TOWARD AN INTEGRATIVE SOMATIC DEPTH PSYCHOTHERAPEUTIC MODEL FOR RELATIONAL TRAUMA: EXPLORING THE PSYCHOTHERAPY CLIENT'S LIVED EMBODIED EXPERIENCE

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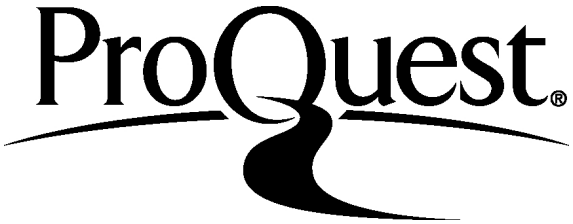

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ABSTRACT

Toward an Integrative Somatic Depth Psychotherapeutic Model for Relational Trauma: Exploring the Psychotherapy Client's Lived Embodied Experience

by

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This qualitative phenomenological study explored the experiences of people with relational trauma in NeuroAffective Relational Model (NARM), a somatically based psychotherapy. Utilizing an interdisciplinary approach of depth psychotherapy, neuroscience, attachment, and somatic therapy, the literature review examined the multifaceted impact of relational trauma and the mechanisms of implicit memory and somatic psychotherapy. The literature review also presented verbal and nonverbal therapeutic actions that theoretically support processes of change for the psychotherapy patient. Although much has been written theoretically about the psychotherapy patient's experience, there has been scant qualitative research from the perspective of the psychotherapy patient.

The researcher conducted interviews with six individuals who had been in NARM therapy to contribute to our understanding of the experience of the somatic, cognitive, emotional, and relational processes in the clinical dyad. The research participants included four females and two males, ranging in age from 30 to 63 years old. Using Giorgi's phenomenological method, interview transcripts were analyzed. Essential constituents were made explicit, and a refined structural description synthesizing the NARM patients' common experience was developed.

The research identified 11 constituents that comprise the essential structure of the lived embodied experience of being in NARM therapy. They include (a) the patient connects to his inner experience of emotions, thoughts, and sensations; (b) the therapist finely attunes to the patient; (c) the therapy experience is present focused; (d) the body and its expressions and sensations are tracked and incorporated; (e) images facilitate the patient's process; (f) the patient's movements are enacted and processed; (g) the patient experiences a new embodied authentic sense of self; (h) the patient's personal resources are highlighted; (i) metaphor supports the patient's process; (j) the therapy experience is titrated; (k) relational patterns are explored.

The study suggests the value and efficacy of a resource oriented, integrative, psychobiological therapeutic approach which supports affect regulation for patients exploring implicit and explicit processes of self that were shaped by relational trauma. The research indicates that a holistic divergent discourse supports organization, integration and individuation.

Key words: relational trauma, somatic psychotherapy, implicit memory, depth psychology

Acknowledgements

The journey towards my dissertation began a long time ago, actually around my dining room table with a nightly question that I debated often with my beloved mother, "Is it nature or nurture?" This question and many others about the human psyche infiltrated our conversations, and she instilled in me a deep curiosity and love for the vulnerable and resilient psyche. I would also like to acknowledge Dr. Aline La Pierre, my mentor and teacher. Thank you for collaborating with Dr. Heller on creating a clinical psychotherapeutic clinical model that includes the whole gestalt of the patient. Dr. Ginette Paris's input into this manuscript was invaluable, as she was initially patient with me, which gave me a strong scholarly foundation upon which to build. University professor Dr. Lillian Rojas inspired me to research and learn about relational trauma so as to find healing of its pernicious manifestations. In the true spirit of the gift of relationships, I want to acknowledge the loves of my life, my husband John, who has loved me like no one else. Through this deep love and attunement, I am connected daily back to my true self. Lastly, to my dear children Chandler and Carter, my deep love for you, and yours for me, have been the greatest rewards of my life and remind me daily of the complexity and extreme power of love.

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The style used throughout this dissertation is in accordance with the *Publication Manual of the American Psychological Association* (6th edition, 2009) and *Pacifica Graduate Institute's Depth Dissertation Handbook* (2014-2015).

