the improved body consciousness to the body work. Only 27 (22%) thought that the positive change in quality of life was due to the body work. However, the experience of body work seemed to be key for the recommendation of the therapist: 124 (87%) of the patients would recommend the therapist, 9 patients had actually indicated that their therapist had not used body work and they therefore would not recommend him/her.

About the stability of the therapeutic result

State of psychological well-being and social competences

Since the termination of the therapy and the time of questioning we see a general and significant ($p < 0.001$) further improvement in two thirds of all patients in all areas questioned (see Table 3). Only a mere 3-5% of the patients claimed a worsening of their condition since termination of the therapy.

Table 3. Changes of general feeling and social competence since termination of the BAT until time of questioning (n=142).

Variable	Unchanged		Better		Worse		Sign-test P<
	n	%	n	%	n	%	
General feeling	28	(19.7)	104	(73.3)	8	(5.6)	0.001
Ability to make contact	45	(31.7)	89	(62.7)	6	(4.2)	0.001
Ability to work	54	(38.1)	77	(54.2)	8	(5.6)	0.001
Self-esteem	35	(24.6)	101	(71.1)	4	(2.8)	0.001
Self-acceptance	37	(26.0)	99	(69.7)	4	(2.8)	0.001
Assertiveness	46	(32.4)	89	(62.7)	5	(3.5)	0.001

Problems of relationship

Since the termination of the therapy and the time of questioning we see also in this area further significant improvements ($p < 0.001$)

Physical suffering

Significant improvements ($p < 0.001$) were seen also here. Somatic problems which had improved or disappeared during the therapy did not return thereafter or improved even further.

The question of satisfaction with the therapeutic result

Of the 142 patients 107 (75%) said that they were satisfied with the result of the BAT and had no need to enter a second therapy. However, 35 (25%) patients of whom 21 had terminated their BAT between 1990 and 1993 and 14 who had terminated between 1993 and 1996 indicated they have gone into another therapy since. Another bioenergetic therapy was chosen by 6 patients (“with a therapist of the opposite sex from the first therapist”). Of the remaining 29 patients 14 chose another not further specified body psychotherapy, 2 went into psychoanalysis, 8 chose a cognitive therapy and 5 did not indicate the form of therapy they had selected

Discussion

The investigation of the efficacy of BAT with patients from private practices who had actually terminated their psychotherapies at least 6 months, even up to 6 years earlier, shows that it is absolutely possible to collect significant data retrospectively, after the termination of therapies, and that such data not only substantiate the efficacy of the therapy but also testify to the stability of the achieved therapeutic result. In an earlier investigation done by Gudat (1997) immediately at the end of therapy it was already shown that BAT is a highly effective form of psychotherapy. Thus study confirms Gudat’s results. With Gudat’s and the present study the school of BAT has provided the first two important proofs of efficacy of the method.

Both of these studies are field studies. They were done outside of the usual university setting. At the latter very different strategies and techniques for researching are available, and usually also the financial means which allow extensive studies with appropriate control groups.

All the previously published efficacy studies (cognitive-behavioral interventions, client-centered cognitive therapies and others) were done using a university and not a field setting (Grawe et al. 1990 and Lambert & Bergin 1994). These studies differ from ours as the length of time of therapy was determined from the beginning (usually a set number of sessions, never extending over a year) and that patients were randomly assigned to the experimental and control groups. The rules of a university setting differ from those in private practice settings and it is this discrepancy which often leads to the accusation that private practitioners are unscientific in their approaches. This is certainly a first possible criticism of our work. A closer look shows that by “unscientific” most often is meant the lack of controls. To use a waiting group as control, e.g. to let them wait on purpose or in other words, to deny them therapy is considered unethical by private practitioners. A control group consisting of needing yet untreated individuals is therefore unthinkable. One could however, think up a plan whereby a similar group of patients from another therapeutic direction participates in such a study, e.g. would be also sent the questionnaire. This design would suffer from other drawbacks, e.g. that some of the questions would not be relevant for the other group or more seriously to set up a competitive situation.

A second point of criticism could be that for the proper calculation of the degree of effectiveness, a control group is necessary as reference point. However, it can be argued that it is also possible to calculate the effectiveness based on the percentage of the patients who improved corrected by the percentage of the patients who did not, but changed for the worse. On this basis the results we obtained are considered excellent (compared to the aim of an assessment of “good”(see Tables 1a and 1b)): 62% of all patients improved regarding their psychological state, 45% regarding their self-acceptance, 41% regarding their self-esteem and 39% regarding their assertiveness. The improvement was still very good, but somewhat less in the areas of ability to make contact (35%) and ability to maintain a job (25%). However, keep in mind that in these two areas only 19% respectively 15% of the

patients placed “poor” marks before therapy. Thus, while taking into consideration possible distortions of the correct answers due to e.g. the time elapsed since termination of the therapy, overall the improvements are impressively substantiated.

A further issue is the heterogeneity of the patients as seen by the ICD-10 diagnosis and the fact that due to the anonymity of the returned questionnaires no correlation could be calculated between diagnosis and therapeutic effect. This problem did not exist in the study of Gudat (1997) because he questioned the patients himself at the end of the therapy and had a DSM-III diagnosis from their therapists available with which to correlate the data. We assume however, that similar to the equal distribution pattern of the patients’ sexes before and after questioning, the distribution of the ICD-10 diagnosis remained equally constant. In any case the patients can essentially be found in only three categories: F4 (58%, neurotic, stress-induced and somatic disorders), F6 (13.5%, personality and behavioral disorders) and F3 (12.3%, affective disorders). All of them show positive improvements after a Bioenergetic Therapy. F40 clients (panic disorders and phobias), a subgroup of F4, are rarely found among our patients. A high percentage of F4 patients seems to be a general phenomenon among the clientele of private practices. Thus, not only Gudat (1997) but also Frossard et al. (1993) noted this, whereby interestingly in the latter the F4 patients were in therapy of psychoanalysts. One can then further conclude that it is not so much the form of psychotherapy being offered which guarantees a good outcome, but more likely the availability of the therapist at the time.

Patients in our study were in therapy on the average for 91 hours, in Gudat’s (1997) 75 hours and in Keller et al.’s (1997), who describes efficacy and overlasting effect of Jungian therapies, 193 hours. When a therapy treats not only the symptoms but aims at modifying traits imbedded in the character structure of the personality, a long-term therapy is required. The necessary processing times for analytical work can never be dealt with and integrated in a short-term therapy (Gudat 1997, Keller et al. 1997, Seligman 1995).

A third point of criticism concerns the questionnaire. An officially tested and validated questionnaire measuring 3 time points at one time and including questions about body work does not yet exist. It was therefore necessary to resort to a self-constructed inventory, which had to satisfy the above criteria and yield a high return. Considering the retrospective point of questioning – for many patients up to 6 years after they terminated their therapy – we judge the 49% return as very high indeed. Amstutz (1992) sent her VEV questionnaire out two years after the end of treatment and had a return of 74% with the BAT patients and of 50% with the AT patients. It is well-known that the expected return of a questionnaire decreases proportional to the complexity and differentiation of the questions, especially if these are distributed over several pages. The well-known Bernese comparison-of-therapies-study (Grawe 1990), which was prospective and which by its design should have a very high return expectancy, only yielded answers from 27% of the original 230 patients divided into four groups.

How trustworthy are the anonymous and retrospective answers of our patients?

Would it have been better to design a questionnaire to be answered by a person close to the patient? To find a person close enough to have followed the process and development of the patient during his therapy could be a very difficult and time-consuming endeavor and would decrease most certainly the number of returned questionnaires. In addition the influence of the patient or his well-being on the other person near him cannot be assessed. If the questioning is done while the therapy is going on, let us say before it really begins and at several time points during the therapy, then we have the problem of influencing the therapy, the therapist and the patient. And if we try to find a relative or person close to the patient to assess the patient’s well-being, we would be entangled in endless distortions and problems of validity.

The validity of the answers of the patients are indeed worth of a discussion. Questions relating to therapy are so personal that only a subjective questioning can provide reasonably valid answers. If the questioning is done during distinct intervals while the therapy is going on, the answers can first tell us something about the process going on and eventually also about the outcome. But influence on the

therapy could never be disproved.

Every form of data collection has its drawbacks. Retrospective questioning described here, e.g. neither therapist nor patient had any idea that sometime in the future an investigation would take place, has the unique advantage that any influence on the therapeutic process is eliminated.

Retrospective answers, however, place high demands on the memory. We assume that a patient remembers his state of well-being when he first went into therapy, almost as well as he can describe his current state of being. A problem arises only for the "middle section of the memory curve" (Baddeley 1979). Baddeley showed that this part is not remembered as well as either beginning or end. Still we assume that the time point of terminating the therapy was a very memorable one and that a patient is very capable of describing his well-being and how he felt then. Other distortions, like deliberate untruths are of course always possible and beyond any control, yet we believe that a self-judgment, especially when done anonymously, can be trusted.

One could argue of course that only those patients answered the questionnaire that were happy with the result of their therapy. As a counterargument let us consider this: first, some patients noted changes for the worse for some items and surely answered very truthfully and second, not all patients recommended their therapist (13% did not). Therefore, some not-so-happy patients must have also returned the questionnaire. Presumably they are also among those who started a second therapy. And, last but not least, there may be quite a number of former patients who at the time were quite satisfied with their therapy but who show no interest whatsoever today in discussing any aspect of it.

The body work in Bioenergetic Therapy may be a weighty aspect, but it is never considered alone. A major emphasis is placed on integrating the body work (or better the insights made through the physical and also verbal interventions) with the personal history. Therefore, the outcome of a bioenergetic therapy is always the sum of many things. Although we assumed that our patients would be ascribing a high efficacy to body work with regard to gaining new insights, we were disappointed in the answer, as only 56% did so. Even fewer (46%) felt that body work was the cause of their improved quality of life. Clearly the exact variables that are causing the overall very positive changes in BAT cannot be pinpointed at this time. The theory that it is mainly the body work needs further investigation. The Bernese study, (Grawe 1990) with a very similar clientele to ours, also tried to answer the question what exactly led to the positive result, and they did not find an answer either. We assume that the quality of the relationship between patient and therapist plays a major role and plan to study it further.

Setting a therapeutic goal, however, seems to be an important factor affecting the outcome of the therapy. The majority of our patients (86%) had such a goal in the beginning, a third claimed to have reached it and half of them claimed to have reached the goal partially. Even such a partial attainment of the goal is for some patients a major achievement, as it implies an improvement of the psychopathological state. Laireiter (1997) wrote that the mere existence of a goal already has a very positive influence on the outcome of the therapy.

Investigation of the stability of any item always requires a retrospective approach (Hautzinger 1994). In the Bernese study this was done both 6 months and 1 year after termination of the various therapies. They found the achieved results stable after 1 year regardless of the therapeutic form chosen. In our study we could show that all our variables without exception were stable or improved further in 75% of all patients and this over a time period for up to 6 years, far longer than only a few months. Included in the 25% of the patients where this did not apply, are probably also those 5% of the patients who indicated a change for the worse since the termination of the therapy. Still, 3 out of 4 patients needed no further treatment. The results of Jungian long-term psychoanalysis (Keller et al 1997) are very similar: 70% of their patients indicated a further improvement 6 years after having their analyses ended. Here again we see that long-term therapies may provide much more stable results than short-term therapies.

We would like to see the data presented here as a step in the direction of quality control of bioenergetic therapies. Even if we take into consideration that one or the other patient did not remember all that well, and that his answers are not the absolute truth and even though due to the anonymity of the returned questionnaires we had regrettably to omit a more precise analysis of the result in relation to the diagnosis, it can no longer be assumed that BAT is not a serious form of psychotherapy. It takes an equal place among psychoanalysis, Gestalt, and cognitive therapy. The positive results and the long lasting effect speak for themselves. It does not mean, however, that BAT can now take a rest – on the contrary it is hoped that research will be stimulated and that many extended studies, especially those investigating the process, will follow.

The original data were published in an article entitled "Zur Wirksamkeit bioenergetischer Psychotherapien und Stabilität des Therapieresultats: eine retrospektive Untersuchung" by Christa D.Ventling and Urs Gerhard in Psychotherapeut 45: 230-236, 2000. Urs Gerhard was responsible for the questionnaire and Barbara Annen for the statistical analysis. I thank both of them for their commitment. The study was financially supported by the Swiss Association of Body-Psychotherapy (CH-EABP).

