

LISTENING TO THE BODY:  
PRAGMATIC CASE STUDIES OF BODY-CENTERED PSYCHOTHERAPY  
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## ABSTRACT

Body-centered Psychotherapy (BcP) is a growing clinical discipline and field of academic investigation. The present research employs the Pragmatic Case Study Method (“PCS Method”) to study systematically how verbal and somatic interventions are combined in three 12-session cases with the same, experienced therapist. In accordance with the PCS Method, the cases begin with a presentation of the therapist’s theoretical approach, or “guiding conception,” and a description of how it applied to each client. Case process data included qualitative analysis of sessions 1, 6, and 12, using three inductively-derived themes to facilitate cross-case analysis: how the therapy (i) helped clients feel “nourished” by their internal resources; (ii) employed the use of touch along with talk, and (iii) balanced a focus on bodily experience with the narrative of a client’s life story. The outcome data were based on videotapes and transcripts of selected therapy sessions; pre- and post-therapy scores on standardized, quantitative measures; a pre- and post-treatment goal-setting interview; and a semi-structured, post-therapy, outcome interview. The outcome results revealed substantial progress in all three clients, including statistically significant quantitative changes in standardized measures in two of them. Distinctly different patterns of progress occurred, as the therapist tailored therapy to the needs of each client.

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## TABLE OF CONTENTS

LIST OF TABLES.....	ix
LIST OF FIGURES .....	x
PREAMBLE: THE LIMITATIONS OF LANGUAGE .....	1
INTRODUCTION BY THE AUTHOR .....	2
I. INTRODUCTION AND REVIEW OF LITERATURE .....	5
Defining Body-centered Psychotherapy .....	6
Rationale for Body-centered Psychotherapy .....	9
Brief Review of Touch in Psychotherapy Literature .....	11
Two Chairs and a Table .....	12
What is Distinctive About BcP: A Clinical Overview.....	14
Neuroscience and BcP .....	18
Studies on Body-centered Psychotherapy.....	21
A Type of Psychotherapy Integration.....	28
Rationale for the study .....	30
II. METHOD .....	31
Overview.....	31
Conceptual Design.....	31
Research Design.....	35
Body-centered Psychotherapy Practitioner.....	36
Subjects.....	37
Consent and Confidentiality .....	37
Procedures.....	38
Documenting Laurie Schwartz’s Guiding Conception.....	38
Overview of Treatment Protocol .....	38
Data Collection and Measures .....	39
Data Analysis .....	44
Strengths and Limitations of the Study.....	47
III. GUIDING CONCEPTION OF PRACTITIONER .....	49
Preface: Laurie’s Office.....	49
Section I: Theoretical Development .....	50
Section II: Guiding Theory .....	54
The Model of Health.....	54
What happens: The Model of Dysfunction in Development .....	56
Physical Touch.....	59
Establishment of Therapeutic Alliance.....	60
Therapist’s Use of Self.....	60
Case example .....	61

Section III: A Holistic Model of Clinical Practice.....	61
The Referrals.....	61
The Clients.....	62
Assessment.....	63
Formulation and Treatment Plan .....	64
A Note about Diagnoses .....	64
Treatment Plan.....	64
Final Conclusions: The Spiritual Journey Inside Clinical Practice .....	66
IV. INTRODUCTION TO CASE ANALYSIS.....	67
Themes Used in Case Analysis.....	67
Theme 1: Helping Clients Feel Nourished.....	67
Theme 2: Using Physical Touch.....	67
Theme 3: Working with Narrative Versus Body .....	68
A Note about Language and Formatting.....	69
V. THE CASE OF “JAN”.....	70
Client.....	70
Introduction.....	70
History of Client .....	72
Assessment.....	73
Qualitative Assessment.....	73
Quantitative Assessment.....	74
Goals for Therapy: Goal Attainment Scaling .....	76
Formulation and Treatment Plan .....	77
Diagnosis.....	77
Strengths .....	77
Action.....	78
Session One.....	78
Sessions 2-5: Summary.....	91
Session Six .....	92
Sessions 7-11: Summary.....	104
Session Twelve .....	104
Concluding Evaluation.....	112
Quantitative Results.....	112
Discussion of Quantitative Results .....	114
Goal Attainment Scale Results .....	116
Qualitative Results: Exit Interview.....	117
Case Analysis Theme Results.....	118
Summary and Integration of Results.....	122
VI. THE CASE OF “TERRY”.....	124
Client.....	124
Introduction.....	124
History of Client .....	126
Assessment.....	127

Qualitative Assessment.....	127
Quantitative Assessment.....	128
Goals for Therapy: Goal Attainment Scaling.....	129
Formulation and Treatment Plan.....	130
Diagnosis.....	131
Strengths.....	131
Action.....	132
Session One.....	132
Sessions 2-5: Summary.....	144
Session Six.....	145
Sessions 7-11: Summary.....	159
Session Twelve.....	160
Concluding Evaluation.....	173
Quantitative Results.....	173
Discussion of Quantitative Results.....	175
Goal Attainment Scale Results.....	176
Qualitative Results: Exit Interview.....	178
Case Analysis Theme Results.....	181
Summary and Integration of Results.....	184
VII. THE CASE OF “RAY”.....	185
Client.....	185
Introduction.....	185
History of Client.....	187
Assessment.....	188
Qualitative Assessment.....	188
Quantitative Assessment.....	189
Goals for Therapy: Goal Attainment Scaling.....	190
Formulation and Treatment Plan.....	191
Diagnosis.....	192
Strengths.....	193
Action.....	193
Session One.....	193
Sessions 2-5: Summary.....	210
Session Six.....	211
Addendum.....	225
Concluding Evaluation.....	226
Quantitative Results.....	226
Discussion of Quantitative Results.....	228
Goal Attainment Scale Results.....	230
Qualitative Results: Exit Interview.....	231
Case Analysis Theme Results.....	233
Summary and Integration of Results.....	236

VIII. CROSS-CASE ANALYSIS.....	239
IX. DISCUSSION AND CONCLUSIONS .....	251
REFERENCES .....	259
APPENDIX A: LIST OF THEMES .....	268
APPENDIX B: CONSENT FORM .....	271
APPENDIX C: OUTLINE OF ASSESSMENT MEASURES.....	275
APPENDIX D: EXIT INTERVIEW .....	276
APPENDIX E: SUMMARY OF JAN’S TREATMENT SESSIONS.....	277
APPENDIX F: SUMMARY OF TERRY’S TREATMENT SESSIONS .....	280
APPENDIX G: SUMMARY OF RAY’S TREATMENT SESSIONS .....	283



## LIST OF TABLES

1. Jan's Initial SCL-90-R Scores .....	74
2. Jan's Initial TEaM Scores.....	75
3. Jan's Initial Goal Attainment Scale .....	76
4. Jan's SCL-90-R Results .....	112
5. Jan's TEaM Results .....	113
6. Jan's Scale of Bodily Connection (SBC) Results.....	113
7. Jan's Goal Attainment Scale Results .....	116
8. Terry's Initial SCL-90-R Scores .....	128
9. Terry's Initial TEaM Scores .....	128
10. Terry's Initial Goal Attainment Scale.....	130
11. Terry's SCL-90-R Results .....	173
12. Terry's TEaM Results.....	174
13. Terry's Scale of Bodily Connection (SBC) Results .....	175
14. Terry's Goal Attainment Scale Results.....	177
15. Ray's Initial SCL-90-R Scores .....	189
16. Ray's Initial TEaM Scores.....	189
17. Ray's Initial Goal Attainment Scale .....	191
18. Ray SCL-90-R Results.....	226
19. Ray TEaM Results .....	227
20. Ray's Scale of Bodily Connection (SBC) Results.....	227
21. Ray's Goal Attainment Scale Results.....	230

## LIST OF FIGURES

1. Professional Activity as Disciplined Inquiry .....	33
2. Graph of Jan's SCL-90-R Results.....	112
3. Graph of Jan's TEaM Results .....	113
4. Graph of Terry's SCL-90-R Results .....	174
5. Graph of Terry's TEaM results.....	175
6. Graph of Ray's SCL-90-R Results .....	226
7. Graph of Ray's TEaM Results.....	227

## PREAMBLE

### THE LIMITATIONS OF LANGUAGE

Adjectives such as *rough*, *smooth*, *soft*, *hard*, *tender*, and *painful* are devoid of meaning without direct points of reference that are based in previous tactile life experiences.

- Hunter and Struve (1998)

One of the central challenges of Body-centered Psychotherapy (BcP) is finding language for a person's complex felt experience. Articulating sensation-based experience into language is profoundly difficult. Since the terms developed in the following pages are constructed by this author, readers will have to use an imaginative leap from the cognitive realm of reading to their felt experience of sensations and feelings.

For example, statements like "I feel like I'm coming home to myself" express a core experience of Laurie Schwartz's BcP clients. This phrase refers to the primal, non-verbal experience that an infant has which says: "Here I am" and "I know that I am." Such phrases are often spoken by clients in BcP therapy; they are attempting to communicate what they are sensing internally.

In this dissertation, I have attempted to enliven the inner, felt experience through vivid case descriptions. However, in my personal experience, the full understanding of such work is greatly enhanced by actually experiencing the "slowing down of time" through BcP, the grounding touch of a well-contained practitioner, and the feeling of sensing one's own gestures in mindfulness.

## INTRODUCTION BY THE AUTHOR

The body is the physical aspect of the personality, and movement is the personality made visible.

-Mary Starks Whitehouse, Founder of Dance Therapy

In good qualitative research, researchers “own” their unique roles as participant observers (Elliott, Fischer, & Rennie, 1999). As the researcher, I did not conduct the therapy, still I met the clients, administered the instruments, and most importantly, analyzed and wrote up the results. I am introducing myself to the reader so that my biases and training are out in the open and not enclosed in the following pages as a masked truth. I also must acknowledge that my observations are influenced by the views I hold about the importance of this topic.

I am the daughter of a psychiatrist mother and a bodyworker (Rolfing) father. From my mother, I enjoyed a family culture that welcomed emotional expression and direct communication. Growing up, I was also privy firsthand to subtle, soft forms of bodywork such as Shiatsu, which I experienced in the form of slight pressure applied by my father to my forehead whenever I could not fall asleep. I also experienced the harder form of Rolfing, in which strong pressure is applied to the fascia (the connective tissue of the body), thereby releasing the musculature and allowing one to stand more aligned, upright, and taller.

Through this bodywork I have come to better understand the interrelatedness of mind and body. Alongside such physical changes through Rolfing, I have experienced my consciousness change. I have found myself feeling lighter and straighter, and at the same time more “grounded.” This groundedness is both physical and mental – I have experienced feeling more solid in my physical body (standing on the ground) as well as within my sense of self (more accepting of whoever I am in that particular moment). Additionally, I have come to see the therapeutic interplay between psychological and physical well-being. Many people fear Rolfing because it can indeed be very uncomfortable. Yet especially when I have consciously breathed through the pain, I have found that I can release tension, long-held injuries, and misalignment in my body, as well as sorrow and other feelings.

I have had many experiences of the profound mind-body connection, especially through such interventions, to the point that I believe that there is indeed a “bodymind” that transcends our dichotomist language, and that this concept needs studying within therapeutic contexts. These experiences with bodywork have had the greatest impact on my selecting training in clinical psychology.

I am currently studying for a Doctorate of Psychology at Rutgers University. Although I decided on a traditional, verbally-based psychotherapy training program, I continue to have strong interest in developing a role for the physical body in therapeutic assessment, formulation, and treatment. I strongly believe that humans have a drive towards physical contact and that throughout life this remains an appetite as strong and often undernourished as other drives for love and attachment. I believe touch can be immensely powerful as a tool for healing, and certainly, as this dissertation discusses,

one's bodily experience is extremely powerful and ought to be harnessed as an important force in treating body/mind injuries and illness. I and many others have experienced how working on the physical plane also changes psychological experience. Yet how can touch and body-oriented therapies be used with appropriate boundaries? Such provides the basic question that has driven the three years of this research, as well as potentially much of my future career. Clearly, answers will only come through further study.

As for the implications of doing research on body-centered techniques, it is my hope that this work will contribute to the exploration of more research methods consistent with the nature of what is being studied, e.g., methods that combine quantitative and qualitative data, measures that are made explicitly for the BcP framework, more use of videotaping in body-oriented research, as well as other empirically sound methods. I hope this work also advances the informed use of holistic therapies in mainstream medicine. I believe that invasive surgeries ought to be a last resort, and despite some reimbursement for chiropractic medicine, many forms of massage and bodywork are under-represented in the practice of medicine and insurance compensation. More research and practice using methods with integrity to their holistic subject matter are needed.

## CHAPTER I

### INTRODUCTION

There are no disembodied minds. Accordingly, no psychological theory is completely independent of physiology.

-Rubinstein (1965)

[T]he ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body.

-Freud (1960)

A number of independent thinkers in the matter of technique will say to themselves: why stop? Certainly one gets further when one adopts “pawing” as well, which after all doesn’t make a baby. And then bolder ones will come along who will go further to peeping and showing, and soon we shall have accepted in the technique of analysis the whole repertoire of demiviergerie and petting parties, resulting in an enormous increase of interest in psychoanalysis among both analysts and patients.

- Freud in letter to Ferenczi (as quoted in Jones, 1955)

Somatic Psychology is a developing branch of psychology based on the vital connection between psychological symptoms and physical states. Whereas the term Somatic Psychology refers to the academic study of the phenomenon (there are accredited programs currently at Santa Barbara University, California and Naropa University, Colorado), Body-centered Psychotherapy (also known as “Body Psychotherapy,” “Body-oriented Psychotherapy,” and “Somatic Psychotherapy”) refers to the clinical, body-oriented approaches to treatment.

Although many therapies attend to bodily experience, what distinguishes Body-centered Psychotherapy (BcP) as a unique subfield within psychology is the centrality of somatic, sensory-based experience throughout diagnosis, formulation, and treatment (e.g., see such pioneer therapists in the field as Ferenczi, 1953; Kurtz & Prester, 1976; Lowen, 1958; Reich, 1945). Additionally, physical touch is more often used by BcP therapists, even though many BcP therapists do not use touch or only introduce it tangentially.

### Defining Body-centered Psychotherapy

The European Association of Body Psychotherapy (EABP) and the United States Association of Body Psychotherapy (USABP) both emphasize that BcP's fundamental premise is that no dichotomy exists between mind and body:

The common underlying assumption is that the body is the whole person and there is a functional unity between mind and body. The body does not merely mean the "soma" and that this is separate from the mind, the "psyche." Many other approaches in Psychotherapy touch on this area. Body Psychotherapy considers this fundamental. ([www.eabp.org](http://www.eabp.org))

The USABP offers a "brief description of body psychotherapy" which includes emphasis on helping clients "not only through talking," but also by becoming more "aware of their bodily sensations as well as their emotions, images and behavior" and "conscious of how they breathe, move, speak, and where they experience feelings in their bodies." (<http://usabp.org>). The following definition is quoted at length, as it highlights several important components of BcP that will be discussed later in this chapter:

All experiences, as well as distortions and denials of reality and other defensive maneuvers, are reflected not only in peoples' thoughts and feelings but also in the way they move, how they breathe and how the structure of their bodies has evolved over the years. To say that a person has his or her "feet on the ground," "leads with the chin," "has a stiff upper lip," or "their head in the clouds," are not mere figures of speech, but



literal observations of the way our bodies express ourselves. How a person says something may be as important as what he or she says. Underlying this approach is the assumption that we are embodied beings and that there is a unity between the psychological and bodily aspects of being. (Ibid)

BcP emphasizes a belief that exploring the relationship between mind and body is “important for understanding the psychodynamics of an individual and for facilitating psychological change” (Klem, 1985), and that there are limitations to talk as a means of bringing about effective personality change (Caldwell, 1997b). These styles of psychotherapy aim to reduce a client’s physiological and psychological symptoms most often through helping the client learn more about how bodily sensations affect psychological well-being (Kurtz & Prester, 1976; Totten, 2003). Furthermore, such explorations are important to explore as they occur within a therapeutic relationship:

There are as many different approaches within Body Psychotherapy as there are within traditional psychotherapies. These may include meditative techniques to help clients get in touch with their bodily sensations, emotionally expressive techniques (e.g. kicking, making sounds, reaching, moving away or towards another person, eye movements), responding to certain questions, movements to help clients become more aware of their bodies, ways to release and deepen breathing, touch where appropriate and agreed upon, and observations to help clients become more aware of what they are feeling and where in the body. Clients may work lying down, sitting or standing. *These methods are used within the overriding importance of the relationship between the client and the therapist.* (Ibid).

Whereas BcP interventions cover a range of areas, not all body-oriented techniques require touch or physical manipulation. Reich (1945) and his disciples incorporated many manual techniques, including wringing towels and lying on rollers as ways to elicit emotions held in the physical soma. These schools are often considered the “harder” approaches in so far as they often involve neuromuscular manipulation of the client by the therapist. Other “softer” body psychotherapy schools such as Focusing (Gendlin, 1978; 1996) or Hakomi therapy (Kurtz & Minton, 1997) use light touch to help

clients attend to their bodily experience and often do not go beyond asking clients to close their eyes and tune in to their physical experiences in the moment. “Softer” approaches form the basis of the work that will be studied in this dissertation.

Despite varying levels of physical touch in treatment, all BcP practitioners believe that verbal dialogue is limited. As Wilhelm Reich, an analysand of Freud’s, who is often considered the foundational figure of body psychotherapy, explained, language can easily be used to mask one’s experience:

Human language often functions as a defense. The spoken word conceals the expressive language of the biological core. It is my opinion that in many psychoanalyses which have gone on for years the treatment has become stuck in this pathological use of language (1945, pp. 360-361).

Theorist-practitioners such as Fritz Perls and Eugene Gendlin further developed Reich’s thinking through Gestalt therapy (Perls, 1969; Stephenson, 1975) and Focusing (Gendlin, 1978), trying to get beyond language alone to incorporate the body in the work of therapy. Gendlin (1996) explains how cognitive reframing is not effective as the sole agent of change: “You must sense whether it has brought a bodily change or not. A real change is a shift in the concrete bodily way you have the problem, and not only in a new way of thinking.” (p. 9)

While such assertions are fascinating and intriguing, they are difficult to translate into operational research concepts to study BcP’s efficacy and unique properties. Although there exists an extensive literature on the healing power of touch (Field, 2001; Harlow, 1974; Montagu, 1971) and on touch in psychotherapy (Hunter & Struve, 1998; Smith, 1985; Smith, Clance, & Imes, 1998), BcP has been mostly developed clinically.

Body-centered Psychotherapy is therefore an under-developed area of academic study. Although BcP practitioners have existed for over 50 years (Reich, 1945; (Johnson

& Grand, 1998), and BcP has both a theoretical rationale for its effectiveness (Staunton, 2002; Totten, 2003) and a clinical lore about its therapeutic outcomes (Caldwell, 1997b; Frank, 2001), there has been very little systematic empirical research on its process and outcome. Promisingly, both the USABP and the EABP have recently organized committees to develop scientific studies and publish their findings in newly-developed scientific journals, including the *USA Body Psychotherapy Journal* (published by the USABP) and *Body, Movement and Dance: An International Journal for Theory, Research and Practice* (to be published by Routledge, 2006).

Because of this wide range of practices within the field of Body-centered Psychotherapy, the terms within the field remain vague. This frustrates researchers, yet the field has developed a diverse and energized community of practitioners. The challenge lies in developing systematic ways to research and specify these practices. This dissertation will illustrate how the body is focused on in psychotherapy in the work of Laurie Schwartz, M.S. (Masters of Science in Counseling), L.M.T. (Licensed Massage Therapist), the BcP practitioner who agreed to have her work documented for this study.

#### Rationale for Body-centered Psychotherapy

In early life development, tactile input is the primary sensory modality (Suiter, 1983). Children develop complex cognitive frameworks through the skin (Montagu, 1971) and through non-verbal communication between the caretaker and infant (Schoore, 1994). Hunter and Struve (1998) explain how tactile contact is the first “language” an infant learns. Only later does verbalization become a central component of learning, thereafter virtually superceding other senses as the primary means of processing information (Hunter & Struve, 1998).

Therapists of all persuasions address the complex interplay of cognition and biology in psychotherapy, yet many would say that physicality is not an avenue for a traditional, verbally-oriented “talk” psychotherapist. A number of pioneer therapists, however, thought that talk did not always sufficiently address psychopathology (Ferenczi, 1953; Kurtz & Prester, 1976; Lowen, 1958; Reich, 1945). These therapists became the forbearers of BcP. They drew from a variety of sources, including the extensive literature on the healing power of touch in various settings (Field, 2001; Montagu, 1971), as well as from training in psychoanalysis, bodywork traditions, movement, and dance therapies. Out of these diverse fields they developed the clinical traditions of BcP.

The basis of the BcP model is the focus is on how language and somatic work are combined in a single therapeutic encounter. As therapists help clients “translate” their body sensations, affects, and movements into psychological language, it is hypothesized that they assist clients in re-integrating aspects of their nervous systems that may not have been sufficiently processed. In other words, it is proposed that BcP therapists help clients connect somatosensory and limbic functions with higher-order cortical brain functions through the combined psychotherapy. In its more explicit and comprehensive focus on reconnecting the nervous system with cognitive functions, Body-centered Psychotherapy may offer an essential healing component that is rarely adequately addressed in other therapies.

### Brief Review of the Touch in Psychotherapy Literature

Touch is a powerful communication tool, and can be used to benefit patients (Field, 2001).<sup>1</sup> Many theorists and researchers have attempted to promote touch as a means of healing (Montagu, 1971). Most literature specifically on touch in psychotherapy examines “spontaneous touch” (Horton, 1994; Raab, 1996; Suiter, 1983). In BcP, however, touch is an explicit technique of therapy.

Studies of touch in psychotherapy were categorized by Horton (1994) as follows: 1) surveys describing therapists’ attitudes and behaviors regarding touch; 2) clinical case studies, usually of special populations such as people with schizophrenia, children, or schizoid personality types; 3) experimental studies; and 4) theoretical debates regarding the ethics, usefulness, or dangers of incorporating touch into the therapeutic relationship. Horton found that only a small fraction of the papers addressed the use of touch with non-psychotic outpatients and even a smaller number viewed touch from the patient’s perspective. (p. 3-4). There are also a number of books that have addressed the topic of the use of touch in psychotherapy (Hunter & Struve, 1998; Johnson & Grand, 1998; Smith et al., 1998). One issue particularly germane to the present discussion is the recognition in the literature of the long-standing taboo against touch in the culture of psychotherapy. Horton (1994) described that those who support the use of touch in psychotherapy offer a challenge to this all-encompassing taboo against touch (Horton, 1994; Hunter & Struve, 1998; Mintz, 1969).

Many believe the controversy surrounding touch in psychotherapy may have begun as early as during Freud’s career. In the beginning of his clinical practice, Freud was known

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<sup>1</sup>Although this dissertation supports the use of touch as a healing modality, in no way whatsoever does this author encourage the use of touch indiscriminately. Any touch can be easily abusive or interpreted as seductive and must be done by persons trained and supervised.

to hold clients' heads to encourage hypnotic processes (Smith, 1998). Only much later did Freud become vocally against physical touch in psychotherapy. Many say that Freud's protégé Ferenczi (1953) was much more active exploring touch in the analytic dyad, which some suggest may have led to some of the most charged aspects of his rift with Freud (Jones, 1955).

Fear of touch includes the fear that it is used primarily to gratify the patient, or even worse, the therapist. Suiter (1983) raised the question of whether touch in psychotherapy is a result of the therapist's countertransference needs rather than an appropriate response to the client's needs. Certainly, many psychoanalytic thinkers have been concerned about "hug therapists" who they claim over-gratify patients. These therapists collude to help patients avoid "deficits of early childhood [which] cannot be repaired through symbolic parenting, but must be grieved and accepted" (Horton, 1994, p. 16). From this perspective, touch provides an artificial salve that bypasses what should be the main work of therapy.

### Two Chairs and a Table

Most talk therapists, confronted with the difficult theoretical and boundary issues and extensive training involved in combining work on a client's body and psyche, will refer clients for adjunctive physical (a.k.a. bodywork) treatment. The two-practitioner model, combining a body worker and verbal therapist, each working in his or her area of expertise as a treatment team, is a useful one. Most massage and bodywork practitioners do not get training in dealing with the emotional aspects of their interventions, while talk therapists rarely learn anatomy or receive the important training needed around the boundaries of touching clients. In this conjoint configuration, the client moves between

two separate offices: one office with a table (i.e., bodywork table), the other office with two face-to-face chairs.

There is a major critique of this conjoint configuration: often the emotional experiencing (often activated through bodywork) and the verbal processing (i.e., “working through”) occur weeks apart. In BcP, however, the bodily felt experience and the verbal processing occur simultaneously. In this one-therapist model, the treatment often incorporates both the table and two chairs in a single office. Clearly, this model requires sophisticated training so that both aspects are sufficiently addressed.<sup>2</sup> It is this integrative model that is the topic of this study.

The present research builds on previous systematic, empirical studies to help fill the need for more such investigations in BcP in order to create a solid scientific foundation for the field. Specifically, this investigation includes in-depth, systematic case studies involving qualitative process compared with standardized quantitative measures to examine how BcP integrates the body into psychotherapy, as seen through the work of Laurie Schwartz, a widely known BcP practitioner with 25 years of practice in the field. The main questions guiding this study include: What does BcP therapy look like? What themes in BcP therapy are unique or distinguishing? And how does BcP therapy integrate talk and touch in a unified therapy? In addition, by looking at what is distinctive about a BcP approach, this study can begin to contribute to the question of whether it is effective to combine talk and touch in a single therapy, and if so, what are the mechanisms of change in such a therapy.

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<sup>2</sup> The European Association of Body Psychotherapy is very explicit about training requirements for its members, including completion of a personal psychotherapy, a training in somatic psychotherapy, ongoing supervision, a practice of psychotherapy, and the acceptance of its code of ethics. (EABP guidelines, as cited in Heller, 1999).

### What is Distinctive about BcP: A Clinical Overview

Caldwell (1997a), an academic clinician who founded the Department of Somatic Psychology at Naropa University in Colorado, discusses some of the important tenets that cut across models of BcP. Following from the axiom of the unity of mind and body, Somatic Psychology emphasizes the interrelationship between body and mind such that the body is a blueprint of the psychological experience of a person: “Somatic psychology believes the body literally holds all of its history” (p. 15). BcP practitioners, therefore, often work with gesture, breath, and posture as a way of accessing the physical reflection of psychological experience.

Some themes (see also Caldwell, 1997b; Staunton, 2002; Totten, 2003) culled by this author which appear common to many BcP schools include: 1) an integration of somatic awareness alongside cognitive and emotional awareness to a greater degree than talk therapy; 2) an understanding of the nervous system (including neurobiology) that informs the work and reinforces the integration of somatic and cognitive processes; 3) an influence of the psychodynamic tradition and specifically of Wilhelm Reich (1945); 4) a conceptualization of psychopathology within a holistic, energy model in which blockages occur in the body that are reflected in a person’s psyche (Freud, 1960; Lowen, 1958), and therapeutic techniques that must address both levels in treatment; 5) an introduction of touch as a potential technique at the outset of treatment; 6) an explicit focus on sensory awareness (often referred to as mindfulness) of internal sensations as an important seat of information (Kurtz & Minton, 1997); and 7) encouragement of adjunctive body work for muscular tension. Many of these are actualized in the work of Laurie Schwartz, the BcP practitioner studied here.



One of the greatest challenges in studying body-oriented techniques is to find verbal language to capture the experience of body-awareness. Additionally, certain terms that are used in BcP such as “flowing energy” and “being grounded” are not freely understood and accepted in Western science. One of this dissertation’s goals is to examine such concepts and to try and concretize them through their application in the therapy cases. These terms will be discussed in more detail in Chapter III, which elaborates on Laurie Schwartz’s theoretical model or “guiding conception,” and will be illustrated in the case studies of Chapters V, VI, and VII.

The concept of “energy flowing freely in the body” is a particularly challenging concept to describe in language yet is central to the experiential core of BcP (Kurtz & Prester, 1976; Lowen, 1958). Although there are many ideas that underlie this concept, most BcP practitioners believe that there is a life force (also known as Chi or Prana), that is, an energy that is fundamental to a person’s wellness. There is both a literal, physical aspect to this energy as well as a symbolic one: when Chi is flowing freely and properly through the body, it has a pulse-like, rhythmic physical movement as well as a metaphoric flow at the psychic level that provides comfort, flexibility, and grounding in one’s life and relationships (Caldwell, 1997a; Smith, 1985).

As Caldwell (1997a) states: “Our ability to stay receptive to inner sensation and energy in an unconditional manner is seen as a prime component of healthy self-identity” (p. 9). When Laurie Schwartz describes pulsation and breath, she is referring to this systemic motility, which is the person’s system “in flow.” This flow is considered essential for a person’s nervous system to regulate. In fact, this concept of “self-regulation” as the basis of health is found across BcP theories. Self-regulation, in

Laurie's Schwartz's terminology, is an internal feedback system in which one has "the ability to stay related with one's own sensations, affects, thoughts, images, and impulses while staying related with others." Laurie Schwartz's guiding theory will be elaborated upon in Chapter III.

Caldwell (1997a) elaborates on "energy" as a basic concept in BcP work, and how the exchange of energy connects the physical and psychological from a somatic perspective:

It is the form and process of our energy exchange with the outside world that determines much of our sense of who we are and how we act. Do I shrink when under stress, or do I blow up? In this field, we examine how people absorb energy from the environment, how they process it, and how they express it back out, similar to a biologist studying how a plant absorbs sunlight, engages it in photosynthesis, and excretes oxygen. Events are seen as stimulating our energy flow...When someone compliments me, blood rushes to my cheeks and makes them hot. If I have been criticized, I will shrink in the chest area. Or if I shrink in the chest area, I am likely to interpret someone's words as criticism...Whether we use our energy in responsive or reactive ways is seen as one of the core themes of somatic work. Energy is often seen as being overbound or underbound in the body, as a result of our using either tension or collapse as a defense strategy. (p. 8)

BcP assessment therefore involves attending to the client's bodily movement, and where both physical and energetic movement might be blocked. As Caldwell explains: "Many somatic psychologists will 'read' the body as a form of diagnosis, noting how the body is held, what shape results, and what emotions, beliefs, and behavioral strategies ensue" (Ibid, p. 17). Furthermore, "Somatic diagnosis is an assessment of where the person is moving in his or her body and in life, and where he or she is not." (Ibid, p. 11).

Smith (1985) discusses the concept of "body reading" in which the therapist must observe and translate the language of the body. He posits that "a person's physical structure is a statement of that person's psychobiological history and current psychological functioning" (p. 70). Furthermore he theorizes how bodies become frozen:

Body reading is based on the concept that *structure is frozen in function*. Those parts of the body which are used and nourished grow toward their genetic limits. Those parts which are not exercised and nourished do not develop fully, or may atrophy, become diseased, or even stop functioning altogether. Behind the use, nonuse, or misuse of the body are the organismic decisions made in response to the parental messages given. When these messages are toxic, and have been introjected, the result is nonuse or misuse of the body. Certain parts may [also] be damaged by physical trauma. The tasks for the therapist in reading a patient's body is to see the physical structure, note the physical phenomena present, and generate hypotheses as to that patient's psychological dynamics based on the phenomena seen. (p. 70)

To understand such blockage in movement of the body, Caldwell (1997a) describes three important issues of early development that are crucial to BcP assessment and formulation: space, time, and effort. Space “has to do with how much of it we take up, how much room there is for us in the world, and how we face different directions within it. It is illustrated by how expanded or contracted our body is, how much space we use to move in, and where we draw our ability to form healthy relationships” (p. 14). Time “has to do with speed and pacing. Having our rhythms respected while negotiating how to synchronize them with others is the task here” (p. 14-15). Effort invokes amount of personal efficacy, power, and satisfaction. “Do I have enough energy to perform any action to its completion? Is it OK to have as much or as little energy as I feel?” (p. 15). Laurie Schwartz addresses these elements in her guiding conception (see Chapter III).

Additionally, Caldwell (1997a) describes two important perspectives that BcP has brought to psychotherapy treatment, both of which are central to Laurie Schwartz's guiding conception. One is a process orientation, in which how clients tell their stories becomes much more important in treatment than what the story is. The second is that BcP focuses almost entirely in the here-and-now. Unlike many therapies that have a historical orientation, BcP is decidedly more present-oriented. “Somatic therapists either design

exercises that invite felt-level material, or simply urge the client to track and stay with sensation and feeling and allow them to reveal themselves” (p.18). Both of these perspectives are noticeable in Laurie Schwartz’s treatment style. Little background history is taken on the clients. The work is present-centered, with here-and-now experiments forming the backbone of this treatment. “Take a moment...” is one of Laurie Schwartz’s most common phrases. “What do you notice now in your body?” is another.

### Neuroscience and BcP

Somatic psychotherapy has found an important scientific base in neuroscientific data (Schore, 1994). Much of human early experience is pre-verbal and encoded before the neocortex develops into language (Montagu, 1971). Freud ignored this aspect of infant development, when the use of touch appears to be most crucial to psychological health and well-being (Horton, 1994). The pre-verbal experience of infants within early attachment is just beginning to be brought back to the fore of understanding human development (Aron & Anderson, 1998; Porges, 1997; Tronick, 1989). Although most have assumed that these experiences are not processed, there is growing evidence that early life development which is pre-cognitive and pre-verbal has strong emotional resonance and provides a great deal of information to the growing neonate (Caldwell, 1997a; Schore, 1994). In fact, many suggest that touch, and body-oriented techniques, are best suited for addressing the pre-verbal levels of experiences (Montagu, 1971).

Schore (1994), a developmental neuroscientist, distinguishes this crucially sensitive period (between ages 0-2) in the infant’s development of affective self-regulation and highlights its dyadic nature. He proposes a “psychoneurobiological model of the

ontogeny of self-regulation” in which the caretaker mediates the child’s social environment, and in doing so, “directly influences the evolution of structures of the brain that are responsible for the future socioemotional development of the child” (p. 62).

Stated another way, research evidence supports that hormones and neurochemicals released through the relational connection help the infant’s brain develop:

The object relational-induced release of growth-promoting (trophic) biogenic amines and neurohormones allows for the experience-dependent critical period growth of connections between subcortical and cortical structural components which neuroanatomically mediate the regulation and expression of emotion. (p. 63)

During this sensitive period, the early non-verbal right hemisphere learning begins to connect to left-brain language processing. The roots of psychopathology, posits Schore (1994), are “developmental arrests [which] are in essence pathologies of affect regulating functions of the affective core of the self” (p.444). As will be elaborated in Laurie Schwartz’s guiding conception, psychopathology is this inability to self-regulate.

Affect and the bodily experience of affect have also become more central to clinical researchers who are exploring systematic ways to bring these experiences into treatment. Many of these research-based clinicians use videotapes of sessions as an important means of capturing subtleties of clients’ physical experience of affect. This research-based work helped refocus clinical work on the importance of the somatic experience of affect in clinical treatment, as well as reconceptualizing the regulation of affect within the physical dyad (Fosha, 2000; McCullough Vaillant, 1997; McCullough et al., 2003). Although these therapists work predominantly through talk, they acknowledge the importance of the client’s physicality in session (e.g., “How does it feel in your body?”).

Additionally, rapid developments in understanding the nature of traumatic reactions at the site of brain function have led to exciting and innovative empirical support for BcP (Levine, 1997; Rothschild, 2000; van der Kolk, 1994; van der Kolk, McFarlane, & Weisaeth, 1996). Much of this work addresses the interconnection of brain regions, and draws heavily upon the model of the triune brain.

The triune brain, a term coined by Paul McLean (1964), is important to an understanding of the intentions and goals of Body-centered Psychotherapy. The human brain is divided into three parts: the reptilian brain (instinctual/ brainstem), mammalian (limbic), and human cognitive (neocortex) brain. Each of these parts of the brain developed at different epochs in human evolution and serve vastly different functions. The reptilian brain deals with instinctual responses at a far quicker rate than conscious cognition. Sensations such as hot, cold, tightness in the muscles are all quickly processed through this part of the brain (which is important in understanding trauma responses, explained below). The limbic system is the site of emotion, as well as important in memory (Damasio, 1999). The neo-cortex, the “human brain,” is the site of higher-order functions, such as human cognition.

The function of the neo-cortex (e.g., conscious thought) overrides instinctual and limbic functions, thereby making our brain circuitry unlike other animals. Yet during trauma often the circuitry goes awry. van der Kolk (1996) discusses how trauma signals often do not reach the neo-cortex, but remain solely in the brain stem and limbic system, activating fight/flight responses without cognitive awareness. The person literally cannot talk or think clearly when the trauma is activated. Too often people with trauma, unable to tolerate the high activation of their nervous systems, have become dissociated from

their bodily responses (Rothschild, 2000). Working with trauma involves helping people gain awareness of their bodily experience in sensation (e.g., tingling in the chest, tightness in the throat) which helps a person reorient and allows the sensations to be “metabolized” and move through the nervous system to completion (stopping the incessant firing of these incomplete pathways). This is why Laurie Schwartz often describes healing trauma as focusing on integrating adult consciousness with “the language of sensation.”

BcP, therefore, focuses on this integration of the different parts of the brain. While all therapy works to re-circuit the brain, the involvement of the sensory level suggests a more complete integration than other treatments. As Laurie Schwartz moves between a client’s sensory (i.e., early, non-verbal) experience as well as affective and “adult consciousness,” she works to help clients develop a new integration of the neural connections between the brainstem, limbic, and neocortex – a.k.a. the sensory (thalamus), affective (limbic), and cognitive (neocortex) aspects of self. This focus on integrating cognition, affect, and behavior with bodily sensations while in a therapeutic relationship (integrating across the triune brain) is one of BcP’s significant contributions to the field of psychotherapy.

#### Studies on Body-centered Psychotherapy

The longstanding clinical field of BcP has only recently emerged in academic circles, and, as of now, few systematic studies have been conducted. Klem (1985) confronted several gaps in the field: “There has been more practice of body psychotherapies than theoretical discussion, and more theoretical discussion than research. Of the research that has been done, much has been descriptive with poorly defined concepts” (p. 3). Europe

has developed a much stronger, more sympathetic community to BcP. Subsequently, much of the current research is being conducted in Europe.

The most comprehensive set of references to BcP exist on a CD-ROM Bibliography developed by the European Association of Body Psychotherapy (Young, 2002). A new version will be published in 2005 with an additional 1500 entries. While many of these are theoretical articles and chapters, an increasing amount of research is being conducted and published. May (2002) also conducted a comprehensive literature search over the previous 30 years and found 23 empirical BcP studies. A brief review of such studies follows.

The first major prospective clinical trial is currently underway in Germany and Switzerland (Koemeda-Lutz, Kaschke, Revenstorf, Scherrmann, Weiss, & Soeder, 2003). In this study, eight major BcP outpatient clinics are together studying the effectiveness of BcP under natural conditions. Clients filled out a series of measures: Beck Anxiety Inventory, Beck Depression Inventory, the Inventory of Interpersonal Problems, the “Selbstwirksamkeitserwartung (SWE; a measure of self-effectiveness), and the Symptoms Checklist 90- Revised (also used in this study). Clients were sampled at three points in treatment: beginning of therapy, after six months, and at termination, as well as a one-year post-treatment follow-up.

For a control group comparison, the patients in “body-psychotherapeutic treatment” (n=157) were matched according to similar “sociodemographic data, level of impairment and psychopathology” with control groups from other studies (Schwarzer & Jerusalem, 1999). The authors refer to these comparison data as coming from other studies on outpatient patients. Previously, the idea for a wait-list control group had been rejected



due to ethical concerns. Using ICD-10 criteria, diagnoses, and symptom profiles for BcP patients were found to be similar to other outpatients. However, average amount of education was higher for BcP clients than for other outpatients.

Preliminary results are promising, finding that after six months of BcP ( $n=78$ ), small to medium effect sizes were reported across all clinical categories. Tests of significance were one-tailed t-tests, with small effect sizes having a significance level of at least .05 or higher. Effect sizes were classified as small (0.2-0.5), medium (0.5-0.8) and large ( $>0.8$ ). By the end of treatment, in the BcP cases thus far analyzed ( $n=21$ ), scores in all the clinical symptom scales went down. For example, substantial improvements were reported, including large effect sizes of 0.82 in expected self-effectiveness and 1.40 in depression. For subjects with clinical (33.1%) or raised (35.7%) levels of depression on the BDI, by termination no subjects (0%) showed clinical depression and only 10% exhibited any symptoms of elevated depressive levels.

The authors also underscored the importance of the significantly large increase in self-effectiveness (0.82). Self-effectiveness, “an important resource in handling stress and emotional problems,” has been shown to be a relatively stable personality variable (p. 13). This result suggests that BcP works on personality factors as well as symptoms.

Limitations include the type of control condition, as well as self-report measures as the sole source of data. Furthermore, it is not clear what standardizations were used across BcP treatments in the various sites. Yet this study is important in its efforts to examine BcP in an ecologically-valid, naturalistic setting. In addition, the broad coordination and extensive cross-pollination between the researchers and the clinicians at the many sites involved make this study particularly noteworthy.

To assess outcome and stability of the efficacy of bioenergetic therapy looking at patients at multiple BcP sites, Ventling and Gerhard (2000) conducted a retrospective study of 319 former patients seen in a private practice setting. Drawing from the patients of sixteen certified bioenergetic therapists of the Swiss Society of Bioenergetic Therapists, the authors collected data from former patients who had a mean of 91 sessions (usual range was 26-50 sessions), and who terminated therapy between six months and six years previously. The former patients were sent one of five versions of an anonymous questionnaire, which addressed psychological and physical conditions, interpersonal and psychosomatic problems, the effect of bodywork on physical consciousness, cognitive insights and changes in quality of life. Subjects were asked to rate the effectiveness of the therapy on a Likert scale with 1 (*very effective*) to 5 (*not at all effective*). The responses demonstrated that for 75% of the patients, bioenergetic therapy proved to be effective to very effective and that the results lasted from at least 6 months up to 6 years. The authors discuss the limitation of lack of a control group, the limitations of self-report, retrospective review, as well as the responders possibly being bias towards those satisfied with treatment.

This study was particularly important because it looked at the stability of effect of Body-centered Psychotherapy over time. Additionally, the researchers attempted to discern the role that bodywork had in the therapy treatment. According to the survey data, bodywork only accounted for 56% of the patients' "reason for gaining new insight" (p. 9). However, for 87% of the patients, the bodywork appeared to be a crucial component in whether they would refer their therapist to others. Interestingly, there were nine patients who reported that their therapist had not used bodywork "and they therefore

would not recommend him/her” (p. 9). The authors noted the extreme difficulty attempting to tease out effects for each aspect of treatment, and as expected, the relationship between client and therapist appeared to be the most important.

In examining a BcP treatment, Bourque (2002) applied Somatics,<sup>3</sup> a type of BcP, for treating people with chronic pain. She selected chronic pain particularly because it “challenges the traditional division between physical and mental processes” (p. 1), thereby offering an illustration of a diagnosis that BcP may be most helpful treating. Using a case study method, she examined four subjects with chronic musculoskeletal pain who engaged in eight weekly Somatic Psychotherapy sessions. Pre and post-test data were collected. Measures included the West Haven Yale Multidimensional Pain Inventory, the McGill Pain Questionnaire, the Activity Pattern Indicator, the Beck Depression Inventory-II, the Affect Balance Scale, the Visual Analog Scale, and the Brief Depression Rating Scale. Qualitative data were also derived from the treatment, and included videotape review (also used in this study).

Post-treatment, Bourque qualitatively analyzed videotapes of the sessions in addition to the quantitative results, which indicated an improvement through decreases in pain experience and increases in pain-free activities in 3 of the 4 subjects. Overall, the therapy “increased their sensory awareness, decreased muscle tension, improved breathing patterns, increased relaxation, and decreased pain” (p. 5). Bourque commented that for the subject whose pain sensitivity increased, it possibly suggested an improved sense of awareness of the person’s realistic condition, having reduced shame, guilt, and denial of the person’s condition.

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<sup>3</sup> Somatics “involves the physical sensation and experience of the client as part of the therapy process, seeking to release, re-orient and re-pattern somatic and psychological aspects of the client through experiential activities, movement, touch and verbal processing” (Bourque, 2002).

Using a single-case design, Bridges (2002) examined two sessions of Lowen's Bioenergetic Analysis integrated with a short-term psychodynamic treatment model (McCullough Vaillant, 1997; McCullough et al., 2003). He used the Achievement of Therapeutic Objectives Scale (ATOS) developed by McCullough et. al (2000) to rate the defensive and affective awareness of the client as captured on videotape. The ratings data indicated that the introduction of bodywork to address clients' "somatic defenses against affect" shifted the therapy dramatically, including a statistically significant increase in affective expression. Bridges concludes by advocating strongly for using more empirically-validated measurements and research designs such as single case designs in BcP research.

Also using a single case, Price (2002) examined the effects of adding an 8-week adjunctive BcP therapy alongside an ongoing verbal psychotherapy for a woman with childhood sexual and physical abuse. Price used both qualitative data and quantitative measures such as the Symptoms Checklist 90- Revised (SCL-90-R) for general psychological health, a physical symptom checklist, and the Crime-Related Post-Traumatic Stress Disorder scale, as well as the Profile of Mood States (POMS), which was given at every session.

The client demonstrated significant improvement on the standardized quantitative measures as the SCL-90-R and the POMS in such areas as depression, anxiety, and obsessive symptoms, as well as decreases in her physical symptoms. In addition, the client qualitatively reported improvement in "feelings of safety, ability to tune in to internal processes, and ability to access emotion." Price's findings have to be interpreted with caution, however, as combined treatment effects were potentially present, since the

subject was also engaged in weekly psychotherapy, as well as started a “low dose” of Prozac during the initial week of the study. Nevertheless, Price described a change in her client’s bodily experience, a result often reported as an outcome of BcP treatment: “The experience of inner safety was a profound change that contrasted with her usual experience of braced inner vigilance” (p. 235).

A recent meta-analysis of massage therapy (MT) research, drawing from studies in a wide range of fields (e.g., psychology, nursing, medicine, and kinesiology), found MT significantly effective for both physiological and psychological outcomes (Moyer, Rounds, & Hannum, 2004). Additionally, reductions in trait anxiety and depression were MT’s largest effects, similar to those found in psychotherapy meta-analyses. The authors speculate that combining massage and psychotherapy may significantly increase effectiveness more than either alone. Furthermore, they emphasized that no study has ever examined the “psychological interactions” of MT, including “the amounts and types of communication, both verbal and nonverbal, that take place between massage therapist and recipient; the amount of empathy perceived by the recipient on behalf of the therapist; whether the psychological state of the therapist is important.” Such questions are at the forefront of research on integrating psychological and physical therapies.

Other scientific studies are in German or languages other than English, and many other BcP sources include books and dissertation studies. For example, using a phenomenological approach as her guiding framework, Green (1984) combined Lomi Work and Psychosynthesis to examine how clients responded to a combination of transpersonal psychology and breathwork, deep tissue touch, structural alignment, visualization, and emotional release techniques. Besides offering vivid clinical vignettes

of her combined approach, most useful are her discussions on the ethics of touch therapy, the dialectic between evocative and directive approaches to working with clients, and the implications of doing therapeutic work from a spiritual base.

In addition to the work discussed within neuroscience, the trauma subfield, and affect research, neuroimmunology has significantly advanced the link of consciousness and physicality by exploring the “somatic network” of peptides and receptors throughout the body which feed back emotions to the brain (Pert, 1997). Pert’s findings on the scientific basis of “mindbody” (a term she uses in her work) hold great promise to understanding the complex feedback loops in connecting the psyche with the body.

#### A Type of Psychotherapy Integration

Body-centered Psychotherapy offers a model of psychotherapy integration that can be viewed from both an assimilative (Lampropoulos, 2001) and a theoretical integration perspective (Safran & Messer, 1997). Assimilative integrationists (Lampropoulos, 2001; Messer, 1992) would argue that BcP involves inserting body-oriented techniques such as physical touch, the “language of sensation” (Levine, 1997), and physicality (gestures, movement, etc.) into a developmentally-oriented psychodynamic therapy (Aron & Anderson, 1998), or vice-versa.

Most useful to considering BcP from an assimilative perspective, in which BcP techniques can be assimilated within the dominant psychodynamic theory of attachment and early childhood development, is for the case in which therapists may want to include BcP techniques in their clinical practices (Lampropoulos, 2001). Many therapists might benefit from such additional techniques (e.g., BcP’s sensory-based language) that can potentially evoke more embodied experience and emotionality in clients.

Theorists such as Wolfe (2001) argue that incorporating techniques into a theory ultimately modifies the dominant theory, so that assimilative integration becomes “accommodative integration.” However, the author of this dissertation argues that Body-centered Psychotherapy itself offers a new comprehensive and integrated theory. BcP therefore represents a theoretical integration, which includes a trauma-oriented, sensory-based theory (Gendlin, 1978; Levine, 1997; van der Kolk, 1994), movement and dance therapy theories as well as psychodynamic attachment-based theory. These theories are integrated into a dominant theory in which the body is introduced as a central focus of a theory of psychotherapeutic treatment that also incorporates many common psychotherapy factors (Staunton, 2002; Totten, 2003). BcP therefore offers a more encompassing theory than an assimilative psychodynamic theory with “body-oriented” concepts included.

One result of considering BcP as a theoretical integration is that psychotherapists ought to be able to train directly in a BcP treatment model. In order to do this, as elaborated in Chapter IX, training will have to be sufficiently sophisticated to incorporate both verbally and physically-based interventions. Furthermore, the inclusion of sensation as a focus of treatment alongside emotion, cognition, and behavior – while also employing many common factors – widens the scope of psychotherapeutic practice. Despite skepticism regarding the difficulty of developing a unified theory of psychotherapy, BcP offers a potential contribution to the dialogue on developing a metatheoretical integration (Safran & Messer, 1997).

### Rationale for the study

Body-centered Psychotherapy practitioners continue to search for a place in the psychotherapy canon. Because there is sparse empirical and scholarly research on BcP's theory, methods, and practices, this dissertation uses case studies as a suitable strategy for beginning to systematically study BcP in detail and in context. The case study method offers a distinctive perspective for articulating the themes and ideas that theoretically inform the work that is currently being practiced in the clinical field.

This dissertation explores the questions of how verbal and somatic interventions can be used in a single therapy, that is, how these seemingly diverse therapeutic means can be best combined into a single modality in line with a theoretical integration model of psychotherapy integration (Safran & Messer, 1997). It uses the Pragmatic Case Study Method to investigate in a systematic way how a particular BcP practitioner conducts therapy in particular cases (Fishman, 1999). This investigation places the practitioner's work in the context of her guiding conception (see Chapter III), which includes her theoretical assumptions concerning problem assessment, goal setting, techniques, treatment plan, and intervention. The aim is to contribute to development of theory, research, and practice in BcP, a therapy with promising potential for enhancing clinical practice.



## CHAPTER II

### METHOD

Our data is [sic] facing the complexity of experienced sensations while organisms are interacting with each other directly.

- Michael Heller (2001)

#### Overview

The present study employs a case-based method for empirically studying Body-centered Psychotherapy. This method involves both (a) the in-depth, qualitative study of three individual cases, using inductively-derived common analytic categories to facilitate cross-case analysis, and (b) the use of standardized, quantitative measures of initial presenting problems and outcomes of clients so as to compare the clinical characteristics and therapeutic outcomes with those in other studies.

#### Conceptual Design

There is a growing trend in psychotherapy research to examine patterns of process in context (Greenberg, 1986; Greenberg & Pinsof, 1986). Whereas previously in psychotherapy process research there was a focus on correlations among discrete variables at fixed time points, the emphasis has shifted to looking at how variables change over time. Greenberg & Pinsof (1986) explain: “A frequency approach just did not seem to fit therapists’ experience of therapy. Advanced therapists do not operate in

terms of frequencies; they perform acts in specific contexts and in specific sequences” (p. 14). Thus, examining the sequence of how variables shift from one event to another is a useful approach to understanding the application of a practitioner’s work.

Furthermore, there has been a movement towards more contextualized knowledge in the current postmodern intellectual climate. Theorists such as Gergen (1991) and Peterson (1997) explain the shift away from modernism in science to a paradigm that is more relativistic and idiographic. The concept of universal, knowable truth has been replaced by more local knowledge, embedded in the particulars of the knower and the known. That is, what may be the clearest path for the most effective treatment for one client may not be so for another. Out of this paradigm arose Peterson’s (1991) Disciplined Inquiry model, an individualized, client-oriented approach to action research (Schön, 1983; Stricker & Trierweiler, 1995) within applied settings. The present study uses the Pragmatic Case Study Method (Fishman, 1999; 2005), which is based on Peterson’s Disciplined Inquiry model.

The Disciplined Inquiry model, which is outlined in Figure 1, is a type of contextual, individualized model that offers a way to study systematically what is effective about how professionals practice in real-world settings. Its fundamental tenet is that its focus “begins and ends in the condition of the client” (Peterson, 1997, p. 188). The model enacts this view by attending to the particular needs of clients within situations, which are captured through systematic and rigorous case studies (Peterson, 1991).

As shown in Figure 1, once a client’s situation and presenting problems have been described (component A), the Disciplined Inquiry Model calls for a setting forth of the practitioner’s “guiding conception” (B). This is the overarching theory a practitioner

brings to his or her work, as informed by previous research and clinical experience (C). The guiding conception is then traced as it interacts with the specific needs of the client, through the steps of assessment (D); formulation, including treatment plan (E); action, or intervention (F); monitoring evaluation and feedback (G); possible recycling through earlier steps (H-K); and concluding evaluation (L). The feedback processes are the essential, action-research components of the Disciplined Inquiry Model.

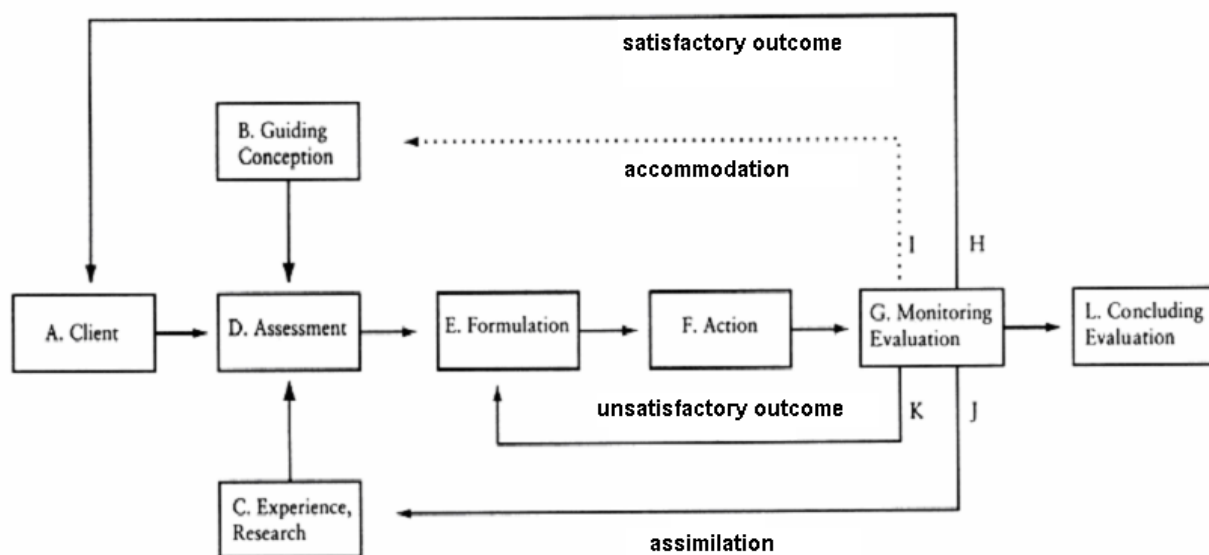


Figure 1. Professional Activity as Disciplined Inquiry  
(adapted by S. Messer, 2004, from D. Peterson, 1991 and D. Fishman, 2005).

Following the logic of Disciplined Inquiry, the Pragmatic Case Study Method (PCS Method) allows psychological events to be studied within their contexts. Fishman (2000) provides an overview of the components of the PCS Method:

A pragmatic case study always takes place in the context of a particular human service program. The program is intended to remediate psychosocial pathology and/or to promote psychosocial health. The case study itself describes in systematic and narrative detail the particular subject who is being helped, the nature of the client's problem, the type of human services being offered, the theory that justifies the approach, the

process of service delivery, the quantitative and qualitative evaluation of the program's success in addressing the client's problems, and how the outcome is conceptually and functionally related to the theory and process. (p. 5-6)

The PCS Method therefore offers a structured way to investigate what about an applied psychological treatment is distinctive and useful (Fishman, 1999; 2005). By studying systematically how a practitioner's guiding conception – which includes the practitioner's assumptions about theory, epistemology, program goals, and ethics – influences the process and offers feedback to a system (Peterson, 1991), the PCS Method allows a case study to look directly at an applied psychological service like psychotherapy – in a specific context with a particular client – in order to assess its utility. Additionally, using Disciplined Inquiry, the PCS Method also offers a systematic process of data collection and analysis.

In the present project, the PCS Method is being applied to three case studies. While treatment length of the actual cases is open-ended, only the first twelve sessions will be included in the formal part of the research. Data consisted of a series of process and outcome measures (discussed below), as well as transcripts of the videotaped sessions of BcP. The videotapes themselves were a crucial source of information – both as independent sources of data and as a method for practitioner review. Part of the data analysis consisted of the therapist and researcher reviewing the videotapes of these sessions to articulate how the therapist's guiding conception interacted with the client's presenting problems and goals and how she integrated that information into her theory and procedures which guided her next interventions.

The objective of this study, through applying the Pragmatic Case Study Method to three cases of Body-centered Psychotherapy, is to contribute to the field by examining the

theoretical underpinnings of actual cases in order to elucidate concepts of how the theory and techniques of BcP may be useful and distinctive. The goal is to begin the explanatory process that will contribute to an understanding of BcP and Somatic Psychology.

Following the work of such pioneers as Klem (1985), this study will define terms for future research, thereby creating a framework of concepts for further study in BcP.

Ultimately, it is intended that these cases, once published, will become a part of a growing database of pragmatic case studies (Fishman, 1999; 2005) that will help practitioners make informed choices about matching treatment with clients (Howard, Moras, Brill, Martinovich, & Lutz, 1996). These cases will contribute to a movement towards “patient-oriented” research, which views the client as the basic unit of analysis. This may be contrasted to the more typical, group-based treatment research, both the “efficacy” and “effectiveness” varieties, which view the intervention model and associated treatment procedures as the basic unit of analysis (Howard et al., 1996; Lambert, Hansen, & Finch, 2001).

### Research Design

This study is comprised of three case studies treated by BcP practitioner Laurie Schwartz. Each treatment was open-ended with regard to length. The research included the entire therapy or the initial twelve sessions, whichever came first. The data consisted of quantitative pre- and post-assessment measures, transcription of videotaped sessions, review of the video and transcript with the practitioner and researcher, and an exit interview with each subject. These measures are described in more detail below. The intent of the study was to clarify this BcP practitioner’s guiding conception and to examine how it functions across several treatments.

Standardized self-report measures are used in this study because they have shown good predictive validity in relation to outcome (Greenberg & Pinsof, 1986). Furthermore, a mixture of observational methods (i.e., the therapy videotapes) and client self-report questionnaires between them capture both behavioral and experiential data (Greenberg & Pinsof, 1986). This study also examined the client's process across sessions as a way of contributing to the development of process research on BcP. A number of themes for analysis were developed inductively both through the careful review of the videotaped sessions with the practitioner as well as by the researcher independently. The final themes used in analysis were selected by the researcher and represent a small sample of possible themes identified for discussion; they were selected for their focus on combining verbal and somatic interventions.

#### *Body-centered Psychotherapy Practitioner*

The BcP practitioner for this study, Laurie Schwartz, was selected through a network of BcP practitioners because of her 25 years of experience and training in the field, her highly regarded reputation among practitioners, and her commitment to research. She recently completed a Masters in Counseling, specializing in bereavement, from Pace University, New York. Her certification in Massage therapy is from the Swedish Institute in New York City. In addition, Laurie Schwartz is a certified Rubenfeld Synergy Instructor, a master clinician of Hakomi therapy (which is a "soft" form of BcP), and currently an advanced trainer and supervisor of therapists in Somatic Experiencing method (explained further in Chapter III). Previous to this study, Laurie Schwartz had been videotaping clients for several years with the intent of engaging in clinical research. Her training will be elaborated upon in her guiding conception (see Chapter III).

### *Subjects*

The subjects consisted of three individuals, two females (Subjects 1 and 2) and one male (Subject 3), recruited from the general New York City area, who were interested in experiencing a course of BcP. They were recruited for the study from new referrals within Laurie Schwartz's practice (Subjects 1 and 2) as well as via advertisement postings in different universities in New York City (Subject 3). This was not a representative sample of all potential therapy clients; the intent of recruiting subjects was to select several people who were interested in the distinctive potentials of BcP. The first 12 sessions were offered at a reduced fee for subjects participating in the research protocol. If subjects were interested, the practitioner did an initial screening by phone. She also met with each subject to assess his or her appropriateness for the study. Contraindications included crisis conditions, such as suicidality, severe depression, and intense difficulty with separation. If a subject seemed suitable for the study, the researcher met with him or her to review the consent form as well as administer the several assessment measures. Specific demographic information about each subject will be elaborated on in the case chapters V, VI, and VII.

