

Somatic Psychotherapy Today

Summer 2012



A PUBLICATION OF THE UNITED STATES ASSOCIATION FOR BODY PSYCHOTHERAPY

Summer 2012

NYU Postdoctoral Program
&
Psychophysiologic Disorders Association

PRESENT

WHEN STRESS CAUSES PAIN

Innovative Treatments for Psychophysiologic Disorders

Saturday, October 6, 2012
8:30 AM - 5:30 PM

The New York Academy Of Medicine
1216 5th Avenue, New York, NY (at 103rd St.)

Objectives

- To understand the link between psychosocial stress and pain and other physical symptoms
- Learn to assess clients with medically unexplained physical illness
- Learn to use psychotherapy to relieve somatic symptoms
- And more...

Keynote Speaker: Raja Selvam, PhD.

Faculty

- Lewis Aron, PhD, ABPP - Director of NYU Postdoc
- Frances Sommer Anderson, PhD, SEP - NYU Postdoc
- Sharone Bergner, PhD - NYU Postdoc
- David D. Clarke, MD - Oregon Health & Science University
- Mary-Joan Gerson, PhD, ABPP - NYU Postdoc
- Alan Gordon, LCSW - USC
- Spyros Orfanos, PhD, ABPP - NYU Postdoc Clinic Director
- Evelyn Rappaport, PsyD, SEP - NYU Postdoc
- Forest S., MA, MS - Boston U.
- Howard Schubiner, MD - Wayne State University
- Eric Sherman, PsyD - NYU Postdoc
- Peter Zafirides, MD - Ohio State University

Register at: <http://www.ppdassociation.org/events/when-stress-causes-pain>

For more information email Frances Sommer Anderson, Ph.D.
at: stress.causes.pain@gmail.com

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The Multi-Faceted Nature of Making Sense:
Meaning-Making Therapies for Children, Adolescents and Adults
 October 21, 2012 · 9 AM to 4:30 PM
 Hotel Palomar - Westwood · Los Angeles, CA

Ed Tronick, PhD, Pat Ogden, PhD, Bonnie Goldstein, PhD, Marilyn Davillier, LCSW

Join us for this interactive day-long workshop:

Pat Ogden and Bonnie Goldstein will begin the workshop by exploring *Somatic Meaning Making: A Sensorimotor Psychotherapy Approach*.

Ed Tronick's presentation will explore *Polymorphic Meaning Making Theory*.

Marilyn Davillier will present A case study of meaning making therapy with a four-year-old entitled, "*Pretend you feed me*".

Attendees will be introduced to a range of clinical issues; segments of videotaped sessions will help to illuminate treatment; time will be allocated for group discussion.

Early registration rate: \$145.00 until Oct.10 (includes box lunch), \$155.00 thereafter, if space is available.

For registration information <http://lifespanlearn.info> or call 310.922.3868

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From Our Editor

Read our webpage version at www.issuu.com/SomaticPsychotherapyToday
Yes, it really is www.issuu.com/SomaticPsychotherapyToday

Welcome to our Summer Tertulia.

Originally a Spanish word, tertulia references a social gathering with a literary or artistic focus—like-minded folks attend regularly scheduled events to share their recent creations, be it poetry, short stories or other writings, art work, songs, and so forth. In honor of our theme: Multicultural Impacts on Psychotherapy, we invite you to enjoy our stories, poems, and artwork that reflect the diversity of our contributors and the awareness that our cultural identity impacts our lives.



Warmly,
Nancy Eichhorn MA, M.Ed., MA



From Our Cover Designer

Inspiration is a funny thing, and so is the medium that you can use to express yourself. There are so many different means of expression: written, sung, painted / drawn, and movement. This small list doesn't even begin to cover describing the ways we accomplish this. For me it starts with a theme, then I Google, and then I use drawing tools on the computer to accomplish my goal. My hope is to convey the theme in a way that is pleasing and expressive with a quality of movement to it.



Diana Houghton Whiting



We invite you to write an article or be interviewed for our upcoming issues. And/or submit your view of Somatic Expression for our new art gallery. All written submissions will be edited, and all writers/interviewees have final approval before publication. We appreciate your knowledge and want to share your story. Please contact Nancy Eichhorn at MagazineEditor@usabp.org

Upcoming Themes:

Fall: Integration and Collaboration
Deadline: July 15, 2012

Winter: Considering Client Compositions
Deadline: October 15, 2012

Readers Write

There are times friends, students, clients, and colleagues write to express feelings, to discover thoughts, to make meaning of sensations. The writing style is not as important as the personal presence felt in the piece. Throughout the pages of this publication you will read poems, short stories, essays, notes, and reflections that readers have offered.

Readers are invited to submit their writing as it applies to the current issue's theme. It does not have to address the theme directly. Let the theme be a guide for what comes in response to the theme. Because of space limitations, we cannot print all the submissions we receive. We will edit all submissions and writers will have the chance to approve or disapprove all editorial changes prior to publication. In consideration of invasion of privacy and libel, please change the names of the people involved in your writing, and inform us that you did.



Infant Death: Multicultural Perspectives on Bereavement and Grief and Possible Interventions

A Conversation with Joann O'Leary

By Nancy Eichhorn

Parenthood begins in pregnancy regardless of the outcome. Mothers and fathers start to bond with their baby through imaginings about who they will be and how their life together will be in *utero*. The premature death of that baby can be one of life's most painful experiences. Healthcare providers face many challenges supporting families who have experienced a failed infertility treatment, miscarriage, fetal death, stillbirth, or Sudden Infant Death Syndrome (SIDS). There are similarities and differences in bereavement and grief and coping strategies for perinatal loss starting with grief itself, a universal emotion shared through human experience. Bereavement, however—the actions and rituals surrounding death and grief—is shaped by cultural forces.



A cultural group is defined as people who share a common origin, language, customs, styles of living, and a sense of identity (Schaefer, 2010). As the cultural composition of the United States continually changes, providers must keep pace. Offering culturally competent support for bereaved families starts with providers acknowledging that cultural differences exist and that people do not grieve the same. Within each cultural group variations exist in values and beliefs that influence the grief response such as: the age of the mourner; parental perception of the loss (an early miscarriage can be as traumatic as SIDS); nuclear and extended family perceptions and support (in some cultures the mother is blamed for the loss regardless of what happened); family traditions; gender; religious beliefs; geographic region; educational background; economic status; prior experiences with death and loss; the real or potential loss of the relationship with one's partner; and the historical background of the group.

The degree of assimilation and acculturation is also associated with how families handle bereavement and process the fetal/infant death. Assimilation is the cultural absorption of a minority group into the main cultural body whereas acculturation is the process of adapting to a new culture which may lead to loss of traditional rituals and ceremonies (Shaefer, 1999). One's country of origin, beliefs, and religious preferences determine bereavement rituals that direct the mourning process. For example in some cultures (i.e., Taiwan) talking about death and expressing grief are culturally bound taboos. In other cultures questions come with the loss of a child, such as "Why?" or "Could I have done something to prevent this?"

While others, such as immigrants from Iran, believe it is God's will and surrender to their acceptance.

Joann O'Leary, MPH, PhD, a consultant in prenatal parenting and field faculty at the University of Minnesota's Center for Early Education and Development, does research and writing with parents on pregnancy following infant loss. She had the opportunity to interview three Somali women seeking to explore how the loss of a baby is viewed by their community. "They all said it was 'God's Will.' Finally, after 30 minutes, one of the women said to me, 'You keep asking us the same questions over and over. Why?' I replied I was trying to figure out what happens to their grief because it stays in the body. Then the women started telling me the story of their loss and how hard it was but ended the story with, 'It was God's will.' This story reflects the same message given by society 50 plus years ago and still continues today for many parents in Western society as well."

There is hope for change, however, as seen in a recent award given to a Muslim woman who used art to speak out about the silence around pregnancy loss. Her work represents a stark reminder that we must create a safe space for the expression of women's motherhood stories worldwide (Retrieved from http://www.huffingtonpost.com/clare-winterton/miscarriage-humaira-abid_b_1397874.html). Other cultures understand the importance of remembering a deceased baby is still part of the family/community

Continued on page 33

Join the Conversation

Communication is an essential part of all relationships, and the Internet affords opportunities to network with like-minded colleagues and participate in forums that challenge your thinking and ways of doing. Join the conversation and voice your thoughts on the USABP and the EABP websites as well as on Facebook, Google, LinkedIn, ResearchGate and more.

Somatic Perspectives on Psychotherapy is a joint publication of USABP and EABP. It offers a series of free monthly conversations, mostly with clinicians, occasionally featuring leading thinkers in related fields. Stimulating ideas are discussed as well as clinical examples in a conversational manner that helps you get a sense of what it's like to see things through each guest's eyes. The conversations are recorded as mp3 files which you can listen to on the site or download to your computer/player. Printable transcripts are available on request a few weeks after a conversation is published.

Be sure to hear USABP conference presenters on *Somatic Perspectives on Psychotherapy*



Pat Ogden (Sensorimotor Psychotherapy): June 2012

Jack Rosenberg & Beverly Kitaen-Morse (Integrative Body Psychotherapy): July 2012



Creating a Social Stir: How do you direct interested consumers to you?



Today's average consumer often starts his/her search for a practitioner online. And though Facebook and Twitter continue to generate daily conversations between billions of users, search engines—notably Google and Bing—are capturing their share of profile postings attracting more of a general audience seeking services rather than friends looking to connect with friends, or colleagues wanting to advance their career by linking in with others in their respective field. Google and Bing are now offering free profile listings and business listings, even positioning on Google Maps and Google Places as well as Pay-a-Fee services for advertising. Savvy social networking practitioners can make the best of these free tools to generate business listings, profile postings, effective keywords, people finders, and more.



Create your Google Plus Profile at: <http://plus.google.com>, be sure to create different Circles of Contacts and invite people to join: <http://www.findpeopleonplus.com> or <http://plusfriendfinder.com>

Create your Google Places Profile at: www.google.com/places, be sure to enter up to five service categories such as: psychotherapist, counselor, therapist, psychologist, couples therapist, family therapist.

Be sure to create your free Business page on Facebook: <http://www.facebook.com/pages/create.php>

Create a free Mobile Version of your Website

Start at <http://www.google.com/site/help/intl/en/mobile-landing-pages/mlpb.html>

Not sure if your website looks good on an iPad or Smartphone already?

Check it out at quirktools.com/screenfly

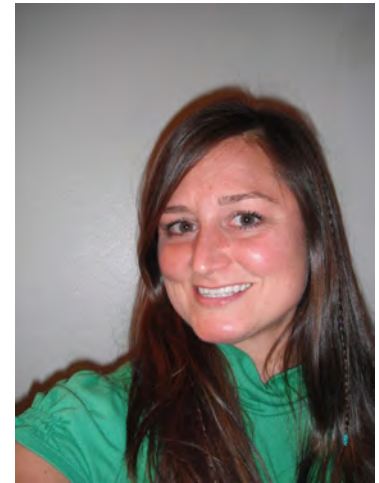


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Touching the Untouchables in India:

How Massage Therapy Benefits Both Client and Therapist

By April Murdock



It is rare in our Western society to face someone with leprosy. Chances are, no one reading this article will ever have that experience. However, all of us face rejection and pain on some level—whether our own or others’—and by understanding their purpose, we can learn to transform these struggles for our benefit. This article shares the personal account of a San Diego massage therapist who spent a season in 2011 volunteering her service to leprosy patients in India, and how she was touched in return.

My first patient is an elderly man with rigid fingers, tattered clothes, and a willing but unsure reception to being massaged. He moves slowly through the community center, a bit dim with natural light streaming in through the open doorway and glassless windows. The fans above us are spinning but seem to offer no relief from the thick sticky air. There is a line of similar-looking adults patiently leaning on canes and crutches or seated in plastic chairs. A beautiful woman with a red dot between her eyebrows pushes herself on a board with wheels to join them, her sari covering what remains of her legs.

Seated on a low stool with a basin of antiseptic water between us, I prepare to massage the thick, dark skin of my patient’s hands and arms with oil while his deeply ulcerated feet soak. The doctor has sent him my way after briefly explaining that I will massage his limbs if he desires. Numerous volunteers from Rising Star Outreach have helped him wash his feet before, but never has anyone offered to massage him. This experience is a first for both of us. He seems unsure what to think, but there is a calm look on his face and he accepts.

As I begin massaging his gnarled hands and curled fingers, applying the paraffin wax up to his deltoids wearing latex gloves, a brief sense of futility comes upon me, a feeling that what I’m doing will have no effect because his hands seem stuck far beyond what massage can accomplish. Remembering that my intention is not to fix him but rather to make a human connection on an interpersonal level and to improve circulation on a physiological level, I continue my work with hope.

I ask him, “Vallikidah?” meaning, “Does this hurt?” He smiles and says, “Illai,” which is Tamil for “No.” I continue rubbing his hands

and forearms for a few minutes, and when I finish, he smiles and thanks me, “Romba nandri.” He will go next to Navamani, the nurse who will dress the ulcers on his feet and calves.

For thousands of years, those with leprosy around the world have been stigmatized and sent to colonies away from the rest of society so they don’t contaminate others. In India, they have been designated as “Untouchables”. Leprosy patients often present with shortened fingers and toes (if they even have all of them) or “claw hands” with tendons seemingly frozen into a contracted position. Bottoms of feet are usually covered with deep, raw ulcers, frequently exposing the bone. In some cases the skin may have light-colored splotchy spots or weeping sores. These people often become beggars, either because their disabilities prohibit them from working or their employers release them, afraid that the leprosy employee will infect others and drive away customers.

The culprit in this condition is not a flesh-eating disease, as some suppose, but an airborne bacteria that resides in the mucous membranes of the nose and throat and attacks the peripheral nerves (especially hands and feet). As the disease progresses, sensation becomes limited so leprosy patients don’t feel cuts, burns, blisters, even rats gnawing their toes at night. When our nervous systems are working properly, we subconsciously alter our gaits in subtle ways to avoid creating hot spots and blisters. We pause to hold that stubbed toe or jammed finger, somehow making it feel better. We limp when we’ve sprained an ankle, and we baby the overused wrist. We drop anything when it’s too hot, and of course, we would never consider reaching bare-handed into a fire to fish out a coal. We curse our pain, yes, but have we pondered what life would really be like without it? Without the protective mechanisms that



pain provides, the patient is often not aware of danger and has no motivation to take his hand out of a fire, to clean a wound, or to limp in favor of a blister that keeps rubbing raw and growing worse. Patients may walk or run on a broken limb, further breaking the bone because the local nervous system isn't communicating with the brain. Pain does not tell them when to stop. Gangrene can set in with neglected wounds requiring amputation in severe cases.

It was not until the 1930s that doctors found an antibiotic to counter the leprosy-causing bacteria, which unfortunately developed resistance to the medicine. During the mid-1980s a multi-drug therapy (MDT) was introduced that has proven to be extremely effective in treating leprosy. According to the World Health Organization, the prevalence of leprosy has reduced 82% from 1985-1996 because of this MDT. However, nerve damage is irreversible so even if the patient is no longer contagious, he or she will still experience the lack of sensation, claw hand, or shortened fingers that developed prior to treatment. Not only must the patient deal with the physical ef-

fects of the disease but stigmatization continues as well. On an emotional level, leprosy patients may struggle with lower self-esteem, fear, frustration, and sadness for loss of function, family, social standing, and jobs.

The younger generations, with access to healthcare, have benefited from modern medicine, so it's rare to see a young leprosy patient, at least near the cities. Experts say that 95% of the world's population is naturally immune to the disease, and those who contract it usually live closely with others already afflicted, so I never worry that I will get sick.

A passion for learning and service, combined with serendipitous circumstances, have led me to volunteer in India with Rising Star Outreach during the spring of 2011. Professionally, I work as a massage therapist in San Diego with special interest in somatic bodywork to combine hands-on healing with mental and emotional health. I also work as a counselor with youth in residential treatment for behavioral and emotional challenges, but I leave these fulfilling

jobs for three months to volunteer giving massage therapy to leprosy patients, among other service activities. I have two main intentions in going: 1) learn more about the purpose of pain, and 2) change the stigmas I carry about myself and others, to achieve deeper peace. I reason that by touching the untouchables, I will actually help transform my perception of those parts of myself that I wish not to own. Having more clarity in these matters, I believe, will give me more space to provide healing work for others.

As I visit the colonies, all of my massage clients are elderly leprosy patients who are no longer contagious and have never received massage. I wonder what the culture of touch is among the untouchables, who are so named because the larger population has rejected them. But what is acceptable within the colonies? And what is acceptable for them to receive coming from me, an outsider? The patients' children whom I teach at the rural Rising Star school when I'm not with the medical team are quite affectionate with each other, but I don't see it among their leprosy-afflicted parents and grandparents. There may be many reasons

for this difference, most notably the generational gap.

Initially the elderly patients may hesitate to see me for massage, and some outright refuse, but those who try it seem afterward to always appreciate the gentle touch, indicated by handshakes, hugs, deeper breathing and lots of smiles. I surmise that my foreignness actually makes many patients more willing to work with me than if I had also been Indian, that differences in our cultures of touch somehow dispel any existing taboos. That is, generally an Indian man would never let a woman give him a massage but knowing that it's okay in my Western culture, and seeing me as an authority figure with the medical team—it somehow becomes okay for them. For me, there is an exhilarating blessing to be the first person to give someone a massage, and I feel honored whenever someone trusts me to touch them for healing, whether I'm paid or volunteer.

Many gesture for me to work on their shoulders and neck, with some requests for backs, arms, or legs. Standing behind one woman seated in a folding chair, I sense the slight smile spread over her face as my elbow sinks into the softening muscles of her rigid shoulders and she exhales deeply. When was the last time she truly relaxed? I wonder. Intrigued, two of her friends stand in front of us, and one good-naturedly makes silly faces to tease her while they wait for their turns. A sense of humor is



alive and well among the people I meet in India.