Chapter 1

Purpose Statement

The purpose of this phenomenological, qualitative study is to understand how people with relational trauma experience the NeuroAffective Relational Model (NARM), a psychobiological clinical intervention. NARM, a psychotherapeutic model developed by analyst Laurence Heller, integrates both cognitive and somatic clinical interventions to work therapeutically with intrapsychic and interpersonal issues caused by relational trauma (Heller & LaPierre, 2012). Utilizing a depth psychological approach, study participants, who have experienced relational trauma and have been treated with NARM interventions, will be interviewed to obtain descriptions of their lived experience. The intention is to produce a phenomenological description of themes or patterns that emerge from NARM psychotherapy patients in an effort to further illuminate the process of change.

Introduction

The father of depth psychotherapy, Sigmund Freud, discovered a revolutionary psychotherapeutic method to treat mental illness, which he called psychoanalysis. For the past 100 years, psychologists, psychiatrists, and psychotherapists inspired by and in reaction to Freud have utilized variations of this theory to treat patients' symptoms, neuroses, and existential angst (Ellenberger, 1970). Depth psychology, because of its philosophical underpinnings, has primarily focused on the relationship between conscious and unconscious processes of the mind. Both Freud and Carl G. Jung understood the language of the unconscious to be symbol, metaphor, image, and dream, and depth psychotherapists have utilized this language in mythopoetic approaches facilitating their

patients' individuation process (Paris, 2007). However, "there has been less attention paid, either by Jung or his followers, to what he [Jung] pictures as the infrared pole—where psyche merges with matter" (Saban, 2011, p. 94). The field of depth psychotherapy would, therefore, benefit from the integration of somatic interventions that bridge the gap between the mind and the body—interventions that consider individuals as psychobiological beings. In utilizing an interdisciplinary approach, the lived body that one *is* instead of the body that one *has* can be integrated into the psychotherapeutic encounter, given that perceptions, thoughts, feelings, and cognitions are always embodied.

Researcher's interest in the topic.

For 5 years I have been on a journey that has involved learning how to be a clinician whilst balancing my own individuation process. A profound calling from the deep recesses of my psyche has driven me to work in the mental health field as a licensed marriage and family therapist. It is a challenging, humbling, and yet fulfilling endeavor. I have witnessed the debilitating effects of relational trauma in my clinical work with patients with personality disorders, disordered eating, dissociative identity disorders, severe anxiety, and depression. Using depth psychotherapeutic interventions such as working with images, dreams, symbols, and myths, I strive to facilitate my patients' individuation process, helping them to discover who they are beyond their symptoms. Depth psychology has always considered the innate healing wisdom of the body, and this trend continues in somatic depth psychotherapy today. Because neuroscience can be considered the dominant myth of our time, I am endeavoring to integrate neuroscientific theories and practices into my somatic depth practice through training in the

NeuroAffective Relational Model (NARM). The NARM approach works simultaneously with the physiology and the psychology of those who have experienced relational trauma, and focuses on the interplay between issues of identity, and the capacity for connection and affect regulation (Heller & LaPierre, 2012). NARM works with the functional unity of the body-mind, and is rooted in the principles of depth psychology. As Jung (1948/1969) noted, "it seems highly probable that the psychic and physical are not two independent parallel processes, but are essentially connected through reciprocal action" (p. 18). I decided to add NARM's somatic and cognitive interventions to my therapeutic toolbox because the model supports the inclusion of the body in the clinical encounter in the present moment, a trend that is becoming more widespread in the field of depth psychotherapy today. For my dissertation research, I am interested in the experiences of patients who have suffered relational trauma and have been treated using NARM interventions. Through interviewing, researching, and analyzing patients' experiences of NARM, I hope to gain a deeper understanding of their lived experience, in order to facilitate and enhance the process of change.

Relevance of the topic for depth somatic psychology.

Freud and Jung's seminal contribution to psychology was the development of a new model of mind that included both conscious and unconscious processes (Ellenberger, 1970). Both Freud and Jung considered the unconscious to be more closely connected to the body, to the instinctual, than consciousness. Through their clinical encounters and personal experiences, it became evident that the psychic emerges out of the biological; thus, who one is as a person is inseparable from who one is in one's body. Through his work with women suffering from hysteria, Freud discerned that the psyche speaks

through the body and that somatic symptoms are an expression of unconscious processes (Heller, 2012). Jung (1936/1969) described the functional unity of psyche and soma, stating, "in reality, there is nothing but a living body. That is the fact: and psyche is as much a living body as body is living psyche: it is just the same" (p. 396). This understanding of the functional unity of body and mind has continued through depth psychology theorists such as Robert Bosnak (2007), Joan Chodorow (1999), Ginette Paris (2011), Tina Stromsted (2007), and Marion Woodman (2009).