Appendix 1

Results of Bioenergetic Therapy (BAT)

Sex: female male Start of BAT:
 Age (years) now: End of BAT:

The following questions refer to the time period immediately **before the therapy**.

Before therapy

My general feeling was : poor satisfactory good
 My ability to make contact was: poor satisfactory good
 My ability to work was: poor satisfactory good
 My self-esteem was: poor satisfactory good
 My self-acceptance was: poor satisfactory good
 My assertiveness was: poor satisfactory good

I had relationship problems with my partner
 children
 parents
 colleagues
 friends
 superiors

I suffered physically due to pains/problems of digestive tract
 circulatory system
 headaches, neck tension
 lower back
 sleep disorders
 others

I needed medication to relieve the pains

The following questions refer to the time period **at the termination of the therapy**.

At termination of the therapy

My general feeling was: poor satisfactory good
 My ability to make contact was: poor satisfactory good

- My ability to work: poor satisfactory good
- My self-esteem was: poor satisfactory good
- My self-acceptance was: poor satisfactory good
- My assertiveness was: poor satisfactory good
- I had relationship problems with my
- partner
 - children
 - parents
 - colleagues
 - friends
 - superiors

- I suffered physically due to pains/problems of
- digestive tract
 - circulatory system
 - headaches, neck tension
 - lower back
 - sleep disorders
 - others

I needed medication to relieve the pains

The following questions refer to the time period **between end of therapy and time of questioning**.
(If you experienced neither aggravation nor improvement, you need not mark anything)

Since ending the therapy and today

- My general feeling has improved changed for the worse
- My ability to make contact has improved changed for the worse
- My ability to work has improved changed for the worse
- My self-esteem has improved changed for the worse
- My self-acceptance has improved changed for the worse
- My assertiveness has improved changed for the worse

My relationships problems with

- partner improved changed for the worse
- children improved changed for the worse
- parents improved changed for the worse
- colleagues improved changed for the worse
- friends improved changed for the worse
- superiors improved changed for the worse

My physical pains in the area of

- digestive tract improved changed for the worse
- circulation improved changed for the worse
- headaches, neck tension improved changed for the worse
- lower back improved changed for the worse
- sleep disorders improved changed for the worse
- others improved changed for the worse

My need to take medication has decreased increased

The following questions refer to changes in the quality of life **during the therapy**.

During the time of therapy

My personal hygiene	improved	<input type="checkbox"/>	changed for the worse	<input type="checkbox"/>
My creativity has	improved	<input type="checkbox"/>	changed for the worse	<input type="checkbox"/>
My eating habits	improved	<input type="checkbox"/>	changed for the worse	<input type="checkbox"/>
My sexuality	improved	<input type="checkbox"/>	changed for the worse	<input type="checkbox"/>
My vitality has	improved	<input type="checkbox"/>	changed for the worse	<input type="checkbox"/>
My circle of friends	improved	<input type="checkbox"/>	changed for the worse	<input type="checkbox"/>
My physical activity	increased	<input type="checkbox"/>	decreased	<input type="checkbox"/>
My hobbies or time devoted to	increased	<input type="checkbox"/>	decreased	<input type="checkbox"/>

Did you have a therapeutic goal at the beginning of the therapy ?

yes no

Did you reach this goal ? yes in part no

Did your therapist do body work ? yes no

(If your answer is NO, skip the next 4 questions)

Would you have liked more body work? yes no

Did you gain a new body consciousness through body work ?

yes in part no

Did you gain new insights through body work ?

yes in part no

Are changes in your quality of life mainly due to body work ?

yes in part no

Did you enter a new therapy since terminating the BAT ? yes no

If yes, what type of therapy did you chose ?

Would you recommend your therapist ? yes no

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Biography

Ventling, Christa D. (1930), received a M.Sc. at the University of Lausanne (Switzerland), followed by a DPhil at the University of Oxford. She has held research and teaching positions at Iowa City, Johns Hopkins, and Maryland University. She has published over 50 articles. She studied psychology at the University of Basel, Switzerland, graduating with a Masters and honors. She was certified in 1995 as a bioenergetic therapist. She is an active member of the Swiss Society of Bioenergetic Analysis and Therapy (SGBAT) where she heads the section of science and research. She is the winner of the First Prize for Outstanding Research in Body Psychotherapy, awarded at the USABP Conference in Baltimore, MD, June 2002. She is the editor of "*Childhood Psychotherapy: A Bioenergetic Approach*" and of "*Body Psychotherapy in Progressive and Chronic Disorders*" (both published at Karger, Basel, 2001 and 2002). She has two grown children and three grand-children and works in a private practice in Basel, Switzerland.

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Dance/Movement Therapy in a Psychiatric Rehabilitative Day Treatment Setting

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Abstract

The theoretical basis and practical applications of dance/movement therapy within a psychiatric rehabilitative day treatment are explored. The unfolding of psychotherapeutic process through the embodiment of one's own subjective experience is consistent with the philosophy of a psychiatric rehabilitative day treatment modality, which allows room for integration of different experiential levels.

Concepts of body level integration, facilitation, maintenance, or improvement in interpersonal functioning, provision of a safe, contained forum to address emotional issues by using group movement, imagery, symbol, and metaphor are pivotal to the psychotherapeutic interventions created in dance/movement therapy groups. A case presentation illustrates how dance/movement therapy carries forward a process of physical, emotional and psychological integration.

Keywords

Dance/movement therapy in a psychiatric rehab – Dance movement – Intervention – Psychotherapeutic

The Creative Arts therapies in Psychiatry

Creative arts therapy programs, including art, dance and movement, music and drama therapy, were an integral part of the overall programming in several day treatment centers in this country until the advent of managed care. In these progressive settings, a philosophical belief that creative development of the individual is necessary to ensure the highest possible psychological and functional levels was respected. As Fink (1988) states,

Using the media in which they have been trained, art, music, dance, poetry, and drama therapists all play a significant role in the overall armamentarium of psychiatric institutions and agencies in the care of the mentally ill. Their specific roles in assessment are valuable. As contributors to the assessment of the patient, they play a prominent part in helping to shape the diagnostic work. Their knowledge of symbols and their use of the clues derived from unguarded patient interaction are often essential in the diagnosis and treatment planning effort. . . . every patient deserves a full biopsychosocial assessment. It is important for patients to be viewed from every dimension (pp. 175-176).

Badaines and Ginzberg (1979) also stress the role of creative arts therapies as pivotal to an holistic approach to the person, much needed in the psychiatric arena.

Zwerling (1989) indicates that:

. . . the nonverbal media employed by the creative arts therapists more directly tap emotional rather than cognitive processes in patients . . . [and that] the creative arts therapies evoke responses, precisely at the level at which psychotherapists seek to engage the patients, more directly and more immediately than do any of the more traditional verbal therapies (p. 23).

Goodwoman (1993) states that,

The arts and creative expression help to build interpersonal and communication skills, increase

avenues for [raising] self esteem and providing opportunities for problem solving and decision making. . . . Most importantly, the arts program offers opportunities for empowering the patient by enhancing and building strengths [i.e. creative thought, insight, self motivation, decision making, interactional skills] which are essential to recovery and re-entry into the community (p. 43).

Furthermore “the arts offer the opportunity to use symbolism to express difficult issues in the life of one person and the life of society” (Stanton-Jones, 1992, p. 95). It is unfortunate that current managed care practices have stripped away many opportunities to address the whole person for those in need of mental health services. The use of creative arts therapies has often been eliminated because they were deemed superfluous, expensive and/or un-reimbursable. It has often been decided, without any input from accurate longitudinal studies, that it is more “cost-effective” to prescribe medications and “case manage” patients using psychopharmacology, behavior modification techniques (Donald, 2001; Kessler, 1998; Robinson, 2002; Schreter, 1995) and evidence-based therapy (Mace, Moorey, & Roberts, 2001) than to devise a comprehensive treatment plan addressing the different and varied needs of an individual in need of psychiatric services.

Dance/movement therapy in psychiatry

As defined by the American Dance Therapy Association (1974), dance/movement therapy is “the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual.” Since its first appearances in the U.S. mental health system (during the 1940s), dance/movement therapy has continually refined its theoretical foundations through contributions by many fine clinicians; their work solidly connected the pioneers’ intuitive assumptions with the larger body of psychological theory and practice. All movement therapists share a belief that “body movement is the most primary means of communication” (Bernstein, 1982, p. 5), and employ a variety of bodily techniques, aimed at fostering self awareness and connecting inner psychic processes with feelings and experiences in the outer world. Individual styles reflect each practitioner's preference for one or more of the major psychological frames of reference, providing a variety of different approaches, such as Adlerian, Jungian, Gestalt, systemic, psychoanalytic, experiential, transpersonal, and so forth (Bernstein, 1979, 1984; Levy, 1988).

Dance/movement therapy’s early pioneers, such as Marian Chace and Trudi Schoop, worked in psychiatric institutions: St. Elizabeth Hospital (Washington, D.C.), Chestnut Lodge (Washington, D.C.), and Camarillo Hospital (California), thus laying the foundations for the current body of theory and knowledge (Bernstein, 1979, 1984; Levy, 1988). More recent literature explores the role of dance/movement therapy in psychiatry and specifically in day treatment settings (Govine, 1971; Payne, 1992; Stanton-Jones, 1992).

Because dance/movement therapy uses both verbal and nonverbal modalities, it is deemed “especially effective in engaging patients whose capacity to participate in strictly verbal group therapy is limited” (Sandel and Johnson, 1983, p. 134). For psychiatrically disordered individuals, dance/movement therapy may offer ways to develop healthier defenses against anxiety and emotional pain by exploring their own movement coping strategies, by relating to others on a nonverbal level within the group’s movement, by uncovering feelings through symbols and imagery in a safe environment. Creativity, movement expression, group interactions, connecting nonverbal material to personal meaning through the use of words, and containment and metabolization of group processes by the therapist are all important factors in the unfoldment of a dance/movement therapy session (Bernstein, 1979, 1984; Chaiklin, 1975; Dosamantes-Alperson, 1979, 1981; Govine, 1971; Pallaro, 1993, 1996; Payne, 1992; Romero, Hurwitz, and Carranza, 1983; Sandel, 1982; Sandel and Johnson,

1983; Schmais, 1981; Silberstein, 1987; Stanton-Jones, 1992; Stark, 1989).

Stanton-Jones (1992, p. 10) summarizes five theoretical principles underlying the foundations of dance/movement therapy in psychiatry as follows,

- the mind and the body are in constant complex reciprocal interaction;
- movement reflects aspects of the personality, including psychological developmental processes, psychopathology, expressions of subjectivity and interpersonal patterns of relating;
- the therapeutic relationship established between the patient and the dance/movement therapist is central to the effectiveness of dance/movement therapy;
- movement evidences unconscious processes, in a manner similar to dreams and other psychological phenomena;
- the creative process embodied in the use of free association in movement is inherently therapeutic.

She also indicates (p. 92) the fundamental goals that dance/movement therapy promotes in a day treatment setting as:

- body level integration;
- facilitation or maintenance or improvement in interpersonal functioning;
- provision of a safe, contained forum to address emotional issues by using group movement, imagery, symbol, and metaphor.

Effective use of dance/movement therapy in a day treatment program

A prominent psychiatric rehabilitative day treatment center for adults in San Francisco offered services to approximately eighty patients, provided by a multidisciplinary staff of clinical psychologists, psychiatrists, counselors, family therapists, social workers, nurses, psychiatric technicians, substance abuse counselors, vocational, activity, art, dance, music, and drama therapists. It also featured a training program for interns from varied mental health disciplines. This program was pivotal to the global delivery system of community mental health services provided by the City and County of San Francisco, until its restructuring-within new managed care parameters- in 1995.

Patients were referred to this day treatment program by various sources within the county such as hospitals, acute diversion units, crisis clinics, transitional residential treatment facilities, supportive housing systems, board and care homes, outpatient clinics, as well as private practitioners and agencies. The sexual orientations, ethnic and racial origins of its clientele were diverse, reflecting the cultural diversity of San Francisco's population as a whole. Patients suffered from a wide range of psychiatric disorders, such as schizophrenia, affective disorders, and personality disorders. Quite a few also presented with polysubstance abuse problems.