Neither of us speaks the other's language, save for a few phrases, which is challenging for a massage therapist who often relies on her clients' vocal feedback to confirm her intuition. I am developing greater sensitivity for felt sense and perceiving body language. Actually, this language barrier becomes one of my greatest frustrations because I'm not able to converse with these people and learn their stories like I had hoped. There are so many questions I would like to ask them, not just about their experience with the massage but about their

lives, their families, struggles and joys. Our medical director, an Indian named Dr. Susan, is fluent in English and the rest of the medical team speaks some so I can refer to them when I most need translation. But the others are busy with their own tasks, and I am left to do my work, learning to let go of my need for the concrete verbal as I trust the intangible interchange between myself and the ones I touch. I trust that my contact is still effective even if I don't know why the patient's tension is there, how long she's dealt with it, how it impacts her daily activities, or how she is interpreting the experience.

Language proves to be not only a source of frustration but also one of great humor. One day, after driving along a bumpy dirt road for an especially long time, the van pulls into a very small colony that I've never visited before. An equally small, aged woman comes forward to welcome us. Her once-bright sari is faded and tied loosely on her bony frame. I press the palms of my hands together and bow slightly to greet her, saying the customary, "Vanakkum" or "Hello." However, what comes out instead is, "Vallikidah" which we've already learned means, "Does this hurt?" Navamani, the nurse, gives me this funny look and bursts out laughing. I realize my mistake and laugh as well. Our new friend doesn't seem to notice and goes to help us set up. At random times after this moment, Navamani looks at me with her palms together in greeting and says, teasingly, "Vallikidah?"

There is not enough time to spend in the colonies, a fact which I lament as we spend almost half of our time just driving around Chengleput, Tamil Nadu state in southeast India before returning to the Rising Star campus in the afternoon. *I went to great effort to come to India, and I'm barely even doing what I came here for* is a burdensome thought that I seek to reconcile. My energy and motivation are high and there is definitely need, but for logistical reasons I am limited in how much I can give in this season of my service. So I capitalize on this driving time to pick Dr. Susan's brain and learn the phrases I most need with my clients. We talk about many different topics,



“Be the change you wish to see in the world.” Gandhi

between my reading of books like *The Gift of Pain: Why We Hurt and What We Can Do About It*, which chronicles the profound work of pioneering leprosy researcher Dr. Paul Brand with leprosy patients in India for several decades. It is this work that most opens my mind to the necessity of pain in life as Brand describes the consequences of not feeling pain. In the dozens of leprosy patients’ feet that I wash, I see the deepest of ulcers that go through the thick layers of tissue to the bone. And I must say, as difficult as it may be, I am glad when the patients feel some pain in the washing—this means they have some sensation and their prognosis is better. Those who feel no pain have no motivation to care for themselves.

Another interesting feature of leprosy that I learn from *The Gift of Pain* is that patients often feel disconnected from their feet and hands. Because the patients can’t feel their limbs, it seems they are not a part of the body and therefore they have no ownership. A lack of physical pain does not preclude one from feeling emotional pain, however, illustrated by one of Brand’s patients who said, “I can’t feel pain, but I am suffering.” I am familiar with dissociation in response to trauma, which is curious to me in contrast to the sort of dissociation among leprosy patients. This is a subject for further study.

I also read Gandhi’s autobiography and still feel deeply inspired. In a vague sense I always knew I admired the author credited with, “Be the change you wish to see in the world,” but now I know specifically why—he was genuinely humble, deeply devoted to truth, and he diligently practiced what he preached. For example, he didn’t take comforts for himself that others couldn’t have, and he didn’t ask anyone to do anything that he wasn’t doing, such as cleaning latrines or fasting. Many of his teachings of “ahimsa” or non-violence appeal to me and reading about Gandhi has made more obvious to me ways in which I could strengthen my character. Searching my own heart, I know more corners I can refine.

Perhaps these long van rides and quiet times of reading and reflection, then—times which I preferred to be busy serving the people I came here for—actually serve a great purpose for my own growth. Despite my frustrations with the schedule and worry that I’m not using my full energy how I wanted, I make the best of the situation.

Our patients make the best of their situations as well, doing what they can to help carry water for the foot baths, for example, or sweeping before we set up our stations in the community room. One leprosy colony, Bharathapuram, has become quite famous for its artists who paint vibrant, unique landscapes and images that they sell around the world. Most of the artists have limited flexion in their hands because of their disease, and some are missing fingers. One man in particular has only stubs for thumbs and yet, impressively, handles his paintbrush with great dexterity. I am learning that limitations are what we make of them. The artists are eager to show their work, and many are eager to receive a massage. After I give one woman her first-ever massage, gently kneading her shoulders, neck, and arms, she tearfully



grabs my face in her stumpy hands and pulls it close to hers, smiling and thanking me, “Nandri! Romba nandri!” with many more words I can’t interpret, but I understand her pointing heavenward and smiling, kissing me and blessing me. We embrace and I tell her, “Parava illai” for “You’re most welcome.”

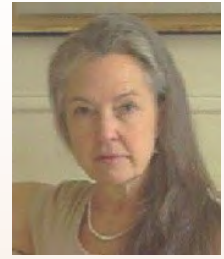
April Murdock, BS, CMT, is a massage therapist in San Diego specializing in Relational Somatics and offers bodywork as a practical pathway to peace. She also works as a counselor in residential treatment with youth needing behavioral and emotional support. Regular volunteer massage work with women in a holistic transformational recovery program, mentoring Burmese refugees, and visiting orphans in Tijuana add meaningful variety to her work. April is a student of Nonviolent Communication and the Arbing Institute, organizations which teach compassionate communication and how to change from resistance to a responsive way of being. For more on April’s India experiences and for future follow-ups on her study of pain, personal healing and peace, she may be reached at bodywork4peace@yahoo.com.

All photos courtesy of April Murdock.



Pat Ogden: Pioneer of the Past, Wave of the Future

by Jacqueline A. Carleton
Excerpt by Nancy Eichhorn



Editors note: The article you are about to read is an amalgamation of extracts from a comprehensive article originally authored by Jacqueline A. Carleton. To honor her manuscript, I crafted an introductory article to invite readers to immerse themselves in the entire body of work on our website: www.usabp.org. You will find the complete article in its original format in the Specials section of Somatic Psychotherapy Today.

With her glowing presence illuminated by a halo of light red hair, Pat Ogden entralls psychotherapists attending her trainings and conferences. Her relaxed but energetic presentation style mirrors her manner of being, which is richly infused with a background in movement, massage, structural bodywork, yoga and dance. She simply flows and is particularly easy to follow.

She adheres to the intellectual lineage of the pioneers of the past while simultaneously riding the wave of the future. Since beginning her career in the late 1960s teaching yoga and dance in a psychiatric hospital, Ogden has consistently expanded her therapeutic schema incorporating elements from trauma work, attachment theory, neurobiology, and psychoanalytic and relational perspectives.

In her pre-conference workshop to be held at the 7th annual USABP Conference in Boulder, Colorado, Ogden will grapple with “Implicit Conversations, Therapeutic Enactments and Dissociation: A Sensorimotor Perspective.”

“The subtext of unconscious processes and communications that take place during the therapy hour are arguably more significant than verbal content,” Ogden said. “These implicit processes, visibly reflected in gesture, posture, prosody, facial expressions, eye gaze, and movement habits, take shape before the more rational and linguistic left-brain and neocortex are fully developed. They reflect the ‘implicit self’ which might be relatively unified, or comprise several dissociated parts of the self. A renewed interest in these implicit processes is emerging, not only for the purpose of making them conscious, but also for inquiring into the role of the implicit selves of both

therapist and patient in clinical practice.”

During the pre-conference workshop, Ogden will address ways to highlight implicit, ‘embodied’ mentalizing, and the centrality of body experience as a primary source of therapeutic action working within a clinical process that is ‘safe but not too safe’ to foster adaptive affect regulation, processing of therapeutic enactments, and integration of dissociative parts. Her knowing, the depth of theory and method and relational being, was formalized into Sensorimotor Psychotherapy in 1981 over breakfast with Ron Kurtz, the founder of the Hakomi method of psychotherapy.

“Ron challenged everything I had ever been taught about psychotherapy,” Ogden said, referencing her initial meeting with Kurtz in the early 1970s. “He introduced me to how to integrate the body in psychotherapy and confirmed the intuition I had that working through the body could really help people. That was a huge shift for me, and I actually quit graduate school in social work to move out to Boulder with Ron in order to apprentice with him. We traveled around together in the US and Mexico, teaching, and in 1980, he and I and a few others started the Hakomi Institute.”

Though Ogden loved Hakomi and the work she did with Kurtz, her interest was grounded in movement, posture, and structure, and how that contributed to psychological healing. Kurtz suggested she start her own branch of Hakomi calling it Hakomi Bodywork. The name changed to Hakomi Integrative Somatics before resting at Sensorimotor Psychotherapy.

“Many therapists talk about working with the body, but what they usually mean is working with body awareness,” Ogden said. “Sensorimotor Psychotherapy goes beyond body awareness to facilitate processing on a

sensorimotor level. You can also think of sensorimotor processing in terms of movement and action. We’re always taking in information and processing information through the movement of our bodies. It’s not just in our minds and emotions. So if somebody has a certain posture or way of moving, such as a trauma patient who became immobile during childhood abuse and did not actively defend herself, that becomes a procedural pattern that greatly influences the quality of her life and how she processes information. She’s walking around with her body tight and her arms pinned to her sides, without the felt possibility of being able to push away or fight back. She processes stimuli very differently from someone whose body is relaxed but able to defend from harm. We need to change the processing in her body itself to increase her options, which would in turn exert a positive effect on emotional and cognitive processing.”

Over the years, Ogden’s work continued to differentiate from Hakomi. She moved toward trauma work in the 1980s distinguishing between how to work with trauma and how to work with non-traumatic developmental issues, distinguishing between those two types of injuries and pinpointing how each one calls for different interventions and different methodologies, yet also emphasizing how they overlap. Concepts from attachment theory and neurobiological perspectives combined with psychoanalytic and relational perspectives have continued to augment her work.

“With traumatic memory, you’ve got to be really careful not to go to the core of that memory in a way that’s going to exacerbate the patient’s symptoms and re-traumatize them. A traumatized individual needs to regulate hyper- and hypo arousal in order to bring dysregulated arousal into a window

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Cultural Competency and Psychotherapy

A Conversation with

Gisele Fernandes-Osterhold

By Nancy Eichhorn



How do you identify yourself culturally? What impact does this cultural identity have on your world view, on your relationships, on your embodied sense of place?

These questions, though important, are often left unspoken in therapy sessions. Instead, therapists' unconscious or unexpressed assumptions and biases can lead to a potential failure in connecting emphatically and effectively with a culturally "different" client. The neglect to attune to the cultural level of identity (in oneself and in the client) may contribute, within the therapeutic relationship, to the reproduction of mechanisms of oppression and discrimination that clients live with on a daily basis. Yet, by becoming more aware of one's own cultural background and worldview, and engaging in these types of dialogues with clients, therapists can come to understand their culturally diverse clients in vibrant, resonant ways.

"A client called to make an appointment. She spoke to me in English and asked that the sessions be in Spanish for her and her husband," said Gisele Fernandes-Osterhold, a psychotherapist in private practice, University professor, and mental health consultant who has been serving culturally diverse communities in the San Francisco Bay Area for the past 12 years. "They both looked physically Latin and spoke Spanish, and I wondered about their ethnicity. When I asked how she culturally identified herself she replied, 'I feel like I'm an American.



I was born in Mexico, and when I was three-years-old I came to the United States.' So, even as she prefers to speak Spanish and looks physically Latin, she identifies as an American. It's important for therapists to start to understand the client for who they are, not what we assume them to be."

A Brazilian immigrant herself, Gisele culturally identifies in terms of her native

country. She explained that culturally diverse peoples are often grouped together under over-generalized labels such as Latin or Hispanic. "In my case," Gisele said, "when I say I am Brazilian, this is already an example of how the cultural identity of a person is complex. Even though I'm South American, I am not Hispanic, because my first language is Portuguese. However, being fluent in Spanish and able to relate to Latin American values has been essential to my success in my clinical work with the Latin community. Like many of the clients I serve, I feel at home here in the United States as well as in my country of origin; it's an integrated embodiment that relates to the land, the people and the language in a very unique way in which the sense of belonging to one place is permeated by a feeling of belonging somewhere else."

Specializing in culturally diverse populations, Gisele has worked with clients representing a wide range of races and ethnicities as well as age groups and life circumstances including incarcerated teens, children in early intervention programs, children with disabilities, bicultural couples, and members of the lesbian, gay, bisexual, transgender (LGBT) community. An important piece of cross cultural competency for Gisele is for therapists to become aware

of their own culturally shaped worldview, their assumptions toward other cultural groups, and to understand how that worldview is unique to their own background as well as their clients. From a place of respect, humility, and sensitivity, they can then design interventions that make sense within the clients' internal and external reality of race, ethnicity, class, ability/disability, religion, sexual orientation, and gender.

“How I develop a treatment plan is based on what is important and relevant to the client not what I think they need. The traditional psychotherapy model had a tendency to pathologize and make behaviors and ways of being a dysfunction in clients when actually it may be sound in their value system. The traditional model of psychotherapy is rooted in historical cultural context emphasizing individualism, autonomy, independence, and the pursuit of personal dreams. This is different when working with clients from a collectivist culture where, for example, family interdependence and shared decision making is valued, or where people play out gender roles inside their families in ways that might be viewed as ‘wrong’ from an individualistic frame. Therapists must enter their clients’ worldview to grasp what strengthens and is resourceful for them, and what makes sense



for them within their containing paradigm,” Gisele said. “I pay a lot of attention especially in the first few sessions to questions about life style, values, sexual orientation, immigration history - anything that is part of their unique story is important.”

What is the Story of Your Immigration?

Gisele asks clients how they came to be in the United States, knowing the journey itself and the displacement from one’s land of origin impacts their view of life and possibility in the U.S. People come for different

reasons—fleeing dangers and scarcities, seeking political asylum, or entering as refugees. Some hope for a safe haven far from the reaches of dictatorship and war.

Others try to escape hopeless poverty, crossing the border through the desert traveling for days with almost nothing. It becomes a traumatic rite of passage

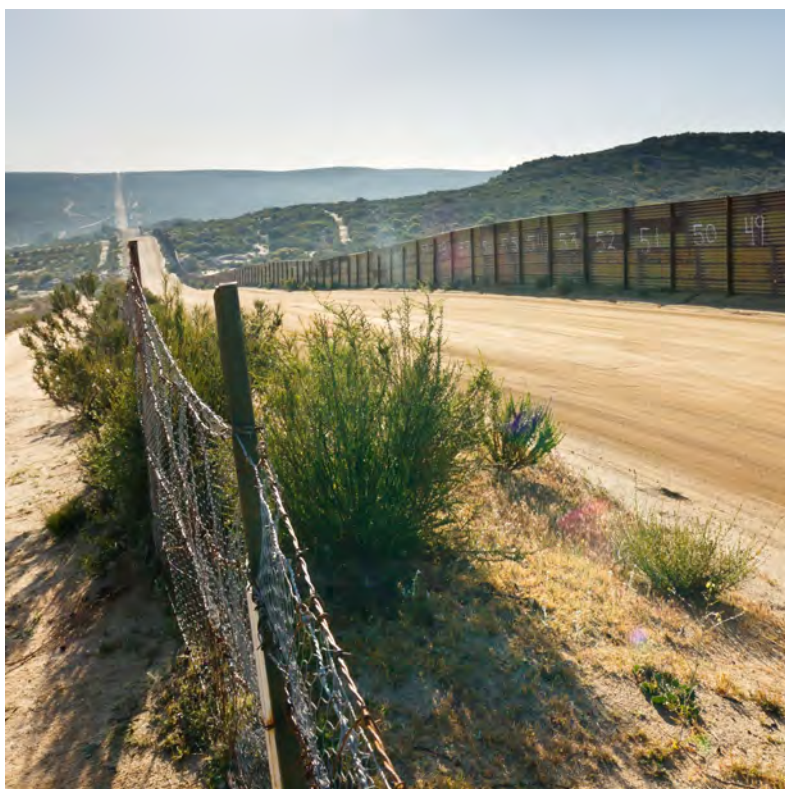
leaving the hardships in their country to seek the American Dream. They are the illegal population with hardly any support systems in this society. But, some come with visa, education and privilege viewing the U.S. as a place of new opportunity. And they too, cope with struggles around acculturation, missing their homeland or being in new bi-cultural relationship.

“The level of acculturation is important, psychologically speaking,” Gisele said. “Are they assimilated, integrated, isolated? What is the importance placed on maintaining the culture of origin versus adapting to mainstream culture? Every immigrant goes through the process of coming to terms and reflecting about their identity regarding country of origin and mainstream American culture. Hopefully they have the opportunity to integrate (internally) different aspects of their identity, finding ways to honor their roots and to be part of the mainstream culture.”

Cultural Competency

Starting in the fall (2012), all California graduate programs in psychology are required to have community mental health and cultural competency as part of the curriculum.

“It’s finally here. They finally recognize the importance of understanding the client’s world view,” Gisele said referring to the bill then Governor Arnold Schwarzenegger signed two years ago at the behest of the California Board of Behavioral Sciences.



Gisele has taught Cross Cultural Psychology at the California Institute of Integral Studies and John F. Kennedy University for four years now. One thing she teaches is that the development of cultural competency is bi-directional involving both therapist and client, each impacting the other. Clients may not have thought about how culture impacts their lives and therapists may not have considered their own views.

“Counselors must look at their own bias, values, and relationships to people culturally different from them. They have to understand themselves and these populations, or they will reproduce the mechanisms of repression and discrimination inside the therapeutic relationship,” Gisele said.

Historically and to this day, therapists have been taught to attune to the inner world of the client, to note insights, feelings, body sensations, and so on. Now, therapists are asked to view the client within the contexts of family, community and institutions that are part of the system that impact how this person feels in the world and informs them about who they are, and what is and is not possible for them.

The role of the culturally competent therapist becomes that of an agent who at times interacts with systems. They may be asked to help clients find resources in the community, or to participate in meetings at school or court, to interact with other professionals and care providers or even to perform therapy in public places like hospitals, schools. Far from having a social work mind frame, Gisele recognizes that the culturally competent therapist uses these types of interventions as a deeply meaningful part of the therapeutic process with many minority clients. Another important consideration for psychology students is to examine their privilege in society and to begin to understand how power differential in therapeutic relationships can be impacted by this notion.