Neuroscience research lends support to depth psychological theories of the unconscious and has extended the concept of the unconscious (McGilchrist, 2009; Mancia, 2005). Specifically, neuroscience has confirmed the existence of the unconscious, which it describes as implicit memory (Paris, 2011). In his seminal treatise, *The Master and His Emissary*, psychiatrist and philosopher Iain McGilchrist (2009) described how emotional stimuli are processed unconsciously using the right brain hemisphere, further validating the work of somatic depth psychotherapy. However, according to McGilchrist, the picture of hemispheric differentiation emerging from neuroscience research is complex. The hemispheres have complementary perspectives: both sides process words and images, but in distinctive ways. Regarding development of a corporeal sense of self, McGilchrist explained, "The right hemisphere matures earlier than the left, and is more involved than the left in almost every aspect of the development of mental functioning in early childhood, and of the self as a social, empathic being" (p. 88). According to attachment theory, this sense of self is created through repeated patterns of emotional, interpersonal interactions between the infant and the primary attachment figure, which create an attachment schema that contains generalized beliefs

and expectations about relationships and about one's worthiness to receive love (Bowlby, 1969).

Implicit memory is formed during the infant's first 18 months of life due to the earlier development of the brain's right hemisphere (McGilchrist, 2009). Implicit memory contains repression and dissociation, and is also created through repetitive habitual acts of perceiving, relating, responding, and acting and is enacted behaviorally and felt affectively as who we are. The right hemisphere mediates the implicit processes of the subcortical limbic system, which is involved in the organization of the autonomic nervous system; therefore, it plays a key function in the organization of one's embodiment (McGilchrist, 2009). The right hemisphere is the master of "emotion and the body [which] are at the irreducible core of experience" and hence is responsible for personality development (p. 185). The corporeal sense of self is mediated though the unconscious and is felt as the "primacy of affect" (p. 184). It is through this lens that one attends to and experiences the world. The right hemisphere is also involved in "theory of mind" or one's capacity for "mentalization," which is a reflective function of the capacity to understand what happens in another person's mind (Fonagy, 2000, p. 108).

The right brain is the facilitator of unconscious relational processes, and early experiences of relational trauma reside within this hemisphere. Repeated interactions of neglect or abuse cause disruptions in the neural circuitry of the right hemisphere and impair the growth of regulatory fibers in the brain (McGilchrist, 2009). Specifically, when the attachment figure is not attuned to the child, lateral communication errors occur between the right and the left hemispheres of the child's brain. This less coordinated connection results in a reduced capacity of the left brain to process overwhelming

emotions and affect, leading to fragmentation of mental processes and embodied affect dysregulation (McGilchrist, 2009). In addition, relational trauma can block the communication of higher right to lower right subcortical systems, leading to intrapsychic and interpersonal pathologies. Neural dysfunctions in the communication processes of the hemispheres, laterally and subcortically, create the various symptoms with which clients present clinically, such as dissociation, depression, anxiety, eating disorders, and interpersonal issues.

McGilchrist (2009) further described the engagement between right and left hemispheres, explaining that the neural networks that form the implicit processes of the right hemisphere are associated with metaphor, affect, emotion, and wholeness. These networks function to ground the explicit, linear, analytical, language-oriented left hemisphere. The process of bringing the world into meaning begins in the right hemisphere and is processed through the left hemisphere "but must be 'returned' to the world of the right hemisphere where a new synthesis can be made" (p. 195). Through somatic depth psychotherapy, a client can gain an insight, which is processed in the analytical left hemisphere; however, a deeper integration can happen when the felt emotions of the insight are anchored in the body, where it returns to the right brain. Through the process of intentionally adding the assistance of the body to cognitive processes in the clinical encounter, patients can gain some self-organization of implicit processes (Heller & LaPierre, 2012).