The agency stressed a "therapeutic community" model, with staff working with clients in a "living-learning" context, providing a secure, supportive environment and numerous arenas for participation, team building, responsibility taking, self-examination and change. Badaines and Ginzberg (1979) describe a therapeutic community as "a structured environment conducive to learning new, more adaptable behaviours, achieving greater self-understanding and awareness and increasing self-responsibility" (p. 74).

The day treatment program offered individual and group psychodynamic psychotherapy, behavioral-cognitive therapy, family therapy when possible, psychopharmacological treatment, mental

illness education, crisis intervention, art, dance/movement, music, drama and activities therapies, substance abuse recovery, academic, pre-vocational and vocational training, independent living, communication and social skills development. This unique program aimed at the integration of several aspects of each individual's life and prepared the client for re-entry into the community at large. Patients were responsible for the development and implementation of their own treatment goals, aided by their primary therapists and their treatment teams. They participated daily in several groups (from the categories listed above) which were selected based on: (1) the goals that they themselves wanted to achieve and (2) the stage of their treatment (initial phase, active-treatment phase, and termination phase). Patients were followed by a primary therapist who acted as advocate for them and maintained contacts with other care providers (within and outside the county system) and the patients' families. The primary therapist was part of a larger treatment team which, in weekly meetings, discussed and reviewed patients' progress, appropriate treatment modalities and plans, as well as the emergence of individual and team transference and countertransference issues.

This program offered three weekly dance/movement therapy groups for patients whose individual treatment plans included movement explorations of their particular treatment issues. The size of these groups varied according to the overall census and the patients' treatment needs, never exceeding a maximum of twelve participants. Patients could enter these groups at any time but they needed to commit themselves to work within this therapeutic form for an extended period: drop-ins were not encouraged. Two weeks' notice was required for termination purposes. A registered dance/movement therapist led the group, often aided by a dance/movement therapist in training, and reported patients' progress or difficulty to the client's primary counselor. The room was a spacious one, in the basement of the facility.

Structure, goals and interventions in dance/movement therapy with psychiatric patients

The basic structure of a dance/movement therapy session in a day treatment setting, as facilitated by these two authors, involves an interactional approach to dance/movement therapy, including utilization of rhythmic body movement, development of group images, and attention to both socialization and cooperative play. Different stages of group process and cohesiveness are noted as each session unfolds, and differing interventions are warranted (Pallaro, 1993; 1996).

Depending on the energy level of the group, patients may start out sitting or standing in a circle. A dance/movement therapy group typically begins with a warm-up, to help the participants get in touch with their bodies. Each participant's mood and affective state—as well as the atmosphere of the whole group—may be sensed through this initial contact. When music is used, the therapist tries to match its rhythmic components to the energy level of the group. If the group stabilizes through rhythmic action and allows cohesiveness to emerge, more expressive themes and specific feelings are explored. There is always an improvised movement closure and an opportunity for verbal exchange at the end of the session.

In working with psychiatrically ill patients, the first fundamental goal is to encourage body level reintegration by increasing body-self awareness (Pallaro, 1993, 1996). Using the so called “Chace approach” (Bernstein, 1979; Sandel, Chaiklin and Lohn, 1993), the dance/movement therapist utilizes movement reflections to establish a therapeutic relationship, offering each client an opportunity to integrate his/her split off parts, and reintroduce a sense of physical reality. Establishing such a nonverbal bond allows basic trust to develop, upon which further movement explorations may be built.

Movement warm-ups and non-directive improvised movements typically promote vitalization, integration, activation, and motivation in the client (Schmais, 1985). Working with the psychiatric population, Chaiklin (1975) defines her basic goals as:

- aiding body integration and awareness;
- fostering a realistic sense of body image;

- increasing movement vocabulary and affect;
- strengthening impulse control.

Frequently, dance/movement therapy groups in a day treatment center consist of patients who are still in the process of stabilizing after an initial recompensation while hospitalized. The dance/movement therapist gauges and moderates both pace and content for the group's work so that even the lowest-functioning member may participate. Thus, one immediate goal may be to help patients to overcome their fears about being in a group as opposed to focusing on self-exploratory or interpersonal themes (Yalom, 1970).

The development of a realistic body image is a concept frequently mentioned in the context of body level reintegration. Body image formation is linked to the process of early psychological development which, in turn, correlates with a series of movement tasks progressively unfolding during each developmental phase (Bernstein, 1979; Mahler, Pine and Bergman, 1975; Stern, 1985). While body image formation is in part "dependent upon the visual and tactile exploration of the surface of one's body as well as the sensations derived from inner organs, skeleto-muscular systems and the skin" (Siegel, 1979, p. 93), it is also influenced by both verbal and non-verbal as well as bodily responses from others throughout one's own life (Banchemo, 1988; Bernstein, 1979; Chaiklin, 1975; Espenak, 1981; Geller, 1974; Pallaro, 1993, 1996).

According to Siegel (1979, 1984) and Naess (1982), outer aspects of body image include the awareness of body boundaries (as to where one begins and ends), and the sensibility of body space (as an inner felt knowledge which allows one to be spatially comfortable in relation to other persons and things). Body image, awareness of body boundaries, sensibility of body space, all partake in the formation of the body-self. To achieve a realistic sense of body-self, movement interventions need to address both the inner aspects of body image formation and its outer aspects, leading to the interpersonal dimension within a group context.

Involving both conscious and unconscious components, body image as a felt-sense of self is defined by "positive investment in, awareness of, and control of the body" (Rice, Hardenbergh and Hornyak, 1989, p. 253). Thus,

In the psychotherapeutic process, in order to strengthen, modify, or integrate the representations and the experiences of one's own inner self, it is absolutely necessary to start from the body and its experiences (Pallaro, 1993, p. 289).

Specific movement interventions aimed at fostering awareness of one's own sense of self, via explorations of the body-self, include sequential warm-ups, patting one's own body, defining its outer limits, centering, grounding, molding, reflecting, and mirroring.

The second major objective in dance/movement therapy groups with a psychiatric population involves maintaining or increasing patients' level of interpersonal functioning (Geller, 1974; Stanton-Jones, 1992). Personal effectiveness and autonomy is fostered by encouraging each individual to initiate a movement, which is subsequently imitated by all other participants. This technique also explicitly allows for expression of nonverbal empathy among the group's members. By encouraging all patients to take turns at creating new movements and mirroring one another, socialization is learned:

The object of a therapeutic process directed at fostering one's sense of self in relation to others will be awareness of feelings and states of mind associated with interactional movements. Movement experiences such as mirroring, leading, and following will provide the frame for the body-self to experience reflection, empathy, and engagement in relation to others (Pallaro, 1993, p. 289).

Group cohesiveness is enhanced through rhythmic movement experiences (Geller, 1974; Pallaro, 1993, 1996; Schmais, 1985; Stanton-Jones, 1992). The use of props such as balls, balloons, ropes, scarves, and so on, can further promote and deepen group members' interactions. When focusing on socialization, the dance/movement therapist utilizes verbalization primarily "as a stimulus for body action, differentiation of self, recognition and expression of feelings" (Stark and Lohn, 1989).

The third fundamental goal involves patients' release and externalization of their emotional processes within a safe "container" (Geller, 1974; Stanton-Jones, 1992). Simple dance steps or movements involving body action prepare the group members for increased emotional expression (Chaiklin and Schmais, 1979) and for kinesthetic imagery to unfold (Dosamantes Alperson, 1983). As soon as the group has developed sufficient cohesiveness, more expressive themes evolve. A clear group structure allows for controlled cathartic release of feelings such as joy, sorrow, rage, helplessness, and frustration. Movement statements, kinesthetic and kinetic exploration of symbolic images, embodiment of metaphoric themes and life stories are frequently accompanied by verbal acknowledgments and interpretations which clarify patients' experiences and may elicit insight. According to Chaiklin and Schmais (1979, p. 25), verbalization in dance/movement therapy, "serves to invite insight, identify affect, and further interactions."

Ultimately, verbalization allows the unconscious material, manifested either in the nonverbal behavior of the group or in each individual's body movements, to become conscious. Thus, verbalization can enhance the integrating effect of dance/movement therapy (Dosamantes-Alperson, 1984; Pallaro, 1993, 1996; Sandel, 1978; Siegel, 1984; Stark and Lohn, 1989).

To further illustrate the benefits of dance/movement therapy in a day treatment setting, a case study follows.

Case illustration

Jeremy was a tall, slender, and well-groomed thirty-four year old single Caucasian male who was referred from an inpatient acute psychiatric unit to the day treatment program. Stressors preceding Jeremy's current hospitalization were the death of a friend who had overdosed on heroin, his living situation, his loneliness and lack of intimate relationships, and a change of therapist. He increasingly became psychotically paranoid, feeling "physically attacked by negative energy and bad karma." He began to think that he could pick up other people's feelings and thoughts, and felt as if people were laughing about him. Out of despair at not having an intimate relationship with a woman, he became suicidal and was then hospitalized. He was diagnosed with schizoaffective disorder, major depression, alcohol and drug abuse. He was psychopharmacologically treated with a neuroleptic, an antidepressant, and a sedative.

Jeremy's psychiatric history goes back to his teenage years. He was born and grew up in the Carolinas with his younger sister. His father was a college professor, described by Jeremy as an alcoholic who was very threatening and verbally abusive toward him. Jeremy described his mother as distant and cold; he frequently stated that he felt abandoned by her, especially in situations when he needed her comfort and warmth. Jeremy did not recall ever having been hugged or held by his mother or father. He always spoke of his childhood in intellectualized and abstract terms, frequently describing it as "a traumatic time." As a teenager, he began to smoke marijuana and to ingest LSD, mescaline, and alcohol. Once he reached high school, he was already heavily into drugs, became a total loner, with no friends or activities he enjoyed, and started to display aggressive and violent behavior.

Jeremy was first hospitalized at age sixteen, for two years, and finished high school in the hospital. For the next eight years, Jeremy went in and out of drug rehabilitation programs. At age twenty-five, he moved to San Francisco, where he first connected with Alcoholics Anonymous and Adult Children of Alcoholics self-help groups. Unable to hold a job, he lived in hotels and apartments throughout the city as a disability assistance recipient, and was periodically treated in half-way houses,

day treatment programs, and outpatient psychotherapy without perceived improvement. Although Jeremy's social and psychological functioning gradually declined, he maintained his sobriety for the eight years prior to admission.

Course of treatment

According to his understanding, Jeremy was hospitalized this time because he had developed a tolerance toward his antidepressant medication. He experienced an ongoing angst about his lack of intimate relationships with women. This, he thought, was his main problem. He wished for nothing more than a close relationship and went through “mental pains” thinking about meeting someone. His personality expressed itself in many paradoxical ways: he had an affinity for obscure and morbid aspects of life; he wanted to be special, to stand out. He desperately wanted to be close to others and loved but had no clue as to how to make that happen.

Jeremy was, at the same time, a very friendly, intelligent, and shy man. He hardly ever asked for attention. In any group of people, he would usually become invisible, fading into the background. Jeremy also had a wild and playful side, but he seldom expressed it for fear of being inappropriate. In the day treatment program, he had agreed to work on these goals:

- decrease paranoid and obsessive thoughts,
- reduce isolation,
- improve the ability to form and maintain relationships.

While maintaining his individual psychotherapy and psychopharmaceutical treatment, he was first assigned to a few verbal psychotherapy groups, but it was soon clear that he had difficulty participating. He was very preoccupied with paranoid thoughts; he would either be quiet and absorbed in his own reveries or would expound on his and others' problems, intellectualizing his emotional process, distancing himself from his feelings and from other people around him. The treatment team then decided to move him into the dance/movement therapy groups to facilitate achieving his goals through creative media.