Privilege acquired by a Euro-Caucasian background, upper socio-economic status, higher education, heterosexuality, and ability of body can all contribute to a stance of privilege in society that might be very dif-

ferent than the experience of a culturally diverse minority client who receives services from community mental health agencies and non-profit organizations.

The Client Has a Problem Not is The Problem

From a cultural competency perspective, a shift occurs in the way clients are viewed. The relationship is more of an ‘I-You’ versus an ‘I-It’ instead of objectifying the client as “problematic”, or “dysfunctional”, the therapist sees the client as a person who has a problem that is co-created by the system or environment the client is part of. “We look at structures surrounding the client and how they are interacting with it,” Gisele said. Years ago, while working as an elementary school consultant, Gisele visited a classroom where the teacher was quite



upset with an Chinese-American child because he did not respond when spoken to and furthermore he looked down. The teacher felt disrespected. Gisele observed the classroom behaviors and then spoke with the boy’s mother.

In their culture, the mother explained, children are taught that adults are authority figures, and when an adult talks, children are encouraged to not make eye contact and not to answer back; otherwise, it is seen as being disrespectful. The child, in his own sense, was being respectful; the teacher was pathologizing his behavior from her cultural paradigm. Her inability to understand his reality embedded within a family’s cultural value system impacted her ability to see this

boy for who he was and relate effectively.

There are many ways in which a psychotherapist may misunderstand a client based on differences in style of communication and body language. Gisele described a few concepts that illustrate how a somatic oriented interpretation may be influenced by cultural traits.

The first involves proxemics—the space between people. In some cultures there’s a big amount of space between bodies, others are closer. Latin clients shake hands and kiss on the cheek or hug. Gisele’s response in return is a cultural consideration—she has to clinically consider where the behavior is coming from and not judge them for crossing a boundary.

The second involves kinetics—body movement including gestures, facial expressions, eye contact, and different ways of using the body. Latin clients and African American clients have a wider range of gestures when speaking, more facial expressions, Gisele said. She does not interpret this as pathology; she knows it is simply one way of expressing oneself. A client may be loud. Her tone may be expressive with a whole

lot of physical animation going on. Because the white Anglo standard is to be more contained, Gisele said, some therapists may think the client is above her window of tolerance, they may think her nervous system is activated. They may be misreading this client.

The third involves paralanguage—vocal cues such as pausing, remaining silent (which is often seen as resistance), the speed and rhythms of speech and the loudness of their voice.

And the fourth involves high and low context of communication. Low context communication has a strong emphasis on the verbal, words only. Other cultures tend

to have a high context—they rely on a lot of nonverbal cues. Latin and Asian clients may not tell you straight up, and if you don't catch the nonverbal cues, you will miss them, Gisele said.

“I had a Latin client who kept missing her appointments. When we were setting up the next session together I asked her, ‘Same time next week?’ She said, ‘Yes.’ But I had to look at the whole context—I had to notice the tone, hear the hesitancy in her voice. I had to understand that her ‘Yes’ was actually a thinly veiled ‘No. She did not tell me ‘No’ directly because I am viewed as an authority figure, even though that time didn’t work for her. She couldn’t just say to me that she had to be with her sister and would have preferred the session at a different time. I had to see the hesitancy in the body and make contact with that. I had to check-in with what was going on instead of labeling her missing our appointments in a pathologizing form. In reality, however, minority clients are often viewed as resistant, disrespectful, and accused of not valuing the therapeutic work in situations like these.”

According to Gisele, conversations about culture are necessary to attempt to understand the client’s world view. Therapists must recognize that the therapeutic relationship it is not an egalitarian one; there is a very real power differential, which is often amplified for minority clients who may not only have more hierarchical worldviews, but also a history of experiencing of discrimination. That places the client in a vulnerable position in face of the authority of the therapist and asks for unique considerations when working with minority clients. The therapist needs to be very aware and take clinical and ethical responsibility to not reproduce the repression and disempowerment their clients already feel in the world.

“The ball is in the hand of the therapist here. In order to become more culturally sensitive and effective, therapists have to make an effort to work on themselves and get educated,” Gisele said. “I’m telling my students to do the work. Don’t blame the victim, don’t pathologize because you don’t understand, don’t discriminate because you are different and don’t understand the experience and choices of another. When a new client comes in, I try to learn about that client’s culture and what historical or current challenges they might face in this society or their country of origin. While an atti-

tude of curiosity and openness towards the client is key, you cannot expect the client to educate you.”

“The transgenerational trauma lives in the psyche and body of the client,” Gisele continued. “It’s very important to understand the legacies of the holocaust, slavery, civil wars, dictatorship, immigration, and poverty, and how that gets passed on generationally. We can’t minimize the impact of slavery in the African American youth population for example or disregard what it means for a family from El Salvador to have lived through the atrocities of the civil war or for a Muslim woman from Bosnia not be able to go back to her country. These things are real, they are part of history, and they do impact people profoundly.”

“On the other hand, from a privileged Caucasian mainstream frame of reference, it might be relatively easy to think that one can choose to ‘pull yourself by the boot straps’ and see a world full of possibilities. In doing so, a therapist may invalidate the client’s experience.

“Instead, they should ask their client, ‘How is it to be a 17 year old and black? How is it to look at the future and what do you see?’ There is a great deal of helplessness there. We have to work to advocate and empower them in a real way so they can navigate in a society that doesn’t really work for them. In order to be able to do that, we have to learn to recognize and tolerate our own feelings of helplessness, despair, anger or shame in the face of what our client’s experience.”

Gisele Fernandes-Osterhold, MA, MFT is a licensed psychotherapist, clinical supervisor and graduate level professor at John F. Kennedy University and at the California Institute of Integral Studies. Her clinical orientation in body-oriented approaches to psychotherapy includes trauma treatment, Gestalt therapy and family system. Originally from Brazil, Gisele moved to the Bay Area in 1999, where she has been working with diverse clients in community mental health and private practice settings, being particularly involved in serving the Latino population. She has developed a profound interest to cross-cultural issues, which has become one of the main topics of her clinical work, teaching, and consulting.





Reflections

By Christine Gindi

Somatic psychology empowers us with a unique opportunity to recognize how we embody, perpetuate, and heal from the stress and potential trauma implicit in racism. As somatically informed practitioners, we can become active participants in the eradication of racism and its implicit threat by recognizing and changing the connection between our psychobiological state, attunement to others, and our own biases and behaviors. Essentially, each of us holds the precious possibility of countering the neural pathways that reinforce threat response and racist oppression thus advancing the goal of antiracist transformation.

While many people still tend to define racism as malicious, overt acts, many targets of racism experience covert racism through nonverbal communication, which can express hostility, disgust, and danger. Covert racism often plays out in unconscious, implicit, or procedurally learned ways such that individuals of privilege may be unaware of the racist undertones in their actions and beliefs. The impact of covert racism on targeted populations can possibly make them more sensitive to the non-verbal messages.

Psycho-biologically informed body-centered therapies have profound implications for addressing the effects of racism on both individual and societal levels. Their ability to transform neurobiological feedback loops associated with the stress response can help us to understand how we distinguish between safety and threat, hallmarks of psychobiological theory, and expand the discourse on racism to include mutual psychobiological self-regulation. As members of society, we can either support or degrade the self-regulatory capacity of others based on their limbic resonance and behavioral expressions of relative safety or danger. Providing nonjudgmental

supportive methodologies enables people to examine their own psychophysiological organization, both singularly and in relationship to others. These faculties help us examine our attitudes, assumptions, feelings, and beliefs, including those around race and racist oppression, and how they inform our own stress response when treating clients.

As a Person of Color, I have learned to be exquisitely sensitive to communication, both verbal and non-verbal, out of my own sense of self-protection and safety in a dominant Caucasian society. Dr. Stephen Porges' concept of neuroception, which describes how neural circuits distinguish whether situations or people are safe, dangerous, or life threatening, greatly helped me understand my own experiences with race (Porges, 2004). When I learned how certain behaviors can trigger feelings of safety and trust or withdrawal and aversion, I personally felt validated because I could apply his theory to my experiences with racial bias (my own and others). I strongly feel that a race-based dialogue focused on our visceral experiences of safety and danger with each other can open the door to a deeper, authentic form of inquiry and transformation as we approach questions such as: How has our implicit memory been shaped by social conditioning?; What intergenerational stories have we been raised with about certain ethnicities?; Were they race based warnings?; What kind of images of dominant and target populations have we been exposed to repeatedly throughout our lives?; and How do we embody dominant societal narratives which perpetuate racial biases? These are important questions, and they are especially relevant for somatic practitioners who represent institutional forms of power.

While somatic psychology can contribute to the theory and treatment of race-based trauma, it is also essential to examine case studies and specific examples of how racism affects individuals in a variety of

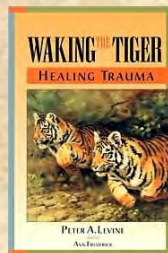
ways. In a study of 209 interviews of middle-class African Americans, Feagin and Sikes (1994) as cited in Thompson-Miller and Feagin (2007) demonstrate the cumulative and long term effects of racism, and the intergenerational transmission of trauma and coping. This in-depth study offers a very personal view of what Feagin and Sikes (1994) term "chronic energy loss" (p. 110). They describe how individual energy loss frequently has domino-like effects on an individual's family, friends, organizations, and community (Thompson-Miller & Feagin, 2007). In one interview, an engineer made it clear how the discrimination he faced at work stressed him out and affected his relationship with his son (Thompson-Miller & Feagin, 2007). He came home with excruciating headaches and chest pains and lay in bed with a cold compress on his head while his son tried to spend time with him. He stated that he believed the stress of racism he experienced directly affected and hurt his son. This is the kind of specificity that mental health professionals need to understand.

Therapists need to be aware of how they may be perceived as potential perpetrators of racist oppression. Instead of focusing on limited reference points of personal experience with race, therapists need to be educated on how historical and systemic privilege and power differences affect survivors of racism. I have felt a specific power difference in my own somatic trainings where curriculums never acknowledged the accumulated stress of racism, homophobia, and other forms of discrimination. The glaring absence of the stress of oppression reinforces its silence and invisibility, which can in turn make training participants who experience these stressors feel invisible as well. The amount of blinded privilege of somatic trauma healing training programs that do not address social oppression in curriculums, books, and teachings, is mind boggling. It angers and saddens me that when People of Color simply tell the truth

about their oppression there is still a taboo that labels them as whiners, trouble makers, complainers, ungrateful, and angry.

The psychological warfare of racism can accumulate and be stressful; it can feel especially isolating when it is detrimental to speak painful experiences out loud to others for fear of being blamed or being labeled as overly sensitive. Perhaps it is shame and helplessness that trigger people who hold privilege to readily attack survivors of racism as responsible for their own oppression. Debating whether an act of discrimination is racially motivated can be crazy making at times for targets of racism. Many survivors suffer from covert and overt forms of racism and often feel pre-occupied with the haunting debate about whether an event was actually racially motivated.

When I read *Waking the Tiger* by Dr. Peter Levine (1997), I had a powerful insight. While the nature of a potentially discriminatory act can be confusing, Dr. Levine confirms that the stress experienced in the body after the supposed act is real. By defining trauma not as an event, but as a response in the nervous system, Levine shifts the therapeutic focus to how the individual regulates his or her nervous system in the aftermath of trauma. Dr. Levine's physiological description of trauma holds that a person's nervous system may become dysregulated because of the perception of danger which is physically experienced in the body (Levine, 1997). In learning to define trauma by its symptoms, rather than by the event that caused it, we can develop perspectives that will help us recognize trauma when it occurs (Levine, 1997). This does not mean that an event does not matter; this is especially true because the impact of racism continues to be denied and minimized. The event matters and the body takes precedence in the healing.



Therapists must not collude with blaming survivors of racist oppression for their own oppression but validate their physiological stress response as real because of the perception of threat. Therapists must also challenge the taboo that aims to silence People of Color about their oppression within themselves. Racist incidents don't occur in a historical vacuum nor is racism a conflict from the past primarily dealt with as an intergenerational issue. It is ongoing practice with deleterious psychological and physiological effects that affirm and symbolize an intergenerational experience of stress and trauma in the midst of enormous danger and hostility.

Therapists must consider how racism currently stresses and potentially traumatizes targeted populations, especially how people continue to experience danger, hostility, and life threatening situations on a number of levels. By learning about systemic and institutional forms of racism, therapists can challenge their own racist assumptions and judgments that may be viscerally felt in the room.

Fostering empathy through mindfulness of one's nonverbal psychobiological attunement with clients can assist therapists in becoming more culturally sensitive and realize their own embodied racial biases. The therapeutic dyad inherently involves intercultural communication because of the intersecting worlds of power between therapist and client. Both therapist and client may indeed be unconsciously defensively tracking for signs of threat in each other in the context of an intercultural communication. It is also important for therapists to understand how society's failings to substantively address the continuing challenges of racism emerges from a lack of shared vocabulary and experiences, an insufficient collective understanding of the difference between personal attitudes and sys-

tematic discrimination, sparse data about racial inequity, and a lack of historical knowledge about how power and privilege operate (Harris-Lacewell, 2010).

In addition to cross-cultural training for therapists, body centered therapies offer unique opportunities to attune and empathize with survivors of race-based traumatic stress in a conscious psychobiological way. Somatic psychotherapist Susan Aposhyan (2001) trains clinicians to be psychobiological regulators, both for themselves and interactively. By assisting people to explore and change their experience with others on a felt sense level, somatic therapies can help challenge unconscious negative beliefs and suspicions about others always being sources of threat and potential perpetrators of racism.

Dr. Allen Schore (1994) defines empathy as nonverbal psychobiological attunement. In his book, *Affect Regulation and the Origin of the Self*, Schore (1994) explores the inherent inseparability of somatic experience and emotions through the lenses of developmental neuroscience and developmental psychology. He analyzes attachment as a physiological process and notes how the mother acts as an "auxiliary cortex" interactively moderating the infant's arousal level. The interactive process between infant and caregiver occurs through sequential nonverbal exchanges including physical contact, eye contact, and vocal tone. Schore's focus on attachment disorders, psychopathology, and therapeutic treatment of primitive emotional disorder is founded on right hemisphere communications. The right hemisphere is dominant for



the perception of the emotional states of other humans (Schore, 1994). Schore proposes that the co-created system of mutual regulation facilitates change, specifically the regulatory transactions embedded in the emotion communicating attachment relationship between the patient and therapist (Schore, 1994). In other words, Schore repeatedly emphasizes the importance of working somatically within the therapeutic alliance.

Learning how we experience each other on neurobiological levels is empowering as we understand and heal our own potentially embodied forms of racism. Physiologically understanding how we relate to each other expands the discourse on racism by exploring how we affect each other on neurobiological levels. The transformative capacity of somatic therapies carries great potential for changing the neural pathways of racist oppression that manifest in a multitude of contexts. We can begin to consciously explore and unravel our psychobiological choreography associated with racism in order to champion each other's humanity. It takes ego strength and emotional forti-

tude for each of us to deeply examine how we organize around race in unconscious or implicit cognitive and physiological ways. I strongly encourage therapists to explore their own embodied racial biases and what nonverbal messages they may be communicating with their clients. As therapists we have the opportunity to begin healing the legacy and enactment of oppression and become advocates for social justice.

Christine Gindi, MDiv, MA, SEP is a Feminist Womyn of Color. She has professionally trained in multiple body-based therapies including Somatic Experiencing, Sensorimotor Psychotherapy, Craniosacral and Polarity therapies, and Yoga instruction. She has presented on healing from the trauma of social oppression at JFK University and the Center of Study of World Religions at Harvard University. Her long career in socially responsible nonprofits and foundations illustrates her passion for creative interdisciplinary strategies for community transformation. She currently writes a column for the USABP magazine, and is training to become a diversity facilitator and licensed somatic psychotherapist. She

holds a B.A. in the Study of Religion from UCLA, a Master in Somatic Psychology from John F. Kennedy University, and a Master of Divinity degree from Harvard University.

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International Connections

By Asaf Rolef Ben-Shahar

What a delight and an honor to be contributing to this new, fresh, and innovative magazine about somatic psychotherapy. It is a real privilege to practice as a body-psychotherapist today, as the psychoanalytic world is becoming increasingly curious and open to hear about and possibly integrate the somatic practices. Perhaps the time for wider acceptance of (some of) Reich's ideas has come, the same ideas which once instigated such resistance and fears, to the extent of burning tons of his books not that long ago, in 1956.

In its intricate political and sociocultural matrix, Israel, where I now live, is a unique place to practice body psychotherapy. On the one hand you can find the Muslim and Jewish orthodoxy for which attention to body in general and touch in particular is a definite taboo. On the other, Tel Aviv is considered one of the most open cities in the world for the gay, lesbian, bisexual and transgender (GLBT) community.

Most Israeli Jewish men and women who come to therapy have served two or three years in the army, having developed particular muscular and emotional armour. Whether the security threats are real or not, most people in Israel live in a state of hyper-arousal, hypervigilance, and defensiveness characteristic of trauma clients.

At the same time, many of my clients grew in a Kibbutz, and, as was customary, were separated from their parents only few days after birth, their attachment system is confused, disorganised yet normalised by society. Imagine working with someone who was parented by a collective community with no personal attachments and is therefore struggling to establish and maintain self-regulatory capacities? Or in a post-traumatic country, where dissociation is frequently the defence of choice (Rolef Ben-Shahar, 2009). Can you fathom the complexities of therapeutic trust and encouragement of openness when the more common societal messages involve being-on-guard, conflict and mistrust?

In this regular column, I hope to share with you some of my experiences and challenges as an Israeli relational body-psychotherapist (and as a person). But perhaps, before moving on I should introduce myself.

My name is Asaf. I am a father to two lovely girls (Zohar and Shuy) and a husband to Tom (a unisex name in Hebrew). I love music and dancing. I also love wildlife and am slightly obsessed with tattoos. If it wasn't for Tom, I'd probably sport a full body-suit by now. After living and practicing in the UK for eleven years, my family and I returned to Israel about three years ago and are still trying to integrate both worlds (sometimes more successfully than others).