### *Consent and Confidentiality*

Informed consent was an important part of the study. Subjects were required to read an extensive consent form (see Appendix B) that outlined the various aspects of the study including measures, questionnaires, and face-to-face interview. They were also apprised of the role of videotaping and audiotaping of sessions. All names and identifying information were changed to protect the anonymity of the subjects. The study was approved by the Institutional Review Board of Rutgers University in September 2003.

## Procedures

### *Documenting Laurie Schwartz's Guiding Conception*

Drawing from the framework of Peterson's (1991) Disciplined Inquiry Model (see Figure 1), before studying the three specific cases, it was necessary to document Laurie Schwartz's guiding conception. The overall guiding conception is informed by the therapist's past clinical training, as well as clinical and research literature. This documentation process was based on a series of approximately six two-hour interviews conducted by the researcher with Laurie Schwartz. In these interviews, conducted between September and December 2003, Laurie Schwartz elaborated on her training, as well as theoretical and procedural aspects of her clinical practice. The final documentation of Laurie Schwartz's guiding conception is in Chapter III.

### *Overview of Treatment Protocol*

Before treatment began, the subjects met individually with the researcher. They each completed several self-report measures as well as an interview-based goal measure. Within the study, each subject received 60 minutes of treatment per week for twelve weeks. The BcP sessions consisted of focused, body-oriented psychotherapeutic techniques and education, e.g., subjects were asked to attend to their internal physical sensations for cues to their mental states. At the end of the treatment (or the end of 12 sessions), the subjects were again assessed to evaluate their level of functioning and whether they experienced any changes due to their treatment experience. Subjects were also interviewed to determine their subjective experience of the treatment process and symptom change.<sup>4</sup>

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<sup>4</sup> Throughout the treatment each subject also filled out weekly questionnaires, which took 15 minutes after the session yet within the same day as that session, and another questionnaire, which also took 15 minutes,



## Data Collection and Measures

The data collected for this study consisted of:

1. Pre-and Post-Therapy Standardized Quantitative Measures
2. Videotaped sessions
3. Post-Treatment Subject Exit interviews

Details about each data source are provided below. Please refer to Appendix C for an outline of the assessment measures, including the time sampling for each measure.

### *Pre-and Post-Therapy Standardized Quantitative Measures*

Before beginning the study, the researcher met with each of the subjects for an initial interview in order to review and sign the consent form. Additionally, subjects completed approximately one and a half hours of questionnaires. These included: the Treatment Evaluation and Management (TEaM) Scales (Grissom, Lyons, & Lutz, 2002); the Symptom Checklist 90-Revised (Derogatis, 1993); the Scale of Body Connection (Price, 2004); and Goal Attainment Scaling (Kiresuk, Smith & Cardillo, 1994). The same measures were given at post-treatment, along with an hour-long interview.

The Treatment Evaluation and Management (TEaM) Scales (Grissom et al., 2002) comprise a self-report assessment for life history, psychological symptom severity, and personality disorders. They are designed to provide a standardized, comprehensive view of outpatients' emotional, behavioral, and diagnostic status. There is one composite, global score, called the "Behavioral Health Status" (BHS) Index, as well as three subscales designed to measure the phases of therapeutic progress: Subjective Well-Being, Symptom Checklist, and Functional Disability. The Symptom Checklist and the Functional Disability scales are also divided into seven symptom subscales and three

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immediately prior to the next session. These additional process measures went into extensive detail about clients' reactions to each session and were not included in this study.

functional disability subscales. The TEaM also has a therapeutic bond scale, a malingering index and a substance abuse screener, which were not used in the present study (Grissom et al., 2002).

In a recent article, Grissom et al. (2002) described the development of the TEaM scales and present data documenting their reliability and validity: “The internal consistency (coefficient alpha) for the full BHS scale ( $\alpha = .88$ ), [and] the BHS subscales (Subjective Well-Being,  $\alpha = .82$ ; Symptom Checklist,  $\alpha = .90$ ; Functional Disability,  $\alpha = .84$ ), the Bond Scale ( $\alpha = .83$ ), and [the] Satisfaction Scale ( $\alpha = .83$ ) were all sufficiently high to treat each scale as a single construct” (p. 406). Furthermore, the correlation between the TEaM’s Symptom Checklist and the Global Severity Index of the SCL-90-R was .88, “suggesting that the Symptom Checklist is a valid indicator of the extent and severity of psychiatric problems” (p. 407).

The Symptoms Checklist 90- Revised (Derogatis, 1994) is a widely-used self-report instrument which gives a sense of bodily and psychological symptoms. The test was designed to detect psychiatric symptoms in normal people. The scale has 90 items and uses a five-point Likert scale ranging from “not at all” to “extremely.” The total score ranges from 90 to 450; lower total scores indicate better psychological health. The three global indices include: Global Severity Index (GSI), the overall score which is the mean of all symptoms; the Positive Symptom Distress Index (PSDI); and Positive Symptom Total (PST), based on the total number of positive (i.e., more dysfunctional) symptoms present. Additionally, the SCL-90-R has nine factor scales (each based on 10 items): somatization (SOM), obsessive-compulsive (O-C), interpersonal sensitivity (I-S), depression (DEP), anxiety (ANX), hostility (HOS), phobic anxiety (PHOB), paranoid ideation (PAR) and psychoticism (PSY).

The SCL-90-R has shown both high test-retest and internal consistency, and no practice effects (Croft, 2003; Derogatis, 1994). There are more than 940 studies demonstrating reliability and validity. Internal consistency reliability coefficients range from .77 for Psychoticism to .90 for Depression. Test-retest reliability coefficients range from .68 to .90, with most coefficients between .80 and .90 (Derogatis, 1994). The SCL-90-R also offers a computer-generated clinical report, in which certain assessments are offered. Some of the statements from the report will be quoted in the case chapters.

The Scale of Body Connection (SBC) was developed by Price, a university-based Body Psychotherapy researcher, to assess a person's subjective sense of embodiment. The SBC has two distinct, uncorrelated dimensions measuring body awareness and body association. The SBC is comprised of a 5-point Likert scale in which items range from 1 (not at all) to 5 (all of the time). The SBC includes 12 items to measure body awareness and 8 items to measure body association. The Body Awareness scale ( $\alpha = .85$ ) measures conscious attention to sensory cues indicating one's bodily state, such as tension, nervousness, or peacefulness, with higher scores indicating more body awareness. The Body Dissociation scale ( $\alpha = .79$ ) measures degree of separation or connection to one's body and emotional experiences, such as ease or difficulty attending to emotion, with higher scores representing more ease of connecting with bodily experiences and emotionality. The scale has demonstrated construct validity through exploratory and confirmatory factor analysis (Price, 2004).

Goal Attainment Scaling (GAS; Kiresuk, et. al., 1994) is a measure developed for clinical and research purposes to help articulate measurable outcome goals. Goals may be set by different persons, such as the client, therapist, or researcher, depending on the purpose of the GAS. In this study, at the intake interview, the researcher assisted the client in setting

a number of goals, operationally defined in behavioral terms at five points along a scale. The five points range in terms of the rater's expectations of goal attainment in therapy, from "-2" (much less than the expected results), to "0" (predicted or expected results), to "+2" (much more than the expected results). At follow-up, the client was asked to rate degree of attainment of each of the goals using the scale developed at intake. In addition, the client's behavioral functioning on the scale at the beginning of therapy is also rated.

An example of the usage of the GAS can be seen in one of the subject's goals, which was to "stop smoking." The goal was behaviorally-defined on a spectrum from still smoking one pack per day (-2) to having a plan to quit (0) to having quit (+2). Some studies have shown the GAS to have a therapeutic impact as it helps a patient clarify goals for treatment (Fisher & Hardie, 2002). Studies have indicated satisfactory inter-rater reliability and concurrent validity for the GAS (Schlosser, 2004). Cardillo and Smith (1994) also provide a lengthy discussion of GAS reliability, which was determined by the variability of raters. Most salient to this study is that the goals were both identified and scaled by the clients, with clarification of the process by the researcher.

Since treatment was supposed to occur naturalistically, at the initial interview by the researcher, subjects were not asked for clinical history. Additionally, they were informed that the assessment measures were going to be kept separate until the end of treatment, and were instructed that if the measures administered evoked any reactions or clinical details, they ought to be communicated directly to the clinician.

After the treatment, the subject spent an hour and a half with the researcher to complete a post-treatment evaluation. First, the GAS measure was scored by the researcher with input from the client. Secondly, the subject filled out the same measures as pre-treatment, including the TEaM Scales, SCL-90, and SBC Scale.

Since the objective measures (both pre- and post- treatment) were used as a quality check for the qualitative analysis, only after the initial analysis of the cases was completed were they viewed by the clinician or researcher, at which point were they compared with the other data as a source of reliability information and quality control. In other words, with this set of procedures, the objective measures functioned as an independent source of data against which to compare and contextualize the qualitative results. Within-subject, pre and post measures were compared and are discussed in each case chapter.

#### *Videotaped Sessions*

There is an extensive history of using videotapes of sessions in psychotherapy research (Alpert, 1996). McCullough et al. (2003b) describe some of the benefits of videotaping: as a way for therapists to review their work, assess how interventions were received, and, most importantly, discover what might have been missed initially. “It is particularly helpful in affect-based therapy since video of the patient’s face may well reveal affect that the therapist missed during session” (p.1). In this study, videotaping the treatment sessions provided an important source of data, because examining the way that a BcP practitioner works with the client offers a level of “objective” data and thus a most useful way to understand the work.

Selected sections of each subject’s therapy sessions were additionally reviewed together by the therapist and researcher in order to discuss and elaborate on the treatment process. During these sessions, the practitioner discussed her guiding conception (see Chapter III), including interventions used and revised according to subject feedback. This process helped explicate the way the practitioner’s guiding conception played out with each subject.

#### *Post-treatment Subject Exit Interviews*

Directly after completing the 12 sessions, the subject had an exit interview with the researcher. Unlike the initial interview, at which the researcher did not explore clinical

information, this meeting included a semi-structured interview developed by the researcher (see Appendix D). At this point, subjects were debriefed about the study and asked any remaining questions.

## Data Analysis

### *Qualitative Data Analysis*

This study uses Peterson's Disciplined Inquiry model (1991) to articulate a clinically useful "microtheory" (as elaborated by Greenberg and Pinsof, 1986). It seeks to develop this microanalysis through "thick" description, as well as a combination of qualitative and quantitative approaches within the pragmatic, client-centered focus (Fishman, 1999). As Greenberg and Pinsof (1986) suggest, developing context specific microtheory is an important guide in psychotherapy process research. The term microtheory refers to specifying moments and episodes "(the "when") for empirical investigation," as well as the process and outcome variables "(the "what") to be examined in episodes" (p. 9). As the authors explain: "Without good microtheory, research increasingly resembles a fishing expedition with a relatively low likelihood of discovering significant process-outcome links" (p.8). They propose that the pressure to clarify and develop microtheory will lead to an evolutionary process in which therapists are forced to refine and specify further psychotherapeutic theory. The PCS Method was utilized in this study due to its ability to lead to a BcP microtheory (i.e., Laurie Schwartz's guiding conception), and thereby contribute a necessary step to empirically defining BcP theory.

In explicating the work of BcP therapist Laurie Schwartz, the researcher and clinician identified themes that are involved in the theory of a BcP treatment. These themes became the basis of the narrative analysis. Not surprisingly, since this study involved an inductive analysis based on a large data set, many themes were identified. The researcher selected

three core themes for individual case analysis so as to guide cross-case analysis. All three themes relate to the overall question of how a practitioner alters her guiding conception based on the needs of the individual client. The themes used for the analysis are explained in Chapter IV; the total list of themes is found in Appendix A.

Using these three themes as the lens, the case analysis consisted of combining the various sources of data, particularly drawing heavily on the transcripts of the videos as well as the video review with the practitioner, in order to describe how the practitioner assessed the client's needs, how she formulated the client's process, and through treatment monitored the client's responses and reintegrated them into her theory of practice. Stated another way, how Laurie Schwartz worked with each client along the three dimensions provides the orientation for the process analysis.

Due to the extensive amount of data, the detailed analysis was limited to sessions 1, 6, and 12, which were analyzed in depth as well as explicated in narrative format. This detailed analysis was based upon both the researcher's independent review of the videotape and transcripts of these sessions along with the detailed review of the sessions in meetings of the researcher and the therapist.

The in-depth sessions are reported in a narrative format as a way to ground the reader in the data of the case.<sup>5</sup> Despite the narrative format, however, not all aspects of the session are included; that is, thematic narrative sampling was conducted by the researcher to provide a focus for analysis. It is important to note that focusing primarily on sessions 1, 6, and 12 portrays a linear model that runs counter to Laurie Schwartz's more holistic style of working; it was a compromise to structure the analysis. The in-between sessions for each case are summarized in Appendices E, F, and G.

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<sup>5</sup> In the case of Ray, only sessions one and six were described because he terminated treatment after session six.

### *Quantitative Data Analysis*

By conducting an initial analysis of the cases without the quantitative data, the latter were able to serve both as a quality control and offer a second, independent perspective on the therapy. Since the narrative and quantitative data each have a distinct and different strengths and limitations, convergences and divergences in these two types of independent data were important to analyze.

The objective measures additionally functioned as more than quality control. They provided a normative context for comparing the three clients with the larger client population. The statistical test that appeared most consistent with the themes of the treatment was the Reliable Change Index (RC) developed by Jacobson and Truax (1991) to measure “clinically-significant change.” The RC requires an indicator of test-retest reliability for the measure in question. Such indicators were available for the SCL-90-R measures. Since the only indicators of reliability for the TEaM measures were internal consistency, for the TEaM measures, test-retest reliability was estimated from the internal consistency indicators. Because of this, it should be noted that statistical conclusions for the TEaM measure are probably over-estimates of actual significance, since internal consistency indicators of reliability tend to be higher than test-retest indicators. Statistical significance was set at the two-tailed probability of .05 or less. Scores that did not approach significance were analyzed for their descriptive trends.

A few additional, important points about the TEaM and SCL-90-R scores should be noted: All scores on these two measures were converted to T-scores, with a mean of 50 and a standard deviation of 10. The scores on the TEaM measures were calculated so that the higher the score, the “healthier” the client – that is, the higher the level of functioning and the lower the level of symptoms. Moreover, for the TEaM measure, the normative



population on which the T-scores are based are psychotherapy outpatients, so that a score of 50 is representative of the average outpatient, a score of 40 is one standard deviation worse than the average outpatient, and a score of 60 is one standard deviation better than the average outpatient.

The scores on the SCL-90-R measures were calculated so that the higher the score, the “less healthy” the client – that is, the higher the level of symptoms. Moreover, for the SCL-90-R measure, the normative population on which the T-scores are based are a nonpsychiatric, “normal” population not in psychotherapy, so that a score of 50 is representative of the average normal person, a score of 40 is one standard deviation better than the average normal person, and a score of 60 is one standard deviation worse than the average normal person.

In sum, the focus of this study’s analysis will be what Greenberg and Pinsof (1986) refer to as “the techniques of sequential and contextual analysis” (p. 14), which were used to look in-depth at three cases of a single practitioner of body psychotherapy. A comparison of the results yielded by the researcher’s analysis of the qualitative data and by the quantitative measures across the subjects is addressed in Chapter VIII.

#### Strengths and Limitations of the Study

This study draws on an effectiveness rather than on an efficacy research design. In other words, it is concerned with examining what happens in the naturalistic practice of BcP rather than with investigating practice in an externally controlled environment. This study can be considered a preliminary examination of Body-centered Psychotherapy.

There are several quality controls in the research design. One is the use of several sources of data, including, for example, videotapes of sessions, standardized questionnaires, and semi-structured interviews. Another source of quality control is that the standardized,

quantitative, self-report surveys were only scored and analyzed after the videotapes were analyzed, preventing the possibility of the quantitative results affecting the interpretation of the qualitative results. A third control is the inclusion of different perspectives on the qualitative data, including those of the independent researcher, the client, and the therapist. However, the main portion of the analysis was completed by a single researcher, although informed by the therapist, which does not provide the opportunity to assess rigorously the reliability of the analysis. This limitation could have been addressed by having additional researchers separately analyze the data and compare their results with those of the original researcher. Unfortunately, this option was not logistically feasible.

The ways in which subjects were selected also offered a limitation. Additionally, in terms of traditional psychometric considerations, an individual case is an  $n$  of 1 does not directly generalize to other cases. That is, each case studied in extensive, “thick” detail has the capacity for high internal and low external validity. As more and more cases of a similar type become available, however, it will become more possible to develop external validity via inductive generalizations across the group of cases as a whole (Fishman, 1999, 2005).

Videotaping influences both the practitioner and subject. However, the practitioner in this study was already videotaping many of her therapy sessions, which she has used for teaching and supervision. Therefore her videotaping of sessions is reflective of her current work, and does not introduce a new variable. Reviewing sessions with another person during treatment did veer from the practitioner’s usual practice and introduced an unknown variable.

## CHAPTER III

### LAURIE SCHWARTZ'S GUIDING CONCEPTION

The focus of this chapter is to articulate practitioner Laurie Schwartz's guiding conception of practice ("B" and "C" in Figure 1) as elaborated by Peterson (1991). (Hereafter she will be referred to simply as "Laurie.") Subsequently, in the case chapters V, VI, and VII, we will examine how this practitioner's guiding conception interacts with the client's needs in a "thickly-described," systematic way (Fishman, 1999). This chapter is divided into three sections: the first traces Laurie's professional training, highlighting how each training added to her skill set; the second elaborates her guiding theoretical concepts; the third describes her clinical practice, including her ongoing process of assessment, formulation and treatment planning.

#### Preface: Laurie's Office

To understand Laurie's practice, one must first understand the fish tank in her office apartment. Although her work involves helping clients slow down to listen deeply to their inner sensations, Laurie practices on a high floor of a skyscraper in the middle of one of the noisiest and busiest city miles in Manhattan. Yet once you step inside her comfortable office suite, it is entirely quiet. The only noise is the fish tank, which bubbles soothingly. Interestingly, there are no fish in the tank. Instead, it is an awareness-changing device, subtly shifting the listener's consciousness from the noise of the street and "normal" consciousness to a more present mindset. Just by walking into her domain, a client is inclined to slow down and listen intently.

## Section I: Theoretical Development

### *Early Education: College and Peace Corps*

Laurie began her professional studies receiving a B.A. at Grinnell College, Iowa. Based on a tutorial system, Laurie studied “Mind, Language and Reality” as her first seminar. This love of studying people led her to three years in the Peace Corps in Kenya, where she taught music. During this time she developed a love for physicality through drumming and became keenly aware of the embodiment expressed in different cultures:

[White European-American] culture is based on creative impulses, creativity, manifestation – making things happen, doing, thinking, and feeling. We are an extroverted culture. Unlike China or Japan, where there is more attention to being receptive, valuing going slow, mindfulness. We are so focused on the individual – there is a loneliness in our culture. Tribal cultures have a lot less loneliness and isolation, but don’t have the same privacy and autonomy.

A key component of her therapy involves following the particular learning patterns of her clients as they are embodied in gestures, manners, voice tones, etc. When she returned from Africa, she encountered the burgeoning work of Ilana Rubenfeld, which “turned my universe around.”

### *Ilana Rubenfeld Synergy*

The Rubenfeld Synergy method is one of the first systems of BcP (Caldwell, 1997b). Ilana Rubenfeld was a Julliard-trained conductor who realized that there were powerful connections between verbal and somatic emotional processing. She left the conducting world and went to Esalen Institute in California, where she met and trained with leaders such as Moshe Feldenkrais and Fritz Perls, who were innovatively studying body awareness and psychotherapy. She combined her trainings into the development of Rubenfeld Synergy – a combination of Gestalt therapy, Feldenkrais work, Alexander Technique, and group process work (Rubenfeld, 2000).

Feldenkrais was one of the foremost body-oriented movement teachers of the twentieth century. He developed Awareness Through Movement, a system of movement exercises based on the belief that the way to change the mind is by changing the body. Feldenkrais believed that a flexible body meant a flexible mind – if you teach the legs to move then the mind will get more flexible. Laurie learned a great deal about how to track the body and to work with the integration of emotion and physical body. Despite the powerful results, Laurie wanted further training in psychological theories.

#### *Art Therapy*

Concurrently, Laurie was training as a Gestalt art therapist with Elaine Rapp at the New Gestalt Institute and in Freudian-based art therapy with Erica Steinberger at the New School for Social Research in New York City. She found that many of the art techniques helped clients build more self awareness in imaginative ways. Laurie found art particularly useful for clients who were overwhelmed by their affect and needed a safe intermediary way to express themselves. Art therapy taught Laurie a flexible, creative style and is reflected in her assessment tool of the series of eight pictures (explained in Section III below).

#### *Massage School and Jin Shin Jyutsu*

After her Rubenfeld Synergy training, Laurie obtained a massage license at the Swedish Institute in New York City. In addition to the official licensure (which allowed her to practice Rubenfeld Synergy), massage school exposed her to Jin Shin Jyutsu, a type of Chinese energy work which was brought from Japan to the United States by Mary Burmeister. Through Jin Shin Jyutsu, she learned about theories of energy flow in the body, principally in the meridians, as well as other Eastern approaches to understanding the body:

That's when I got interested in relationship of muscle to meridian to emotion. Why do some people get bodily symptoms and what is causing them? And what is a healthy body? How do you integrate a person's awareness of their body with their everyday life? How would listening to pulses help to understand your inner world?

Massage school provided Laurie with excellent training in addressing clients' physical needs, but very little on emotional needs of the client. Laurie recognized that further relational training would be very important for her in working with the body.

### *Hakomi Therapy*

Hakomi therapy was developed by Ron Kurtz, who applied a systems orientation and a Buddhist way of living to working with the body in a psychotherapeutic way. Kurtz had been in analysis with John Pierrakos, the founder of Core Energetics.<sup>6</sup> Hakomi (which means "How do you stand in relation to the many realms" in Hopi) has five main principles: mindfulness, unity, organicity, non-violence, and mind-body-spirit wholism (Kurtz & Minton, 1997). Hakomi therapy teaches that humans are self-organizing systems organized around habit patterns, at the center of which is a core state of being. That core state is accessed through a process of mindfulness – in which the person watches his or her own bodily sensations, thoughts, feelings, images, memories, and core beliefs. Mindfulness will be described in more detail in Section II of this chapter.

Many theoretical concepts and techniques crystallized for Laurie through her Hakomi training, as it combines Feldenkrais, Freudian character theory, Reichian character theory, the Eastern approach of mindfulness, and a systems orientation. Laurie is currently on the faculty of the Hakomi Institute as a teacher and supervisor.

Since Laurie found that the majority of her training in Hakomi emphasized mindfulness, and in most instances the client's eyes were closed, she felt the need to seek additional

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<sup>6</sup> Pierrakos was himself a disciple of Wilhelm Reich, the grandfather of Body Psychotherapy.

experience and training in working with transference and countertransference reactions, as well as aggression and trauma. Laurie wanted further training about how to work with complex feelings in the therapeutic alliance, particularly negative transference, as well as the more overwhelming traumas of her clients, which led her to investigate the training program of Dr. Louis Ormont.

#### *Modern Group Psychotherapy*

This training with Louis Ormont, Ph.D. involved a great deal of group work in the here-and-now around affect and interpersonal communication. Laurie emphasized how this work was very different from Hakomi, which was introverted, as Ormont's work was very extroverted – with people discussing their thoughts and feelings that were happening towards each other in that present moment in the training groups. Ormont's training emphasized verbal, emotional communication in the present moment, which was a complement to Laurie's other trainings.

#### *Training in Jungian Psychotherapy*

Laurie underwent a three-year professional enrichment training in Jungian psychotherapy with Don Kalshed, Ph.D. During this training, students were exposed to prominent Jungian analysts, who shared their orientations towards transformation, and Jungian concepts such as shadow, complex, and anime. This training gave her the ability to work with dreams and archetypes, as well as more facility in working symbolically with clients by using metaphors.

#### *Somatic Experiencing*

Laurie was first introduced to Peter Levine's work at a Hakomi conference, where she witnessed Levine renegotiate a trauma from beginning to end. Soon thereafter, Laurie had a client who would dissociate as he was becoming mindful of his somatic states. She flew to

Boulder, Colorado for two weeks, where she watched Levine work with the client and take him through many states of trauma renegotiation and resolution. As she later came to understand Levine's method, in its rigorous step-by-step through the body's impulses, she saw how it is possible to help the person renegotiate and resolve long held traumatic memories through the "language of sensation."

Laurie started studying the effects of trauma on peoples' nervous systems and how trauma affects a person's ability to stay present, as well as have effective boundaries in relationships. She began to ask about healthy embodiment and why it is so rare in our culture. She is now a supervisor in Somatic Experiencing with a focus on helping therapists remain grounded in their own nervous systems as they do this difficult work.

### *Masters of Science in Counseling*

Due to recent changes in New York State licensure laws, Laurie returned to school for a masters degree in counseling with a specialization in loss and bereavement at Pace University. She has completed the requirements and has become a licensed M.S. in counseling in New York State.

## Section II: Guiding Theory

### *The Model of Health*

In Laurie's theory of BcP, the ideal of health is for a client to move towards a more related way of being with one's self and body, aware of sensations, feelings, and thoughts, while staying related to other people. This therapeutic model draws from psychodynamic developmental theory, including object relations and self-psychology elements focusing on the mother-infant dyad (Aron & Anderson, 1998; Schore, 1994).

In Laurie's theoretical framework, individuals have a core essence which, given supportive conditions in infancy, guides the person's development into a fully-formed



healthy adult. If children are loved and nourished, then they can be creative, feel seen, have social engagement; they learn that their needs can be met, that they can express themselves, and successfully follow their impulses. If the parent is relaxed and grounded and gives the infant a feeling of containment, the infant has a chance to become “oneself” – a person who learns that there is a boundary around him or herself as separate and not just as an extension of another person. All of these help a child feel happy and balanced, with a core self that is capable of communicating a broad spectrum of feeling states.

As studies have shown, much regulation of affect occurs between caretaker and infant (Porges, 1997; Schore, 1994; Tronick, 1989). A large part of a child’s self, including the ability to regulate its own nervous system, develops in this dyadic connection (Schore, 1994; Tronick, Bruschiweiler-Stern, Harrison, Lyons-Ruth, Morgan, Nahum, Sander, & Stern, 1998). It is through this relational process that children develop a sense of self as well as a self in relationship, a concept which forms the backbone of Laurie’s method of BcP work.

Since much communication between mother and infant is somatic and non-verbal, it is in this early stage of development that persons begin learning to self-regulate, i.e., modulate their affective levels within their nervous systems. The goal is to encourage health by helping people biologically self-regulate and enjoy emotional resiliency (Caldwell, 1997a). Biological self-regulation means that a person’s nervous system can fluidly go through states of activation and discharge (Levine, 1997) while staying “contained” and emotionally resilient. Contained or grounded means that a person has “somatic boundaries,” in which energy remains within the person’s body (e.g., a client feels an impulse to fight) and can be worked out through image or cognition so she or he need not be in a fight/flight response of attack (e.g., punch someone) or withdraw (e.g., act cold and reserved). Emotional resiliency

means the ability to let emotions flow through one's system without having to act on them impulsively or deny them by blocking or repressing.

Health has an interpersonal aspect, as well as a somatic component. Health is being able to “be” in one's body, name feelings verbally, move in a fluid way from one feeling state to another, discriminate between them, make decisions freely, tap into creative inspiration, and self-regulate one's nervous system. Therefore, health involves learning to remain in one's body consciously while staying in relation to others.

*What happens: The Model of Dysfunction in Development*

Due to genetic, biological, societal, and emotional factors, many people grow up not to be embodied or grounded. Often the result of inadequate holding by caretakers, lack of mirroring, and not enough experience of feeling separate and contained, is that the body must overcompensate in order to hold the “self” together. The “armoring” of the body – the holding patterns that often make up a person's rigid or collapsed body posture, can result from these early psychological deficits (Kurtz, 1990; Kurtz & Prester, 1976; Reich, 1945). The effect of such developmental deficits is that many adults do not know how to connect with their inner resources, i.e. allow their selves to be nourished. Therefore, one of Laurie's main tenets of practice is aiding clients in bringing characterological patterns to consciousness as an important part of the healing process. The process for achieving this is working in mindfulness-based consciousness.

Based on Buddhist meditation practice and a central tenet of Hakomi therapy (Kurtz, 1990), mindfulness is an awareness-based state of consciousness in which a person has heightened attentiveness to his or her inner states, without judgment. Mindfulness usually occurs with the eyes closed as clients look inward and stay present for whatever thoughts, feelings, memories, images, impulses, and sensations emerge moment-to-moment. Laurie's

theory of change focuses on helping a person understand and heal the wounds of an infant/caretaker breach by encouraging clients to witness, experience, and understand their habit patterns and how they are organized, in order to change them. If a person can get into a state of mindfulness, she or he can come to observe their beliefs and habit patterns manifest in their body through physical behaviors and gestures – and in doing so access a core self (Kurtz, 1990). Throughout the treatment, Laurie sets up “experiments in consciousness” to see both how clients respond and how they understand their responses (e.g. “I always thought that I had to live with that tightness in my back. I never realized I was angry”).

BcP practitioners believe that transformation doesn’t happen in ordinary consciousness. Mindfulness is a process of slowing down to notice: “Let’s take a moment...as you stay with your hands, notice how your hands feel on your leg.” Mindfulness, because of the heightened awareness, often gives people the sense of the altering of time. “Some report that five minutes seems like an hour; others that an hour is experienced as five minutes. It’s not hypnosis, but it’s a light trance.” With its focus on slowing down to understand the subtleties of bodily awareness, mindfulness is considered a bridge between normal consciousness and the unconscious.

Yet clients who cannot access mindfulness often have serious trauma histories resulting in severe hypervigilance (e.g., the case of Jan). In Laurie’s model, trauma is conceptualized as energetic impulses frozen in the nervous system without discharge (Levine, 1997; van der Kolk, 1994). When events cause enormous “shock trauma” (e.g. rape, violent attacks, military action, disasters, accidents, etc.), they flood and override the coping of the nervous system. Levine (1997) describes how unlike animals who shake off the freeze through twitching, shaking, or moving, which helps them regain their normal function, often humans do not move through the survival response to resolution. People are impacted by traumatic

experiences, and if they cannot metabolize them cognitively, emotionally, and sensorily so that the person does not complete the response, the energy remains potentiated in the nervous system; thus the person remains “frozen in time” (van der Kolk, 1994).

Many people live in a state of traumatic hyper-arousal, which leads them to feel exhausted and depressed, suggesting over-stimulated nervous systems without sufficient discharge. Laurie explains how she finds people use medicine too often to regulate the nervous system or push through bodily discomfort to such an extent that they numb their awareness of their bodily states. In these cases, the sympathetic nervous system continues to fire in the brainstem and limbic system (activating fight/flight) without adequate regulation by the parasympathetic nervous system (which activates calm and relaxation).

The focus of trauma-oriented work is therefore to bring the nervous system back into biological self-regulation by completing the frozen response. Laurie believes clients can be helped to resolve trauma by slowing them down so their bodies can complete defensive orienting motor responses (Levine, 1997). She follows Levine’s model of going step-by-step through the “felt sense” of bodily sensation so clients learn to stay in their bodily sensations as well as learn the language of sensation (i.e., tingling, freezing, warmth). Unblocking frozen trauma in the nervous system often involves such physical discharge as heat, sweating, palpitations, shaking, and twitching.

It is not, however, enough to experience one’s bodily sensations. A lot of Laurie’s work therefore involves helping clients be able to relax in their bodies, because if a client cannot access relaxation, then they cannot work at the levels of high excitation of trauma without fear and tension overtaking them. Therefore, the first aspect of Laurie’s work is to teach her clients to access their inner resources, i.e., experiencing positive feelings of relaxation and grounding. Ultimately the goal is for clients to access their inner resources for themselves.

This means to know what their sources of nourishment are, both internally (take a bath, read, meditate) and externally (call a friend, set a boundary with a person, etc.). If they were to tell their stories without such bodily grounding, they would merely be reliving the trauma sensations without any healing effect, and once they know how to access their own resources, they have much more capacity for resilience.

### *Physical Touch*

To understand the role of touch in Laurie's guiding conception, it is important to understand that there is a direct connection between mindfulness, awareness of sensation (for healing trauma), and touch. Awareness of inner bodily sensations does not come naturally to many people who are traumatized or characterologically cut off from their bodies and bodily sensations. Touch is used as an important technique for teaching clients awareness of their own body sensations, i.e. their "felt sense." Often without any physical touch, a person can stay largely cognitively oriented, cut off from much of their experience. Touch can therefore help clients develop a sense of their inner sensory world, and thereby develop kinesthetic and body ego.

At the beginning of therapy, Laurie prepares clients for the touch component in her treatment, and revisits their comfort and safety frequently. As discussed in Laurie's consent form: "Touch may be used as an 'experiment in mindfulness' to support ('take over') physical protective posture. Nothing will be done without your approval and your sense of feeling safe and right about it. You are invited and encouraged to discuss openly and freely with me any question or concern you might have about the process we are in together at any time." In addition to the informed consent at the outset of treatment, Laurie additionally asks for explicit permission before she uses any physical touch.

It is unusual for Laurie to touch a client within the first few sessions, as it takes time for appropriate safety to develop in the alliance and to understand how touch technique will interact with a client's needs. Laurie emphasizes being in the moment with the client and following the needs of her client, trying to let the client's unconscious lead the way. In Laurie's own words, "My conceptual model is I don't force myself to diagnose or analyze a client right away – if you are in the present moment and have implicit trust in the body, and you partner them moment to moment, then memories that are stored in the cells of the body will reveal when the person is ready."

#### *Establishment of Therapeutic Alliance*

First and foremost Laurie stresses the importance of developing a secure therapeutic alliance: "It is the broth of the soup. Only after that alliance are the techniques and methods." Although this common factor is true across psychotherapies (Messer & Wampold, 2002), since trust and safety are so important to BcP, including new language and body-centered techniques, the extent that the alliance is necessary is worth underscoring. Consistently in their feedback, the subjects cited the safety that Laurie created in their relationships as essential to their being able to do the BcP work and experience change.

#### *Therapist's Use of Self*

The embodiment of the practitioner is crucial to helping the client become embodied. Laurie uses a metaphor of two trees: "I have to be really rooted if my client is not rooted; I'm trying to teach them to root – how can they root and then come out into the world if I'm not rooted? I must live, embody, and practice from the inside what I teach...If I don't model it, I will not impact my clients."

### *Case Example*

A boy sexually abused at age seven was only aware of numbness in his body. In Laurie's assessment, his body appeared frozen. With Laurie's guidance, he closed his eyes and entered a state of mindfulness. He started to have image of his cousin coming into the room; he spoke with great affect of the fear and his need to be protected. His legs were tight and began shaking. Laurie joined him with empathy and gently placed her hands on his legs and held them to give him safety. Through the safety she offered by her "containment" in pressure on his legs, as well as her calm presence in dyadic connection, he relaxed, at which point his whole body started to shake. According to Laurie's guiding conception, the nervous system was processing biologically what it could not at the time of threat. The boy shook for several minutes, then slowed, and stopped, completing an emotional and biological response. At the next session, he reported feeling lighter and less stiff, having a more heightened awareness of his body, including a capacity to feel sensations in his body.

### Section III: A Holistic Model of Clinical Practice

Unlike therapies that describe linear models of assessment, formulation, and treatment planning, BcP is a more "holistic" therapy which involves an ever-reflexive cycle of formulating as one treats, and incorporating the information into assessment as a movement towards a treatment (Shannon, 2002). Such reflexivity therefore inherently limits the development of discrete categories of clinical assessment, case formulation, and treatment planning; the sections below were created by the researcher.

### *The Referrals*

Many of Laurie's referrals come referred from clients she has worked with or through her various training programs. She has had a private practice for 25 years and presently teaches and supervises therapists who are studying Hakomi and Somatic Experiencing.

Since the field of BcP is small, Laurie also gets regular referrals from practitioners in Colorado and California and from clients in other cities who have family or friends in New York City. Most people come to BcP after trying other therapeutic modalities; many clients are searching for relief of chronic symptoms or want more embodiment after many years in other therapies. For example, one woman had been in therapy for twenty years, yet had not felt she had worked through her issues to resolution.

*The Clients (“A” in Figure 1)*

Laurie differentiates among five types of clients, namely: 1) those who struggle with a specific “external” issue (e.g., marriage, relationship or resolving some conflict with a family member); 2) those who are interested solely in talk-based psychotherapy; 3) those who know someone who has tried BcP and are interested in trying it; 4) those who already have a primary therapist and want BcP as an adjunctive treatment; and 5) those who want long-term-oriented therapy and require Laurie to gather a lot more information about their past, as well as discover what the clients’ needs are.

Another important distinction Laurie makes in clients’ needs is whether or not they are in crisis. Crisis-oriented, symptom-focused work is very different than growth-oriented, long-term treatment. When clients come in crisis, Laurie brings them in right away to address the symptom and work on grounding the client. For clients not in crisis, Laurie spends more time in assessment. She finds out what they’ve done in past that’s helped them, including previous therapy and bodywork experiences. In this case, she gives them a questionnaire to take home to give her information about their work, life, and health, as well as goals and intentions. These are the type of client who were inducted into this study.



*Assessment (“D” in Figure 1)*

A BcP assessment involves taking in both verbal data and the physical data of the client. Often the first step of Laurie’s assessment process begins on the phone. The first step is to understand: What is leading them to call me at this point in their life? What made them choose me? Who referred me? Laurie often meets with potential clients in order to assess if they are appropriate for BcP. Even for this study, Laurie initially screened clients by phone, and met briefly with one of them in order to assess whether they would be appropriate for the study – particularly since videotaping was a crucial requirement, and it demands more of the client in exposing their process.

For clarity’s sake, the researcher categorized aspects of Laurie’s assessment of a client’s embodiment. However, her assessment blends all the following aspects:

Essence: Where is this person in relationship to self? To their caretakers? How far is this person from the ideal notion of health?

Biological: Is this person able to regulate biologically? Does this person know what self-regulation looks like and feels like?

Embodiment: How are they connected to and with their body? Where is energy moving or not moving in their body? Are they able to stay in their body?

Sensation: Are they aware of sensation? –e.g., my jaw is tight, my upper body feels empty, my lower body feels like lead. Are they able to ground in sensation?

Affect: Can they be in a feeling state? Can they articulate a feeling state? Do they have emotional resiliency? Can they be in touch with all their feelings and still function?

Cognitive: Can they identify thoughts and beliefs that are influencing their daily life?

Family systems: What are the developmental experiences and memories that are affecting their sense of self? What affecting them might be generational?

Goals/Intentionality: What would you like to work on today? That is, where are they in their life journey and what would be helpful in this stage?

Consciousness/Awareness: How much awareness does this person have? Where is their awareness of their feelings, my presence – who am I to them?

Mindfulness: Are they capable of mindfulness? Are they capable of tracking? How do they feel about going into mindfulness, especially closing their eyes?

### *Formulation and Treatment Plan (“E” in Figure 1)*

To create a formulation, Laurie begins and ends with the questions: what was missing in development that this person needs in the present moment? How is that person in relationship with his or her body and how ready is someone for this work? Laurie uses four kinds of questions for formulation: Does the client know how to be grounded? What is missing for the client at the level of bonding? What is the intention of the client? Can the client access mindfulness?

### *A Note about Diagnoses*

Due to Laurie’s holistic focus, she does not use traditional DSM-IV-TR diagnoses. The diagnoses in the cases were formulated by the researcher as a guide for readers, and do not reflect the work of the practitioner.

### *Treatment Plan*

Interventions can be conceptualized on four different levels:

The Developmental Level: She strives to identify and support clients’ unmet developmental needs, to learn to nourish and develop in ways they were not able to at a young age (i.e., a person who did not have enough contact learns to “hold herself” and someone without enough mirroring learns to affirm himself). Additionally, Laurie helps clients make the unconscious conscious.

The Trauma/biological Level: Laurie works with clients to come out of trauma reactions and re-regulate their nervous systems.

The Characterological Level: She often works to attend to habit patterns so clients can understand their characterological organization.

The Dream/Spirit Level: Laurie works with dream analysis and imagery to access formerly unaware beliefs, feelings, and behaviors. She follows the psychodynamic principle that such access leads to more healthy control and life choices.

In the first few sessions (1, 2, 3, and 4), Laurie is not trying to “add to the system.” Instead, she wants to assesses how a person is organized, e.g., what defenses they use to survive. She is analyzing character structure as well as looking for the unmet developmental

needs beneath the coping defenses. Also, she is looking at what resources a person has and how they empower themselves in situations.

In the middle sessions (5, 6, 7, and 8), Laurie is working on how to continue to find nourishment and inner resources in the middle of painful material. The clients are actively working to bring nourishing imagery (e.g., “who would you place in the room with you?”) and exploring what it is like inside their bodies. Spontaneous gestures are followed and examined in mindfulness.

In the later sessions (9, 10, 11, and 12), the client has learned new skills such as being able to access inner resources and nourishment. As more traumatic sensations and memories emerge, the client can practice finding inner resources within herself. These sessions are about practicing skills and continuing to bring oneself back to the body

#### *Use of Art: Picture Exercise*

An excellent example of the interweaving of assessment, formulation, and treatment is Laurie’s drawing technique. Towards the beginning of therapy, she asks her clients to draw a series of eight drawings. She explains that picture #1 should represent how they feel at the present moment, #8 where they would like to be “If you could walk out and feel full and whole,” and #2-6 are in between, “just see what the unconscious brings up with permission to express itself.” She finds these pictures immensely helpful in getting a better understanding of her clients (assessment and formulation), as well as helping them clarify goals for therapy (treatment plan). Furthermore, she often uses them in session. Thus, when references are made to pictures in the case chapters, it is to this integrated series of pictures drawn by each client.

*Working with Dreams*

Laurie uses dreams as a diagnostic tool to assess what is going on in the unconscious. Often Laurie will ask clients to recount the dream in mindfulness as a way to integrate the dream with the clients' experiences in the present moment. She often asks clients to keep dream diaries and then uses them in the clinical work.

*Final Conclusions: The Spiritual Journey Inside Clinical Practice*

There is a part of this BcP therapy that Laurie defines as spiritual. As Laurie explains, "I believe that most people did not have a satisfying bonding experience so they are comfortable in their own skin. A goal of a lot of spiritual disciplines is to feel connected and loving – how am I going to feel loving towards the world when I don't feel loving towards myself. When you feel love you also feel your essence."

## CHAPTER IV

### INTRODUCTION TO CASE STUDIES

#### Themes used in Case Analysis

The case studies in the following chapters represent unique individuals. Examining what each client brought to treatment in terms of presenting complaints, goals for treatment, diagnoses, demographics, and motivation for treatment, and subsequently how Laurie responded to that information in a way that was potentially healing to the client is the crux of what was examined through the following case analyses. The initial analysis of the case material by clinician and researcher led to 19 inductively derived themes (see Appendix A). The three themes described here were chosen due to their salience in addressing how to combine talk and touch in a single therapy.

#### *Theme 1: Helping the Client Feel “Nourished” by Internal Resources*

An important part of a BcP treatment is helping a client feel on a sensory level their inner resources or “nourishment,” e.g., clients feeling relaxed or joyful in their bodies. As discussed in the guiding conception, only when people are grounded in a way that they can connect with their core strength can they tolerate the difficult sensations of trauma. It is the back and forth (i.e., “pendulation”) between a client being exposed to the trauma sensations, then to nourished feelings of inner strength or “resource,” that provides the

healing. Ultimately people can experience nourishment freely in their bodies without subsequent trauma sensations.

Too often the work of verbal psychotherapy has been problem or deficit-focused. BcP's emphasis on working with the bodily experience of positive feeling and the other sensations that get in the way of feeling enjoyment (often through tightness or fear sensations related to guilt, shame, anxiety) offers a major paradigmatic shift in treatment. BcP is therefore first and foremost around "empowerment": helping clients find their nourishment in an embodied way and then helping clients stay empowered to stay connected with their inner resources even while facing uncomfortable or unbearable sensations of trauma. How Laurie works with each of these clients with the goal of feeling "nourished," and subsequently how she works to help them maintain pleasurable feeling in the face of trauma sensations is an essential component of this BcP approach.

### *Theme 2: Using Physical Touch*

This is the theme that provided the fundamental issue for this study. The hypothesis was that touch can provide a healing modality that is different from talk. How does a BcP practitioner use touch in therapy? When to touch the client, at what points in treatment, and what is the client doing that leads to introducing touch? How does she initiate it? What are the constraints? Does touch work change as people get used to the technique in therapy? And most importantly, how is it used in conjunction with verbal interventions?

### *Theme 3: Telling the Story: Working with Narrative Versus Body*

This theme involves the complicated question of how much clients have to tell their stories in order to address how to combine talk and touch in a single therapy. Laurie's guiding conception includes the belief that a client must be adequately grounded before

telling a trauma narrative, otherwise the client may get overwhelmed and healing will not occur. At times clients attempt to continue their verbal narratives, as they seem more inclined to “figure out” through talk and thus appear at odds with Laurie’s body-orientation. Often there is some struggle between therapist and client around how much to focus on body techniques versus verbalizing at a point in the treatment.

#### A Note about Language and Formatting

In studying this experiential BcP, it is quite difficult at times to find language to capture the experience of body-awareness. Where possible, body language has been incorporated in the data in brackets within the quotations. The reader may assume that if no specific language is used, the client is sitting on a sofa with Laurie sitting in a chair directly across from the client. As described in Chapter III, Laurie’s office is replete with soft items, including a large couch, a carpeted floor, and a body-length pad used for floor work (e.g., case of Terry, session 6). At times the dyad will have eye contact, but more often clients will have their eyes closed, reclining, working in mindfulness.

The reader will also note that in each case’s formulation section there is no separate section on treatment plan. As Laurie’s treatment develops inductively, consistent with the Disciplined Inquiry model, a section entitled “Monitoring Evaluation” (“G” in Figure 1) follows each narrative session, which summarizes how Laurie incorporated what she learned in order to continue formulating her individualized treatment plan for the continuing sessions.

In the narrative sections of the cases, this researcher’s commentaries precede and introduce the quoted material discussed. Additionally, particular emphasis on certain phrases in the quoted case material was accentuated by the researcher with boldface type.

## CHAPTER V

### THE CASE OF JAN

*What I sense is happening is that the frozen part of me is unfreezing, you know, and so it's present. Yeah, I feel it. It is present. I feel that it is a part of me that I haven't been connected to that was frozen and so I have a lot of joy around the fact that I'm connected to it, you know? So what I'm doing is experiencing it and letting it be present because that's what I longed for is to be connected to myself. That seems to be what's happening, which is what I want. So it's kind of like I want to honor whatever is happening and whatever happened that I'm now experiencing.*  
*-Jan, session 11*

Client ("A" in Figure 1)

#### *Introduction*

Jan, a 49-year old, Caucasian, Catholic, divorced, professional woman, presented with long-term symptoms of tension and anxiety around sexual and physical abuse by her father. She had no explicit memories of sexual abuse, but had vague memories of being struck from behind by her father, as well as very strong physical sensations of fear in her body, which she felt were indications of incest. Jan also suffered from chronic anxiety and neck pain. Jan enjoyed success in her professional career, yet had been in two failed marriages. For the past several years she had made a commitment to "get off these toxic relationships" and heal herself.



Jan was referred by a church friend, who is currently a client of Laurie's. At the time of referral, Jan had been in talk therapy for about five years, and additionally had been seeing a bodyworker for about two years for chronic neck pain. With the consent of Jan's other therapists, Laurie treated Jan alongside the other therapists as her third co-therapist offering particularly her trauma-oriented BcP. Jan maintained all three appointments weekly; all therapists were informed of the others.

Jan's tense, rigid posture and constricted affect were important themes throughout treatment. She was often very uptight and serious, unaware of any sense of relationship with Laurie. As Laurie explained the focus of their treatment to this researcher: "She's decided to stop the re-enactment. She is just learning to trust people. She's dealing with trust, love, and mutuality. Can she allow more emotional connection?" In fact, Jan showed little affect except when she was discussing her artwork – at which times she would begin to laugh and beam with joy. Jan had a long-term interest in artistic and spiritual pursuits. During the treatment she remained focused on her art and her spiritual growth, including planning a career change to the healing arts.

Of the three clients examined in this study, Laurie assessed that Jan appeared the most impaired, both most traumatized in her body as well as interpersonally. Jan was not, however, in crisis. Additionally, she represents Laurie's fourth type of client (see Chapter III), one who already has a regular talk therapist and seeks BcP as an adjunctive therapy.

Jan's case provides an excellent illustration for BcP work since Jan was expert at "tracking" and articulating her bodily sensations. In fact, she often got so involved in her moment-by-moment sensory experience that there was little place for emotion or relationships. Unlike many BcP treatments which involve extensive education around

finding and experiencing bodily sensations, Laurie's work with Jan was mainly to bring her to a feeling of safety within her body so that she could begin to relate externally with others again.

### *History of Client*

Jan was the youngest of three siblings of an intact family. Her father was a well-respected medical doctor, which led the family to live on the grounds of a mental hospital for several years. Jan had come to realize that she probably suffered in childhood from an anxiety disorder that remained undiagnosed, despite the fact that both parents were in the mental health field.

She remembers her father as being cruel and short with her; her few memories of outright physical abuse are being hit from the back. Her mother she considered an enabler, who would watch the abuse and not intervene. The abuse by her parents has weighed heavily on Jan, causing a deep-set suspicion of others that she has embodied in a rigid, frozen, tense demeanor. She had functioned well professionally, but, as she unveiled across the sessions, she had remained largely numb and "overfunctioning" (as many people in trauma cope through action without feeling), keeping two husbands solvent as they remained gainfully unemployed.

Several years prior, after her second husband emptied their joint bank account, she finally resolved to bring her attention and energy to her own self. She entered talk therapy, which led to a conjoint referral for energy/body work to relieve some of her intense neck pain. Over the course of this treatment, she found Laurie, and embarked on a third journey into healing her trauma.

## Assessment (“D” in Figure 1)

### *Qualitative Assessment*

Laurie’s initial assessment involved examining whether Jan had sufficient access to her internal resources to “contain” her traumatic experiences and her present PTSD symptoms. Whether a client can feel grounded and access a sense of internal calm is a precondition to working with the difficult sensations of trauma (Theme 1). Therefore, Jan had to be able to find her internal calm and remain grounded before she could open up her trauma narrative.

Laurie assessed that Jan was not calm and grounded, but instead her body seemed frozen and constricted. Jan lived “with a lot of tension in her joints and tissues” suggestive of long-held trauma. Her speaking style was rapid and flat, without much affect or relational sensibility. Laurie assessed a strong hypervigilant quality in Jan, who appeared constantly on alert. For example, Jan would interject nervous comments of “right” and “yeah” constantly while another spoke. Laurie assessed that a major challenge would be to learn how to work with Jan’s rigidity and hypervigilance, and how physical touch might be useful and appropriate (Theme 2).

At the same time, however, Jan was readily aware of her bodily sensations. She had an amazing ability to notice and track her sensations. She also approached this work with rigor and intensity; she would report the slightest changes in her bodily experience with utmost seriousness. Sometimes it would seem odd how keenly and specifically she would track bodily changes with almost no affect: “I can feel some discharging now. Those little jerks. They seem sort of scattered really, some of them around my ears and my neck and some of them are around my hands and then some of them are around my upper body.

It's really scattered. There's one in my leg. But they're little, they're really tiny. Mm-hmm." At these times, Jan would stay almost entirely in her bodily experience, unconnected to her narrative or relationships in her life. (Theme 3). Unlike other clients, who would jump out of sensation into story, Jan stayed almost entirely on the physical level. She would track without any relational component or interpersonally-directed affect. It was almost as if her numbness and frozenness from her early trauma cut her off from a free-flowing affect with others (Schoore, 1994).

Laurie also assessed that Jan did have access to some core internal strength and was able to nourish herself through creativity, as well as her impulse to share her joy with others. Jan was also able to identify the pain that has led her to seek treatment and throughout she was extremely motivated to understand what had gone wrong in her life and make changes accordingly.

### *Quantitative Assessment*

As described in the Methods section, Jan was administered a series of quantitative measures before the beginning of treatment. The clinician was blind to the measures throughout the study, including the GAS. Her understanding of the client's assessment and formulation evolved over the therapy. The initial scores are given here. The final measures and discussion are at the conclusion of this chapter.

Table 1  
Jan's Initial SCL-90-R Scores\*

<b>Global Severity Index</b>	67	<b>Depression</b>	60
<b>Positive symptom distress index</b>	66	<b>Anxiety</b>	74
<b>Positive Symptom Total</b>	63	<b>Hostility</b>	54
<b>Somatization</b>	63	<b>Phobic Anxiety</b>	58
<b>Obsessive-Compulsive</b>	57	<b>Paranoid Ideation</b>	71
<b>Interpersonal Sensitivity</b>	69	<b>Psychoticism</b>	79

\*All scores are T-scores with mean of 50 and standard deviation of 10. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning.

Table 2  
Jan's Initial TEaM Scores\*

<b>Subjective Well-Being</b>	59.48	<b>Post Traumatic Stress Disorder</b>	45.11
<b>Depression</b>	63.57	<b>Symptom Checklist</b>	53.04
<b>Anxiety</b>	47.84	<b>Personal Functioning</b>	68.03
<b>Phobia</b>	46.75	<b>Social Functioning</b>	62.24
<b>Obsessive-Compulsive</b>	49.48	<b>Vocational Functioning</b>	67.87
<b>Somatization</b>	59.65	<b>Functional Disability</b>	68.09
<b>Panic Disorder</b>	56.67	<b>Behavioral Health Status Index</b>	61.49

\* All scores are T-scores with a mean of 50 and a standard deviation of 10. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning.

On the SCL-90, Jan's initial scores according to the computer-generated clinical report were in the "clinical range" (at least ten points above the mean) on several subscales, including Anxiety, Paranoid ideation, and Psychoticism. Her high levels on all three symptom indices: the Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total Index, reflected the severity of her initial symptoms. Her TEaM responses reflected Jan's high levels of functioning, which was consistent with her active professional life.

On the Scale of Body Connection, Jan's Body Awareness Scale was 4.083, and her Body Dissociation Scale was 2.25. She endorsed "all of the time" for such items as: "If there is tension in my body, I am aware of the tension" and "My body feels frozen, as though numb, during uncomfortable situations." She endorsed "none of the time" for such items as: "I am aware of internal sensation during sexual activity," and "It is difficult for me to pay attention to my emotions." Such scores indicated that she appeared to experience a great deal of attunement towards her unpleasant internal sensations and had difficulty with experiencing inner pleasure.

*Goals for Therapy: Goal Attainment Scaling*

As illustrated on the Goal Attainment Scaling graph below, Jan identified three goals for the treatment. The first involved her remembering more vivid, factual memories of her abuse. She had previously only had vague sensations, and hoped to have some clearer recollections through doing this BcP work. Secondly, she hoped to be able to express her anger in constructive ways, by speaking up in her relationships. Thirdly, she found that one way she could monitor the terror and obsessive fear she felt was that upon waking she would make endless lists in her head. Jan's goal was to feel less of this anxious, generalized fear, a goal she felt would be reached when she made fewer lists.

**Table 3**  
**Jan's Initial Goal Attainment Scaling**

<b>GOAL</b>	<b>Connect to childhood memories</b>	<b>Get to rage</b>	<b>Control her terror – operationalized as making mental lists upon waking</b>
LEVEL OF ATTAINMENT	Scale 1 Importance: 9	Scale 2 Importance: 7	Scale 3 Importance: 9
Much less than expected (-2)	Nothing happens – no change in memories *	Speaking up once a year	No change *
Somewhat less than expected (-1)	A flash of memory	Speaking up once every three months *	Watch self but make a list anyway
Expected level of outcome (0)	One more memory	Speaking up once every month	1 day/ week not making lists upon waking up
Somewhat more than expected (+1)	One more memory with explicit details	Speaking up twice a month	2 days/ week not making lists
Much more than expected (+2)	Multiple factual details remembered	Speaking up once a week	3 or more days/ week not making lists
COMMENTS	A memory means a detailed factual historical childhood memory	Speaking up: "Speak loudly and articulately about what is making me angry in relationships outside work."	How distracted she feels is indicated by list making

\* = Before the study

### Formulation and Treatment Plan (“E” in Figure 1)

Laurie formulated that Jan lived in a state of hypervigilance, always prepared for intense threat, fearing that if she were to relax and enjoy herself, her father might enter the room and hurt her. This hypervigilance and interpersonal fear kept Jan from feeling safe in relationships. These dynamics were reflected in the Paranoid Ideation and Interpersonal Sensitivity scores of the SCL-90-R. Laurie hypothesized that in order for the therapy to address the interpersonal part of Jan’s experience, first Jan had to come back into bodily self-regulation with herself.

#### Diagnosis

A traditional DSM-IV-TR diagnosis has been provided by the researcher.

Axis I: Generalized Anxiety Disorder 300.02  
 Post-traumatic Stress Disorder, Chronic 309.81  
 Axis II: R/O Schizotypal Personality Disorder 301.22  
 Axis III: Neck pain  
 Axis IV: Memories of childhood physical and sexual abuse  
 Axis V: GAF= 55 (Current)

#### Strengths

Despite the severity of her trauma, Jan had many strengths. An intelligent and highly-successful professional woman, Jan was capable of managing a great number of tasks with relative ease. During the time she engaged in this study, she also saw two additional therapists, as well as eventually pursued a new job and applied for graduate school (in pastoral counseling). Although she occasionally displayed some strong schizotypal characteristics (i.e. getting lost in her sensations), she could be enthusiastic and caring. As a deeply spiritual and religious woman, Jan was very committed to her own and others’ healing. She wanted to involve herself further with healing and religion and decided to pursue a degree in spiritual counseling.

## Action (“F” in Figure 1)

*Session 1: “Creating a ‘Manger of Safety’”*

From the outset of the session, Laurie began assessing Jan’s bodily experience. Laurie noticed right away Jan’s pressured tone and rigid posture, with a lot of strain in her neck, indicating her extensive discomfort and potential trauma. Additionally, Jan’s feet were constantly moving as she spoke, which indicated to Laurie that there was activation throughout Jan’s body. Laurie began conceptualizing that Jan had considerable trauma symptoms. Although Jan had the ability to seek out pleasure (a.k.a. connect with her inner resources), she seemed unable to enjoy her positive feelings. Their first meeting was just before Christmas, and Jan explained that she intentionally was choosing not to see her parents this holiday season, which Laurie noted appeared to give Jan some feeling of nourishment and inner resource. Since this was the first session, Laurie was also trying to build alliance and relationship.

Right from the beginning of the session, Jan introduced her experience of living in a constant state of fear. As Jan described this fear as well as her chronic neck pain, Laurie assessed how Jan connected her psychological experience with her body. Laurie wondered in what ways Jan understood her symptoms.

C: I did things that I wanted to do...that make me feel good...you know. And this is a result [laughs]. I have this in my neck. My neck, it hurts.

As Jan had commented that she imagined Jan’s father would go to Laurie and talk to her, Laurie explicitly asked more about Jan’s image of her father intruding in her life. Jan associated further with her own physical body, connecting it to her narrative of fear.

T: And you think your neck hurting is connected to that?

C: Mm-hmm. **And I keep thinking that my father’s going to show up and tell me that, you know...there’s something wrong with what happened, and I should be happy and I should be taking...you know...doing something for them, or something like that.** [sigh]



T: So that's the thought you have. Your father will show.

C: That he'll appear... and he'll...

T: And if he would appear, he would say to you?

Laurie remained as close as possible to Jan's imagery and "tracked" Jan's responses in her body and gestures. Jan had intellectual insight that her bodily fear was not based in current reality. Nonetheless, this insight had not alleviated her chronic bodily experience of fear and threat.

T: You should be thinking of [your parents]?

C: Yeah...or 'What the hell do you think you're doing?!' That's what he usually... 'What the hell do you think you're doing?!' I don't know where he would go after that. I mean...the thing about it is, he'd have to...**He's in his late 70's and he would have to fly here. And then he would have to get past my doorman...I mean, you know [laughs] But it doesn't help me any. I continue to, you know... I continue to have that emotional sense that he's going to do that. It's an intellectual...Yeah, intellectually I know that this is, you know.**

T: Mm-hmm.

C: But, um, **emotionally, my body...it's really my body...**It isn't even my emotions, **but it's my body is just, like, getting ready for him to come. And so I can't enjoy myself. I can't relax and just be in the present.** This is terrible.

T: So you're always anticipating...

C: Uh huh.

T: Being threatened...

C: Mm-hmm.

T: That someone is coming...

C: Mm-hmm. Yes.