Once in the dance/movement therapy group, Jeremy adapted to the role of the “reasonable” group member. Rarely if ever late, he never resisted nor refused to participate, always seemed to work hard and to give his best. During the first two months of dance/movement therapy, Jeremy did not actively initiate movements on his own, but predominantly followed what was introduced by other patients or the group leader. He simply did not consider the possibility that impulses coming from him could, should or actually would impact the movement adventure. Hardly looking around himself and too shy to take in the presence of other patients, he introduced exercise-like movements, preoccupied with “doing them the right way.” He generally initiated movement at the periphery, hardly ever involving the core of his body, which was tense and rigid.

During this initial phase, Jeremy's treatment goals emphasized body-self awareness and body level reintegration, including exploration and expansion of his movement preferences and their opposites. The flow of his movements was bound, in part reflecting his tendency to repress and withhold his feelings from flowing freely. His tenuousness and difficulty in staying with his emotional process was reflected in the quickness of his movement effort. However, it was also this effort quality that carried Jeremy's “quick” mind, his creative and spontaneous side and, later on in treatment, his ability to become lively and excited in relation to ideas and people.

The movement dialogue between Jeremy and the dance/movement therapist first began with mirroring and amplification of his movement patterns, slowly moving from the periphery to the core of his body. Through encouraging a general body awareness, experiencing polarities within the continuum of all effort qualities, and learning to differentiate between inner and outer stimuli, Jeremy slowly gained and expanded his sense of body-self.

In the third month of dance/movement therapy, Jeremy became more trusting and subtle changes

began to take place. Taking turns in a Chacian circle, his face would brighten when he was to initiate a movement sequence. Excited and pleased as others followed his pathways and rhythms, he began to make contact with others and include interactional movements. As his rigidity decreased, he gradually let go of the exercise-like skits, began to expand his movement repertoire, challenging the group members with new and creative movement ideas, often wondering out loud, "Let's see if you all can do this!"

Still, structured movements - as in the warm-up part of the session - were important to him. He never tired of the "nerfball" game during which group members call out each other's names: he needed this structure in order to feel safe, only then was he able to ask for contact. He became very pleased when his movement suggestions were heard, especially when he was asked to lead the group and all group members followed his movement ideas. As his confidence grew, his spontaneity and authenticity increased.

The more Jeremy gained access to his body, to his own rhythms and movement impulses, the more he seemed able to express his wish to interact with others. Jeremy's playful and spontaneous side began to emerge. Slowly, he started to take more risks. Jeremy usually moved with lightness, allowing room for his gentle and sensitive ways and manners. Although he regarded himself positively for this, he also felt incapable of taking a firm stand, setting boundaries, or expressing angry feelings. His spatial effort was direct, his movements did not expand beyond a narrow kinesphere.

However, Jeremy had become a very active member of the group; he had established his place, allowing himself to interact and to be seen. At one point, the group theme focused on the expression of anger through noises, screams and shouts, with matching angry movements. The goal for each group member was to become the most obnoxious with the loudest voice. Jeremy outdid everybody in strength and length of his scream and appeared elated, observing that he did not know he had this side to him. As it was generally difficult for Jeremy to be assertive, it was through play that he discovered he could in fact assert himself. Props - such as the "nerfball," that he could squeeze and twist, balloons that he could hit gently or very hard, and stretch-bands that he could pull and push - enabled him to tap into his strong movement effort and helped him to literally "get his feet onto the ground."

While slowly increasing his movement vocabulary, both his range of affect and his ability to process feelings increased. In the seventh month of dance/movement therapy, Jeremy's rigidity softened even more as he allowed himself to close his eyes, rhythmically swaying his body and snapping his finger to the beat of a slow song. After that, he began to request the same song at the beginning of every session, every time closing his eyes and entering "a state of mellow, soft, bouncy, and fuzzy feeling." In his experience, these moments felt as if he was removed yet present and unafraid to be abandoned.

This last movement sequence preceded Jeremy's kinesthetic experience of wishing to be held in someone's arms. When encouraged to give form to this image, he folded his arms around his own shoulders, closed his eyes, and gently swayed to the music, with a blissful smile on his face. The theme of holding and comforting oneself was carried on by other patients, until this specific group session ended with a group hug initiated by Jeremy. It seemed important for Jeremy to give expression to the theme of longing for closeness, which was central in his life, and to face his fear of abandonment. Jeremy took this chance and embodied his longing for closeness while others mirrored him and shared this experience with him. Jeremy had finally allowed himself to embrace his feelings, to give them a kinesthetic presence, and to feel supported by others around him.

In his treatment, this moment marked a shift from his pattern of distancing himself from his feelings and from other people by being absorbed in obsessive and paranoid thoughts. During his last dance/movement therapy sessions, he increasingly adopted the role of group leader. He had successfully internalized the structured movement experiences which allowed him to both explore and express his feelings among and with his peers. Interpersonal relationships became possible through Jeremy's increased ability to reach out. The group, as a safe container, helped Jeremy to stay with his emotional process while holding and allowing his experience to deepen. He had learned to release and

externalize his feelings in appropriate ways.

In fostering body awareness and body integration, Jeremy began a dialogue with his inner experiences. As he kinesthetically explored and strengthened his body-self, he gained access to his inner self, which in turn allowed him to make room for a greater range of movement and affect. Acceptance and validation of his inner experiences allowed him to feel safe enough to reach out to others and share his embodied metaphors. Feeling supported in sharing kinesthetic images and life stories with the group members permitted Jeremy to change his lifelong pattern of isolation.

Eventually, after more than a year of treatment, Jeremy transitioned from the half-way house into a supported independent living situation. His ability to relate had notably improved, enabling him to enter an intimate relationship with a woman and to start a twenty-hour per week volunteer position as a clerk.

Conclusion

Dance/movement therapy within day treatment centers and partial hospitalization settings is especially recommended for psychiatrically ill individuals who lack sophisticated verbal abilities and who need to learn socialization and interactional skills. They may benefit from the dance/movement therapy work because it allows them to explore their capabilities, fears, and longings in a supportive, playful and safe environment. Patients who display a distorted body image have opportunities to explore the internal images they have created about themselves and to modify them based on interactions with other group members. Patients who present diffuse body boundaries engage in movement experiences which strengthen the sense of their bodies' outer limits and ultimately their body-self. Those who rely upon enactment for communication learn to control their impulsivity and those who have difficulty expressing their emotions or hide them beneath their intellectualization defenses find a safe way to creatively access their feelings and understand the meaning of their unconscious behaviors.

Understanding their own behaviors ultimately assures both a better quality of life and the ability to critically rely on their own resources, thereby avoiding unnecessary services and further costly hospitalizations. Managed care in the mental health field today most often fails to provide patients with such opportunities. Until the advent of managed care systems, partial hospitalization and day treatment programs were highly structured, comprehensive as well as coordinated within the delivery of psychiatric services, and multidisciplinary in the treatment and care plans in which patients and their families could participate. They had been proven therapeutically valid as well as economically viable (American Association for Partial Hospitalization, 1990; Campling & Haigh, 1999; Cutler, 1992; Greenberg, 1983; Hamill, 1981; Mosher and Burti, 1989; Neffinger, 1981; Parker and Knoll, 1990; Schreer, 1988; Weiss and Dubin, 1982). Patients' rehabilitation was emphasized in their education about mental illness, in their learning of social and communication skills, in their engagement in purposeful activities, and in development of their vocational skills. Inpatient hospitalization was avoided as much as possible but made available when necessary.

Although U.S. health-care costs have escalated dramatically and health-care reform is absolutely necessary at this point in time, Eist (1995) asserts that "managed care poses such great threats to patients that it has no place in psychiatry" (p. 1). According to Alleman (2001), Bachrach (1995), Eist (1995), Kirschner & Lachicotte (2001), Kuttner (1995), Pipal (1995), Stoil (1995), and Stone (2001), managed care is profoundly and adversely affecting the course of medical and psychiatric services and the quality of care provided. The critique of managed care as "limiting the duration of treatment, interfering with necessary hospitalizations, and placing market concerns above clinical judgment" (Bachrach, 1995, p. 1229) has yet to positively influence the current strategic cut-downs of programs and dilution of provided services.

Jeremy's successful course of treatment with the preferential approach of dance/movement

therapy shows the crucial importance of creative arts therapies within a psychiatric rehabilitative day treatment program. Outcome studies and longitudinal studies are needed to effectively document such successes and thereby offer alternatives to the drastic cuts in viable multidisciplinary mental health treatment programs under managed care systems.

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Biography

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Therapist's Body Awareness and Strength of the Therapeutic Alliance

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Abstract

This study examines a possible relationship between a therapist's body awareness and strength of the therapeutic alliance. The hypothesis is that there will be a positive correlation between a therapist's body awareness and the strength of the alliance. The Body Awareness Questionnaire (BAQ) and the Working Alliance Inventory (WAI) were the instruments used in this study. Other data were also collected, including time spent in physical activity and time spent in awareness practice. Data indicate a relationship between physical activity and strength of the therapeutic alliance, but not necessarily body awareness. Further examination of the relationship between body awareness and the strength of the alliance is discussed.

Keywords

Awareness – Body awareness – Strength – Therapeutic alliance – Therapist's body awareness and strength

Introduction

This study sets out to determine whether somatic awareness on the part of the therapist supports strength in the therapeutic alliance. It is a basic survey correlating body awareness and strength of the therapeutic relationship. The hypothesis to be tested: *There is a positive and significant correlation between body awareness on the part of the therapist and the strength of the therapeutic alliance.*

Research shows that, regardless of therapeutic modality or technique, the strength of the therapeutic alliance is the best predictor of therapeutic outcome (Marmar et al, 1989 and Gaston and Marmar, 1994). Positive alliances lead to the strongest outcomes. What makes for a positive alliance? Edward Bordin identified three elements that, regardless of what therapeutic modality is used, make an alliance. They are goals, tasks, and bond. *Goals* are the outcomes the client and psychotherapist want to work toward, *tasks* are the means to the goals, and *bond* is the relationship between client and psychotherapist. The elegance of Bordin's model is that the alliance functions independently of therapeutic technique. Bordin weighs the alliance more toward goals and task because he feels that working on these elements helps to build the client-psychotherapist bond; therefore, a focus on goals and task, rather than bond, strengthens the alliance (Bordin, 1994).

Other research weighs bond as more important. In Luborsky's object-relations model of the working alliance, bond is central to outcome (Luborsky 1994). His research shows that a strong alliance correlates highly with the quality of the interpersonal relationship formed by client and psychotherapist. Henry and Strupp (1994) organized their inquiry around the importance of what they termed the "person" of the psychotherapist in the client-psychotherapist relationship. The person of the psychotherapist includes disposition, like and dislikes, etc., in short, who the therapist is as a human being beyond his role as a therapist, beyond their training and expertise. Henry and Strupp also equate the alliance with the interaction between client and psychotherapist. Their previous research had suggested that the psychotherapist was effective if he or she could relate to the client in a warm, empathetic manner (Henry and Strupp, 1994). They concluded that the *therapeutic relationship, or alliance, is the interpersonal process in the patient-psychotherapist dyad.*

Henry and Strupp reached this conclusion after formalizing a brief dynamic psychotherapy (Henry et al, (1993 a, b) they called Time Limited Dynamic Psychotherapy (TLDP), which emphasizes the relational aspects of brief therapy. Psychotherapists focused on relational transactions and used predetermined interventions. The TLDP training did succeed in aligning the psychotherapist's behavior with the desired protocol. Unexpectedly, the more psychotherapists behaved in the prescribed way, the

more the interactions with the clients became hostile (Henry et al 1993a). The training, it turns out, was counter-therapeutic to strengthening the alliance. The authors concluded that some kind of fundamental training in moment-by-moment interpersonal process should be a foundation for any later training in psychotherapy (Henry and Strupp, 1994; Henry et al, 1993a,b).

In a recent survey of literature on the therapeutic alliance, Adam Horvath notes that most research emphasizes the client and not the psychotherapist (Horvath 1994), by centering on the client's response to treatment and to the psychotherapist. The client's sense of the alliance is usually measured by verbal cues that indicate the congruence of understanding between client and psychotherapist (Watson and Greenberg, 1994; Benjamin 1974). Rarely is it measured by body responses.