I am also a psychotherapist, writer, and trainer for about sixteen years. As a psychotherapist, my work is relational body-psychotherapy, integrating trancework and Reichian body-psychotherapy within a relational framework. I enjoy writing and have written dozens of professional papers on psychotherapy, body-psychotherapy, hypnosis, and their integration. I am an international board member for *Body-Psychotherapy Publications* and an associate editor for *Body, Dance and Movement in Psychotherapy*. My book about relational body psychotherapy will be published in the next few months (in Hebrew, in Israel) and will hopefully be translated into English at some point. My PhD dissertation (*Surrender to Flow*), focused on the moments of surrender in three different fields: relational psychoanalysis, body-psychotherapy and hypnosis, and these three form the axes of my theoretical and clinical curiosity.

As a trainer, I have been teaching and training in Israel and Europe, in both academic and clinical settings, and am still coming to Europe regularly to teach. The Israeli scene of body-psychotherapy is very exciting, and I am privileged to bring some of the European developments into the training. One of the greater challenges in moving from the UK to Israel concerns the status of body-psychotherapy. In the UK (and many other countries in Europe), body-psychotherapy is considered a relatively known and respectful psychotherapy modality, well acknowledged as a legitimate system of theory and clinic for providing psychological service, and accepted within all major umbrella organizations. Moreover, such acceptance assisted an integration within modern analytic ideas and establishments such as Chiron (Hartley, 2009), as well as individuals like Nick Totton (1998, 2002, 2003, 2005) have contributed to the British growth of relational body-psychotherapy in its on-going fertile dialogue with other therapeutic modalities.

In Israel, on the other hand, the Israeli Psychological Association is a very powerful institution, which for years monopolized the psychological arena. Body-psychotherapy in Israel has indeed been taught for some years, but is still considered esoteric, bordering on

complementary and alternative therapies and less a psychological profession. And so, from working as an established professional, alongside psychologists and psychiatrists, within National Health Services and publishing in professional journals, I have become a practitioner of pseudo-psychological esoteric bodymind alternative medicine.

This complex situation is one of the primary motivators for me in writing and creating a comprehensive training programme and attempting to reclaim the professional place that body-psychotherapy deserves: within the ranks of psychotherapeutic practice and not at its margins, touching on alternative medicine or new-age religion. Together with three wonderful colleagues, we have created, structured and are planning to launch this year a three-year post-graduate programme (for practicing clinicians) in contemporary body-psychotherapy, which will focus on psychodynamic and relational body-psychotherapy.

This training aims to help mental health clinicians integrate embodied philosophies, principles and indeed techniques in their practice. Alongside the core course, there will be modular courses in philosophy, diagnosis and interventions.

Relational Body-Psychotherapy Occurs in Moments of Presence and Knowing

One day, Sharon, a woman who grew up in a Kibbutz, arrived to the therapy room beaming with pleasure. Our previous session was a very challenging session, where I had disappointed her as well as got upset with her response. She explained her delight: "I was waiting to receive a text message or an email from you telling me that therapy was over, but you are here." Even though it was clear to me that therapy should continue, her sentence was nonetheless resonant, the thought had indeed crossed my mind, and at the time I pondered about it. *How come a difficult session made me want to call the whole thing off?* I knew that working through our difficulty was the right thing but I felt practically ashamed for having her in my room.

Sharon is a sixty-year old woman who left the kibbutz at twenty. Her earliest memories concern the dreaded journey from her parents' room in the Kibbutz back to the children's quarter, where she was to spend the night. Only one girl from her class-year spent the night with her own parents, and their family was criticized for being individualist and spoiled; Sharon yearned for her mother to insist that she, too, stay the night with them. Her mother did not. Even though she has been seeing me for nearly three years, and our connection is solid, every tiny rupture is immediately conceived as the end of therapy. She is familiar neither with repair nor with dyadic-regulation. Instead, Sharon knows how to survive, and she does it extremely well.

As Sharon learns to engage with me more fully, relationally and bodily, her survival skills are challenged. Suddenly, it is not as easy to function in the world. Should I support her in maintaining a defensive and numb yet functioning stance? Should I acknowledge her need to fall apart? Need I give provision for that? Allow the girl to "spend the night" when knowing she would pay a price for that in a society still bound in deep shaming of the needy, the interdependent, the vulnerable? While these questions would probably engage clinicians anywhere, I feel that the Israeli socio-political attachment system presents an even more complex set of questions, since the very therapeutic endeavour of opening to tenderness and authenticity as well as the softening of body-mind defences might threaten to weaken the individual in their social environment.

Body psycho-therapist Julianne Appel-Opper (Appel-Opper, 2010) would probably call it *the culture in the body & the body in the culture*. As a relational body-psychotherapist, cultural, racial, gender, sexual and generational con-

texts are central to my curious engagement in therapy. In this column, I hope, together, we can grow greater curiosity to the manner in which these aspects find their way into embodiment.

I hope that we can share some interests and dialogue, and I welcome your feedback, comments, questions and challenges. You can email me at asaf@imt.co.il

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By Dawn Bhat

Research in Brief: Cultural and Social Influences on Somatic Experience

By integrating brief reviews of research relevant to somatic psychotherapy today, my objective of this column is to keep world wide readers aware of current scientific investigations into a variety of subjects advancing our field. For one, a recently published study examined cross-culturally somatic experience or more specifically visceral state perception. Drawing from the literature on social psychology and neuroscience, the last article is new research on the neural representation of pain. Both studies indicate that somatic experience can be influenced socially and culturally.

The Accuracy of Perceived Visceral States Cross-Culturally

Ma-Kellams, C., Blascovich, J., & McCall, C. (2012). Culture and the body: East–West differences in visceral perception. *Journal of Personality and Social Psychology, 102*(4), 718-728

Culture and the body was the subject under investigation by researchers in psychology from the University of California, Santa Barbara, and the Max Planck Institute for Human Cognition and Brain Sciences in Germany. Published in February 2012 in the *Journal of Personality and Social Psychology*, the study showed that the phenomenon of the mismatch between the subjective and the objective was no different for perceived visceral states and their objective measures. This study aimed to answer the following questions: Are there cultural differences in the accuracy of an individual’s somatic perception? Do East Asians perceive somatic experience differently than European Americans?

Ma-Kellams et al. (2012) examined visceral state perception to determine if Asians were less sensitive to somatic experiences by conducting four different studies. While most research to date has been on observed measures of bodily changes, this study makes an important contribution to mind-body science by focusing on the subjective experience. While a paucity of research has focused on perceived bodily change, fewer, if any, studies have focused on cultural differences related to visceral perception. This examination is one of the first of its kind.

In this investigation, visceral perception was defined as self-detection of autonomic responses, which is fundamentally a human experience. This view was taken from the theoretical perspective of William James, who is often referred to as the father of American psychology. In the early 20th century, James

contributed to the James-Lange theory of emotion, which is a hypothesis on the nature of human emotions. As one of the earliest theories on emotion, it posits that emotions or feelings are the result of the physiological (bodily) changes generated by the autonomic nervous system. However, the sequence has been challenged by Walter Cannon, who suggested that bodily changes and emotions can co-occur. Irrespective of the sequence, modern theorists (Wiens, 2005; Russel, 1991, 2003) have not only linked interoception with emotion but have postulated about it culturally.

Cultural backgrounds or culture-specific constructs may mediate visceral perception, an internal awareness of interoceptive processes. The authors, Ma-Kellams et al. (2012), indicate that Asians are more likely to report somatic processes when describing emotion and to somatize psychological ailments but it is unclear why. One explanation “is that somatization may reflect an inability to accurately perceive one’s bodily states (i.e, such somatization suggests a culturally bound tendency to misperceive one’s own internal states)” (Ma-Kellams, et al., 2012, p. 719). Poor interoceptive abilities in Asians may be attributed to Asians placing more on the external context, an interdependency, when perceiving internal states.

This investigation looked at four separate studies designed to examine differences between cultures (Asians and Americans) on perceived visceral perception and its accuracy. The first study used a mixed experimental design such that there was a 2 X 2 matrix

of culture and biofeedback conditions of heart rates measured by EEG. These participants listened to auditory tones representing their measured heart rates to establish a baseline. A slideshow of three photographs was presented on a computer screen and the subjects received feedback of either a stable or decreasing heart rate. The participants then rated how pleasant or unpleasant the photographs made them feel. Two more sets of photographs were shown; however, false biofeedback was randomly assigned to two conditions (stable or a decrease in heart rate). “Asians and European Americans did not differ in their actual heart rate activity during the task, nor did their heart rates change as a function of the false feedback” (Ma-Kellams, et al., 2012, p. 720). However, Asians rated positive photographs as less positive when they were given the false biofeedback of a decrease in heart rate. Whereas, Americans did not shift their rating with false feedback.

The second study used immersive virtual environment technology and these authors looked back at the misattribution of arousal study (Dutton & Aron, 1974) that showed when men were approached by a female experimenter after crossing a bridge or while sitting on a park bench they found the female experimenter more attractive in the first scenario because going over a bridge is more arousing physiologically. The bridge scenario was virtually replicated revealing similar results such that there was a transfer of excitation in the Asian participants. Perception of visceral states was more likely to influence Asians’ judgments or attributions of interpersonal impressions.

In third study, EEG measured actual heart rate and participants counted their heart beats in four separate trials. Difference scores between actual and perceived were quantified and the difference scores from the four trials were averaged. Asians had greater mean difference scores than Americans and thus were less accurate in their self perception of heart rate than Americans. As such, accuracy of heart rate detection is an indication of a general ability to perceive bodily states.

The fourth study aimed to answer the findings from the three studies with contextual dependency. The within subject variable was the two conditions of a line drawing

task. After the same heart rate detection difference score as in the third study, the participants were presented with an absolute (same size line) or relative (proportion of the length of the line) line drawing task. The absolute task required ignoring contextual information; whereas, the relative task required taking contextual information into account. Errors were inversely correlated with the level of contextual sensitivity. The Asian participants had more errors, were less sensitive to contextual information, and were more contextually dependent. Given that Asians paid more attention to context and situational cues, they were less accurate in their perceived bodily states dependency of visceral perception. The four studies

each showed the inaccuracy of perceived visceral states in Asians. Lastly, contextual dependency was shown to mediate this effect in the fourth study. While Asians were less interoceptively accurate, they were sensitive to context or cues from the environment. Compared with European Americans, East Asians tend to be more interoceptively inaccurate and attend more to contextual information, which suggests that Asians are driven more contextually than somatically.

This study helps to explain why Asians are more likely to somatize psychological disorders in particular and suggests that culture contributes to somatization in general.

What Social Rejection and Physical Pain Have in Common - No Joke!

Kross, E., Berman, M. G., Mischel, W., Smith, E. E., & Wager, T. D. (2011). Social rejection shares somatosensory representations with physical pain. *Proceedings of the National Academy of Sciences*, 108(15), 6270 -6275.

Social rejection and physical pain share neural and somatic representations in the brain, according to a functional MRI study conducted by Kross et al. (2011). In this functional brain imaging study, 40 participants experienced a recent unwanted breakup. The fMRI revealed a neural overlap between social rejection and physical pain such that “the distress elicited in response to intense social rejection may represent a distinct emotional experience that is uniquely associated with physical pain” (Kross, et al., 2011, p. 6273).

Participants were trained on Social Rejection and Physical Pain tasks and then engaged in the tasks in the fMRI scanner. In the social rejection condition, participants rated their distress. In the scanner, participants were shown a photograph of their ex-partner and a friend and asked to think about the negative or positive experiences with the individual, respectively. By looking at the face of an ex-partner, brain regions and neural networks associated with the affective processes were activated, including the anterior cingulate cortex, insula, thalamus, and the somatosensory cortex. No differences in lateralization were found.

Activation occurred bilaterally in both the right and left hemispheres of the brain. Similar activation was found in the Physical Pain condition. Physical pain was induced thermally; participants were given a warm or a hot stimulation on the forearm.

Social rejection and the affective component of physical pain share neural representations. The second somatosensory cortex and dorsal posterior insula became activated in the nonphysical, emotional components of pain, including intense social rejection. The authors corroborate with the meta-analytic literature that these brain regions are uniquely associated with the emotional experience associated with physical pain. Interestingly, other studies have shown empathy for pain activates the second somatosensory cortex (Keyers, Kaas, & Gazzola, 2010; Hein & Singer, 2008).

In summary, these findings explain why social rejection hurts emotionally. Intense social rejection activates neural networks associated with somatic processes but obviously not the exact representation of physical pain from a noxious stimulus. Physical pain has affective and somatic components shared by intense social rejection. It is im-

portant to note that there are individual differences and biological vulnerabilities that suggest some people may have a particular sensitivity to pain. The authors of this study speculate that “these findings offer new insights into how rejection experiences may lead to various physical pain disorders (e.g., somatoform disorders, fibromyalgia), highlighting the role that somatosensory processing may play in this process” (Kross, et al., 2011, p. 6273). They are also consistent with research on embodiment which suggests that somatosensory process is integral to the experience of emotion.

No wonder we hurt from social rejection similar to the way we experience the affective and somatic components of physical pain—the brain basically constructs and we interoceptively perceive both the same way.

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Current Research Reviewed

By Dawn Bhat

Research from the fields of contemporary medicine and mental health is increasingly validating the mind-body continuum, the heart of somatic studies. Drawing from clinical and basic science, phenomenological and case studies, and literature reviews, this column is dedicated to sharing research from multiple perspectives that may potentially impact the field of body psychotherapy.

It gives me great pleasure to write about research for the United States Association for Body Psychotherapy. When editor, Nancy Eichhorn, asked me if I would write more for *Somatic Psychotherapy Today*, I did not hesitate to accept to contributing as a regular research writer. I've been writing the 'Research in Brief' for the magazine and am looking forward to another opportunity to review current research on interests authentic to that of somatic psychotherapists.

Let me briefly introduce myself. Once I completed my undergraduate studies at the University of Florida, I became interested in research and starting working in scientific publishing at the Cold Spring Harbor Laboratory. Naturally, the next step for me was to work in psychology and neurology laboratories at the State University of New York at Stony Brook. I received a Master of Arts in General Psychology from Queens College in New York City, whose psychology department was housed in the Division

of Mathematics and Natural Sciences with physics, biology, and chemistry. Initially, I was interested in neuropsychology, but I was exploring psychotherapy and yoga as well. I left academia to study yoga formally, the closest thing I could find to mind-body science at the time.

Fortunately, I found Jacqueline A. Carleton, Ph.D., founding editor of the USABP journal. Dr. Carleton invited me to be a summer intern in 2010, and I am still contributing to her ongoing efforts. Among other publications and presentations, I've co-authored a chapter on the autonomic nervous system in body psychotherapy with Dr. Carleton going to press later this year. I gained a deeper understanding of attachment theory, traumatology, and somatic psychology. More importantly, I have experienced many positive transformations on personal and professional levels as a consequence.

I realized that my next step was to get licensed in order to practice counseling and

psychotherapy. Luckily, my first clinical courses were in somatic psychology at the Santa Barbara Graduate Institute (SBGI), my birth place as a budding professional counselor and body psychotherapist. As I move in a different direction academically, I am expecting to graduate with a second Master's degree (a M.S. in Mental Health Counseling) at the end of this year. I am a mental health counseling intern at The Zucker Hillside Hospital of the North Shore LIJ Health System in New York, and have a clinical placement on an inpatient unit in psychiatry.

Writing about research impacting body psychotherapy is exciting for me. I thank Nancy Eichhorn and Dr. Jacqueline Carleton for the inspiration and encouragement to write about this body of literature. Contributing to *Somatic Psychotherapy Today* is an outstanding role for me, as the more I can share with you what is happening in science related to body psychotherapy the better.

Crying Across Cultures

Though tears are an innate human phenomena, not everyone cries the same. According to van Hemert, van de Vijver, and Vingerhoets (2011), cultural differences related to freedom of expression and personality explain differences in crying rather than actual distress or suffering.

van Hemert, D. A., van de Vijver, F. J. R., & Vingerhoets, A. J. J. M. (2011). Culture and Crying. *Cross-Cultural Research*, 45(4), 399 -431. doi:10.1177/1069397111404519

In the present study, cross-cultural psychologists from the Netherlands conducted a study on culture and crying (van Hemert, van de Vijver, & Vingerhoets, 2011) that represented 37 countries. Published last year in the journal, *Cross-Cultural Research*, this particular study examined adult crying as an emotional expression of distress. Because there are currently no theories about country differences in crying, a unique contribution of this article is the theoretical explanations offered for the identified cross-cultural differences. While there are individual-level models of crying, there are no country level models of crying. There is the assumption of isomorphism, which means individual level hypotheses can predict country-level hypotheses.

Crying, a physical expression of an emotion, is a universal human experience. Darwin (1872/1965), Freud (Freud & Strachey, 2005) and others believed culture and civilization inhibited crying. However, adult crying may be cathartic (Vingerhoets, Bylsma & Rottenberg, 2009). Darwin was interested in studying crying cross-culturally so he looked at the psychological antecedents and physiological aspects of crying. Darwin indicated that while crying calls attention it may also bring relief to the crier and that crying can be connected with being moved by a story, bodily pain, and distress. Darwin considered tears as “meaningless byproducts of muscular contractions serving to protect the eye” and also indicated that crying was less prevalent in Western countries than in non-Western countries (van Hemert et al., 2011, p. 401).

van Hemert et al. (2011) remind us that crying behavior has received little attention by behavior scientists. The authors of this study conceptualize crying as an attachment behavior. On an individual level, the function of crying is to signal distress and elicit caregiving and emotional support. Tears are shed in negative situations of loss, conflict, and perceived inadequacy as well as positive situations or as a sentimental reaction. Crying may signal or trigger assistance from others. Somatic psychotherapists may agree another function of crying is such that “tears represent the energy that cannot be worked out in actual behavior” (van Hemert et al., 2011, p. 401).

The present study was based on four following hypotheses:

Hypothesis 1: Individuals living in countries with a more demanding economy and climate cry more often than individuals in less demanding countries.

Hypothesis 2: Cross-national gender differences in crying are positively related to gender differences in access to resources.