The flow of this session exemplifies Jan's hypervigilance and "tunnel vision" around her trauma. Even in the first few moments of their first session, they focused directly on Jan's main trauma issue with her parents. Laurie formulated that Jan appeared to be caught in a cycle of excitation – no matter what she felt, her body told her she must be prepared for the threat of her father's arrival, leaving her hypervigilant, tense, and unable to self-regulate.

Unlike therapists who work to "recover memories" in order to find the historical data of the client's trauma, Laurie was unconcerned with the veracity of Jan's story. In this model of therapy, Jan's experience of trauma in her body is primary, regardless of

historical incidents. Thus, Laurie focused on Jan's bodily experience, instead of searching for content and information through Jan's narrative. In this way, she brought attention to Jan's body. As Jan reclined on the couch with eyes closed, Laurie worked to slow time down for Jan to access what her body was telling her.

T: [Cuts off] Let's just slow down for a minute.

C: Uh-huh.

T: I will be...the nature of this work is to slow time down.

C: Oh, Ok. [sighs]

A "sigh" or deep breath in BcP often indicates discharge. By slowing Jan down, Laurie worked with Jan to relax, allowing Jan's nervous system to unwind and discharge tension (Theme 1). Laurie offered calming words of education and orientation, which Jan "bulleted" with short, vigilant interjections.

T: So, um...It's not that I don't want to hear what you have to say. But for me to help your nervous system...

C: Yeah.

T: The best way, um, I can do that is I will...some, at times, slow you down.

C: Ok.

T: Um, so that we can we can just take one thing that's happening...

C: Yeah.

T: And work a fragment at a time.

C: Yeah.

T: And titration...because the more information, the more overwhelming.

C: Right.

T: So in this work we're trying to...

C: Yeah.

T: Sort of work on the edge of your nervous system...

C: Yeah.

T: And your thoughts and your memories.

C: Yeah.

T: And...

C: Yeah. Because I am overwhelmed. There's no question about it.

Laurie wanted to help Jan self-regulate instead of staying in a state of frozenness that was Jan's accustomed response to feeling threatened. How to help Jan relax her defensive hypervigilance without ensuing panic by helping her access calm in a titrated way

became a major component of their treatment. In this session, Laurie used mindfulness to help Jan discover what makes it hard for her to stay calm and relaxed (Theme 1).

Jan had been discussing her fear in a rushed, mostly cognitive (neocortex) way. Laurie explained afterwards how, at this point in the session, the two were working on “top-down” processing (van der Kolk, 1994), in which Jan was cognitively beginning to notice how she was feeling in her body. However, over time, the goal was “bottom-up” processing, in which the two would be able to track Jan’s bodily sensations in a felt way, and then integrate them cognitively. Bottom-up processing is essentially the way to resolve clients’ trauma held in the nervous system.

Jan appeared to be having a difficult time centering and focusing, so Laurie evoked sensory-based language (e.g., “warmth”) in her soft, hypnotic voice to slow Jan down and help her access her felt experience. Although this intervention does not involve actual physical touch, it has the effect of bringing clients to their bodily sensations (Theme 2) and more to sensory-emotional (limbic/brainstem) bottom-up processing.

Since this was the first session, Laurie was attuned to their therapeutic alliance, and had to be careful about how much to encourage bodily awareness versus allowing narrative to unfold (Theme 3). She decided to encourage Jan to remain focused on her bodily experience and used directives to do so – an example of that tension between leading and following as Laurie searched for a way to help Jan access her inner calm.

T: So why don’t you just take a moment and just feel that you were proactive. Some part of you made this choice [not to see your parents]...because it was the most loving thing to do.

C: Right.

T: ...for yourself.

C: Right.

T: Yeah.

C: Right.

T: So what happens when you sort of go back to the time you made the decision? I’m going to spend my holidays... you know...being with friends and making these choices. And just

take a moment and see if there are any moments over the past week or so, where you had a good time. When you were you with somebody and **you felt the warmth** or...

C: Yeah. There were, um, a lot...you know?

T: Exactly. So let's just pick one. Pick one out of the many many moments that felt good. It's kind of like if...we have a good piece of cheesecake, you know. We don't need to eat it all. We just need to eat one.

T/C: [Laughter]

T: Yeah. And the body will know: "This is good cheesecake."

C: Yeah. Yeah...Yeah....Um. Well...I think um...what I would pick then is...I, um...One of my, sort of, ways to...to nourish myself, is that...um...And this has been going on for a couple of years...is that I, um, decided a couple of...two Christmases ago...that I just would not get a tree and then decorate it and then have to, you know...do the card and the gifts and, you know, the whole thing...You know? And, um, because it's just...

T: Alright so what did you do? I want to go to the nourishment.

C: Right. So...so...so, Ok...So then I thought... I'm just gonna, sort of wait, and sort of see what comes to me, right?

T: Mm-hmm.

C: So, to my great delight, last week...one time...**I was sitting in my living room and I got this idea...Oh! [laughs] What I wanna...[laughs] What I wanna do is, um...I'm a sculptor and I make big things. So I thought, well...Ok. I can build myself...I can make, um, a little manger. Like a life size manger.**

T: Great!

Jan spoke passionately about her recent artistic creation of a miniature "manger" made from craft materials. It seemed important to Laurie to give Jan space to share this in the treatment (Theme 3), as it was not just about the manger, but about an area in her life where she could access strength and pleasure (Theme 1).

C: Ok. [laughs] And so I did. So I got this little stool, and I have this, you know...I have tableclothes. I have a big red tablecloth...and so I put that over that. And then I got my...I got some dried flowers and some straw and stuff, you know... So I got [laughs] and made this. **It's just marvelous! And then I got some twinkly lights and ...those little bitty lights...and I have a little flower vase thing. And I put all the lights in there and it...it sort of glows...**

T: Mm-hmm.

C: And it's sitting right in the middle and it's sort of...Ahh! It's...and I have all my little creatures that are different parts of me, and they're all, you know, around it like the angel... And it's just...It's just [laughs] really quite humorous. It's been very beautiful. **And I've had the most wonderful time telling people about this.** People at church or people at...wherever, or...whoever I think will people will be...who will listen to this wonderful story, you know? And that has been just fantastic.

Jan was thrilled about her manger. Laurie formulated the manger as embodying Jan's need for an object of protection and comfort. Often when a client gets caught up in story,

as in this case with Jan, Laurie slowed her down with the intention of helping her “ground” in her body, that is, to find her inner calm in bodily sensation. (Theme 3) This intervention is repeated countless times as Laurie brings people into mindfulness with their bodies.

T: **Let’s just take a moment...**

C: Yeah.

T: And you might want to close your eyes. If it feels Ok...and just go... Yeah. And let’s go back to that moment when you decided to make a manger... and you had that creative impulse. When you had the thought...And then, how you created it. When you went into action. How you gathered materials and you created this beautiful place for you in your home. A manger. With lights. And angels, where Christ was held, right?

C: Mm-hmm...

T: Kind of like a womb almost.

C: Mm-hmm. That’s exactly what it is.

T: Yeah...So as you allow yourself to turn, just sit with the image of the manger...and the experience of making it. And just slowing things down a little bit... **Are you noticing anything at all that you’re aware of in your body as you take yourself back to the manger, to the creation of it...to the light. Listen to your heart. And just taking a moment and letting me know...what are you sensing in your body? As you slow things down to just be in your body.**

C: Well, I, um...I um...I feel...I noticed that my, my, um...my body just feels good, you know?

T: And when you notice that your body feels good, can you tell me a little more about the sensation of feeling good?

C: Um...

T: Where in your body do you feel the goodness...as sensation?

C: Well I, um...I feel it in...in the, the...in my...this, this...in my torso. Um...but...it sort of feels like warmth, you know... It feels warmer, and it, but...and it feels, um, like it’s vibrating, um, less...or by...or... Yeah...um...or slowly. Um. But...I also notice that same reduction in, um, the, sort of, vibration thing that I’m describing all over my body.

This is an excellent example of how Laurie worked to help a client find inner resources in the body. Laurie focused Jan on the connection between her manger and her bodily felt experience, particularly sensing all the love that Jan gave herself through this project.

T: Great. So let’s just go back and use a breath. So let’s just slow things down. This is what we call Somatic Experiencing. Somatic...because it’s in the body. Experiencing, because you’re feeling it.

C: [Sighs].

Now that the treatment is slowing down, Laurie spoke at length to educate Jan. In addition to the information given, Laurie's intention was to use her voice and rhythm to modulate Jan's nervous system within the dyadic relationship.<sup>7</sup> She slowed her voice to a methodical rhythm, with an almost hypnotic quality.

Voice and sound are important ingredients of embodiment, as voice tone has been shown to activate more right-hemisphere activation, potentially leading to more neural integration (Cozolino, 2002). Laurie often uses her voice as an essential ingredient to the treatment. In fact, some have suggested that her voice has a hypnotic component, in the vein of Milton Erickson (1980). Using voice tone and rhythm can be considered almost a type of "touch," Laurie explains, as by lending some contact yet not actually touching her she could help Jan feel more calm and connected with inner resources. She continued to offer BcP psychoeducation to Jan about "pendulation" between the trauma vortex (painful, uncomfortable sensations) and healing vortex (nourishing ones).

T: It's a felt sense. So when we get into slowing things down and helping you feel nourishment, sometimes we call it the healing vortex. Or we call it, sort of, creating a resource in the body...flow, nourishment... And I will be, over the course of these next ten weeks...I'll be educating you, as well...as well as, **helping you slow time down**...to help you create more and more somatic resources. **And what the body needs is time.** So as you feel the warmth in your chest...and you feel energy kind of softening or settling, I might again repeat it back to you, just to help you savor it...and be with it. And that's the mystery. **The mystery is...as we stay with what's nourishing...we will start to feel more different kinds of sensations. And very often we're going to go from a sensation of warmth, to maybe a slight discomfort...back to where it's nourishing... back to the discomfort. And we call this process "pendulation."** It's how the nervous system starts to learn how to heal and regulate the effects of trauma. So we'll be combining talking, you know, connecting with each other with images and memories and feeling. So part of what I call this is, sort of a fine-tuned intimacy because you're being intimate with yourself through sensation. **And I'm sort of in some ways like holding the cradle...as if your body is the gift of life, and this**

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<sup>7</sup> In a comment on this technique, Laurie explained that there is controversy in the BcP community about how much to use techniques such as using the therapist's nervous system to slow down the clients, as it might create a dependency on the therapist. In any relationship there is dyadic interplay as each person is influencing the other in the intersubjective space (Aron, 1998; Schore, 1994, Tronick, 1998). Ultimately, however, the goal of treatment is for Jan to be able to self-regulate. At this point, though, Jan appeared largely unable to access her resources herself. So Laurie helped her slow down and find her calm in mindful awareness.

**room, my voice, this space, is kind of like the manger holding you...so that you can learn and develop more calmness...more comfort.** And when we're working with the effects of trauma, sometimes we have comfort and then we have a little discomfort. So it's not like we live in comfort 24/7, but the goal is to help your nervous system regulate. **So as opposed to say, living with a pain in your neck that never leaves, so you're spending your whole day trying to figure out what to do for your neck. What we want to do is bring you into comfort, and then see if we can just feel the edge of the discomfort...and then back to the comfort and the warmth. And then we notice what happens next.**

[pause] Are you following?

C: Mm-hmm.

T: Yeah. So again, just bringing your awareness back into your living room... And what you notice back in your body?

C: [Big sigh]. Well...I'm thinking that being in with that, that image...and then, um, **hearing your voice especially...um...This room too, but your voice especially.**

Some clients would need a lot of education and alliance-building in this early stage.

Jan was much more interested in focusing on her body than on their relationship and immediately began observing her bodily sensations in mindfulness. With great seriousness, Jan introduced her experience of "energy fluid" that ran through her body, offering soothing warmth and electrical energy.

C: I have, um...I call it um...**I call it like an energy fluid**, is what I call it. Um...that happens to me at different times, but it sort of...It's sort of...It's definitely not blood, but it's definitely fluid and it pulses from the very low part of my body, upward.

As they talked, Jan felt it expanding. Laurie noted that Jan was able to use mindfulness to observe and experience her body's sensations in detail. Now the focus had to be on "pendulating" (moving back and forth) between Jan's experience of nourishment (what Laurie refers to as the "counter-vortex" or "healing vortex") and her experience of panic and trauma (i.e., the "trauma vortex"). Laurie was navigating how to follow and track the sensations that Jan introduced, but Jan's body was ultimately the leader of the session. Laurie wanted to encourage Jan to remain within her experience and stay related, so Laurie brought Jan's awareness to this dilemma. The question remained whether Jan could remain in contact with her bodily experience and still stay in relationship.

T: Nice. Yeah. You're just feeling...getting the expansion...as you feel. Again, we call this organicity because it's your body's own healing potential. As we slow time down and give you a chance to feel the support of gravity and the movement of the fluid...and you can sense more traveling...more expansion. And so it starts in contact with the pain on the left side of your neck. Just notice what happens spontaneously and again as you continue to stay with the warmth and with the flow. And your job is just to be with your experience...moment by moment. **And what I'd like is for you to stay with your experience...if it's a choice between leaving the experience and talking, or staying with the experience and being nonverbal...then I would invite you to just take the extra time to really let these sensations continue to move.** You will be developing this ability to be in sensation and also be verbal. All right. You're doing great.

Laurie encouraged and educated Jan about how to access pleasure alongside some of her traumatic sensations. Jan stayed very engaged in the process of tracking.

C: Ok, now...I don't know if you can see it but the fluid is moving so strongly that it's making my body jerk. I can feel it in my neck and in, um...my arm hurts when I move...jerk it...

T: Yeah. And we call that...sometimes we call that discharge. Um...so it's the, the body learns how to contain the healing energy. It's kind of like when water flows around rocks. You know, sometimes if there's tightness it will jerk a little. Whereas when water is flowing through sand, it just flows through the sand, it's so porous. So when there's tension in the body, and the energy is trying to move through tension, sometimes we'll feel a twitch...or we'll feel a jerk as the energy is pushing through. We could call it resistance, or we could just call it, sort of like, compacted earth.

C: Mm-hmm.

T: You're doing great. Your job is just to feel it. And then you'll notice, after the twitching or the jerking, often there'll be maybe a little more heaviness. You'll notice some tingling, or something else.

C: I, um...I guess what I notice after I feel it...is that twitch, or jerk, is that...the fluid seems to be...right after the...right after the jerk happens there a, like a rush of the fluid to that spot, but also to an area quite large around it. So it's like a, it becomes like a throb...Like a fluid. Which feels good actually. So the twitch feel kind of disconcerting, like a jerk. But then, the sensation after that is, you know...really nourishing.

T: Exactly! Beautiful.

This is an excellent example of "pendulation." As Jan moved into the good feeling, the trauma sensations arose. They worked to move back and forth between the sensations.

C: Yeah. That's how I experience it. So I experience it as a little bit frightening but also very positive. You know, at first, whoah! But it feels so good that I just...I don't know...that I just accept that that's how it is.

T: Ok, so the more we go slowly...the more the energy of the symptom can start to discharge and flow back into that fluid. That's why it's really important that we include the whole body. So even though the discomfort might be say, in your neck. We want to help you feel your whole body. It's like a whole manger, right?

C: Right.



Laurie assessed that Jan did not appear “grounded” while describing how the energy moved through her body. The belief is that without having a grounded body, i.e., a “container” for Jan’s feelings, impulses, and sensations, Jan will not be able to self-regulate. Thus Laurie shifted her focus to helping Jan become grounded and contained. She brought Jan’s awareness to the soles of her feet as a way to become more grounded.

- T: The body has to hold everything. That’s why I might say, sense your spine or sense the soles of your feet...your buttocks...
- C: See, now I can feel the, um, the pulsing of the fluid down in the back of my calves and in the bottoms of my feet.
- T: Exactly.
- C: I don’t feel it here. But I feel it in my...it’s interesting...in my calves and in the bottoms of my feet.
- T: Yeah. So just allowing yourself time to savor the fluidity as it moves through the back of your calves and down into your feet. You’re doing great. You’re a tracker. Right, that’s what it’s called. Internal tracking.
- C: Oh, I’m a tracker?

Jan resonated strongly with the label of “tracker,” and by doing so, began to make more contact with her characterological organization.

- T: Well, I’m using the term “tracking” because...
- C: Uh huh.
- T: **Because tracking is sort of becoming intimate with sensation.**
- C: **Oh, Yeah. I do that. Oh...I very much...I very much do that.**
- T: Yeah.
- C: **It’s very important. For some reason, it’s very important to me. I’m not quite sure, but yeah. It’s definitely.**

Laurie started to notice how, despite Jan’s great awareness of her bodily sensations, she remained mainly disconnected from her emotions; Jan appeared to live primarily in sensation without affect. Laurie started formulating her long-term treatment goal to help Jan explore her affect and connect it with her felt sensations, both empowering and traumatic ones, in a slow, mindful process of treatment. She used the image of “holding” (Theme 2) to help Jan feel safe (Theme 1).

- T: So what’s great is that you have that natural ability to tune in and feel and sense...like the warmth and the awareness of the sensation in your calves and down into your feet. [pause]

So Somatic Experiencing, the essence is really...I'll be continuing to teach you how to be in this place of the resource. And the resource, sometimes we call it the healing vortex. It's the place of fluidity. It's the place of warmth. The place of flow. And in some ways it's kind of like creating a manger because what we need is the feeling of being held.

C: Right.

T: Of being safe.

C: Right. One of the things that...**this being held thing is huge for me** is that...One of the, the, um...things that I come to in therapy is, um...that I don't, um...**that I wasn't held very much as a child...and when I was held it was a very scary thing.** Yeah, being held is extremely important.

T: Mm. So it's kind of like a core theme.

C: Mm-hmm.

At this point, Jan articulated her experience of being dissociated from her body, in which she lived with an awareness of feeling "outside" of her body. The strength of their alliance working with such difficult material within their very first session is noteworthy.

T: So another breath. So, you knew that to give yourself the healing that you need, your home needed to be like a womb. With that awareness, like, you were able to choose your home and the different rooms representing different aspects of the womb, with the manger in the center. Very good. Just see where in your body you also feel the center of that womb here? Your body is also your home. Your home on Earth. Another home that you live in.

**Where do you sense the womb of your body right now?**

C: Well, see...I...I...My first impulse is to say that I don't. Um...**then it's a strange thing for me to think about...the fact that I live inside of my body, because that's really something that I haven't done very much of, I've really been outside of my body, you know?**

T: Mm.

C: I don't know how I did that, but I did. **So, part of what I'm yearning for, is to find that center inside, you know?** Um...It's all sort of a discovery for me. Yeah. It's a discovery. It's not something that I, I could, would immediately say, 'oh there it is.' While I track...**while I'm very aware and I'm tracking almost continuously, or as often, or as much, as conscious as I can, I don't ...**

T: You don't have the secure, sort of, sense that there is a place...

C: Yeah. I don't. I don't. **Even though intellectually I know that it's there. I don't feel it.**

Using Jan's imagery, Laurie talked about how Jan's body is a resource of safety.

Immediately, Jan felt threatened.

T: So, that might be an intention that you might have for yourself. It sounds like your home is that place. The manger is that place. **And maybe, you might consider just discovering how your body could also become that place.** You just want to sit back. It seems like an intention that you might have for our time together...discovery of a safe, womblike, nourishing place inside your own skin. A place for you to rest and be nourished.

C: I have...um...

T: What happens when I say that?

C: **I think that my father is coming.**

As the fear emerged, Laurie used “pendulation”: she asked Jan to access a nourishing image to complete the fear response (i.e., instead of freezing at the tiger, pushing it away) and in doing so, begin to discharge the frozen energy that has been trapped in Jan’s nervous system.

T: So you would need some kind of protection...and reassurance, that whoever was going to destroy your peace...would be sent away, prevented from violating your boundaries.

C: Mm-hmm.

T: I’m going to ask you in your imagination, if you could imagine some thing, or a few things...it could be a person. It could be a spirit. It could be an animal. It could be anything. What would you need to protect you from your father’s presence? Just kind of the very first thing that pops up. If we were going to help you feel safe in creating this womb space for you...and we were going to protect you from the danger of your dad destroying this, the way it was destroyed when you were little. What do you need? What do you imagine?

C: [long pause]. Part of it is, um, there’s many things that are involved, I think but, um...um...one that I am really aware of is that, um...for me to, um... There’s a there’s a ...sort of living, um...to live in God’s embrace. Because I have the sense that the feeling, as well as the intellectual knowing that, that is the protection and the safety that is large enough...that there are other things that are useful, you know...like, um...having financial independence, distance...I mean, he’s 3,000 miles away or whatever it is. And **there are other things that are...that I can do that are more tactical, that are protecting**, you know? But, in the ultimate sense, which is where my father really comes at me in the...in the ultimate sense...and, in, in that place, the thing that there’s **...to me there’s one thing that protects me and that is God**. That is the ultimate creation, you know?

T: Exactly.

C: That is what...so the idea of living in that embrace, um...and living my life in that way...to put myself in that womb, in that context, you know?

T: Exactly.

C: To put myself in that context...that to me is it. And so I, um...

T: That’s the ultimate safety and protection...

C: Mm-hmm...

T: To kind of like...be in the manger with God.

C: Right.

T: So it sounds like for you, ultimate resourcing is to be really connected with God the father.

C: Mm-hmm.

Laurie worked to help Jan develop her inner resources in imagery by evoking details of her building’s lobby and the felt experience of them walking out together. This image of them walking in the lobby vividly captured the experiential and relational emphases in the therapy, as Laurie wanted to reassure Jan that they were in this therapeutic

relationship together so that Jan would not repeat the trauma of dealing with her threat by herself. Jan appeared to feel safe with Laurie, invoking her as a “buddy” there to protect her and keep her safe.

T: But for now, just...just imagine that I’m going down with you. We’re going into the lobby together.

C: [Sighs]

T: We’re able to walk on the street. We’re just hanging out. Just imagine me as your buddy. Is there anything you imagine I would say to you as we’re walking down the street? Any way I would touch you? Would I put my arm around you? Would I say anything to each other...

C: Yeah. You’d probably, I guess you’d probably say that we don’t have to do everything that’s on our list for today.

Laurie educated Jan that self-regulation happens over time. Therefore, she reassured Jan that they could trust that the process was happening on its own time frame.

T: So we can take our time, and do one thing at a time...

C: Yeah.

T: We won’t forget the list but it’s Ok to take time.

C: Yeah.

Finally, Laurie acknowledged that they had not yet addressed much of Jan’s history, and (as with her other clients) she intended the first session to be for meeting in the present moment without much background. History would be explored organically as it arose.

T: You’ll know I didn’t ask you a lot of questions today. I didn’t go through a lot of history and you filled out a bunch of forms with Amelia...and it felt more instinctual for me to just be with you. We will pay attention to what’s on your list. I think...what you got today is a really important...

C: Is really important...

As the session concluded, Laurie helped Jan integrate what she experienced into her cognitive framework.

T: And what, what are you discovering, like what thought do you have as you feel yourself in the warmth, the calmness...? Is there anything you’re aware of, a thought you’re associating...?

C: Well, I’m just sort of curious as to how I can create this again. That’s how I’m thinking.

T: And I'm working with you about the belief system. Somebody who is living in this place... What would they have to believe about life? What would you have to believe?

C: Um, that, um, uh, you know, that good, is um, greater than evil. Something like that. You have to believe in the ultimate, that the creation is primarily good, not primarily evil. That's what comes to mind. That's the belief system.

Jan sighed deeply, appearing more deeply grounded and embodied. Laurie attempted a verbal experiment to work with her maladaptive belief system.

T: So what happens when I say that to you: 'It's ok for you to believe that God's creation is good'?

C: [Big sigh].

T: That creation is goodness.

C: Yeah. [Big sigh]. That is um, that is a belief that I have sometimes, and other times go with, the opposite belief is present.

Jan was starting to see herself vacillate (i.e., "pendulate") between experiences of safety and threat in her body and thoughts. Laurie concluded by acknowledging the trust that Jan had placed in her and this process.

T: So I don't want to give you too much today... Thanks for your trust.

C: Oh sure.

### *Monitoring Evaluation of Session One ("G" in Figure 1)*

In this early session, as Laurie worked on building an alliance with Jan, Laurie was careful not to overload Jan's system. Instead, Laurie worked to slow Jan down and educate her about mindfulness. She used imagery to understand how Jan was organized, and reflected the imagery and spiritual beliefs that Jan used. She conveyed a clear message to Jan that all her sensations were to be embraced and understood. Note that there is no direct touch (Theme 2); all work with Jan at this point was in imagery.

### *Sessions 2-5: Summary*

In sessions two-five, Laurie worked to deepen their working alliance and relationship. Laurie aimed to increase Jan's physical awareness of how she was organized around threat: whenever there was positive affect, there was negative affect as well. Not much

history was divulged, as Jan mainly tracked her moment-to-moment sensations throughout these sessions. The BcP work evoked a lot of discharge in Jan, which she described as “strong jerks” and other somatic sensations. When Jan did focus on her thoughts, they were of old, painful memories of herself as a scared little girl. Laurie made her first physical touch (Theme 2) with Jan by sitting across from each other, leaning towards each other with hands out, pushing palm to palm. This technique was to help Jan feel her boundary physically in her body. Although Laurie introduced touch, it was sparsely used due to Jan’s strong somatic reactions to anyone close to her. Throughout these sessions, Laurie helped Jan feel more internally comfortable and “centered” (Theme 1) and slow her down so she could remain in her body (Theme 3). For Jan, this type of work did not appear to cause much conflict, as remaining in her body seemed her choice of action. Whether this was a defensive posture was not explored, and the content of the sessions remained mainly focused on her sensation-based present experience.

*Session 6: “Fear of the Naked Lady”*

In the beginning of this session, Jan arrived ebullient about having recalled a memory of father coming to hit her. As she elaborated during her initial Goal Attainment Scaling, having a concrete, reality-based memory of her father’s abuse was an important goal for her treatment. This was one of the first vivid specific memories of her father abusing her that she had ever recalled. Despite the pain of the memory, Jan was also excited by the spontaneous way it emerged. This may have been another indication of how Jan was progressing through therapy, since according to Laurie’s guiding conception, when a person becomes more embodied and grounded, that person will be able to metabolize more traumatic material. Thus, Jan’s increased ability to access internal comfort and

resources (Theme 1) may have allowed her to be able to process more difficult sensations of her memories.

T: Okay. So it's a big week?

C: Yeah, yeah. Just a lot. Yeah, and I wanted to tell you about this memory that I had this morning...it was really unusual because the other memories that I had before **I would describe as body memories where I physically remember the impact of it, like you know in the past I'll be laying on the floor or sitting in a chair resting comfortably and then I'll feel in my flesh how my flesh felt when he was hitting me.** I don't have a recollection of when or where or anything else but I just feel it in my flesh. Okay, and so I write that down.

T: And when did you...?

C: But today, **so today this is a different thing.** So here I am walking to come here and thinking about what's going on and all of a sudden I get this, **I have this really clear recollection of a minute, a second and a half or two seconds of him being here, so I can see his head and I see his hand coming at me and hitting this side of my head really hard** and then I keep...what I wrote down is my neck creaks so I didn't break my neck but I can sense and hear my neck creaking with this. Ok. It's very much from the hits coming this way and going like that. Remember how we were going like that?

T: Yeah.

C: It's like I see . . . **What's really startling for me is that this is a visual, there's a sense of it, but I see him. I'm seeing him.** I'm having a visual, more of what I would consider, a memory, what you would typically think of a memory where oh yeah I remember like a movie, like a videotape. I never... **this is new.**

As discussed, Laurie never addressed the veracity of the memory, but consistent with her BcP trauma-based treatment, focused on Jan's sensory experience. Laurie carefully observed Jan to see how grounded she remained through the telling so that she would be able to allow the sensations to go through her instead of freezing in the face of them. Laurie assessed that Jan was not yet able to access calmness and nourishment in her body on her own sufficiently to renegotiate this moment of threat.

T: This happened today?

C: Yeah like 20 minutes ago because I was getting my coffee and I was going to do my little form while I had my coffee. But the thing was...

T: But it's interesting because we were asking to orient around the previous session and what you noticed this week.

C: Right because...

T: And your unconscious sort of gave you that.

C: So this is a very weird feeling. So I'm thinking to myself well now I'm really aware that I'm not completely connected and there's a lot more there that I'm not connected to. So that's what I was thinking about while I was walking here - well I wonder what it is that I'm

not connecting to that I'm really afraid of connecting to, you know what I mean? I wonder what that is.

T: Right.

C: And then I have this memory of this and so I'm thinking oh okay.

T: Great.

C: Yeah.

Jan also described sensing a change in her awareness, in which she was “unfreezing” and becoming more aware of her feelings. Although she felt fear, consciously experiencing her fear actually calmed her. This recognition was an important shift that has occurred through the treatment. Developing more awareness of feelings is common to many styles of therapy; however, what makes BcP therapy distinctive is the inclusion of bodily sensations within that awareness, so that clients can connect their physical sensations with their affective narratives. Thus it was not merely “fear” that Jan was aware of, but she also connected the feeling with the tension in her neck. By having more conscious awareness of her somatic responses and their relationship to her narrative, she became more able to “metabolize” them and hopefully resolve long-held bodily sensations of her trauma.

C: Yeah, kind of what's been really noticed this week is that I feel, the way I said it, it's hard for me to articulate, but to try to say it is that **I feel more connected to my fear, to my frenzy**. From the past, whatever this is, I recognize there's nothing to be afraid of right this minute. So I feel more connected to this. It's sort of like I feel much better because I'm more connected but I feel I'm really aware of how agitated I am and how afraid I am, so it's kind of like...**So I've been kind of in this place where I feel agitated and yet I feel much more peaceful on the other hand because thank god I'm more connected.**

T: Exactly.

C: I'm thinking to myself... And then I get this which is totally out of the blue and totally uncharacteristic **because usually what will happen is my neck will hurt, my neck hurts or my or, you know, my shoulder, or something physical happens to me.**

T: So usually you have the symptom, a somatic symptom.

C: Right.

Although she still remained very aware of her inner sensory experience, including her physical tension, she seemed to have a new perspective on her awareness.



**C: I have a tremendous sense of electrical**, I think I even wrote this down, all kinds of electricity, you know? **Ahhh. It's hard to stay grounded because I have this electricity and this, I'm so aware.**

Jan was even able to comment on how she had sped up and lost her feeling of being calm. Laurie focused on slowing Jan down further and helping her find her calm again.

T: Yeah, so let's take a moment, yeah and the energy can be speedy. When we work through trauma memories we do it slow, we slow time down, it's like one-seventh the speed of the mind because the body needs more time to orient... and the language that I've been sort of teaching you, the language of sensation is a lot slower than cognition and thought. So let's take a moment now and just orient to your body, checking with your hands, checking with your feet, the soles of your feet, and just notice what happens when you start to bring your sensitivity and your awareness more into your breath, that's it, and more into sensation. Is that okay?

C: Yeah, yeah.

T: And can you sense any place in your body that feels relatively comfortable, either grounded or relaxed?

C: Maybe like, um, the palms of my hands feel pretty good and underneath my ankles, where my ankles hit the ground.

As Jan once again found her inner calm, it was quite surprising what a powerful and painful image emerged from Jan.

T: Great, so just letting yourself turn towards the...

C: See now I'm having the, well **I can just hear myself shrieking and just screaming.**

Here is an important example of what a trauma symptom frozen in the nervous system (Levine, 1997) looks like: Jan had the somatic memory of shrieking, yet it was not clear if she ever shrieked. It was as if all these years Jan was shrieking on the inside, yet never actually expressed or completed the shriek. Instead, it remained frozen in her nervous system. Laurie worked to keep things slow.

T: Okay, so we're going to go slow. So as you start to feel the comfort in the palms of your hands and in your ankles you can remember or hear the voice of you shrieking.

C: Mm-hmm.

T: And do you have a sense of what age? Were you a little girl?

C: Mm-hmm. **I don't know if I really shrieked or if it's just like I wanted to shriek and it's sort of like**, I don't know you know what I mean, **I can't tell that...**

Laurie worked on helping Jan accept this powerful and painful experience. She helped Jan delve further into the imagery and bodily experience of shrieking. Jan located

herself as a little girl, but despite the powerful image, her affect was relatively flat, without much emotional expression.

T: **So just give yourself permission to hear the shriek.** Does it sound like it's coming from any particular direction? Left or the right?

C: It feels like it's coming from the top of my head.

T: Top of your head?

C: Uh huh, maybe just inside the top of my head.

T: And it's like a shriek.

C: Yes, definitely me screaming.

T: You screaming?

C: And I'm like five or four

T: Five or four.

C: Maybe six.

T: **So would it be okay to just give yourself permission to see that six-year-old discharging and shrieking as you feel that energy, that shrieking moving through your head. So when we're little girls and we're so violated we probably need to shriek**

C: Yeah.

Laurie stayed close to Jan's experience, encouraging her to complete the action of shrieking in order to discharge the long-held energy.

T: Because all that energy and the terror is frozen in the nervous system. If you could've, you probably would've shrieked back then.

C: Right.

T: But now you can.

C: Right.

T: So now you can give your soul permission to do now what it couldn't do back then.

C: Yeah.

As Laurie encouraged her, Jan associated to a very intense, specific memory that became important in the treatment.

T: You're doing great. Just trust the process, yeah. Feel the shrieking? See that little girl?

C: Mm-hmm. Remember the time when we were at that house and we were in the kitchen and then we got the little dog, remember that?

T: Yeah.

C: It's that, it's that time period. Uh huh. And I can't remember if I told you the story about that house and my father, and I was in the basement, did I ever tell you about this? I was in the basement? Uh [pause], there was a mental patient, a hospitalized mental patient, a woman, and somehow . . . **We lived on the grounds of a state hospital**, my dad was the director of a state hospital that was in [state], a state mental hospital. So we had this monstrous house, which is the one I remember where we lived, okay? And because it was [state] and it was very cold, the hospital grounds, the buildings, were all connected by tunnels. We had...there was a tunnel entrance so my father could walk from our house to the hospital without having to go out in this horrifying snow. And so I was playing in the

basement, I would play, because our play place was in the basement with all our toys and stuff, and so **I was down there playing by myself and this lady**, a mental patient somehow wandered into the tunnel and our door wasn't shut to our... **so she walked in and she was completely naked**. She was maybe, I was like five... and as I looked I just, she was sort of wrinkly and saggy so she must've been you know, I don't know. And then she had these beads on, long beads. She was completely naked, and her hair, and then she had these beads, okay, **and she's coming in and she's coming towards me right . . .**

This exchange was an illustrative moment of the struggle over how much narrative to tell in BcP. Since BcP's focus is often clearly sensory-oriented, there is rarely a place for a long history. Additionally, since Laurie believes that a story told without embodiment will not be helpful to the client, she interrupted Jan to slow her back down to her sensory experience (Theme 3). Even as Jan responded to Laurie's techniques with a large sigh, however, it appeared that she needed to complete her story.

T: Slow down for a minute, yeah, check in for a minute.

C: And so...

T: Slow down.

C: Yeah.

T: Just take a minute, is that okay? I mean we're going to go through the story but I just want you to...

C: Yeah. [Big sigh]

T: Check in with your body as you...

C: I was thinking about the shrieking and then that **I clearly remember that made the decision not to make any sound** and to be kind of friendly to her and to sort of say "Oh I think I'll go upstairs or something like that because I was afraid of what she was going to do to me. So then I just kind of walked up the basement steps.

They slowly explored the details of the memory together. Laurie led her back into the room, offering her an image of a safe and protected space. Jan appeared to be allowing her nervous system to regulate and discharge through her breath; the release of tension in her body was palpable.

T: Okay so just see that moment, you don't orient until, just see yourself looking up and you first notice this strange woman, naked, coming at you.

C: She was walking pretty slow you know?

T: Uh huh, yeah, and notice what's happening in your body right now as you see the image of this woman walking through the door naked, walking slowly.

C: Well . . .

T: And what's happening in your body right now?

C: **I'm feeling calmer now.**

Jan showed new behavior by linking her physical sensations to her character structure: as she re-experienced these early fearful sensations, she saw how much her drive and affect-less style came from the intense fear she felt as a little girl. Through exploring her sensory experience, affect, and narrative, Jan was becoming aware of her early defenses for survival.

C: And I'm remembering this, I want to use the word approach but I don't know... that I used in those moments when I was so little that I have used in many other crises in my life which is that **I recognized how terrified I was and I also recognized that I had to... you know, in order to survive, in order to navigate this situation I had to put my feelings aside and focus on what it was I was going to, what action I was going to take.**

T: Exactly, there wasn't enough time so you, right.

**C: When I was really clear that I had to survive so it was a very simple and easy decision for me to make, just like a five-year-old it was like okay this is what I'm going to do.**

T: Mm-hmm, so you had that real natural instinct to survive

Unlike earlier in treatment, this time as she associated further into her memory and re-experienced the frightening sensations, she was more able to maintain connected with her inner strength throughout the experience.

C: Then while I was doing this she got close to me like, I don't know, maybe as close as you are, maybe closer, I can't quite, but then she said something to me like "I have a daughter like you." **She said something to me that she was relating to me in some way and this absolutely panicked me.** I mean it was just absolutely like, that I couldn't, my ability just to stay focused.

T: Right, so just see that moment, that moment when she starts to speak to you and gets fairly close and you start to panic. Yeah, and just freeze framing that moment and you begin to panic. And what's happening in your body now?

C: Well, I feel a little better.

T: And how do you know you feel a little better?

C: Um, I just feel more... **I feel more grounded and I feel like some of the frenzy that I had when I got here it seems like it's lifting. Yeah lifting it seems like. It doesn't seem like it's discharging, it feels like it's lifting.**

T: Lifting, uh huh, and you feel more grounded?

C: Mm-hmm.

T: Yeah, so just giving yourself time to savor the experience of the frenzy just lifting. And your head is leaning forward.

C: Mm-hmm.

T: Is that comfortable for your body?

**C: Uh-huh. I just am sort of enjoying feeling grounded, aware of how comfortable it is.**

T: But you're enjoying feeling grounded?

C: Mm-hmm.

T: Yeah and how do you sense your body participating in the feeling of being grounded?

C: Because I, um, **instead of feeling like I'm sort of floating I feel like I'm really sinking into the sofa.**

Once again, this session provided a powerful example of the integration of body and narrative (Theme 3). No longer the frightened little girl, this time while Jan remembered backing slowly away from the woman, searching out her parents, and not finding them, she maintained a sense of calm and “adult consciousness.” Jan was able to “hold herself” in her own body as she had never been able to as a little girl.

Laurie invited Jan to imagine a scene of protection (Theme 1). Jan called upon a lion, then her “ideal playmate” and two girls to “have a tea party” with her. Laurie suggested that Jan needed an adult as well, so Jan brought in a “gentle male person...with a sense of humor and very aware of the importance of his job as a parent.” This father figure would be near her, silently protecting her. Laurie reinforced how hard it was for Jan to feel she always needed to protect herself. Note how Laurie’s language helped connect Jan’s bodily experience with her narrative.

**T: So you were always kind of having to be vigilant and aware of everything that you did.**

C: Oh my, oh yeah.

T: And how it would affect your parents.

C: Absolutely.

**T: No wonder there was not much time for you to really rest.**

C: Right.

T: And you had to be on alert to what they expected. Yeah, that’s a big job for a little girl to do all the time.

C: Right.

**T: And you didn’t feel safe. It sounds like it wasn’t very safe either.**

C: No.

T: So when you sense these two little girls, playmates, and the lion, and this gentle man tuning into you, knowing what it’s like to be fatherly and playful.

C: Right, Mm-hmm.

Jan found a safe, protected place, and discharged tension in her body and breath.

T: And just sense what it's like in your body just to give yourself that memory, a new memory, an image of what it would've been like, what you really needed back then. You needed protection, you needed somebody who could be humorous and comfortable, who could be playful and loving, and also playmates so you wouldn't have had to work so hard all by yourself and figure everything out.

C: Yeah. [Big sigh]

T: A chance to be a little girl.

C: Right.

T: So as we start to give you a new memory of being protected...having the lion, your friends, that man there, your body starts to reorient too. Right?

C: Yeah.

T: Just giving your breath time to expand.

C: Now I can see my . . . I can see my lungs, I can visualize... **I'm getting a visual image of my lungs, especially the lower part of my rib cage, around my middle.** [Big sigh].

T: Is that a nice image?

C: Mm-hmm.

As Jan discharged, Laurie had the impulse to make contact with Jan (Theme 2). As with all clients, Laurie was very careful in her approach and asked Jan for explicit permission to touch her. Using great caution, she asked Jan about whether to sit next to her on her right or left side. As Jan tensed, it became clear that Jan still felt too unsafe in her body; she could not yet tolerate the closeness of Laurie sitting next to her and making physical contact. She did allow Laurie to sit next to her on the sofa without touching her, which was an important physical experience, and sowed the seed for future nurturance through touch.

T: So I'm wondering if it would feel good for you for me to sit next to you and maybe make some contact.

C: Yeah that seems like a good idea, yeah.

T: So would you like me on your left side or your right side?

C: Definitely my right side.

T: [**Sits next to client on sofa**] Animals and people. So just noticing what it's like to sense my presence right here beside you. I want to make sure, you know, give you time to orient with me here. I want to find out if it's better or worse. Mmm. Some gurgling in your belly, huh? Feeling some heat?

C: Yeah, the heat feels good.

T: Where do you feel the sensation of the heat?

C: On my arm and then upper, behind my shoulder. Then I feel the vibration of your voice in my ear, going into my . . . yeah.

T: Mm-hmm. Is it a good thing?

C: Yeah, it's just different for me to have someone's voice close that's nurturing. I have this sort of sense that it's a voice that's close to me then my response is that it must be dangerous.

T: Uh huh, sure. Yeah, so we're giving you time to kind of have a new experience huh?

Laurie wanted to increase Jan's awareness of someone safe sitting close to her; she worked with "contacting" Jan through her voice and presence, without actually using touch. Jan explained that Laurie's soothing tone helped her distinguish between her sensations of fear and calm, and was integral to her process of self-regulating.

T: You're associating someone close to you as danger.

C: Right, their voice.

T: And the voice is dangerous.

C: Right.

T: What do you sense with my voice? What are the qualities when you sense my voice? Does it seem dangerous? Are you trying to check it out?

C: I think that on one level...I have several different levels of experience of it. One is that **it triggers, that it seems like oh my gosh that's a sick danger thing.**

T: It triggers the impulse of danger.

**C: Mm-hmm, right. But then it's like no, this seems like a good thing.**

T: So you have the thought that comes.

C: Right.

T: First you have the sense that there's something dangerous because the memory in your nervous system is associated danger.

C: At the sound

T: The sound. And then you have the thought, "Oh this could be a good thing."

C: Yeah, yeah. The other thing is I have a lot of memories of adult men being dangerous with their voice coming from like where you are. That's really more, um, I don't know what the . . . you know, there's older memories of my dad.

T: So you're associating this direction, somebody on your right side, with being perpetrated.

C: Someone trying to control me.

Not wanting to flood Jan's system, Laurie returned to sitting in her chair across from Jan, and together they explored how Jan's bodily experience changed when Laurie moved farther away from her.

T: So maybe I'm going to move and let's just study a bit.

C: Okay, yeah.

T: Is that okay with you?

C: Mm-hmm, mm-hmm.

T: What happens as I just kind of move back to sitting across from you? **[Therapist moves back across from client]**. Just sensing what that's like in your body, to have my voice, now my body back where it was before.

C: Well it seems um, it's doesn't raise any, it doesn't have the danger, you know it feels like a very comfortable, it feels very trusting, but on the other hand, I don't feel as much warmth as when you were over sitting next to me...

T: Mm-hmm.

C: Which is nice. So it's sort of, you know, a trade-off thing?

T: You feel more trust, more safety, but there's a loss of....

C: Of connection.

Jan's clarity about how her fear cut her off from others was a very important insight. Furthermore, the fact that it was Jan who identified how her fear has kept her apart from others demonstrated how the work was affecting her. Since it was nearing the end of the session, Laurie then drew on the Hakomi teaching of the importance of weaving the regressed child state into the adult ego (i.e., integrating the triune brain). She asked Jan to connect the child sensory experiences to her adult self. The girl inside Jan appeared to be developing more into a relaxed woman.

T: Mm-hmm. Just notice what happens as you sense the woman in you making contact with that five-year-old in your belly.

C: Well the other thing is the little girl, that's funny, is that in this little tea party we would all be dressed up in these outrageous little ballerina type outfits you know, with the gauze or whatever that is, you know little tights. Just outrageously dressed. I always wanted to do that, I still do...

T: So as you sense your hand really making contact with that little girl and giving her permission to dress up and play and have a male presence that is kind, what's it like in your body as you sense that into your breath, your legs?

C: It feels good.

T: Is there anything your hand wants to say to that little girl? Anything you want to tell her or give her right now?

C: Just lots of warmth and humor.

Immediately as she felt calm and centered, she noticed that her body got cold.

T: Yeah and just sense her receiving from you warmth and humor.

C: My leg, the fronts of my legs are cold. My shins are cold.

T: Yeah, so just kind of sensing the sensation of coldness as it moves through you. And your hands, it feels warm in your belly?

C: Mm-hmm.

T: Cold in your shins.

C: One of the muscles in my neck is hurting, it's pulling. But I think it feels like a, I mean **it feels like it's releasing somehow like the coldness in my shins, it feels like a releasing of some kind.**



As Jan opened her eyes, she explored the spontaneous bodily experience and realized how much she felt her vigilance in her eyes.

T: And as your eyes open you start to orient a little so there's like a reorientation.

C: Yeah.

T: It's like you're trying to decide is it safe or is it not safe.

C: Right, yeah it's a confusing . . . **opening my eyes is one of the hardest things that I do.** I don't know for some reason I feel much more in touch with my body than I do with my eyes. I mean something about my eyes, there's a lot going on in my eyes and so that's one of the places where I feel less connected.

T: Very often our eyes are what we orient and our eyes tend to look out for threat.

**C: Right, right.**

As one wall in Laurie's office is mirrored, Jan noticed and commented that she looked different – more peaceful and grounded state than when she began the session. She sat for a moment and savored this experience before leaving.

**C: It's always amazing to me how I look so much different.**

T: Yeah?

C: Yeah.

T: And what do you see?

C: I don't know exactly. Yeah, I don't know I really don't. I can't put my finger on it's but definitely . . .

T: You look different to yourself.

C: Yeah, I look less tense but I can't quite put my finger on what makes me say that you know?

T: Well kind of like the lion, you know your body is softer, your muscles have let go.

C: Right.

### *Monitoring Evaluation of Session Six ("G" in Figure 1)*

Laurie noticed that Jan was increasingly able to stay with internal feelings of pleasure (Theme 1). However, Jan still remained fearful and needed active intervention to remain calm in her body. Laurie had the impulse to use touch (Theme 2) both to nourish Jan and to understand more fully how she was organized. Laurie took the lead from Jan, who needed Laurie to move slowly with her impulse, as Jan did not yet want touch. Finally, Jan indicated wanting to tell more story in this session. Unlike other clients in

which telling story is often seen as a defensive, distancing maneuver, for Jan, this request might have suggested a desire to become more related (Theme 3).

*Sessions 7-11: Summary*

These sessions were heavily about discharge in Jan's body, yet at the same time, about becoming more related to Laurie. At Laurie's request, Jan made a timeline of her major life events and told more of her life story in session seven. Even without much affect, Jan's story still was full of sad, unhealthy relationships and trauma. Touch was introduced more directly (Theme 2) with Laurie sitting next to her using light massage on her sore shoulder. In another session, Jan was able to feel direct anger at her father instead of diffuse fear. Across these sessions, Jan felt many sensory changes and verbalized her changes in an increasingly related way.

*Session 12: "Moving into a New House"*

Right from the beginning of this final session, Jan described having had a profound shift in her inner experience. She used the metaphor "like moving into a new house" to describe this change in her relationship to herself. She described it as both exhilarating and disorienting. Additionally, Jan appeared much more calm and easily allowed Laurie to touch her neck and the base of her skull (Themes 1 and 2). By the end of the session, she felt grounded and was able to remain so while focusing on her early abuse.

C: Oh definitely, just very, **like moving into a new house**, you know?

T: Oh.

C: That's the analogy that comes to me right this minute.

T: Moving into a new house?

C: Yeah, **you know how you want to do it but then you can't find stuff and you know what I mean?**

T: Looking for boxes . . .

C: Yeah and then you don't know, you know, where's the kitchen and you have to turn left or turn right, you know what I mean?

T: **Getting to know a new house?**

C: Yeah it's like that, that's sort of how I feel.

T: So you're in your new house now?

C: Uh huh. I think what it is, I think what's happening is that I am functioning, I'm sort of shifting my functioning from my head into my lower part of my body and it's that shifting, I think that's what's happening.

T: Your awareness is shifting.

C: Yeah like the decision making. **Instead of the decision making being up here the decision making is lower in my body.**

Since this was the final session of the treatment (for this study), Laurie's focus was on summarizing and integrating their work. As they reviewed their work in therapy, Jan described being on the treadmill and feeling her center of gravity having changed. This was still rather typical of Jan's verbalizations; they were more physical and sensory than relational. She reported what she noticed as a physical shift, unsure of what it meant to her, or what it might mean in relation to other people. Now Jan's "problem" had shifted; she now had to adjust to this new inner experience.

T: And maybe just take a moment to kind of sit with this moment of time, sort of knowing where you were before we began the study.

C: Yeah.

T: And just kind of remembering that initial invitation when you first heard about this possibility and your decision to participate. And then all the different sequences that we went through, traveling really.

C: Yeah.

T: And now you came in talking about sort of like your center of gravity is changing.

C: Yeah, like last night I noticed again when I was at the gym on the treadmill I'm **clearly, I am lower on the treadmill**. It's really startling. **And the treadmill has not changed, you know what I mean?** I mean it's like literally me. I mean I used to feel like when I was on the treadmill that I was about, my center of gravity or my whatever, now it's more here. **[client gestures to lower on her body] So I feel closer to where my feet are running on the treadmill, yeah, like about twelve inches lower to the treadmill, yeah.**

T: And you like that feeling? Does it feel good? Does it feel different?

C: **Well it feels different and I trust that it's a good thing, you know, what I've noticed doesn't seem to be either good or bad it just seems to be a difference**, you know what I mean? **Whereas the less racing in my head seems to clearly be, I prefer that.** This whereas this center of gravity difference is just wow it's really a difference but I can't really tell what it's doing. It's just like . . .

Jan's increased self-awareness could also be seen in how she approached the change in her felt sense; she studied the change and did not immediately assume the shift in gravity was "a good thing." By asking more poignant questions about how she felt, with

humor and a sense of joy, she demonstrated significant change for a woman who had lived in a state of internal rigidity and tension for years. Now Jan could more easily access calm and engage in less obsessional thinking. She remarked on it herself.

T: Let's just take a moment and check in with where you are right now with your eyes closed or open.

C: I guess the thing that keeps coming to mind about when I started the, you know the invitation as you were asking me, what seems to be really something that I didn't expect to happen is I was talking with Amelia when I interviewed with her before we started and she was talking about these twelve weeks and look at and evaluate the different time. **I think I even said to her, I was kind of laughing,** and I said you know twelve weeks in terms of a course of therapy, **I mean I've been in therapy for five years and I know that if you take that into twelve weeks, I mean to me to have a really clearly defined change in that amount of time seemed implausible and that was, you know I feel much different. I'm quite amazed by that.**

Here Jan offered important feedback as to how Laurie helped her in the past twelve weeks. Laurie acknowledged the changes Jan described and encouraged Jan to describe the changes concretely.

T: As you're sitting here now right, on week twelve from where we began, maybe you could just take a moment and sort of ask yourself what is different for you. What feels like it belongs to you now, it's not just one minute experience that passes?

C: Well I feel, um . . .

T: You mentioned the awareness in your lower body has changed.

C: Right.

T: And the racing in your head seems to have changed.

C: And I would say, you know what feels to be, feels like it belongs to me is the sense that my being in my torso, yeah and somewhere else, either exterior to my body or in my head. **Before we started I would have feelings of warm energy going up in my torso or I would have lots of pain in my torso, I mean I would have all sorts of things going on in my torso. I was giving it lots of attention, listening and those kinds of things, um, and I still do that it just that it seems like my being is more there [client puts hands to chest].** I can't really describe it. **That's the idea that I was moving into a house, that's what it feels like.** That's the most clear I would say.

In Laurie's language, Jan's body belonged more to herself now. Jan was able to articulate a softness and grace that was distinctly new – she now felt more emotionally connected with her sensations, her body, and her “self.”

C: I guess what comes to me is the compassion that my torso has for my head. Because I feel like my head is very much in a sort of, less but it's definitely in a frenzied sort of place

and my body seems, my torso seems to be aware of that and wanting to acknowledge and nurture it, that's the kind of words that come to my mind, something like that. Yeah.

As they experienced Jan's compassion towards her body, one noteworthy point is that part of BcP change lies not in the experience of pain but in the person's relationship towards that pain. Thus, as Jan described her continued neck pain, it is her different stance in relation to her own sensations that is the greatest change.

T: Yeah, and as you develop that place of being and compassionate presence then you can turn towards that part of you, speak to her, hold her, comfort her. Just notice right now what it feels like to be aware of the compassionate being that you are and how that part of you would like to be in relationship with your mind right now. Notice if there are words that part of you would want to say or if there's a gesture, a way that is to hold or touch that frenzy. Sometimes just acknowledging.

C: Yeah, I'm aware that my neck and the back of my head hurt, you know?

T: Mm. So right now you're feeling the sensation of pain or hurt in the back of your neck.

C: Right.

T: And what else do you sense in your body? Places where you're not hurting? Perhaps your torso, your pelvis, the soles of your feet, your legs? You want to acknowledge the part of you that's hurting but also see what else you become aware of as you notice. Your arms resting on the couch, your hands . . .

C: Oh I sort of, I feel like my torso and my pelvis, maybe my feet, **but my torso and my pelvis are sort of like compassionate onlookers or like a parent that doesn't know what to do. That's kind of how it feels.** Yeah like a parent that's not quite sure what to do, that's what it seems like to me.

Jan was able to express herself with both confidence and affect not present in earlier sessions. She appeared much more comfortable with herself as well as with Laurie. She talked about her relationship with her body like a loving parent to a child. She asserted herself as well by requesting to see the pictures representing her goals she had drawn several sessions ago.

C: One idea that for some reason it seemed like it would be a good idea is I was thinking it would help my head if I put those pictures that I drew of my stages, you know?

Laurie retrieved the images and they spent some time looking at the images, all the while checking in with Jan's body. As they reviewed, Jan described the "flowing of energy" through her body. Again, Laurie felt she wanted to introduce touch and asked Jan

if she would like some support to any part of her body. Jan immediately suggested having some support to counter the pain at the base of her skull. Such receptivity suggested a new ability to accept support from Laurie comfortably (Themes 1 and 2).

C: I can feel some of the flow going up through the front of my neck through my chest.  
 T: And as you feel the sensation of flow moving from your chest into the front of your neck and noticing the back of your neck, arms, legs, the movement of your breath, yeah, rocking in your head. And just letting your jaw soften. If I was going to support you or touch you in your body anywhere do you have a sense of where you might like to have contact, physical contact? Is there any place?  
 C: I think the back of my neck, yeah. On the bottom of the back of my skull.

Before Laurie touched, she approached Jan with the same fastidious care that she has taken throughout the treatment. In this final session, Jan remained calm as Laurie approached her, sat beside her, and softly touched her head. Part of the sad cost of trauma is that often people are so frozen that they cannot take in the nourishment needed to unfreeze their numbness and resolve their pain. By working so slowly and carefully, Laurie had helped Jan become comfortable in allowing others to make contact with her.

T: So how would it be if I just sat beside you and gave you some support there?  
 C: Seems like a good idea.  
 T: So I'll sit on the left side?  
 C: Yeah please. **[Therapist sits on the left side of the patient.]**  
 T: I'm on your left side right now.  
 C: Mm-hmm.  
 T: **Just notice how it feels to have me here before I touch you.**  
 C: Yeah it seems okay.  
 T: It seems okay.  
 C: Mm-hmm.  
 T: Yeah. Is there any way you get that feedback from your body that it feels okay?  
 C: Yeah well **I know because I don't have any sort of freezing response.** If you were on the other side usually what happens is I get some kind of freezing startle response kind of, something definitely like that, but I don't seem to have that.  
 T: You stayed pretty connected the way you were before?  
 C: Yeah.

The two then had a long interchange in somatic language as Jan tracked her sensations, and made some connections between her psychological and physical states.

C: I'm feeling some kind of those jerks, those little energy jerks.  
 T: Mm-hmm. And where are you feeling flow?

C: Um, up in through the middle of my chest, along my spine, and then up through the middle of my neck. Then I feel the stretching across the back of my neck and then around my neck muscles in my collarbone. All the stretching is into my right, from my left to my right. **I think it has something to do with the fact that I feel safe on my left and not on my right. Something about these things are connected.**

T: Alright, and if you stay with the impulse to stretch and the feeling of flow notice if there's a thought or an image that comes in this place. Or a feeling. It's okay to just stay purely in the sensation too.

C: **I feel like my torso is bigger and my head is smaller.** Yeah.

T: Your torso is bigger

C: Yeah and my head is smaller.

T: Your head is smaller. And then you talked about a pain in your neck and your torso and the rest of your body being like a parent that doesn't know what to do.

C: Right.

T: How is that now?

C: Well, uh, **my body, my torso feels like it stumbled on something, figured out something to do that's a good idea.** You know?

T: Mm-hmm.

Although Jan was still not highly relational, her language had shifted such that she used more positive and loving language. Additionally, instead of triggering a fear response, she was able to allow herself pleasure right in the session.

T: So just allowing yourself to stay with that sensation of warm energy.

C: That feels great.

As Jan discharged, Laurie continued to "hold" her and educate her about the discharge of her trauma freeze. While doing so, Jan spontaneously identified an important connection between the fear and anger at her father and the pain in her neck. This was a very important realization for Jan about how she had embodied her fear.

T: That's right, just trusting the experience from moment to moment. Little jerks in your shoulders, little jerks through your thighs as the sensations flow through you and the warmth. Our body is our home from head to toe. And when we're traumatized and overwhelmed we freeze and we go into survival threat so we don't have a chance to be in that way, and as we feel safer and safer our body can reorganize. **But your body protected you too. It was your best friend.**

C: Right, right.

T: And what's happening now you just kind of moved your head?

C: Yeah, I think now, I think I'm thirsty and I think I should, yeah, I should tilt my head a little this way.

T: Another impulse. **[Therapist places her left hand on the client's forehead].**

C: Yeah. Yeah that feels good. **My neck is saying that I got whacked like this a lot of times.** That's exactly what it's saying.

T: And that happened several times?

C: Oh my yeah. **It was my primary interaction with my father.**

T: Was for him to whack you?

C: Uh-huh. **I think that I developed some kind of thing where I moved my head in that same direction even when he wasn't whacking me. Sort of anticipating...** or I don't know exactly.

T: Traumas...your body starts to respond a certain way, anticipating threat or preparing for threat, or trying to protect yourself from threat.

C: Right, yeah.

T: So as you sense your head and your neck now you have permission to rest.

C: Now there's a lot of fluid going up through the back of my head where your hand is. Where your right hand is maybe.

T: Mm-hmm. And it's a pleasurable sensation?

C: Very.

To complete the integration, Laurie asked Jan for language to describe what was happening. Jan was able to resolve this feeling through a very self-loving statement.

T: Yeah, so what is your body and soul learning right now? If that fluid had a voice what would it say to your neck? To your head? To that little girl who was beaten, hit?

C: **"We love you"** or something like that.

Jan seemed to have completed some important process. She was very thirsty (often a sign of somatic release) and asked for water, which Laurie brought her. Unlike in early sessions when she verbalized almost constantly, now she spent a few minutes in silence, drinking her water peacefully.

C: [Drinks for a few minutes]. Thanks. Ahh. My head feels really different.

T: Yeah, giving yourself some time to sense your head, your neck.

C: Yeah.

T: Your torso, your arms, your pelvis, and your legs. You started the session talking about coming into your house and also wanting to feel the flow.

C: Yeah. **My neck feels much different now and my head feels like the electricity was gently brushed away or something.**

As the session wound down, Jan assessed her body as "80% peaceful and 20% in some different place." Interestingly, Jan asserted herself to come back into relationship in the last moments of the session, indicating how much she was able to feel safe within herself in order to enjoy relating to another.



T: And where do you feel that 80% in your body as sensation? Where do you feel that flow of peacefulness? [**Therapist places her right hand behind the client's neck**].

C: Well it seems like it's in my, in all of my tissues but his seems like, yeah all of my tissues and then the 20% seems like it's sort of scattered up in my, the back of my upper back and my neck and my head. You know that's what it feels like.

T: Yeah so just letting yourself acknowledge the sensations of peacefulness in your tissues. Soft tissues, everything is resting in the soft tissue. This process will continue. Uh-huh. How are you doing?

C: Pretty good. **I think I want to open my eyes now.**

In the final moments, the two “located” her within her artwork and her journey, within the visual pictures, language, emotion and her internal sensations.

T: Okay. There are your pictures.

C: Yeah. I feel like I'm moving between three and six. Yeah.