Current neuroscience research, including functional brain imaging studies, have demonstrated the power of unconscious procedural memory in shaping one's sense of self and creating "implicit relational knowing, that is knowledge of how to be with others"

(Renn, 2012, p. 119). Consistent with depth psychological theories, the studies suggest that the mind and the body are a functional unity; therefore, disorders considered psychological must be reconceptualized as psychobiological. Relational trauma is a core phenomenon by virtue of the simple fact that children are still developing stress-regulating mechanisms; hence, overwhelming experiences are inevitable and shape the personality of every human being. These traumatic experiences are buried in the implicit procedural memory fibers of the right brain relational unconscious and in the nervous system (Schore, 2012). The forefathers of depth psychology worked with the invisible yet appreciated that often "the body carries what the psyche does not want to see" (Paris, 2011, p. 59). They also understood that integration of split-off affects is imperative for self-organization and individuation. Together with myth, metaphor, dreams, and images, the body and its sensations are another means to reach the right brain relational unconscious and work through relational trauma. In this dissertation, through interviewing psychotherapy patients, the aim is to garner a deeper understanding of the cognitive and somatic interventions that patients consider to be effective in relieving mental suffering and in supporting their mental health and wellbeing.

Definition of terms.

This interdisciplinary study will draw from three main theoretical orientations: depth psychology, somatic psychology, and NARM. Depth psychology is a contemporary academic discipline sourced by the humanities and associated with the foundational work of Jung and Freud. "Depth psychology claimed to furnish a key to the exploration of the unconscious mind, and through this a renewed knowledge of the conscious mind" (Ellenberger, 1970, p. 490). Barratt (2013) defined somatic psychology as

> the psychology of the body, the discipline that focuses on our living experience of embodiment as human beings and that recognizes this experience of embodiment as human beings and that recognizes this experience as the foundation and origination of all our experiential potential. (p. 21)

NARM is a phenomenological psychotherapy model that supports patients' mindful awareness of the cognitive, emotional, and physiological self in the present moment to work with their defense mechanisms, which were caused by unmet developmental core needs (Heller & LaPierre, 2012).

Relational trauma is a key term used in this study. The *Oxford Dictionary of English Etymology* (Onions, 1966) traces *relational* to *relate, relative,* and *relation.* Relate is defined as "bring into connexion or comparison," relative as "kinsman," and relation as "connexion" ("Relational," 1966, p. 753). The word *unconscious* refers to "the totality of all psychic phenomena that lack the quality of consciousness" (Sharp, 1991, p. 145). *Implicit memory* includes sensory, emotional, and procedural memories, attachment schemas, instincts, and inner objects, as well as stimulus-response conditioning. This "memory . . . shapes one's emotional experiences, self-image and relationships" (Cozolino, 2006, p. 128). The term *traumatic* derives from the Greek, meaning, "caused by a wound" ("Traumatic," 1966, p. 938). Relational trauma is defined as any emotional attachment experience that cannot be processed or regulated (Kalshed, 2013). McGilchrist (2009) defined *affect* as follows:

> Affect may too readily be equated with emotion. Emotions are certainly part of affect, but are only part of it. Something much broader is implied: a way of attending to the world (or not attending to it), a way of relating to the world (or

> not relating to it), a stance, a disposition, towards the world—ultimately a "way of being in the world." (p. 184)

Affect regulation refers to a process that "facilitates the transfer of implicit procedural information in the right hemisphere to explicit declarative systems in the left. Thus, body-based, visceral-somatic experience is symbolically transformed into emotional and intentional states of mind that become available for reflection and regulation" (Renn, 2012, p. 87). *Self-regulation* refers to the emotional regulation developed by the infant in concert with a caregiver; there is a relationship between the nuances of affect regulation and the development of the self (Schore, 2012).

Research problem.