Hypothesis 3: Individuals in countries that are looser, less religious, and allow more freedom of expression of individual feelings cry more often than individuals in more restricted countries.

Hypothesis 4: Cross-national gender differ-

ences in crying are positively related to gender differentiation in values, stereotypes, and women’s power.

Hypothesis 5: Individuals living in countries with higher population scores on neuroticism and extraversion cry more often than individuals from countries with lower scores on both personality features.

Participants in this study were 2,497 men and 3,218 women representing 37 countries from the International Study on Adult Crying. Two crying inventories were utilized: the General Tendency to Cry (10-point scale, ranging from hardly to very easily) and the Time Elapsed Since Last Crying Episode (7-point scale, ranging from less than one day ago to more than a year ago). This study examined whether crying was indicative of distress, of cultural norms about the expression of distress, or as a result of personality differences. Crying proneness and actual crying behavior were the primary constructs evaluated. For the latter, it was assumed a shorter delay indicated a tendency to cry more frequently; whereas, a long delay meant less frequency in crying behavior. Construct validation methodology was employed to indirectly measure distress at the country level. Averages of crying proneness and last crying episode were compared across countries.

“The Distress, Expressiveness, and Personality Hypotheses were tested by examining the associations of the different country-level indicators to female and male crying scores” (van Hemert et al., 2011). The distress model assumed that subjective well-being was inversely related to adult crying behavior. Other variables factored into the distress model included the prevalence of depression, of climate demands, living conditions measured by cross national product per capita among others, including gender differences. The emotional expressiveness model included measurements of the level of democracy, for example. As such, crying was positively related to freedom of expression and individualism. The personality model involved the Big Five personality traits, neuroticism and extraversion, and were expected to be positively related to crying. Larger differences in gender related

crying were found when men and women have access to more resources.

Sociocultural indicators of crying and country characteristics were identified. This study found that individuals from cultures facing distress due to exposure to taxing conditions may not have a tendency towards crying as originally hypothesized. Conversely, crying distress was associated with happiness and wealth. In addition, crying expressiveness was associated with countries characterized as more individualistic and democratic. Furthermore, countries reporting higher levels of the personality characteristic, extraversion, also reported more crying. In sum, individuals who self-reported to cry more often were living in more affluent, democratic, extraverted, and individualistic countries. The authors suggest that the differences relate to freedom of expression rather than to actual suffering. Cultural differences in expressiveness and personality explained country differences in crying rather than distress.

Researchers and clinicians working from a somatic point of view have considered releasing emotions a cornerstone to their work. Eugene Gendlin (1996) wrote about “the cry place” from which tears well up (p. 16). Gendlin asserts that for catharsis some experiential steps might be needed first. Furthermore, according to Gendlin’s (1996) experiential method: when a client first cries, I might say, “The tears are welcome. I hope you can welcome the tears” If I see a client suppressing tears, I ask about it. If the client says, “I can feel tears, but I can’t cry,” I usually say, “Please send a message down there to let the tears through whenever they do come.” Children are taught that they must not cry. The therapeutic ethos now says that we must cry. If we leave a message with the guard there that says, “Let the tears through whenever they come,” than when they come up naturally, they are let by.

Reich as well as contemporary somatic theorists such as Peter Levine (1999), have indicated that crying is a primitive reflex and is a discharge of sympathetic activation. As such, allowing the impulse to cry

may serve to restore fight responses. According to Levine (1999), “If the client has a fixed pattern of crying, you might ask them to just stay with the impulse to cry in order to help them learn to contain and integrate the emotion. Other clients might be emotionally shut down, and it is very useful for the tears to flow” (B2.12). Somatic Experiencing may consider crying as an unspoken voice, one indicative of dispelling trapped energy from the body (Levine, 2010).

When working somatically, clinicians often find that their clients experience crying as cathartic. After crying, the body can relax. However, depending on what culture a client may identify with, there may be differences in working with releasing the autonomic nervous system. Distress may not be the primary explanation for crying as release and discharge of the autonomic nervous system as is generally considered on an individual level. On a country level, expressiveness and personality characteristics influence crying more so than actual pain and distress.

By thinking culturally, somatic psychotherapists can connect deeply with a client especially when working to move a client through a painful distressing event. Shedding tears may flow freely for some, those from more expressive, individualistic countries. When working with individuals from cultures that lack expressiveness and tend towards introversion, crying may not be believed to be a normative behavior. Crying may be distressing for any client to experience; however, in the presence of an embodied psychotherapist, crying may be relieving on an individual level.

In the body psychotherapy model, self-regulation involves the capacity of the body to reorganize and establish homeostatic balance in the autonomic nervous system via involuntary processes such as spontaneous movements, shaking, laughing, yelling, and crying (Carroll, 2009). In our somatic view, crying may be a release of deeply held emotional tension stored in the body from past traumas that were too painful to deal with at that time. Through release (i.e., crying) a client is returned to a calm vis-

ceral experience restoring a healthy, resilient, regulated nervous system in general. Applying techniques from modalities of body psychotherapy may be done artfully when considering social and cultural differences.

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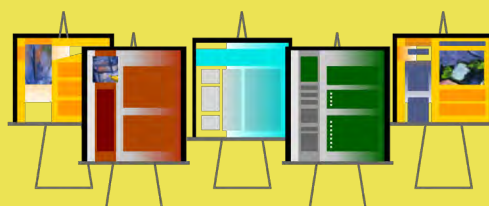
The Body in Psychotherapy: The Pioneers of the Past - The Wave of the Future

Poster Session

The USABP Research Committee seeks submissions for POSTER PRESENTATIONS to be presented at the August 10-12, 2012 Conference. Individuals attending the conference who are engaged in preliminary data analysis or who are in proposal development for a quantitative, qualitative, or mixed methods research project, are encouraged to submit a 250-300 word abstract for consideration in our poster session. Topics may include theoretical, substantive, or methodological contributions to somatic and body-centered psychotherapy research, or approaches to the dissemination of findings. The research can be theoretical, descriptive, correlational, or experimental.

This is the best way to present preliminary work on innovations in the development and use of somatic theories and methods, to interact with other researchers and receive feedback on your work, as well as network and establish one's presence and identity as a body psychotherapist. Posters will be presented during dedicated sessions, where you and other poster presenters will have the opportunity to speak one-on-one with conference attendees about your work. You are also invited to bring handouts and other media to make the most of your session time. It is also an important step in becoming competent and known as a researcher. Individuals selected to display their posters must be registered for the USABP Conference.

The deadline for abstract submissions is July 31, 2012. All requirements and guidelines as well as the submission form are available at www.usabp.org (a link is available on the home page). For ideas on how to create a poster presentation, please see the Spring issue of *Somatic Psychotherapy Today's* article on the perfect poster presentation—www.usabp.org and www.issuu.com/SomaticPsychotherapyToday.





Filipino Americans: Cultural Awareness and Clinical Applications

By Lorna Pham

According to the U.S. Census 2010, Asian Americans were the fastest growing group in the United States within the last decade. It was estimated between the year 2000 to 2010 the Asian population has increased by 46%. Chinese (4 million), Filipino (3.4 million) and Asian Indian (3.2 million) continues to dominate as the three largest groups of Asian Americans.

Much research has been done on Asian American culture, specifically on Chinese Americans and Japanese Americans. However, little research has been done on Filipinos and Filipino Americans. Historically, when someone mentioned Asians or Asian Americans the first thing people thought of were people of Chinese and Japanese ethnicity. Moreover, Filipinos were the only ethnicity that was placed in different categories in the United States; they were categorized as Pacific Islander, Asian, Hispanics, or place them in a separate category as Filipino (Nadal, 2009).

So what do we need to know about Filipino Americans? What makes a Filipino American different from other Asian Americans?

As a Filipino American myself, I think the first and foremost important information that we need to know is their cultural history. It does not have to be a detailed account of the history of the Philippines, but just enough information to acclimate oneself to the culture. Filipinos have endured hundreds of years of colonization from

Spain and almost fifty years colonization from the United States. About 70% of Filipinos speak English compared to 60% from other Asian counterparts (Reeves and Bennet, 2004). About 80% are Catholics (this is due to the Spanish influence) and most Filipinos have Spanish surnames. Filipinos have a diverse mixture of cultures including aboriginal roots (Austronesians), Malaysia, Chinese, Spanish, Arab, and Spanish.

A Filipino family consists of the grandparents, parents, and children. Often times, the nuclear family has a close relationship with their extended family, this includes the aunts and uncles. There is always a respect for the elders in the culture, we show respect to the elders by “blessing of the hands” or called “pang mamano” (placing the elder’s hands on our forehead). Filipinos are very hospitable, warm, and friendly. Every time I visit Filipino friends at their homes, their parents will bring out food and drink and casually ask questions about my family such as, what province are they from, how many siblings do I have and so forth. They always try to make guests feel at home and welcomed.

One of the most common assumptions about Filipinos/Filipino Americans is that they can adapt relatively easily to the life in the United States, unlike other Asians, because of the strong presence of the English language in the Philippines. But this not the case, those who came to the United States as an adults or those from the first generation struggled to adapt to the American culture. Moreover, second generation U.S. born Filipino Americans have also struggled for a sense of identity. This is a common trend for Asian Americans in general who have parents that came to the United States as adults and are trying to raise their children with the same values as their place of origin. It almost becomes cultural warfare. According to the 2001 President’s Advisory Commission on AAPI, Filipino American adolescents have the highest rate of reported depressive symptoms and suicidal ideation compared to their other Asian counterparts.

The Filipino community has acknowledged that there has been a huge gap between the first generation and the second

generation Filipino Americans. First generation feels that there is a sense of cultural identity with the second generation Filipinos. The second generation is split between two cultures. They know that they have an obligation to follow their parent's Filipino culture but at the same time conforming to the American culture. They not only struggle to fit in these two cultures but are also alienated by the Asian Americans because they do not follow the "model minority" mentality.

Filipino Americans are sometimes labeled as criminals or intellectually inferior to Chinese Americans. Like most other Asian Americans, Filipino Americans rarely seek mental health because of the stigma. They believe that personal issues should be dealt with at home and not to disclose it to outsiders, including mental health professionals. Because of the close family relationship, a family member might feel that they are ruining the reputation of the family if they disclose the issue to outsiders. They fear bringing "shame" and "guilt" to their family.

So What Can We Expect When Treating Filipino Americans?

When conducting a psychosocial assessment with Filipino Americans, Nadal (2009) recommends inviting family members or other trusted individuals to participate in the clinical interview. Sanchez and Gaw (2007) relate that Filipinos have a collectivist approach to problem solving and that decision making is often a family matter, and that Filipino Americans regardless of age may still turn to their families for support and guidance (Nadal, 2009). Filipino Americans have a strong sense of filial obligation; they are expected to defer their decision making to older family members and/or parents as a gesture of respect. Sometimes they designate a spokesperson, usually one who has the highest education in the family or one who has the most seniority, or one who is viewed as the most sensible, to assist with decision making.

Filipino Americans are proud individuals who are exceptionally sensitive to criticism and negative feedback (Nadal, 2009).

Therefore, it may be helpful to deliver comments, suggestions, and recommendations, in a respectful and sensitive manner to maintain rapport and motivation. It may be helpful to assume the role of an "expert" as it parallels the Filipino value of expressing deference to authority. Cimmarusti, (1996) cautions the clinician from directly confronting a client, especially at the onset of treatment, as this is likely to lead to feelings of shame which oftentimes result in premature drop out.

Often times the client may inquire about the therapist's family of origin, training, even asking about mutual acquaintances. If the therapist is able to successfully navigate this process by assuming a professional position yet conveying a warm, genuine personality, the client may feel at ease and motivated to attend treatment (Root, 2003). Filipino Americans may invite their therapists to attend social functions as a way of conveying appreciation and strengthening the therapeutic bond (Root, 1997).

It is widespread practice for Filipino Americans to present the therapist with a small gift as a token of appreciation, which if declined may result in the client feeling discouraged and slighted (Root, 1997). When working with a member of a particular culture group, we must develop an understanding of the specific cultural values and norms of that group. With regard to the Filipino culture, the Western trained clinical psychologist or therapist may not be aware of the cultural history of the Filipinos and should not generalize that all Asian culture experience the same cultural barriers.

Lorna Pham PhD came to the United States at the age of 12 with her brother and her mom. She is of Filipino descent and is fluent in Tagalog and English. She has lived in California all of her life. She majored in sociology at UCR before earning a Masters in psychology at Pepperdine in 2004. She received her doctorate in psychology from CGI/TSCPP in 2011. She has been in the social service field for over 10 years servicing children, developmentally disabled adults, and adults as a consultant, and currently works for a county and state funded agency as a quality assurance. She is married to a Vietnamese American, and has a 2 ½ year old daughter.

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Resources

Jacqueline A. Carleton, PhD and the USABP Interns



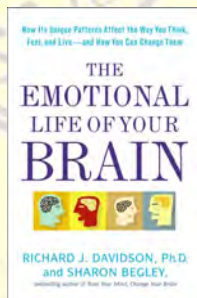
Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy. Francine Shapiro. 2012. ISBN: 9781594864254. New York: Rodale. Reviewed by: Diane Botta, Columbia University

With *Getting Past Your Past*, Francine Shapiro has succeeded in crafting a book that is both accessible and revelatory. Shapiro, the creator of EMDR, begins the book with a few intriguing anecdotes intended to arouse the reader's curiosity:

- “Why would a beautiful, intelligent woman keep picking the wrong men, and then when they try to break up with her, throw herself on the floor clutching their legs, begging them not to leave?”
- Ben is a successful businessman. Why is he hit with anxiety whenever he has to make a presentation?
- Stacey has been trying one therapist after another for years to discover why she has an almost constant feeling of dread, fears of abandonment and an eating disorder. Strangest of all, she has repeated images of the color red and a candle. It makes no sense to her, but it has been going on for as long as she can remember.”

As Shapiro goes on to explain throughout the course of the book, the root of their suffering lies in the way unprocessed memories are linked with automatic emotions, physical sensations, and beliefs that were experienced earlier in life. However, she notes that identifying the memory connections is just the first step in changing how we think, act, or feel. It's not enough to understand where something comes from; we must also know what to do about it. Shapiro underscores the importance of awareness, as she instructs readers how to create their own logs tracking triggers and associated images, cognitions, emotions, and sensations (TICES). Through patient narratives contributed by clinicians, Shapiro delineates how touchstone memories contribute to

the crystallization of phobias, panic disorder, and PTSD and how these memories influence the production of negative cognitions, specifically those relating to a lack of safety/vulnerability, and a lack of control/power. Furthermore, through the introduction and explanation of key self-control techniques such as the Safe/Calm Place technique, the Breathing Shift technique, the Cartoon Character technique, the Floatback Technique, the Spiral Technique, the Lightstream Technique, the Affect Scan, and bilateral stimulation, Shapiro provides readers with a powerful arsenal of tools that they can use to identify and manage the memories that underlie personal and relationship problems, and recognize when professional help would be useful. Most importantly, Shapiro reminds readers that persistent negative emotions, beliefs, or behaviors are not causes of sufferings, but symptoms that can abate once the unprocessed memories associated with them are processed.



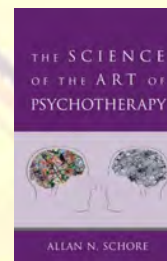
The Emotional Life of Your Brain. Richard J. Davidson, Ph.D. with Sharon Begley. 2012. ISBN 9781594630897. New York: Hudson Street Press. Reviewed by: Diane Botta, Columbia University

In *The Emotional Life of Your Brain*, Richard J. Davidson, author of *Train Your Mind, Change Your Brain*, has joined forces with Sharon Begley, science writer for the New York Times, to fuse the worlds of neuroscience and mindfulness, proposing that we all perceive reality through the lens of six emotional dimensions: resilience, outlook, social intuition, self awareness, sensitivity to context, and attention. Your Resilience style influences how your brain typically responds when faced with adversity; your Outlook style is determined by where you lie on the spectrum of pessimism and optimism; your Social Intuition style colors your sensitivity to nonverbal cues, such as body language and tone of voice; your Self-Awareness style is related to how attuned you are to what typically drives your behavior; your Sensitivity to Context style is influenced by how well you can determine what constitutes appropriate behavior at work or at a funeral, and your Atten-

tion style is determined by your level of focus, or how easily your thoughts flit about from stimulus to stimulus. Davidson goes on to explore correlations between certain emotional styles and ADHD, autism, and asthma, noting, for example, that those asthmatics who are most sensitive fall toward the Slow to Recover end of the Resilience style. Davidson also includes a wealth of research relevant to somatics, noting that “people with greater left-frontal activation, associated with a more positive emotional style, had the strongest immune response” (since the left frontal lobe connects to the amygdala, it enables it to suppress emotional outbursts), and that heart “contractility is influenced by the sympathetic nervous system, which is the key constituent of the fight-or-flight response and has been implicated in stress or distress. The stronger the brain activation in three key regions—a sector of the right prefrontal cortex, the insula, and the amygdala—the stronger the cardiac contractility.”

While our genetic inheritance may influence our set point for each spectrum, Davidson emphasizes research that suggests that there is greater potential for neuroplasticity than previously thought, and sets out to prove that through training our mind-bodies with the help of mindfulness techniques and exercises, such as single-pointed meditation, affect scanning, and creative visualization, we can rewire our brains and significantly alter our emotional styles, indelibly improving our existential experience.

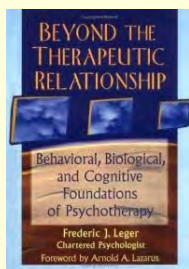
The Science of the Art of Psychotherapy. Allan N. Schore. 2012. ISBN: 978-0-393-70664-2. New York: W.W. Norton & Company. Reviewed by: Kavita Bommasamudram Stonybrook University



Schore has made revolutionary breakthroughs with his methodology to intertwine the fields of psychoanalysis and neurobiology. Since these fields have been previously approached independently, he has developed an understanding of psychotherapy with a basis in neurological mechanisms. The paradigm shift he continuously describes is a means of bridging the problems between the brain, mind,

and body through a scientific (re)-exploration of these areas and their connections. Specifically with the brain, this includes a shift in focus from the conscious, verbal left hemisphere to the unconscious, nonverbal right hemisphere. This has become possible through the increasing use of neuroimaging techniques which has resulted in, “exponential growth of neurobiological research of the emotional and social processes”. Schore utilizes this research to set the foundation for “modern attachment theory” with neurobiological roots, which has led him to develop what he calls “regulation theory”. This basic model can be used for both research and clinical purposes.