T: Are there any words associated between three, four, five, and six?

C: When I look at them I feel I'm going back and forth.

T: Yeah, we often say transformation is like the leading edge and then there's the edge we're coming from, the trailing edge and the leading edge. Part of healing is going back and forth and reorganizing emotionally, energetically, biologically.

C: **Yeah I feel like I'm reorganizing.** Yeah.

T: It takes time.

C: Because it's such a big shift. **A huge shift for me.**

T: Exactly, your whole nervous system. When we come out of frozen energy or disassociation or all the things we had to do to survive threat, which ended up becoming a habit pattern.

C: Right.

T: And a way of surviving.

C: And then I recreated it too by the people I married and the situations I got myself into.

T: And now you're taking the time to devote your healing to yourself.

C: Right.

And with this, the session ended.

### *Monitoring Evaluation of Session 12 (“G” in Figure 1)*

Since this was the concluding session for the study, Laurie intended to use the session to review and integrate their work together. She wanted to assess what had helped Jan, and what her goals and expectations could be for the future. Jan appeared to have made two major shifts: she was now able to access inner resources and ground herself, as well as feel much more integrated in her connection between head and body. For future sessions, Jan would continue to work on relating to herself as a loving as well as to others. Jan and Laurie contracted to continue treatment, yet planned a hiatus for a few weeks to complete the study.

## Concluding Evaluation (“L” in Figure 1)

*Quantitative Results*

**Table 4**  
**Jan’s SCL-90-R Results\***

	Jan 1	Jan 2	Pt diff	RC	Sig at p≤.05
<b>Global Severity Index</b>	67	58	9	-1.59099	
<b>Positive symptom distress index</b>	66	47	19	-3.35876	*
<b>Positive Symptom Total</b>	63	61	2	-0.35355	
<b>Somatization</b>	63	55	8	-1.41421	
<b>Obsessive-Compulsive</b>	57	57	0	0	
<b>Interpersonal Sensitivity</b>	69	60	9	-2.06474	*
<b>Depression</b>	60	58	2	-0.4	
<b>Anxiety</b>	74	63	9	-2.45967	*
<b>Hostility</b>	54	40	14	-2.6943	*
<b>Phobic Anxiety</b>	58	54	4	-0.83406	
<b>Paranoid Ideation</b>	71	57	14	-3.3955	*
<b>Psychoticism</b>	79	60	19	-3.96177	*

\* All scores are T-scores with a mean of 50 and a standard deviation of 10. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning. RC indicates the Reliable Change Index (Jacobson & Truax, 1991).

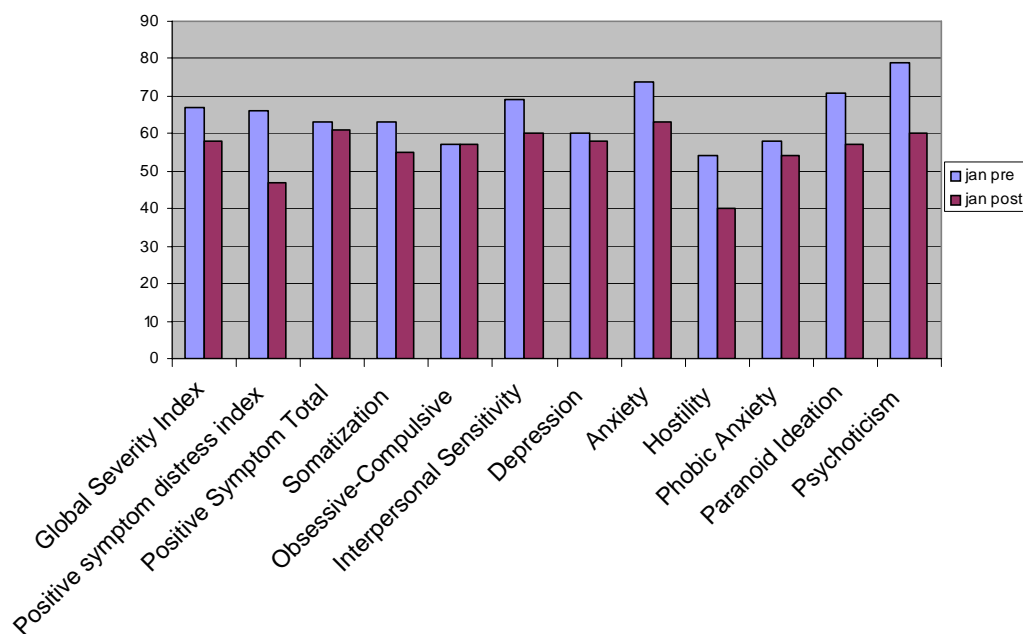


Figure 2. Graph of Jan’s SCL-90-R Results.

Table 5  
Jan's TEaM Results\*

Subscales	Jan 1	Jan 2	Pt diff	RC	Sig at $p \leq .05$
Subjective Well-Being	59.48	65.44	5.96	0.993333	
Depression	63.57	60.08	-3.49	-0.74407	
Anxiety	47.84	57.49	9.65	1.489027	
Phobia	46.75	50.71	3.96	0.571577	
Obsessive-Compulsive	49.48	53.32	3.84	0.64	
Somatization	59.65	59.65	0	0	
Panic Disorder	56.67	52.49	-4.18	-0.81977	
Post Traumatic Stress Disorder	45.11	49.16	4.05	0.640361	
Symptom Checklist	53.04	55.58	2.54	0.567961	
Personal Functioning	68.03	57.57	-10.46	-1.61401	
Social Functioning	62.24	58.01	-4.23	-0.56526	
Vocational Functioning	67.87	54.55	-13.32	-1.81262	
Functional Disability	68.09	56.05	-12.04	-2.12839	*
Behavioral Health Status Index	61.49	60.16	-1.33	-0.27149	

\* All scores are T-scores with a mean of 50 and a standard deviation of 10. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning. RC indicates the Reliable Change Index (Jacobson & Truax, 1991). Because test-retest reliabilities were not available for the TEaM, internal consistency reliability of coefficient alpha was used to calculate RC, which therefore is likely to offer a slightly higher RC value.

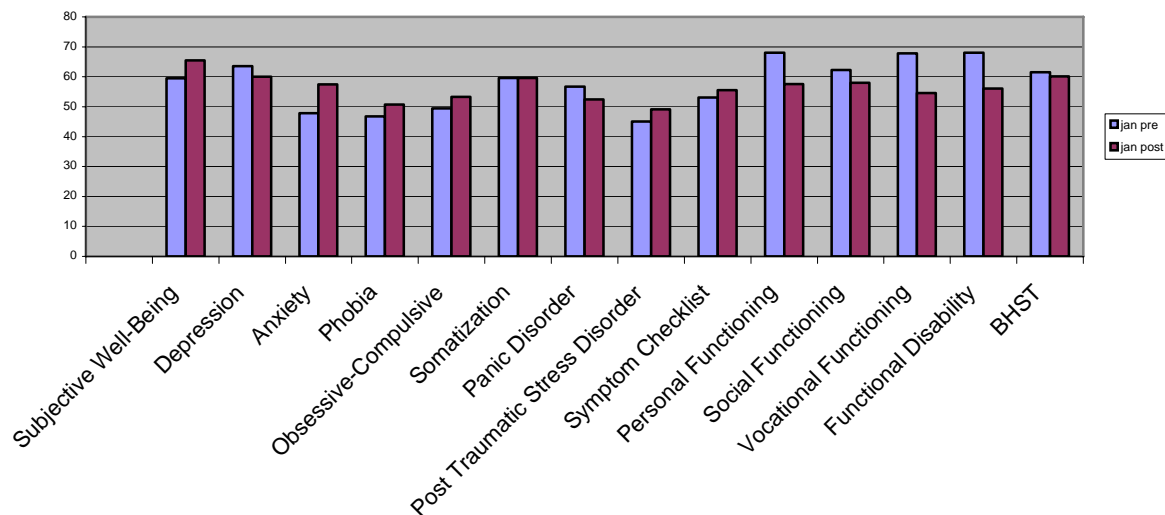


Figure 3. Graph of Jan's TEaM Results.

Table 6  
Jan's Scale of Body Connection (SBC) Results\*

Subscale	Jan 1	Jan 2
Body Awareness	4.1	4.3
Body Dissociation	2.3	3.3

\* Higher scores indicate increased Body Awareness and Body Connection.

### *Discussion of Quantitative Results*

At the end of the 12 sessions, Jan's clinical profile on the SCL-90-R went down dramatically. Of the 12 scales, at post-treatment 11 decreased, and all 10 were under clinical levels (below 61). At the beginning of therapy, Jan's symptom picture had been in the clinical range. In the words of the SCL-90-R computerized interpretive report, her Somatization had been "unquestionably in the clinical range"; her Anxiety was "consistent with the emergence of a psychiatric disorder of serious magnitude"; her Paranoid Ideation was "almost certainly associated with a formal psychiatric disorder which possesses clear paranoid overtones"; and her Psychoticism (indicating a withdrawn lifestyle) suggested profound alienation or "intense confusion." After treatment, she experienced statistically significant decreases in six subscales: Positive Symptom Distress Index, Interpersonal Sensitivity, Anxiety, Hostility, Paranoid Ideation, and Psychoticism.

Such statistically significant changes, which are consistent with her qualitative results, illustrate important findings for how Jan changed through BcP. For example, Jan experienced a significant decrease in her Anxiety scale, which included many somatic aspects of anxiety such as trembling and tension, as well as terror, apprehension and dread. This was a main focus of Laurie and Jan's work together, and thus provided an important corroboration of their work. Jan's reduction in Psychoticism from 79 to 60 – her biggest change in T-scale points – could have been from Laurie's "validating" her body awareness and helping her to put this in perspective and not to be as upset by it. Additionally, Jan's Interpersonal Sensitivity subscale, referring to her self-consciousness,

feelings of inadequacy, and marked discomfort during interpersonal interactions, decreased significantly at post-treatment. Given the centrality of relational problems for Jan, her significant drop is an important finding across her work in therapy. At post-therapy, Jan's Anxiety score of 63 was still "slightly elevated," suggesting continued difficulty, again consistent with the qualitative findings, but not to the extent it had been previously.

On the TEaM scales, six subscales increased and seven decreased, which indicates no clear pattern. The decrease in Jan's Functional Disability subscale was the only statistically significant finding. As often the case in psychotherapy studies, it is possible to interpret this finding as indicating that Jan may have been doing better by doing worse. Specifically, she was increasing her awareness of her symptoms, and in the past two weeks spending less time socially and more time experiencing her symptoms (crying, sleeping less). This interpretation is consistent with her qualitative data, which indicated that Jan was going through dramatic shifts in her awareness and internal experience at the end of the twelve sessions. It is for this very reason that the study allowed for a continuation beyond the twelve weeks. Jan intended to continue treatment. Allowing herself to feel worse seemed to indicate her commitment to working-through in the therapy.

While the Scale of Body Connection does not allow for statistical analysis, because a content analysis of Jan's responses indicated an increase in her connectedness to her bodily experience. Additionally, Jan showed much more integration of her physical and emotional world in her responses. For example, on the item "I notice how my body changes when I am angry," she moved from "most" to "all of the time."

### *Goal Attainment Scaling Results*

Results on the Goal Attainment Scaling (scored by the client at the exit interview) indicated that Jan improved on all three of her goals. She was more able to experience and express her anger in a healthy way by speaking up once a week, as compared with her baseline at the beginning of therapy of once every 3 months. She felt more relaxed and in control upon awakening, going from a baseline of obsessively making lists every day to three or more days per week of not making such lists. Additionally, she had a more complete memory of some of the early abuse than at baseline.

**Table 7**  
**Jan's Goal Attainment Scaling Results**

\* = Before Study \*\* = After Study

<b>GOAL</b>	<b>Connect to childhood memories</b>	<b>Get to rage</b>	<b>Control of Terror – operationalized as waking up and making lists in head</b>
LEVEL OF ATTAINMENT	Scale 1 Importance: 9	Scale 2 Importance: 7	Scale 3 Importance: 9
Much less than expected (-2)	Nothing happens – no change in memories *	Speaking up once a year	No change *
Somewhat less than expected (-1)	A flash of memory	Speaking up once every three months *	Watch self but make a list anyway
Expected level of outcome (0)	One more memory **	Speaking up once every month	1 day week not making lists upon waking up
Somewhat more than expected (+1)	One more memory with explicit details	Speaking up twice a month	2 days/ week not making lists
Much more than expected (+2)	Multiple factual details remembered	Speaking up once a week **	3 or more days/ week not making lists **
COMMENTS	A memory means a detailed factual historical childhood memory	Speaking up means “loudly and articulately about whatever is making me angry in relationships outside work.”	How distracted she feels is indicated by list making

## *Qualitative Results*

### *Exit Interview*

Jan was ebullient about the therapy and the effects it had on her experience of herself in her body. Particularly salient about Jan's analysis of her treatment was her emphasis that no single therapy alone would have been enough: "I feel much different than I did in December - a profound difference. I think the change is a result of my commitment to healing in combination with the variety of therapies that I am doing. I firmly believe it is the combination – one or another as a stand-alone would not have given me the results."

What was distinctive about Laurie's work with Jan was its emphasis on positive feeling and calmness. "What Laurie is doing is help me feel calm, deeply feel calm. What I notice is that I have a much greater sense of peace, calmness in myself. My day to day living is calmer. I'm not distracted so much by being upset or worried or in pain. So I'm more engaged in the present." She feels more able to assert herself with others and speak up more, yet still wishes she could "let loose." She is making fewer obsessive lists. And most importantly, she feels more alive and present, with less generalized pain and fear. Jan has noticed waking up calmer, and even at times having to lie down and relax, in a way she finds "very, very healing." At these times, she finds that listening to the sensations of her body informs her behaviors, which is an important internalization of Laurie's work.

Jan offered an important perspective of someone who can examine BcP from a comparison with talk therapy. Given that she has become a proponent of both, her analysis of each part is very helpful:

Talk therapy has helped me examine it and peel away a lot of the layering I do in my daily life to function...defense mechanisms, stories I tell myself, it helps to pull those away. The other two therapies were helping me eliminate immediate pain or surface issues or conflicts. But in terms of how to resolve my own pain as a human being, my own physical experience of the trauma and the hurt and the pain, it wasn't healing that. Which is what I'm experiencing with what Laurie's doing.

However, Jan adamantly felt that she needed all three therapeutic components: the work on her deep felt sensations (BcP), as well as both help with skills and coaching in her day to day life (her talk therapist) and with physical muscular pain (her body worker). "I might leave the session feeling more calm in my thoughts and energy, but I still would have the pain in my neck. So that's why I'm saying the combination is a really big deal."

In fact, Jan felt that BcP alone might not have been enough:

I would be frightened to do it as one piece. I've played the scenario out: Now I'm feeling better, but the day-to-day facts of life are not better. Unless I have the tools and the supports to resolve some of those day-to-day specific questions, how do I deal with my father, how do I deal with an abusive boss, apply to graduate school? I need the support for those in addition to feeling better. Because if I just felt better without having the skills and the coaching in those other areas, I'd be sitting in my apartment feeling better but not going anywhere.

Thus Jan offers important insight into the integration of BcP, as well as the tension between addressing the body versus working with a client's narrative (Theme 3). Jan was aware that without the detailed narrative component that she got from her talk therapist, she might not have had the tools to translate what she learned with Laurie (a concern that appeared in Terry's treatment).

#### *Case Analysis Theme Results*

*Theme 1: Helping clients feel "nourished" by internal resources.* At the beginning of treatment, Laurie witnessed how immediately upon feeling happy or satisfied, Jan would freeze as if her father were about to come upon her. Laurie



formulated that Jan was largely unable to access her internal resources without fear. Her treatment plan largely focused on: a) bringing Jan's awareness to understand her rigidity and embodied fear and b) helping Jan access an internal sense of calm and nourishment without feeling under threat.

That much of the treatment addressed helping Jan connect to her sensations in a new way, without much work on interpersonal relationships, was a very conscious choice by the BcP therapist. Laurie formulated that before Jan could access emotion or interpersonal relationships, she needed to feel safer in her own body. Laurie's treatment goal was resonant with Jan's agenda, as she had distanced from many relationships, and felt that she had to reestablish safety within herself before she entered any new relationships.

As Jan felt more embodied and grounded, she was able to elaborate on more painful memories across sessions. Thus, she became able to "pendulate" between nourishment and trauma with more flexibility and less fear. As the data indicate, Jan's relationship to herself shifted in a positive direction. In Jan's own words: "Well [my hands] both feel really loving to me... And it seems like the rest of my body is just being patient with my head, just sort of letting it find its rhythm." (Session 10)

*Theme 2: Using physical touch.* This case illustrates how, with minimal actual physical contact, a BcP therapist can still work with a body-orientation, using physically oriented language and imagery to help a client become embodied. Jan was often overwhelmed by the experience of physical closeness, so Laurie worked by just sitting next to Jan instead of touching her. When they did make physical contact, it mostly

involved Laurie putting her feet on top of Jan's for several minutes, to help her relax and feel grounded by connecting with her feet on the floor.

A summary of their physical contact follows, as well as moments of “non-traditional” sitting orientation, either sitting next to one another on the couch or on the carpeted floor:

Session 2: Laurie and Jan touched by sitting across from each other, pushing hand to hand, to help Jan feel her boundary in her body.

Session 5: Laurie worked with light touch on Jan's jaw, neck, back; put her feet on Jan's feet to ground her.

Session 6: Laurie suggested touch, but given Jan's high level of arousal merely sat next to her on the couch without any touch.

Session 7: At the end of the session, Laurie used touch – feet on feet at the very end to ground Jan.

Session 8: They touched hands to hands, as in session 2, for a felt experience of a boundary.

Session 9: Laurie used touch of hands to hands, repeating the experiment from session 8 to push away the bad – coupled with language – “get away!” so Jan could continue to savor space and rest on inside.

Session 10: They did not touch, but they started the session sitting on the floor with a large sheet of paper on which Jan drew the assessment pictures. Later in the session the two conducted an experiment, L sitting next to her on the couch, as Jan explored what sensations arose in her body.

Session 12: Jan allowed for light touch with her neck and the base of her skull. The quality of the ease with which Jan was able to have Laurie touch her was visible in this final session.

Imagery also proved to be an important aspect of “feeling touched” without physical contact, which was significant in Jan's treatment. Laurie used a lot of imagery of protection to bridge the gap between Jan's needs for contact and her anxiety around being touched. Additionally, in each intervention using imagery, Laurie evoked an interpersonal focus through inviting others to join Jan in the image. Jan responded well to

this technique; in one scenario, she created an elaborate fantasy world of protection with animals close to her; in another, she surrounded herself with her three therapists and religious monks to soothe her. Even when Laurie introduced physical touch to Jan's therapy, she was very careful to track how Jan felt having someone close to her. This protection of Jan's boundaries, while also encouraging more interpersonal contact through imagery and physical touch, was important in Jan's shift to a more related stance.

Also noteworthy was the high frequency of language of discharge that Jan spontaneously used to describe her sensory experience in the sessions. As previously discussed in Levine's (1997) theory, ending traumatic "freeze" in the nervous system includes sensations such as shaking to discharge tension. Jan instinctively described in very specific language feeling "jerks" and "a warm fluid" moving through her body.

*Theme 3: Telling the story: Working with narrative versus body.* It was striking that Jan told very few details of her life story in the treatment, e.g., in only one session did she give factual history. Most important in Jan's case, however, was that she also had a concurrent talk therapist with whom she met weekly throughout this treatment. Jan emphasized at the end of treatment that she could not have imagined doing this work or having such progress without her combination of therapists. Jan was aware that without the narrative component that she obtained from her talk therapist, she might not have had the tools to translate what she learned with Laurie (a concern that appeared in Terry's treatment). "If I only did [BcP], it would have taken me to a certain point, and then I'd want something else. I am sure it's the combination that was best for me." Therefore, although she did not use much narrative in Laurie's treatment, perhaps this was because

telling her story did play an important part in her concurrent treatments outside of Laurie's office.

Another aspect of the narrative work was how Laurie helped Jan feel she had extensive time to experience whatever she needed to in the treatment. This intervention of Laurie's to "slow time down," repeated over and over, created permission and recognition for Jan's suffering that seemed extremely healing for her. Jan explained throughout treatment that having people take her pain seriously had provided the most important healing. As Laurie continually affirmed that Jan could take time in a way that she never had as a little girl to work through some of the intense, painful experiences that have been long-held in her body, Jan softened. As Laurie often reassured Jan that they would take as much time as her body needed to work through her experience of her terrified young self, Jan's pain no longer had such hold; she found new sensations emerging that felt good to her, and with permission, she became more able to stay with and experience them.

#### *Summary and Integration of Results*

As the quantitative and qualitative data corroborate, after the 12 sessions Jan appeared calmer and more accepting of her inner experience than she was before the study: "My day to day living is calmer. I'm more at peace. I'm not distracted so much by being upset or worried or in pain. So I'm more engaged in the present." She felt more able to assert herself with others, speak up more, and make fewer obsessive lists.

Most importantly, she felt more alive and present, with less generalized "vague pain" and fear. "I feel calmer when I wake up. I feel calmer all the time." This calmness reflected Laurie's guiding conception, which largely focused on helping Jan access inner

resources in order to confront her traumatic memories and sensations. Jan remarked on the success of this work, as she experienced many inner bodily changes as well as cognitively, as she reported her “head is slowing down.” Jan cited this change in her relationship to her sensory experience as the unique contribution of BcP.

Another striking change is how Jan’s language shifted into more affect-oriented and relational speech, using words such as “loving” instead of affectless sensory imagery such as “jerks.” Previously she had appeared very detached, as if all of this were happening outside herself. Afterwards, she appeared less dissociated, as if she felt she belonged in her body in a more compassionate way.

The changes Jan gleaned from these sessions and her other therapies were also translated into actions in her outside life. While in the BcP therapy, she decided to look for a new job; towards the end of the treatment she found and successfully changed jobs. She was also accepted at graduate school in religion and art. In the last four months, she functioned at a high level: she saw three therapists concurrently, took two classes, went regularly to the gym and church, as well as applied to graduate school. Based upon an informal, three-month follow-up after the end of the study, Jan shared that she continues to function in a happier and more related way, as she has taken major steps towards establishing a new career in a people-oriented, helping profession.

## CHAPTER VI

## THE CASE OF TERRY

*You know, I never thought of the body having a language this way. I mean you know obviously something scares the daylights out of me [pounds chest], that you get [chuckles] or something really, really painful that you get [puts hand on heart] and you block [grasps throat]. This that you are teaching me, I didn't make any connection. If I weren't here and I got cold, I would normally either try to ignore it, and given the amount of physical garbage you know I went through when I was little, it's usually my reflexes. I would pretend or I would try to correct the physical sensation by you know like running hot water over my hands, or putting gloves on if I could find them...*

-Terry, Session 7

Client ("A" in Figure 1)

*Introduction*

Terry, a 60 year-old Caucasian, professional, divorced woman, was referred to Laurie by a colleague who had been a client of Laurie's. Terry had been married twice, had one now-grown son from her first marriage, which she described as horribly violent and abusive, and was currently in a less-than-satisfying relationship. She felt blocked, unsure of the next steps in her life. She presented for therapy to address some of the pain and sadness that she had been carrying for years. She was also a chain smoker, a habit she detested yet found herself unable to control. She had briefly tried therapy before, but had not engaged in treatment.

Unlike “therapy-experienced” Jan, Terry was a newcomer to therapy. Terry represented Laurie’s third type of client, who knows someone who has undergone BcP, but has no previous experience with this work. Even though Terry was not in crisis at the time of coming, her long-term issues had finally risen to a level that required attention. Additionally, although Jan was from a similar demographic as Terry, she had experience with therapy and so began her BcP treatment without many concerns or questions. Terry had a lot of fear of therapy. She was afraid of the painful feelings that would emerge as well as feelings of shame for taking this time for herself.

The case of Terry is an excellent example of working with developmental trauma. A very adaptable and agreeable woman, Terry could be pleasing to such a degree that she fulfilled her own needs only through meeting others’ needs. Much of her treatment was formulated as being a case of “unmet needs,” which Terry had compensated for by seeking love and nourishment by taking care of others. How to help her discover how she nourished herself (Theme 1) and work with physical touch as a way to meet her unmet needs became a central part of treatment (Theme 2).

This case is also an excellent illustration of how Laurie worked on alliance with an inexperienced client. Despite her fears, from the very first session, Terry was able to experience and express much painful affect and sensations in the treatment. Issues of trust and working through were very important as Laurie experienced some significant ruptures with Terry, who desperately wanted to tell her story. Yet, as the therapy continued, when the pace scared her, Terry was able to articulate her need to slow treatment down. Their tension around talk versus body-orientation raised the important issue of the role of narrative in a body-centered treatment (Theme 3).

*History of Client*

Terry was the eldest child of married parents. She was born while her father was on duty during WWII. After the war, he was a traveling salesman and often away. She described her mother as a very anxious woman who dealt with her nervous energy by constantly moving her body. From her mother, Terry learned that it was not acceptable to relax. Terry also remembered that her mother often unfavorably compared her to others, sending a message that she was “never good enough.” Terry compensated by always being a caretaker. She had vivid memories of caring for her younger sister and two younger brothers (six and ten years younger)— feeding them, putting them to bed, reading them stories. She remembered enjoying taking care of them, but “I never really got to be little.” This dynamic of taking care of others became a prominent aspect of her personality, allowing her to function well when focusing on the feelings of others, but left her with little ability to allow herself joy and nourishment herself.

Terry was married twice, first to an emotionally and physically abusive husband with whom she had her only child, a son. She referred to the abuse that she withstood over many years only in vague terms. Terry admitted that she had great difficulty discussing what she endured in that relationship and only seldom did she refer to it. Once, she described his constant threats of taking away her son from her. This theme of tolerating abuse while remaining a caretaker was an important pattern for Terry to address in treatment.

Terry’s second marriage was brief. She described herself as “safe for the first time in my life.” She left her second husband, however, because she had fallen in love again with her high school sweetheart, Jack. She did not have an affair, but merely had started a



letter-writing correspondence with Jack. Yet, when she told her husband that she was writing Jack, he put an ultimatum to her, and so she left him.

Unfortunately for Terry, Jack seems unwilling to have a full relationship with her. Most of their connection occurs through an intense email correspondence. The two see each other rarely, and have never consummated their relationship. Terry yearns for more connection with him, yet knows she will probably never get it. When asked at intake about her goals for treatment, she never mentioned this relationship. Only after several sessions did Terry admit to Laurie that her “missing attacks,” in which she felt intense pain at not having her desire for closeness with Jack fulfilled, was really the reason for her coming to therapy now.

Terry also had lived for approximately twenty years in France. There were several times throughout the treatment when she referred to words in French (“ca suffit,” “assez”). It is interesting to note how Laurie drew on Terry’s bilingual sensibility to advance her integration of cognition, physical sensations and emotional expression, and sought to find the precision in wording necessary to obtain more vivid emotional resonance with Terry.

#### Assessment (“D” in Figure 1)

##### *Qualitative Assessment*

Laurie described Terry with “softness, yearning, longing, and melancholy” in her appearance. She assessed that Terry seemed “worn out,” as if she did not feel any power to nurture herself. Terry admitted to having “a lot of sadness” within her. She showed great difficulty receiving help and nourishment without immediately moving into the role of taking care of the other. This was apparent right away through her extensively-

accommodating and deferent style. Laurie assessed that Terry was not able to sense her inner resources and feel relaxed and nourished.

Terry had some intensive medical problems when she was very young. One of the most excruciating was a severe case of eczema, dating from her birth. In the first session, Terry spontaneously recalled an early memory of being tied down to keep from scratching. Terry was also a pack-a-day smoker, and had been so for decades. She had started smoking to ease the itch of her severe eczema and then “leaned heavily on the cigarettes” during her abusive marriage. Terry wanted quitting smoking (or at least preparing to) to be an important treatment goal. Interestingly, Terry neglected to mention another severe body trauma until almost the end of the treatment – that she had been blind in one eye for at least half her life. It was hard not to speculate that there was much more abuse and grief in Terry’s past than what she recounted in these sessions.

### *Quantitative Assessment*

**Table 8**  
**Terry’s Initial\***

<b>Global Severity Index</b>	61	<b>Depression</b>	68
<b>Positive symptom distress index</b>	53	<b>Anxiety</b>	63
<b>Positive Symptom Total</b>	63	<b>Hostility</b>	40
<b>Somatization</b>	53	<b>Phobic Anxiety</b>	58
<b>Obsessive-Compulsive</b>	57	<b>Paranoid Ideation</b>	49
<b>Interpersonal Sensitivity</b>	62	<b>Psychoticism</b>	60

\*All scores are T-scores with a mean of 50 and a standard deviation of 10. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning.

**Table 9**  
**Terry’s Initial TEaM Scores\***

<b>Subjective Well-Being</b>	<b>47.33</b>	<b>Post Traumatic Stress Disorder</b>	<b>57.26</b>
<b>Depression</b>	<b>56.60</b>	<b>Symptom Checklist</b>	<b>60.86</b>
<b>Anxiety</b>	<b>57.49</b>	<b>Personal Functioning</b>	<b>68.03</b>
<b>Phobia</b>	<b>62.62</b>	<b>Social Functioning</b>	<b>60.13</b>
<b>Obsessive-Compulsive</b>	<b>61.00</b>	<b>Vocational Functioning</b>	<b>67.87</b>
<b>Somatization</b>	<b>59.65</b>	<b>Functional Disability</b>	<b>67.53</b>
<b>Panic Disorder</b>	<b>56.67</b>	<b>Behavioral Health Status Index</b>	<b>59.66</b>

\*All scores are T-scores with a mean of 50 and a standard deviation of 10. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning.

Consistent with Terry's presentation at intake, on the quantitative measures she appeared depressed, lonely, and anxious. On the SCL-90-R, several of her subscales were reported on her computer-generated report as in the "clinical range." Particularly Terry's Depression level at 68 was "manifestly elevated, and evidence suggesting a true depressive disorder may be present." She endorsed "Quite a bit" for items such as "Feeling lonely" and "feeling blue." Her Anxiety score of 63 suggested a level "significantly elevated and clinical in nature." Terry's record also indicated some social alienation "which should be explored further." Her TEaM scales indicated a high level of personal and vocational functioning, which was consistent with her successful professional position. Her social functioning was lower, which reflected her difficulties with relationships.

On the Scale of Body Connection, Terry's scores reflected a relatively low degree of bodily awareness and comfort with her inner sensations, e.g., "When I am tense, I take notice of where the tension is located in my body," ("a little bit"), and "I feel separated from my body," ("some of the time").

#### *Goals for Therapy: Goal Attainment Scaling*

Terry identified three goals for therapy in the Goal Attainment Scaling procedure. She wanted to quit smoking, something she had long wished to do but had never succeeded. She was realistic in that 12 weeks may not be sufficient to quit; she wanted at minimum a plan in place for quitting. Her second goal involved spending more time writing in a journal, since professionally she spent much of her time writing for others, and now she wanted to spend more time writing for herself. Finally, she admitted that she felt somewhat lost in her life, and needed a new life goal "to be excited about." She

hoped that through the treatment she might identify some new goals for the future. As she admitted later, this goal really described trying to find a way out of the “missing attacks” she felt with Jack, but at the time of the intake, these are the goals she listed.

**Table 10**  
**Terry’s Initial Goal Attainment Scaling**

<b>GOAL</b>	<b>Stop Smoking</b>	<b>Finding her voice in writing</b>	<b>Finding a new life goal</b>
<b>LEVEL OF ATTAINMENT</b>	Scale 1 Importance: 8	Scale 2 Importance: 7	Scale 3 Importance: 8
Much less than expected (-2)	1 pack/day *	Not at all *	Having no clue *
Somewhat less than expected (-1)	Be thinking about quitting with a plan	On occasion writing in journal	Having 1 possibility
Expected level of outcome (0)	Have a plan to quit and belief she can quit	Once a week writing in journal	Having defined three possibilities
Somewhat more than expected (+1)	Have signed up for a program	Twice a week	Having 1 very strong choice
Much more than expected (+2)	Have quit	3 or more times per week	Knowing what to do next

\* = Before Study

#### Formulation and Treatment Plan (“E” in Figure 1)

Laurie formulated Terry’s difficulties as her suffering from an early developmental trauma in which she was not adequately contacted, held, and mirrored when she was very young. Laurie described how Terry’s demure, deferent and exceptionally other-oriented style suggested a breach at the level of existence: can I belong? Laurie formulated that Terry coped with this anxiety by creating the belief: “My survival depended on loving other people. Giving love was my life.” Laurie hypothesized that Terry had mostly

worked hard to love others, and was not very capable of loving and nurturing herself without guilt and self-attack.

Since Terry appeared nourishment-starved, Laurie wanted to create some new nourishing experiences that might be very beneficial for her. Therefore, she planned to help bring Terry back into her body in order to access her inner strength and resources (Theme 1). Laurie formulated that for this type of deprivation-based trauma, Terry would probably be a client who could benefit greatly from physical touch in the therapy (Theme 2). Laurie also hypothesized that Terry often used her telling of her story as a defense: “to go into the story without spending much time in her body.” Therefore, as described above, Laurie’s interventions were intended to keep Terry focused on her inner awareness and experience and less in narrative disclosure (Theme 3).

#### Diagnosis

Axis I: Dysthymia, Early Onset 300.4

Axis II: None.

Axis III: Eczema; blindness in one eye; shoulder pain; chain smoker.

Axis IV: Unrequited relationship; history of physical abuse.

Axis V: GAF= 65 (Current)

#### Strengths

Terry had a number of important strengths. A very successful professional writer, she had written for many highly-regarded professionals. Terry’s ability to express herself indicated a very strong intellect and a gift for articulation which showed throughout treatment. Repeatedly, Terry was able to articulate her inner world thoughtfully and in clear and vivid terms. Additionally, despite its drawbacks, her tendency to care for others revealed her great strength as a loving woman, mother, and friend. Terry raised a healthy son in the midst of an abusive marriage, and to her credit, was able to leave, literally,

with her life intact. Since then, she continued to function very well despite many setbacks, including caring for her aging parents (she began several sessions discussing caring for her ailing father), and being unable to drive due to her limited eyesight. She also was in the process of mentoring several of her high-status colleagues in their writing skills with much success.

### Action (“F” in Figure 1)

#### *Session 1: “Linking Her Body to Feeling”*

In this session, Terry appeared to have a great deal to share about her long life lived without much support (Theme 3). Terry described herself as having “a genuine capacity for joy, but a lot of sadness.” Throughout the session, she often put her hands up to her chest, physically indicating her sadness. Laurie worked to slow Terry down and make such gestures more mindful. Terry responded well to Laurie’s interventions, and connected her physical gestures to her longstanding characterological pattern of overfunctioning.

Building the alliance from the very start, Laurie warmly acknowledged all they have done together to begin this “journey.” Terry seemed to appreciate Laurie’s acknowledgement of all the effort she had needed to overcome her resistance to therapy. When Terry continued by expressing some sense of pleasure, Laurie right away asked Terry – without going to any of her history – about her bodily experience of “good.” This intervention exemplified the combined assessment and treatment in BcP, as Laurie was assessing Terry’s level of embodiment at the same time as she was educating Terry on how to bring awareness to her body.

T: Well, so, we’re finally...

C: Yes [laughter]

T: So, what a journey, huh?... To get to this moment of time...

T/C: [Laughter]

C: Yes, in more ways than one...

T/C: [Laughter]

T: Right, right

T: So, yeah, how does it feel to be here?

C: It feels very good; it feels very good. Um, I'm really welcome here...this, very much.

T: Uh huh

T: And when you say it feels good, do you have ah, a bodily experience right now, when you check-in.....kind of curious?

At the same time that Laurie brought Terry's attention to her bodily sensations, she also socialized Terry to BcP by offering the implicit message that this therapy was going to be bodily focused.

T: And when you say it feels good, do you have ah, a bodily experience right now, when you check-in.....kind of curious?

C: Um, well, outside, **I was ah... watching the bubbles in the aquarium [giggle].** And I was coming from a very important lunch... and...I was, I can tell you about it another time, but, um, and so, I was thinking about that, and I feel...**I did notice how warm it was, um, and it's very soft. Uh, it feels good.**

Laurie noticed how Terry associated to bubbles, describing both a pleasurable memory and using a kinesthetic description. This suggested to Laurie some attunement by Terry to physicality. Terry, however, appeared to want to give a lot of information. Laurie noted that desire, yet wanted to work on helping Terry access inner sensation through bodily awareness (Theme 3). Thus, she brought Terry's awareness and the focus of the session back to the bubbles (Theme 1). Using the imagery of "warm and soft" is how Terry can become more connected to her inner resources and grounded, according to Laurie's guiding conception.

T: So, yeah, so, **just take a moment now and just acknowledge the warmth and the softness, the softness of the couch and the warmth, the memory of the bubbles.**

C: Let them come next to the pearl...

T: Just take a moment and just close your eyes and **just allow yourself a little bit of time to rest in that image of the joy of the bubbles coming up,** the feeling of the softness, the warmth and just notice anything you might experience as you allow yourself the time to savor the bubbles, the warmth, the softness...anything at all that you might notice...Where are your hands, huh? Is there an impulse in your hands? Sense that movement. Let your hands do that movement. Just like that, exactly. **What do you notice in your body?**

As they worked with this soothing kinesthetic experience, Laurie encouraged Terry to explore her felt sense in a more complete way. As Terry closed her eyes and sensed within herself, she spontaneously gestured with her hands. Laurie asked Terry to repeat it slowly to explore the gesture with somatic awareness. Here was an example of how Terry's body led the session, yet once whatever experiences were brought into the room, Laurie guided and directed.

C: Yeah, and I was noticing that I felt really completely relaxed, except for my hands.

T: Ah.

C: And it was as if the tension...and I mean, sometimes my hands hurt, but, um, I don't usually, it's as if they were the only parts of me that were not relaxed.

T: And everything was relaxed, but underneath your wrist?

C: Yeah.

T: The tension that was normally in your shoulders seemed to be in your hands?

C: Yes.

T: **So you felt that impulse...So, could you do that movement slowly?** Like a fish in water, or like an octopus, just spreading...yeah...so notice what happens when you follow that impulse...and you sense your body relax, relaxing. Take a breath. Yeah, just staying very curious, as you're feeling your fingers in your hands, sensing the quality of the energy...in your hands, your wrists, and just notice anything else you're aware of in the rest of your body...in your breathing or through your torso...that's it...into your pelvis...that's it...I just invite you to relax into the experience.

C: I feel peaceful.

When she slowed down her movement, Terry was able to access a peaceful feeling. She responded to Laurie's direction and acknowledged noticing a heightened awareness when acting slower with mindfulness instead of rushing through her movements. Laurie reinforced her growing awareness.

T: When we do body-centered work, we often slow time down. So, you will hear me at times just letting you slow down time, to stay with nourishment. And then we want to keep some sort of being sensitive to what happens when you can just rest in the peacefulness.

Terry took Laurie's lead and went further: by studying her hands and the sensations she experienced within her body, Terry associated from her physical movement to her characterological style of constantly "doing." This was an excellent illustration of



Hakomi therapy's theory that character structures organized from developmental deficits can be "read" in the body's habit patterns and gestures (Kurtz & Prester, 1976).

C: You know, it's interesting to hear you talk about slowing things down because, uh...I come from a long tradition of...**I didn't found the tradition but I inherited the tradition of coping via acceleration.**

What followed was a discussion of how Terry learned her patterns in her family.

Terry mentioned Laurie's soothing, calming voice as something which made her immediately feel safe. As previously discussed, Laurie uses her voice a lot in trauma work – both the quality and pacing are important components of helping clients slow down. It is a way of touching the clients without touch (Theme 2).

C: That's what struck me the first time I talked to you was...the quality of your voice and the pace of your voice...

Laurie continued to use her own embodiment through her voice tone and rhythm to model embodiment to Terry. She offered an educative piece to orient Terry further. Note again, very little history has been taken. Laurie's focus was on the embodiment aspect of the work, spending little time on the past in a "cognitive fashion." Often an active choice point exists between getting a client's history and slowing the client down (Theme 3).

T: This form of therapy, um, we slow things down, and um, usually from week to week, I'll also have you check-in and see what your intention is – sometimes your intention will come from something that's going on in your outside life, or a dream, or a situation with somebody...um, sometimes it might be that it comes from your body, if you say you're not sure, we might just tune in to see the information that comes from your body...**the context for the work is basically that all life happens in the body through sensation.** And that our thoughts, our feelings, our memories, our images, our beliefs are all stored on a cellular level in our organism. And what I do is I stay with people in the present moment and then together, we see what happens next. Sometimes I'll ask you a question or I'll slow things down or we'll try an experiment. Um, so, interacting with you, and then I'm sort of backing off. Sometimes we say, it's like um, I'm the midwife that helps you make the discovery for yourself. And so, it's kind of a whole creative process.

From this invitation to focus on body and sensations, Terry immediately associated to an intense somatic and affective early memory: from birth and throughout her early childhood she suffered from severe and painful eczema.

C: You know, it's very interesting to me about that.... **I don't know why I never really thought about this before, because once I started thinking about it...but it was partly about coming to see you and something else triggered it,** I don't know what it was, but. When I, um, **there was a question there about the earliest childhood memory...**and, uh, I've been thinking about how few childhood memories I can, you know, dredge up and it suddenly hit me, that.... Oh! I know what it was. I was at work and I was doing an article on eczema and um, they made a new discovery and they were talking about how debilitating eczema was and that they found that it was this autoimmune disease and stuff. **And I was born with really terrible eczema,** I mean, I really terrible...uh....and my earliest memories are of having tar, you know, on my arms and legs and ace-bandages and having my hands tied, so I couldn't scratch myself...

Terry's spontaneous association to a very influential and painful somatic experience in her early life may indicate an important "result" from the BcP treatment. Had Laurie asked for history directly, she may have learned some information about this event, but not with the richness of this embodied memory. Terry's ability to experience her early memory with the accompanying felt sense evokes the potential power of this work, as it may have allowed for a spontaneous re-experiencing of affect, memory, image, and bodily sensation, all the while within a safe relationship.

As Terry continued to recount this early traumatic memory of being held down, unable to scratch herself, believing that the eczema was her fault, Laurie chose to listen without delving further into the memory because trust in the alliance needed to be built. It was only their first session and the memory was very "old and deep." In a later session, Laurie might ask Terry to go into her body as she talked about the eczema. However, in this session, Laurie intended to create a "reflective, empathic, mirroring space" for Terry to tell her story, merely noting how Terry had organized to cope with the trauma.

As a successful professional woman, Terry had developed a certain coping style to self-regulate in response to trauma. She has adapted and has been able to function well, yet Laurie noticed how Terry sequenced her comments, from the story about eczema to guilt and reconciling her belief that “it wasn’t my fault.”

C: And I just started thinking about all of the events that I probably went through and what I remember most is somebody saying to me, “don’t scratch”...[laughter]...um, and one of the things that really helped me because when I was growing up, anything like eczema or asthma or any of that was considered psychosomatic, so, you not only had the misery, but you had the feeling that there was something wrong in you that was causing that and so.... it was....a double whammy, really. And my nephew, um, God rest his soul, was born, he was the only one in the family who had this skin condition I did.

T: Mm.

C: And obviously he was born quite a while after I was. [laughter...] **And I remember seeing him as a baby with this horrible thing, and thinking, “my God, you know, it wasn’t my fault!”**

As Laurie brought the focus back to Terry’s body, Terry spontaneously closed her eyes. Terry seemed to be “grounding” in her bodily sensations more of her own accord.

T: So, let’s check in, and see...what are you noticing?

C: I’m noticing, uh, a feeling like, my God, I have a very legitimate... I’m very, very, aware of the surface of my body.

T: Uh-huh.

C: Very, very. Usually, if I have any awareness, it’s you know, what’s tense in the muscles or...**but I’m very aware of my skin.**

T: Great! Yeah, so, just take this time and let yourself bring your awareness to your skin. Yeah. Because when you were a little baby and were just born, your skin had some rashes on it... and just notice what it feels like now...

C: [Big sigh] Yes.

As Terry sighed and physically touched her face, she appeared to make a new contact with her skin in that very moment. She seemed to be working through an old trauma held in her skin, including the feeling of being ugly, damaged, and having untouchable skin.

T: Be aware of your skin.

C: You can actually touch it. [puts her hands to her face]

T: You don’t have to scratch it...you can just touch it. What does it feel like?

C: It feels really good.

T: Yeah.

C: **I often wondered why I have had such a feeling of ugliness my whole life** and I, you know, I was ugly. You know, I mean...I was...

T: The eczema...

- C: Yeah, yeah, it was really not a nice thing to look at.  
 T: Was it on your face too?  
 C: It was everywhere.  
 T: So, you felt ugly, and you also felt like it was your fault, and you were also all tied up...and you were also very young, and little, a time when babies like to move and stretch...  
 C: [big sigh] Yeah.  
 T: You are a very courageous soul to get through all that...to get where you are now.  
 C: Thank you. **It's amazing to me, that connection. [tears up]**

Terry finally contacted her full affect. As she teared up, Terry acknowledged that her sadness was an important part of what has brought her to therapy. She herself described the somatic mind-body connection between her skin and her sadness; one might say that sadness was trapped in the skin.

- C: I have had, um, I've had a lot of sadness in me forever that I couldn't quite feel, I couldn't quite get to the bottom of it. Not, I couldn't quite, I couldn't.... [Laughs].

As Laurie began to address Terry's sadness, she used a very visible, concrete, embodied imagery of a well. Terry connected this imagery with her own body, gesturing to a line from her head down her esophagus to her belly as a "well of tears."

- T: Just notice everything that happens. Where in your body...?  
 C: You know it really does...it's as if I can feel the shape of the well going right down there...  
 T: Uh-huh. Great. Let yourself feel that.  
 C: It's just that....  
 T: So you're sensing the well, sensing the shape....going down your throat, your chest, your diaphragm, into your belly. Just kind of stay with it ...feel that well...the boundaries, feel that shape...  
 C: It does have a very specific shape...  
 T: Right, yeah... A very specific shape. So, does it curve, does it go straight?  
 C: It goes straight down...  
 T: Straight down.  
 C: It's about that wide.  
 T: A few inches wide. And how deep does it go?  
 C: It sort of goes from there, just straight.... It doesn't hurt.  
 T: It doesn't hurt, right. And is there a texture? Does it feel like it has a wall?  
 C: Yes, yes, kind of like a ceramic...like a ceramic....  
 T: Like a vase?  
 C: Yeah. [real upbeat]  
 T: So just kind of touch into that ceramic shape. Sensing the sides, the boundaries. That well.... **Acknowledging your sadness. If you look in there, looking into the well and the water and the tears. And just notice if there is any thing that you see when you look into that well, any image or memory?** There doesn't have to be... just asking...

C: Sniff

C: I just saw two faces...uh...just for a second...in...reflected in water... One was mine, and, the other was Jack's and Jack is the man I just had lunch with ...and...it's such a huge, long story, but anyway. He was the first love of my life...

Throughout this session, even while exploring painful memories and feelings, with Laurie's encouragement, Terry remained in touch with her body and her felt experience within her own skin. From this place of re-experiencing, Terry began to tell her story.

C: [sighs]. That's another thing. You know, what happened there was, ah, I, I had been in a very abusive first marriage. I mean, just [pah!]...and uh, I, I didn't know, I didn't know it was a sin...I was living in France, thought it was my fault, you know. But now everything I realize I was just a walking textbook, you know, of what happens in situations...so I couldn't get out of it and uh, and finally I did, not because I was brave enough to make a decision, but because it really was so bad...there wasn't much choice...and then I married again and it was a very compatible, it was the antithesis of my first marriage and I think my second husband and I, we both were really looking for safety...and we gave it to each other...and it was...and then I, I went to a high school reunion and I saw Jack again and, um, we started corresponding and uh...he...you know I guess I went through that whole getting bashed around stuff...um, with a form of amnesia almost ...and I just blocked it out and went on and didn't think about it... ..and um, but I do, really...I just sort of shut the whole door. **But when I met Jack again and I would write something to him and he would say something like, "you always used to say that" or "you never used to say that"...and I had this feeling he remembered me better than I did, you know? And he did.**

Laurie formulated that Jack became the mirroring object for Terry's unmet early developmental needs. Despite having safety for the first time, Terry ended up following Jack, who offered her "a new developmental bond of mirroring," as well as "a repetition of her absent father." Terry's deep feelings for Jack have also raised her awareness of her unmet longings for receiving love.

C: [continues] And then my husband...you know...I started feeling that I was doing something that wasn't morally good, because I hadn't told my husband I was having this correspondence...I wasn't seeing him or anything, but it was very important to me. So, I talked to my brother, and he said, "Oh, I think you should tell your husband, because he'd want this for you"...and I was thinking I don't want to do something....it felt weird to have this private in that way. So, I told him...and... I couldn't...and...um, you know, and he gave me an ultimatum, I had to stop writing to him or leave...and, uh, you know, it was the hardest decision I ever made, um, because I, I was safe for first time and I hadn't spent a lot of time in safety, and I remember thinking I must have a self-sabotage gene. I mean, here everything is okay, and what am I going to do, but blow it all up again? But I just felt as if, you know, I would be living some kind of a lie.

Laurie noted that despite the “self-sabotage” of her actions, Terry had acted with deep integrity. Laurie could see how important the truth was to Terry, who had been uncompromising in making sure that her husband knew about her correspondence, even if it ultimately meant losing him. She respectfully acknowledged how hard this woman has worked to survive her trauma of unmet sense of security, and started to formulate how Terry must have very deep unmet developmental needs that led her to give up her first sense of safety for this relationship with Jack.

C: Yeah. And I seriously, to tell you what a mess I was, I was seriously considering lying to my husband and telling him I wasn't writing him any more, so that I could stay, you know...

T: And have both....

C: And have both. We had just inherited his mother's house, so for the first time we weren't in financial whatever....And we worked on the house for two years to clean it out...and I loved it, you know? And I was 55...and I thought I'm really ever too old to go camping....but, I just, I know I couldn't do it, but then I went through a period of really feeling.... utterly desolate...I wish I'd known you back then...the day I moved out of my house it was New Year's Eve and I didn't know what town to go to, so I went to a town where I didn't know anyone, and I had caught the flu from my son, and I was sitting there with these boxes and I had nothing to listen to music with. And I didn't know you needed cable TV to watch, you know. And I was sitting there thinking that, you know, I had no idea where I was going to go from there or how...

Laurie appeared to gather Terry's clinical history in an “organic” way. She did not ask for linear questions and responses, but listened as Terry desired to tell it. After gathering this information, Laurie returned Terry's attention back to her body; using imagery, Laurie encouraged Terry to develop a somatic, cognitive and affective integration of this experience.

T: So, what happens, take a moment now, when you kind of sit with yourself, today, right now, right here, in the present time, just sensing the woman you are now....When you see that woman back then with the house and the boxes on New Year's Eve... How do you feel towards her? What would you say to her? How would you contact her?

C: I would say, you know, my son used say to me... I have a wonderful son, who loves me, he really loves me. He used to say, “Mom, you're a f#\*king lunatic!” [chuckles] But, I would say to her that, “I'm really proud of her”, because she did something that made no sense to anyone, including herself, um, she...ah.... had a very deep-seated need for approval...and her family pretty much freaked and thought she had lost her mind...um, and she just had this feeling that, you know, if there was ever any hope of being true to herself

this was it, and then... You know though times in your life when there's really a fork in a road, a real, real fork. I mean they happen all the days, all the time, and usually you look back and you say "oh yeah" or I did this one or I did this one..." That was really, Uh [groans], I remember just a really an overwhelming temptation... I...she was, she was scared, broke, lonely, getting old...Um, I mean, it was a disaster, and she made it through.

Laurie focused Terry on connecting somatically with an experience of her inner strength (Theme 1).

T: And you are proud of her.

C: **I am very proud of her...**

T: Let's just take a moment and just feel. "I am proud of her."

C: I am proud of her

T: Yeah. But she made it through.

C: **[Big sigh]**

T: Just kind of sit with that awareness...of following truth, true to thyself, to thy own self be true..." You were true to yourself

C: She was a strong lady. I mean she was a f\*ing lunatic, but she was a strong lady!

T: I think so... Yeah.

C: **[Big sigh]**

T: Just take a moment in the present time to kind of sense what it feels like in your heart and your soul and your body...

C: It feels very full.

T; ...just very full...And when you feel the feeling of fullness ...how do you notice that as sensation?

C: **I have...ah... a feeling of, um, uh, how can I say...it's not a pressure, but there's a sense of expansion...**

T: Expansion!

As they explored how Terry coped with these painful experiences, Laurie started to notice a trend in Terry's behavior, which led her to hypothesize about Terry's character organization, what Hakomi refers to as the "organization of experience."

T: What is the universe telling you – in this place of expansion and this smile?

C: Um [sighs]. I think I'm not used to that feeling because I... sort of have a sensation of, um, **you know, once, that one time when I was really, really ill...**

T: **[interrupts] Wait, go back...**wait, go back...let's go back...so you're not used to that feeling...

C: So, I was going to say I have a feeling of, of observing myself...feeling...

T: Great! So let's just hang on that part of you that's just observing yourself...yeah, sometimes we need to have different qualities of connection, so observing yourself...feeling the expansion...feeling the smile...and just kind of, feeling yourself as the observer.

Yeah...And how is that? Just being in the observing, out of the expansion.

C: Yeah. You know, what I was starting to say....I know my mind thinks all the time.

One can see the struggle between the two participants whether to focus on the body or the narrative (Theme 3). Even though Laurie was still strongly in an assessment phase, as she saw Terry move quickly from one topic to another, she was beginning to get a picture of how Terry was organized. Terry too had some awareness of this aspect of herself. She may not have known what it meant, but on some level she understood her lack of embodiment and her coping defense. Laurie used that information in her assessment about Terry's unmet developmental needs.

T: [interrupts] you know that about your mind....

C: **Oh my goodness, yes.** My son, once we were having dinner with friends and he pulled out a napkin on it and went [drawing noises] this is how my mother's mind works...[Laughs].

T: So, I'm just getting to know you today and getting a little....

C: [Laughs]. Of an experience!

T: Yeah, and seeing how your mind sort of travels, right, you have, like, different associations, one thing to another...

As usual, Laurie brought Terry back to her body.

T: Your mind jumped and what happens to your body when your mind jumps?

C: Um, when my mind jumps I forget about my body...because I think...

T: [interrupts] Oh, okay, so, when your mind jumps you forget about your body...

C: Yes. [sighs]

T: Yeah, so just kind of sitting there with that awareness...and if your body was going to speak to your mind, while it's watching your mind jumping, is there anything your body would say to your mind...?

C: "Wait for me." [Laughs].

T: "Wait for me?"

C: Yes! [Laughs].

T: "I want to go with you."

C: Is there room on that horse for both of us?

T: Right. Can we travel together?

C: Yes, yes. Mmm. Mmm.

The therapeutic alliance seemed strong throughout this session. Terry took risks revealing painful information, and Laurie worked hard to track and mirror Terry's experiences, which led to important results. Now Laurie was careful about how to end the session. It is important that clients leave feeling grounded and contained, and thus they



need time to integrate what has occurred in the session. Often Laurie will review the session, asking them what they will hold as a way to integrate it into their “normal consciousness” for the week and thereafter. She did this with Terry.

T: So, let’s just take a moment...before we start to kind of complete for today...and just see what it feels like right now...yeah....there’s a lot of richness you brought today...and we will be able to go back and revisit some of these places in more depth, and take more time...and sensing where you are right now with where we traveled to today...and see if there is anything you want or you need or you would like to kind of take with you from our session....

C: I feel as if you’ve already given it to me. [chokes up] You know, I tried therapy only once before...

**T: What is it that you feel that you want to take with you?**

**C: The sense that I can go on this journey with you.**

T: Okay.

C: And that I will...you know I have had to be very self-reliant. A lot of people have relied on me. I feel as if for this, this I need to rely on somebody else because I...

T: [interrupts] Some permission for you to go on your journey...and have me joining with you...

C: and that...

T: [keeps talking] You can rely on me...

In this concluding intervention, Laurie stayed firmly on the imagery, integrating the cognitive work with Terry’s felt experience, as well as emphasizing their alliance. Laurie knew that the treatment would only work if Terry felt safe with Laurie. She encouraged Terry to connect the work they have done in session around feeling safe with her bodily experience so that Terry can really know what it feels like to be “safe” in her being, not just in her mind.

T: **And we can do it together...you don’t have to do this all by yourself...**and you’re safe...and how it feels...yeah, just sensing the beginning...just the beginning. You’ve already brought a lot of your riches.

**C: Safety... is a really good feeling.**

T: Is a really good feeling. So, whenever we get a great a feeling, what do we want to do? We want to slow time down and let the body absorb that on a cellular level. So just give yourself a little bit of time to feel the safety...sense the movement of your breath...feeling your back against the pillow, sensing your hands on your legs, your feet touching the earth...the feeling of containment... awareness of safety...and the movement of your breath...and just notice as you acknowledge the safety...**and acknowledge your body...your body telling your mind “I’ll be with you.”** And just notice if there is any image that emerges out of this sense of safety in the present moment ...a painting or a picture that was born out of the feeling in your body...a feeling of safe...

C: It isn't visual, but it's very...  
 T: It could be kinesthetic.  
 C: Yes, yes. Very much.  
 T: And what's the quality?  
 C: It's a combination of buoyancy and being enveloped...  
 T: So the feeling of being enveloped and surrounded and feeling buoyant.  
 C: Right.  
 T: Great...Mm. Great.  
 C: Thank you.  
 T: You're welcome  
 [End of session]

*Monitoring Evaluation of Session One ("G" in Figure 1)*

This session was an example of how Laurie moves back and forth, "stitching together" both narrative and experiential embodiment work in a session (Theme 3). Terry began to give a great amount of information, which she appeared to need to tell. Several times when Terry began to speak Laurie directed her to look at "what was happening in her body." This set a tone and intention for the style of working, which was much more present-oriented, body-focused, and less historical. Terry was able to follow Laurie's lead, and began to slow down, close her eyes, and look inside for what was happening in her body, which led to other powerful memories and sensations.

Laurie formulated from this early work that Terry did not have the capacity to nourish herself and connect with her inner resources (Theme 1). Terry appeared to have a developmental trauma that had inhibited her from freely taking care of herself, unless she did so through taking care of others. Future work would need to focus on how Terry could learn to access her own inner resources by herself.

*Sessions 2-5: Summary*

In these middle sessions, Laurie worked to help Terry access inner calm and relaxation without guilt or intellectualization (Theme 1). They explored how to keep Terry embodied and connected to her felt experience even as she wants to tell her story

(Theme 3). They discussed Terry's difficulties feeling her own anger and how anger was never allowed in Terry's family. They discussed anger as an important activating force of life. In session 2, Laurie made her first touch with Terry, on her shoulder, the part of Terry's body where she felt she stored her anger (Theme 2). In session 3, Terry explained that she was satisfied that she contacted her anger, but felt "she doesn't have much of it." In session 4, she admitted her real reason for therapy was to solve her "missing attacks." She associated to being in a cage and realized how desperately she desired physical contact and touch. In session 5, they explored how Terry did not feel adequately nurtured by her mother. Laurie evoked touch by giving Terry a pillow to hold, which helped her connect to her inner resource of taking care of others.

*Session 6: "Finding Her 'Feisty'"*

This session turned out to be an important illustration of BcP "working through." Terry began this session by reporting how the previous session had stirred up a lot of sadness inside her as "grief in every cell of my body." Terry's ability to speak about her strong reactions to Laurie indicated an important level of trust and connection in the treatment. Furthermore, Terry used much more vivid, sensory-based "embodied" language to describe her inner experience, which indicated a strong positive change from the treatment in her ability to track, notice, and draw from her inner felt experience. As Laurie witnessed Terry's newfound strength and profound sadness, she introduced one of the more extreme BcP interventions: working with the client lying down on a table or floor pad. In this case, Laurie invited Terry to lie down on a pad on the floor to receive relaxing touch therapy. To begin the session, Laurie assessed how Terry was feeling.

T: Hmm... So how are you today?

C: You know, that was something that last session...that was really something. I was uh... I...uh, **I was really sad afterwards.**

T: Mmm.

C: Whoah... um...[sigh]... **I think I wrote down at one point I just had this sensation that there was grief in every cell of my body**, you know it was ...but it was **just such an incredible thing being able to go there** and not just say out loud, you know, because there isn't much I have allowed myself to think that I haven't said out loud to somebody. **But there is some stuff that I hadn't gotten around to allowing myself, and it was the feeling of being feeling unwanted**, you know? And uh [big sigh] I think that I was so tired, you know, **Monday night I was like cooked spaghetti, but the amazing thing was that I really felt as if I touched bottom, you know, and um, and I think I wasn't really sure there was a bottom, which is one of the reasons I wasn't very anxious to go down here...**[Laughs]. If I go down there I might not get back up.

T: So there's space, that there is a...

C: So, I really want to thank you. I mean, it was just a, that was just a huge, it's so huge that I haven't really processed it yet. You know, I just sort of ahh... [big sigh].