In light of these findings on the psychotherapist's role in therapeutic alliance, it seems crucial for a psychotherapist to be able to cultivate genuine human warmth with the client, an ability to track moment-to-moment fluctuations in process, and a presence and spontaneity that transcend formulaic interventions. Training in somatic psychology at Naropa University emphasizes awareness of body sensations and movements, both obvious and intrinsic, in both the psychotherapist and client (Aposhyan, 1999; Caldwell 1995,1996). How these skills are best developed may be determined by an understanding of how the body responses of the psychotherapist play a role in therapeutic interaction.

Method

Two instruments were mailed to practicing therapists along with a brief survey collecting biographical data. This survey included how many hours per week the therapist engages in physical activity, how many hours per week the therapist engages in an awareness practice (martial arts, yoga, meditation, etc.), and how many years the therapist has been practicing.

The definitions of time engaged in physical activity and time engaged in awareness practice were not strict. A menu of suggestions was given for each, though the respondents were allowed to include other activities that they felt constituted awareness practice and physical activity. For example, some respondents included raising their children and prayer in their definitions of physical activity and awareness practice respectively.

The *Working Alliance Inventory* (WAI) (Horvath and Greenberg, 1986) was the metric used for measuring the strength of the alliance. It is a 7 point, 36 item Likert scale instrument, which can administered to both client and therapist. For this study, only the therapist's portion of the instrument is used. Each respondent is asked to answer the questions of the WAI with a particular client in mind that they have selected for the purposes of the survey. The client is not involved in the survey, and identity is not divulged.

The *Body Awareness Questionnaire* (BAQ) (Shields, et al, 1989) was the metric used for measuring awareness of non-emotional body processes. The BAQ provides an easy way to administer a pen and paper instrument for body awareness. It is a 7 point, 18 item Likert scale instrument.

A Pearson product correlation determined the correlation between scores of the BAQ and total scores and sub-scale scores of the WAI. BAQ and WAI scores are also correlated with years of practice, time engaged in physical activity, and time engaged in awareness practice. A positive correlation between WAI and BAQ scores supports the hypothesis.

Sample

From a listing of 1400 psychotherapists advertising in a national yellow pages, 311 names were randomly selected. Surveys were mailed in October of 1999. A total of 314 surveys were mailed. Of these, 57 were returned. Of the 57 returned, 11 had incomplete data and were not used. This leaves a sample size of 46 from a survey of 314 from a potential pool 1400 psychotherapists.

Limits

This study is a pilot study of the correlation between therapeutic alliance and body awareness on the part of the therapist. There is no attempt to determine causality. This study does not address how

body awareness relates to the personhood of the therapist, only that there might be a relationship between body awareness and strength of the alliance. It does not investigate if or how congruence between body awareness, cognition and behavior is a factor. The study does not look at how awareness informs moment-to-moment interaction, or how awareness might be a component of training for therapists. It is, however, an attempt to investigate whether body awareness and by extension, the body in moment-to-moment interaction, might be an element in the research of the therapeutic alliance.

Survey Limits.

The instrument used in this study is limited in its scope. The study only examines the strength of the alliance from the point of the view of the therapist. This is the weakest view of the alliance, since the client's perception of the alliance is the strongest measure of therapeutic outcome.

Instrument limitation.

The BAQ is a limited instrument in regards to the kinds of awareness discussed in both the review of literature and the theoretical development of this study. It is a reliable instrument for the reporting of normal, non-emotional body processes and is awareness of a general kind (Shields, et al, 1989). The kinds of awareness discussed elsewhere in the literature may be too subtle to be captured by the BAQ. Changes in heart rate, distal pulse and blood pressure-the kinds of bodily responses measured in studies of physiological response under conditions of empathy-are the subtle physiological responses of moment-to-moment interaction (Levenson and Ruef 1992, 1997). Such fine measurements are not captured by the BAQ directly.

The WAI seems a good choice for measuring and differentiating elements of the alliance. It is a reliable measure of the alliance from the perspective of both the client and the therapist (Horvath and Greenberg, 1986). Both the WAI and BAQ, however, are self-reporting instruments and are subject to the limitations of any kind of self-report instrument. There is no objective standard for responding to the instruments.

There is another source of potential error in correlating these two instruments. Not only are the ratings of a client subjective, respondents chose which client they rate when completing the WAI. It is reasonable to assume that a respondent would choose a favorable client, or one with whom they have a stronger alliance. There is no way to factor against this bias because the study did not randomly select the client.

Results

A Pearson product coefficient analyzes the relationship between data elements collected. For sample size of $N = 46$, the correlation coefficient is significant at the 0.05 level when $r \geq 0.286$. A correlation coefficient is calculated for combinations of the BAQ, WAI and its sub-scales, hours of awareness practice per week (HrA), hours of physical activity per week (HrP) and years of practice (YrPr). The r values for the correlations are listed in Table 1 below. The bold type indicates significant positive correlation at the 0.05 level.

Table 1: Correlation coefficients between survey scores.

	BAQ	WAI	Goal Sub Scale	Task Sub Scale	Bond Sub Scale
BAQ		.205	.309	.206	-.060
Hr P	.322	.371	.354	.317	.295
Hr A	.353	.018	.066	.092	.103
YrP	-.264	-.177	-.161	-.081	-.210

Bold type indicates significance at the 0.05 level.

In this particular sample, there is significant correlation between BAQ scores and the goal sub-scale, hours of physical activity and hours of awareness practice. The hours of physical activity also correlates to all sub-scales of the WAI and the strongest correlation to the goal sub-scale. Put another way, those therapists with a stronger sense of the alliance spend more time in physical activity. Time spent in awareness practice has weak correlation with all of the WAI sub-scales.

The BAQ shows the strongest correlation with both hours of physical activity and hours of awareness practice. This makes sense since the BAQ is a measure of awareness of body function and changes. Other studies show an increase in BAQ score with an increase in physical activity (Skrinar, et al, 1992; Rani and Rao, 1994). In effect, these correlations merely corroborate that the BAQ is a valid instrument for body function awareness.

Discussion

In the strictest sense, the correlation between the BAQ score and the *total* WAI score is not statistically significant. The trend of the *r* values, however, is positive, which supports the hypothesis that strength of the therapeutic alliance correlates with body awareness. When looking at the sub-scales of the WAI and other data collected in the study, other observations not predicted by the hypothesis emerge. The data supports some relationship between physical activity and therapeutic relationship.

The theoretical considerations discussed in the Introduction suggest a strong and significant correlation on the bond sub-scale. This is not the case. Body awareness did significantly correlate with the goal sub-scale of the WAI, but, in fact, trended negatively with the bond sub-scale. This is a surprising finding, suggesting that bond weakens with body awareness.

Several possible explanations can be suggested. One is that, though physiological responses on the part of the therapist happen, one need not be aware of them in order to respond while in relationship. This means that the body supports the alliance, while awareness may detract from that support. This makes awareness not a necessary ingredient in the strength of the alliance.

This explanation suggests that congruence may be a more critical element. If a therapist's words are not in alignment with what is happening in their body, there will be a dissonance that is detectable by the client through their body. This study does not address congruence. A design incorporating physiological response matched by verbal exchange would address the role congruence plays in the therapeutic alliance.

It also may be that Bordin is correct in his assessment that goals and task are more important than bond. A possible interpretation of the negative correlation of the bond sub-scale and the BAQ supports this view.

The correlation between the goal sub-scale of the WAI and the BAQ was surprising and not predicted by the considerations given in the Introduction. The inference here is that those who are more aware of their bodies tend to be more attuned to the goals of therapy. Put another way, people who are more aware of their body functioning tend to be more goal-oriented in their therapeutic relationships. It is not clear how body awareness as measured by the BAQ relates to goal orientation as measured by the WAI. One hypothesis is that therapists who are more physically active are more goal-oriented in

general, which carries over to the therapeutic relationship.

Only hours of physical activity correlates with any or all of the WAI sub-scales. The data suggest there is something supportive in the therapeutic alliance by having the therapist engage in physical activity. Physical activity is not defined in the survey, though a menu of suggestions is given. Besides the activities on the menu, respondents also include in physical activity such things as rearing three boys. As -seen by the respondents, physical activity has a wide range of meaning. Because of the lack of definition, there is no identifiable element in physical activity which accounts for the significant correlation in this study.

This opens a new line of inquiry about the nature of physical activity and it's relationship to the therapeutic alliance. The question to be asked: *what is it about physical activity that correlates with strength of the alliance?* One possible hypothesis is that physical activity could provide a measure of rejuvenation and energy to the therapist, which carries over to the therapeutic relationship across all sub-scales of the alliance.

The data indicate that body awareness training may play some role in the strength of the therapeutic alliance. Future research must sharpen the question of how physical activity supports the therapeutic alliance. In order to understand how the body supports the alliance, finer tools are needed, and hypotheses, which test a theory directly, must be established. This means clear definitions of what counts as physical activity need to be established. Future research needs a more refined instrument for understanding the subtlety of moment to moment interaction, and this research should include the development of such an instrument.

Summary

We can conclude the following:

- More body awareness on the part of therapist tends to supports a stronger therapeutic alliance.
- Physical activity contributes to the therapeutic relationship in ways not accounted for in the theoretical considerations of this study.
- A more subtle measure of body awareness is needed in order to measure the kinds of bodily shifts that happen in moment-to-moment interaction.
- More specific hypotheses need to be formulated for both testing the subtle bodily communication that happens in moment-to-moment interaction and the role physical activity on the part of the therapist plays in supporting the therapeutic alliance.

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Biography

Douglas Radandt holds an MA in Philosophy from the University of Montana and an MA in Body Psychology from Naropa University. He has certificates of training in Hakomi Integrative Somatics, Body-Mind Systems and has trained in Matrix Leadership. Douglas has taught massage students in the skills of body awareness for five years. He currently has a psychotherapy private practice in Boulder, CO. He may be reached at Douglas Radandt, PO Box 2043, Nederland, CO, 80466, 303.588.7476 or d.radandt@worldnet.att.net. The author wishes to acknowledge the support of Christine Caldwell, Susan Aposhyan, Mary Ann Foster, Howard Aposhyan, and the many students he has learned from through the years.

Somatic Tracking and the Ethical Use of Touch

Jaffy Phillips

Abstract

The somatic practice known as *tracking* (close observation of the client's bodily expression as well as of the therapist's bodily experience) is presented as a tool to help therapists identify and assess subjective aspects of the client's experience and of the therapeutic relationship which need to be evaluated in an on-going manner when using touch. Clinical and ethical considerations involved in the use of touch are reviewed, and specific applications of somatic tracking in the assessment and use of touch are presented. This article is based on the author's master's thesis submitted in partial fulfillment of the requirements for the Master's degree in Body Psychotherapy at Naropa University, 2002.

Author's Note: This article follows the publication of an article by Kerstin White in the previous issue of this journal which addressed ethical and clinical implications of the use of touch in psychotherapy. These areas are therefore only briefly summarized in the following article. The reader is referred to this earlier article as well as to the references listed for more detailed information about these important aspects of the use of touch

Keywords

Body – Contact – Ethics – Hakomi – Somatic tracking and the ethical use of touch - Touch

Introduction

The use of touch has a long history in the field of body psychotherapy, and serves as a cornerstone for many of the forms of work that are practiced today. It is a powerful intervention with the potential to heal many of the difficulties for which people seek psychological help. However, as revealed by years of cultural, theoretical, and ethical controversy surrounding its use, the use of touch is relationally and ethically complex and requires skillful assessment and application. This complexity results from the fact that touch is a physical and relational experience that is generally imbued with layers of cultural and psychological meaning. The meanings evoked by touch are often unconscious or non-verbal, and they often manifest somatically and/or relationally before the client is able to articulate anything about them. Boundary issues, transference, and countertransference are the most common examples of this kind of response; unaddressed, these issues can wreak havoc in the therapeutic relationship and ultimately damage the client. The tracking skills presented here can help therapists identify and address these aspects of the client's subjective experience and the interpersonal complexities that can arise during the use of touch. These tools allow both therapist and client to monitor the impact of touch contact and to adjust the use of touch accordingly. With this information in hand, therapists are equipped to explore and address the client's experience of touch in ways that will be meaningful and empowering to the client while concurrently safeguarding the integrity of the therapeutic alliance.