Any clinician trained in depth psychotherapy understands the pervasive, debilitating effects of relational trauma. As Jung (1948/1969) stated, "we are all agreed that it would be quite impossible to understand the living organism apart from its relation to the environment" (p. 152). The self emerges within us and among us and comprises complex psychobiological dynamic processes that self-organize and move towards homeostasis and individuation (Shahri, 2014). Relational trauma happens throughout the developmental stages. When a child's "needs are frustrated, the child faces perceived existential threat or suffers from contact deprivation not being seen for who he or she is, or being seen as an object for the parents' narcissistic needs" (Shahri, 2014, p. 1). Empathy, mirroring, and attunement by the parent are exchanges that an infant requires during the first 3 years of life in order to develop a coherent sense of self and identity. When a child looks into an empty mirror, or experiences neglect or abuse, it is traumatic.

Chronic early patterns of dysfunctional interpersonal interactions between caregiver and infant/child create an unstable felt sense of self, which is internalized as nonverbal and unconscious. Loss of the empathic surround and the ensuing relational trauma cause profound psychological and physiological suffering throughout one's life span. Suffering is experienced through overwhelming emotions, "energetic states of the body," and feelings, which are "perception of emotions or body states" (Shahri, 2014, p. 2). This overwhelm, without internal or external soothing, leads to a psychobiological state of affect dysregulation and disorganization. Such affect dysregulation impacts personality development and creates a baseline from which self-organization and identity distortions are shaped. Identity distortions materialize as pathological symptoms, personality disorders, poor interpersonal relationships, and somatizations. These are the issues typically presented in the clinical encounter.

According to Donald Kalsched (2013), "early relational trauma results from the fact that we are often given more to experience in this life than we can bear to experience consciously" (p. 10). Unbearable, repeated instances of relational trauma can cause an individual to dissociate as a defense mechanism. Through this defense mechanism, certain aspects of the core self become ego dystonic and fragments of experience are laid down in implicit memory in the relational unconscious (Wilkinson, 2006). Jung (1934/1964) described the psychic split:

> Disturbances caused by affects are known technically as phenomena of dissociation, and are indicative of a psychic split. In every psychic conflict we can discern a split of this kind, which may go so far as to threaten the shattered structure of consciousness with complete disintegration. (p. 139)

He understood that fragmentation and dissociation were the pernicious effects of relational trauma. Today, trauma theorists and therapists have confirmed that these split-off emotional experiences are often stored in the limbic and nervous system of the psyche-soma and encompass implicit processes. According to McGilchrist (2009), dissociative defenses feel like a "psychic death and an inability to sustain a sense of 'inner aliveness'" (p. 235). Chronic dissociation effectively damages the right brain, affecting communication between the subcortical and cortical layers and impeding right- and left hemispheric integration. A disconnection occurs between the central nervous system and autonomic nervous system. The general disconnection between systems and neural fibers inhibits self-organization, resulting in a collapse of subjectivity and intersubjectivity (McGilchrist, 2009). In extreme cases of child abuse, an individual's sense of self can be extremely distorted or even nonexistent.

Relational trauma is a core phenomenon because no one escapes childhood unscathed (Kalsched, 2013). Therefore, the field of somatic depth psychotherapy, which is dedicated to understanding psychobiological life, would benefit from research that deeply explores the inclusion of the body to activate neurogenesis—"a process that stimulates neural stem cells to differentiate into wholly new neurons in the brain" (Siegel, 2010, p. 42). The aim is to use the assistance of the body to promote neurological changes that enhance the patient's capacity for resilience and agency, and in this way facilitate the patients' healing from relational trauma.

Research question.

The inclusion of somatic interventions in conjunction with cognitive interventions is becoming more common in psychotherapy today. Trauma has a strong biological

component, and therefore, the body can be one of the therapist's most valuable resources (Levine, 1997). Numerous somatic approaches have influenced modern theories of body-mind therapy. Examples include Eugene Gendlin's (1982) focusing method, Peter Levine's (1997) somatic experiencing, Ron Kurtz's (2007) hakomi approach, Pat Ogden's sensorimotor therapy (Ogden, Minton, & Pain, 2006), and Jungian analyst Arnold Mindell's (1993) process-oriented psychology. For this dissertation research, however, I have narrowed the scope to the study of the NeuroAffective Relational Model (NARM) interventions in the therapeutic dyad in the treatment of relational trauma.