Terry's image was very powerful and somatic: "I had this sensation that there was grief in every cell of my body." Despite her sadness, Terry described a deep connection to her felt experience, suggesting that Terry has changed: she was more embodied, "contained," and more able to access her inner sensations.

Terry's deep well of sadness does not scare Laurie, as she described Terry's fear of no bottom as a normal response: "When a person is grounded in their body such that they can metabolize any sensation, then they can survive the bottom." Therefore, Terry appeared to Laurie as having more access to her resources so she could experience this low place and survive it.

C: **Yeah, and the only way I have been able to nourish myself, is by, you know, giving it out**, and then, every once in a while, I remember when I was teaching and I loved teaching. I still love it, but I don't do it very much. And um, that **I would get into a state of just utter depletion, you know, and uh, and I would get this feeling that I was a, you know a gas station and people were coming by and tanking up and driving off, and no one was coming to fill the tank back up**, so I've had these sort of cyclical depletion things. I mean, nothing stopped me from functioning. I'm really good at functioning no matter what the hell life brings me [laughs], but um.

T: That's great.

C: It's useful. But the other thing, well, two other things. **I have been much more aware of you know how my body is** and you know I woke up this morning and I really did not want to get out of bed, and, uh, I was just realizing just how comfortable I felt. That I could feel the sheets along you know my back and my legs. I was thinking, "Laurie would be proud of me." [Laughs].

Laurie noted that when Terry spoke of her acute grief “in every cell of my body,” she could have said, “Take a moment and pause here to notice how comfortable you feel here as you remember the sheets on the backs of your legs and you have the thought ‘Laurie would be proud of me.’ What do you notice now?” But as Terry talked about feeling like she was a gas tank depleted along with how comfortable her body was while feeling sheets, Laurie assessed that Terry was “pendulating” between her nourishing feelings and the traumatic sensations, so she followed Terry’s lead and let her associate freely.

Additionally, despite struggles around talking (Theme 3), Terry’s admission (below) is an important indication of the strength of the alliance: she tells Laurie both about her missing attacks, as well as her fear about revealing them to her. She also gave Laurie feedback that it was the safety she created that allowed Terry to believe she could get help with them in this therapy.

C: So, um, and the other thing that was really huge, and I wonder if I did ask you about this. You know, I, **when I came to see you, the main reason I came to see you, and it took me until the third or fourth session to be able to tell you, but it was this missing Jack thing.** And I had reached the point where, I just kind of thought, even if it means, you know, breaking that relationship, which I couldn’t begin to imagine how to do that um, if that’s what I had to do to stop hurting, that was what I was going to have to do... [long discussion]. **And I was saying to him that what I felt you were teaching me was that uh the vulnerable part not only isn’t a bad and evil part, but that it’s fragile but it’s also a nice part, you know, the best part, even.** And then you know, I was thinking, imagine that it turns out that everything we spend our lives trying to overcome, you know, all of those weaknesses and imperfections, and if that’s really what we’ve been looking for, you know.

Laurie hypothesized that Jack had become a substitute for Terry’s unmet mothering needs, and furthermore, that Jack might be reacting to Terry’s yearnings with fear that he’ll be devoured. Laurie formulated that Terry will need to tolerate her grief, and work on connecting with her own wholeness, because it seemed that Jack was never going to give her what she wanted. In order for Terry to learn to give it to herself, she needed more experiences of nurturance, which she had never known. In the previous session,

Laurie introduced somatic exploration of Terry's sense of nurturance by having her hug a pillow. In this session, Laurie wanted Terry to experience a nurturance she had never received. Since Terry has had the experience of feeling connected by giving love, but not the feeling of connecting through love coming in towards her, Laurie felt that "feeling cared for is the missing experience and being able to relax and be nurtured in relationship is the goal for this experiment," explained Laurie. She suggested that Terry lie on a pad on the carpeted floor where she could relax and receive light nurturing touch (Themes 1 and 2).

T: So I was wondering if you're open to it, we might spend some of the session having you lie down, seeing what it's like to receive. How does that feel?

C: That feels really nice.

This intervention to work on the floor was an important choice point in this treatment. (Laurie described it later as a "huge intervention.") Laurie explained that having Terry lie down and get passive and vulnerable might help her be more able to accept care from others, but also might regress her too much and overwhelm her. Laurie hoped to help Terry enjoy the experience of being cared for like a child, while still allying with her "adult ego," so that Terry could integrate such powerful emotional work.

Terry appeared receptive to Laurie's suggestion to work with touch. Yet instead of immediately lying down, Laurie asked Terry to attune mindfully to her body while sitting up. It is worth reemphasizing that Laurie's careful attention to helping clients contact their sensory experiences remains the missing capacity and the basic tool for transformation, not touch itself. Attention to Terry's bodily experience from moment-to-moment remained the most important intervention, as misunderstandings around touch interventions could be easily present. As Terry tuned into her body while sitting upright,

she noticed she felt rigid and ungrounded. Terry easily could have attributed her rigidity to lying down, as opposed to knowing that she felt that way before lying down.

T: Before we shift, though, I'd like to just check in with your body in this posture.

C: Okay

T: Because lying down, your relationship with gravity will change. Just allowing yourself to notice, what you're aware of in the present moment, where you feel grounded, where you feel any constriction or tightness.

C: Um, I keep having this image of an Egyptian statue. **I feel like an Egyptian statue [Laughs]. And I feel very much that my weight is here, not really on my feet.**

Terry was able to articulate that while sitting up she was having a problem making contact with the ground. Laurie wanted to teach Terry to ground herself through her lower body, and used several grounding techniques focusing on Terry's legs, knees, and feet before lying down: she pointed out that Terry keeping her feet close together comprised a fear posture, whereas separating her feet helped energy flow through the bottoms of her feet and legs. She also made her first touch with light pressure on Terry's knees to stabilize them and raise Terry's conscious awareness of her lower legs and feet. Laurie noted that as Terry remarked that her knees were tense, Terry appeared more able to track herself, as well as overall more curious and internally-focused.

T: **I'm going to just make some contact with your knees. Just see what it's like to just push against my hand a little bit**, that's right, uh-huh, and release, and push in the opposite direction, and release. **What's going on in your body?** Anything at all.

C: It seems as if there was more tension in my thighs before than I realized. They feel less tense now. I wasn't aware they were tense.

T: What about down into your feet? Do you feel your feet, or more like they're separate?

C: No, I do feel them. There's not much sensation between my knees and the bottom of my feet. **It's as if whatever is between there and the floor isn't really attached to me. [Laughs].**

Although it would have been easily possible for them to stay in this sitting position, they decided to move towards having Terry lie down with Laurie sitting behind her head. Laurie has Terry "check in" with her experience, and introduced a Hakomi experiment of listening to a phrase and studying her reaction in mindfulness. As described in the

following exchange, Terry responded very well to Laurie's interventions that connected words with Terry's bodily experience. She contacted the "I don't think so" part of her that kept her from relaxing, she discharged with a big sigh. Terry seemed very responsive to these interventions and appeared to be learning how completely she is organized around fighting her own impulse to relax and feel supported while letting go.

T: So just sensing, yeah, sensing your posture, your alignment, and the movement of your breath. And just notice if there are any images, it could be real or imaginary, and give yourself permission to receive. Imagine yourself receiving. Just notice anything at all that reveals itself to you. It could be a shape, a color, an image, a face.

C: I feel very, very comfortable, but I, there isn't anything coming right now.

T: Okay. And when you feel very comfortable, how do you feel that in your body?

C: [Sigh] Um, it's just a sense of not having to work, um, you know, just being able to let go. It's soft, you know? It's kind of, I was going to say it's like floating. It isn't exactly like floating because I have a very strong sense of gravity, um, but, I think it's just that, that sense of support everywhere, that's really, that's really really nice...

T: Great. So just letting yourself feel that support everywhere.

C: Mmm...

T: And notice what it's like to just watch the process of letting go. And maybe, if it's ok, try on the sentence, "I give myself the gift of letting go."

C: "I give myself the gift of letting go." **It's funny, part of me feels that just saying that, as if it's starting to fight me.**

T: Mm-hmm. Exactly.

**C: Like, you know, "I don't think so."**

T: Exactly.

C: [Big sigh]

Terry appeared to be learning a great deal about her defense against rest and how she would fight with herself by telling herself that she must work. As Laurie helped Terry relax, they examined Terry's belief system while relaxing, so they could explore her conflict through direct sensory experience. Therefore, Laurie reflected the voice back to Terry using her precise language (a Hakomi technique), so that Terry could feel heard and acknowledged, as well as getting more information about what that voice enacted on her inner world.

The interplay of sensation and cognition throughout this session is noteworthy.

Although many therapists consider maladaptive cognitions entirely mental, Terry



described her thoughts as bodily sensations, more inside her being than merely in her head. By working with the bodily experience of Terry's maladaptive cognitions, Laurie harnessed a powerful change that could not happen if either was addressed in isolation. This matrix of thought, feeling, image, behavior and sensation allows for a neural reorganization that can be very healing to clients. Working in this interconnected way, which includes sensation, appears to be the most salient strength of BcP treatment.

T: So there's a part of you that emerges that fights letting go and says "I don't think so."

C: Mmm.

T: And the voice that says, "I don't think so," is it coming from inside or outside?

**C: Inside. But it's not, it's as if it isn't really my voice, but it's down in me and it's... I almost have this sensation of something tugging me back,** and very sarcastic kind of or something, it's very uh, very judging of me.

T: So a very sarcastic, judgmental voice that says "I don't think so."

C: Right.

T: Was there anybody who was like that growing up and was judgmental and sarcastic in your life? That had those... ?

**C: Yup. It was my mother.** You know I guess. I mean, **that was such a strong sensation. I was feeling before that sentence. I was really feeling as if I was letting go, you know, and then saying the sentence was just very much of a "who do you think you are to be indulging yourself like that!"** Um, don't you think there are enough people in the world who have you know, real problems to deal with and you know, here you are...

Terry began to "pendulate" between feeling relaxed and connected to her resources (Theme 1) and this self-critical voice intervening to cut her off from pleasure.

T: Indulging yourself and letting go. So that would be your mother's voice. Not giving you permission to rest. **So, before we had sort of the words and your body was fine and letting go. And** as soon as we made it a little more cognitive, it shifted and we got to see the other side. So just check back in with your body right now...sensing your hand, your left hand on your belly. What do you notice as you scan through right now?

C: Um, I, I notice that um, a lot of the muscles have, you know, gotten, they've ratched it up or something.

T: So the muscles got a little tight. Do that with your hands. The muscles went from there to there. Where were they before?

C: Before, they were like that.

T: Like that.

C: And then they just, funny from here up...

T: They started to tighten?

C: Yeah. And my legs don't feel very different. But the whole, yeah, from there up, it's like **"Oh, I should sit up and go scrub something...."** [small laugh]

Terry continued to gain awareness of how she is embodied: she could see her muscles respond to her beliefs, and then how she felt activated to work hard all the time. Laurie continued working with the pendulation by helping Terry to come back to her inner sense of resources. This was not an easy session for Terry; she appeared to need some reassurance throughout, as she had great difficulty allowing a new experience of pleasure to happen. She asked Terry where she might want touch, mindful to empower Terry to choose for herself where she wanted comfort. Laurie remained acutely aware of Terry's nonverbal cues. Laurie explained that it is particularly important to track how clients' breathing changes. Terry was taking deeper breaths, there was gurgling in her belly, and her feet were moving, which all suggested she was not as frozen and rigid and that her nervous system is discharging and relaxing.

T: Yeah, so I just want to acknowledge that kind of comfort and nourishment, that your mom didn't have it for herself either. So, when we go from the verbal to the nonverbal, **if I was going to touch you, see if it's giving you permission to let go, where would your body like to have some contact?**

C: I guess my shoulders.

T: Mm-hmm... So we can always change it. Let's just see what happens when I bring my hand to that spot. And we can always readjust it. We can change... Listen to your body and you can tell me if you want more pressure or less pressure, if you know... **[therapist touches clients shoulders].**

C: It feels really good.

T: And just... that's it, give yourself time, time to feel the contact of my hands with your shoulders. [long nonverbal pause]. A little gurgling down in your belly.

C: Yes there is.

T: And a breath.

C: Sorry.

T: No need to apologize. There's energy in your belly. It channels through as you start to release. As you let go, very often energy starts to discharge down in your intestinal system. You'll hear some gurgling.

C: Mmm.

T: Does it feel ok?

**C: Yes, it really does. The pressure feels really good. The warmth feels really good.**

As Laurie checked in with Terry, it is noteworthy to see how strongly Terry stayed attuned to the other person in the relationship (e.g., by asking Laurie in her moment of

internal focus how she is doing), and how hard it was for her to attend solely to her own needs in the moment. Laurie could have addressed that: “When you ask me, what are you imaging how I might be doing?” But she decided to leave that alone, and stay with the imagery.

T: Mm-hmm. How are you doing?

C: It’s amazing. I was just for a second remembering, even before when I was sitting and you had your hands on my knees and I was pressing out, so there’s a feeling of, um, I’m trying to find the words...

T: You’re doing it with your hands, you can describe it.

C: Um, as if we’re pushing against each other, but it’s a very comforting feeling, you know. And, as if, um, because of that, **there’s something in my shoulders that can leave via you, that I can’t get rid of by myself.** You know that’s always where the tension goes. **And they really don’t feel tense right now. How are you doing?** [Laughs].

T: Fine. So if my hands had a voice and they could speak to this area, your shoulders, if they could speak, what would they say if they could talk? What’s the very first thing that comes into your mind?

Terry associated to a very playful image. Laurie assessed that Terry was beginning to contact some early, non-verbal experience.

C: It’s a very kind of playful “hi.” It’s a very nice, warm “hi”

T: Playful. Just notice anything at all that you notice as you feel the contact with your shoulders, as you hear the words. As you experience the touch with the words “hi.” “Hi.”

C: **It’s nice [sigh].**

T: It’s a nice feeling. What do you sense then a nice feeling at the level of sensation in your body?

Terry was now much more able to take in the warmth and nourishment now. As she introjected the good feeling, again she “pendulated,” when she moved from the positive to a painful sensation of her “shoulders used to schlepping.” Interestingly, she referred to not driving, but did not say why. It was not until almost the final session that Terry introduced difficulties with her vision, which have led to her being unable to drive.

C: You know, after a few moments when your hand doesn’t move, it feels as if the warmth is not coming from outside. It feels as if it’s in there. And that’s not something my shoulders are used to feeling.

T: Mmm.

C: They’re used to lugging a lot of stuff. You know I don’t drive, so I schlep a lot of stuff.

T: Right. Which is a new feeling to feel. The warmth in your shoulders. Carrying and schlepping a lot, working hard.

C: And being rained on a lot.

T: So what are your shoulders discovering in this moment of time? Is there anything your shoulders are learning about life?

C: They like having somebody take care of them. [small laugh] And it's just a very natural kind of feeling.

Terry spontaneously associated language to her physical experience. Laurie follows up with exploring it. Interestingly here it can be seen how the client's personality structure becomes manifest in the dialogue and bodily experience.

T: And you've been taking care of a lot of people. And gotten nourishment from giving. We're just adding in another option.

C: **I like this option a lot.** Mmm. You know, just to have it be Ok to want to be able to give yourself permission... I think that's been the battle. Oh, there's a great line, something about shoulds and shoulders...where did I hear this? Somebody said these are my 'should-ers.' Isn't that great?

T: I should do this and I should do that. All the burdens of what I should.

C: Isn't that great?

T: Yeah.

C: I've got a really great pair of "should-ers."

A powerful aspect of this interchange was how the entire focus was on Terry and her physical sensory experience, full of emotion, within a new, caring relationship with another. This was certainly a new experience for her.

T: Yeah. What word would you give them now, a new word, instead of a should-er?

C: Wow.

T: What do you imagine? It doesn't have to rhyme.

C: Good! Gosh, I don't know. The image is like, like a seesaw, there's somebody on each end and they're taking turns and they're laughing, and they're seeing who can make the other one go "whoop!" [small laugh]

T: So you see a seesaw, with one person on the one side and one person on the other side, and they're going back and forth, huh? And they're going up and down...?

C: It's not always the same one. I guess before, instead of being able to get that, I felt more like the one that the seesaw was [gestures of back and forth]... Yeah, like it was my job to carry the seesaw.

They continue the bodywork release, with Terry discharging through gurgling in her stomach and general comments and sighs of release. Terry reported that the education around the theme of the vortex/counter-vortex by Laurie was very helpful to her, as Terry felt she was experiencing it in that moment.

T: Is it ok if I made contact with that area?

C: Oh yes. You know I was thinking just before about vortex and counter vortex and just how incredibly helpful that was for me, and that, you know, the permission to let go and the “I don’t think so” you know, we’re like an accelerated version of that, you know, passage from one to the other, and that **the more there is that “oh, I actually can let go,” the stronger the “I don’t think so” gets.**

T: What happens to the “I don’t think so”?

C: It gets stronger. It’s almost as if it gets more powerful and I’m thinking maybe, you know, it’s like the raging of a tyrant that kind of knows its days are numbered and its trying to scare you into submission, so it’s going to really, really, really make you hurt so you don’t get any wise ideas.

Laurie worked with Terry learning to contain both images. She normalized Terry’s experience and offered education around both being possible, loving aspects of Terry as a whole person.

T: So, what can we, if we consider both parts essential ingredients to the wholeness, and there’s some way you’re organized so that both are important, both are valuable, what would it be like to find a way for the two of them to coexist or dance together?

C: That’s what, that’s what I think we’re getting there.

T: Yeah, we’re moving in that direction. Because it’s true, we have both vortexes and either we dance back and forth between the two, or we find what gets born when those two exist together, sometimes a third emerges. And then sometimes the part that says “I don’t think so” is like a protector. It’s like the quote that you gave me, from your friend, if you let go, what was scary that happens, what part would be corrupted or vanish again. Sometimes the protector is saying, “I don’t want vulnerability. I don’t want letting go, because something dangerous could happen or you could get hurt, or I’m here to protect you from letting go, keep you strong.”

C: Mmmm.

T: So if we can just look at each part with curiosity, we can discover why they’re both important.

C: That’s a really useful thought.

Laurie evoked the area of object relations by linking Terry’s survival strategy to her early experience with her mother.

T: So it might not have been good to let go with your mom, because your mom was kind of a taskmaster. But, and here you are, and I’m offering you permission to study, explore what it would be like to let go. But sometimes we’re very loyal to our parents, even if they didn’t give us what we wanted, there’s a loyalty, a deep unconscious loyalty.

C: And I do have that.

T: So we’re going to have to see what your mom needs to be able to let go. I think about what would have been different for your mom in her life if she’d been able to let go. Circumstances kept her in a different place, so she was probably frightened to see you relaxing and letting go.

C: That’s a really helpful way to look at it because I...it’s true, I had a sense of betraying something in her.

T: If you get your needs met...

C: So that's useful. I can find a way to protect her and it'll be easier.

Intending to connect Terry positively with her mother, Laurie introduced another experiment, which had an unexpected yet productive outcome: instead of freeing Terry to thank her mother, Terry found herself suddenly furious at her mother. This profound anger shook Terry to her core – she had always been so identified with being a gentle woman, and suddenly she accessed a deep rage she had never consciously known. Additionally, Terry became aware of how she embodied within her deep conflicting feelings about her mother as both the nurturer and the woman who hurt her deeply. These realizations were so startling that she sat up and went right back to the couch.

T: **What would it be like to say to your mom, “I thank you for the gift of life and for everything you have taught me.** I ask for your blessings now that I can also let go and relax. I ask you to bless my life that I can learn to relax. I will always thank you for the gift of life. And I will always carry you in my heart. And I would also like you to bless me when I let go and relax.

C: [Big sigh].

T: So what happens when I say all that?

C: **It got pretty turbulent down there. [Laughs]. Mmmm!**

T: Down where? In your belly?

C: Everything just kind of started coming...MMMMM!

T: Shaking up. Like a tornado?

C: Um, yeah, uh, well more like, um, you know those toys for children that make a lot of noise when you...

T: A rattle.

C: Exactly! It just got very noisy. **But, I will think about that. I won't repeat that.**

T: Was it a bad noisy or a good noisy?

C: Well, it was a bad noisy. I think...

T: So shaking things up.

C: Yes, and I think the first part was harder to say about you know, thank you, um, I think...**[Client sits up]**

T: Have you sit over here before we stop.

C: **[client moves back to sofa]** I think I uh, the anger was kind of I don't feel like saying “thank you” right now [Laughs].

T: Right, of course

C: **And then I was a massive contradiction... it was like what do you mean, thank you!**

T: Right, that was definitely my words, not your words. Yeah, so it helped to see that not “thank you, I'm pissed!” Remember on your pictures, right, we had number 3 was anger.

C: Yeah

T: ...with a black line...

C: Yeah. But I, I, I really, the second before, I felt so protected at first. Then when you were saying, you know, “thank you for”...

T: For the gift of life, not for all the garbage.

C: I know, I know. But I couldn't quite, **I didn't feel like saying “thank you” period** [Laughs].

T: So, just take a moment. What do you really want to say? What's your truth?

C: You know, I don't know, um, I want to say, um, **I know you really wanted to do the right thing and I know that you tried very hard to be a good person, and I know you're young and scared and lonely and damaged, but you were pretty awful to me and you never let me be little and you always... and see now, here we go, part of me is thinking poor thing, 21 and she's got two kids...**

T: **But not you. I know, you leave yourself...**

C: Right. But, but me, it's just ah...you know, why it wouldn't be so bad if she just couldn't do the nurturing, **but that she made me feel that there was something bad in me because I wanted it**, that's what I think was not a nice thing to do.

Terry's anger had finally becoming tangible and visible enough for her to experience and explore it in their relationship. She appeared activated and energized, the opposite from her usual “worn-out” stance. Terry even described herself as “feisty” – a surprisingly playful and lively term for her new experience of being.

She also repeatedly exclaimed her surprise at the amount of trust she had placed in Laurie in order to uncover such deep feelings and express them in their relationship.

T: That was pretty intense. I mean I took a big risk by adding that in, it kind of opened up.

C: Yeah.

T: You seem very alive right now.

C: [Laughs]. Yeah. I guess I feel pretty alive.

T: Check in with your shoulders and your legs and your feet and see...

C: **I'm feeling feisty.** [Laughs].

T: Yeah, good, that was part of your pictures!

C: [Laughs].

T: We were hoping for feisty.

C: Yes we were! [Laughs].

T: You said feisty was buried in there. Remember?

C: **[Laughs]. Hi, feisty.**

T: That big black line.

C: Yeah, that's right [Laughs].

T: Feisty. **I welcome your feistiness.**

C: Thank you! Really?

T: Yeah

C: Oh....

C: Gosh, I was thinking that was such an awful...**I can't believe I was able to tell you the truth. I guess I must really trust you.** Can you imagine being able to say to somebody, “I don't want to say thank you to my mother for anything”?

T: Yeah that's great.

C: Boy!

As time was nearly up, Laurie wanted to conclude the session while supporting Terry, who had taken many risks in this session. Laurie reassured Terry that regardless of content, her experiences were acceptable and welcome, and reinforced that she was on the journey alongside Terry, also wanting her truths. Laurie also humbly acknowledged that she might have made a “mistake,” especially with the unexpected outcome of upsetting Terry through the experiment. Laurie felt this intervention was particularly important given Terry’s vulnerability throughout this session.

T: **It’s not just somebody, it’s somebody who’s supporting your journey, also wanting your truth.** And again, you know, I need to acknowledge, we did a few experiments today, you know like me saying “thank you” brought up the anger and the feistiness, which is good.

C: Hmm...

T: Sometimes, you know, a mistake is a good thing because it opens up awareness, just like when we say, “I want to let go” and “I give myself the gift of letting go” it brought up “Uh Uh.”

C: Yeah.

Laurie checked in with Terry’s body one more time before she ended. Additionally, she offered some concrete suggestions on how Terry could take care of herself if she felt ungrounded, including calling Laurie. Such concrete advice about grounding (e.g., taking a warm bath) is more often used by bodyworkers, thereby offering another distinction between BcP therapy and many verbal psychotherapies in the way it focuses on the client’s physicality as well as mental experience.

C: We covered a lot of ground, didn’t we?

T: Yeah... And how is your body in this position before we transition, check in with your neck, your shoulders....

C: I feel weary though, I feel as, I mean you know, not bad, but as if I feel as if, you did all the work, but as if **I feel as if I did a lot of work.** [Laughs].

T: You did.

C: I feel as if I did a lot of... You know my body feels the way it felt the other day, you know the nearest grocery store is 2 ½ miles and I really lugged a lot of stuff and when I got back, **my shoulders and my arms were so tired, you know that muscle fatigue...that’s kind of how my whole body feels.**



T: That's very common when, when you start to release some of the somatic experience of trauma has to do with holding, being strong, the cells are tight, so as you start to discharge and relax and release, there's going to be heaviness and fatigue. It's common. It's a common experience. **If you can rest, take a warm bath, your body will re-regulate. And just keep watching and if anything feels like it's not changing or you need to call me during the week, please do that if you feel stuck, or if you feel like you're caught in something that's not shifting.** Okay.

C: Thank you.

T: You're welcome.

### *Monitoring Evaluation of Session Six ("G" in Figure 1)*

From early in the therapy, Laurie had felt that Terry had been greatly deprived of touch in her very early life. Laurie therefore used this session to explore Terry's unmet needs for contact, and create "experiments in sensation" to learn how to provide for this need. These experiments interplaying language and touch unexpectedly opened Terry up to very powerful and surprising experiences (to both of them) within the session.

In hindsight, Laurie discussed that it may have been too soon for Terry to lie down and become so vulnerable. Particularly using something as intimate and powerful as touch, a BcP therapist has to be very careful to titrate the work. Laurie explained that some people criticize BcP for its power in uncovering defenses, suggesting that doing so may flood the client. Creating a new experience to fulfill Terry's unmet need had to be enacted slowly and carefully, and Laurie had to assess whether Terry was able to remain connected with her inner resources enough to remain contained at this level of depth, or whether she was going beyond her defenses. Despite the possible misstep, Laurie acknowledged Terry's affective reactions and the two worked together to explore them as fully as possible.

### *Sessions 7-11: Summary*

In these later sessions, Terry demonstrated substantial changes in her awareness. She was more willing to remain curious about and focus on her inner experience. After the

influential previous session, Terry came to session 7 feeling very “shaky.” Laurie spent most of the session grounding Terry. Laurie also revisited the pace of that last session as a “mistake” and they processed it together. In session 8, Terry reported that something had “shifted in me.” Laurie offered touch with Terry’s sore shoulder. Terry connected the pain in her shoulder with some of her feelings about Jack and the burdens she carries. In session 9, Terry resolved to stop smoking “for her son” on her son’s birthday. In session 10, Terry felt sleepy, so they worked on having her lie down and enjoy relaxing in the session. From this place of experiencing her inner calm, Terry associated to painful memories of being blind in one eye for over thirty years. They worked on her verbalizing permission to herself to enjoy without her judgmental side coming up. In session 11, Terry told Laurie about receiving the gift of a spa vacation from her colleagues and accepting it without guilt. She planned to attend the spa the weekend before session 12.

*Session 12: “Coming Home to Myself “*

In this final session, Terry spoke of a number of significant changes from the treatment. She described enjoying the spa immensely, indicating her greatly increased ability to accept nourishment for herself without remorse or guilt (Theme 1). She also acknowledged another exceptional change: she reported having gotten angry with her friend Susan. Terry spoke with joy about having expressed her spontaneous feeling and setting a healthy boundary for herself. In this final session Laurie also worked to help Terry reinforce this new experience. She encouraged Terry to experience anger while still feeling connected to the other person by introducing an experiment: using physical touch Laurie sat across from Terry and pushed hands to help Terry experience and internalize

the sensations of healthy assertion (Theme 2). Terry expressed a lot of relief from this experience as she made the realization that anger could be a safe connector.

In the beginning of the final session, Laurie reminded Terry of the end of the study, and checked in with how she was feeling. Terry reported a significant change in having enjoyed a relaxing, guilt-free time at the spa. Furthermore, she indicated an important shift in her object relations when she described how she had internalized Laurie's encouragement and was able to take in nourishment by herself (Theme 1).

T: So, how's your week been?

C: Well, uh, my weekend was great. I went to the spa, you know.

T: That's right!

C: Oh my goodness, [Laughs]. That was some experience, I have to tell you. Oh! It was really, it was just wonderful. It really was. You know, I was thinking when we got there, um, Friday night that I would never have wound up there if somebody hadn't given it to me as a present.

T: Right.

C: And um, **I felt, kind of oh my goodness, what am I doing here?** But, it was just great, it really, just to stop and swim and lie around and get a massage and eat like a pig [Laughs]. It was great. **And I thought of you a lot because I really was, you know, I turned my head off pretty much, I mean, for me, anyway.** [Laughs].

While paying attention to her sensations in her body at the spa, Terry described having had spontaneous memories of her early life. She found herself picturing all the houses she had lived in and seeing the inside of these houses for the first time. She interpreted this feeling of being inside as "coming home to myself." Terry's image of "coming home to myself" is very powerful and also quite similar to Jan's statement. Laurie explained that such a declaration is often articulated in BcP, as the work often provides a sense of coming to feel at home to one's body. No longer experiencing herself as disgusting and stared at for her eczema or only through her ability to do for others, Terry was able to lie in a room and be comfortably alone with herself.

C: **There was a meditation room, I was just lying there, you put your feet up kind of thing. And, very sort of dark and quiet. And uh, for some reason, I started thinking of all the places I had ever lived.** And, it turns out there are 20 of them. Which is a pretty

good number, I mean even for how old I am, I guess. And then I tried to go inside the different places and I could see everything very vividly from the fourth place on. And the move to the fourth place when I was 14 and **I had NO sense at all of what was inside the other houses and ...**

T: Before the age of fourteen, huh?

C: Yeah. And I went back to the place where I was born a couple years ago and I wouldn't have expected to remember much about that because I was too young when I moved from there. And I didn't get to go inside, but it was very evocative because it was near an air force base. My father was, you know, flying in the war. And, that particular place, I don't think it changed much, you know. I can't remember anything about [city]...I mean, **I can remember things from outside the house**...like roller-skating on bricks, there were brick sidewalks, and sharing lollipops across the fence with a somebody who turned out to have chicken pox. [Laughs]. Um, and stuff from starting school. **But I have absolutely no recollection of inside the house.**

T: So, what does that mean to you when you think about it?

C: I was wondering. You know, because I have some very vivid memories of my siblings and friends and school. I can see school clear as a bell. **So, something, the only thing I could think of, was that I didn't really live there**...you know, in my...

T: You didn't feel alive or present.

C: Yeah.

T: You didn't feel like you really existed.

C: Yeah, you know, it's ah...

T: So, kind of sit with that thought now.

C: Yeah.

T: "Perhaps I didn't really live there."

C: It's an amazing. I was glad it came to me while I was in a quiet place while lying down, because it didn't glom me, but...

T: Does that feel related to the sense of emotional turmoil that's emerging for you?

C: I think. I don't know if I get the connection exactly, **but I have a feeling, I guess of um, coming home to myself.**

Laurie followed Terry's associations to coming home, as she wanted Terry to integrate that experience with where she had come from in the treatment process.

T: When do you have that feeling of coming home to yourself?

C: I'm thinking in this whole process that's how I've been feeling, you know.

T: So, just kind of during this past 12 weeks, this journey of coming home to yourself.

C: Yes. And, you know, throwing some baggage off my back [**client opens arms wide**] and seeing some obstacles that I, you know, just facing something, I mean I don't know whether it was just that I couldn't face them, or that I couldn't see them either so I didn't know what I was supposed to be facing, um....

They worked with Terry's spontaneous gesture of opening arms wide, and Terry described throwing baggage off her back by facing things she had been avoiding. They explored her several postures: Terry describes her closed posture as feeling "natural," whereas her open arms felt unnatural and "obnoxious, as if I own the world."

Although Terry had changed a great deal in her awareness of herself, she still struggled with finding a comfortable position in relation to others. Laurie invited Terry to think of an image from the treatment to integrate their previous work, as well as to bring Terry to her body. Laurie suggested the image of Terry holding her son. Instead, Terry associated to the pictures (she called them “panels”) that she had drawn and stated confidently how she could now be inside her experience as well as observe it with more awareness.

T: What I’d like to do is almost like sort of take a snapshot.

C: Mmm.

T: So we don’t have to go back into detail.

C: Right

T: More like a picture...”Oh I remember the moment I was holding my son.”

C: Yes

T: Feeling the love I had for him.

C: Yeah, that’s a very powerful memory and um, the day that we did the 8 panels, that was very, that was very powerful, um, just seeing um, you know, just to have a visual path there. And I guess, in the process, I... um, **I felt a strange combination of being more unified than I have been and at the same time, being an observer of myself.**

When Laurie now would bring Terry in touch with her bodily experience, Terry explained that she felt more integrated, yet a part of her was still uncomfortable with being inside her physical sensations. Laurie formulated that Terry’s need for contact and validation was still strong: “It was not clear if she was willing to let go of the external and go to the internal without coaching.”

**C: I guess that a lot of process has felt like an oscillation between feeling more integrated and feeling, more not exactly dual, but as if there’s a part of me that’s looking on to, into the rest of me...**

T: So kind of integrated and also observing?

C: **Yeah, as if some of the sensations, um, were happening to somebody else.** But I think it’s, I think it’s because usually when I hit something hard, I get that rope and I pull myself up and over it, and **this process I didn’t try to run away from it or shove it down or find a way to climb over it.**

T: Right. So you didn’t use those ways of organizing to find a way to climb over it.

C: Right, and I think **that’s why I did experience turmoil because I felt that there was turmoil down there clearly, and that if I was ever going to go through it instead of over it, um, this was ...**

T: You have to tolerate feeling of turmoil.

C: Right.

As Terry spoke about how she had changed through treatment, her breath slowed. She described feeling more comfortable with what was beyond her control.

T: And sometimes, when feelings are popping through, we feel like we're losing control.

C: Right. And I think that's exactly right...

T: And that's scary.

C: I think that was very disorienting and it made me...It scared me because I had a feeling, that is just kind of coming right this second, that you know the whole Pandora's box thing, you know like, uh oh, you know, **I opened the box, how do I get the lid back on? [Laughs]. But there's a real sense of possibility.** [Sigh].

An important change could be seen in Terry's connection with her body, as throughout this session, she spoke while often gesturing with her body (Theme 3). It was also possible to see how Terry appeared more curious about herself and more willing to examine her gestures for meaning without shame or self-consciousness.

T: [continuing above] Now?

C: Yeah, but I haven't defined yet what I think I mean by that, but I do feel it. **[Client holds hands to her chest, close to her heart]**

T: Ok. So just take a moment and feel your hands touching that part of your body, kind of pausing, feeling that sense of possibility. And as you give yourself time and space to acknowledge. Permission to feel that sense the possibility without having to define it. Just notice what happens spontaneously, naturally, without effort.

C: There really is a sense of, um, you know, flowing...

T: Ah.

C: ....and that's really nice.

T: And when you feel a sense of flowing as a felt experience, where do you feel that quality of flowing happening?

C: Right there. **[client holds hands to chest/heart, then releases them out in front of her]**

T: Mmmm.

C: It's just...um...**[client repeats gesture]**.

T: That's right, just let your hands make that gesture. That's it. Feel that gesture.

Terry used the encouragement to become aware, through her gesture, of her defense of how she "stuffs things down," minimizes, or ignores things. As exploring the gesture turned into exploring Terry's maladaptive beliefs, here was an example of how focusing on the body often connects with working on the cognitive aspects within BcP.

C: I think what's there now is the...I think I have a quandary between, um, you know, **the flow thing feels as if there's this generosity thing that's really who I am, but I can't always act generous because I have to take care of myself and...**

T: **Now what if you use the generosity toward yourself?**

**C: Yeah, this is the part that I'm still working on.**

T: Right, your cutting edge is how can I let myself receive the love...

**C: Without feeling selfish. That's the trick.** That's what...and...um...

From this discussion of how to take care of herself without seeming selfish, Terry remembered an important experience during the past week: She had expressed appropriate anger and set a boundary with her friend Susan without feeling selfish.

C: Oh, you know, last week I got angry at somebody.

T: Oh, who?

C: She's a really good friend of mine. She's a colleague and...

T: That was in your pictures, remember you said, "there's anger there." You got angry!

C: I invited another colleague to lunch because it was her birthday. And Susan came, the next thing we went for a walk to get some coffee or something. And she said, "I have to tell you, you know, I was really upset that you didn't invite me to go have lunch with you." And so I said, "Oh, I'm really sorry, I didn't mean to hurt you." She said, "If I had done same thing to you, you would have felt bad." I said, I really think I'm pretty much of a golden rule person, and I don't think I would do to somebody. I said, "I don't think I would be hurt if it were her birthday and you took her to lunch." Anyway....

T: When did you angry?

C: Well, so, the conversation, she went on for about 45 minutes. And I had apologized. "I had this, I had that." And then we went back to the office and started working and she brought it up again. **And at that point, I said, "Susan, that's enough!"** [Laughs]. And she just...she said, "What?" **She had never seen me angry. And I didn't even feel it coming. You know, I knew I was getting a little tired of it, you know, but man did I get mad at her!**

T: Great.

C: Oh!

T: She was startled?

C: She was very startled

T: Not a behavior they expect Terry to express.

C: Yes!

T: So, how do you feel about yourself knowing you had this spontaneous impulse to say, "Susan, enough!"?

**C: Well, you know what the amazing thing was, I didn't actually even feel guilty that I got mad at her.**

As Laurie had formulated, Terry's belief system had been "If I receive love, I'm selfish." Through their work, Terry experienced a new belief: "I am able to get mad and stay connected and not feel guilty." They explored whether Terry could feel love without feeling selfish by examining the guilt that arose after Terry's impulse to assert herself.

T: Why would you? Why should you?

C: Because anger is definitely not a good thing.

T: It's a good thing if someone is battering you and you need to establish a boundary. Feel that.

C: Yeah, yeah.

T: And what do you want to say her?

**C: Enough! [she gestures with her arms].**

T: Feel that.

C: Yeah, yeah.

T: Enough! And just sense your arms.

C: Yeah.

T: And your legs.

C: Yeah.

T: And your chest, the energy.

C: [Sigh] Yeah.

T: What does it feel like?

C: It feels good [Laughs].

T: Yeah, exactly.

C: Enough! [Laughs].

T: You're very alive...it's your assertion.

C: Yes! And then, afterwards, obviously, I didn't want to hurt her and I didn't want her to be upset. But, I didn't feel, I didn't feel, you know, I mean I went in and gave her a hug and I said, "Let's not have this conversation again for at least 10 years." And it was fine. And she said, "We have to talk more about it." **And I said, "yeah, but not now."** But it was funny because I, I just, and I can't believe I almost forget to tell you. Because when I went home that night, I thought, "Wow, I have to tell Laurie about that." I really did...

Terry appeared more expressive and "activated in her body" than in earlier sessions.

Yet Laurie noticed some fear emerge after Terry expressed herself; her body appeared to tense, and she seemed to look for reassurance. Laurie worked to reinforce Terry's new experience of assertion. She created an experiment having Terry set a boundary and stay mindful in order to integrate the cognitive, sensate and affective aspects of assertion.

Note how Laurie selected specific language that embodied the proper affective reaction, which in Terry's case meant finding the words in French.

C: That's right! You know, I've always loved, you know, the Italian word for that, it's "basta." And there's something about that...

**T: What do the French say?**

C: "Assez."

T: Assez. Like stop?

C: Or "ça suffit." It suffices, literally. Ça suffit.

**T: So what are you learning about yourself when you let yourself have that permission to set that boundary, ça suffit, enough?**



C: Yeah, huh...you know, actually, **it's a very physical sensation of... it's like weightlifting, it's like taking something that's pressing and pushing it.** [Client gestures with hands].

As Terry spontaneously gestured with her hands, Laurie introduced a physical touch experiment to help Terry assimilate her experience of boundary setting (Theme 2).

Formerly, Terry had believed that anger was entirely destructive – anger had meant either hitting (or sadly, being hit), or distancing. Through this experiment of pushing hands, Terry experienced the cognitive, emotional and sensory aspects of anger as a way to connect with clear boundaries. As Terry allowed herself to experience her anger, she began to see the healthy side of assertion, which she found so transformational that she exclaimed “holy smokes.”

T: So let's try a little experiment. I'm just going to meet you. I'm not going to overpower you.

C: [Laughs].

T: Overpowered by you.

C: Okay

T: Just feel what that's like inside. **[Therapist moves chair closer and sits across from client close enough to put her hands up to her].** And what would you say? What are the words that would go with this gesture?

C: **[Client puts hands up to meet therapist's].** Oh, okay, so if you were really trying to push too hard? Ça suffit.

T: Yeah, and check in with your arms, your heart, your spine....your belly...

**C: You know, that is an amazing feeling. Wow.**

T: Yeah, just hang out with that feeling you're having.

C: Wow, because you know what's incredible is that I just have to let go for a second and then I'll come back [lets go with hands]. But the sensation, every time I thought of anger, the image that always comes is that [curls up in ball]....and I've always, I think I've always been terrified of it because...

T: Well, that's more of an image of protection, right.

C: That's what I just realized.

T: Do that again.

C: Yeah. [curls up again]

T: When you think of anger, you go into almost like a womb-space.

C: Yeah, a “don't hit me” sort of thing. And I guess my association because it's that way, I've been scared out of my mind to feel anger because I see it as such a wounding, cruel...

T: Exactly. That's when anger gets merged with a traumatic injury.

C: The idea that you could be angry and not have it be destructive and horrible is like, you know... But this is fun [laughter; **client puts hands up again**] definitely!

T: Your aggression....your assertion.

C: Yeah. And it's not a bad thing.

**T: It forces us to connect.**  
**C: Yeah.**  
**T: Not disconnect. It brings connection.**  
**C: Wow, that's incredible. Huh. Holy smokes. I never....**

Through this physical experiment, Terry realized how anger could be a positive connector within relationships, and how by setting boundaries for herself she can support herself and the other person as well.

T: Then you define your boundaries. Then you're saying, "You're not going to violate my boundaries." Whereas, when you're little and you get violated, it's like oh, you can't protect yourself.  
 C: Yeah, yeah. And anger is kind of...see that's the thing...and I do know that when, you know, there have been, I mean, if anger is like expressing a truth that you know somebody is not going to want to hear, I don't suppose that's really anger, except I've done it once in a while when I was angry  
 T: Well, maybe, and again, you know, she would go on and on until you set a boundary.  
 C: Well, I guess really that until I stopped her, she wasn't going to stop.

One of Laurie's basic rules of treatment is that in order to help a client embody a new felt sense within the nervous system, it is important to practice the new experience at least three times. So Laurie brought Terry back to her felt experience of saying, "That's enough!" to Susan.

T: Try it once more.  
 C: Okay.  
 T: **I want to give you another felt sense.** So, what's her name?  
 C: Susan.  
 T: Her name is Susan. And what was she saying?  
 C: She was saying, you know, "well, there's one other thing, you know, about um..."  
 T: Okay, I'll play Susan. So, "Okay, I'm not finished yet. I think I need to tell you more about, I mean, you really..."  
 C: "Susan!"  
 T: "...you didn't invite me and you know, there's another thing I need to tell you about remember when I..."  
 C: "That's enough!" [**Puts up hands.** Laughter]  
 T: Uh huh. **Feel your legs. You want to ground.**  
 C: Yep.  
 T: Uh-huh.  
 C: Yeah.  
 T: Come forward a little just to sense your pelvis. And look at me and go, "That's enough."  
 C: "That's enough." [Puts up hands; Laughter]  
 T: Feels good, huh?

C: It does. **Wow. This whole boundary thing, you know, I have never really had a lot of them.**

T: And once more, just kind of say it, try it again, maybe from your belly or...

C: **Okay. [Laughs]. That's enough!** [gestures with hands]

T: Uh-huh. I want to feel you push through, push into the earth. That's it, relax your back, so you're not hurting yourself. What's happening in your arms, your spine?

C: I'm just really, I'm pushing

T: You're really pushing.

C: Wow.

T: How does it feel to make contact and say, "That's enough?"

C: That's enough!

T: Come forward. [moves chair forward and puts her hands up]

C: **That felt good.** [pushes against therapist's hands]

T: Keep pushing out.

C: Okay, now, you know one thing I just noticed. Like, it feels like I don't need to push that far. It feels...as if...I don't need you to go to the other side of the world.

T: Just a little bit. Just dance with it.

C: Okay. Yeah, 'cause it's when, you know, when it gets so it's like a bar against your chest, and you haven't pushed back yet, that's when it's not good. Ça suffit. [Laughs]. You know one thing I just realized, that one of the reasons I think I like speaking French so much is because I could say things in French, like swear words [Laughs] that I could never say in English.

As Terry experienced her anger, she associated to her mother's response to anger. Since Terry's mother would detach when she was angry, anger was always a form of disconnection, which was too overwhelming and too frightening for Terry. Having this new option of setting boundaries offers Terry more choices of behavior. As Laurie explained in her conceptualization, trauma can lead to rigidity and living in limited ways, while health means having more options and resiliency. Even Terry's use of "rainfall" suggested her increased somatic sensibility.

C: What you said about anger as connection, that is so true and you know I can remember feeling my mother furious at me, but she would never tell me what I did that was so awful. I used to sometimes go to somebody else's house and they'd have like a shouting match and I'd think ah, you know like rainfall.

T: Right, like life, freedom.

C: Yeah!

With this new experience in her body, and 15 minutes left to the session, Laurie suggested they return once more to the series of pictures as an external way to help Terry contact her progress. As Terry associated words to the pictures, she described herself in

the images across treatment going from “rigidity” to “flow.” As she spoke the words, Laurie described how Terry’s “internal flow” could be seen in the affective expression on her face and in her gestures, as Terry opened her arms widely, taking up more space. In these last few moments she truly appeared a woman changed: she moved through a gesture to a sense of pleasure, associating to an image of bubbles, an image she found very nourishing (Theme 1). Even when Terry joked about her armor, Laurie assessed that Terry was mindful of her conflict with a certain acceptance and sense of inner calm that had not been present before (Theme 1).

C: That and the geyser one, they have kind of like the straight-jacket that’s being taken away.

T: Straight-jacket taken away.

C: **Yeah, just very flowing and unchecked.** Just a lot of you know just like, **belief in their own flow.**

T: Belief in their own flow. And how would your body move to represent these two images.

C: [Sigh; makes a big arm gesture]. Sorry, did I do anything with that? Ok...

T: So make that gesture again

C: Chooom [big arm sweep].

T: Choom. What is it like when you check in? When you close your eyes and check in?

C: [sigh]

T: Your arms? Your breath?

C: It feels very good. [Laughs]. The image that just came to me was, and I don’t know why, you know when you’re little and you have that little metal, that bubbles...

T: Bubbles...blowing bubbles...

C: I love bubbles. I don’t know why, just whoooh.

T: Just seeing that image of bubbles and the flow and fluidity with the gesture. Just check in with the quality of sensation in your body. And checking in with your arms...the movement of your breath.

C: You know, it strikes me how often I either sit this way [with arms close] for real or might as well be. [Laughs]. I mean, that [opens arms] feels very unusual...

T: It’s like a leading edge for you, again.

C: Yeah.

T: Unusual because it’s not familiar for you to let allow yourself to open and expand that way.

C: And it feels very like, “uh oh, where’s the armor?” [Laughs]. You know, like, are we sure that we’re...

Even with the positive changes, Laurie assessed that Terry still needed some external support, and asked Terry to explore images that will help her remain connected with her

inner strength in the outside world (Theme 1). Terry associated to a hug and gestured as if giving herself one (Theme 2). As they examined the gesture of Terry opening and closing her arms, Terry connected meaning to her closed and open stances. An open posture she associated with entitlement, power, and “obnoxiousness,” whereas the closed posture still felt more comfortable as she was “used to this.” Laurie worked with her to become more aware of her projection onto an open stance, and reframed the posture with a new possible meaning: “here I am, I can be open.”

At the same time, Laurie supported Terry’s need to maintain her closed posture. At the present time, what was comfortable for Terry was to go back and forth between old and new experiences. Additionally, a hug gesture was comfortable to Terry. Laurie assessed that in terms of Terry’s object relations, when mutuality exists – each is protecting the other – is when Terry can feel most relaxed and open.

T: What would you imagine would support you in this place to help you feel safe, anything at all that you could bring in to support or protection? It could be a person, a part of nature, a thought....

C: The river is very good for that. Um, and, you know the people I care about, um, you can’t hug somebody without doing that first...

T: The river and people that you hug.

C: Yeah, and maybe not even in that order, but **when somebody you care about, or somebody you love and trust, when you’re holding that person, that love is protecting both of you. [open arms]** This feels so....you know like my arms are more comfortable in this gesture **[curls up]...I think they’re more used to this gesture...**you know my muscles recognize this.

T: So, what are your arms saying to you in this posture?

C: Um, well, they would probably say to me, uh, “you’re not actually in danger right now, **why do you think you have to, um, protect yourself as if somebody were about to punch you?**” Or something like that.

T: So, you’re not in danger. You don’t have to protect yourself.

C: Right. [Cough], excuse me. Um, that feels very natural. That’s the hug thing. And you know one thing, that this gesture **[opens up arms]** for some reason, I, it doesn’t feel natural. And I don’t know whether it’s only a self-protection thing or whether I know a lot of people who sit like that.

T: Yeah, but when it’s a new gesture and your body hasn’t really become familiar with it.

C: Because some people sit like that and it’s sort of obnoxious...like here I am, I own the world.

T: That could be one attitude.

C: **[Laughs]**.

T: It could be something else. Here I am, I can be open.

C: Yeah, that's what it would be. Yeah. [sigh]. You know who would sit like this is my son. He actually would.

T: He would be comfortable. So just slowly let your arms go in the other direction. Taking your time. Gently and slowly. Noticing anything at all. Feelings.

C: **[brings arms in]. This is getting back into the comfort zone. [Laughs].**

T: There's the comfort zone. Just notice that that's comfortable

C: And I don't know if that's just my creakiness... or...

T: That's the comfort zone. That's not turmoil, that's comfortable...yeah, just to know that gesture is comfortable and then going in further.

C: Yeah. And that feels comfortable. I do that sometimes... [raises arms up].

As Terry looked at the final picture, she pulled her body in again, crossing her arms and legs, as if she feared that she would regress endlessly into her upsetting feelings of the "trauma vortex." Laurie reframed her fear once again as a normal part of the process: "Turmoil is not all of who you are, it's a moment in time." As they concluded, Terry appeared lighter and more accepting of her own process of change.

T: So, there's often confusion between, am I going to go back there, or is it that I'm going forward and I finally feel safe enough to tolerate these feelings, doesn't mean I'm going to go back there, I've overcome them, but I might not have given myself the safety or permission to feel these things.

C: Yeah, that's exactly it. Phew. And I think what's disorienting is that you, I mean last week at this time, I really thought I had pushed backwards, I thought, you know what had I done? But it is that, you know, there is a lot of stuff that I couldn't have gotten through it and felt it at the same time, there was just no way in hell.

T: And when we can't go through it and deal with it at the same time, we either push it down, like you said, or we run from it.

C: Both of which I'm really good at. [Laughs]. This has been a wonderful session. You know?

### *Monitoring Evaluation of Session Twelve ("G" in Figure 1)*

Laurie's intention for the concluding session was not to uncover new material, but for the two of them to evaluate how Terry had integrated the BcP treatment. In the ease with which Terry explored nuances of her felt experience and physical movements throughout this session, Terry demonstrated a much more engaged stance with her internal experience, noticing sensation, feelings, and observing her thoughts.

Terry was also clearly able to hold her good feelings and stay connected with her inner resources more easily, without the same level of fear and guilt that stopped her previously. For example, towards the end of the session, as Terry observed an image, she gestured with her hands. As they slowed the gesture down and she opened her raised arms, they could both see that she was much more able to allow herself to experience a nourishing feeling through the gesture. Additionally, Terry allowed herself to play with the experience, enjoying it (Theme 1), and not jumping into her story (Theme 3).

Through such interactions it was possible to see Terry's increased ability to connect with her sensory experience and stay with the positive sensations of her internal experience.

Terry still appeared to need some reassurance; she had not entirely worked through all her guilt and fear of asserting herself or giving to herself. She had, however, confronted a major issue of expressing her anger, and was able to access the important feeling of connecting through assertion.

#### Concluding Evaluation ("L" in Figure 1)

##### *Quantitative Results*

Table 11  
Terry's SCL-90-R Results\*

	<b>Terry 1</b>	<b>Terry 2</b>	<b>Pt diff</b>	<b>RC</b>	<b>Sig at p≤.05</b>
<b>Global Severity Index</b>	61	56	-5	-0.88388	
<b>Positive symptom distress index</b>	53	50	-3	-0.53033	
<b>Positive Symptom Total</b>	63	58	-5	-0.88388	
<b>Somatization</b>	53	53	0	0	
<b>Obsessive-Compulsive</b>	57	49	-8	-1.46059	
<b>Interpersonal Sensitivity</b>	62	60	-2	-0.45883	
<b>Depression</b>	68	62	-6	-1.2	
<b>Anxiety</b>	63	59	-4	-0.89443	
<b>Hostility</b>	40	40	0	0	
<b>Phobic Anxiety</b>	58	54	-4	-0.83406	
<b>Paranoid Ideation</b>	49	41	-8	-1.94029	
<b>Psychoticism</b>	60	53	-7	-1.4596	

\*All scores are T-scores. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning. RC indicates the Reliable Change Index (Jacobson & Truax, 1991).

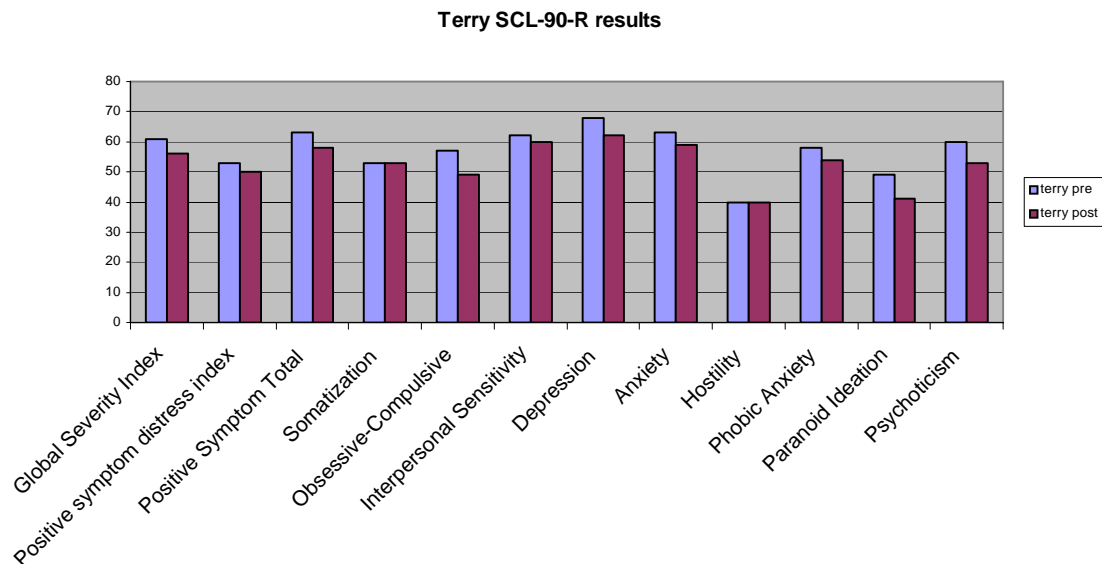


Figure 4. Graph of Terry's SCL-90-R Results.

Table 12  
Terry's TEaM Results\*

Subscales	Terry 1	Terry 2	Pt diff	RC	Sig at $p \leq .05^8$
Subjective Well-Being	47.33	54.42	7.09	1.67113	
Depression	56.60	63.57	6.97	2.10153	*
Anxiety	57.49	60.71	3.22	0.70266	
Phobia	62.62	62.62	0	0	
Obsessive-Compulsive	61.00	64.84	3.84	0.9051	
Somatization	59.65	59.65	0	0	
Panic Disorder	56.67	60.84	4.17	1.15655	
Post Traumatic Stress Disorder	57.26	57.26	0	0	
Symptom Checklist	60.86	63.96	3.10	0.98031	
Personal Functioning	68.03	68.03	0	0	
Social Functioning	60.13	66.46	6.33	1.19626	
Vocational Functioning	67.87	67.87	0	0	
Functional Disability	67.53	69.21	2.32	0.42	
Behavioral Health Status Index	59.66	64.10	4.44	1.28172	

\*All scores are T-scores. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning. RC indicates the Reliable Change Index (Jacobson & Truax, 1991).

<sup>8</sup> Because no test-retest reliabilities were available for the TEaM scale, internal consistency reliability of coefficient alpha was used to calculate RC, which is likely to be higher.



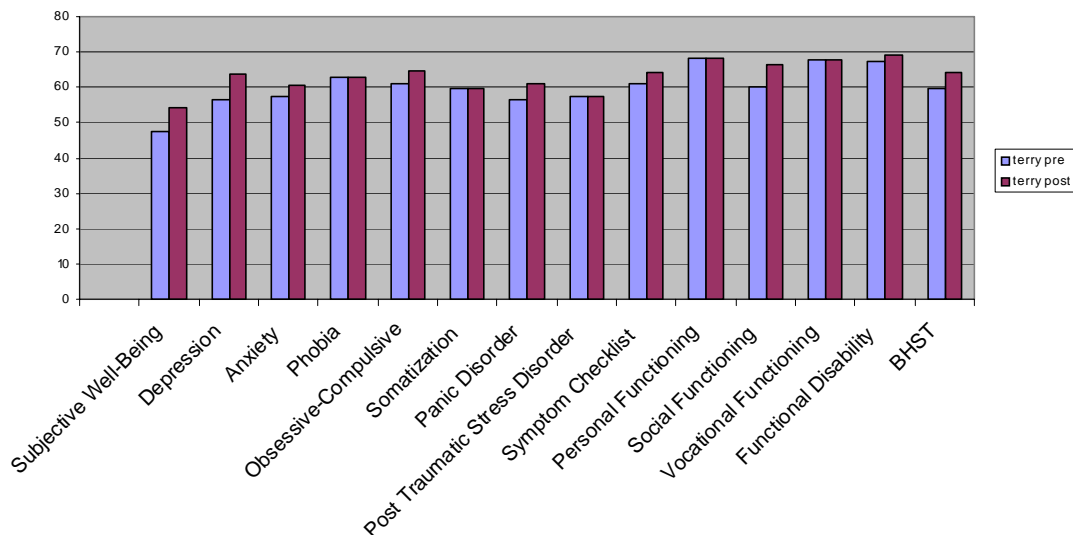


Figure 5: Graph of Terry's TEaM Results

Table 13

Terry's Scale of Body Connection (SBC) Results\*

Subscale	Terry 1	Terry 2
Body Awareness	2.9	3
Body Dissociation	3.4	4

\* Higher scores indicate increased Body Awareness and Body Connection.

### *Discussion of Quantitative Results*

Terry's clinical profile on the SCL-90-R changed from clinical to within normal limits after the 12 sessions. Pre-study, she appeared clinically depressed, as well as lonely and anxious. After treatment, Terry's scores were mostly "within normal range." Although none of her SCL-90-R scores were statistically significant using the RC calculation (which may be due to her lower initial symptom levels), a trend can be noted in which 10 of 12 subscales decreased, some by one standard deviation. These findings suggest a trend towards decrease of symptomology, which is consistent with Terry's qualitative findings.

Terry still suffers from depressive symptoms and some social alienation, which is understandable given only twelve sessions of treatment. However, her final profile on the SCL-90-R indicated someone in the normal range, distinct from the clinical levels of her initial profile. Her Depression subscale of 62 is still elevated, which suggests continuing difficulty with painful feeling – as even her relationship with Jack is largely unaltered – but not to the extent it had been previously. Her Anxiety score remains at 59 in a “moderate level,” yet this may be Terry’s normal range of functioning, which appears consistent with her own statements. On the TEaM scale, nine scales increased, which suggests an overall trend toward improvement. There was also a significant decrease in the Depression score, which appeared to be her main source of symptomology. She had observed early in the treatment that she had “a lot of sadness” within her, and thus such a shift corroborates the work that she did in therapy to address this depression.

On the Scale of Body Connection, her items shifted towards more awareness of herself. For example, “When I am tense, I take notice of where the tension is located in my body,” she earlier endorsed “a little bit” and now “most of the time. With “I feel separated from my body,” she previously indicated “some of the time,” and now only “a little bit.”

#### *Goal Attainment Scaling Results*

Terry enjoyed success in her treatment goals as indicated by the Goal Attainment Scaling. She was able to develop a concrete plan to stop smoking. She also began to write more for herself, another important goal in helping her find her own voice. As for her final objective of “finding a new life goal,” Terry admitted it was really a substitute for dealing with her “missing attacks” with Jack. Sharing her real goal with Laurie, as well as

expressing her difficulty discussing it, were important indicators of the successful aspects of the treatment.