OVERVIEW OF CLINICAL AND ETHICAL CONSIDERATIONS

(Summary drawn from Barstow, 1999; Caldwell, 1997; Durana, 1998; Geib, 1982; Horton, Clance, Sterk-Elifson and Emshoff, 1995; Hunter and Struve, 1998; Kertay and Reviere, 1993; Kurtz, 1990; Smith, Clance, and Imes, 1998.)

Clinical Importance of Subjective Assessment

- *Boundaries and intimacy.* Touching is an intimate act and one that carries the potential to invade the client's boundaries and/or to trigger strong transference reactions. It can also be a confusing and/or

overwhelming experience for a client with poor boundaries or a poorly developed sense of self.

- *Client individuality.* There are only very general guidelines about the kinds of client populations for whom touch is indicated or contraindicated. Within these categories, each client is individual, and each therapist/client dyad has its own unique characteristics in terms of the quality of the relationship as well as the transferences and countertransferences present.
- *Variability of meaning.* The same kind of touch will be experienced by different clients in different ways, depending on the circumstances, the client's personal history and cultural background, personal qualities of the therapist, and the quality and duration of the therapeutic relationship. It is important that the therapist avoid re-enacting negative aspects of the client's interpersonal or touch history and/or reinforcing any of the client's negative associations to touch.
- *Ethical protection of the client.* It is only ethical to use touch with a client when it is both clinically advisable and used in the context of informed consent. With many clients, asking permission to touch is not enough: the client may say "yes" when they mean "no," or there may be aspects of their prior experience that contraindicate the use of touch.
- *Self-protection.* The potential for misunderstanding of the use of touch in psychotherapy is high. Our cultural norms, in combination with Freud's legacy (the touch taboo in psychotherapy) support the interpretation of all touch as sexual and/or invasive. Given the complexity of the therapeutic relationship, the power differentials that exist, and the unknowns of the client's history, it is wise to proceed with caution.

General Assessment Factors

Client Factors

- History and issues, including touch history.
- Ego strength, level of functioning, diagnostic category.
- Relational dynamics (historical).
- Cultural norms.
- Boundary awareness and ability to say "no," in general and to the therapist.
- Does the client want to be touched?
- Quality of eye contact.
- Quality of verbal contact.
- Quality of reality contact.
- Congruence of verbal and somatic presentation.
- Would the use of touch be in accord with the current needs of the client?

Therapist Factors

- Degree of appropriate training.
- Ability to maintain clear therapeutic intent and boundaries.
- Familiarity with the use of touch through own experiences in therapy.
- Knowledge and awareness of own relationship to touching and being touched, including potential countertransference reactions.
- Attitude and feelings toward client.
- Degree of comfort with touch and physical closeness.
- Ability to manage client's potential sexual and/or emotional responses to the touch.
- Ability to access and make use of support including personal therapy, supervision, and peer support to process feelings and countertransferences related to the use of touch.
- Congruence of the use of touch with the therapist's beliefs, attitudes, and values in the context of the present relationship?

Therapeutic Relationship Factors

- Strength, length, and quality of the therapeutic alliance.
 - Has trust been established?
 - Are the boundaries of the relationship understood?
 - Is there sufficient openness in the relationship to process the client's responses to touch, which might include negative or ambivalent feelings towards the therapist?
- Is the proposed use of touch understood by the client, and has informed consent been obtained?
- Would the physical intimacy of the touch exceed the level of emotional intimacy present in the relationship?
- Does either therapist or client experience the suggestion of touch as a demand?
- Is the client in control of all aspects of the physical contact?

Ethical Concerns

- Potential for the misuse of power, through the power differential inherent in the therapeutic relationship and the power differentials present with differences in age, gender, and/or status.

The risk of exploiting or reinforcing power differentials can be minimized by: 1) careful assessment of client's ability to set boundaries; 2) setting up the use of touch in ways that are empowering to the client; and 3) openly acknowledging the power differentials in the relationship and discussing their potential with the client.

- Potential for touch contact to lead to or be interpreted as sexual contact.

The risk that touch will lead to sexual contact or will be misinterpreted can be minimized by: 1) the presence of a clear contract; 2) clarity about one's own intentions and motivations for touching a particular client; 3) clarity about one's own sexual boundaries; 4) finding other outlets for sexual and intimate contact; and 5) scrupulous use of supervision.

- Potential that touch will be used to gratify the needs of the therapist.

Touch can be used by therapists to gratify other (non-sexual) needs, including the need for intimacy and closeness, the need to be experienced as a nurturer by the client, and/or the need for physical contact. Therapists can minimize the risk of this type of exploitation by becoming familiar with their own needs through personal therapy and self-awareness practices, establishing outside sources for their gratification, and regular use of supervision.

- Signs of danger.

Signs that indicate that touch may be being used in ways that are potentially injurious to the client include: 1) differential use of touch with different gendered clients; 2) touch used in an unexamined way in response to a client's request; 3) touch that occurs in secret, or reluctance of the therapist to discuss his or her use of touch with colleagues or a supervisor, and 4) touch that occurs in the context of sexual attraction, on the part of either therapist or client.

Somatic Tracking Defined

The specific techniques and definitions presented here were developed by Ron Kurtz and others in the context of Hakomi Body-Centered Psychotherapy, and have been adapted and expanded by the author to address the assessment of the use of touch. (Barstow, Meredith, Del Prince, Grace and Fauchaux, 2001; Hakomi Somatics Institute, 1999; Kurtz, 1990; Ogden, Bowen, Minton and

Dickenson, 1998.)

Tracking

In Hakomi Therapy, tracking is defined as the close observation by the therapist of both spoken and non-verbal aspects of the client's experience. According to Kurtz (1990), tracking is "looking for signs of the other person's experience, like moist eyes, all kinds of facial expressions, tone of voice, gestures (small or large, but especially small), changes in posture, movements, even the style of a movement or a voice" (p. 83). Other things that can be tracked include: positioning, emotional expression, energy, skin tone, states of consciousness, and congruence or incongruence among these different avenues of expression. These signs can be subtle, and are often missed or ignored in ordinary interaction. According to Kurtz, skillful tracking requires mindfulness and receptivity on the part of the therapist: a state of mind that is "open and sensitive and not so much task-oriented" (p. 84). As the term is being used here, tracking is not limited to the client's experience: both therapists and clients are encouraged to track their own experience in a similar manner.

Applied to the client, tracking allows the therapist to gather information about things that are present but not being named, such as how the client feels about what he or she is talking about. It also provides immediate feedback about the client's response to interventions and allows the therapist to monitor the impact of the therapeutic process without having to distract the client with unnecessary questions. This information can be used in several ways: to help the therapist understand and make contact with the client's present experience, thus facilitating mindfulness, expanding the client's self-knowledge, and deepening the therapeutic relationship; to help the therapist form hypotheses about the client's history and core beliefs, thus facilitating the therapist's ability to demonstrate deeper understanding and strengthening the therapeutic relationship; and to help the therapist formulate therapeutic strategy and assess the potential impact of different interventions. Applied to the therapist (by the therapist), tracking increases the amount of information available to the therapist, and makes it more likely that countertransference responses will be noticed and skillfully interpreted.

Mindfulness

Mindfulness is an essential component of tracking both the client and oneself as therapist. Mindfulness is a state of consciousness similar to a meditative state. It involves turning one's attention inward and becoming a witness to the contents of consciousness. Aspects of experience that can be mindfully attended include the presence and quality of thoughts, emotions, associations, sensations and other aspects of bodily experience. As a state of mind, mindfulness is focused on present experience in a way that is "willfully passive" (Kurtz, 1990, p. 28), with the intention to simply observe rather than evaluate or change what is observed. The practice of mindfulness allows one to slow down and gather primary data about one's present experience before being swept up in habitual reactions, thoughts, judgments, and beliefs. Access to this primary experiential data creates the possibility of responding to the experience in a way that is chosen rather than habitual, and provides insight into our core beliefs and habitual responses to experience.

In Hakomi therapy, ideally both therapist and client spend a significant part of each session in a mindful state. The therapist's mindfulness looks different from the client's and serves the therapy in a different way. The therapist's mindfulness supports the therapy by allowing the therapist to notice aspects of his or her own experience, the client's presentation, and the interaction that might normally be overlooked and that may be valuable to the client. It also allows the therapist the opportunity to notice and contain any personal countertransference reactions. The client's mindfulness allows the client to learn about him or herself and to access hidden beliefs and other important aspects of his or her experience. The therapist can access mindfulness through practice and intention; the client's ability to become mindful depends on the state of the therapist and of the therapeutic relationship. When there is enough safety and trust in the relationship, the client can be encouraged to become mindful by slowing

down and turning his or her attention inward in order to notice aspects of his or her internal experience. This process is supported by the therapist's mindfulness and ability to speak quietly and simply from that state.

APPLICATIONS OF SOMATIC TRACKING TO THE ASSESSMENT OF TOUCH

Somatic tracking can be used to help therapists assess both the appropriateness and the impact of touch as an intervention. It can also provide data that can help both therapist and client deepen their understanding of the client's experience of touch, thus strengthening their ability to make conscious choices about its use in the therapy. Durana (1998) states that in addition to questioning the client about the use of touch, therapists can look for signs and cues to help them know if they have violated a physical or psychological boundary or are at risk of doing so through the use of touch. These cues include somatic cues, feeling cues, countertransference cues, and energetic cues (p. 276). All of these cues can be experienced through the body, and are included in the concept of somatic tracking presented here. The wealth of information available through somatic tracking provides a safety net for therapists using touch because it allows them to recognize and respond to negative or potentially transference aspects of the client's experience that the client may not be aware of or eager to talk about.

There are four primary ways that somatic tracking can be applied in the therapeutic setting: 1) the therapist observes the client's bodily presentation; 2) the therapist observes his or her own bodily experience in the presence of the client; 3) the therapist observes his or her own physical experience through the hands or other parts of the body that are in contact with the client during touch; and 4) touch is offered in an "experimental" fashion in which the client is encouraged to become mindful of his or her experience of the touch contact (Kurtz, 1990, p. 111). The following paragraphs present specific examples of the use of each of these categories of somatic tracking in the assessment of touch as an intervention.

Tracking the Client

Tracking the client's bodily presentation can be used to help assess the appropriateness of touch in two primary ways. First, it can be very helpful while taking the client's touch history. In this case, postural shifts, changes in breathing, and other aspects of the client's bodily presentation may indicate things like hidden discomfort with a topic, areas of dissociation, or incongruencies between the client's verbally and somatically expressed experience. The therapist can use these cues as signs to explore the topic verbally in more detail with the client, and/or the cues can be brought explicitly to the client's attention in order to help him or her become aware of deeper aspects of his or her experience. For example, the invitation to explore a slight restriction in the breath that occurs during the client's description of his or her experience of touch in a particular relationship may help the client to identify areas of discomfort or other aspects of that experience that may be new to them, and that may also be relevant to the exploration of touch in the therapeutic setting.

Second, tracking the client's body can provide a means of recognizing potential boundary violations or other reactions to the use or imminent use of touch. Physical withdrawal upon approach is an obvious sign that touch is unwelcome; however changes in the quality of eye contact, breath, and more subtle shifts in posture can also indicate aspects of unconscious experience that may need to be either explored verbally before proceeding with touch, or explicitly investigated as part of the experience of touch. Whether or not touch is actually used, tracking the client's body and naming what is observed creates the opportunity for the client to become aware of previously unconscious aspects of his or her experience in relation to touch, and for this material to be explored as part of the therapy and the decision to use touch.

Tracking Oneself (Therapist)

The therapist can use awareness of his or her own bodily experience to support the assessment of touch in several ways. Durana (1998) states that “somatic cues (in the therapist) provide information about responses in the client, how a specific touch intervention affects the client, and so on. Interpretation requires that the therapist be attuned to his or her own body” (p. 276).

Boundary awareness is an important area where this skill can be useful to therapists exploring the use of touch. According to Durana (1998), “boundaries have a palpable and usable reality that can be experienced by the therapist” in terms of the client’s energetic presence, or how much personal space the person occupies (p. 276). These boundaries shift in the context of a boundary violation. Therapists can use their felt sense of the client’s boundaries to track for the possibility of boundary violation through or during the use of touch, as well as to help bring the client’s awareness to somatic and other aspects of his or her boundaries.