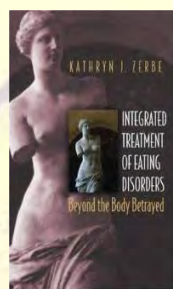
This two-part book is a compilation of the progressions of regulation therapy since 2005. The first part delves into the contributions of affect regulation therapy (ART), and the clinical neuropsychanalytic framework. The second section overlays the new ground-work in developmental affective neuroscience and neuropsychiatry. Schore also investigates how this relates to the patient-clinician relationship, with an interesting focus on how the brains of both the patient and the therapist change during clinical experience. Schore also explains how the psychotherapist should approach their treatment neurologically. With an understanding of developmental, affective, and social neuroscientific mechanisms of the brain, psychotherapists can heal on a deeper level. Both the patient and the clinician can benefit from the mutual attunement of these conscious and unconscious psychobiological affects through proper communication and regulation on the part of the patient and the understanding clinician. Geared towards psychotherapists and scientists, this collection of the latest applicable research and advances in clinical practice creates an enriching centrality between these two realms in the mental health profession.



Beyond the Therapeutic Relationship: Behavioral, Biological, and Cognitive Foundations of Psychotherapy. Frederic J. Leger. 1998. NY: The Haworth Press.

Reviewed by Malorie Mella, New York University

Drawing on 25 years of clinical research, psychologist Frederic J. Leger analyzes psychotherapeutic theory in this thought-provoking work. The main goal of *Beyond the Therapeutic Relationship* is to address the lack of progress in psychotherapeutic research and practice and to provide a mode of revision. Leger asserts that the field of psychotherapy has come to a standstill due to its largely disjointed nature and lack of empirical research. Psychotherapists are mainly insular in their practices and theories, and Leger suggests analyzing the underpinnings of such theories to find common and universal factors. Such commonalities will work to form the base of a new “transtheoretical psychodynamic” therapy, which also draws from various scientific fields of study. There must be an awareness of research in neurology, information processing, nonverbal behavior, and consciousness in order to understand how the different aspects interact and facilitate the therapeutic change seen in patients. All of these interactional factors have bases in behavioral, biological, and cognitive fields of study. Psychotherapists must not function in isolation, but instead communicate and integrate knowledge from these fields of study to revise psychotherapy theory and apply it to practice. By doing this, Leger believes that a higher order theory will emerge in psychotherapy and the current stagnant nature of the field will dissipate.



Integrated Treatment of Eating Disorders: Beyond the Body Betrayed. Kathryn J. Zerbe. 2008. ISBN: 978-0-393-70442-6. NY: W.W. Norton & Company, Inc.

Reviewed by Jillian D. Farrell, New York University

Eating disorders, with their complexity and uniqueness, challenge even the most adroit therapists and practitioners. Every case comes with idiosyncratic stories and causes that have

brought the patient to his or her disordered eating, making it difficult to decipher which of the extensive number of interventions to employ, especially since one must be cautious given that minute involvements can bring about drastic shifts in this sensitive group of individuals. Struggling with this point of issue herself as a renowned professional in this field, Kathryn Zerbe elucidates research regarding eating disorders while extracting distinctive insights that practitioners can implement to suit the individualized needs of the client. She strives to highlight and clarify the intricacy in treating the mental and physical morbidities that are just part of the engulfing manifestations of internal agonies and interpersonal troubles impairing the life of an individual with an eating disorder.

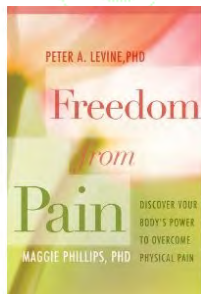
For clinicians of all levels of experience and family members seeking to learn more about treatments available for their loved ones, *Integrated Treatment of Eating Disorders* consolidates an amalgamation of treatments that can be utilized to create an integrated and distinct treatment plan.

With an integrated approach, Zerbe makes it easy for therapist to access insights from studies in biology, society, and psychology, as well as knowledge derived from educational, cognitive-behavioral, psychodynamic, pharmacological, and motivational developments. The book is divided into three sections that guide the clinician in devising and implementing an integrated treatment plan. In the first section, a roadmap to the phases of treatment is given providing suggestions, strategies, and explanations that can impart clarity for the clinician. Next, treatment and recovery is described from the perspective of the developmental life cycle. The final section goes on to tackle some of the specific issues that arise when treating eating disorder patients. Within each section, Zerbe enriches the text with her own clinical case examples and advice, as well as sample dialogues and charts.

For Zerbe, treatment and recovery of eating disorder patients is much more than symptom control. *Integrated Treatment of Eating Disorders* is an enlightening tool for all mental health professionals undertaking the challenge of treating eating disorders. Filled with applicable and feasible knowledge, this resource outlines how to confront the multifaceted issue of eating disorders in a more effective and thoughtful way.

Resources With a Technological Twist

Jacqueline A. Carleton, PhD and the USABP Interns



Freedom from Pain: Discover Your Body's Power to Overcome Physical Pain. P. Levine, & M. Phillips, (2012). ISBN: 9781604076639.

Boulder, CO. Sounds True.

Reviewed by Dawn Bhat, M.A., Long Island University

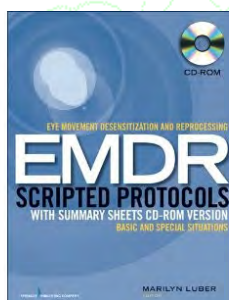
In this brand new volume, Peter Levine, Ph.D. and Maggie Phillips, Ph.D. bring principles of Somatic Experiencing (SE) and other techniques including hypnosis, journaling, guided imagery, and affirmations to relieve those suffering from pain. As pain may be experienced physically, emotionally, or related to traumatic stress, the authors propose that pain is actually multi-dimensional. Since physical, emotional, and trauma-related pain characteristics overlap, effective treatment needs to include the body-mind connection. SE utilizes the language of sensation to get to the felt sense experience and is an effective way to get to the root of pain. By freeing the body from pain using “bottom-up” methodologies, a balance is restored in the nervous system, the energy body is revitalized, and there is a refreshed sense of aliveness.

Freedom from Pain offers steps towards reconnecting to and befriending your body with simple, practical exercises that are available on the accompanying audio CD. Coupling insightful techniques from SE, pain is presented in comparison with trauma and the threat response. Somatic techniques give the experience a safe place in the body while owning disowned parts. By shifting painful sensate focus using mindful awareness, grounding, and extending the out breath, self-regulation is achieved.

Given the problematic aspects of treating pain medically, such as dependency and addiction, Levine and Philips teach safe and effective ways to overcome and manage physical pain. The audio exercises will take readers on a journey through profound inner discoveries while establishing healing, transformation, and resilience. Readers, those suffering from pain as well as

their clinicians and practitioners, may walk away pleasantly surprised and optimistic about a pain-free future.

Eye Movement Desensitization and Reprocessing: EMDR Scripted Protocols, Basics and Special Situations. M. Luber, 2009. ISBN: 978-0-8261-2237-7. NY: Springer Publishing Company.



Reviewed by: Kavita Bommasamudram, Stonybrook University

This CD-Rom version of the book focuses on the Eye Move-

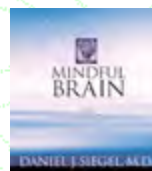
ment Desensitization and Reprocessing model (EMDR) as an effective psychotherapy modality for healing clients. In its development over the past twenty years, EMDR has proved to be a valid treatment choice for trauma and terror victims. The original EMDR procedures and trauma protocol have been extensively researched and have been proven to be as effective as cognitive behavioral therapy and psychodynamic therapy. While this psychotherapy methodology has been applicable to a wide array of disorders, certain protocols in this text remain to be fully researched and authenticated.

EMDR is based on the adaptive information processing (AIP) model, which is based on the assumption that human beings have an innate capacity to attain health and wholeness. When traumatic experiences and memories block this natural movement, it leads to the inability to connect to present information and maladaptive distortions, images, and feelings. These dysfunctional memories can lead to psychological symptoms that eventually manifest in a variety of physical/psychological disorders. To help these individuals, they need to reprocess these memories so that they can reconnect with other neural networks in their brains and resume healthy functioning. This approach blends both psychological and physiological theories into a standard set of procedures and clinical protocols to aid in this liberation. It also includes research on how the brain processes information in the procedure.

These protocols allow the mental health practitioner to access the traditional and newly developed methods that can integrate both past, present, and future issues with the use of the eleven-step Standard Procedure to address the current problem. Divided into nine parts, each section includes the eight phases of EMDR treatment as well as worksheets that the clinician can use to summarize important client information for easy reference.

The CD-Rom is intended for clinicians who have read Shapiro's text (2001), and for those who have received EMDR training, which includes trainers and consultants. It is emphasized that integrating this model into daily therapy practices has proven to be more difficult in the passing years, which is why it contains step-by-step information on the scripted protocols in EMDR to enhance the expertise of beginning practitioners as well. As EMDR is a complicated process, it is not intended for untrained or unlicensed clinicians who do not understand the intricacy of EMDR or for those who do not know the exact problem that they are working on with their client.

The Mindful Brain in Psychotherapy [DVD]. Daniel Hill (Director) and Daniel J. Siegel. 2008. PSY Broadcasting Corporation.



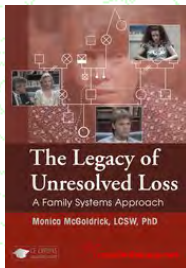
Reviewed by: Kavita Bommasamudram, Stonybrook University

This DVD series has mainly been designed for psychotherapists and other related professionals in the interpersonal neurobiology approach to the brain. The applications are derived from many different scientific disciplines to bring together a common conceptualized view of mental health, and in general for psychology and psychiatry. It even extends in usefulness in other fields such as education, parenting, mindful practice, and business. Knowledge of neuroscience in conjunction with psychotherapy creates a solid scientific foundation that can be applied to clinical and practical therapeutic settings to promote better mental health.

Siegel emphasizes nine key aspects and their relevance to therapy, family, psychology, and mental health practice. These are: body regulation; attuned communications; emotional balance; fear modulation; response flexibility; insight; empathy; morality; and intuition. These nine attributes are related to the mindfulness and “mindsight” as Dr. Siegel has termed, which relates to the human capacity for a person to map their own mind and the minds of others. He notes that having this sight is important in relationships, and that the particular combination of insight and empathy is crucial in this mind mapping. The first eight of these points are clinically proven outcomes of mindful training, and can be set as psychotherapy goals for positive mental health.

This audio set is divided into four lectures, with the final DVD devoted to questions and answers from the audience and Dr. Siegel respectively from the four lectures. To aid those with less scientific background knowledge, there is a professional library known as, “The Norton Professional Series in Interpersonal Biology,” which contains books that have the relevant science information ideally gathered for psychotherapists and other related professionals. It further explains the scientific terms and theories behind this integrated exploration. Dr. Siegel is the founding editor of the Interpersonal Neurobiology series in this library translation for the mental health practitioner. This collective series is a revelation of groundbreaking scientific work and bringing practical use of this knowledge to the clinician, who can then properly educate their patients and clients towards a healthier life through these mindful practices.

The Legacy of Unresolved Loss: A Family Systems Approach. By M. McGoldrick (2006). ISBN: 2467709069697. DVD. Mill Valley, CA. Psychotherapy.net



Reviewed by Dawn Bhat, MA, Long Island University

In this DVD set of eight counseling sessions, family therapist, Monica McGoldrick, delivers an approach to family that focuses on unresolved losses. Historical connections to the past may play a role in present problems, ones that often bring a family into therapy. In this presentation, losses of the connections to relatives may leave members of a family dull and flat with poor communication. Since being connected is what individual members of the family want, the therapist facilitates interactions that promote sensitivity, security and deep connection. A major tenant of this approach is that losses and what has come before are sacred and help to get us through life.

Reinforcing family connectedness minimizes problematic emotional distance in families, penetrates defenses, and enhances interactions. McGoldrick is directive, once trust is gained, as she artfully pushes the past blocks. Issues such as reconnecting distant family members and dealing with cut offs are also addressed. The effectiveness of techniques within the therapeutic relationship such as joining and confrontation are explored. Talking about the pains of loss as well as the love and hate that arise in family relationships is therapeutic. Furthermore, McGoldrick allows for growth within the family and future forward thinking, anticipating problems in the event things go wrong.

Seeing a family therapist in action in session was a marvelous learning experience. It showed how to gain the family’s trust and gather information about the family history. Uncovering intergenerational losses is an important way to reveal hidden family issues that may be masked by presenting problems. It is important to help family members mourn losses—people tend to become disconnected because of their losses. At times, the therapist sees some family members separately. This approach uses the genogram as a key assessment tool in working with families.

The accompanying manual for instructors, professors and training directors is designed to facilitate an understanding of many issues commonly experienced by family therapists. The instructional manual offers suggestions for group discussion on topics, such as

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Somatic Expressions

Welcome to our newest feature in
Somatic Psychotherapy Today.

While our publication honors the body in all its ways of being, words have carried the weight thus far. This issue marks our movement into alternative means of bodily expression available in an online magazine format.

We invite your submissions—photographs of original sculptures, paintings, scenes that resonated within, movements captured by a lens—along with a title and brief description.

multicultural family counseling. Other key issues for family therapists presented in the manual include segmenting the family for other sessions, the transparency of the therapist, discovering shared histories, working with power imbalances, being direct, and counter-transference reactions. The eight sessions are also transcribed verbatim.

in ways not always honored in Western societies; we have the opportunity to learn other ways of including a deceased baby in a family's life by honoring the complexity of diverse ways of being together in life and in death.

Fetal and infant death is often unexpected, and culturally there may not be rituals or traditions to support grieving parents through the experience. To effectively support culturally diverse clients, therapists must start with a self-assessment of their own cultural background as well as their attitudes toward other cultures. Everyone

happened and no one mentions the loss. Yet babies often represent the hopes and dreams of the entire family and just letting go is not possible or healthy. According to O'Leary, parents need to cry and talk about their deceased baby, regardless of how many weeks pregnant they were. This helps them understand they are still parents, they have the right to name this child, and there will always be a hole in the family for this baby.

"Prenatal motherhood involves an embodied relationship with the unborn child resulting in the mother's special awareness of her unborn baby that no one else knows or can truly understand" (O'Leary, War-

We have biophysical profiles looking at heart rate, fluid, breathing, muscle tone and can see when the baby is under stress in utero."

This reframes the focus of health care from a mother as caretaker to one of a parenting framework that encourages parents' sense of empowerment, awareness, and intuitive knowing of their unborn child. "Mothers can and do know when their infant is at risk and try to get help before their baby dies," O'Leary said. "One woman contacted her health care provider who said, 'You're due next week, it's normal for babies to slow down before birth.' He dis-

Fetal and infant death is often unexpected, and culturally there may not be rituals or traditions to support grieving parents through the experience.

views different cultures through their own lens, which affects their ability to provide competent care for clients whose backgrounds vary from their own. It's critical to ask families what they need and not make assumptions about a person's grief based on their failure to either show emotion or display what appears to be an overwhelm of emotion and somatic response. Providers need to fit within their clients' system and not judge them for not adhering to their own. Each culture has their own ways, and immigrants dealing with Western systems are often blindsided by bureaucracy—State and Federal rules—and regulations may conflict with their religious and cultural beliefs and traditions.

In general, babies die, get buried, and parents are told to forget about it and move on. O'Leary provides support groups for parents who have suffered the loss of a baby as well as the pregnancy that follows. There is a strong sense of isolation and lack of support in coping with a pregnancy or infant loss. Parents' feelings may range from shock to disbelief, guilt, blame, anger, and hostility. Many push through their normal routine because it may be socially or culturally expected and often hear statements such as "get over it" or "it was for the best" or the pregnancy is treated as if it never

land, & Parker, 2011, p.1). An enduring bond exists as parents learn to live with the death of their child, often not understood by others around them. In fact, continuing the attachment is believed to be an integral part of the healing process because the death alters how parents behave in pregnancies that follow as well as raising children born after a loss (O'Leary, 2004). Many parents have had to face their grief of the previous loss alone; thus, often withhold the news of pregnancy until after the first ultrasound or until the unborn baby's first movements, or until, in some instances, the baby is born.

O'Leary created a framework for parenting during pregnancy that involves changing the focus from "when the baby comes" to "the baby is already here". This framework teaches parents how to focus on fetal movements, to notice when it kicks, how it kicks, when it is slower or becoming rapid. She explains to parents that it is important to get to know their unborn baby's patterns so they know when there is a change. "Parents come up with this sense of a light bulb turning on and say, 'Oh yeah, that makes sense,' as they learn to pay attention to what they are noticing about their baby. Even 10 years ago I couldn't say it was a reciprocal relationship but now science is showing it's true. Technology is changing.

missed her fears and concerns and two days later this baby was stillborn." O'Leary suggests it's time for a paradigm shift in health care delivery so that a mother's intuitive knowledge of her baby and her body is integrated with the caregiver's knowledge and medical technology. "Today's obstetrical care has increasingly become medically managed, often denying or ignoring the intuitive knowledge and concerns of mothers," she said. "Discounting or ignoring a mother's concerns undermines her intuitive knowledge of her baby and her confidence as a parent and could put the baby at risk."

Dealing with parents who have experienced a loss, O'Leary believes her framework helps parents' in a normal pregnancy learn to know their baby and, for parents who have suffered a loss, learn their grief is legitimate. O'Leary works to help parents reframe who they are as a parent to a deceased baby because she believes that it is crucial for the baby that follows. They are still a parent to the deceased baby even though its physical presence is gone as they enter a new pregnancy with the sibling that follows. O'Leary noted that they don't have to let the deceased baby go. She encourages them to talk about this baby, to have pictures up, and speak about the baby on holidays, just like any deceased relative. The

mother's state of mind during the next pregnancy impacts the next baby in *utero*. The new unborn baby needs to know that it is not replacing the baby that died and that it does not have to make up for that sibling, still a part of the family only not physically present.