**Table 14**  
**Terry Goal Attainment Scaling Results**

\* = Before Study \*\* = After Study

<b>GOAL</b>	<b>Stop Smoking</b>	<b>Finding her voice in writing</b>	<b>Finding a new life goal</b>
LEVEL OF ATTAINMENT	Scale 1 Importance:	Scale 2 Importance:	Scale 3 Importance:
Much less than expected (-2)	1 pack/day *	Not at all *	Having no clue *
Somewhat less than expected (-1)	Be thinking about quitting with a plan	On occasion writing in journal	Having 1 possibility
Expected level of outcome (0)	Have a plan to quit and belief she can quit **	Once a week writing in journal	Having defined three possibilities
Somewhat more than expected (+1)	Have signed up for a program	Twice a week	Having 1 very strong choice
Much more than expected (+2)	Have quit	3 or more times per week **	Knowing what to do next
COMMENTS			** This goal was not rated in the final analysis, as Terry admitted it was a stand-in for her real goal of getting over the “missing attacks” with Jack. The fact that she was honest about her real goal meant reaching a new level of disclosure and overcoming her shame.

## *Qualitative Results*

### *Exit Interview*

Terry praised the therapy: “It’s been a very meaningful experience for me.” Initially, she explained, she had enormous resistance to treatment. Having spent most of her adult life in France in a ‘non-therapy’ culture, “it felt alien.” A year prior to this study, she had therapy, yet found it unsuccessful as the person was “quite aggressive” and “it just made me shrink.” In this therapy, Terry described being deeply moved by the early memories she accessed, which were “very unexpected,” from her very early life “of 55 or 57 years ago,”<sup>9</sup> and which helped develop her empathy for herself.

The most striking change resulting from the treatment was how Terry developed more compassion for herself: “My relationship to my flaws has changed. I don’t feel guilt for the flaws. Guilt has been a full-time job for me. I don’t feel shame. I feel some level of compassion for myself. And that’s a very different relationship.” This change in her level of acceptance was noteworthy throughout her comments. Terry also spoke with newfound clarity about her character organization (“The caretaking is the only thing I know how to do”) and with compassion about the lack of nurturance in her life:

I think what emerged from these twelve sessions is how much I was taught and taught myself to surmount those things. I had a fair amount [of hardship] and I got pretty adept at it. There is something about going into something instead of going over something that was very revealing. For example, I have a lot of pain in my shoulder. And Laurie said something about ‘breathing into it.’ That was very helpful.

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<sup>9</sup> In her previous therapy, the therapist kept pushing for memories while Terry had only wanted to work in the present. But in this therapy with Laurie, who kept telling her to stay present, Terry reported that she kept saying “but but but.” Terry wondered aloud if it was because the present-focus took away expectation of having to remember. “If because I thought I had to stay where I am it freed me, where if someone had told me I had to I would have blocked. It did happen very often when... I had a lot of physical problems when I was young, and I hadn’t thought about them.” These early memories of physical illness proved very important in the treatment.

The power that was unleashed for Terry in the treatment was acceptance of herself – through the treatment, Terry came to find out she was knowable. “I always thought if I had the courage to go down there, I thought I’d find a monster chained in the basement. When I went down there, I found there wasn’t anything that evil. That was a really nice discovery.”

Terry’s tone became more one of compassion, a striking change from her earlier style in which she had been very judgmental of her faults and needs.

I kept thinking, ‘This hurts. If I had any guts, I should be able to not hurt anymore, and I couldn’t. And then it was kind of, ‘Ok, it hurts. It’s safe to look at the fact that it hurts. And it’s safe to look at the fact that once again someone who says he or she loves me is not behaving as if that’s the case.’ One of the things that was so awful was that it brought me back to that place in the crib where no one was picking me up.

This change in her compassion for herself appeared in her relationship with Jack, in which she was finally able to stop blaming herself for his inability to have a full relationship. Even in the way she described this shift, she noted that she could feel the difference physically:

In this therapy I realized that the whole time up until then I kept looking for what was missing in me that I wasn’t doing. The therapy helped me see that it wasn’t about me. There are reasons he can’t do it. I felt as if a mountain range had been lifted.

Another example of change was in Terry’s relationship to smoking. In the treatment she learned how much she depended on smoking to soothe herself. Making the connection between the addiction and her own need for nurturance allowed her to find other ways to nurture herself. When offered the spa invitation before the last session, she was able to accept without guilt, and she brought a patch for quitting smoking to the exit interview.

Additionally, Terry described an important change in her experience of anger. Allowing herself to express anger with her co-worker and then experiencing it physically as a connector by pushing hands with Laurie were both major breakthroughs: “I always thought of anger as something so diabolical and wounding. My associations are of hiding under something or behind something. This idea of anger as connection just blew me out of the water. It really, really did.”

When asked about what was not helpful about treatment, Terry expressed that sometimes it had a “New Agey” feeling. She explained that she finds some aspects of U.S. culture too self-centered, which the treatment invoked: “I’m lying on this mattress in this womb-like place...what am I doing?! That was hard for me.” Yet despite her strong resistance, she found that she experienced some of her most important changes from the body-focused work. “I did appreciate the touch used in the therapy. I do believe there are emotions that can only be communicated through touching. Words go around them but they can’t be communicated the same way.” Similarly, Terry appreciated Laurie’s language of vortex and counter-vortex as it didn’t have the pathological connotation: “it was just an energy reversal.” It helped her see a cycle in her moods and sensations, instead of seeing every painful feeling as a backwards slide.

Another issue that was important was the tension between leading the client into the body versus following them through talking, which remains an open question for further study. There were times she wished she could have said, “I don’t really want to do this [body-oriented technique].” Consistent with her dynamics, Terry confessed that she didn’t voice her discomfort often in the sessions. She was ashamed that she wasn’t comfortable with them. At the same time, however, “A lot of the biggest breakthroughs

happened through the body. “That sensation of pushing [gestures with palms out] was big for me. I guess for the most part, the parts that were least comfortable probably took me the farthest.”

### *Case Analysis Theme Results*

*Theme 1: Helping clients feel “nourished” by internal resources.* Laurie assessed that Terry appeared “depleted,” with not enough activation in her nervous system. Laurie helped Terry learn how she is organized around taking in nourishment through caring for others, and through that awareness, learn to take in nourishment by accepting love and letting others care for her. Finding ways for Terry to find her internal nourishment to replace smoking or caretaking became a central theme for how Terry changed in this treatment. When Terry was offered a spa weekend right before the end of treatment, she enjoyed herself without guilt.

*Theme 2: Using Physical Touch.* Touching in this treatment offered an important example of how Laurie’s guiding conception interacted with Terry’s needs. Laurie formulated that using physical touch could be an important intervention to help Terry understand her early developmental trauma around lack of nourishment as well as experience the nourishment she never received. However, physical touch for Terry brought up powerful feelings of longing, as well as fear of selfishness; all difficult emotions that needed a lot of resources to work through. Working slowly and with great sensitivity to timing and safety in treatment was crucial in maintaining their treatment alliance across the sessions:

Session 2: They worked to locate anger in Terry’s painful shoulder. Laurie made her first use of touch by gently massaging Terry’s shoulder.

Session 3: Laurie worked with Terry around offering her a new nurturing experience. She used touch with Terry's head by sitting next to her and supporting it. It was very hard for Terry to release herself from the other's perspective and not worry about how the other person was feeling.

Session 4. No direct touch, but Terry associated to being in a cage and realized how desperately she desired touch.

Session 5: Laurie evoked touch by giving Terry a pillow to hold, which helped her connect to her resource of taking care of others.

Session 6: Laurie wanted Terry to experience more nourishment, including using touch by having Terry lie on a pad on the floor and receiving touch.

Session 8: Terry reported that she felt something had "shifted in me." Laurie offered touch, yet made sure to empower Terry to lead where to touch. They worked on her sore shoulder. Terry started to discharge with sighing, and as she had a "resource" image of a raft, her pain lessened.

Session 9: Terry discussed wanting to quit smoking. Laurie taught Terry a physical stretch for Terry to help with cravings.

Session 10: They worked with accepting that it's Ok to be tired and rest. Terry lay down again (not since session 6). They worked on touch with her face and eyes, leading her to associate to a lot of painful memories.

Session 12: Terry realized anger could be a connector. They made touch by pushing hands to feel a physical sensation of a boundary.

As Terry uncovered feelings of anger and sadness, she felt more comfortable experiencing her positive feelings, which also led to her feeling more entitled to the comfort of being touched. It can be hypothesized that she may not be willing to accept a relationship without contact for much longer. However, although this has shifted, Laurie noted that Terry still needs a lot of reassurance. It is unclear if she has sufficiently internalized the change to be able to assert herself in her relationship with Jack.

*Theme 3: Telling the story: Working with narrative versus body.* How Laurie intervened with Terry's narrative remains an important illustration of how Laurie's theoretical framework interacts with the needs of the client. Terry had never been in



therapy before, was 60 years old, survived a violently abusive marriage, and was currently in an unfulfilling “long distance relationship.” She appeared to need to talk. To Laurie, however, a lot of Terry’s storytelling was a defense against connection. How to get Terry out of “story mode” was a big aspect of her intention for the treatment. Laurie holding Terry to her body versus allowing her space to talk was a central friction in the treatment. Although Terry’s learning to support herself through finding and holding nourishment in her body was crucial, telling her narrative may have also helped Terry develop resources. “Sometimes I wanted to skip the whole body thing and just talk,” Terry admitted. How much to interrupt talking to focus on the body illustrated the difficulties of combining verbal narrative and body-oriented techniques in a single treatment and requires much further research.

Another area about which Terry spoke frankly was the difficulties of switching from the verbal to the more physically-oriented modes. Terry admitted that sometimes the transitions between talking and working in the body was hard to manage. There were times when she was frustrated with Laurie cutting her off when she was talking. “Sometimes I’d be talking and I would be in ‘breakthrough territory.’ What do you mean stop?!.” She came to accept it, but it never got easier for her to integrate the work. “I had a sense of discomfort and frustration at first. But then I came to see it that I’m not liking it, but it will be good for me [small laugh].” Knowing when a therapist is working with resistance versus pushing a client’s boundaries too far is very important in BcP work and demands further research with appropriate feedback from clients. Ultimately, though, it mattered less what the technique was than what was the strength of the alliance: “Frankly, there’s a quality that Laurie has...she created a space where I felt safe. I think the nature of the therapy mattered less to me than the quality of her presence.”

### Summary and Integration of Outcome Results

Terry worked on a major identity shift in this treatment. She became much more able to access her inner resources by herself (Theme 1). Her acceptance of the spa was an important example of her being able to accept such body-oriented nourishment. Through their work Terry became more flexible, able to see herself as one who gives and also feels entitled to receive. Both the quantitative and qualitative data suggest that as a result of this BcP work, Terry has become less depressed. This shift could be seen in the therapy room: Unlike early sessions in which Terry had little bodily awareness, over time Terry began to adjust her own pillows, which suggested she felt more entitled to access comfort. And with that comfort seemed to come a greater love and compassion for herself. Overall, Terry increasingly came to know herself and accept herself.

The treatment also helped Terry work on her anger. Laurie formulated that a lot of Terry's sadness, grief, and melancholy came from her having frozen around anger. As Terry became angry, she also felt a new sensation of power; she discovered a new way of being in connection with people such that she was finally able to feel safe enough in her own skin to set a boundary with others. Through the treatment she experienced she could be angry and assertive and still survive.

As both the quantitative and qualitative data indicate, Terry made some important strides through the therapy, yet her work was not yet done. Terry intended to continue working with Laurie. If she will continue these sessions now that the study is over is still an open question. Whether she has shifted enough to be able to give freely to herself remains to be seen.

## CHAPTER VII

## THE CASE OF RAY

*One of my suite-mates, he got really drunk... He would start to bend over, like real tense, like ball up his fists, almost like he'd start to ball up his body. So, I was like, "Man, you got to stretch out, you gotta breathe, man." So, I was like lifting his arms like that, so he would kind of spread out some, breathing in... So I was like, "this guy's got to relax," because he kept wanting to do this [tenses and clenches fists] and I was like, "That's the wrong thing you have to do. You've got to let your body flow" [raises and stretches arms out]. So I was like [to his other helper friend] "Man just hold his hand." So then both of us were kind of like holding his hands like that. All of a sudden, he seemed like way more calm. And he started to breathe much better and then after a while, it was almost like he completely sobered-up and then he was clear as if he hadn't had a drink all night. I couldn't really tell like what was giving me the idea, but it just seemed like I knew exactly what to do. I think like with this session, when you get relaxed and in tune, it stays with you for a while. I think because of that, I could kind of tell, I was more able to respond to the inner qualities rather than just like, "Oh, my God, he's drunk, we gotta get him to bed." I was more like, "He doesn't need to go to bed. He needs to like flow a little bit."*

-Ray, on learning mindfulness, Session 2

## Client

*Introduction*

Ray, a 23 year-old African-American male, was the only client in the study to be referred through the public advertisement, as he saw the posting for subjects on a flyer by his university. Having no previous experience with psychotherapy, Ray had called because he was "curious" about therapy. A senior at a college in New York City, Ray did not identify any acute problems, but wanted to learn more about himself. Ray had taken a

year and a half hiatus from college and had recently returned to college in New York City. As he approached graduation, Ray felt trying therapy could enable him to realize his goals.

During Laurie's initial interview with Ray, he demonstrated an ability to work in mindfulness to a degree sufficient for Laurie to feel the therapy could be productive. They negotiated a contract in which Ray would not pay for the treatment (the original advertisement offered a 50% reduction for agreeing to the research), and instead would complete extra artwork in exchange for the waiver in fee. Ray was an unusual client for Laurie, as he was truly a therapy newcomer, unsure of what he wanted from the therapy, and had neither friends nor acquaintances who had informed him about the BcP work. He was not in crisis.

Ray's case was illustrative of someone from a demographic that rarely seeks psychotherapy, let alone BcP. Ray came from an African-American family in the South, had never previously had therapy, nor knew much about therapy. At 23, he was much younger than the other subjects. He was also grappling with earlier developmental stages of identity and career development than Terry or Jan. As the only man in the study, this case also raised the important issues of sexuality in the transference.

Ray ended his treatment with Laurie after six sessions. We can only hypothesize about how Ray might have changed with a longer course of therapy. This example of an early termination does offer some interesting insights into the naturalistic study of BcP, including what works and what does not, and for which types of clients.

*History of Client ("A" in Figure 1)*

Ray was born to a middle-class, African-American family in the Southern United States. Both his parents were successful professionals. There was a period in Ray's early life when his parents had some marital difficulties, including a year during which his father lived away from the house. During that time there was "a lot of shouting" between his parents. He reported that they reconciled and have since had a stable marriage.

Several times Ray spoke fondly of his father, who used to play sports with him. He described feeling very connected to his grandfather as well, and overall feeling a strong obligation to become a "man of his family." As the eldest male child in his family, Ray explained that this role dictates certain responsibilities and expectations from the family. He explained that he was particularly responsible for his younger brother, with whom Ray talks nightly by phone. He also has an older sister and a younger sister. Ray barely mentioned his mother except in reference to her "working a lot."

Ray described himself in his early life as being "a big trouble maker." He reported that he "liked getting into trouble" and often did not do what was asked of him. During high school, Ray sold drugs, despite the fact that he did not appear to need the money. This behavior resulted in his expulsion from one school.

Ray also had been a very big "partier." He reported having had sexual experiences with many women, drinking heavily, and smoking marijuana regularly. In their pre-study intake, Ray had raised concerns with Laurie about his sexual life, because, until only a few months prior, Ray had engaged in much casual sex – so much so that in the last six months he had decided to become celibate. He had, however, reformed some of his ways. He had taken off from college to live abroad in Australia, where he had a positive and

transformative experience. He had fallen in love for the first time and experienced his first sexual relationship with emotional involvement. He had only recently returned to college prior to joining this study. Back at a mainstream university, he felt different and isolated from his classmates. Ray appeared to be struggling with many issues of identity that he hoped to explore in the treatment, particularly how to manage his lofty goals and romantic ideals while dealing with the constraints of the everyday world.

Ray did not present with a specific identifying problem, nor was he consciously aware of acute distress. Both his lack of distress and not paying for the therapy may have contributed to his having less motivation to meet the requirements of the study. He often seemed not fully engaged in treatment. For example, he arrived at one session with a hangover, missed at least one session without calling, did not return phone calls, disappeared for several weeks and, in the end, dropped out without discussing it face-to-face (it was by a phone message). Ray did, however, complete the final exit interview conducted by the researcher, thus some of his feelings about treatment were known and will be discussed in the exit interview section at the end of this chapter.

#### Assessment (“D” in Figure 1)

##### *Qualitative Assessment*

From the outset, Laurie was aware that Ray had a story unlike that of many of her clients. He was a young African-American male with neither any therapy history nor awareness of therapy in his family. Additionally, unlike the other subjects who were much older and established, Ray had a college mentality, facing challenges regarding identity and career. Ray was also smoking marijuana regularly at the beginning of the study (he quit after session 5), but had sworn off casual sex and was trying to remain

faithful to his spiritual aims. He also had several artistic pursuits, including writing and performing poetry, and painting.

Ray's personality style in the therapy room diverged from the other subjects' more compliant attitudes. He responded to Laurie in a challenging and assertive manner. He made many comments about the physical surroundings of her office, pursued her to disclose personal information to a considerable degree, and tested her extensively regarding whether she was judging him ("Do you think I have a sexual problem?"). To build trust, Laurie subsequently disclosed more with him than with the other subjects. In fact, much of the treatment focused on building trust in their alliance.

#### *Quantitative Assessment*

Table 15  
Ray's Initial SCL-90-R Scores\*

<b>Global Severity Index</b>	63	<b>Depression</b>	59
<b>Positive symptom distress index</b>	51	<b>Anxiety</b>	66
<b>Positive Symptom Total</b>	65	<b>Hostility</b>	62
<b>Somatization</b>	59	<b>Phobic Anxiety</b>	47
<b>Obsessive-Compulsive</b>	64	<b>Paranoid Ideation</b>	59
<b>Interpersonal Sensitivity</b>	63	<b>Psychoticism</b>	64

\*All scores are T-scores with a mean of 50 and a standard deviation of 10. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning.

Table 16  
Ray's Initial TEaM Scores\*

<b>Subjective Well-Being</b>	70.73	<b>Post Traumatic Stress Disorder</b>	61.31
<b>Depression</b>	63.57	<b>Symptom Checklist</b>	60.5
<b>Anxiety</b>	60.71	<b>Personal Functioning</b>	64.55
<b>Phobia</b>	62.62	<b>Social Functioning</b>	66.46
<b>Obsessive-Compulsive</b>	45.64	<b>Vocational Functioning</b>	67.87
<b>Somatization</b>	56.43	<b>Functional Disability</b>	68.37
<b>Panic Disorder</b>	60.84	<b>Behavioral Health Status Index</b>	68.61

\* All scores are T-scores with a mean of 50 and a standard deviation of 10. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning.

Unlike his self-described "problem-free" status, several of Ray's subscales on the SCL-90-R were in the "clinical range" according to the computer-generated report. Ray's

Obsessive-Compulsive subscale of 64 was “clearly in the clinical range, and indicates further assessment as to whether the symptoms may be due to anxiety or depressive disorders, or potentially indicate an obsessive-compulsive syndrome.” The SCL-90-R also indicated that Ray suffered from self-deprecation, feelings of inferiority, and a sense of inadequacy, which the report considers suggestive of a narcissistic disorder.

Ray’s Psychoticism score described “an intense experience with social alienation” which was consistent with his reported experience of feeling distant from many of his peers. Ray’s Anxiety score of 66 suggested either an underlying anxiety disorder or anxiety due to another disorder. Given these data, Ray’s extensive verbalizations might have indicated an underlying anxiety disorder. Ray’s high level of anxiety may also explain his drug dependence. His Somatization score of 59 also indicated “enhanced distress associated with somatic complaints.”

On the Scale of Body Connection, Ray indicated little to no subjective distress. He endorsed such items as “It is difficult for me to identify my emotions” as “a little bit” and “I distract myself from feelings of discomfort” as “none of the time.”

#### *Goals for Therapy: Goal Attainment Scaling*

Ray identified three important goals for treatment. He was particularly focused on advancing himself in his career and through his artistic expressions. He wanted to increase his writing output, so one goal was to be writing almost daily. He also admitted that many opportunities “find” him, and he hoped that such opportunities would continue to increase. Finally, Ray felt he lacked control over his sexual impulses. He had engaged in many casual sexual relations and was seeking to harness his urges and develop a caring



relationship. The first step to prevent further casual sexual encounters, he thought, would be through “going on dates.”

Table 17  
Ray’s Initial Goal Attainment Scaling

<b>GOAL</b>	<b>Writing</b>	<b>Finding opportunities for advancement available</b>	<b>Going on dates</b>
LEVEL OF ATTAINMENT	Scale 1 Importance: 10	Scale 2 Importance: 10	Scale 3 Importance: 10
Much less than expected (-2)	Writing 2 days per week	Less than one opportunity appears a week *	None *
Somewhat less than expected (-1)	Writing 3-4 days/wk *	1 job offer or opportunity per week	1 every few months
Expected level of outcome (0)	Writing 4+ days/wk	2 opportunities/wk	1 date a month
Somewhat more than expected (+1)	Writing 5 days/wk	3 opportunities/wk	2 dates a month
Much more than expected (+2)	Writing 6+ days/wk	4-5 opportunities/wk	Every week

\* = Before the study

#### Formulation and Treatment Plan (“E” in Figure 1)

Laurie sensed that there were two sides to Ray that were important to her conceptualization. One side was that he was a self-described “nice guy” with intense lofty spiritual pursuits. The other side was that Ray was someone with a great deal of aggressive energy to discharge, and little ability to do so. During their pre-session, Laurie had found Ray easily able to access mindfulness and stay with his inner sensations. Also, she admired his impulses towards art and creativity, which augmented her interest in working with him.

Despite Ray's powerful and inspiring intentions, his behavior often contradicted his beliefs. He would speak about many lofty goals within the therapy session, yet outside of therapy he would forget his forms and miss sessions without calling. He eventually dropped out without completing any of the final forms. With his professors and family as well, Ray appeared to struggle with a lot of disconnection between how he wished to be seen and how he realistically acted in his endeavors.

Laurie understood a lot from the pictures Ray created to explain how he envisioned his potential progress through therapy. His first picture of where he started was an atom, described by Laurie as "amorphous, just going from thing to thing, fragmented." His final picture was a tree, "to be rooted, grounded." She conceptualized that Ray had the goal to move from disconnected energy to a rooted tree. Laurie wanted to help him ground himself in safer, more nourishing ways than through sex, drugs, and violence.

Laurie also viewed Ray as very "oral and needy." She described how Ray "pulled" for a kind of mothering and that she instinctually felt like accommodating him. For example, he asked for food in their pre-session intake; she gave him cookies. Laurie assessed that Ray was seeking some sustenance and was curious about what he could find in this treatment. As the treatment developed, Ray became a practicing Muslim who appeared to find sustenance in Islam, eventually to the exclusion of the therapy.

#### Diagnosis

Axis I: Cannabis Dependence, Without Physiological Dependence 304.30  
 R/O Anxiety Disorder NOS 300.00  
 Axis II: R/O Narcissitic Personality Disorder  
 R/O Antisocial Personality Disorder  
 Axis III: None.  
 Axis IV: Returning to school; becoming religious  
 Axis V: GAF= 58 (Current)

## Strengths

Ray demonstrated important strengths in several areas. Through his stories and pictures, Ray exhibited a highly artistic, inspired, and poetic soul. Ray determinedly sought “pure truth” above and beyond convention that, although it often got him into trouble, also challenged conventional expectations for what one might expect in life. For example, he spoke of spending nights in Australia sleeping soundly on the beach and rising to greet the morning sun. Not willing to live according to the norm, Ray attended college in a non-traditional way and then, by accepting Islam full-force, continued to embrace a non-traditional path. Having been accepted at a prestigious university, he also clearly had intellectual strengths, which were further evident in his desire to write and seek exceptional opportunities. Finally, his loyalty to his family and community demonstrated strength. Of all the subjects, Ray appeared the most located in an ancestral story in which, although there were many pressures placed on him, he also drew on a wisdom and power of his African-American forbearers as he quested to find himself in what he considered a confusing and conformist world.

### Action (“F” in Figure 1)

#### *Session One: “Do I have a problem?”*

From the first moments of this first session, it appeared that both Laurie and Ray were aware of the power differential between the therapist and client. Laurie, who wanted to create safety, worked hard to help Ray feel comfortable. For example, Ray wore his shoes throughout this session. Since her clients generally remove their shoes before entering her office apartment, this was already an indication of Laurie’s pull to meet Ray without enforcing her regular boundaries.

Additionally, it became immediately apparent that Ray “needed to talk.” Laurie wondered to what extent his busy, professional parents had ever really listened to him. She sensed Ray would need a lot of time to discharge, as well as for her to understand what would calm him and give him nourishment.

In response to the unspoken authority dynamics and awkwardness about this “strange situation,” in the beginning of the session, Laurie encouraged his talking freely in order to create an environment of safety. Ray jumped in right away and started asking Laurie many challenging questions, including queries about her spiritual practices and drug use. To send him a message of safety, Laurie responded directly to his questions, implementing self-disclosure and revealing some elements of her personal life, including her age and some aspects regarding how her parents viewed her.

C: Did they [Laurie’s parents] know you did drugs?

T: Huh?

C: Did they know you did drugs?

T: A little bit. But they weren’t that interested. They were preoccupied with their own problems.

C: Aw, I see....

T: I was...compared to my peers, I did...minimal.

C: Oh really?

T: Oh yeah

C: So, when were you a teenager?

T: Before you were born; you’re 23?

C: Yeah. So, you grew up in the 60s.

As Laurie openly disclosed certain aspects of her past experiences, her intention was to send a message to Ray that it is safe to disclose. He segued organically into his history.

T: I was born in [place].

C: Ah, that’s how old my parents are...they were, um...

T: Your parents grew up in [place].

C: My dad grew up in [place] but like my mom moved around because her dad, was in, I guess it was the army. It was one of the...military...

T: Mmm.

C: So, she went to high school in [state].

T: [that state]?

C: Mm-hmm. I just, I don't know if that's where he ended up. At a certain point...Here's what's going to happen. They were like, the army kept moving them around...and then 'we want to send you all to Germany.' And then my grandma, was like no, so I think he retired, and then, so the reason they are in [state] is 'cause they went, no, my mom went to law school. They both went to college in [state]. 'Cause my mom was too young to go away to school. And so, that's where they met and....

Without any prompting, Ray continued to divulge his history. He discussed the town in which he grew up. As he jumped somewhat from topic to topic, his speech was rapid and slightly unclear. At one point, as he remembered the restaurants in his hometown, he referred to "nasty food" with some aggression. The concreteness in Ray's verbalizations offered clues to his character organization.

C: Yeah, It's pretty nice, I mean, we pretty much got there. I don't think, I wouldn't say that about it now, because it's being a...it's market's a focus now of like corporations, so, it's a lot...a whole lot of construction going on. That's what made it nice, was like the quietness, the smallness of it. Because it's a regular...I mean it's a full-sized city, like everything is there. But like, when I was younger, you really feel like you just knew everyone, you know. And ah, now... now like, there's nothing but restaurants in [town]. And like, seriously, well there's shopping centers too, so like, there are so many restaurants. They're filthy. They're serving nasty food. So, yeah, it's losing its touch, but uh...

Laurie stayed with his experience and followed with encouraging him to find inner resource. When Ray talked about the aspects he disliked, she brought him back to what he liked in order to understand how he finds nourishment (Theme 1). Ray responded to her redirection; he associated to his childhood neighborhood with a powerful nostalgia, reminiscing about how much he enjoyed his early life and community.

T: But growing up there?

C: **Growing up there was the best.** Yeah.

T: **What did you like about it?**

C: **The one thing I didn't like....**

T: **What did you like?**

C: Oh, what did I like. Okay, uh...Well, I liked it because our neighborhood was like real mixed. And I didn't really appreciate it so much until I sort of got a little older and traveled away from the neighborhood and stuff....I don't know, like. We used to all like, everyone, there was a pool...a main pool and basketball court. We used to all be there. I mean all, I just say everyone because it was just like everyone I knew. You know what I mean? Like, it just felt like everyone was there – And all my friends. None of us really thought about that....but looking back, I'm like wow, 'cause some of them were Indian, obviously, Black,

Hispanic, and White, and Asian. And like, I didn't like, like really notice the difference that there were differences...like...or I don't know...

As Ray described his strong feelings of belonging in his early life, Laurie began to wonder about what his life has been like since he left that neighborhood. Although not directly addressed, one might wonder about how, as an African-American male in the United States, Ray has found the comfort and safety in other communities since his early multicultural one.

T: A very multi-ethnic environment where...

C: Yeah, it was just pure luck.

T: A kind of acceptance...

C: Yeah, it was just pure luck. 'Cause that's all that my parents really wanted. They're not...they just... want a quality of life and they don't really care who's in it; you know what I'm saying...as long as you're doing it right, it doesn't matter what you're doing, sorta. So, they're just like glad that there a lotta kids that we can kinda be friends with around in the neighborhood... 'cause it's easy for them, they don't have to drive us nowhere. They don't have to worry where we are... 'cause we're just somewhere in the neighborhood, you know what I mean?

As Ray talked further about the neighborhood, it became clearer to Laurie how important these early experiences of blending in and bonding with others were for him. His descriptions about this time in his life were filled with affect and longing. Interestingly, he also inserted that one of the highlights was "gunfights," where aggressive feelings were safely expressed between friends.

C: Yeah, for example, until when I was in kindergarten, until about, I guess maybe like 9<sup>th</sup> grade, we lived in this house. You know what a cul-de-sac is?

T: Mm-hmm.

C: Okay, so like, so like there's this street is kinda narrow, just like that. And our house was at the very bottom of the cul-de-sac. And then like...but there were kids like so our whole block it seemed like, almost every house had kids our age...y'know, kids we could just play with and stuff. The whole block used to get together and we'd have gunfights. One kid had a set of toy guns. Some of the lots were not built yet, so there was like construction stuff going on sorta. So, like, so we could even make like little fortresses and stuff like that. And then...after I was like probably third, fourth, fifth grade then we used to play more sports, more than just games. It was the same thing. We never had to leave our street, really. Sometime we did because we had other friends around, but like our elementary school we just walked to school or rode our bikes. And the same thing, it really was just like happy...

Laurie reflected the positive sentiments in Ray's story.

T: It sounds like a very happy childhood.

C: I mean, stuff went bad when we were kids...but that aspect of it...I had so much fun growing up, especially when you have three brothers and sisters. I mean that's like automatic friends. You know what I mean. I had a good time...yeah, just like... as I think about it now, I really had a good time.

In her assessment of Ray, Laurie acknowledged that she felt it was important for Ray to discharge this information. She did not want to interrupt his telling of this story, as he appeared to be “leading somewhere,” and since they were building trust, it seemed important for her to follow his lead. Only after Ray spoke at length and discharged about his early life, did Laurie bring his awareness to his body. He responded with some affect, yet quickly returned to his story (Theme 3).

T: What do you notice now when you check in with your body right now as you think about those good times?

C: I feel kinda giddy almost. Almost like I just want to run and play, 'cause we were talking about playing. I get nostalgic about home. And uh...I almost feel...sometimes I almost feel sad. Not 'cause of bad things that happened, but just 'cause like, it's just like a time that will like never come again, you know? But right now I don't feel that way.

T: So a precious time in your life.

C: Yeah, it's so precious. And like, I don't feel anything negative. But it's just sad just because it's gone. You know what I mean? I don't wish I had a gun now or something. It's just, it'll never happen again. That's like unbelievable...y'know?

Unlike with her other clients, whom she brought and kept with their bodily experiences very early in treatment, Laurie decided to meet Ray's need by continuing to follow his story. As Ray continued to give information, he introduced some important content about how he connected with his inner resources in his early life: by getting into trouble. Ray disclosed his long history of trouble-seeking.

C: I used to get in trouble, but not really with like my friends. Like, I don't know, I guess like, when my friend like, we all sort of got in trouble, but not really with each other. We went somewhere else to get in trouble. All we did together, in high school was just play basketball and just talk about girls, like that's it. We went somewhere else to get in trouble.

T: When you say trouble, what was constituting trouble?

C: Oh, well, um...

T: Trouble...

C: Well, like I got kicked out of school when I was a freshman. Two of my friends got kicked out when they were seniors and then...

T: In high school?

C: Yeah

T: For what?

C: Ah, **for dealing drugs. So, yeah...that was kind of the low point in my career...**And then, um, what I mean by saying on our own...I didn't really...None of my...I guess a couple of my friends ah... smoke weed. **That's what I sold, not crack [laughs].** A couple of my friends smoked weed, I didn't really talk to them about it, I didn't really talk to anyone about it that didn't need to know and so uh...

T: So, how'd you caught?

C: Well, I just got told on. Somebody else got caught and then they told on me, so,...you know? So at that point like...certain things like I guess. **'Cause I was always bad, like even in elementary school, I was always getting in fights ... I was yelling at teachers, not listening to teachers, like, just anything. I seriously sought out things to do.** At the same time, my parents loved me because I was nice and I was polite because in my house I was raised...so...they were just kinda like alright...he's just...

T: You had this mixed thing. You're a nice person, but you had some anger and aggression.

C: Yeah, yeah, yeah, A lot. **I used to be really angry. Yeah. I used to be really angry.**

Laurie wondered what triggered so much aggression in Ray in his early life.

T: Was there anything, in particular, you can remember that happened before you started to get angry?

C: Um.

T: Like anything happening in your....?

C: Yeah, my parents used to fight a lot. And, um, our house, it wasn't that stable like...things were always like....sort of fucking up. Like, I don't know, I can't really describe it. But it was like, you couldn't never really, you could never be relaxed. It was always like, uh...

T: Some tension in the house?

C: Yeah, I'm trying to describe it. It's like, you couldn't never get a solid footing because stuff would always change or like the ball would get dropped or stuff all the time. You know, just like, you never knew when you were going to have a good day 'cause then if your parents fight and then like all your, everyone in the house is upset, really... And as a kid, you don't feel like there is anything you could do about it.

As Ray described his parents fighting, Laurie continued to listen for indicators of early trauma in his childhood.

T: So pretty helpless?

C: Yeah

T: When your parents were fighting, they argued when you were little?

C: Up until like 9<sup>th</sup> grade they had like serious problems. Like, um, I mean like, they...they...separated for a while and then um...you know...

T: You lived with whom?

C: Well, I lived with my mom. But my dad...he still lived in the same neighborhood. My dad had an apartment right outside the neighborhood. So like, he was there every day for some reason, they were beginning to get along. But just because we get along, we should live apart for a little while to make sure it's solid...I don't know what they were doing...

T: Did it work?

C: It worked.



T: Are they together now?

C: Yeah, yeah, yeah, Uh-huh.

T: They are happy now?

C: That was only like a year, when I was in fourth grade and so... **I just got pleasure. I literally enjoyed getting in trouble. Like, I don't know any other way to describe it.**

As Ray described getting into trouble, Laurie noticed he shifted into a “happy, energized state.” Ray actually became quite activated, joyful, and in touch with his inner resources, when describing being obstinate.

C: Even though getting punished, it was like, I would wait it out, it's worth it. Anytime, **I was like, it's worth it. Not a question, it was never a question, it was worth it. Whatever happens, I was going to do it.** And I was like, what ever happened, happened.

T: So, the punishment wasn't...

C: I used to get my ass whopped. [laughs]. It was hurt; it was awful. I just...I didn't care. I was like, that's just the price you pay. I mean, if you have \$10 and you're hungry; so you've got to live with the fact that you no longer have \$10. I mean, that's just how it is. So it's like, is it worth it? But I will, **yeah, it's worth it.**

T: It was worth getting your ass whooped

C: yeah

T: To be rambunctious.

C: I just...

T: What kind of thing did you enjoy doing that...

C: **I liked breaking any rule**, so like any...

T: Breaking any rule was fun for you...

C: Any rule that was there, I would break it. So, if the teacher said, “alright class, like, we're all going to the cafeteria to watch some video....I would, **“I'm not going” and I wouldn't.** I was almost like I wanted to sit in the classroom. I just couldn't go. I would just sit in the classroom until they got back. Just like, things that...some stuff I did out of pure energy, like, didn't have an intent in mind. I would be hyper and would yell something out that isn't like appropriate or you know, things like that.

T: You were kind of a comedian.

C: Yeah, yeah...a comedian and also some of it. Some things I said just to be funny. And some stuff I just did I wasn't really thinking about it... Sometimes, I'd just yell and I don't realize it. **I'm just hyper, so like, I don't really realize.... I guess I scare people sometimes.** Not so much now. Just because I'm like so hyper, I guess some people they take it as aggression or something. So, you know, there's a lot of people that are like...

At this point, Laurie chose to highlight Ray's “hyper” state of high activation.

T: You have a lot of energy.

C: Yeah.

T: You've always had a lot of energy?

C: Yeah, as far as I can remember...yeah, I mean, as far as anyone remembers...my parents and stuff...my other relatives that know me before I can...

T: So, so based on the meeting we had...

C: Mm-hmm.

After acknowledging his high energy level, Laurie brought Ray's attention back to the study. Evoking the study explicitly was a distinctive intervention, unlike any she used with either of the other clients in this study. Laurie formulated that Ray needed more "grounding" and "containment," so she often invoked the study as a way to contain some of his energy within the boundary of their roles.

Ray's style of responding to Laurie also differed from the other clients. As Laurie shifted their focus to the study, which also refocused on their authority relationship, Ray responded by asking Laurie a very direct and probing question about whether she thinks he has "a sexual problem." The motives behind Ray's challenging question were unclear. Most likely, Ray had anxiety about this issue, and after discussing many early memories with Laurie, he felt safe enough to share his concern. Yet the question seemed a test to Laurie. Through this inquiry, Ray forced her to choose between diagnosing and pathologizing his sexual drive or normalizing it.

T: Do you have any questions now about this study?  
C: Yeah, do you think I have sexual problems?

Laurie decided against labeling Ray's challenges with sexuality as a problem, but rather explained it as energy discharged in a way he has needed to self-regulate. Additionally, she framed his sexual energy as a theme that could be discussed and explored without shame within their therapeutic relationship.

T: You're asking me? If I think you have sexual problems?  
C: Yeah, because we talked yesterday....last week about like some of my little thoughts and stuff like that. I really, I don't necessarily feel insecure, but at the same time I wonder and I figure, you've probably talked to people so much, that like, you would know. You know? Not do I have problems, just what do you think about my thoughts or my sayings about sex, from our last conversation? Like, what impression did it give you?  
T: **Hmmm, well I think, I'm interested in getting to know you better.**  
C: Mm-hmm.  
T: But, based on your trips in Australia. I got the feeling on your being in Australia, you had a lot of different interactions with women in Australia.  
C: Yeah.

T: You were kind of, were fancy free.

C: Yeah.

T: And you did have sex in Australia.

C: Yeah, yeah.

T: **I just got the sense that you know, you're just taking some time now just be with your own energy. I didn't consider it a problem.**

Unwilling to categorize or judge Ray's behavior as essentially problematic, Laurie appeared to have passed the test. Ray appeared relieved and encouraged by Laurie's normalizing his sexual energy.

C: Yeah. I don't think it's a problem either, but it does seem a little weird. Not to me, but to anyone else. They're like, "What do you mean?" Like you know, when we'll be talking to the girls. For example, last night I went to a bar and my friend wanted to talk to a girl and they were like cute, but...I'm like. And he's like, "What, why don't you want to talk to them..." What I was really trying to say is that I have standards, you know, like. It's not enough, just like, "Oh! she's cute, let's hook up..." That's just not enough. Like, you know, So, um, it's hard to explain, because I don't know. Man, I guess in that aspect, I've matured a lot ahead of most guys I know.

Despite the fact that neither labeled him as pathological, Ray's main issue appeared to be having significant amounts of energy (e.g., sexual, physical, anxiety) and finding appropriate ways to discharge this energy. In the past he had mainly used marijuana or sex; now he was looking for new ways to contain his internal energy.

T: You're looking for something more meaningful?

C: Yeah... 'cause I talk to girls about...like...I just tell them...yeah, y'know, if it comes up...I'll say, yeah, I actually haven't had sex since May on purpose..... They're like, "why, what guy doesn't?". You know what I mean? I think it's important for girls to know that because most girls, because of like to... either the way they've been treated, or seen others, that's that they've come to expect...There's more to it. Since I know that and since I'm living that way, I think it's important to show that example. Not to make anyone do anything, but just so you realize there are options. Like, you can expect more from guys. And guys, same thing, you can expect more from yourself.

Ray continued to discuss ways he has tempered himself, such as through his current state of celibacy, as well as fasting. This exchange helped Laurie assess that Ray had been able to contain and control some of his energy.

T: What would you say if you were talking to say, a group of men now about values and being sexual and what you have learned.

C: Well, what I've learned, which I almost knew before I learned it, is that um, like that you really are like in command of yourself. Meaning that...um... like you don't, like you don't just have to like give, you know what I'm saying, to every urge. And there's nothing...there's nothing really... sex isn't all that. It is all that, but at the same time it's not. Like there's so much more to life, to really be thinking about...there's so much more, um, you can be doing internally...but you won't, because for some reason, sex just becomes everything, I don't know. It's a great distraction. So, it will always be there, it will always be a distraction. **But, I don't know, like it just needs to be tempered.** I don't tell anyone what to do or what not to do. But my whole thing is just suggestions of what to think about. Because everyone will make different decisions based on what they know. And different things make different people happy. But my reasoning is, **I wanted to let, really have, command over my life by sacrificing things. So like, I fasted for a while. I did a fasting routine actually for a few months and, um, I still do sometimes. I really feel like, I was...I felt more free, as well as stronger because of it.** And then I began to do other things, like, even though you're hungry, if you know you're not going to eat, something about it, just opens your mind up. I can't explain it. And the same thing with sex. I'm just like, this is one thing I'm going to sacrifice. I didn't think anything was like wrong. I wasn't having problems or something. I am just going to give it up and just let it go. Just to, you know, just to see what happens. And I feel stronger now, I really do....

As Ray continued to talk at great length about his sexual and personal control, Laurie redirected him from the story (Theme 3) to the study by asking him about the forms that he has been asked to complete. This intervention again was a way to bring him back to the framework of the session.

T: Do you have forms from last time?

C: Yeah, oh sorry.

Laurie's rearticulating the formality of the arrangement quickly caused Ray to react to her authority in a defensive and challenging manner. He returned to asking Laurie probing, personal questions and testing her values.

C: Oh, Ok.... Where did you grow up again?

T: In [place] in Long Island...

C: Oh okay. **What do you really think about weed?** Like you used it, you stopped, you've been around others who have?

Again, Laurie seemed transparent enough to "pass" his test, so Ray continued. As Ray became more animated and activated in discussing his affinity for marijuana, Laurie

brought him to his bodily experience, all the while trying to understand the nature of his desire for drugs.

**C: I don't think I'm addicted, but I LOVE it...** I don't smoke all the time, but when I do, it is like everything. It's everything. It's so tight.

T: What is it? What does it make you feel?

C: It's just like...you know, it just feels good. And the way I make sense of that is, like, what does sugar taste like? It tastes sweet. It doesn't taste like that...but at the same time, sugar doesn't have its own flavor, and when you put sugar in something, 'oh it doesn't taste like sugar, it just tastes sweet.' It just feels good. I've done things. Um, well, I can't think of much things I haven't done high...But like, so some things I've done, and on top of all that, I was high. You know? Something about it, I don't know, it just knocks things up a notch. And also, like for my mind, I think a lot when I smoke...but sometimes...or really all the time, but sometimes I think out loud and sometimes I don't...but uh....

Laurie again stopped Ray to bring him to mindfulness, and Ray readily responded with his bodily sensations, connecting his high energy levels with his sensory experience.

T: So, let's check in for a minute and kind of, and see where you are.

**C: Okay, I'm all tense, man.**

T: You're tense.

C: Yeah, I'm excited. [laughs]. I'm not like tense, but I'm tense because I'm excited. [leans head back]

T: Let's just take a moment and see what it's like to just check in with how...

C: Close my eyes?

T: It's like to check in with and experience the sensation of tension and excitement in your body as sensation. And just give yourself some time to notice your hands, your arm, the movement of your breath. I'm going to talk to you a little bit about mindfulness.

Mindfulness is the ability to observe your experience and to be in your experience and describe to me, in a new language, what's happening in your body right now.

With very little coaching, Ray was able to describe his bodily sensation in very specific language, including his state of flexion in his muscles.

C: Well like, physically, I mean, I can feel my heart beating. And like, you know, like, my arms, like even my breathing, it feels excited. Like, I don't know, I just feel really excited. And um...

T: And when you feel really excited...

C: Uh-huh.

T: **What's the sensation in your body?** How does your body participate in the experience of excitement?

C: **It's like my muscles are like half-way flexed.** Like, you know, you could flex it all the way, or you can relax it all the way....but they're like half-way flexed. Every single one in my whole body. Even my hands and everything are all like half-way flexed.

Ray followed his description of feeling “half-flexed” by depicting a readiness to spring, almost like an animal. Interestingly, Ray’s image of the animal ready to leap fits directly with Levine’s (1997) descriptions of the frozen trauma state, in which someone is activated, trapped, ready to spring, but unable to complete the motion. Laurie wondered about the nature of Ray’s high activation energy – whether it developed from a trauma state of activity, in which Ray was frozen in a fight/flight reaction and must learn to discharge his energy in order to self-regulate.

T: In between full flexion and relaxation.

C: Yeah, I guess if I’m fully flexed, you’re almost like constricted. It would be uncomfortable, but they’re just like half-way flexed. It’s not so much that I want to spring, or something, **but I feel so ready to do like, anything...**

T: So there’s readiness.

C: Yeah.

T: Readiness to do anything?

C: Yeah.

To bring Ray back to his bodily experience with mindfulness, Laurie integrated a psychoeducational component to the therapy by suggesting a “menu” of possible experiences – cognitive, affective, imaginal, memory, or impulses – that he might notice.

T: Just hanging out and observing the sensation of readiness, the feeling of readiness, the quality of energy in your muscles ....and in between full flexion and relaxation... and just giving your body and your soul time. Just notice what it’s like to take a little time to sense and observe what’s happening in the present moment. **You might notice a shift...you might notice something changing energetically....changes in your breath...changes in how your body is experiencing gravity...you might notice an image or thought or feeling or even a memory...or you might have an impulse...**

As Ray became more mindful, he described an experience from the previous week directly after he and Laurie met for their initial pre-study evaluation. Apparently, he had become so activated by being in mindfulness during that intake meeting that afterwards he skipped all his classes, played basketball manically, and ended up punching a wall.

C: Yeah, well, man, yesterday when I told you, or last week when I said I wanted to play ball and I also had this image of smashing a mirror. Right after our session, I went and

played ball. **I just HAD to. And then I missed a lay-up and I wasn't mad, but like, I was just so excited, that I just punched the wall and I fucked my hand up.**

**T: Oh my God!**

C: Yeah, I know [laughter]

C: I know, I had to get X-rays, but it was just a bruise. And uh, yeah, sometimes...I just, so like, now, I feel like real uh, not the same way, like it's going to happen again. That's why I remember like, I remember I felt this same way last week because. **Like I somehow feel that feeling last week, let...maybe because I became so conscious of it due to our session, basketball came on my mind so strongly that I skipped all my classes the rest of the day, yeah, that was Thursday, so I skipped all my classes and played ball for like three or four hours. And uh, I just had to man. I remember it so strongly because it stood out in my mind so much last week...**

T: When you go back to the memory of going to play basketball for those three hours, how would you describe to me what you see when you see yourself on the basketball court?

In this excerpt, Ray revealed important diagnostic information about his struggle to self-regulate: Ray appeared unable to “tame” or contain his energy in constructive ways. Laurie wanted to help Ray understand his triggers for his high activation and potential calming strategies. As a first step for him to better learn to regulate his own nervous system, Laurie started to encourage Ray to slow his pace down in order to help him notice his bodily signals.

T: So as you remember the feeling of being slower and playing on a new level....

C: Mm-hmm.

T: And check back in with your body right now, right here...As you remember your experience of feeling in tune with yourself in a new way...your instincts, your impulses, what do you notice happening right now in your body?

C: Well, I feel, ah, I feel myself calming down...just a little bit, like gradual...

T: So as you observe that gradual process of calming down and just notice any subtle changes in your breathing, in the flow of energy, in your chest, in your arms, give your body time to feel the sensation of calming...Where do you notice that feeling of calm?

C: It's like right there. **[client gestures to center of chest]**

Despite his “blind spots” as to consequences of his behaviors, Ray was very capable of locating and articulating his bodily sensations.

T: Ah-hah. Right in the region of your chest. Does it have a shape to it?

C: Nah, but it's like, something like, it seems to like all, whether I'm either tense or calm, the tenseness will dissipate from there or the calmness seems to like dissipate from here **[client gestures to chest again]**. I'm not sure why.

T: You don't need to analyze anything or understand right now. It's okay to just experience and feel and sense. So as you notice that place in your chest where you're witnessing the sensation of calm, organically...and just notice what happens next, anything at all....

Ray discussed his common experience of “spacing out,” and how important “spacing out in class” was to him as a way to follow his own body’s “rhythm.” Again, Ray appeared to be struggling with finding pro-social versus anti-social ways of regulating his nervous system, while still maintaining his creative and artistic non-conformist impulses and behaviors. He then mentioned a professor who “picked on him.” His relationship with this professor became a theme throughout treatment. Ray’s description revealed a somewhat sexualized way he interpreted how she acted towards him.

C: It’s not like I’m like, oh, forget you all, and I’m just going to space out...I still will be thinking about... it sparked something in me...class discussion is going somewhere else. So, it’s like I’m basically not participating. So, I mean, one of my teachers, it bothers her. **But, I think she picks on me because she likes me. I don’t think she picks on me in a negative way. But, I think she points stuff out like that because she likes me, I don’t think it bothers her at all.**

Following these remarks, Laurie did not encourage additional attention towards Ray’s professor, but instead returned to his having punched the wall. She wanted to assess whether their therapeutic work was too intense for him, and determine whether he would get too activated and be unable to calm himself down. Laurie decided to go back to helping Ray access his inner calm and resources (Theme 1). The passage below illustrates Ray’s development of an image of his inner resource. In this example, it is possible to see his poetic, romantic side of strength. As he lay on the beach with the sun on his forehead, he had a powerful sense of embodiment, pleasure, and calm. The challenge for him was how to integrate his competing impulses.

T: So just checking back in, with the sensations of your body, we’re talking about calming, we’re talking about the ability to rest, feel sort of quiet...and we’re also talking about what gets you more activated, what makes you not want to stay present...we’re just kind of exploring a little bit...As you check back in with the sensations with your body, do you notice anything changing or are they staying the same?

C: Um, I don’t know, about the same. Like, I’m just pretty awake. So, I don’t feel, like, changing that much.

T: When you feel pretty awake, what do you notice?



C: I just feel pretty fresh. Sometimes, like, I'll be hyper, but I'm actually tired, but, like, I still have some energy, even though I'm sleepy. **But when I'm awake, I'm fresh, I feel like I'm beaming, y'know? That's how I feel now,** when sometimes I just feel a little energetic.

T: So as you allow yourself to enjoy the experience of being awake and beaming and fresh. Sometimes we refer to this as more feeling resourced or empowered in your own being. When you're in this place of feeling awake and refreshed... what image reveals itself to you in this place?

C: Um...like, **I feel as like the sun is shining on your forehead.** Cause like that wakes you up when it's hot, but it also puts you to sleep. Like if you're at the beach, for example, 'cause I used sleep outside a lot when I was in Australia, so I used to notice this. The sun will wake you up, because it makes it hot, at like 9:00 in the morning. But then, at the same time, if you're lying at the beach, it puts you to sleep. I'm real, I feel real awake, but at the same time I know I'm going to be tired soon. I didn't get that much sleep last night, I'm just wide awake now. The same thing waking me up. It's just 90% waking me up and 10% of it is also causing me to be a little tired...I know that balance is going to shift and eventually I'll want to sleep, like take a nap. I feel like I'm at the beginning of a cycle...but the whole cycle involves that shining sun on your head and just warming you up.

Now that Ray was calmer, Laurie brought his awareness to the moment before he hit the wall. She wanted to make him aware of the sequence of his impulses, thoughts, and actions. Despite her slowing him down, he did not appear able to examine what the impulse was that led him to hurt himself.

T: So, when we work together, we're going to be going between some of your personal history and what's going on in your life in the present and then back into your body. So when you tell me about your basketball experience last week, and how smooth you felt, and there was this moment when you sort of got angry and your hand punched into the wall. **I'm just going to ask you to go to that moment right before you got angry and right before you felt that impulse and punched the wall. What do you remember? When you go back to that moment before you hit the wall.**

C: Right before I did that, 'cause I missed the lay-up, **how the fuck could that happen.** [laughs]. It's like...

T: You missed the lay-up, and you had a thought, "how the fuck could that happen."

C: Yeah, you know 'cause like my momentum was...so, there's a wall behind the goal, like here's, here's the goal. If you're traveling toward the goal, like, you're going to be naturally headed toward the wall. So, when it happened, I was like, What! Damn! I don't know, **I guess it was like in protest. I seriously punched the wall in protest.** [laughs].

T: Protest because you missed the lay-up?

C: Yeah, yeah, I was just like, how the fuck did that happen? I guess I asked the wall, because there is no one else you can really ask that question to like...

T: So, you kind of had that thought, how the fuck could that happen and you just, your arm just moving forward toward the wall.

C: Yeah, I didn't think to do it, in other words. **[client shakes head]**

T: Mm-hmm, you had no thought.

C: Yeah, yeah, yeah, I didn't think to do that at all. I don't really remember being conscious of doing it until like...

Since the session was nearing its end, Laurie reviewed the session's content as a way to educate him more about the process and reflect on his reactions across the session.

From her comments, Ray related to a nourishing image of being with his friends.

T: Before we complete, just kind of check inside with your hands, your body, and notice if there is anything you want to remember to take with you from our time together today...**Any highlights for you in this particular session?** You talked a little bit about your mom, your dad, your childhood, joy and kind of the nostalgia of growing up, and having your friends close by. We talked a little bit about how you kind of like to make trouble and how it's kind of fun for you...

C: Mm-hmm.

T: And you're willing to take the punishment because pleasure of being rambunctious and protesting was more special to you. We talked a little bit about how close you feel to your brother, your siblings and a little bit about your mom and dad and kind of growing up and hearing some of their arguments...and we connected that a little bit with when you started to feel a little bit more angry or boisterous. Your dad kind of leaving and coming back, kind of staying close to the family. You asked me a little bit about my opinions about your sexual energy and how you sort of see that by fasting or sacrificing certain things, you feel stronger for it. It's a way you experience your own strength by withholding certain things. For you, you had lots of opportunities to be sexual...and right now your values are more about the person. You're not necessarily running on instinct. You don't need to conquer women right now. You talked a little bit also about school and some parts are more boring and you don't want to sort of sit still and have these impulses to move and we explore more where that comes...I'm interested and curious in when you really feel the flow of energy and when you start feel, we call that a little activated, the energy is strong, and you have the impulse to run or play ball or you just don't want to sit in class... part of your impulse is to get out of the situation. I'm curious what's going on the point at which you lose the feeling of pleasure. I'll probably talk to you a little bit about self-regulation. Self-regulation is sort of like the ability to observe what's going on in your body. Like when you went and you hit that wall.

C: Mm-hmm.

T: You just did it, it was instinctual. And thank God, you didn't really cause too much damage. **But sometimes, before we have an impulse, and we do something that's hurtful, if we learn how to stay with the energy, it will discharge, it will go through the body....** Energy going through the legs or through the arms, so we'll kind of explore that over time. **We know that in the session, as you paid attention and entered mindfulness...**

C: Mm-hmm.

T: **...your body started to change states, just by paying attention. Things kind of regulate. But it does mean sort of taking your awareness off of the external world. So, anything that you want to remember about our time together I just reviewed?**

C: Yeah, because I'm going back home soon, so I really...you know, I think, this is something I really want to do...is to let some people I'm going to see know that I really do appreciate them.

In the last moments of the session, Ray raced to tell more story, while Laurie hinted that it was time to end. Ray's naïvete towards therapy could be seen particularly when he

asks if he can open his eyes. In this awkward interchange, it was hard to know what Ray was thinking about the BcP treatment thus far.

T: Okay, great. So we will continue...

C: Open my eyes? [laughs] Yeah, I didn't want to break the thing.

T: Yeah, that's a transition when you open your eyes from being inside...So what do you notice as you come back into the visual world?

C: I forgot what everything looked like, but then when I see it again, it's like being reminded rather than remembering, almost. So, it's like I didn't remember it until I saw it. There is a certain...there's an essence that stays with you about things, but that sensation of it goes. So, even though the sensation of it goes, my relationship with it was still present. So as soon as the sensation comes back, I'm completely familiar. You know what I mean?

Laurie asked how Ray was feeling one more time to make sure that he would be leaving "contained." Ray used the question as an opportunity to talk about how sexually charged he felt. A pattern of how Ray associated many of his feelings with his sexual energy was becoming apparent. In this session he linked feeling calm to his sexual feelings, and in a later session he felt his aggression towards his professor as sexual (he was very frustrated with her, and yet he wanted to "f#\*k her").

T: So, how are your feeling right now? And you were you able to still kind of feel the calmness in your body?

C: Yeah, yeah, **I have to admit man, I've felt really, really felt a lot of sexual tension lately. Like, it's unreal. So, like, even when I feel calm, I still feel like it somewhat.** I feel like I'm going through a growth process and it's making me horny, you know what I mean? I feel like I'm growing, like I've been so hungry. Even like my nails have been growing like real fast and stuff. So like....

T: Yeah, so when I meet with you next time, maybe we can pick up with this.

C: Yeah, I don't know what to do about it.

T: This is the first time you're mentioning it to me.

C: Yeah. We should talk about it more. That's pretty much the most interesting thing on my mind right now.

T: So maybe we can start with that next time, what is the tension or the sexual energy...how can you metabolize it.

C: Yeah, let's definitely do that. [small laugh]. Because it doesn't bother me, but at the same time it's very occupying. So, yeah, I don't mind talking about it at all. Cool.

T: Cool.

### *Monitoring Evaluation of Session One ("G" in Figure 1)*

Laurie wanted Ray to attain greater self-awareness through mindfulness, particularly in regard to how his body has its own language. Yet from the very first session, Laurie

saw that when Ray became mindful, he could not contain the energy. For example, as soon as he had felt frustrated, he had punched a wall. Furthermore, that energy led him to antisocial behavior: he had skipped all his classes and played basketball instead. Laurie wanted to help Ray express his energy in safer, more regulated ways.

Laurie also noticed how Ray would tell lengthy stories, “spaced out” to anyone but himself. Ray’s tendency was to become lost in his words and no longer aware of being in a relationship with others (Theme 3). Interrupting Ray’s lengthy monologues and bringing his awareness to his body as well as to their relationship in the room became important in his treatment.

Interestingly, physical touch did not thus far arise in Ray’s formulation or treatment (Theme 2). Ray was so activated – and since touch often brings more stimulation to a person’s nervous system – much work needed to be done without physical contact. In addition, Ray’s developmental deficits were not yet clear, and thus further exploration would be necessary before introducing touch. Finally, the complication of a cross-gender dyad in the alliance suggested being very cautious with touch in general, and particularly with Ray, given his hypersexualized dynamics.

#### *Sessions 2-5: Summary*

In these middle sessions, Ray worked on issues of identity. He explored his goals for his life, how he was trying to make behavioral changes in his life vis-à-vis his relationships with women, and how to direct and contain his energy in different ways. Although he had a long-term interest in spirituality, he was in the process of becoming a devout Muslim during the treatment. His conversion entailed stopping many of his “partying” behaviors. Despite high intentions and lofty goals, however, he struggled with

having his actions, such as canceling a date with a woman he really liked, engaging in casual sex with someone else after session three, smoking marijuana frequently, and coming to session with a hangover. Ray and Laurie worked on his difficult authority relationship with a professor, and across the sessions Ray began to speak and engage more appropriately with the professor. Laurie used her first and only touch with Ray on his shoulder, briefly, at the end of session five, responding to his explicit request.

*Session 6: “Quitting Weed, Becoming Devout”*

Unlike the other final sessions in this study, this session with Ray was not intended to be the final session. However, since he dropped out after only six sessions, this session can be analyzed from several different perspectives: a) the changes evident as a result of the therapy; b) the possible trajectories had he continued; c) what factors might have led to his dropping out; and d) what might have sown potential seeds of future changes.

Ray had not appeared for the previously scheduled appointment. Thus, at the beginning of this session, Laurie addressed Ray’s nonappearance. There was clearly some repair that needed to be made in the alliance. Laurie was decidedly struggling with whether to attribute Ray’s lack of commitment to therapy to his age and developmental level as a college student, and thus how much to encourage Ray explicitly to keep his agreements.

C: Um...oh, yeah, so, two of my friends came up from D.C. One of them stayed with his friend was in the city and had his car stolen out there. Um, I was helping him get around as far as police stations, back and forth, just whatever. Um, it took up all my time and so last week, I had like a lot of assignments – compositions, tests and papers. So, by Thursday, I was just dead. I wasn’t stressed out I was just literally, not even physically exhausted, I was just tired. I didn’t pass out, but I almost passed out, man, badly.