Durana (1998) gives the specific example of sexually abused clients, who may contract energetically or “disembody partially” in response to a perceived boundary violation (p. 276). According to Durana, “these cues may be even more revealing than the words of the client, since the client may not even be aware of the changes taking place” in his or her boundary (p. 277). Exploring the therapist’s sense of a strong “no” or sense of other changes in the client’s boundary with a client who has verbally agreed to the use of touch provides the client with the opportunity to uncover ambivalence or other aspects of his or her relationship to touch and to boundary setting that might otherwise have been overlooked. Verbal processing of these discoveries can be used to help both therapist and client make more informed choices about the use of touch.

The ability to track one’s own bodily experience can also help therapists with the sometimes difficult task of recognizing and differentiating countertransference responses. The therapist’s bodily experience can provide clues about the client’s experience (a form of objective countertransference), and it can also inform the therapist about personal (subjective) countertransferences that might influence the therapist’s thinking about the use of touch. With experience and self-awareness, therapists can become familiar with their own countertransference responses- both subjective and objective. This information can be used to guide the therapist in his or her choices about the use of touch: strong personal countertransference responses (such as a strong desire to comfort the client) may contraindicate the use of touch; other countertransferences can help guide the therapist in their choice of interventions and topics to explore with the client. (Differentiating these responses may require the assistance of a qualified supervisor.)

Durana (1998) offers an example of using the therapist’s bodily experience to inform therapeutic strategy. He describes a somatic response that involves a slight tightening in his upper abdomen, and states: “having learned to recognize this personal sensation allows me to distinguish it from potential countertransference and to use it as a professional cue to engage the patient” (p. 276). Therapists can also use awareness of their own bodily experience to track for dissociative or other trauma-based or unconscious states in the client; the presence of these states can affect whether and how the therapist proceeds with the use of touch. For example, this author sometimes experiences a strong holding in her belly that she has learned to use as a cue to check for the presence of unnamed fear or overwhelm in the client. Depending on the client, touch might be contraindicated in this case because of the lack of boundary present, or it might be indicated as a way to help the client ground and feel safe.

Tracking the Experience of Touch Contact (Therapist)

This category of tracking refers to that which is experienced through the therapist’s hands or other parts of the body that are in contact with the client during touch. It is most useful to those who have training in specific touch techniques such as bodywork and energy work; however it is included here because there is such a vast amount of information that can be sensed through the hands, even without special training. This information includes aspects of the client’s presentation such as energy, temperature, the quality of the skin (e.g., closed or open), movement, vibration or trembling, muscular

and energetic holding, tension patterns, relaxation or yielding into the touch, stiffening or resisting the touch, qualities such as fullness or emptiness, and shifts in or incongruencies among any of these aspects during the course of the touch contact. Some practitioners also track emotional states in their clients through touch.

As with the two categories of tracking listed above, this information can guide the therapist in the assessment of the impact of the touch. It also provides the therapist with data that can help deepen the client's verbal exploration of the touch experience as well as provide both therapist and client with more information to support the ongoing assessment of the use of touch in the therapy. For example, bringing the client's attention to a trembling in the tissue as touch is initiated might help them to become aware of a part of themselves that does not want to be touched or that wants to be touched differently; it might also lead to memory and useful processing of a past experience or belief. Exploration of these discoveries might or might not lead to changes in the touch contract between therapist and client.

Encouraging the Client to Track His or Her Own Experience

The skill of tracking one's own bodily experience can also be taught to clients as a tool for self-awareness and as an aid in the therapeutic process. A client in a mindful state is in a position to notice things about his or her experience of touch contact or about his or her response to the suggestion of touch that might not be tracked by the therapist, and that might not enter into awareness under normal circumstances. When shared with the therapist, this information can be used (as above) to help assess the ongoing appropriateness of touch contact, and as a jumping off point in the exploration of touch-related issues. This approach has the added benefit of equalizing some of the power differential in the therapeutic relationship because it empowers the client to become aware of his or her own experience, rather than waiting for the therapist to name it for him or her.

One way to maximize the benefits of this type of exploration in the context of touch is to set up the use of touch as an experiment³, in which the client is directed to simply observe what happens inside in response to a particular touch or to the suggestion of touch. Experiments of this type are commonly used in Hakomi therapy (Kurtz, 1990). They are designed to help invite aspects of the client's experience or history into the foreground of awareness. While the experiment is being performed, both therapist and client remain mindful: the therapist tracking the external signs of the client's experience in response to the touch or suggestion while the client tracks his or her internal experience.

CONCLUSION

Touch represents one end of the continuum of relational proximity and distance that is fundamental to the field of psychotherapy. The healing opportunities that are available through touch and human closeness are vast- both for therapy clients and for the culture at large. It is a shame that our culture has embedded so much fear into such a simple, ubiquitous human act. Given this situation, the use of tracking skills helps therapists to stay in contact with both themselves and their clients, and provides a wealth of information to help navigate the personal and cultural complexities of the touch experience. With so much information available, it is arguably difficult to make the kinds of gross therapeutic and ethical errors that are sometimes associated with the use of touch. In addition, in the event that mistakes are made, they do not have to signal a therapeutic crisis or termination. Tracking

³ The term "experiment" can sound somewhat dehumanizing when applied to people: in this context, the term is used to refer to an attitude of openness, of having no investment in a particular outcome, similar to the attitude underlying the scientific method. The presence of this attitude welcomes the unpredictable and engages the curiosity of both client and therapist. This creates a space in which new information or aspects of the client's experience are welcome, and into which these aspects can emerge without shame or judgment.

empowers therapists to quickly identify and recover from mistakes in ways that honor the client's experience, support his or her therapeutic learning, and may even deepen his or her trust in the therapeutic relationship. Tracking also empowers therapists to effectively help clients work with and through their wounding around touch, rather than skirting the issue out of fear. It is this author's hope that the information presented here, used in conjunction with appropriate training and supervision, will be a useful tool for therapists making decisions about the use of touch in their practices.

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Exploring Healing with the Experience of Breath: My Story

Margot S. Biestman

Abstract

The author explores how healing through breath is a dynamic process, a search for balance and flexibility. Through personal examples, she describes how pain from trauma can be transformed by breath into a life-giving force—toward healing. By shifting from thinking, to the physical sensation of our breath movement, we discover a vast intelligence within our body. Whereas trauma is experienced as broken connections, breath connects us on many different levels.

Keywords

Exploring healing with the experience of breath – Healing with breath – Middendorf

This story begins with a trauma. I fell, while trying to climb onto an upper berth of a train, while it was moving around a curve in the Sierra Nevada Mountains. Being very agile at the age of 70, I grabbed onto the mattress above to hoist myself up. I later learned that it was the top mattress, which was loose. It had a slick under-surface, and I slid on it, 7 feet down to the floor of the train, landing on my coccyx. Like an airplane crash, the blow shot through my spine and compressed and fractured my thoracic vertebra, T-12, while on its way, delivering a severe sprain to my entire lumbar spine. *Excruciating pain, shocking!*

Traumas. We've all had them, in one way or another—whether by accident, war, even a perceived war with a parent, partner, friend. I'm interested in the choices I have in how I respond to any kind of trauma, which can become locked in my body. Within my physical body, I include my mind, psyche, and spirit. I do not experience them as separate.

I could choose to succumb to this traumatic circumstance, or become fortified from it. Though I wanted to be fortified, I must admit that part of me collapsed. My spine did not support me to stand or walk. My spirit felt broken. Part of me wanted to give up responsibility. I could not sense my Self. I can now, five months later, more fully understand my ambivalence about living and dying at the time of trauma.

Trauma is broken connections.¹

I began to ask anew, “When I am in so much pain, conflict, disorganization, how do I enter the world of my body to explore its intelligence, its wisdom? How do I tolerate so much unknown, when I’m scared, separated from my Self?” I tried to cling to what I knew already—familiar ways and patterns of being in the world. I needed a bridge to move from the familiar, to the unknown. Breath was my bridge that could link me between unconscious and conscious, known and unknown.

Quite early on, after my initial shock, I made a critical decision to shift from my thoughts and fears to simply sense my physical body and the natural movement of my breath under my hands, which I’d placed on the center of my torso. I recognize breath as the essence of life, so I brought full presence to its movement, and did nothing more than to sense and allow my breath to guide me, one breath cycle after another. Each cycle was different from the one preceding it—something new each time. I allowed breath movement to fluctuate from moment to moment, as it responds to whatever happens in my life. I could eventually sense my own breath rhythm develop. This led me to begin to trust that my breath that comes and goes on its own without disturbance or control, would support all the healing forces within. I knew my body held the trauma and it was through my body that I could heal. The key was within the God given gift of breath I received when I was born.

I sensed at a basic sensory level, that my innate resources would empower me to continue to grow, heal, and evolve, to become as fully human as possible. Somewhere, deep down within my core self—my

essential being—wanted to be Self-responsible—and live my life.

“We are living, breathing, pulsing, self-regulating, intelligent organisms, not merely complex chemistry sets. There is an innate resiliency of the human organism when it is supported and guided.” (Peter Levine)ⁱⁱ

I knew I could reach out to others I trusted immediately. It is through my physical sensation of body with breath moving through it that connects me to my soul and spirit, to my partners, and to the world beyond. My mind follows, but does not lead—that is, when I choose to be “breath aware”.

I’ve had a history of serious back pain, and had explored a variety of approaches toward healing before finding *The Experience of Breath*—a work developed by Professor Ilse Middendorf of Berlin, Germany over the past 65 years. I had taken workshops for several years before entering an intensive 3 and a half-year training program in this work with Juerg Roffler, Director of the U.S. Middendorf Breath Institute.ⁱⁱⁱ After setting up my practice for a few years and continuing as a post-graduate student in trainings, I became a member of the teaching and training staff. I had learned something about the nature of healing, but I was now being asked to learn so much more than I ever dreamed.

Perhaps my fall was no accident. It was a time to heal more deeply, from prior shocks to my system. I am, after all, not my story. I am my essence, when I am moved by the breath that moves me. It called me to listen to it, to follow it.

But I didn’t always do what my breath was asking for. When I didn’t listen or follow it, I found the way rocky, stormy sometimes. Trying to avoid or get rid of the pain only seemed to increase it. It wasn’t easy when pain and conflict were difficult to bear. There were times when it was easy to give my Self up. Fear and various ego states would take over.^{iv} Sometimes I could sense breath movement but “I” did not participate in the process. This collapse of Self, combined with my back injury, showed in my posture, and I became discouraged. I learned that even when—and especially when—my pain or conflict was especially challenging, I must be aware enough to not let the act of giving my Self up sneak up on me. Or if it does, then I must grab my Self back and tone myself up by taking the palms of my hands to physically tap the parts of my body that I can reach. This action helps me to sense my physical body and to become alive again with sensation, which stimulates me and my breath.

Often I wanted the process of healing to happen faster than was possible. In acknowledging this, I discovered that I could not move my structure or have it be moved ahead of my breath by anyone. Though wanting to heal fast is understandable as part of my human nature, it actually slowed my healing. When “I” returned to sensing the movement of breath, I sensed myself as whole, and accepted all of my humanness.

At one point, I explored meditating with breath for five minutes and then allowed myself to be moved by my breath into my daily life. I discovered that I needed to be alone and more with myself than out in the world with others, until my “doing” and “being” came more into balance. I realized I had a choice. Too much “doing” brought me to a point of collapse. “To be or not to be?” took on new meaning for me. The question became embodied. Basically my decision boiled down to really living my life or partially dying in it.

Healing took more *time* and *patience* than I had allowed. Yet patience, when I came to it, gave me the experience of not being discouraged. The rocky places did serve a purpose—to give me more humility and compassion for myself and others.

Along the way, I discovered more about what healing is for me. It’s about allowing and accepting what is, as it is—not knowing what will happen next. It’s about participating, being in the process of experiencing the movement of breath and its effect, rather than observing or imagining it, without expectations or pre-conceptions.^v It is about courage to go deeper to an even greater unknown—and sensing that is the place to be for healing and growth to take place. Breath is what leads me to the next step, which comes from recognizing and experiencing that breath actually moves me. The next step, however small, leads to the next and the next, until more substance of being is created.^{vi} If my breath is in its natural state I cannot push myself nor be pushed to do something. When I recognize something that is a truth for me and I understand it somatically, then I can heal. I become self-responsible.