Doing presentations both in the United States and Europe, O'Leary frequently has adults approach her with comments such as one young woman who said, "I just realized I was a child born after loss hearing about the indicators," such as feeling a deeply rooted sense of anxiety without knowing why, feeling shell shocked. This young woman commented that she'd felt this anxiety all her life and simply dismissed it, not realizing it might have stemmed from her mother's anxiety during the pregnancy. This led O'Leary to begin researching adults born after loss. From this O'Leary found common character traits including overachieving, seeking recognition from parents, and carrying an underlying fear that they are not good enough. She has also found these adults understand the deep feelings of grief, some believing they experienced grief in *utero*, knowing at some level another baby was there before them that died. On a positive note, O'Leary found that even adults who had a difficult attachment relationship with their parents were in helping professions and all spoke of the need for parents to understand the emotional needs of children. In her research with parents raising children born after loss she also found a shared common theme of more sensitivity to others emotions. Even teachers report to these parents that their children are kinder to peers, and to those with special needs, and they are more open in general.

Grief can be gift if providers take the time to learn about their clients' beliefs and adjust their interventions accordingly. Even small snippets of data can help clients through the grieving process. While there is no universal approach to bereavement and grief, there are ways providers can intervene, support, assist, and instruct their clients as they negotiate the loss itself and over time perhaps another pregnancy. Because fetal/infant loss is not often openly discussed, many parents are not prepared for the experience lacking traditions as well as support. Research is also lacking because it is unethical to withhold grief support for a control group while supporting an experimental group (Shaefer, 2010). Qualitative studies offer some information about specific cultures but results cannot be generalized to a larger population. At this point, what is known is that each family has individual needs and providers must learn to listen and live with diverse needs that may at times be inconsistent with their own beliefs, values, and traditions.

For more information, The National Center for Cultural Competence at Georgetown University Center for Child Health and Human Development offers a wealth of information on cultural competency as well as self-assessment tools for practitioners to determine their beliefs and biases and make changes when supporting their diverse clientele (<http://nccc.georgetown.edu/features/CCHPA.html>).

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In Iranian families, infants belong to the parents as well as to the extended family and the loss is mourned by all, though they will not cry in public. There is a belief that nothing is an accident and that everything happens for a reason. Yet, parents are often blamed for the death; the mother, in particular, is blamed, and she may blame herself. There is also a cultural fear of talking about loss. Sharing poems and their powerful use of metaphor can provide solace as the writings describe emotions parents have hard time expressing.

African Americans experience a ratio of two to three times higher rate of infant mortality than the majority population in this country. And those who live in urban, less affluent areas and who are less educated make up a large population of the women who experience infant loss. These women may not express grief openly to non-family members. There is often singing and praying over the open casket, and a "falling out" that is manifested by collapse and an inability to speak.



Staying Present: The Body and Culture

By Amber Gray

Body movement is viewed as the most primary mode of communication and thus can be utilized with all individuals no matter what the age, dysfunction, or cultural heritage. Lewis (1986)

Lewis' sentiment is reflective of the universality of movement as a language. It also points to whether movement is extensively applicable as a nonverbal, somatic, therapeutic modality. While Lewis may not have made this assumption, I want to assert that a common misconception is that the knowledge that movement is a universal language is interpreted to signify that it is possible to understand the meaning of movements, gestures, and expressions across all cultures. While human development theories hold movement as the first language for all people, culture is a strong mitigating influence on the meaning of any movement, gesture, or somatic expression.

Because many of the somatic therapies currently taught are based on extensive theories about non-verbal therapies that are actually quite language dependent, and quite culture bound (e.g., usually, they come from Europe or the Western United States), I wish to offer case material from a truly non-verbal therapeutic process with a young man in Haiti. This case, I believe, illustrates how easy it is to infer meaning from movement, and how all the theoretical underpinnings in the world still don't equip us to know, precisely, what the meaning of movement is.

In almost twenty years of working as a Somatic Psychotherapist, Dance Movement Therapist (DMT), and Continuum Movement teacher, with refugees and survivors of torture seeking asylum in the US, and in places as diverse as Darfur, Haiti, Lebanon, Indonesia, Republic of Georgia, Peru, Australia, Norway and The Palestin-

ian Occupied Territories, I believe that presence is one key ingredient to useful somatic therapies in diverse cross-cultural settings. I am referring to the same presence Daniel Stern (2004) writes about in "The Present Moment in Psychotherapy and Everyday Life" where you focus on the presentness of the moment you are living in now and experience the essence of your life bound within the feelings and thoughts, the actions and reactions that cross your mind in the passing of 3 to 4 seconds of a present moment— "the small but meaningful affective happenings that unfold in the seconds that make up now" (p.8), and that Sharon Salzberg references in her "Loving Kindness" work (1997). Salzberg describes loving kindness as the antidote to fear and so through this practice, we can remain more centered in the reality of the present moment. And I am referring to the presence that is actually quite difficult to describe and teach,

and can be learned only through extensive practice. I believe true somatic, or movement based, psychotherapy with survivors of traumatic experiences, in diverse cultures, is simply impossible without the depth of presence that enables one to witness and not judge or interpret; be comfortable with not knowing; and be willing to allow the clients to be the experts, even in their own not knowing or inability to speak, articulate or move.

The meaning of somatic experience can only be known by the person in whose body the memory, sensation, or experience resides. DMT, which traces its oldest roots to ancient traditions that incorporate dance movement and rhythm into the therapeutic process, offers both a trained and an intuitive ability to understand, read, and listen to another with the presence of our full bodied awareness. Often the language spoken does not include words.

I have chosen a case study that took place in Haiti prior to the earthquake because it integrates ongoing disaster and trauma exposure with work with survivors of torture, my primary clinical focus, in an other than ideal clinical setting. And because much of the work I did in Haiti, post earthquake, was of a more immediate crisis response nature and did not include consistent follow up work, this work allows for in depth inquiry.

Case Study:

George is a 17-year-old boy who is severely undersized from malnutrition and abuse. He was found on the streets of Port Au Prince, Haiti, tied and bound at his wrists and ankles, where he stills bear scars from the tight ropes. He was repeatedly tortured and beaten for many years.

I worked with George at a home for mentally and physically challenged children in Haiti. When I first met him, he would not participate in group activities. His body posture was fixated in the position he was found and tortured in. He was tightly bound in a twisted fetal position on the floor and always faced the wall with his head turned to the right. He never interacted with the environment or other people. He was mute and constantly gazed downward. He sat for hours and days in this state, only eating or preparing for bed when approached.

George responded to only one invitation; if he were approached from his left side he would grab the outreached hand and push hard into the person approaching him. He would then push his companion around the periphery of the home, up and down all the stairs, and through every room, never crossing through the center space. He always remained peripheral, and he always pushed with force. When he was approached from the right side, he turned away. It was as if this was a boundary that couldn't be approached; while I could never know this, for sure, my own felt sense was that he could not quite negotiate this boundary. I felt confused by his response. It bears noting that George's single-armed pushing pattern (called a homologous push in Body Mind Centering) can be indicative of a very early developmental movement essential to



boundary formation that appeared to be truncated at a fixated, frozen shoulder. Rather than fixate on this, I remained curious about this possibility.

Initially, I allowed George to push me to get a sense of his movement patterns and efforts. One day I decided to push back and did so with resistance. He immediately spun his body to the right and into me, completely merging his body with mine and burying his head into my abdomen. I remembered my prior sense of a violated boundary and this action was uncomfortable for me. Even though I felt he was "too close", I initiated this interaction several times. I learned that George either only pushed away with force or moved into my body in a way that I experienced as enmeshed. It looked to me like either complete isolation or complete fusion, when he was approached on the right side.

Following this interaction I encouraged George to "differentiate" from me by allowing him to push me around the space in his usual way. In our next session, I tried something different: I met his push with a different intention. Rather than push back in resistance, I received his push. I wondered if my resistant push may have too directly mirrored his push, which in trauma work can, in my experiences with clients, re-activate a relational wound. From a theoretical perspective, his merging response may also have indicated forced fusion with a perpetrator. In non-verbal sessions like this, I will never know (this is what I refer

to earlier as the not knowing) and it may not be of service to the person to interpret or push for a story. In this case, since it wasn't possible to know the story, our interactions were based solely on felt sense and non-verbal, somatic communication. In order to sense into my actions or "interventions", I had to maintain my presence. I listened to my own body's cues to suggest what might be of service to this young man with a history of horrible violation.

Initially, this new way of relating appeared to confuse him. He froze, then began to turn left to right and right to left, as if he were a dancer twirling in my arms. He attempted to wrap himself around me again, spinning to the right. I was prepared. I gently steered him to the left in a non-threatening, compassionate manner, and turned him to face away from me. I rested my hands softly on his shoulders in a gesture that intended to communicate reciprocity and support. He stood there for a while, as if contemplating this, then tried to wrap himself into me again. When I gently encouraged him to keep my preferred distance from my body, he tried to push me around the space. I allowed him to do this briefly, thinking he might feel more in control of his body in space (and having no idea if controlling a body in space had any relevance in his cultural context). After we walked the entire periphery again I began to meet his push again, steering him gently to center. At this point he followed me, and

as we moved through the center of the home a tiny smile appeared on his face.

In subsequent sessions, I introduced a tuning board as a transitional object and physical boundary between us. As we did our “push and twirl” dance, I wedged the board between us. The tuning board, developed by Darrell Sanchez, is a pliable, circular object, brightly colored and usually pleasing to children. It is used to restore fluidity in a fixated, traumatized body. Transitional objects can support a safe holding environment. He seemed to enjoy the board as it became more familiar; he smiled a little more. I carried it with us on our walks, and when we returned we sat against the wall with it between us, always on his left side. He began to smile even more. The fixation, or muscular stiffness, in his upper body was relaxing and a stronger spinal push (another primary developmental movement in one theoretical framework related to verticality and, in a Western context, sense of self) was evident. Two things changed notably in his posture: he was extending his legs more in front of him, and while he still faced right, he did not face directly to the wall. His posture and movements appeared more relational in that they did not pull back, or draw away from. They moved or gestured *towards*.

At this point, I began to supplement our walks with range of movement exercises to gently encourage George to bridge more

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with his environment. As we walked, I raised my arm up, or squatted low, or opened my arms wide, inviting him to join me. As he became more comfortable with these movements, he began to increase eye contact with an occasional peek at me. He began to smile more, suggesting some social engagement.

As George appeared to grow more comfortable with me, we began to play ball. Initially, he would catch it if I threw it, but not return it. Eventually, he began to roll it back to me with a strong homologous push, a developmental move that precedes reaching, which is considered a relational action. I created the ball game to introduce another transitional object, and to encourage George to face me more directly. Each time he looked at me, I said his name softly acknowledging that I saw him.

Continued attempts to involve George in group activities were initially unsuccessful. On one of my last days, however, we began

with our usual dance, which by now was a familiar greeting. George then took my hand and led me to the wall, where we sat down with our backs against the wall. He placed the tuning board between us and extended his legs fully out in front of him with a homolateral reach, a yet more advanced and relational developmental movement. Several of the staff noticed this and expressed surprise. They had never seen him do this. He continued to sit facing into the room, and when other children began to gather around and play with balls and balloons, he remained. I initiated our ball game, and shortly another child joined us. The three of us played ball. The director of the center commented that he had not seen George interact like this in his two years there.

George’s kinesphere (in simplest terms, “space bubble”) had expanded so that he bridged more with his environment, which was beginning to include other people. His timid eye contact continued to increase, so that I saw him more. An increase in his shy smiles increased the affect dynamic in our interactions; I felt him more. He was pushing with fewer fixations, and seemed to be learning to reach out in relationship with the environment. Now less protective of his right side, he began to allow me to approach him from there, as long as he could see me. He was beginning to orient himself towards others in a way I perceived as more relational. When it came time for me to return to the United States, I trained all the staff in the use of the boards and balls so that George’s work could continue, as one of the greatest disservices we can do in an international context is only show up to do the work without supporting a context for it to continue.



Two young Haitian boys: Dreamstime stock photography

Discussion:

This is a particularly interesting case of DMT because our work was entirely non-verbal. George did not speak at all, though he understood Haitian Creole. Our communication consisted almost entirely of movement (other than when I uttered his name).

Without a story, or history, and without verbal exchange, I can only respond to what is present in the current time and space. So there were essentially two organizing frameworks I was working with: My theoretical frameworks, which serve to ground us as clinicians in challenging cases, and my “surrender” for lack of a better word, to only the present moment, movement based interaction occurring between us.

My initial clinical evaluation of George indicated a child with severe developmental trauma caused by torture. His virtual isolation in a tiny kinesphere and his inability to oscillate in and out of relationship made me curious if he had ever known healthy boundaries in relationship. It appeared that these relational dynamics shifted in our time together.

While my first instinct to push back may have challenged George, it provided me with useful information to get curious about. I imagined George had perhaps internalized his early experience of torture in a body frozen and fixated in physical postures rooted in fear. On the rare occasions that he moved, he did so only by keeping a safe distance from his companion. His daily life actions were, literally, peripheral and isolated.

As our movement dialogues continued and he began to expand his individual movement range, his interaction with the environment and other people eventually increased. His increased use of developmental movements such as homologous pushes and homolateral reaches, early neurological actions that a healthy child moves through as s/he attunes to and explores his/her environment, seemed to accompany a relational shift. I believe his increased use of these movements was restoring his developmental integrity as he reconnected with the primary movements that constitute

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healthy development. As George explored more of his environment, he showed increased affect through his slight smiles and gradual attempts at eye contact. Ultimately, George was able to maintain his presence in a group of very active children and to look at me almost directly and smile, which made our relationship feel slightly more reciprocal, to me. That level of interaction was not present when we began.

And, without the benefit of any verbal communication, other than conversations with others at the program, I don’t really know, in the way modern humanity usually defines knowing, what George’s story—past, present, or future was.

This work relied on the interaction and communication of our movement, fueled by internal sensations and perceptions each of us was responding to. In simplest terms, what I experienced and observed was a shift in a young man’s ability to engage with the world around him. It has been said that it is through dance that the history of a people is enacted. If this is true, it can also be said that the history of an individual is enacted through the body. Dance/Movement therapy honors the powerful connection that the human body has to life experience. What began as a limited movement repertoire of turning away from the world, into a wall, progressed towards a dance that included shared smiles, pushes, reaches, twirls, eye contact, play, exchange and reciprocity.

In the work of Stephen Porges, social engagement is possible to “read” through facial expressivity, gaze, prosody of voice, posture during social engagement, mood and affect, and state regulation. I would expand this to include movement in respect of those who are literally silenced by the

horrors they have endured. All of these shifted in ways that were, if nothing else, more relational and more present, if presence is defined as our ability to pay attention to only what is occurring in this very moment; to suspend judgment and interpretation and simply bear witness; and to be willing to be courageous enough in our curiosity to ask questions that may not have answers.

Amber Elizabeth Lynn Gray, MPH, MA, ADTR, NCC, LPCC, provides training and consultation nationally and internationally on clinical treatment for survivors of severe, interpersonal trauma. Her most recent roles include the following: Director of The Program for Victims of Organized Violence and Torture in Haiti; a psychotherapist at Rocky Mountain Survivors Center, Denver’s torture treatment program, for almost six years as well as Clinical Director of the program for over three years. Amber is adjunct faculty at Southwestern College, and was Visiting Faculty at New York University’s Trauma Studies Program for three years. She was on the faculty at the Colorado Center for Social Trauma from 1999-2001. She is a graduate of The Naropa University Somatic Psychology program, and has a Masters in Public Health from Columbia University. She has over twenty-five years experience in human service and working with displaced people, refugees, and survivors of human rights abuses, and over 13 years experience working with survivors of civilian and combat-related war trauma, torture, domestic violence and ritual abuse. Her expertise is in the development of individual and community-based culturally congruent treatment models for trauma recovery that reinforce individual and communal resilience. She has presented nationally and internationally and provided training for health and mental health professionals and paraprofessionals on such topics as working with traumatized refugee children, models for the cross-cultural application of psychotherapy, innovative approaches to trauma recovery that integrate local, individual and community resources and traditions, clinical issues in work with survivors of combat, war and political violence, and stress management

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Pat Ogden: Pioneer of the Past, Wave of the Future

of tolerance,” Ogden said. “But it’s different with attachment.”

“We’re really looking at the integration of the body, its movement and structure and posture and how it’s shaped itself in the context of early attachment,” she continued. “We know the brain develops in the context of early relationships but so does the body. A child, even an infant, will abandon actions or distort actions that are not effective in producing the desired outcome. For example, if proximity-seeking actions such as eye contact and reaching out are not met effectively by the attachment figures, they start to become distorted, and they actually shape the person’s movement patterns. You do go to the core of that attachment-related pain because then you can regulate it in the relationship, expand affect regulation capacity in terms of increasing affect array and intensity, shift those cognitive distortions and express those powerful attachment-related emotions. We want to get under those attachment-related defenses that were formed in order to maximize the goodies of the attachment relationship.”

More recently, Ogden shared that concepts from Stephen Porges’ Polyvagal Theory, Allen Shores’ enactments, and transference and counter-transference experiences have found their way into her work. Influenced by Philip Bromberg’s work (*The Shadow of the Tsunami: And the Growth of the Relational Mind*) and its impact on the therapeutic relationship, Ogden noted that Bromberg “describes this whole idea of enactments where the therapist’s history interfaces like hand and glove with the patient’s history.”

“This is so interesting to me,” Ogden said. “These enactments are not only inevitable, they can be used in a very positive way for healing and for insight and awareness for both parties, and I find that fascinating. I grew up in the humanistic tradition, where you’re supposed to be able to provide a corrective experience for your client, and if you find yourself judging your clients or disliking them or not wanting to be with them or angry with them, you’re supposed to kind of get over it. A newer way of looking at these things is that all that is grist to the therapeutic mill because it contrib-

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utes to the inevitable enactments. To work enactments through what takes place within the relationship can provide great opportunity for healing.”