NARM was developed by psychoanalyst Laurence Heller (2012), a student and teacher of Levine's (1997) somatic experiencing, who specializes in the integration of psychodynamic and body-centered approaches. I have been using NARM psychobiological interventions in my clinical work with positive outcomes. I aim to explore the possibility of promoting neurological changes in implicit processes, to support integration and regulation and thereby facilitate the healing of relational trauma. My research question asks: How do people who have experienced relational trauma experience the NeuroAffective Relational Model (NARM) as a psychobiological intervention?

NARM is founded in depth psychological principles in that it utilizes emotions in the here and now to uncouple unconscious, adaptive survival styles (defense mechanisms) that cause intrapsychic and interpersonal conflict. NARM principles work holistically towards clarifying the role of relationship difficulties as they affect a person at all levels of experience: physiological, psychological, and relational. The model outlines five adaptive survival strategies created around developmental core needs that

were unmet in the primary caregiver-child dyad. These five survival strategies—connection, attunement, trust, autonomy, and love and sexuality—are "ways of coping with the disconnection, dysregulation, disorganization, and isolation that a child experiences when core needs are not met" (Heller & LaPierre, 2012, p. 4).

Through NARM interventions, patients' direct physiological and psychological experiences are tracked and attuned to in a finely honed way to enable them to connect with their vast inner world. Freud associated the child's bodily sensations with the development of the self and "had seminal insights about the grounding of the psyche in the energetic experiences of our embodiment" (Barratt, 2013, p. 19). NARM returns to Freud's insights with specific body-mind clinical interventions to uncover unconscious processes, support affect regulation and mentalization, and integrate split-off psychobiological energies. Moreover, the therapist focuses on the patient's own resources to support resilience, agency, and self-organization, and to allow disidentification from cemented adaptive survival strategies and identity distortions (Heller & LaPierre, 2012).

Chapter 2
Literature Review

Depth Psychology, Somatic Psychotherapy, Attachment Theory, and the Relevance to the Study of Relational Trauma

Depth psychology.

The fathers of depth psychology, Freud and Jung, identified somatic expressions of the unconscious, beginning with Freud's theory of psychoanalysis (Ellenberger, 1970). This section is not an exegesis of their work, nor is it intended to capture the magnitude of their thinking; instead, it will focus on their extensive reflections on the psyche-soma relationship, and their perspectives on certain tenets of relational trauma.

Freud.

Freud believed the body to be the dwelling place of the soul, yet he began his career as a scientist, as a researcher in neurophysiology. He first practiced as a neurologist and then began to focus his clinical practice on the diagnosis of hysteria. Freud realized that many of his patients were neurotic; they were suffering from hysteria, a condition in which "there is a physical disability without a discernible physical cause" (Heller, 2012, p. 359). Rather than focus on the physical, Freud gravitated towards psychological explanations for his patients' physical ailments.

Josef Breuer, one of Freud's first collaborators, described the case of a female patient, Pappenheim, who was experiencing physical symptoms of paralysis and speech dysfunction. Under hypnosis, Pappenheim discovered a memory of a disturbing incident of which she had no conscious memory. Once this repressed memory was uncovered, the emotion tied to it was discharged, and she was relieved of her physical symptoms. The case was published in a book, *Studies on Hysteria* (Freud & Breuer, 1895/2004). In this

book, Freud and Breuer hypothesized that unconscious mental conflicts can give rise to somatic symptoms. These symptoms can be alleviated when the memory and its affects are discharged, which can lead to a therapeutic healing. Freud (1924/1953) maintained that "symptoms represented an abnormal form of discharge for quantities of excitation which had not been disposed of otherwise" (p. 289).

Freud did not discover dynamic unconscious processes but rather brought the concept to the natural sciences and explored ways to work with the unconscious clinically. The dynamic unconscious comprises "what was presently known and has since then been subject to repression" (Renn, 2012, p. 15). Freud's seminal insight was that when humans are in conflict with themselves, their consciousness splits. He posited that the psyche often uses symptoms of the body as symbols to express its conflicts, and thus psyche and soma are inextricably intertwined (Mitchell & Black, 1995). Freud's initial theory proposed that when the psyche experiences relational trauma, which can cause unbearable pain, the body becomes the container for the affects (Kalsched, 2013).