**T: That’s why you didn’t show.**

**C: Yeah, and I was trying to call, but I don’t know why, but I could not find your card. I know you gave me one in my coat twice.** Um...

T: With the manila envelope.

C: The white thing?

T: Yeah. Did you lose that too?

C: The form like.

T: With the forms in it. Did you fill out the forms?

C: Oh, no, I didn't. But that's just a white piece of paper, it's not the card. I think you ripped the card off to write a new appointment, or something. It's just like a sticky note or a post-it or something.

Laurie decided not to pursue this, as she believed the issue would probably re-emerge and could be studied later. She shifted to his present life and the relationship with one of his professors, as several of their interim sessions had focused on how Ray has been struggling with respecting her authority.

Ray still appeared to display a manic, energetic quality, speaking quickly, yet he also discussed some significant changes from their work in treatment. He reported having resolved some of the problems with his professor and treating her with more esteem. This new respectful behavior indicated an important shift for him in his comfort with authority and particularly with women who have power over him. He apparently no longer felt uneasy with her, either trying to seduce her or berate her. He described how they had moved to a more respectful and cordial relationship.

T: How have you been? Busy?

C: Good. Yeah, I've been busy, but everything's been under control. It's high maintenance at this point.

T: How's your professor?

C: Ah, yesterday, I turned in this paper. I came late on purpose. I had the shiniest red apple from the store. So I walked in [laughter] and I put the paper down and I then I went like [breath, breath]. So, I set it down and gave it to her. Like some serious kiss-up. Whatever, I was just doing it to be cute.

T: What was your communication what would you want to tell her with the red apple?

C: Oh, you know, it's like that classic little student thing, or something. You know, like, have you ever seen those little children's books or somewhere the kids bring the teacher apples.

T: Did she smile?

C: Yeah, she was like, thank you, so, it was good. And even in class, like, I've made a point to like, um, participate, um, basically and ah, also, one class I just did not do the reading. No, I did the wrong reading. The syllabus is like messed up. In fact, I don't even have it. So, um, but it's by the right author, thank God, so she didn't notice. 'Cause I said, "when Martin Luther talks about this, blah, blah, blah" and she didn't catch that I was talking about the was the wrong book, because it was the right author. So she waited all class; the class was about to be over, she said, "before we leave, I want to talk about the question that Ray emailed me

this morning.” Because, we’re all supposed to email her questions every morning, before class. So, I was like, “Oh really?” So, that was cool. It kind of showed like, not so much personally, but I guess teacher-student wise....

T: Acknowledging you.

C: We’re on the same page, I guess. It’s all good, you know what I mean [laughter].

Ray then reported another important change: he had decided to stop smoking marijuana. Ceasing to smoke marijuana was a significant behavioral change for a former everyday smoker. This decision stemmed from a bolder dedication to his growing religiosity.

C: And, uh, **that’s it man, and I quit smoking weed.**

T: When did you decide to do that?

C: Uh, just over a day ago ‘cause I’m a Muslim now, as I said. So I can’t. You know, it’s rebellious to say, “I’ll do this a lot, and I won’t fornicate, but I’m going to do this.” Just like, what?! The concept of Tauhid, which is you don’t associate anything with Allah and you don’t put anything before Allah. So, for me to say, “Well, the Koran says this and, I don’t care, like I’m just going to do this anyways.” That’s rebelling and that means if you put that thing before God that actually means you are in effect worshiping that thing. So, yeah, so I was just like, it’s like, “well, that’s easy.” And it is easy.

Laurie explored this decision with Ray to help him integrate his impulses and behavior. Ray explained how he “metabolized” his urge to smoke marijuana on April 20th, a counter-culture holiday. He remained committed to his new religious path.

T: So, Allah, says to give up what? No drugs?

C: Intoxication. It teaches against intoxication.

T: What else is intoxicating? Sex too?

C: It also teaches against fornication, but not in the same passage, but I was already cool with that.

T: So, you made a decision to give up weed.

C: Yeah

T: ...and to make Allah your priority.

C: Yeah, and uh, I mean.

T: Do you feel good about it?

C: I do. I mean, it’s 4/20 today, so obviously, the urge to smoke arises, but...

Similar to Terry’s process of quitting cigarette smoking, Laurie inquired about how Ray was planning to nourish himself instead of smoking marijuana (Theme 1).

T: What are you going to replace 4/20 with?

C: Nothing. It doesn’t replace...

T: It’s over.

C: Yeah, it's like you don't replace a tumor with something else, you extract it, you know what I'm saying?

T: And when you extract a tumor, what's left?

C: I mean, what's left is like, well I guess that would have left a hole, except that hole or whatever, is now replaced, **I guess it is replaced by faith. 'Cause it's like I feel stronger with Allah because I made that sacrifice.** As long as I hold onto that, I'm holding out on everything. Any promise that's given to you is not like a guarantee for example. It wasn't promised. Like, Abraham was promised a son, but it's not like it will be next weekend, no matter what you do, it's going to happen. You know, you still gotta do right. And it took a long time, so you've got to hold that faith for a long time. So things that have been revealed to me, even before I was a Muslim, it's going to take faith for you to reach that. It's like, I guess you could look at it from a secular stand, it's like a contract. Yeah, we promised you this money, if you come to work, you know what I'm saying, 9-5, or you play for this team, or whatever the contract is for.

By now Laurie and Ray appeared once again well allied. Together they explored Ray's commitment to his faith at which time Laurie brought his attention to his body. Ray wanted to keep discussing Allah, but Laurie focused him more explicitly on the therapy and his goals to help him become clearer on his intentions through treatment. As previously noted, Laurie used the language of the study more with Ray than with the other subjects. Terry and Jan were both committed to their healing processes such that they were highly motivated to do the work. Ray's curiosity about the process brought him in for treatment, but it was unclear how much he felt therapy could help him. Subsequently, his lack of motivation to stay focused on working towards specific goals was certainly a risk factor for his dropping out.

T: [continuing quote from above] You gotta show up.

C: You gotta show up, exactly. Exactly

T: And then practice. And then the reward comes.

C: Exactly, so, yeah.

T: So, let's just take a moment and check in with...

C: [interrupts] With Allah! [smiles]

T: ...Where you are, where Allah is, where your body is.

C: Uh-huh.

T: Where we are on this journey. **We're on session number 6 today, so we're halfway through.**

C: Okay.

T: And we made an agreement for 12. So, from the time you decided to enter into this project until now.

C: I'll be here this summer.



T: I know. I'm looking at it more when you had the impulse to respond to the, um, message on the bulletin board, right, and when you had that impulse and you responded, and we chose you, and now we've traveled a little.

C: Mm-hmm.

T: So, based on where we started and where we are, is there anything you want to tell me about what you've learned, what, maybe your hopes or expectations are for the next six weeks. Any questions? Any insights?

In the moment, however, Ray appeared quite engaged, describing how the therapy had helped his awareness of how he was organized and functioned in his outside life. Ray articulated quite clearly that he has learned a great deal from the treatment thus far.

C: I've probably done more learning, **just because things that you point out about like, you say that at certain times, you feel tingly or jumpy and like the rhythm that your energy comes in, and so I kinda like learn what things might affect me. I've even noticed it.** Like I said, sometimes, maybe I'll be in class and I might just like, I mean I basically won't even notice that I said something because I'm just hyper so just stuff will happen without me necessarily having to consciously do it. And I think, **so I wouldn't say I'm more in control, I just think I'm more aware.** And the question I have is what do you know about people, like, you say, there is a certain energy coming from you or within you. How do people respond to that? How perceptible is that to others? You know what I mean?

Ray appeared very engaged and continued to talk rapidly. Laurie inserted a gestalt technique and encouraged Ray to use the personal pronoun "I" instead of saying "you."

C: The perfect example is on the subway, 'cause you'll just sit down to a random person, and like, you know like, maybe, maybe it's like the guy, if I sit here and a guy is sitting next to me and they're all talking and stuff, I'm more prone to kinda like lean back in my chair and be a little bit more relaxed. But if they're all uptight, and like sitting on there like this, I'll be sitting halfway on the other side of my seat. And I'll probably just be like real calm. I'm I wouldn't necessarily get mad, but I'll take on that demeanor.

T: You're trying to sort of insulate yourself for your response.

C: Response, yeah.

T: To that vibration. You change to different body postures.

C: Yeah, it would change **your** body vibration.

T: Not **yours, mine.**

C: Yeah, I mean mine will change.

Throughout this session Laurie worked quite actively with Ray. In fact, there were several struggles between them over how much to follow his stories versus focusing on Ray's bodily experience (Theme 3). Laurie's insistence with Ray shifted the tone in a way that prevented Ray from ever quite recovering or regaining the same momentum.

T: So, let's do that once more. You gave me two examples.  
 C: Uh-huh.  
 T: The first example was two people sort of talking and they're happy.  
 C: Yeah.  
 T: And it's a pleasurable sensation. If you imagine them next to you, what's your impulse?  
 C: Um.  
 T: Just do it.  
 C: To sit?  
 T: Yeah. Two people next to you...  
 C: Actually, just like this. I would kinda lean back and would be a little more, um, what do you call it, elongated, or something, instead of bunched up. I would be more prone to lean my head on the glass and just relax. **[client sits back on sofa]**  
 T: So do that....you lean back, feeling more elongated.  
 C: Yeah, and **see you can breathe better this way**  
 T: **No, you, say "I."** [laughs]  
 C: Oh, okay, I can breathe better this way because, um, like my neck isn't folded or something. I don't know what it is, but I feel like I can breathe better when I'm ...  
 T: Take a moment. One thing we do in body psychotherapy is we slow things down.  
 C: Uh-huh.  
 T: To feel them. So, if we take a moment and check in with the movement of your breath. And you can feel you breathe better this way, give yourself time to experience your posture, your breath, your connection with the earth. And report to me from the inside, in mindfulness, what you notice in that place.  
 C: My stomach feels better, yeah.  
 T: So, I didn't know that your stomach didn't feel so good. So, you've just become more aware as you slow down.

As Laurie encouraged Ray to integrate his newfound spirituality with his sensations and emotions, their relational rupture re-emerged. Laurie challenged him to be more inside his experience; Ray seemed to respond well to this direction and progress more deeply into his embodiment. Yet the strain in the relationship was not really addressed, and although it did not seem overly significant within the context of the session, it was curious how Ray experienced it since it was his last session before ending.

T: And just notice what happens as you allow yourself to acknowledge this decision that you made yesterday, to really devote your soul and your body to your faith, to your prayers, to your commitment to Allah. Just notice anything at all that happens as you sit with that decision, taking responsibility for your choice.  
 C: It makes me feel good.  
 T: It makes **you** feel good.  
 C: Yeah.  
 T: [slightly mocking tone] So, good is a **nice** word....  
 C: You need more, right? [laughs]  
 T: So, good for you is different than for 300 other people. So, when you say, "it makes me feels good," I'm going to ask you back to the awareness question. And when you feel good,

how do you notice that at the level of sensation? In your body what changes, that you describe as being “good?”

C: Well, um, it’s just like ah, you know, like, uh, it’s not endorphin rush, it’s not like that rush of pleasure, like going through some kind of tingle. It’s like a rush of calm, when it like rushes through my whole body just kind of like...I don’t know how to describe it.

T: That’s a good description, you’re doing great. You moved your hands when you said it’s like a rush of calm. Not like a tingling or excitement. Like a rush or wave of calm or...

C: Stillness.

Laurie continued to invite Ray to bring more of his burgeoning spirituality into their work. She evoked Allah as a way to integrate this important inner resource for him with his bodily experience.

T: That’s a nice sensation, good, stillness. As you hang out in this good feeling, like a rush of calm and stillness, I’m going to ask you another question. I’m going to ask you to allow yourself to give yourself permission to receive any guidance from Allah, in the form of words or vibrations or images. Allow yourself to receive spiritual guidance continuously. Trusting any decision that you make, with Allah in prayer and faith.

C: The words that come to my mind are “La ilaha illallah.” Because I just can’t get over how much that means. Just that one, in English it means, “Allah is...there is no god, but Allah.” It just, I mean, once, that meaning has more and more meanings like everyday. And it’s so simple, you can read it a million times, and be like, “oh, okay”, but it really sums it up for me.

They continued to focus on bringing awareness to his spirituality as it connected to his sensations. Laurie had Ray repeat a Muslim prayer several times and sense how he felt in his body. She asked him if he could access calmness as he said the prayer. Ray began another long discussion of how he wanted to share the word of Allah, and how important talking about it was to him. Ray appeared to be integrating his experiences of having a purpose and a community, both of which he had long struggled to find in words, images, sensations, and gestures.

T: ...just ask yourself what images or impulses do you feel from this experience of calm.

C: I mean, I want to talk to people, like, or show people through what I do, without words, if they will enter into this uh same calm. I basically want to talk, you know what I’m saying.

T: So, you have this impulse to talk.

C: Yeah...It comes up that I’m a Muslim pretty much in most conversations I have, I mean, sometimes I just say it, um, and obviously people are like, “oh, why did you convert?” And that’s pretty much how I explain to them, that, maybe not in those words, but um, that I was in this quest, you know what I’m saying, for peace, and there was in some ways knew how to find, but couldn’t, or knew I had the ability, but don’t know how to find it. **It’s like I can**

**find this, I just don't know how. Whereas, Islam brought that picture like...you know what I'm saying, right into focus. [gestures hands coming together till fingers touch]**

T: Yeah, feel your hands, that motion.

C: Oh, like this... **[repeats gesture of hands together]**

T: Right...That's it. Into focus.

C: Mm-hmm.

T: As you say, Islam, quest into focus, quest for peace.

C: Mm-hmm.

It was hard for Laurie not to be somewhat skeptical in response to the incongruity between Ray's discussion of being a model for the community and his later behavior of quitting treatment. Thus Ray's fundamental schism between his behavior and his ideals was highlighted, as it was very difficult for him to practice what he preached.

T: So that's an intention that you have, to be living in peace and harmony.

C: Yes.

T: And to bring that energy out into your environment.

C: It's my wish to. But I wouldn't actually say that it's a, um, it would be hard to say that was a goal, in a sense that it's not like...

T: It's a way of living.

C: Yes, as far as spreading it, I wouldn't necessarily say that's necessarily a goal of mine because it's not my will that does that. Um, **the only way to do that is, in fact, to make sure my Islam and my submission is correct.** And that's the only way that maybe I could, but still, you know, Allah opens the hearts of whom he will, so... **I know that by my Islam being right, I present the best example of Islam to anyone who would come,** but I can't sit there just...

They began to talk more directly about prayer. Laurie shared a Tibetan prayer with him. Ray really liked the prayer; he continued to discuss Muslim prayer and how centered it makes him (i.e., contained) to wash and prepare for the Sallat, the Muslim prayer. Ray seemed so connected with Laurie around spirituality that an outside observer may have wondered what it was about the therapy that became inconsistent with his religious practice. How did being "a light" for one make the other implausible?

C: I'm learning what it means, I just don't have it memorized. I know everything, except the one thing that I should know, which is that first Sirah. I know to say that in Arabic very well, but I don't know the meaning. Whereas everything else, I know the meaning in English, but I can't say it. So, um. You know...that's my intention. That's what they are telling. That's like the fundamental thing. Don't worry about, there's a lot of theory and you know higher and more complex stuff. Don't worry about that now, just start reading the Koran and just get your prayer right. 'Cause the Pillars of Islam, one of the five pillars, is not

to, not to do Sallat it's to do Sallat perfectly. 'Cause you can sit there prostrating, and the prophet be upon him, he calls that the rooster, going up and down on the ground. [**client bobs up and down**] It's not about saying you've done it, it's about, you know, your intention.

T: Right, exactly, your intention when you speak the prayer you really be in the part.

C: Yeah, yeah, so that's why I don't just pray and I'm thinking about the Knicks or something. It's like, my mind, I'll wait a couple of minutes if I need to just like unwind. You know how you said I'll be like all hyper or something. If I feel that way, I'm like maybe I'll just wait, for a couple of minutes, I might read a little Koran, just to get my mind calm, and to get my mind on Allah and then I'll say the prayers. It's not the prayer itself, it's not your acts.

T: It's the preparation and the orientation.

C: Yeah, usually doing what I'm doing like washing will usually get my mind there. But, you know, it just depends. I just have to check in with myself. You know, how am I going to present myself unto Allah?

Laurie made very intentional decisions to bring Ray's religiosity into their relationship. However, in the quote that follows, the language she used to discuss their relationship, such as calling this conversation between them a "very intimate thing," had a somewhat sexualized connotation. This intervention of bringing the focus to their relationship as "intimate" seemed not well-suited for a client with hypersexualized strivings. Perhaps Laurie was intending to model to Ray just how much emotional intimacy could exist apart from sexual intimacy; yet it did not have the intended effect of bringing them closer. Instead Ray dismissed her interpretation of their having a special relationship and reframed it as just "telling people." One felt that he was somewhat in a trance here, not really aware of Laurie as much as his internal relationship.

T: **So, this is a very intimate thing you're sharing with me.**

C: Oh, really?

T: Well, I think so.

C: Yeah, I mean, **I love telling people about this.** Because they want to know about Islam and I think they should. I think you should hear about Islam from a Muslim, and not from some academic who reads the Koran and fifty other books and thinks they're all the same. You know, so, I guess it is intimate, but I tell people; I get excited. You know what I'm saying, when I tell people. Like, I'll be in class, I'll be doing work, it doesn't matter, when it's time for Sallat, I put all that down, and I wash myself and I put my face on the ground for Allah and for Allah only. I say it. I tell people La ilaha illallah . I mean, there is no god should be worshipped, but Allah. I have no other master, my school, no other things. And that is freedom. Because even if I am my own master of my own life. I know for a fact that I

falter and that I waver and that I make up my mind to do the right thing and can't do it. But Allah is infallible.

Ray continued to preach. Laurie teased him a little, given that he only gave up smoking marijuana the day before. Their alliance appeared able to weather such teasing, but there seemed to be some sort of rift that was not mending. Ray did not seem to want to explore himself, but only to remain inside his newfound system of thoughts, feelings, and sensations. Perhaps Ray discontinued therapy because mindfulness was too dangerous when encountering this new world of Islam. Just as someone falling in love does not want to be reminded of the new partner's faults, so did Ray want to be immersed in Allah without education or reflection.

C: Yeah, an immovable stronghold. So, as long as you hold on, as long as you keep your faith, you know what I'm saying, Allah will be there. But, so, in other words, it's completely on me. Like I can say, some people go a little farther. They'll say, "oh, well, I'll say the prayers, but, you know, I still want to shave." Or, "I'll say the prayers, but, I mean, it's college, we can't drink?" You know, it's not that bad. Whereas I'm somebody, I don't look down on them, or judge them, but I don't want it. Like I don't want some of my life to be here and some there. Now that's why I feel better, now that I quit like smoking weed. It wasn't, it's not that it's bad or I stopped enjoying it. God, that will never happen. But it's just, this one little part of my life was on the other side of the fence. So, it's like, I'm like, why would I keep myself from Allah? It's not that I don't like smoking weed, or think it's bad, but it's because, it's because I'm putting my will against Allah. Whereas Islam means submission. It means submit your will unto Allah. Why would I purposely set myself apart from Allah? And that's what I realized.

T: That's why you made that decision.

C: **It's not hard or anything. I don't think I'm a pothead. Or I don't think I was.**

T: **Well let's see where you are next week or the week after.**

C: **Yeah, yeah, yeah. Don't worry about that.**

T: Time will tell. [smiles]

C: "An Shallah" means God willing, so I say that I quit, I mean "An Shallah", I can't say for the rest of my life, I'm not going to do this, or I'm not going to sin. Already, since I have made that, it's not because I quit smoking that something changed. It's because of what the internal thing has changed. The act has changed. I already feel like my faith is so much stronger. I've been with the brothers, I mean, it's almost like some like spell or something. As soon as I quit, brothers have been coming up to me, man, I really felt that things coming to me. Because part of my heart was turned away from Allah, they may have said these things before, but it's like, it wasn't, I knew it, and it made sense, and I believed it, but it was like, I didn't take it fully to heart. You know, as magnificent as those things may be, because part of my heart was sealed off, by me, by being away from that thing. Part of my intention was to, "alright that's good", and later on tonight I'm going to roll up a joint and I'm going

to say, ‘fuck it.’” You know what I’m saying, but like, how can something be good and you already know, like you already know like alright, that was cool, but “fuck that.”

T: Yeah, so we already talked about your enjoyment in talking. [laughs]

C: Yeah, always.

T: [Laughter] You like to communicate.

C: Yeah.

T: **And so, as you’re talking to me right now, are you also aware of what’s going on energetically, or do you forget that?**

C: **Um, I basically forget it. I mean, I can look back and I realize I was moving a little bit, but you know.**

Now Ray asked Laurie another important alliance-testing question about her motivation in doing psychotherapy. In response, she asked him for his “fantasy.” Although it is common to query a client before answering a question, using a term that is common psychological jargon yet carries a sexual connotation to an untrained ear, raised a question about Laurie’s ability to meet Ray’s needs in the session. Perhaps it was a slip, or an unconscious response to his sexualized energy. But it clearly made him uncomfortable, and although unprocessed, may have encouraged a sexualized dynamic that contributed to his feeling the treatment was somehow sexualized and incompatible with his religious views.

T: Since this is a project of the body, psychotherapy, and a project around consciousness and being, so I’m interested in helping you become more tuned into your own spirit and your own vibrations.

C: Here’s my question...

T: [interrupts]. In order to do that, there has to be a certain amount of awareness of the inside. Because your body is your sacred space, it’s your temple, it’s where you pray, it’s where you breathe, its where all life happens.

C: Uh-huh.

T: So, when you slow down to be with your body,

C: Mm-hmm.

T: ...you can become more aware of what prayer does for you.

C: Yeah, prayer is very physical; I tell you what, especially the Sallat. Yeah

T: You had a question for me.

C: **Yeah, um, like, what interests you about this?** Like you said, my interest is in, you know what I’m saying, the effects of the mind on the body, or the connection. Like, what, why though, you know what I’m saying?

T: Why, what?

C: Like what interests you about like this particular topic or this like aspect, you know what, I’m saying.

T: **What do you think, what’s your fantasy, before I answer the question. [laughs]**

Despite his discomfort, Ray shared that he has enjoyed the treatment and having Laurie listen to him and help him integrate the disparate parts of himself.

C: What's my fantasy? [laughs] Um, I don't know. You don't really seem to have like ulterior motives, like I'm going to use this stuff to find out how to cast a spell. You know what I mean. You don't seem to have an ulterior motive, it just seems like, **I enjoy it because it feels good, basically. It's good to understand these things, it helps me through my everyday interactions, even interactions with myself, within myself. I'm just curious with you, like I don't know.**

Now in response, Laurie offered a long answer, filled with spiritual language.

T: Well this study, Amelia, you know was interested, it's like a new field.

C: Mm-hmm.

T: Some people, you know, will go to pray, some people might go to physical therapy or acupuncture. Some people who need to talk to somebody will go to a counselor or minister.

C: Mm-hmm.

T: And this particular interest of Amelia's and obviously mine, because I've devoted my life to it, has to do with the relationship between mind, body and spirit. It's really more of a phenomenological study – what, how are people organized, how do you bring people back into alignment with themselves.

C: Mm-hmm.

T: So, from the spiritual point of view, we're looking at how is man on this planet and what connects one culture to another culture. Is there a unity here? And then from a more psychological point of view, we're looking at how does someone have a problem and how does the problem get resolved? Because some problems don't get resolved by talking, they get more resolved by processing.

C: Yeah.

They continued discussing spirituality. Ray appeared very interested in Laurie's spiritual insights. In fact, their connection over spirituality formed the basis of their alliance. They worked together to make meaning of Ray's current reality and the conflicting cultures of which he finds himself at the intersection. Throughout the treatment, there were only a few overt references to Ray's racial identity as an African-American male. It was, however, an unspoken constant variable in the treatment, as Ray was a young African-American male being treated by an older white woman. Here they addressed it more in talking about Ray's culture of "door open" instead of "doors closed" and African culture versus American culture. Yet it was not explicitly discussed. One



might surmise that they both needed more time to build trust in the alliance in order to talk about racial dynamics explicitly.

C: What have you noticed about, like, in general, I don't know, you've probably had a lot of patients, probably had a lot, well, you teach too, like, you've probably had a lot of students. How, I don't know, like, if you take America, you were in Africa for three years, is there a difference in how in-tune people are spiritually, or, it doesn't matter where you are, it's just personal, person by person thing?

T: I think mostly it's person by person, but I think there are different cultural effects, like Africans are very tribal. They sleep in the same room, they eat of the same pot, they share a lot more in that cultural setting. You know, people care for each other, if someone is really sick in the village, they all take care of him. The person doesn't just sit in the hospital. He gets absorbed in the community.

C: Yeah.

T: So, in that sense, it's more spiritual because there's more unity and more community.

C: Yeah.

T: Whereas Western white culture tends to push the emphasis on autonomy, the individual.

C: Yeah.

T: There is more isolation.

C: Isolation. My roommates, they'll be in their rooms, just sitting at their computer and they'll lock their door. Like, I'll be like, I want to go say "hi" and the door's locked and I'll be like "oh, they're not home." And then like two seconds later it'll open because they heard me on the knob. I was like, "your door's locked, why?" And there's no reason. They're good guys, but I think that they definitely need to spend more time, like anywhere but their room. I don't understand how they do it, who could probably spend 5-6 hours straight at their computer. It's an unfathomable thought. Like, I could not do it. And um...

**T: Yeah, so we're talking, we came to this discussion, when you asked me what am I doing this study for, what am I interested in.**

C: Yeah, just out of curiosity.

T: **So, was that a good enough answer?**

C: **I'll accept it.**

Their alliance appeared strong again. So strong in fact that Ray shared some of his earlier doubts about Laurie. Similar to when Terry told Laurie how it took her several sessions to share the real reason she came to treatment, so too did Ray deepen in the treatment by telling her of his previous resistance, including judging her based on her office filled with books.

T: Oh, okay, we'll have to stop in a few minutes.

C: Oh, okay.

T: Take a little pause and check back in with your breath, the quality of energy in your body, thoughts, your feelings, and just notice right now in this place, if there is anything you want or you need before we stop, anything you want to remember and take with you.

**C: You want me to say it?**

T: If you want to.

C: Oh,...I like this little time, you know, it's good. 'Cause normally you ask questions that other people don't, or nothing that I want to say that I feel would be inappropriate to say. I guess just the relationship is different, so it's good for me to just to just kinda let my mind.

**You know how they say, let your hair down. I feel like I can do that like in my mind or emotionally.** I just kinda let my hair down or up. I'm black, so it doesn't really hang.

T: So, there's kind of a certain quality of rapport that's happening between us.

C: I have to stop myself before I say something. Sometimes it's like...you know what I mean?

T: You can let down and have some freedom to explore.

C: Yeah, yeah.

T: Time and space.

**C: Yeah, it feels good.**

T: Thanks for your trust.

C: No doubt. Sorry, I was a little crazy at first, because there are so many books and pictures in here. And I was like, "man, what the hell is this." But it's all good.

T: [inaudible] A crazy woman [laughs].

C: Now that I know that you actually haven't read more than half of them, I'm like, you can't be possibly that confused. If you actually read them all, yeah, I'd be like, wow.

T: Well, some information can be helpful. But if you have "x" amount of hours and time and Allah is going to teach you through life, you're going to learn every minute of the day if you're aligned. Whether you're on the subway or whether you have a thought, you're like writing your own script, you're being taught, so each person is on their journey back to the creator. And on some level you don't really need to read. On the other hand, a book can guide your consciousness a little.

C: Definitely, you use the Koran, but it's faith that will truly speak to you.

Laurie concluded by telling Ray a story about all the major world religions' prophets coming to the same watering hole to drink from and realizing they are all the same. Ray mused on Nirvana. It was an intense moment of discussing deep spiritual strivings. Laurie linked this discussion back to Ray's therapeutic process.

T: Okay, remember that picture, that first picture you draw, you mentioned it was like an atom.

C: Uh-huh.

T: Spinning in the cosmos.

C: Yeah.

T: And the last one you drew was like a tree with roots and branches.

C: Oh yeah, that's true. There is quite a contrast there. I have not forgot about those, interestingly enough, I think about them even today. But it's seriously been like a...

T: Well, I know you have stress in school.

C: I've been busy, but not stressed.

T: Ok.

C: Next week to meet, Monday...

With contracting to meet the following week, Ray ended the session.

*Monitoring Evaluation of Session Six (“G” in Figure 1)*

Despite some momentary abrasiveness between Ray and Laurie regarding slowing Ray down, Ray and Laurie appeared to be working well in their alliance. Ray seemed very engaged with the process and had made some important behavioral steps to nourish himself through religiosity instead of sexual relations or drugs. He did not discuss any of his doubts, or suggest an incompatibility between his religious beliefs and the work in treatment. It was therefore a surprise that he ended therapy abruptly after this session.

*Addendum*

At the end of Session 6, Ray had confirmed that they would meet the following week. But they did not meet again, because several days later Laurie received the following phone message from Ray:

C: Hello, this is Ray, and, uh, I was just calling to let you know that, um, I’m canceling our appointments. I just don’t think that it’s appropriate for me to come any more. So, um, yeah, you know, I’ve been doing some reading and things like that in the Koran, and the scripture says that “Those who conceal the clear proof evidence is in the kind which Allah has sent down, after Allah has made it clear to the people in the Koran. They are the ones cursed by the law, and cursed by the curser. Accept those who repent and do righteous deeds, and openly declare: these, Allah will accept their repentance.” So, uh, and I am the one who accepts repentance, and most merciful in Allah. So uh, so uh, that’s something I read that uh put me in perspective about our class, our meeting, so, um, yeah, I guess I’m sorry to disappoint you, but, uh, you know, that’s how it is. So I hope everything goes well. Bye.

Although Ray did not return phone calls, the researcher unexpectedly ran into him on his college campus, at which point he assented to completing the final forms. This was several weeks after his ending the study, which was several more weeks than the other two subjects, yet within the time range allotted for completing the final assessment. However, the caveat must be made that potential intervening life events must be considered in the analysis of his final quantitative scores.

## Concluding Evaluation (“L” in Figure 1)

*Quantitative Results*<sup>10</sup>

Table 18  
Ray’s SCL-90-R Results\*

	Ray 1	Ray 2	Pt Change	RC	Sig at p≤.05
<b>Global Severity Index (GSI)</b>	63	63	0	0	
<b>Positive symptom distress index (PSDI)</b>	51	50	-1	-0.125	
<b>Positive symptom total (PST)</b>	65	65	0	0	
<b>Somatization (SOM)</b>	59	60	1	0.125	
<b>Obsessive-compulsive (O-C)</b>	64	61	-3	-0.3873	
<b>Interpersonal sensitivity (I-S)</b>	63	68	5	0.811107	
<b>Depression (DEP)</b>	59	50	-9	-1.27279	
<b>Anxiety (ANX)</b>	66	60	-6	-0.94868	
<b>Hostility (HOS)</b>	62	59	-3	-0.40825	
<b>Phobic anxiety (PHOB)</b>	47	67	+20	2.948839	*
<b>Paranoid ideation (PAR)</b>	59	59	0	0	
<b>Psychoticism (PSY)</b>	64	71	+7	1.032094	

\*All scores are T-scores. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning. RC indicates the Reliable Change Index (Jacobson & Truax, 1991).

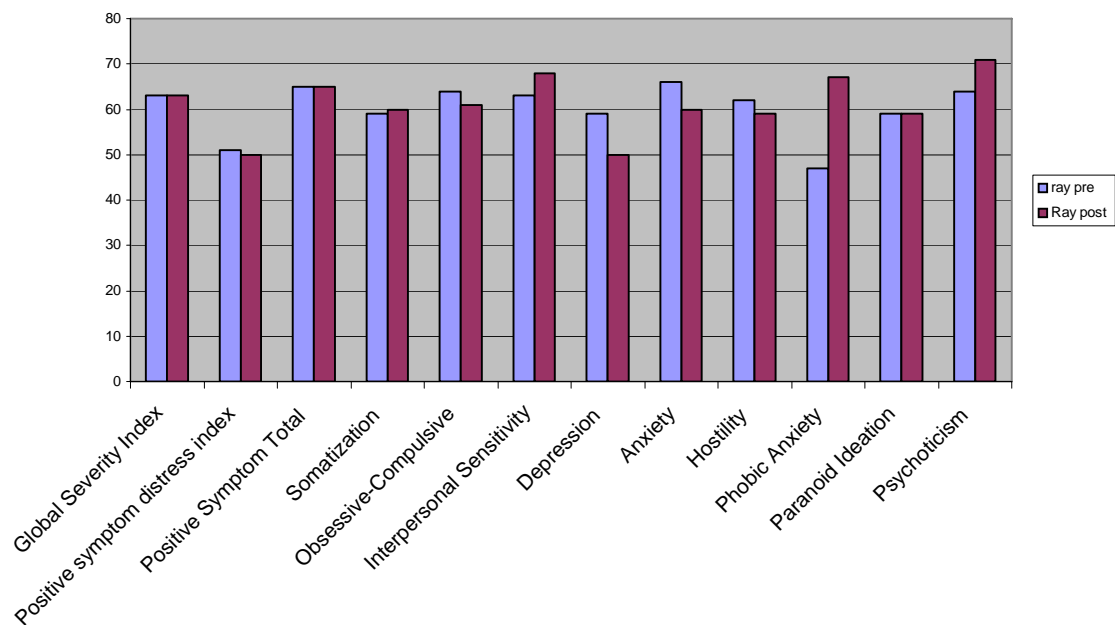


Figure 6. Graph of Ray’s SCL-90-R Results.

<sup>10</sup> Note that Ray’s post-test scores are after six sessions. Additionally, several weeks after the end of treatment elapsed before he completed the post-test scores.

Table 19  
Ray's TEaM Results\*

Subscales	Ray 1	Ray 2	Pt Change	RC	Sig at $p \leq .05$ <sup>11</sup>
Subjective Well-Being	70.73	70.73	0	0	
Depression	63.57	63.57	0	0	
Anxiety	60.71	70.36	9.65	1.489027	
Phobia	62.62	62.62	0	0	
Obsessive-Compulsive	45.64	49.48	3.84	0.64	
Somatization	56.43	56.43	0	0	
Panic Disorder	60.84	60.84	0	0	
Post Traumatic Stress Disorder	61.31	53.21	8.10	-1.28072	
Symptom Checklist	60.5	61.41	.91	0.203482	
Personal Functioning	64.55	68.03	3.48	0.536976	
Social Functioning	66.46	66.46	0	0	
Vocational Functioning	67.87	67.87	0	0	
Functional Disability	68.37	69.21	.84	0.148492	
Behavioral Health Status Index	68.61	69.26	.65	0.132681	

\* All scores are T-scores. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning. RC indicates the Reliable Change Index (Jacobson & Truax, 1991).

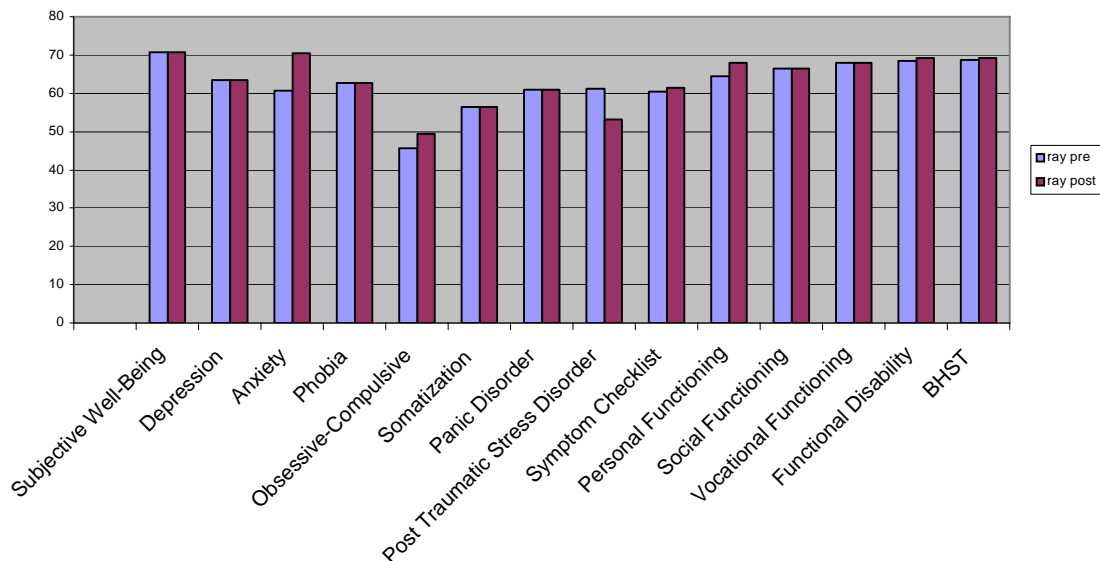


Figure 7. Graph of Ray's TEaM Results.

Table 20  
Ray's Scale of Body Connection (SBC) Results\*

Subscale	Ray 1	Ray 2
Body Awareness	4.1	3.9
Body Dissociation	3.9	4

\* Higher scores indicate increased Body Awareness and Body Connection.

<sup>11</sup> Because no test-retest reliabilities were available for the TEaM scale, internal consistency reliability of coefficient alpha was used to calculate RC, which is likely to be higher.

### *Discussion of Quantitative Results*

Ray's results must be read through the lens of his having had only six sessions of treatment instead of the intended 12. Additionally, at the time of completing the second measures, Ray had transitioned to being a devoutly religious Muslim. Therefore, in analyzing Ray's symptom profile at the final analysis, one can assume that this important transition influenced his responses.

Ray appeared to have found many answers in Islam, which resolved some of his difficulties, while others appeared to remain constant or worsen. On the SCL-90-R, Ray's depression score decreased, indicating an increased sense of life satisfaction that can be seen in his discussions of the enjoyment he has found in practicing Islam. Yet Ray's Phobic Anxiety score significantly worsened, from 47 to 67 (where higher scores indicate increased pathology). This finding may reflect Ray's religious devotion exacerbating some of his phobic, paranoid, and isolationist tendencies. As a newly indoctrinated member of this devout circle of religious Muslims, Ray was being extremely careful in his actions including, as he discussed in his exit interview below, largely avoiding women altogether (e.g., crossing the street to avoid them). Additionally, one can speculate that not coming to therapy was a byproduct of Ray's newly-created barriers due to his religiosity.

Overall, Ray's profile on the SCL-90-R still put him in "the clinical range" on the computer-generated report. His above average Somatization subscale of 59 was "clearly indicative of a clinical picture involving enhanced distress associated with somatic complaints." Furthermore, unlike Terry or Jan, Ray's Obsessive-compulsive score of 64 put him clearly in the clinical range which, according to the report, suggested "discrete

symptoms be evaluated to determine whether these symptoms are associated with performance difficulties secondary to an anxiety or depressive disorder, or represent a true obsessive-compulsive syndrome.” Ray’s Psychoticism score remained at a clinical level of 64 and most likely “reflects an intense experience with social alienation rather than a thought disorder.” This was consistent with his current extreme abstention from mainstream culture due to his newfound religiosity.

Consistent with the disparity found in his pre-treatment scores, the two assessment measures continued to track Ray’s symptomology differently. On the TEaM scales, Ray’s scores appeared much “healthier” (higher above the mean) than on the SCL-90-R. On the TEaM, most of his scores either remained constant or offered some conflicted information regarding his functioning. For example, his Anxiety score increased, which indicated a decrease in anxiety, while his PTSD score decreased, suggesting an increase in anxiety. His overall Subjective Well-Being score remained high.

On the Scale of Body Connection, the scores went in the direction that was predicted by the qualitative analysis, which included an increase in bodily and experiential awareness as well as a decrease in repression. The earlier item “It is difficult for me to identify my emotions” that Ray had endorsed as “a little bit,” he now responded with “Not at All.” Additionally, “I distract myself from feelings of discomfort” he had reported “none of the time,” and now responded “Some of the time.” Additionally, although Ray decreased in his Body Awareness score, it appeared to be a nominal change (from 4.1 to 3.9). The decrease may have been caused by a change in Ray’s decision making vis-à-vis attending to certain bodily feelings, given his religiosity. He reported finding his sexual impulses extremely uncomfortable in his current state, and wanted to avoid them at all costs.

### *Goal Attainment Scaling Results*

Ray improved on his first two goals and, similar to Terry, identified his third goal as no longer valid. His goal of “going on dates” had been a behavioral way to rate his having overcome his problem with casual sexual relations with women. At his exit interview, he explained that this goal had become null due to his religious conversion (discussed further below). What that meant for him was that the religious practice offered an extremely positive way of reaching this goal. “I’ve kind of superceded that goal,” he said proudly.

**Table 21**  
**Ray’s Goal Attainment Scaling Results**

\* = Before Study \*\* = After Study

<b>GOAL</b>	<b>Writing</b>	<b>Finding opportunities for advancement available</b>	<b>Going on dates</b>
LEVEL OF ATTAINMENT	Scale 1 Importance: 10	Scale 2 Importance:10	Scale 3 Importance:10
Much less than expected (-2)	Writing 2 days per week	Less than one opportunity appears a week *	None *
Somewhat less than expected (-1)	Writing 3-4 days/wk *	1 job offer or opportunity per week **	1 date every few months
Expected level of outcome (0)	Writing 4+ days/wk	2 opportunities/wk	1 date a month
Somewhat more than expected (+1)	Writing 5 days/wk	3 opportunities/wk	2 dates a month
Much more than expected (+2)	Writing 6+ days/wk **	4-5 opportunities/wk	Every week
Comments	On review of the scale, the researcher might have not helped the client set an adequate realistic measurement of success in the time – therefore, he may have scored higher on this goal, as he did achieve progress.		**This scale was not rated in the final analysis, as due to Ray’s vow of religious celibacy, he is not currently dating. However, he feels he made progress here, as the goal of dating was to supercede his sexual acting out, which he did so by accepting Islam, therefore “superceding this goal.”



## *Qualitative Results*

### *Exit Interview*

Despite only six sessions, Ray was able to articulate<sup>12</sup> some important benefits from the treatment: “I can positively say that the study is something that I’ve taken with me. Some of the stuff is pretty useful. How often do people get to sit down and have someone give you their undivided attention and try to be understood?”

One change he noticed was now finding himself more attuned to the other person in his relationships. “I’m a pretty talkative person, but I’ve come to realize that conversation does not just mean talking, but also listening.” Given the extent that Laurie struggled to connect with him and uncover his affect underneath his extensive verbalizations (Theme 3), Ray’s commentary on his increased sensitivity to listening to others in his outside life was noteworthy.

Another change was that he now feels more attuned to his own body. He reported going into the study with the belief that listening to his body was important, but talking about it with Laurie legitimized that “paying attention to your own body is very important. Going into how the body feels and the rhythms – waking, phases of awakesness, all these rhythms and cycles. When my body feels tired, even though I don’t think I should be tired. I have to listen to that. This is valid, this matters.” Laurie gave him a framework and education that helped solidify his understanding that, as he elegantly put it: “My body has rights.”

Ray also spoke with greater clarity about his tendency to get “overexcited” or “tense” at times. He seemed more able to acknowledge his habit patterns, and also to

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<sup>12</sup> As discussed, this interview occurred several weeks after Ray finished the treatment.

access a deep felt sense of nourishment. He explained that the work has supported his practice of Islam: “It’s brought a peace or calm to my life. It’s kind of boring now. But in my mind the most exciting thing that’s happening are internal things. I can think more clearly.”

This led to his major transition that happened during treatment. He took on practicing Islam during the therapy. Although it is not clear when Ray began practicing Islam, his level of devotion grew exponentially across the course of therapy. When asked about how the BcP might have influenced his religiosity, he said:

The therapy helped me prepare to accept Islam without that being my intention. By being open and talking about sex, drugs, emotions that you would normally keep in, that part of yourself is closed when you are always holding that in. It’s like a closed fist, it can’t take anything in. I was releasing those last few things in my life. I’ve been in a long process of trying to change my life. The therapy helped me with the last few changes of that in becoming a Muslim. Accepting it came to me at exactly the time that I was ready to accept.

We discussed his dropping out, and what about the therapy was inconsistent with Islam. Ray reported that he thought Laurie was a former Muslim, so he thought it would be appropriate not to continue, because as a “young Muslim” it might be not helpful to his practice. Although Laurie has never been a Muslim, in one session she mentioned her husband had prayed the Salaat prayer for several years. This apparently had been enough to give Ray the impression that they had been Muslim and stopped their practice.

When asked whether if he had been mistaken about Laurie being a lapsed Muslim he would have continued, he still dissented. As hypothesized, the nature of the setting, with the two of them together in the small apartment room, had become problematic. Ray confessed that these days he largely avoided contact with women so as not to be distracted from his path. “Being in the room like that, it’s not appropriate. It’s easier for

me, so I don't have thoughts about sex. I'll walk across the street so I don't have to have thoughts. I do that.”

Ray considered his alliance with Laurie to have been strong. He described liking Laurie's non-judgmental approach. “She is a pretty good listener. I didn't have the sense of an agenda – I could walk in and listen to what I have to say. I think she is pretty good at what she does. She's a pretty calm listener.” In fact, as we brought closure, Ray remarked that he feels her work is “valid and under-appreciated.”

Laurie had built enough safety with Ray so that even when he was unsure of what she was asking, he was willing to try new things. With some of the more “out there” techniques, “it did feel a little awkward, I have to admit, but I just thought ‘go with it.’” Even the touch aspects (e.g., when she touched his shoulder briefly at the end of session five), which were not used extensively with him, he found not so strange: “Because we talked enough and talked about physical things so it wasn't strange to go in that direction.”

When asked if he could summarize what he received from therapy, Ray, like the other subjects, noted the sense of calm and peacefulness in the body as a main shift: “I've come away with some clearer ways methods to express myself – the patience and the calm. I'm always activated in my mind, but not so patient, so now more patient in my own mind.”

#### *Case Analysis Theme Results*

*Theme 1: Helping clients feel “nourished” by their internal resources.* Ray had a relatively easy time working through mindfulness to attain greater contact with his bodily sensations. What was more challenging for him, however, was to find ways to nourish

himself through behaviors that were not antisocial such as either getting in trouble, having casual sexual relations, or smoking marijuana. Much of his treatment was connecting to new behaviors that would lead to the nourishment that he desperately desired through a spiritual and righteous life.

Through the treatment, Ray struggled with many issues of identity, including his family's expectations as well as his own. It seemed as if he were battling between pressures to succeed and be driven (like his parents), or to "party," use drugs, and have sexual relations with a lot of women (like his peers). Through the treatment, Ray spent a lot of time "releasing"—telling stories, showing pictures, and even through breathing. (At one point, Laurie had Ray exhale with a long "VOO"). Yet Ray appeared to need to learn more socially appropriate ways to contain his energy. As he progressed, he seemed to discover more of what he wanted in his life, which entailed actively moving away from certain behaviors.

Laurie understood Ray's desire for Islam: Religion gave him, in Laurie's words, "identity, discipline, brotherhood, and bonding." All of his previous searching took "root" within the practice of Islam. Laurie saw that Ray was able to connect with his inner resources in ways that made him more solid. For example, Ray's sense of strong alienation, as indicated through his qualitative and quantitative data, may be more appropriately resolved through an exclusive religious community than in his former social life.

*Theme 2: Using Touch.* Physical touch was of questionable utility since Ray had a tendency to sexualize most of his inner felt experiences. Given Ray's sexualized

dynamics, it was therefore somewhat surprising that Laurie, who has been extremely careful around touch with other clients, did not query more before using touch with Ray.

Session 5: Ray asked Laurie if she would touch his shoulder (Theme 2). She explored the pain with him and he reported it was not currently bothering him, so she suggested that they not focus on it, but that they could have a session working on it later in the treatment. She briefly touched his shoulder at the end of this session.

Although Laurie had been very cautious with Jan, assessing at every step of the way, her first touch with Ray was somewhat hurried, and without any real processing. She also casually mentioned that a following session, which never occurred because Ray dropped out, could be body-based: “We could do a body session. I’m not going to do it tonight, but we could come back to your shoulder. I could probably teach you how to move energy through. We could do some yoga postures together.”

It is curious how Ray interpreted the touch that was used in the therapy and what he thought about her suggesting they do a “touch” session. It is unclear how much Ray has been touched in his life by women in tender or nonsexual ways. It can be hypothesized that he felt sexual energy towards Laurie and did not know how to contain it. Therefore, as he became more religious, there was more internal conflict over how to use the body-centered treatment while maintaining strict religious practice; therefore, he avoided and dropped out.

*Theme 3: Telling the story: Working with narrative versus body.* The main work of Ray’s therapy was to help contain his activation, which he often discharged through his lengthy narratives. Often Ray would get so wound up in his story that he was unable to maintain a relational focus at all. Laurie encouraged Ray to notice how he disconnected through stories. Laurie had to struggle to hold him from fixating on the stories, which

often created some ruptures in the relationship, yet remained one of the most helpful interventions he mentioned post-treatment.

### Summary and Integration of Outcome Results

Ray's case was a vivid illustration of Laurie's work with a type of client – a young African-American male – who was an unusual candidate for BcP treatment. Also, this case offered an example of a client's early termination from treatment. Despite the brief time, Laurie was able to interact with Ray's needs such that he left with some satisfaction and felt more content in his life than he had in a long time.

An important illustration of the therapy's role in Ray's growth was his newfound ability to work with a professor instead of rejecting and challenging her authority. Previously Ray had been provocative with the professor by leaving class early, not turning in assignments, and acting generally disrespectful. As Laurie coached him, Ray worked through his impulse to act inappropriately, so that he could tolerate more of his own high arousal around this professor. Through their work, he became more comfortable with allowing the professor to be in charge. He repaired their relationship and ended the course on a good note.

As for their alliance, similar to that with his professor, Ray tested Laurie throughout treatment, which forced her to work flexibly to communicate her acceptance of him regarding his drug use, his sexuality, and his spiritual concerns. In their final session, Ray shared how much he valued the treatment and their developing relationship. It was therefore even more surprising that he abruptly dropped out after that session. One can surmise that if Laurie had challenged Ray earlier in the treatment, he might have dropped

out earlier, or it might have forced him to confront his resistance and take therapy more seriously.

The insufficient accord between Ray's overt statements and his actions spoke to something incongruent about Ray. In fact, Ray's quantitative and qualitative data indicated a similarly conflicted symptom picture. The way Ray represented himself in his verbalizations was often extremely positive, filled with excitement and self-esteem. However, neither his quantitative data nor his behaviors (within or outside the sessions) reflected his subjective sense of extreme well-being.

The lack of congruity between the way he expressed himself as relatively problem-free and the way he acted throughout the treatment remained an important variable in the process. Particularly, this incongruity seemed apparent in how readily Laurie welcomed Ray's faith in Allah into treatment and how Ray seemed to enjoy her support and responsiveness to Islam and his spirituality. Yet, despite Laurie's encouragement of Ray's spiritual path, including helping Ray explore his prayers while connecting it to his body in mindfulness, Ray independently decided that the therapy was incompatible with his practice of Islam and terminated without sharing any of his concerns.

Although Ray exhibited a strong devotion to Islam, rescinding his agreement to participate in the study revealed difficulty following through with his commitments. Although clients were free to cease treatment at any point, they were asked to complete the final forms. Despite several phone calls by the researcher confirming his departure, he did not return the phone calls. It was not until the researcher met up with him by chance on the college campus that he agreed to finish the final forms and complete the exit interview, although my paying for lunch had to be an included incentive. In hindsight,

Ray's lack of paying for the therapy, as he and Laurie had arranged that he would exchange artwork for the sessions, was a mistake. Ray's lack of follow-through, often not returning phone calls or showing up for sessions, indicated a lapse in motivation for treatment. Had he paid for sessions, it is possible that he might have been more motivated for the therapy, or not done it at all.

Overall, Ray's therapy experience reflects conflicting themes of dedication, antisocial behaviors, ambivalence, and moves both towards and away from intimacy. He was courageous to try a new experience through BcP therapy, and given his generosity sharing his process, we can learn something illustrative about working with different types of clients.



## CHAPTER VIII

### CROSS-CASE ANALYSIS

#### Overview

The results of the cases reveal how all three clients showed substantial qualitative and some quantitative clinical progress. The results also reveal in-depth details about the clinical process of the therapies. Importantly, consistent with Peterson's Disciplined Inquiry model, distinctly different patterns of clinical process and progress occurred, as Laurie Schwartz varied her therapy approach according to her assessment of the needs of each client.

#### Quantitative Results

As the quantitative data indicate, Jan and Terry each experienced statistically significant improvement from their treatments, yet in different ways. For example, pre-treatment both scored "within clinical range" on particular subscales of the SCL-90-R (Jan on Psychoticism and Terry on Depression), and post-treatment each experienced a significant (Jan) or near-significant (Terry) decrease in that score (Terry's decrease on Depression was statistically significant as measured by the TEaM scales). These subscales also corroborated the qualitative data, as Laurie focused on issues pertaining to these particular themes in each client's therapy.

Ray did not show statistically significant improvement on any of his quantitative scores. In fact, he showed a significant worsening in Phobic Anxiety. This finding may have been due to his newfound, intense religiosity; the practice may have engendered some of his increased separatist tendencies as captured by the Phobic Anxiety scale. Yet, due to Ray's truncated treatment of only six sessions, the time lapse of several weeks between his ending therapy and completing the final measures, and the extensive intervening changes in his outside life, his scores must be considered with great caution. In the qualitative follow-up interview he did speak with satisfaction about the results he acquired through the treatment.

Comparing the quantitative data across the three clients reveals that Jan had the most statistically significant improvement. Jan's symptomatology possibly shifted the most since she initially appeared more disturbed, in terms of reporting more distress and social isolation, than the other two subjects. Additionally, since Jan started at a higher initial symptomatic level, she had more range in which to improve. Although Terry did not experience as many statistical shifts, she did decrease on 10 of the 12 SCL-90-R subscales, with the other two indicating no change, suggesting a general trend towards symptomatic improvement.

Overall, the quantitative measures provide an important normative standard against which to compare the more detailed, but more individualized and contextualized, qualitative results. The results of this study show the importance of collecting both quantitative and qualitative data in future studies, for they perform different and complementary roles in understanding clients' processes and therapy outcome.

### *Scale of Body Connection Results*

The Scale of Bodily Connection (SBC) is one of the few existing measures most relevant to a study examining BcP treatment, as it examines the interaction of psychological and physical experience within one instrument. Yet since the SBC is a scale in development, it could not offer normative data or ways to account for response biases. Furthermore, it was impossible to determine whether a small amount of change in a score (e.g., 0.1 change) represented a meaningful change. Therefore, the scores could be examined only for trends and how they coordinated with the qualitative data.

On the SBC, Terry demonstrated much less initial Body Awareness than Jan or Ray. This finding was confirmed in the case studies, as Jan and Ray already knew how to become mindful and track their sensations, yet Terry needed more education to attune to and remain with her bodily experience. Her improved ability to stay connected with her felt experience without shame was in fact one of the results of treatment that Terry reported helped her the most, which may have been reflected in her increased Body Awareness score, or potentially captured by her increase in Body Dissociation subscale.

On the SBC, Jan had much less initial body connectedness (low score on “Body Dissociation” Scale) than Terry or Ray. She also subsequently made the biggest improvement on decreasing her dissociation (1.0 rise, where higher scores indicate more connectedness), which also reflected her increased ability to remain connected to her bodily experience. This finding is consistent with her trend on other measures to start from most impaired and become most improved.

It is not clear to what extent Ray demonstrated change on the SBC. However, there was a shift in Ray’s response pattern. Pre-treatment, Ray responded with almost entirely

“all” or “none” scores, suggesting a potentially more extreme approach than at post-treatment, in which he gave many more “some” or “a little” responses in his scoring. With further examination, such changes in response patterns could be a useful aspect of future studies.

Given that the SBC attempts to measure the particular skills of bodily awareness and internal sensory experience that are often difficult to capture on solely medical or psychological checklists, the integrated nature of this measure is noteworthy for future BcP research. Since the SBC is still a scale in development, until studies provide normative data and test-retest reliability, this author recommends that BcP research combine it with other measures.

#### Goal Attainment Scaling Results

All three clients made successful progress in addressing their GAS goals through the therapy. Every client reported progress in at least two goals. Both Terry and Ray initially identified a third goal which, through the course of treatment was transformed into a different goal – indicating the utility of psychotherapy in helping clients experience shifts in their beliefs and life plans. Interestingly, it appeared that the GAS procedure helped clients articulate their goals more clearly than in the therapy process itself. Such a measure may be useful in clinical practice, as it appeared to help clients specify their treatment goals and thus enabled them to work more directly towards meeting them.

#### Qualitative Outcome Results

Adapting her range of techniques for the individual cases is an important part of Laurie Schwartz’s guiding conception of practice, which she illustrated within these three cases. Each client’s presentation was unique; subsequently, her diverse strategies led to

varied results. Similarly, what each client sought through therapy also informed Laurie's style of treatment as well as the quality of the client's results.

In Jan's case, upon entering treatment, she was experiencing high anxiety and posttraumatic symptoms, as well as unusual thinking and significant isolation. She had had two exploitative ex-husbands, and was currently taking a break from intimate relationships (either romantic or friendship) to address her longstanding maladaptive patterns. She had had a good deal of previous therapy and was hyperaware of her bodily sensations, and had few relationships outside of therapy. Her behavioral goals included increasing assertiveness and decreasing compulsive fear-driven activity, such as making lists. Jan also had clear ideas of how to use the therapy – she was already initiated into therapy and bodywork, and was able to join easily with Laurie and begin the mindfulness process without hesitation.

Laurie worked to connect Jan's bodily sensations to positive self-experiences, and then to use this "reservoir" to confront Jan's painful childhood experiences (Theme 1). She used touch sparingly as a way to help Jan reverse "freeze" in her nervous system (Theme 2). Jan had an outside support to work through details of her life, and thus was extremely compliant with remaining entirely in bodily-focused work rather than in her narrative (Theme 3). As a result of the treatment, Jan found herself feeling calmer and more connected to her body. She was able to engage freely with Laurie, and enjoyed the work's results such that she planned to continue treatment with Laurie after the 12 sessions studied.

Terry entered therapy with little prior experience with any kind of therapy besides knowing a client Laurie had treated. She was actively depressed, had been in a long-term

violent, abusive marriage, and was currently in an unsatisfying relationship. She had few current outside supports, and had strong resistance to therapy. Unlike Jan who was hyperaware of her bodily sensations, Terry inhibited her bodily sensations. Her goals for treatment included increasing her writing in her own voice, decreasing smoking, and addressing the sadness of her unsatisfying relationship.

In Terry's case, Laurie needed to spend more time coaching and educating Terry to work through her strong resistance. Importantly, confronting Terry's resistance to giving love to herself was the most profound change Terry encountered in the treatment – first through understanding that pattern, then learning how to nurture herself more directly. Laurie used many more touch interventions with Terry than with Jan, and provided a great deal of attention to the alliance with Terry. At the end of the 12 sessions in the study, Terry spoke of continuing but had not yet set up further appointments.

Without even an acquaintance's referral or any prior experience in therapy, Ray was the least knowledgeable about treatment. Instead, without any set goals, he was the most driven by curiosity rather than reported pain. Ray often found himself at odds with societal expectations: He felt "hyper" when his professors expected calm; he engaged in many casual sexual relations, but had difficulty with emotional intimacy; and generally experienced considerable frustration with finding his identity in society at large beyond being a college student. His behavioral goals included increasing his professional opportunities and creating more options for creative self-expression through writing.

Unlike Jan's case, where trust was largely taken for granted, Laurie's work with Ray entailed building trust in the alliance, passing numerous "tests," and disclosing personal information to help him sense that she was "real." Ray had strong beliefs and Laurie

worked to show respect and acceptance – whether they related to drugs, sex, or Allah.

Yet Ray continued to struggle with meeting his agreements to others and to himself. His premature termination indicates that he had not made a solid commitment to the therapy.

### *The Narrative Themes*

#### *Theme 1: Helping the Client Feel “Resource” and Nourishment*

Examining the therapist’s role in bringing clients to their inner sense of nourishment and resources was one of the most important foci of this study. Throughout the sessions, Laurie consistently encouraged clients to find nourishment experientially in their bodies. As her guiding conception predicted, clients need to be adequately connected with their inner resources in order to experience and resolve the traumatic sensations. All three clients vacillated, often rapidly, between feeling connected to their inner resources and experiencing painful sensations, and in all three cases, allowing the feared sensations to emerge and then returning to pleasurable nourishing sensations provided an essential ingredient in their treatment results.