Healing is the process of making sound or whole—restoring to integrity—an original or pure

state of being. It means to come into a balanced, flexible state between mind, spirit, and matter.^{vii viii}

I have had talented and wonderful accompaniment along my path from teachers, colleagues, students, friends, and family. “Humans support and empower each other in the process of transforming trauma”^{ix} to a life giving force. I sense this when I do not project onto others that they should “fix” me or feel sorry for me, and when colleagues, family members, and friends connect with me authentically, while maintaining a sense of their own Self as separate—not merging with me, not projecting nor transferring their experiences onto me.

For a long time I thought healing was to be pain-free—a view based on what I had interpreted from a Western medical model of illness—treating symptoms to alleviate pain.^x Although it is true that when my pain diminishes, I enjoy ease and a sense of well-being, but the absence of pain does not necessarily mean healing. Focusing or shining a light, on pain or conflict does not help me to heal. I have not imagined, nor used visualizations, though these are pleasant to think about and relaxing for a while, but for me, they engage more with my mind than my whole body.

The process of working with my breath helps to integrate my pain within the whole of me—so that I am not my pain. My pain is not my identity.^{xi} Pain is actually the result of postponing a decision for my Self to live my life.^{xii} Breath transforms the experience of pain into healing so that I am able to live my life.

I choose the path of breath, and follow it most of the time.^{xiii} It is simple and profound. I can experience its movement, and I can give over to its intelligence in knowing what my body needs. For example, if I feel anxious, I also sense that my diaphragm is tight, so if I allow myself to connect with my natural breath on its own, I can experience the rhythmic movement of my diaphragm and how it changes from moment to moment. Immediately, upon receiving my inhalation, I become aware of breath movement downwards. Simultaneously, I sense how my diaphragm—which is shaped like a half dome arching into the cavity of my chest—actually flattens, as it contracts down on my organs. Concurrently, my breath movement offers space within my chest and I sense ribs widening, shoulder blades opening like wings. My experience of breath movement illuminates my anatomy. On the transition to exhalation, I experience an opportunity for transformation, and on exhalation itself. I sense breath movement taking direction, making connections, and a flow develops, as the movement rises up along my spine, includes all my back and sides, and begins to spread out onto the horizon. I have a sense of breath clearing through me. Each exhale, each breath cycle shows me something different. While my exhale forms, my diaphragm moves back up, to its domed position, where it began, and my ribs and shoulders settle. I wait here, in the center of my torso, receiving the silence in the breath cycle, until the impulse for the next inhalation begins. My breath moves me in a way that I can sense an inner massage to my organs, my spine. I feel my tonus developing in just a few breath cycles. My anxiety has disappeared or become integrated within the whole of me, my posture is more flexible and upright, my stomach does not feel pinched, and I have an immediate sense of balance and well-being. At this point, if I go into my mind at all, I trust that this simple act of allowing my breath to be as it is—with my presence and sensation of breath moving my diaphragm—supports the healing of my entire being, including blood circulation, oxygen/carbon dioxide levels, lymph, immune, central nervous, and endocrine systems, joints, bones, etc.

Our culture has taught me about the connection between my mind and its intelligence, however, this is not enough for me. I come to understand that the connection between my breath and my body holds a far greater intelligence. Breath reflects every move in my life.

Having wondered for some time why my physical body is so slow to make changes, I come to realize that although our culture has provided ways to learn *about*, or *observe* my body through my mind or through sports or dance, it has not taught how I can *be in* my body—how I can live my life in it. Now I learn that with breath as my teacher, I can participate in experiencing my physical body and its matter, along with the non-physical aspects (psyche, soul, spirit, emotions, thoughts). It is through sensing my physical body with breath that I arrive to greet my soul and spirit. Emotions do not overwhelm me, as they find their home in my body. My thoughts are part of the whole, rather than rule my being. My world opens up to a vast body of knowledge that appears to have no end.

Healing is a constant search for balance. I experience healing as a dynamic process that continues—growing and evolving. I’m not sure that the process ever ends. Layers in my body, mind, and spirit are intricately linked together, each affecting the other.^{xiv} In healthy, balanced states, my physical body is in equilibrium with my emotional, mental and spiritual components. All aspects of my humanness are brought into connection when considering any of my parts.^{xv}

Different layers within myself are intertwined, woven together. Breath movement is the mediator, the integrating force. The depth to which breath can penetrate to unconscious states of being and bring them into consciousness depends on how willing I am to surrender to this powerful force, within my Self. I sense that I am never finished. Perhaps death is the ultimate healing.^{xvi} If so, then living means to me to connect with the Divine—through the breath that breathes me.^{xvii} Living life to the fullest is a preparation for another cycle—another unknown.

I was with my mother, sensing her last breath, when she died. Her life cycle had come to completion, just as the breath has a cycle of inhalation, exhalation, and silence before the next breath comes again on its own. The exhale dies within each cycle, into the silence. Each cycle is complete. Perhaps after death, there are more and more cycles in other forms. I still connect with my mother, on another plane—though we are in different worlds—and part of the whole, within the Divine, that holds us all.

Healing, for me, is connecting on many different levels.

Notes:

¹ Over the past 65 years Ilse Middendorf has developed a work called *The Experience of Breath*. She currently lives and works in Berlin, and maintains a full schedule—leading workshops and training practitioners throughout the world. In 1986, Advanced Seminars of Berkeley, California sponsored the introduction of Professor Middendorf’s work to the United States with her close associate, Juerg Roffler.

² Peter Levine, Ph.D. writes that in trauma, connection is broken with the body/self, as well as with family, friends, community, nature and spirit. “Healing trauma is about restoring these connections.” From “Nature’s Lessons in Healing Trauma,” Foundation for Human Enrichment, Lyons, CO ©2002 pg. 13.

³ Peter Levine, *ibid*, “Nature’s Lessons”, p. 3

⁴ Juerg Roffler became certified as a practitioner in the Berlin institute, and founded the first U.S. Middendorf Breath Institute in San Francisco, with a recent move to Berkeley, California.

⁵ Eckhart Tolle, writes, “To make the journey into the *Power of Now* we will need to leave our analytical mind and its false created self, the ego, behind,” *The Power of Now: A Guide to Spiritual Enlightenment*, New World Library, Novato, California, 1999, frontispiece. In *The Experience of Breath*, rather than leaving my mind and ego behind, I experience them within the whole of me, but they are no longer “take-over leaders.” When I surrender to the movement of breath, and say, “Yes,” to my higher Self, I connect with a Greater Power. As a result, I have a chance to live my life, to my own potential, and my mind and ego become servers of my Self.

⁶ Ilse Middendorf teaches that the discovery of the power of breath is through the *experience in the body*, not through feelings or mental observations, which place a veil on the actual sensing experience of breath with a person’s full presence.

⁷ “If we are able to be fully present and take each step in the Now; if we are able to feel the reality of such things as the ‘inner-body,’ ‘surrender,’ . . . we will be opening ourselves to the transforming experience. . .” Eckhart Tolle, *The Power of Now*, *ibid*.

⁸ American Heritage Dictionary, Houghton Mifflin, 2000 and Webster’s Revised Unabridged Dictionary, Micra, Inc. 1996, 1998.

⁹ William Collinge, M.H.P. Ph.D. writes in *Mind/Body Medicine: The Dance of Soma and Psyche*, excerpted from The American Holistic Health Association’s Complete Guide to Alternative Medicine, Warner Books, Inc., N.Y., “Breath. . . gives the body a greater supply of energy which it can use for healing. . . Since we take a thousand breaths every hour, each breath is an opportunity to contribute to a healing process.”

¹⁰ Peter Levine, Ph.D. *ibid*, p.2

¹¹ Although some research has been done on the effect of Eastern forms of breath practices on oxygen consumption, heart rate, state of mind, etc., there has been very little research in Western medicine on the effect of Western breath practices in the human body. However, there are some studies in the West on breath in relationship to the human body, such as the Framingham study, (refer to the National Institute of Health Database), which “focused on the long-term predictive power of vital capacity and forced exhalation volume as the primary markers for life span. . . 29 years later the same conclusions. . . lung function may predict long life or early death.” (Michael G. White, “Secrets of Optimal Breathing,” manual, www.breathing.com/articles/clinical-studies.htm, 2001 pp. 1-3). These kinds of research studies remained primarily within

the model of treating illness, which has led to techniques in which patients were taught to direct or force the breath. “This can cause people to be trained to do forced inhalations that may actually be harmful in the long run.” (White, *ibid*, p. 6). Although some of the studies mentioned above, did focus on breath in the human body (rather than most studies which used primates and rats, whose breath is different from humans, none of them focused on the effect of the *movement of the natural breath in the body*).

In more recent years, W. Eberhard Mehling, MD studied Middendorf Breathwork and is currently engaged in a new research study, Proprioceptive Training with Breath Therapy for Back Pain, at The Osher Center for Integrative Medicine, University of California San Francisco (UCSF). Juerg Roffler

and I will participate with Faith Hornbacher and Gryta Coates, members of the Middendorf Institute training and teaching staff as breath practitioners

¹² Jon Kabat-Zin writes about pain and identity in his chapters, “Working with Physical Pain: Your Pain is Not You,” p. 283, and “Working with Emotional Pain: Your Suffering is Not You. . . But there is much you can do to heal it.” p. 300, in *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*, Delacorte Press, 1989.

¹³ Conversation with Juerg Roffler, April 2002.

¹⁴ Andrew Weil, MD says in “Breathing: The Master Key to Self-Healing,” audio cassettes, Sounds True, Inc., 1999, “If I had to limit my advice on healthier living to just one tip, it would be simply to learn how to breathe correctly.” Professor Middendorf does not speak of a “correct” way to breathe, but rather for us “to allow the breath to come and go on its own.”

¹⁵ “Breathwork is about reconnecting, embracing, and integrating all aspects of ourselves. . . Such a process. . . can be tremendously healing,” Andrew Weil, MD, *Spontaneous Healing: How To Discover and Enhance your Body’s Ability to Heal Itself*, Alfred Knopf, 1995.

¹⁶ Dennis Lewis writes in *The Tao of Natural Breathing: For Health, Well-Being and Inner Growth*, Mountain Wind Publishing, San Francisco, October, 1996, about discovering the transformative power of natural (whole body) breathing. He draws on his study in the work of Gurdjieff, Advaita Vedanta, Tao, as well as the more experiential Western methods, which includes his work with Ilse Middendorf.

¹⁷ Stephen Levine writes in *A Year To Live*, Random House, 1998, and Sounds True cassettes, April 1998, “Most of us go to extra lengths to ignore, laugh off, or deny the fact that we are going to die, but preparing for death is one of the most rational and rewarding acts of a lifetime. . . gives us an opportunity to enter a new and vibrant relationship with life.”

¹⁸ I sense, with *The Experience of Breath*, the moment when I connect with my natural breath and its rhythm, when I am guided by a greater power, I come to somatically understand some of what Jean Gebser (1905-1973) wrote how this is “the vital breath of reality . . . as actuality on all levels of experience - which is revealed in the gigantic movements of the universe as much as in the emotions of the human heart and the ecstasies of the spirit. It is revealed in the cosmic dance of heavenly bodies as well as in the dance of protons and electrons, in the ‘harmony of spheres’ as well as in the ‘inner sound’ of living things, in the breathing of our body as well as in the movements of our mind and the rhythm of our life.” From *The Ever Present Origin*, authorized translation by Noel Barstad and Algis Mickunas, first published in German 1949-1953, later by Ohio University Press, Jan. 1985, reprint in paperback Feb. 1986. p. 4

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Biography

Margot Biestman is a certified practitioner of Middendorf Breathwork, *The Experience of Breath*, member of the teaching and training staff of the U.S. Middendorf Breath Institute, Berkeley, California, and founding member of The Breath Center of San Francisco, a non-profit organization for the advancement of Middendorf Breathwork. She also has a private practice in Sausalito and The Sea Ranch, California. She is an author and artist, and has had more than 35 years of experience in education with people from ages 3-93. Margot offers demonstrations, individual sessions, classes, retreats, and workshops in *The Experience of Breath*.

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How does material in this manuscript inform

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