In 1895 in the "Project for a Scientific Psychology" (Freud & Breuer, 1895/2004) Freud attempted to reconcile his structural/biological theory of mind with contemporary neurological science. He was unable to reconcile the two, concluding at that time that neurology and consciousness could not yet be connected, while maintaining that the psychic emerges out of the biological (Heller, 2012). Freud hypothesized that disturbing memories and feelings were repressed and "recorded in a different way, to have fallen into a different part of the patient's mind—they were incompatible with the rest of consciousness and were therefore actively kept out of awareness" (Mitchell & Black, 1995, p. 5). Later, Freud proposed that the repressive agency itself is also unconscious

and that this repression creates defenses. As his theory progressed, Freud came to realize that unbearable feelings, such as wanting to avoid anxiety, actually cause repression. However, young Freud moved from hypnosis to free association as a way to uncover and explore unconscious defense mechanisms. In this way, psychoanalysis was born, and with it Freud's first topography: the unconscious, preconscious, and the conscious (Heller, 2012).

For Freud, to speak of the psyche and its deepest longings and terrors is to speak of the body, and specifically of its sexuality, as sexuality formed the building blocks of his libido theory. For Freud, however, sexuality was more than just adult genitalia; it was how one embodies the sensual longings, libidinous sensations, and emotional attachments towards one another throughout a lifetime. He maintained that the implicit intention of human sexuality was pleasure (Ellenberger, 1970). Freud discerned that psyche emerged through an interactive process with others, and in this theory are the seeds of modern day attachment theory.

In clinical dyads, Freud observed that many of his patients reminisced about childhood sexual longings and fantasies. He described anxiety neurosis, and noted that physical anxiety symptoms often occurred with sexual disturbances and undischarged sexual energy, such as erectile dysfunction, premature ejaculation, and sexual abstinence (Boadella, 1973). Freud understood sexual excitation to be a psychic energy, which "could extend itself like an electric charge all over the body in erotogenic zones" (Boadella, 1973, p. 13). This understanding formed the basis of his libido theory. Moreover, Freud noted an apparent correlation between his patients' presenting neuroses and incidents of childhood sexual abuse. This finding led to his theory of infantile

seduction (Heller, 2012). Freud later abandoned this theory due to the widespread backlash received from the scientific community, concluding instead that the memories of sexual abuse were in fact imaginary. Despite the retraction, the theory is relevant today due to the prevalence of childhood sexual abuse and the ensuing relational trauma, since it shows that the theory of neurosis was developed from a trauma concept.

As Freud's theory evolved, he struggled with the finding that it is often difficult to distinguish between objective memories and memories reworked by the imagination. This road block in his theory, combined with a personal dream in which he realized, "I am Oedipus," inspired Freud to conclude that "the impulses, fantasies, and conflicts that [he] uncovered beneath the neurotic symptoms of his patients derived not from external contamination . . . but from the mind of the child itself" (Mitchell & Black, 1995, p. 12). With the realization that the psyche emerges out of a progressive unfolding of sexual instincts and libidinal conflicts, he furthered his theory "in associating body sensation with development of ego" (Kaylo, 2003, p. 1).

The functional unity of psyche and soma forms the foundation of Freud's theories of drive and psychosexual development, and supports the thesis that who one is as a person is who one is in one's body. "The term 'drive' refers to and is based on the principle that organisms have certain physiological needs that when not satisfied lead to a negative state of tension" (Shahri, 2014, p. 3). For Freud, one's psychological development is structured from a biologically derived model that emphasizes the centrality of instinctual processes. Moreover, he proposed that a body part assumes prominence in its interaction with libido in five distinct stages. This orderly chronological progression includes the oral stage (0-18 months), the anal stage (18-36 months), the

phallic stage (3-7 years old), latency (7-11 years old), and the genital stage (from puberty to death) (Mitchell & Black, 1995). One's physiological drives, demands, and instincts are always mediated through the psyche. They are in conflict with each other and are the driving forces behind behavior. At each stage, a primary conflict is confronted. For example, the oral drive (libido) needs a sucking activity, this becomes a wish, and the energy is aimed towards an attachment to the breast, which creates satisfaction. "The source and aim are inherent properties of the drive" (Mitchell & Black, 1995, p. 13). The psyche emerges as an interactive process between one's physical primary instinct (libido) and mental activity, which organizes one's emotional life. For Freud, the sexual drive was not the only drive; he also described aggression as a drive and later "eros and thanatos, the life and death 'instincts'" (McGilchrist, 2009, p. 243).