Each client presented a different style of finding nourishment and retaining it through treatment. Jan and Terry had a great deal of difficulty remaining within nourishing sensations, although their experience of past traumas manifested in different ways. Jan had difficulty feeling nourishment without having fearful sensations emerge of her father attacking her. Terry struggled more with combating nourishing sensations through her own self-attack of guilt and shame. She had introjected a persecuting mother who taught her that if she relaxed and received love, she would be abandoned. Whenever Terry enjoyed herself, she would imagine her mother’s critical voice emerging, telling her to “do something” and not “just sit there.” Ray, on the other hand, was easily able to find

nourishment and retain it. He would often describe himself in session as relaxed, and seemed to find ways to rejoice in pleasure – through smoking marijuana, with women, even in skipping classes and having fun.

More so than with the other clients, Laurie used imagery and focused on Jan's unadulterated experience of tracking her bodily sensations. These techniques were formulated to help Jan regain safety within herself before encountering relationships again. Terry's treatment involved more emphasis on Laurie's providing new nourishing experiences to Terry, particularly involving Terry learning to receive without giving. Much of their treatment work involved her exploring and integrating the new and uncomfortable experience in which she could "be" in a relationship without having to "do" anything (such as take care of or attune to the other). For Terry, physical touch became an important dimension of providing this unmet developmental need. Finally, with Ray, Laurie's work involved helping Ray create a healthier container for his abundant energy through setting limits and rules, so that ultimately he could find sources of nourishment that would exist beyond the moment, i.e., not fleeting or antisocial choices of drugs or troublemaking. Ray's learning about setting limits and containing nourishment eventually supported his practice of Islam.

### *Theme 2: The Use of Touch in Body-centered Psychotherapy*

Several distinct types of physical touch in a BcP treatment can be discerned based on Laurie's work with these cases. The first type involved grounding techniques through physical contact in the form of Laurie putting her feet on top of a client's. This type of touch appeared relaxing and soothing to the client. The second type of touch was through experiments in mindfulness, drawn from Hakomi therapy, such as hand-to-hand touching



while therapist and client are sitting across from one another. These “experiments” require active involvement by the client to explore new sensations. Additionally, although these types involve skin-to-skin contact, they are more isolated interventions than other types of touch (described below), and were more readily introduced into the treatment with less physical or verbal preparation.

A third type of touch involved more bodywork-oriented physical contact in relationship, e.g., Laurie’s sitting next to Terry on the couch with her hand on her shoulder. In this type of touch, Laurie usually supported a part of a client’s body, such as holding the client’s shoulder or head, and gently massaging his or her back or neck. This type of physical touch required more time to build alliance and more interventions before engaging in the touch. This type of touch was also very powerful for Jan, who needed a lot of support around feeling safe with another person next to her.

The fourth type of touch involved lying down. As illustrated in the cases (see Terry, session 6), Laurie has a cushioned full-length mat that she puts on the carpeted floor. She has clients lie on the floor (which in itself offers a certain kind of touch with the floor and the mat). Laurie will often sit on the floor behind the client and gently use some light massage touch on the client’s shoulder, head, or neck as they lie on their backs. This type of touch is intended to be relaxing and nourishing and is used to give a client an experience of touch they never had. For clients who have not had a lot of nourishing experiences, it can be a very nourishing and/or destabilizing experience. It can make clients feel very vulnerable, and involves a level of regression that both the therapist and client must be prepared for (as in the case of Terry). This type of touch has to be done carefully and with a lot of awareness beforehand and with time for integration afterwards.

Physical touch was used according to Laurie's formulation of each client's needs. In Jan's case, Laurie saw Jan's body as being hyper-rigid and needing softness. She wanted to use touch but sensed that until Jan felt more secure in her body, it might increase Jan's rigidity. Laurie's care in checking in with Jan at every step appeared important in empowering her and respecting their alliance. It was a powerful treatment moment when Laurie sat next to Jan on the sofa without touching her and together they explored how, for Jan, that was enough contact. The shift could be seen in one of their final sessions, as Laurie briefly sat next to Jan without any startle. Jan often got so trapped in her bodily sensations that she lost touch with others (as she remarked herself in one session). Perhaps offering touch more forcefully might have "broken through" some defense of Jan's. One can only wonder what it would have been like had Laurie used more touch with Jan, particularly nourishing touch as she did with Terry.

Laurie assessed Terry's body as "in collapse" without good muscle tone, indicating that she was "touch starved." Laurie wanted "to build potency and somatic strength in Terry's body." Touch was used as a main intervention in Terry's treatment. In addition to the nourishing feelings, it also scared Terry to be touched, as it stimulated all her long-held unmet needs.

Laurie used touch sparsely with Ray. Without a larger sample of male clients, it can only be hypothesized that some of the constraints and boundaries arose from their cross-gender dynamic. Nor did Laurie offer touch; when Laurie did touch Ray, it was only after he explicitly requested it. Only after his request did she suggest that they could do a "touch" session in which she worked on his shoulder. Touch for Ray appeared to have

sexual overtones, and it raised many concerns about erotic transference that most likely Laurie would have needed to address had he continued therapy.

In sum, physical touch was an important intervention in the treatments, and may offer a more complete form of healing than talk alone. Although not the case for all clients, Laurie's work demonstrated how physical touch can be successfully integrated into psychotherapy without major complications to the therapeutic alliance. In fact, we have seen how it may deepen the therapy experience for the client. The ways in which touch can be used in psychotherapy calls for more rigorous and extensive empirical study.

### *Theme 3: The role of narrative in a BcP Treatment*

BcP puts the client's somatic experience at the center of the healing process, yet also requires the integration of sensation with cognition, affect, and behavior. Therefore, finding the balance between focusing on the body versus a client's narrative story can be especially difficult. Laurie emphasizes Hakomi's imperative to "stop the story and make contact," and how clients' stories can often take them away from the present moment. Figuring out how to keep a verbose client "within the body and out of story," and how early in the treatment such a struggle can occur, are difficult challenges for this work.

Laurie formulated that Terry often used her stories defensively. Therefore, she would interrupt Terry even at painful parts of her narrative, which created a powerful struggle in the alliance. For Terry, it was hard to be stopped abruptly, and despite her difficulties articulating anger or asserting herself, she was able to express being "a teeny bit frustrated" at Laurie for being cut off from telling her story. It must be asked whether Terry, in her long narratives of loneliness and despair, is the very young child who needed someone to reflect, attend to, and hold her. In this case, cutting off might show

one is uninvolved or uncaring. On the other hand, directing Terry from narrative to focus on the body, while frustrating for her, was by her own admission one of the most helpful parts of the therapy. “A lot of the biggest breakthroughs happened through the body. That sensation of pushing [gestures with palms out] was big for me. I guess for the most part, the parts that were least comfortable probably took me the farthest.” In any event, the question of timing – when to intervene with body-focused work and how much time to allow the client to tell his or her story rather than remain in more direct contact – is an important question for future research.

Ray loved to tell stories. Laurie believed that Ray often talked about experience instead of staying in it. She noticed how during his stories he would get very dissociated (“spaced out” in his words) by talking, and stay out of relationship. But Ray did have a great deal to say. He even remarked after one of their first sessions that he left frustrated that he was not able to say more in the session. Similar to Terry, Laurie and Ray experienced their most severe ruptures in the alliance over who controlled the talking. Laurie often struggled to focus Ray; for instance, she interrupted him mid-story and addressed his tendency to say “you” instead of “I.”

On the opposite side of the spectrum was Jan, who often appeared so internal, tracking and noticing her bodily sensations, that she often seemed unrelated to Laurie. Perhaps it might have helped her had Laurie interrupted her to focus her on the relationship with Laurie or another person. However, Jan had her “talking needs” met through her regular, concurrent talk therapist; therefore, her case is unique in that this work could focus largely on her need to remain in her body.

## CHAPTER IX

### DISCUSSION AND CONCLUSIONS

#### Learning from the Three Cases

The results of the three case studies analyzed in the previous chapters suggest that Body-centered Psychotherapy contributes to positive therapeutic change and offers several important contributions to the discourse on the practice of psychotherapy, including 1) the emphasis on a client's sensations alongside emotion, cognition, and behavior; 2) an expanded range of interventions; and 3) the focus on inner calm within the client's body. Consistent with Peterson's Disciplined Inquiry model, the three cases document the value of combining qualitative and quantitative data in researching Body-centered Psychotherapy, and illustrate how the therapist was able to adjust her techniques based on the needs of each client in ways that appeared beneficial to them.

As previously discussed, a distinct contribution of BcP is its emphasis on working with sensations alongside emotion, cognition, and behavior. New findings within neuroscience research are revealing more information about how trauma is processed in the body, and how it is often not integrated with cognitive processes (van der Kolk, 1994). Body-centered Psychotherapy is leading a movement, both theoretically and clinically, to integrate physical sensation into psychotherapy and thus enhance integration within neural networks (Cozolino, 2002; Levine, 1997). By working on bodily experience

alongside other aspects of maladaptive cognitions and emotions, BcP is presenting a new method to help people assimilate traumatic sensations and resolve long-held trauma.

In a number of ways, Body-centered Psychotherapy offers a more broad-ranging therapy than one based only on verbal interventions. Since the BcP techniques and methods can span a continuum from verbal interventions to active, hands-on work, it can be argued that BcP has more modes for accommodating to a client's individual needs. However, as illustrated in the three cases analyzed, the strong focus on body-oriented awareness in the present moment can be at cross-purposes with clients who want to work largely within their histories and verbal narratives.

Another major contribution of BcP is the focus on helping clients experience positive internal resources through calm, relaxing images, sensations, and feelings. The three clients in this project spoke about experiencing new found "calm" in their bodies as a major impact of Laurie Schwartz's treatment. BcP's focus on experiential, calming strategies corroborates the recent interest in such techniques as mindfulness which are entering the psychological mainstream (Dimidjian & Linehan, 2003; Teasdale, Segal, & Williams, 2003). What is particularly promising in BcP treatment is the seamless integration of this relaxation-focused work within the therapy – not as an added technique – but woven through the core narrative work, moving back and forth without pause.

As to the question of the BcP as a form of psychotherapy integration, this study best advances BcP therapy as a form of theoretical integration. In this integrated model, psychodynamically-based attachment theory is integrated with somatic theories alongside Buddhist awareness-based principles. For example, many BcP therapists consider the

relationship a person has with his or her “body”<sup>13</sup> as analogous to that person’s relationship with the primary caretaker. Thus, learning to be more comfortable within one’s body is a way to overcome past attachment wounds and bond more fully with oneself.

As discussed previously, whereas some of the techniques within BcP may be assimilated into other therapies, based on the cases I studied, I propose that only as a theoretical integration may all the techniques of BcP be utilized. What follows is a discussion of specific techniques and how they might fall into an accommodative/assimilative model. Within the discussion of each technique, it is possible to see the implications for psychotherapists desiring further training in this work.

The BcP technique of focusing on sensation alongside emotion, cognition, and behavior appears most suitable for assimilation into another therapeutic model. In fact, many psychotherapies are incorporating such techniques into their methods. “How are you experiencing that in your body?” is becoming a common question in helping clients understand their experience. A sensory-based awareness can be incorporated into psychotherapy with some alteration of the dominant model (Wolfe, 2001), yet without a complete transformation of the main theory.

Awareness-based techniques also seem easy to incorporate into other therapeutic models. Again, there may be some shifts in the therapeutic relationship that may occur by inviting clients to close their eyes. However, this style of working with the body is consistent with many theoretical orientations, and it does not introduce any important boundary-crossings that must be negotiated. Learning more about working with the body

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<sup>13</sup> In this context, “body” refers to the person’s physical sensations, musculature, and general experience within his or her physical structure.

in imagery could be a particularly useful technique for therapists who want to work more with the body, yet do not have the time or inclination to train as BcP therapists.

Additionally, focusing clients on their inner resources can also be assimilated into other psychotherapies. Such techniques focusing on positive experience may be a significant contribution to more problem-focused therapies.

Most difficult to assimilate into other therapeutic models are the BcP techniques involving touch and floor-based work. These techniques require the most extensive training on the part of the therapist as well as the clearest expectations on the part of the client. In order to introduce these techniques into a therapy session, the therapist must have already explicitly stated within the initial informed consent that such techniques as touching or using light massage are central parts of his or her repertoire. Thus, these boundary-crossing techniques should not be a surprise and must not overstep the safety of the relationship. As illustrated in these cases, even with an initial consent, therapists must proceed with great caution, checking in often with clients during the process.

Using touch-based interventions in psychotherapy remains the most debatable aspect of integration. This author supports the notion that therapists who go beyond the “spontaneous touch”<sup>14</sup> described by Geib (1982) and Horton (1994) to incorporate intentional touch in psychotherapy are fundamentally changing their scope of practice. In this sense, therapists who intend to use touch offer a unique, theoretically-integrated stance. In order to understand and practice with appropriate ethics, therapists who use touch as a primary intervention in practice need to portray themselves as body-oriented

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<sup>14</sup> The concept of spontaneous touch that occurs when a psychotherapist spontaneously touches or hugs a client within the therapy session was introduced in Chapter I.



psychotherapeutic practitioners. Such therapists must seek additional training in order to use touch in practice and cannot remain assimilative practitioners.<sup>15</sup>

As this research has demonstrated, Body-centered Psychotherapy can be individualized to each client in ways that are successful to many. It provides methods of conceptualizing and treating distress that augment mainstream psychological techniques and deserve further investigation. In trying to generalize from the three cases, however, it is important to keep in mind a number of limitations in the present research, including the following: only three clients were studied, there were no control subjects, only one therapist was involved, and one of the clients was simultaneously in two other therapies. Thus, the findings must be interpreted cautiously. With this caveat in mind, the results suggest that BcP appears to contribute to positive therapeutic change.

Since BcP's strength is working on internal experience within clients' bodies, a potential challenge for BcP is that it may have less emphasis on (and therefore time for) working in the external details of clients' everyday lives. For example, within Laurie Schwartz's treatment of Terry, one might argue that Laurie did not adequately address the pragmatic level of Terry's real life issue of resolving her relationship with Jack, who was unwilling to provide her with the intimacy and closeness that she needed. Laurie did not discuss with Terry whether to set a firmer boundary with Jack. This issue definitely would have arisen had they continued to work together longer. Yet it raises the question of whether a brief course of BcP is done best in combination with a talk-based therapy, in which such issues could be explored in more depth. Jan's case, in which this combination was present, suggested that an adjunctive talk-based therapy in combination with BcP might be particularly helpful.

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<sup>15</sup> For example, the USABP has a distinct ethics code, which must be adhered to alongside the APA ethics.

### Need for Establishing High Training Standards in BcP

Since BcP uses touch-based interventions along with verbal ones, this work requires more training of therapists, not less. Thus, issues of training and quality control in BcP are crucial. A main question for BcP training is whether therapists ought to train in traditional psychotherapy programs before learning BcP modalities. Additionally, given the care necessary for physical contact in the therapeutic context, perhaps BcP therapists ought to be required to attend formal massage or other body-oriented training, which include anatomy, physiology, and the ethics of touch. Finally, there is a need for training options for traditional clinical psychotherapists who want to learn more about trauma and the body and who are interested in assimilating BcP techniques into their current practices. Currently, there are inadequate BcP training resources in many areas of the country as well as too many BcP-oriented professionals working without advanced degrees and with little accountability. There is a great need for more rigorous, accredited training programs as well as education for the public.

The area of client psychoeducation is also salient. Socializing clients to BcP includes teaching about processes such as mindfulness and connection to bodily sensations, which are difficult yet essential to the BcP work. The more clients are educated about therapeutic options, the more readily they will be able to use these techniques.

Additionally, as the data in the three cases indicated, a strong therapeutic alliance is essential in this type of work. As the subjects spoke in their interviews, the quality of Laurie Schwartz's presence was crucial; she received a lot of positive feedback for her ability to make the experience safe for each of these very different clients. Although this is true for all types of psychotherapy, the complication of combining both emotionally

charged verbal and touch work – including therapy when clients are lying down in the treatment room – raises additional challenges for the therapist-client dyad. Therapists with inadequate training could easily do harm. Therefore, although one might argue that this is true of all therapies, the “groundedness” of the BcP therapist is very important.

#### Need for Integrative and Case-Based Research Methods

As discussed in Chapter I, BcP is an under-developed area of academic study, and thus, there is a need for more diverse scholarly research. As this dissertation illustrates, case-based research is complementary to group-based studies in terms of deriving psychotherapy models that are rigorous and evidence based (APA, 2005; Fishman, 2005; Goodheart, in press). Specifically, the present research illustrates the potential of systematic, in-depth study of multiple cases, as well as cross-case analysis of the results, in developing a method for analyzing the effectiveness of a model of psychotherapy within an applied setting.

Yet because the knowledge derived from case studies is inductive, what can be generalized from any single case is limited. It is therefore of particular importance to replicate of this type of investigation with many cases in order to generate a database of BcP cases (Fishman & Messer, 2005). Analysis of such a database should yield both a range of different, effective BcP techniques as well as common curative factors across BcP cases and treatment models. To help create such a database, there is a new, online, open access, peer-reviewed journal, *Pragmatic Case Studies in Psychotherapy* (<http://pcsp.libraries.rutgers.edu>). The journal publishes individual therapy cases across the range of theoretical perspectives, and it includes the aim of enhancing systematic and rigorous cross-case analysis.

In line with the specific need for more rigorous study of individual cases of BcP, the United States Association of Body Psychotherapy is in the process of developing a “videotape database” of various BcP styles (USABP, 2004). This database will prove useful for researchers to examine the diversity of BcP models, as well as provide a rich supply of data for future research. Such videotapes and other types of BcP research will be most valuable in helping both practitioners and clients become further educated about the potential benefits and risks of “listening to the body.”

## REFERENCES

- Alpert, M. (1996). Videotaping psychotherapy. *Journal of Psychotherapy Practice and Research*, 5(2), 93-105.
- APA. (2005). *Draft Policy Statement on Evidence-Based Practice in Psychology*. Washington, D.C.: American Psychological Association Presidential Task Force on Evidence Based Practice.
- Aron, L., & Anderson, F. S. (Eds.). (1998). *Relational perspectives on the body* (Vol. 12).
- Bourque, G. B. (2002). *Somatic psychotherapy for people with chronic pain*. Paper presented at the United States Association of Body Psychotherapy, Baltimore, MD.
- Bridges, M. R. (2002). *Enhancing therapeutic emotional expression and experience by the use of body-focused psychotherapy: A single case design utilizing empirically validated methods*. Paper presented at the United States Association of Body Psychotherapy, Baltimore, MD.
- Caldwell, C. (1997a). The somatic umbrella. In C. Caldwell (Ed.), *Getting in touch: The guide to new body-centered therapies* (pp. 7-28). Wheaton, IL: Quest Books.
- Caldwell, C. (Ed.). (1997b). *Getting in touch*. Wheaton, IL: Quest Books.
- Cardillo, J. E., & Smith, A. (1994). Reliability of Goal Attainment Scores. In T. J. Kiresuk, A. Smith & J. E. Cardillo (Eds.), *Goal Attainment Scaling: Applications, theory and measurement*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Cozolino, L. (2002). *The neuroscience of psychotherapy*. New York: W.W. Norton & Company.
- Croft, A. (2003). The SCL-90-R in Clinical Application.  
[www.chiroweb.com/archives/17/10/02.html](http://www.chiroweb.com/archives/17/10/02.html).

- Damasio, A. (1999). *The feeling of what happens: Body and emotion in the making of consciousness*. New York: Harcourt Brace.
- Derogatis, L. R. (1994). *SCL-90-R: Administration, scoring and procedures manual* (3rd ed.). Towson, MD: Clinical Psychometric Research.
- Dimidjian, S., & Linehan, M. M. (2003). Defining an agenda for future research on the clinical application of mindfulness practice. *Clinical Psychology: Science and Practice, 10*(2), 166-171.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.
- Erickson, M. H. (1980). *The nature of hypnosis and suggestion* (Vol. I). New York: Irvington Publishers, Inc.
- Ferenczi, S. (1953). *The theory and technique of psychoanalysis*. New York: Basic Books.
- Field, T. (2001). *Touch*. Cambridge, MA: MIT Press.
- Fisher, K., & Hardie, R. J. (2002). Goal attainment scaling in evaluating a multidisciplinary pain management programme. *Clinical Rehabilitation, 16*, 871-877.
- Fishman, D. B. (1999). *The case for pragmatic psychology*. New York: New York University Press.
- Fishman, D. B. (2005). Editor's introduction to PCSP -- From single case to database: A new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy [Online], 1*(1).
- Fishman, D. B., & Messer, S. B. (2005). Case-based studies as a source of unity in applied psychology. In R. J. Sternberg (Ed.), *The unification of psychology*:

- Prospect or pipedream?* (pp. 37-59). Washington, DC: American Psychological Association Press.
- Fosha, D. (2000). *Transformational power of affect: A model for accelerated change*. New York: Basic Books.
- Frank, R. (2001). *Body of awareness: A somatic and developmental approach to psychotherapy*. Cambridge, MA: Gestalt Press.
- Freud, S. (1960). *The ego and the Id*. New York: Norton.
- Geib, P. (1982). *The experience of nonerotic physical contact in traditional psychotherapy: A critical investigation of the taboo against touch*. Harvard University, Cambridge, MA.
- Gendlin, E. T. (1978). *Focusing*. New York: Bantam Books.
- Gendlin, E. T. (1996). *Focusing-oriented psychotherapy*. New York, NY: The Guilford Press.
- Gergen, K. (1991). *The saturated self*. New York: Basic Books.
- Goodheart, C. D. (in press). Evidence, endeavor, and expertise in psychology practice. In C. D. Goodheart, A. E. Kazdin & R. J. Sternberg (Eds.), *Practice and research perspectives on the evidence for psychotherapy*. Washington, D.C.: American Psychological Association.
- Greenberg, L. S. (1986). Research strategies. In G. L.S. & P. W.M. (Eds.), *The psychotherapeutic process: A research handbook*. New York: Guilford Press.
- Greenberg, L. S., & Pinsof, W. M. (1986). Process research: current trends and future perspectives. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*. New York: Guilford Press.

- Grissom, G. R., Lyons, J. S., & Lutz, W. (2002). Standing on the shoulders of a giant: Development of an outcome management system based on the dose model and phase model of psychotherapy. *Psychotherapy Research, 12*, 397-412.
- Harlow, H. F. (1974). *Learning to love*. New York: Jason Aronson.
- Heller, M. (Ed.). (2001). *The Flesh of the soul: The body we work with. Selected papers of the 7th Congress of the European Association of Body Psychotherapy. 2-6 September 1999, Travemunde*. Bern, Switzerland: Peter Lang.
- Horton, J. A. (1994). *Touch in psychotherapy: A survey of patients' experiences*. Georgia State University, Atlanta, GA.
- Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51*, 1059-1064.
- Hunter, M., & Struve, J. (Eds.). (1998). *The ethical use of touch in psychotherapy*. Thousand Oaks, CA: SAGE Publications, Inc.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.
- Johnson, D. H., & Grand, I. J. (Eds.). (1998). *The body in psychotherapy*. Berkeley, CA: North Atlantic Books.
- Jones, E. (1955). *The life and work of Sigmund Freud*. New York: Basic Books.
- Kiresuk, T. J., Smith, A., & Cardillo, J. E. (Eds.). (1994). *Goal Attainment Scaling: Applications, theory and measurement*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Klem, Y. (1985). *Toward a general theory of body psychotherapy based on the theories of Reichian and Dance-Movement therapies.*, Northern Illinois University, Dekalb, Illinois.



- Koemeda-Lutz, M., Kaschke, M., Revenstorf, D., Scherrmann, T., Weiss, H., & Soeder, U. (2003). Preliminary results concerning the effectiveness of body-psychotherapies in outpatient settings - A Multi-center study in Germany and Switzerland. *Psychotherapie Forum, 11*, 70-79.
- Kurtz, R. (1990). *Body-centered psychotherapy*. Mendocino, CA: LifeRhythm.
- Kurtz, R., & Minton, K. (1997). Essentials of Hakomi body-centered psychotherapy. In C. Caldwell (Ed.), *Getting in Touch: The guide to new body-centered therapies* (pp. 45-59). Wheaton, IL: Quest Books.
- Kurtz, R., & Prester, H. (1976). *The body reveals: An illustrated guide to the psychology of the body*. New York: Harper and Row.
- Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*, 159-172.
- Lampropoulos, G. K. (2001). Bridging technical eclecticism and theoretical integration: Assimilative integration. *Journal of Psychotherapy Integration, 11*(1), 5-19.
- Levine, P. (1997). *Waking the tiger*. Berkeley, CA: North Atlantic Books.
- Lowen, A. (1958). *The language of the body*. New York: The Macmillan Company.
- May, J. (2002). *A review of the empirical status of body-oriented psychotherapy*. Paper presented at the United States Association of Body Psychotherapy, Baltimore, MD.
- McClellan, P. (1964). Man and his animal brains. *Modern Medicine*(Feb 3).
- McCullough, L., Cui, X., Andrews, S., & Kuhn, N. (2000). *Achievement of Therapeutic Objectives Scale Manual*.

- McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003a). *Treating affect phobia*. New York, NY: Guilford Press.
- McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003b). *Videotaping and rating your own sessions: Two valuable ways to improve the quality of therapy*, from <http://www.affectphobia.org/docs/VideoATOS/VideoATOSArticle.pdf>
- McCullough Vaillant, L. (1997). *Changing character*. New York: Basic Books.
- Messer, S. B. (1992). A critical examination of belief structures in integrative and eclectic psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 130-165). New York: Basic Books.
- Messer, S. B. (2004). Evidence-based practice: Beyond empirically supported treatments. *Professional Psychology: Research & Practice*, 35(6), 580-588.
- Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice*, 9(1), 21-25.
- Mintz, E. E. (1969). On the rationale of touch in psychotherapy. *Psychotherapy: Theory, Research, and Practice*, 6(4), 232-234.
- Montagu, A. (1971). *Touching: The human significance of the skin*. New York: Columbia University Press.
- Moyer, C. A., Rounds, J., & Hannum, J. W. (2004). A meta-analysis of massage therapy research. *Psychological Bulletin*, 130(1), 3-18.
- Perls, F. S. (1969). *In and out of the garbage pail*. Lafayette, CA: Real People Press.
- Pert, C. B. (1997). *Molecules of emotion*. New York: Scribner.

- Peterson, D. R. (1991). Connection and disconnection of research and practice in the education of professional psychologists. *American Psychologist*, 46, 422-429.
- Peterson, D. R. (1997). *Educating professional psychologists: History and guiding conception*. Washington, DC: American Psychological Association.
- Porges, S. (1997). Emotion: An evolutionary by-product of the neural regulation of the autonomic nervous system. *Annals of the New York Academy of Sciences*, 807, 62-77.
- Price, C. (2002). Body-oriented therapy as an adjunct to psychotherapy in childhood abuse recovery: A case study. *Journal of Bodywork and Movement Therapies*, 6(4), 228-236.
- Raab, I. (1996). *Touch in psychotherapy: Controversies and applications*. Massachusetts School of Professional Psychology, Boston, MA.
- Reich, W. (1945). *Character analysis*. New York: Farrar, Straus, and Giroux.
- Rothschild, B. (2000). *The body remembers*. New York: W. W. Norton & Company, Inc.
- Rubinfeld, I. (2000). *The listening hand*. New York: Bantam Books.
- Rubinstein, B. (1965). Psychoanalytic theory and the mind-body problem. In N. S. Greenfield (Ed.), *Psychoanalysis and current biological thought*. Madison, WI: University of Wisconsin Press.
- Safran, J. D., & Messer, S. B. (1997). Psychotherapy integration: A postmodern critique. *Clinical Psychology: Science and Practice*, 4(2), 140-152.
- Schlosser, R. W. (2004). Goal attainment scaling as a clinical measurement technique in communication disorders: a critical review. *Journal of Communication Disorders*, 37, 217-239.
- Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

- Schore, A. N. (1994). *Affect regulation and the origin of the self*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Schwarzer, R., & Jerusalem, M. (1999). Skalen zur Erfassung von Lehrer - und Schülermerkmalen. Dokumentation der psychometrischen Verfahren im Rahmen der wissenschaftlichen Begleitung des Modellversuchs Selbstwirksame Schulen. *Freie Universität, Berlin*.
- Shannon, S. (2002). Integration and holism. In S. Shannon (Ed.), *Handbook of complementary and alternative therapies in mental health* (pp. 21-42). San Diego, CA: Academic Press.
- Smith, E. W. L. (1985). *The body in psychotherapy*. Jefferson, NC: McFarland & Co., Inc.
- Smith, E. W. L. (1998). Traditions of touch in psychotherapy. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), *Touch in Psychotherapy*. New York: Guilford Press.
- Smith, E. W. L., Clance, P. R., & Imes, S. (Eds.). (1998). *Touch in psychotherapy: Theory, research, and practice*. New York: Guilford Press.
- Staunton, T. (Ed.). (2002). *Body psychotherapy*. New York, NY: Brunner-Routledge.
- Stephenson, E. D. (Ed.). (1975). *Gestalt therapy primer*. Springfield, IL: Charles C Thomas.
- Stricker, G., & Trierweiler, S. J. (1995). The local clinical scientist: A bridge between science and practice. *American Psychologist*, 50, 995-1002.
- Suiter, R. L. (1983). *A comparison of male and female professionals and nonprofessionals evaluations of the use of touch in psychotherapy*. Kansas State University, Manhattan, Kansas.
- Teasdale, J. D., Segal, Z. V., & Williams, J. M. G. (2003). Mindfulness training and problem formulation. *Clinical Psychology: Science and Practice*, 10(2), 157-160.

- Totten, N. (2003). *Body psychotherapy*. Philadelphia: Open University Press.
- Tronick, E. Z. (1989). Emotions and emotional communication in infants. *American Psychologist*, *44*(2), 112-119.
- Tronick, E. Z., Bruschiweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., et al. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, *19*(3), 290-299.
- USABP. (2004). Real sessions research project. *The United States Association for Body Psychotherapy Newsletter*, Spring, 7.
- van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry*, *1*(5), 253-265.
- van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: the effects of overwhelming experience on mind, body, and society*. New York: Guilford Press.
- Ventling, C. D., & Gerhard, U. (2000). Zur Wirksamkeit bioenergetischer Psychotherapien und Stabilität des Therapieresults: eine retrospektive Untersuchung. *Psychotherapeut*, *45*, 230-236.
- Whitehouse, M. S. (2005). from <http://www.authenticmovement-usa.com/adta.htm>
- Wolfe, B. E. (2001). A message to assimilative integrationists: It's time to become accommodative integrationists: A commentary. *Journal of Psychotherapy Integration*, *11*(1), 123-131.
- Young, C. (Ed.). (2002). *The EABP Bibliography of Body Psychotherapy on CD-ROM*: European Association of Body Psychotherapy.

## APPENDIX A

### LIST OF THEMES

#### Theme 1: Helping the client feel “nourished” by their internal resources

This theme refers to Laurie bringing the client’s awareness to a positive, nourishing aspect of their lives (e.g., loving feelings, a calming image of the ocean). It could be through thought, feelings, imagery, etc. The guiding conception is that the client needs to be able to access nourishment in order to work with trauma sensations. Then trauma is dealt with through “pendulation” (see below). Empowering a client with tools to access nourishment and resources themselves appears to be one of the most important contributions of BcP.

#### Theme 2: Using physical touch

The hypothesis that touch can provide a healing modality which is different or adjunctive to talk is the theme that originated the study. How does a Body-centered Psychotherapist use touch in a therapy? When to touch the client, at what points in treatment, what is the client doing that leads to wanting to touch? What are the constraints? How does she introduce it? Does that change as people get used to touch?

#### Theme 3: Telling the story: Working with narrative versus body

This theme involves the complicated question of how much clients have to tell their narrative verbally in the treatment. Often there is some struggle between therapist and client around how much to talk versus focus on the body.

#### Theme 4: Turning to the body

In this technique, Laurie brings the client’s awareness to the body through mindfulness. She often uses this technique to interrupt a client who is telling a story and speaking in “Ordinary consciousness.” Particularly pay attention to when Laurie says, “Take a moment to....” or “What would it be like to....”

#### Theme 5: Slowing time down

This theme involves the theory that the body-mind (i.e. the nervous system) needs time to resolve trauma at a slower pace than ordinary cognitive thinking. Laurie therefore is constantly slowing clients down in order to access this level of awareness and consciousness. As discussed, Laurie particularly uses her voice to create this slowing effect. This theme is resonant with hypnosis, yet will be addressed here in the context of how it was introduced to Laurie through Hakomi and Levine’s trauma work.

#### Theme 6: Formulation of client’s character structure

This theme involves helping the client understand character structure through exploring the body’s somatic organization and linking it to one’s own personality dynamics.

Theme 7: Telling the story

This theme refers to the client's attempts to continue the story – wanting to talk and figure through verbal narrative. Often there is some struggle between body techniques and verbal at this point.

Theme 8: Integration

Integration involves connecting the somatic work of bodily sensation to thoughts, feelings, images, etc. This appears to be one of the most interesting aspects of the BcP work: How effectively can the person integrate these different aspects?

Theme 9: Tracking and mirroring

Tracking involves noticing what the client is doing moment-to-moment in their affect and body and mirroring it. This can be affective mirroring (“You seem overwhelmed”) or somatic (“you just moved your right foot. What is it saying to you?”). Many of Laurie's comments are intended to mirror and follow the client's affective and somatic material.

Theme 10: “Pendulation”

In this theme, Laurie works to move back and forth between joy (nourishment) and grief (trauma), working with both sides. Often the pendulation happens spontaneously, usually when the client feels positive feelings, some trauma memory or fear will emerge. How Laurie works with pendulation, or how pendulation emerges and how Laurie responds, will be an important theme of the case analysis.

Theme 11: Bringing attention to the relationship

An important technique across relational therapies, this theme involves making the relationship between therapist and client the focus of treatment. This technique can be used for many reasons: to deepen affect, to address resistance, etc.

Theme 12: Introducing spirituality

This is an important theme in Laurie's version of BcP. As this model has a holistic framework, there is an acknowledgement of “something beyond.” The comments related to spiritual aspects depend on the client.

Theme 13: Educating the client

Given that there are many unusual aspects and paradigm shifts in this therapy, including touch, etc, educating the client is an important part of this work. Laurie does a lot of educating and orienting the client to her framework. This theme is salient throughout treatment; although the content of what she teaches changes, Laurie continues to educate across a therapy.

Theme 14: Addressing unmet developmental need

This theme involves when the therapist clearly identifies unmet developmental needs and attends to them in the treatment.

Theme 15: Working on a new belief

This theme involves a client having a new belief, or working on the development of a new belief.

Theme 16: Working on a new experience of self

This theme is about clients exploring new felt experiences of nourishment that they never had before.

Theme 17: Working on safety

The theme of safety is extremely important when working with traumatized people. Although safety is a theme that runs throughout the other techniques, it can be focused on explicitly. Some of the work around protection in the case of Jan would be good illustrations of safety.

Theme 18: Shift of consciousness

This theme involves a moment when there is an active shift in the client's consciousness.

Theme 19: Grounding

Sometimes when discharging, or telling a difficult emotional story, a client will become overwhelmed or very "in their head." At these times, Laurie will work on bringing the energy down in the body. Grounding involves explicitly working to "ground" the client in their bodies. Laurie often does this with evoking language of grounding, such as "Check in with the soles of your feet, your legs, etc."



## APPENDIX B

### CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

Title of Study: *Listening to the Body: Pragmatic Case Studies of Body-centered Psychotherapy*

Principal Investigator: Amelia Kaplan, Psy.M.

#### INVITATION TO PARTICIPATE

You are invited to participate in a research study that is being conducted by Amelia Kaplan, Psy.M., a Clinical Psychology doctoral student at the Rutgers Graduate School of Applied and Professional Psychology, Piscataway, NJ. Ms. Kaplan is the researcher of the study. The clinical treatment will be provided by Laurie Schwartz, L.M.T., a Body-centered Psychotherapist with 25 years of training in body and psychological modalities. This consent form contains information about the study that Ms. Kaplan will go over with you. You will have the opportunity to ask questions and have them answered. When all of your questions have been answered, you will be asked to sign this consent form if you agree to be in the study. A copy of this form will be given to you to keep for your records.

#### PURPOSE

The purpose of this study is to examine the usefulness of a somatic psychotherapy treatment in helping clients reduce physiological and psychological trauma-related symptoms and learn more about how their bodily sensations relate to psychological well-being. The treatment that will be offered through this study is what Laurie Schwartz currently offers in her clinical practice, yet at a much-reduced fee for agreeing to participate in research, which includes completing questionnaires and having your sessions videotaped.

#### PARTICIPANT SELECTION

Three adults over the age of 18 who are interested in a mind/body treatment and growth-enhancement process will be selected to participate in this study. To participate, you must be willing to attend weekly sessions for twelve weeks' duration, engage in approximately 90 minutes of a combination of questionnaire self-ratings and interviewing before the first session and after the final session, and write reflections for approximately 30 minutes after each session. The reflections after each session will be divided between two questionnaires. You will be asked to fill out one questionnaire on your session for approximately 15 minutes on the same day as your session. You will also be asked to arrive 15 minutes early before your next session to fill out a short questionnaire. Three months after the last session, you will be asked to engage in an hour-long interview with the researcher. You may not participate in the study if you have severe depression or

other severe illness, if you feel suicidal and/or have extreme difficulty with separation. In order to best understand your somatic concerns, to participate in this study you must be willing to disclose your medication usage with the clinician and researcher. However, there is no exclusion from the study based on any medication usage. You must also be willing to pay a fee of \$75 per session (see “cost” section below) and agree to be videotaped (see further explanation, below).

### **PROCEDURES**

Your participation in this study will last for approximately three months. The researcher will meet with you once for one and half hours at which time you will fill out several questionnaires. For twelve weeks, the practitioner will meet with you for 60 minutes per week. You will also be asked to fill out questionnaires and reflect on the sessions for approximately 15 minutes after the session on the same day as the session and approximately 15 minutes directly prior to the next session.

Procedures are as follows:

- You will receive 60 minutes of treatment per week for twelve weeks.
- At the beginning of treatment, you will be asked to fill out several forms about your life history and current functioning, including any physical or psychological symptoms you are currently experiencing. You will also meet with the researcher for one hour to discuss your life history and participation in the study.
- Throughout the treatment you will be asked to fill out weekly questionnaires for 15 minutes after each session and another questionnaire for 15 minutes directly before the next session.
- At the end of the treatment, you will again be asked again to meet with the researcher to complete several forms about your current psychological and physical functioning, and whether you have noticed any differences from your experience in the sessions.
- Sessions will consist of focused body-oriented psychotherapeutic interventions, in which you will be asked to attend to your internal physical sensations for cues to your mental states.
- Three months after the completion of the treatment you will be asked to come in for a 1 hour interview with the researcher to assess your current level of functioning and whether you have experienced any changes in your life from your experience in the sessions.

### **RISKS**

If you choose to participate in the study, you will not be exposed to any significant risks. However, you may find treatment to be challenging or uncomfortable at times, as you may in any standard psychotherapy. Should you experience mild emotional discomfort, treatment sessions will be aimed to alleviate it. Furthermore, if necessary, appropriate

referrals will be made. You may be revealing information of a sensitive, personal nature that will be recorded on videotapes, audiotapes, and questionnaires. The researcher and practitioner will take every precaution to minimize this risk (see *confidentiality below*).

### **BENEFITS**

Participating in this study is expected to enhance your therapy experience by providing additional opportunities for you to reflect on that experience. The therapy itself is designed to help you with a variety of possible goals, such as reducing symptoms of stress, anxiety, or depression; gaining insight into your emotional difficulties; and/or achieving concrete goals that you set for yourself.

### **WITHDRAWAL**

Your participation in the treatment and in the study is voluntary; you may decline to participate without penalty, i.e. you may continue treatment at your own arrangement with the clinician. If you choose to participate in the study, you may withdraw at any time without penalty. If you would like to withdraw from the study, please discuss this with the researcher or clinician. You may refuse to answer any questions with which you are not comfortable.

### **CONFIDENTIALITY**

The information in the study records will be kept strictly confidential within the limits of the law. Data will be stored in a securely locked cabinet or restricted-access computer and will be made available only to persons conducting the study. All references in oral or written reports will be carefully disguised so you cannot be linked to the study.

### **COST**

There will be a reduced fee for participating in the research protocol. This fee will be approximately \$75 (half of her current fee), as negotiated by you and the clinician on a sliding scale. You may find that at the end of the course of sessions that you will want to continue treatment. If at the end of the treatment you would like additional sessions, it will be necessary to pay for those interventions at a newly negotiated fee or appropriate referrals will be made.

### **CONTACT**

If you have any questions at any time about the study or the procedures, you may contact the Principal Investigator, Amelia Kaplan at the Graduate School of Applied and Professional Psychology of Rutgers University at 152 Frelinghuysen Rd, Piscataway, NJ 08854, phone number (212) 580-9582. If you would like a summary of the results of the study, please contact the researcher at the above address. If you have any questions about your rights as a research participant, you may contact the Sponsored Programs Administrator at Rutgers University at (732) 932-0150 ext. 2104.

Please sign below if you agree to participate in this research study. You will be given a copy of this form to keep.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Investigator's Signature \_\_\_\_\_ Date \_\_\_\_\_

## VIDEO AND AUDIO TAPING

Participation in this research study requires that treatment sessions be video and audio taped. Tapes may be seen only by key study personnel (i.e. researcher, clinician, graduate assistant for transcription, and academic committee) in order to analyze the treatment process. Codes, rather than names, will be placed on all tapes. The tapes will be kept in a locked cabinet at the office of the clinician and/or researcher. Unless otherwise specified, all tapes will be destroyed at the termination of the study.

Please sign below to illustrate consent that the treatment sessions may be video and audio taped for this research study.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Investigator's Signature \_\_\_\_\_ Date \_\_\_\_\_

With your consent, videotapes may be used for future professional work in the area of body psychotherapy. These purposes, which are beyond the specific research of this study, include:

- a) to train graduate psychotherapy students (e.g., doctoral clinical psychology students) in the process of body psychotherapy, and
- b) to provide qualitative information for additional scholarly analysis about the process of body therapy.

With your consent to use the video, it will first be edited so as to maintain confidentiality and disguise your identity. Secondly, it will only be viewed in conjunction with purposes (a) or (b), by individuals who are under the obligation by specific professional ethics codes (e.g., the Ethical Code of the American Psychological Association) to abide by the strictest levels of confidentiality. If at any point you decide you do not want your tape used for any future academic study, you can so request and it will not be used.

Please sign below to indicate consent that the treatment sessions may be used for future professional purposes, as indicated above.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Investigator's Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you for your participation in this research project. Your involvement is greatly appreciated.

## APPENDIX C

## ASSESSMENT MEASURES

This matrix defines the indices that were used in this study, time sampling (pre-, during or post-treatment), and how many minutes each measure approximately took the subject to complete.

<b>Measure</b>	<b>Type of Measure</b>	<b>Intake</b>	<b>During</b>	<b>Post</b>
Pre-treatment Interview (orientation to the study and signing the consent form)	Interview conducted by researcher	15		
TEaM Scales	Self-report	15		15
Scale of Body Awareness	Self-report	6		6
SCL-90-R	Self-report	12		12
Goal Attainment Scaling	Administered by researcher in interview format	25		10
Post-session questionnaire*	self-report (directly after each session)		15	
Pre-session questionnaire*	self-report (right before next session)		15	
Post-treatment interview (qualitative interview about the client's experience in the therapy)	Interview conducted by researcher			45
<b>TOTAL</b>		1 hour and 13 minutes	30 minutes per week	1 hours and 28 minutes

\* These measures were not included in data for this study.

## APPENDIX D

## POST-TREATMENT CLIENT INTERVIEW QUESTIONS

- 1) What were your presenting problems?
- 2) How do you now understand those problems?
- 3) In what ways have those problems changed through your work in the therapy?
- 4) Has anything changed in your outside life?
- 5) In what ways do you think the treatment has been helpful?
- 6) In what ways do you think the treatment has not been helpful?
- 7) How does this differ from your experience of (or assumptions about) talk  
psychotherapy?
- 8) How did the Body-centered Psychotherapy treatment differ from your expectations?
- 9) How do you think sessions could have been improved?
- 10) Has the treatment changed how you understand other people?
- 11) Would you like to make any recommendations to the researcher and clinician  
regarding future studies?

## APPENDIX E

## SUMMARY OF JAN'S TREATMENT SESSIONS

Summary of Session 1

In this session, Jan was very hypervigilant in her responses, giving an immediate yes or right after almost every sentence of Laurie's. Laurie's dominant guiding conception for this session was to join with Jan in an attempt to educate Jan and slow her down so she can access mindfulness. She used the tone of her voice and verbal education to help Jan access her inner experience, and together they discovered more about Jan's character organization. Laurie used a lot of imagery with Jan; she focused on an image of Jan inside the manger she created alongside a community of healers. Jan was able to voice: "My whole being hurts."

Summary of Session 2

Jan began the session with how she feared that her father could appear at any time. They worked with her spontaneous gesture of her hands outstretched and experimented with Jan "pushing her boundary back." Laurie used her first physical touch with Jan, by sitting across from each other, they pushed hand to hand to help Jan feel a boundary in her body. They also reviewed some of Jan's early memories, including as a small girl her puppy dying and eating some of her favorite foods. Laurie already had assessed Jan's hypervigilance and the necessity to slow time down with her. Jan also recognized the importance of slowing down to move more slowly through her experiences and resolve feelings she's held since she was a little girl.

Summary of Session 3

When Jan arrived at the session and sat on the couch, she adjusted her pillow behind her back for herself, which suggested a level of comfort with the treatment, as well as more ability allowing herself to be comfortable in general. She brought in a picture of a "shell lady" with whom she greatly identified. She started the session talking very quickly, but entered mindfulness about half-way through the session, and became quiet and slowed down, tracking her internal sensations. Laurie worked to help her find inner nourishment.

Summary of Session 4

In this session, Jan explored her awareness around feeling nourishment at work. They identified who supported Jan at her job, as well as explored her anger at not being acknowledged further. Laurie and Jan's alliance continued to strengthen as Jan engaged in a lot of somatic tracking as well as experiencing somatic discharge. It was interesting to see how Laurie continued educating Jan about the work throughout the session.

### Summary of Session 5

In this session Jan brought in an image of a lion. They worked to find Jan's healthy rage. Jan made a comment that her "dad won't be dead until I kill him" as she explored talking about being physically hit and abused by her parents. Jan reported intense tightness of her jaw, neck and back. Laurie used touch on Jan's jaw, neck, and back, as well as put her feet on Jan's feet to ground her. Jan appeared to be increasing her understanding of her relationship with both her parents and increasingly "coming out of freeze." Jan also became very thirsty (a theme across her sessions), and reported a headache. This session is the only one where Jan referred to her mother's role: "My mother would never say any thing, ever. The thing about my mother was she was a mixed bag, I mean there was a part of her that was frozen but she clearly also supported him in controlling us, she liked for us to be controlled and she liked having him to be the bad guy to have to do it and she didn't have to be overt about supporting it. She could believe that hers was a sin of omission and somehow that is her justification but she projected all kinds of anger and rage at us, particularly me, you know, she was not a loving kind of person at all she just wasn't physically abusive. So they were sort of like a team. They were very much a team."

### Summary of Session 6

By this time in the treatment, Jan was very engaged in the treatment. Some shifts in her awareness were possible to see. Jan had a powerful memory of being a small girl and being startled by a mentally-ill naked woman. She remembered not shrieking, just silently being afraid. She realized how remaining frozen in this silent, never-spoken shriek cut her off from a lot of nourishment (Theme 1). Laurie worked with her to understand how Jan had to be vigilant as no one was protecting her. Additionally, they imagine Jan's internal image of a healthy parent. Laurie also suggested some physical touch, but given Jan's high level of arousal, Laurie merely sat next to Jan on the couch without any touch (Theme 2). Jan explained that that was enough contact for her. They use the experiment to continue noticing Jan's reactions as bodily sensations (Theme 3).

### Summary of Session 7

A large amount of Jan's personal history surfaced in this powerful session. Laurie had asked Jan to do a timeline of her life, and the two reviewed the timeline in this session. Before this session, it had seemed as if Jan had been fixated on her very early history. In this session, she revealed a lot of her more recent history as an adult, including tremendous betrayals of her ex-husbands (including one who sold their co-owned home and absconded all the money when he was already unemployed and she had been supporting him for several years). Jan also had another memory of her father's abusing her: "We were at the farmhouse where my father grew up and all his siblings were there, so facilities were very limited in this little townhouse. I was in there taking a bath, brushing my teeth or something, and he thought I was taking too long and so he was pounding on the door and I opened the door and he dragged me out and I was screaming what are you doing this is horrible, it's just horrible." As she discussed her disturbing material, her head started swirling – which led to a need for calming, grounding, and discharge. By the end of this session, Laurie had helped Jan find her calm and resource, and softly used some touch – feet on feet at the very end to ground Jan.



### Summary of Session 8

After the powerful previous session, Jan talked about being distracted and hypervigilant. The two focused on watching this pattern and Jan's increasing awareness, which is giving her the option to let go of the vigilance. They discussed Jan's problems at work, particularly dealing with being senior woman. They again used touch of pushing hands against hands to help Jan feel a somatic boundary. Laurie worked with a nourishing image of protection of Jan in a monastery, surrounded by monks. By the end of session 8, the fact that Jan was able to talk about feeling "happy" in her body was a new experience for her. She appeared to be internalizing the process.

### Summary of Session 9

Jan spontaneously started this session by talking about how she noticed her body telling her that it needed some good feeling (Theme 1). This indicates an increase in her somatic awareness as well as her ability to access her resources herself. She discussed confronting a colleague at work, at which time Laurie stopped her to ground her; they never returned to the story (Theme 3). Laurie repeated the touch experiment of pushing hands to hands in order to move away the bad – coupled with language – "get away!" Jan experienced and savored a new felt experience of internal safety.

### Summary of Session 10

They started the session sitting on the floor with a large sheet of paper, while Jan drew for Laurie. Then she returned to the sofa, and they discussed some of Jan's medical problems, how she felt violated by her doctor, and how it reminded her of the "rape" by her father that she feels in her body.

### Summary of Session 11

The two reviewed the pictures Jan drew of her life and the image of where she hopes to be in her life. Laurie sat on Jan's formerly-forbidden right side. Jan talked about feeling embodied and connected to herself. Jan explained that "there's definitely something happening in my stomach. There's not very much happening in my brain." They spent most of the time focused on this somatic discharge without discussing very much. Jan reported feeling more calm and protected within herself, and starting to be able to experience feelings of anger at her father instead of as diffuse fear in her body: "It's really simple, I'm really angry at him... It's nice to be angry rather than afraid... The feeling is lower in my body, as opposed to when I sense being afraid. That seems to be very much in the shoulders by my head and then maybe above my head. So it's a feeling that I recognize as a good thing. I welcome it."

### Summary of Session 12

In this final session for the study, Jan described feeling in a "new house" of her body. She described feeling her body has a different sense of embodiment which she became aware of as "lower on the treadmill." Finally, to illustrate how the alliance and Jan's experience in her body shifted, Laurie gently used touch on Jan's neck and the occipital base of her skull. (Theme 2) By the end of the session, Jan felt contained and was able to remain resourced throughout a difficult focus on the perpetrator. (Theme 1)

## APPENDIX F

## SUMMARY OF TERRY'S TREATMENT SESSIONS

Summary of Session 1

In this session, Terry represented herself through a long story. She reported having “a genuine capacity for joy, but a lot of sadness.” Terry appeared to want to talk a great deal about her long life lived without much support. Laurie educated her about slowing down and coming into mindfulness. Terry put her hands up to her chest a lot during this session, perhaps physically indicating some of her sadness.

Summary of session 2

The two reviewed Terry's eight drawings. They begin to explore together how much to stay in narrative and how much to address the body. They discussed anger and how it was not allowed in Terry's family. They discussed anger as a force of life and Terry associated to a volcano. They worked to locate anger in Terry's painful shoulder. Laurie made her first touch by touching Terry's shoulder.

Summary of session 3

Terry discussed her father being ill, as well as her brother-in-law. She reported that from the last session she acknowledged her anger but “doesn't feel she has very much of it.” Terry was starting to become aware of how much she uses her high functioning as an avoidance of what she is feeling. Laurie worked to offer Terry a new nurturing experience. She touches Terry's head by sitting next to her and supporting it. It was very hard for Terry to release herself from the other's perspective and not worry about how Laurie was feeling. Laurie used the Hakomi technique to work with Terry's developmental missing capacity for support and self nurturance.

Summary of session 4

Terry confessed that the real reason she finally came to therapy was to deal with attacks of “missing” Jack. She described them as feeling so painful “like I can't breathe.” Laurie worked with Terry on not withdrawing from her painful experiences, but becoming mindful of her feelings and sensations. This normalizing attitude was very helpful for Terry as she was beginning to see how she constantly fought to keep her feelings out of her awareness. Finally in this safe relationship with Laurie, she recognized and grieved the sadness, including associations in her body to sadness at being hit. In this session, Terry was beginning to acknowledge her own pain, and take it seriously – a major change for a woman who always focused on the needs of others.

### Summary of session 5

In this session, they worked through the “missing attacks,” which led to Terry connecting to her early developmental longings. She connected the longing in her body with feeling not adequately nurtured by her mother. Laurie used touch by giving Terry a pillow to hold, which helped her connect to her way of finding her inner resource of taking care of others. Terry reported that this was a very important session for her.

### Summary of Session 6

Terry reported that she had contacted intense sadness within herself: “Grief in every cell of my body.” Laurie wanted Terry to experience more nourishment, including used touch by having Terry lie on a pad on the floor and receive touch. They also conducted an “experiment” of having Terry say thank you to her mother, which brought up enormous, unexpected rage in Terry at her mother.

### Summary of Session 7

After the potency of the previous session, Terry arrived describing feeling very “shaky.” This session offered an important illustration of how the therapist’s techniques interacted with the needs of the client. Terry needed the work to go slower, so Laurie spent most of the session grounding Terry. But even in the shakiness, Terry has clearly learned a lot about her inner experience and the language of sensation. She described how this work is changing her. “You know, I never thought of the body having a language this way.” Even her spontaneous language throughout the session is full of somatically-informed, embodied language e.g., “shaky,” “gaggly,” and “popped into my mind.” Laurie also took responsibility for some of the shakiness and addressed their previous session as a potential “mistake,” in order to help assuage Terry’s fear of not doing something right.

### Summary of Session 8

At the beginning of the session, Laurie and Terry’s microphone wires were tangled. As they untangled the wires together, they laughed about it in a way it was possible to feel how their alliance has solidified. Terry reported feeling something has “shifted in me.” Laurie presented more education around touch and regulation of nervous system. Laurie offered touch, yet made sure to empower Terry to lead where to touch. They focused on her sore shoulder. Terry made a spontaneous fist, and the two explored the gesture in mindfulness. Terry started to discharge with sighing, and as she had the “resource” image of a raft, her pain lessens. This session was an example of Laurie working with Terry through discharge, education, and being with sensation, without the struggle around narrative versus body. Terry reported on the change in her body. “I just feel as if there’s this stone that just moves off me, you know. And I’m not talking small stone, I’m talking boulder. [laughs] You know?”

### Summary of Session 9

Terry brought up her intention to quit smoking. They performed a stretch together that Terry can do to help with cravings. Then Laurie checked in with Terry’s breathing. Terry discussed her intention to quit smoking for her son. She then focused on Jack, and connected the pain in her shoulder with Jack: “And I think that’s why... what we were

doing last week with the shoulder, it was such an illumination because even though that was physical, the whole idea of what do you do with something that hurts when being as strong as you can be and fighting it doesn't make it go away." Terry was learning not to fight her feelings, but breathe through them, thereby metabolizing the sensations and self-regulating. Ultimately, Terry was experiencing herself in a new way; instead of responding to others' needs, she was seeing that her body is at the center of her life.

#### Summary of Session 10

Indicating that she was feeling more at ease with her bodily sensations and her ability to relax without having to work so hard, Terry came to session feeling very sleepy. They worked with accepting that it's Ok for Terry to be tired and experience rest. Terry lay down again on the floor mat (not since session 6). As Terry rested, they worked in mindfulness on how hard it is for Terry to give herself permission to rest, as well as speak her enjoyment out loud (i.e., experience restfulness in a relationship with another person present), without judgment coming up. They also worked on Laurie gently touching Terry's face and eyes, which led her to painful memories. This was an example of "pendulation"—from her state of relaxation, Terry recalled having to wear an eye patch as a child because she was blind in one eye. Laurie worked with Terry on this pendulation from the nourishment to the trauma sensations, and then back to feeling inner nourishment. Terry was beginning to have a sense of how to find her own resource when the traumatic sensations emerged.

#### Summary of Session 11

Terry told a story about getting her friends lost driving her home and how guilty and responsible she felt; she was so overwhelmed that Laurie became slightly overwhelmed listening and disclosed that fact. This intervention offered an example of how Laurie used self-disclosure in her relational treatment and also indicated a sign of their strong alliance. Terry discussed her fear of stopping smoking as well as the upcoming termination. They addressed whether to continue after the 12 sessions or to take time off before possibly continuing. As the treatment would soon be ending, Terry expressed some anxiety about how much she would be able to maintain the gains from the therapy: "And I guess that what I'm sort of feeling, is that a lot of the old structures, you know it's kind of like the USSR, like the old structures kind of are breaking up, you know? Which is good, um, but I think I don't really have the new ones quite in place yet." Terry told Laurie about receiving the gift of spa vacation from her colleagues and accepting it without guilt. She scheduled it for the interim week before the final session.

#### Summary of 12

Terry was activated in this session. She had enjoyed her spa and was able to verbalize that enjoyment. She also reported a feeling that she felt more connected to herself in a way she was "coming home to myself." She expressed a lot of relief as she made the realization that anger could be a connector. She reported having gotten angry at her friend Susan, and told with glee about allowing the spontaneous feeling to be expressed and setting healthy boundary for herself. Laurie and she used touch to push hands together to feel the boundary and connectedness while saying "enough!".

## APPENDIX G

## SUMMARY OF RAY'S TREATMENT SESSIONS

Summary of Session 1

In this first session, Ray wore his shoes throughout the session, which already was an indication of Laurie's "pull" to meet him without enforcing her usual boundaries. He worked on learning mindfulness, and how his body has a language. They worked on his feeling "speedy," and then relaxing. Ray asked Laurie outright about whether he has sexual problems; when she says no, he immediately looked relieved and responded that he did not so either. He also talked about smoking marijuana, and seemed to be testing Laurie about whether it was safe to discuss it without being judged. Finally, he discussed their pre-session, and described how after the session, because he had become so excited from being in mindfulness, that he punched a wall. Laurie worked to assess Ray's ability to act on his impulses, and worked to contain him in more appropriate ways.

Summary of session 2

In this session, Ray removed his shoes. Ray reported how learning mindfulness in the treatment helped him stay with his body so as not to panic when dealing with a friend who was extremely inebriated. Ray told a long story about helping out this friend, then confessed that he was "high" on marijuana during the event. Laurie did not address the drug use, but focused on his intentions for their work. Ray brought up an upcoming date. They had a long discussion of sexuality and his difficulty connecting intimacy with his sexual desire.

Summary of session 3

Ray reported having cancelled the date to hang out with his friends. He told a story of running into an old girlfriend whom he then had sex with over the weekend. They reviewed a timeline that Ray brought and he reported his exploits, including how he hated private school. Ray then confessed he had an alcohol-induced "hangover" during this session. Laurie tried to help him explore what his intentions were in getting drunk the night before their session, but he did not make any connection, and was unable to work in their relationship.

#### Summary of session 4

Ray was a half hour late, so it was a short session. He brought in his series of pictures of both where he was currently in his life and where he wanted to go. Ray talked at length about his family, particularly the men in his family and how he is expected to uphold the family name, be responsible, and be a “rule keeper.” They focus on his bodily experience, and how he was excited about the future. They worked in mindfulness as he learned to pay more attention to sensation and staying related while telling his narrative (Theme 3).

#### Summary of session 5

Laurie asked Ray if he has told anyone about the therapy – he replied “There isn’t much to tell” – and later he goes to the bathroom in the middle of the session. He appeared to be not very engaged and demonstrating this lack of engagement. They spent a lot of the session discussing his frustrating relationship with one of his professors. In this session, there was a lot of alliance struggle between Laurie and Ray. She disclosed how frustrated she is with him and his style. She pushed him to tell her what he is feeling. Instead of confronting Laurie, Ray disclosed that he wants to “f#\*k” the professor he is angry at. Finally, he asked Laurie if she will touch his shoulder (Theme 2). She shared with him that because it was not currently bothering him she won’t focus on it, but that they could have a session working on it later in the treatment. She gently used touch on his shoulder briefly at the end of the session.

#### Summary of session 6

Ray talked about becoming a more devout Muslim. He reported that he quit smoking marijuana. They talked a lot about praying, Allah, and his refuge in Islam. This session had a lot of spiritual content. Ray also exhibited more trust in the alliance; he shared with Laurie that he thought she was crazy in beginning but he had learned he could talk with her. He expressed how much he has come to value the treatment.

#### Addendum: He drops out after session 6 by phone message:

After Ray’s phone message, he did not return Laurie’s phone calls. Fortunately, the researcher unexpectedly saw him on his college campus and asked in person if he would complete the forms. He completed the second set of assessment forms and a final exit interview in exchange for being treated to lunch.