To read in-depth about Pat Ogden’s historical progression, her philosophical beliefs, and the theoretical and clinical examples involved in her current work, please read the original article authored by Jacqueline A Carleton PhD at www.usabp.org following links to Somatic Psychotherapy Today.

To experience Pat Ogden’s approach and learn more about therapeutic enactments through a Sensorimotor Psychotherapy lens please attend her pre-conference workshop at the United States Association for Body Psychotherapy 7th National Conference, August 9-12, 2012 at Naropa University in Boulder, Colorado. For more information log on to www.usabp.org.

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and secondary trauma for individuals and organizations serving survivors. She has taken her work to Indonesia, Darfur, Haiti, Kosovo, India, Croatia, Norway, Mexico, Sweden, Australia, Denmark, Lebanon, and New Zealand. She is Past President of the Board of Directors for TASSC International, Refugee Mental Health Coordinator for the Department of Health in New Mexico, and Director of Restorative Resources Training and Consulting.

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Body-Based Healing Practices for Transforming Trauma With Cultural and Spiritual Diverse Individuals and an Embodied Approach to Re-Search



By Regina Ursula Heß

Standing there in Thailand far from my German homeland, in the middle of Asia's 2004 tsunami's devastation, I felt especially touched by, and drawn to, marginalized people—those who had nothing left and who would have no means to recover. My interest as a clinician and body-based Gestalt psychotherapist in healing approaches to individual and community trauma for culturally and spiritually diverse people emerged.

Surviving this disaster was a major turning point in my personal and professional life. Overwhelmed by the tsunami's wave tumbling me under water, I experienced a feeling of oneness with all that is, which I call an experience of non-duality prompting my own transformative development. Another life-changing moment was the exposure to mass destruction and the trauma of masses of people because of this natural disaster. Being a psychologist and psychotherapist, I felt somehow ridiculous about what I could do with one-on-one psychotherapy in such an environment with diverse people.

In the 90's, I had received a research grant on women's health in India. Since then, I have been studying Yoga and spirituality. I became particularly interested in the human experience and knowledge accessed through the body and healing approaches focusing on the body, including embodied spirituality and interrelatedness with nature. Subsequently, I pursued training in Integra-

tive Body and Movement Based Gestalt Psychotherapy (Petzold, 1996) addressing my strong interest in accessing understanding and healing through the body and spiritual practices, such as Yoga. After the survival of the tsunami, I experienced a desire and a calling to expand my own boundaries towards a more inclusive, open approach to psychology, and was searching for modalities to healing psychological and cultural trauma that include the body, mind, spirit, culture, community, and nature.

I felt it was important to follow my sense of destiny and decided to fulfill one of my life's dreams by obtaining an international doctorate abroad in addition to my German degrees of being a nurse, psychologist, and psychotherapist. I moved from Germany to the U.S. in 2006 to study at the Institute of Transpersonal Psychology (ITP) in Palo Alto, California. At ITP, Professor Virginia Dennehy introduced me to the holistic approach for transforming trauma of the non-profit organization Capacitar International

(U.S.) in my somatic psychology class. Immediately, I felt as a clinician I had found the kind of healing modality that I was searching for after my tsunami experience.

The Capacitar approach (Cane, 2000) facilitates training in a combination of body-mind-spirit practices—such as Jin shin jyutsu (fingerholds), Thought Field Therapy (TFT)/Emotional Freedom Technique (EFT), Tai chi movements, breathing exercises, and acupuncture—to foster the release of traumatic stress in an individual. Furthermore, the training includes raising awareness for the healing of global communities and of nature. Capacitar is a Spanish word, meaning: “to empower.”

A characteristic of the modality is the outreach to underserved and underprivileged populations and ethnic minorities around the world that are challenged by war, genocide, HIV, political violence, and natural disasters. The program also reaches out to battered women, children, and refugees.



Despite its apparent use with trauma, there is a considerable lack of knowledge about the impact of the Capacitar Training on its participants. I was particularly interested to investigate the experiences of change of the Capacitar training participants on the levels of body, mind, spirit, culture, and nature, and I knew “that this must be my doctoral re-search.” I hyphenate the term re-search to emphasize the two syllables “re” and “search.” To me, this emphasis conveys a notion of “I am searching for something that is already there and needs to be uncovered and brought to consciousness that it can be seen and understood.” Once I had started studying the Capacitar approach for my doctoral dissertation, I felt it important not only to analyze it theoretically but also experientially to gain self-experience about the impact. I then participated in the Capacitar Training in San Francisco, California, where I was certified in 2008. The most important experience of change for myself through the Capacitar training was its focus on the innate capacity of the individual to self-help/heal and the multiplicative approach of sharing the healing practices with others. With simple body-mind-spirit practices, the Capacitar training participants learn that they can do something for themselves to improve their healing/well being and life circumstances, in the sense of taking responsibility for themselves. The emphasis is on learning simple practices that can be easily practiced on their own and can be lightly shared with family, friends, and in professional settings that are enhanced exponentially.

The Capacitar training also includes psychoeducation about trauma, healing, and the concept of interconnectedness with body-mind-spirit-community-and-nature. Capacitar’s slogan is “heal yourself so that you can support healing others and the world”. The individual is not dependent on a teacher; therefore, it is an inexpensive and

independent method that can be used with individuals and groups. The only tool one needs is the body. To me, Capacitar is a program compatible with what I had been searching for after my tsunami survival—a healing approach beyond one-on-one or group treatment, not solely based on Western psychological concepts. According to this re-search subject, I was then looking for a re-search method that could capture holistic dimensions of embodied human experiences.

Embodied Phenomenological Re-Search in Psychology

With my doctoral dissertation, I had the goal to explore the impact of the Capacitar practices multidimensionally, including intra/inter and transpersonal/spiritual experiences of change. I was searching for an embodied approach to re-search methodology and found that in the method ‘embodied enquiry’ articulated by Les Todres, Ph.D. (UK). I moved to Bournemouth University, UK, in 2008 for the second half of my Ph.D. to study with Professor Les Todres and specialized in embodied phenomenological re-search in the field of psychology. In an embodied approach to re-search, the body is understood as the carrier of our experiences. Through the body we relate to others and the world, which are intertwined. We are transformed through each other. Todres (2007) focuses on the basic embodied connectedness with the world we live in. Everything I had studied and had been interested in before was brought together under Todres’ approach adding the sense that language and bodily knowing are intertwined. In Todres’ book, *Embodied Enquiry*, I read a quote that felt very inspiring and will accompany my work for the rest of my life and has been a life-changing moment: “Sometimes, the bodily depth of what one has lived through is more

than words can say. Yet such experience looks for words” (Todres, 2007, p. x). The language, the words, the giving voice including aesthetic expression such as poetry (Galvin & Todres, 2009) have been another new piece on my journey, in addition to the new insight in and desire for healing approaches beyond Western psychology after my tsunami survival. This second new insight carries the notion of “the body knows more that we can tell, yet we long to express more of this bodily ‘silent knowing’”. It is a longing to build bridges between the bodily non-verbal experiences and knowing and verbal expression.

Consciously “calling the body for words” was the new part to me, which added to my background of body-based Gestalt psychotherapy. Since then, I have established my personal practice of body talk, which is listening to what my body knows and tells and giving time to let expressions emerge. It is a back-and-forth movement between bodily experiences, bodily knowing, and language. When I allow myself to be guided by body talk, I feel I am slowing down, the world is slowing down, and only when I slow down do I feel an organic rhythm of the world emerging, which feels cyclic to me—everything has its own time—like the tide. This experience is mirrored in a description by the American Buddhist teacher Pema Chodron who said: “When we pause, allow a gap and breathe deeply, we can experience instant refreshment. Suddenly, we slow down, and there is the world” (<http://www.facebook.com/Pema.Chodron/posts/10150485249973220>). It feels like an expansion of consciousness. I integrated “body talk” in the work with my clients and experience that for most clients it needs time and courage to allow for experiencing such a deep bodily connectedness and to let profound expressions find their way to consciousness.

Drawing on Gendlin's (1997) concept of body, mind, and language as interrelational, embodied re-search emphasizes the implicit aspect of experiencing "the more than words can say" and at the same time enhances the possibility of expressing this implicit aspect by embracing the relational interplay of the parts and the whole. The goal is to transcend the limits of language through non-linear aesthetic expressions that touch us and elicit the implicit meanings. It is a non-linear experience, such as listening to music—where the experience is much more than the individual notes. Such a process is assumed as embodied understanding. To add "flesh" to the concept of embodied understanding, which can be enhanced through non-linear aesthetic expression such as poetry, I will share in the following paragraph a personal poem that emerged to me after a few years of personal work to understand and integrate the non-dual experience of surviving the tsunami along with my bodywork practices. It is a narrative-mystic poem, which was "flushed" through me; I did not make this up:

in the tsunami's womb—embodying a universal rhythm
... demons and angels submerged with me
in the tsunami's womb ...
captured by the wave
fearing death
seeing my life's story passing
negotiating: it is too early to go
i am not against you thundered the voice of
the great mother
i am with you
tumbling into a tunnel of light
saying good-bye, the pain of letting go
sadness and grace streaming through my
body
we are your guardians, whispered a choir of
angels in my ears
hearing a sound of pure love

embodying the rhythm of death and life
the universal rhythm of all that was and
ever will be

embodying my destiny

born into a new life out of the tsunami's
womb ...

To me, the poetic articulation of some of my exposure of surviving the tsunami deepened my own embodied understanding and felt like a relief of being able to express some of the overwhelming experiences.

My Re-Search Into the Impact of the Capacitar Practices for Transforming Trauma With Women From Both Sides of the U.S.-Mexico Border

For my doctoral re-search study into the impact of the Capacitar practices, I searched for a re-search location with global sociopolitical relevance where I could reach out to marginalized people. Living in the U.S. at that time, my interest was aroused by the complex problems around the fence, the militarized divide between Mexico and the U.S. and its impact on the people. I had lived for several years with the Berlin Wall in West Berlin, Germany, and felt intrigued to study the lived experiences of people around "walls" globally. Furthermore, I was concerned about the unprecedented killing of women in Ciudad Juárez, Chihuahua, Mexico, the so-called Twin City with El Paso, Texas, U.S.

I investigated the impact of the "Capacitar Body-Mind-Spirit Practices Training" for transforming individual and community trauma with 14 women (called "co-researchers") of diverse cultural and spiritual background from both sides of the U.S.-Mexico border, who were exposed to ongoing lethal violence and crime in the U.S.-Mexico borderlands. The women's embodied experiences of change as a result of the Capacitar Body-Mind-Spirit Practices Training were investigated with semi-structured multiple interviews conducted multilingually (English / Spanish / Mayan). In addition, I collected the women's narrative stories related to the borderlands, and evaluative information about the Capacitar training with the goal to deepen the embod-

ied understanding of the data for myself as the researcher and for the audience.

The most significant results of the phenomenological data suggested that: (1) the majority of the co-researchers' experiences of bodily change through body-mind-spirit practices initiated further integration of past negative (traumatic) and / or positive experiences in an embodied way, including interrelatedness to spirituality, culture and nature; (2) the initial bodily felt shift in awareness led to the co-researchers' desire for more change; and (3) the experiences of change were independent of the cultural or spiritual background of the co-researchers.

Conclusion

What are the implications of a body-based healing approach to the transformation of trauma with cultural and spiritual diverse individuals for the arena of body psychotherapy and its multicultural impacts? In my understanding, one of the most ground-breaking findings of my doctoral re-search (Heß, forthcoming) is the fact that body-mind-spirit practices catalyzed healing transformations for the diverse "co-researchers" regardless of their culture and spirituality. The women's experiences of change in awareness were initiated through outer and inner movements. The findings point to and reinforce the concept of interrelatedness: You and I are intertwined through our sensing bodies. From such a perspective, the body can be the carrier of synthesis, integration, and healing beyond culture and spirituality. These results support experience and body-based practice, re-search, and theory-building beyond exclusively Western psychotherapy conceptualization that need further investigation.

What can an embodied approach to re-search contribute to the field of somatic psychology?

In addition to being bodily experience-based, embodied re-search emphasizes how we can be touched by more creative expressions of human experiences, such as poetry, as illustrated in the poem shown in the foregoing section. It can enhance our feeling,

empathy, and understanding of Self and Other, leading to and understanding of interrelatedness. Another example of how creative expression can enhance embodied understanding of lived experiences related to my doctoral dissertation is the artwork by Ana Maria Vasquez-Leon, a Columbian activist and artist that echoes the assumption of the body as interrelated with Self, Other, and Nature. It is an exemplar of cultural-spiritual embodiment of diversity and the sacred feminine related to the U.S.-Mexico borderlands:



In this artwork, the Lady de Guadalupe of Mexico or so-called Brown Madonna embodies the U.S.-Mexico borderlands, symbolized as a new tree of cultural synthesis that grows in her heart. The tree has new roots in her womb, in addition to the strong roots stretching down deep into Mother Earth. Reprinted with the artist's permission. I am grateful for her generosity.

Lady de Guadalupe

Based on a full sensing body, embodied re-search integrates forms of aesthetic expression in order to make the lived bodily experience “present” in the writer and the reader. When people find themselves in these depictions, it can arouse a feeling of familiarity or unfamiliarity, and an awareness of interrelatedness that can create a sense of “home coming”. In this way, the embodied aesthetic presentation of social sciences re-search data contributes to a transformation and expansion of qualitative re-search methods towards social inclusion of cultural and spiritual diverse people.

REGINA URSULA HEß, PhD became a global activist in the 1990’s, engaging in human rights projects and voluntary work in India and Nepal. She received a research grant for a project on women’s health in India at the University of Chennai. She subsequently worked for human rights and mental health together with local healers at the University of Kathmandu, Nepal. Since then she has studied Yoga and other spiritual traditions. Regina has two decades of clinical experience in Germany as a registered nurse, graduate clinical psychologist (University of Heidelberg) and psychotherapist (integrative body-based Gestalt psychotherapy). She recently completed a joint doctorate with the Institute of Transpersonal Psychology, Palo Alto, U.S. and the “Centre for Qualitative Research”, Bournemouth University, UK. Her doctoral thesis is a women’s study based on “embodied phenomenology” that explored the impact of the “Capacitar practices” for healing individual and cultural trauma with diverse women from both sides of the U.S.-Mexico border. The bridging of performative sciences into social sciences research by using methods such as poetry, art, film, music, and dance etc., is a further research goal. Regina is a visionary and activist, with a primary interest in pioneering global research projects in the fields of transpersonal and somatic psychology. She is planning to teach embodied phenomenological research methods and body-based healing practices internationally. Having survived the 2004 Asian tsunami, Regina has a particular interest in alternative healing approaches to individual and community trauma, and transformative life experiences, including altered states of consciousness.

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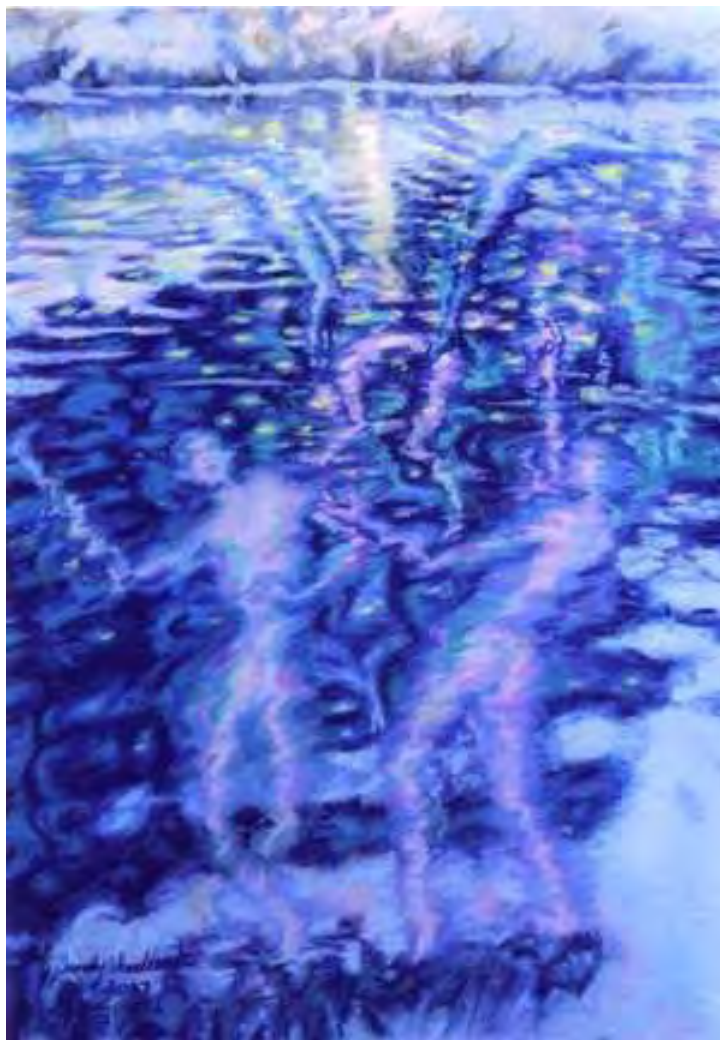
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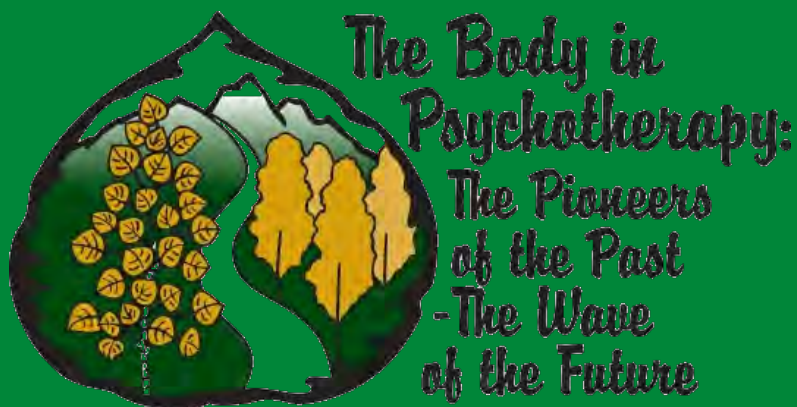
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