Freud eventually moved away from his instinct theory and its repressed libidinous energy, as it failed to lead to therapeutic insights. He began to focus instead on psychic structure and defensive intrapsychic processes. He created a second topography, "with the hope that it would allow for a better management of the drives" (Heller, 2012, p. 402). Based on his expanding clinical experience, he realized and theorized that unconscious wishes and impulses are in conflict with the defenses, and that these defenses are often unconscious. When Freud perceived that the basic conflictual seam was not between consciousness and the unconscious, but inside the unconscious itself, it became necessary for him to delineate the major components of psychic structure (Heller, 2012).

The psyche is divided into three agencies: the id, the ego, and the super-ego. The ego or the feeling of I, is concerned with the present moment and managing the defenses;

the id is the libido and instincts, which originates in the soma and longs for expression; the energy of the super-ego aims to control the libidinal energy of the organism and represents internalized authority (Heller, 2012). Freud's first topography was derived in response to the treatment of neuroses and anxiety; the second grew with Freud's clinical practice as he treated clients with other issues. With his second topography of ego-psychology, Freud moved away from a body-centered theory.

Freud (1923/2001), arguably one of the first somatic psychotherapists, wrote, "The Ego is, first and foremost a bodily ego" (p. 26). The ego is proposed to contain and regulate thoughts, motor activity, and drives. For Freud, the body was a collective structure of meaning and the ground for intersubjective and intrapsychic reality (Kaylo, 2003). Freud proposed that one's psychology is expressed through one's embodiment with sexuality, libidinal sensations, mortality, and through one's dependence and interactions with other bodies. He theorized that one's psychology emerges from one's biology (Heller, 2012). Freud did not, however, work directly with the body clinically during psychoanalysis.

Freud appreciated the effects of relational trauma, understanding that the psyche is shaped by one's experiences with one's mother. One is always longing for, mediating, and managing the effects of that initial symbiosis with mother.

> Throughout Freud's published writings until he died in 1939, he reasserted the importance of sexual abuse and its etiological significance in mental illness. Freud was the person who coined the term "psychic trauma," which, clearly articulated the role of childhood sensitivity to trauma, and described the defenses of denial of trauma. (Vermetten & Lanius, 2012, p. 298)

Freud's later published writings revisited the importance of child abuse and its etiological significance in mental illness. He understood that every human being is exposed to the relative impact of relational trauma, and, if left relationally unprocessed, this affects one's embodied capacity to be in meaningful, functional, interpersonal relationships. "No human individual is spared traumatic experiences; none escapes the repressions to which they give rise (Freud, 1949/1969, p. 66). In support of Freud's work, Schore (2008) wrote, "Freud's model of the unconscious as the primary guiding influence over everyday life, even today is more specific and detailed that any to be found in contemporary or social psychology" (p. 177).

Jung.

Jung was a phenomenologist. He was committed to unraveling the structure and dynamics of the psyche through embodied experiences of intrapsychic engagements with conscious and unconscious processes. Jung pioneered a method to work with and integrate the unconscious using images and dreams, and was inspired by investigations of philosophy, Eastern religion, myths, and ancient alchemy. At an Eranos seminar in 1940 he remarked, "I can formulate my thoughts only as they break out of me. It is like a geyser" (as cited in Jaffe, 1940/1971, p. 8). Jung's ontology, consistent with Freud's, included the underlying assumption that the psyche has many layers, including the conscious ego and the personal unconscious. However, he further proposed a deep stratum of the psyche, the collective unconscious, of which archetypes are an element. For Jung, psychotherapy concerned individuation, "which is like a quest for wisdom, a life-long fascinating adventure, a process of withdrawal of more and more projections, a

continuous recognition of more contradictory impulses within oneself, leading to ever increasing levels of consciousness" (Paris, 2011, p. 64).

Jung understood that the mind and the body were essentially connected through reciprocal action; however, the actual nature of that connection was beyond the scope of his experience and education. He wrote, "although it seems certain to me that psychic energy is in some way or other closely connected with physical processes, yet in order to speak with any authority about this connections, we would need quite different experiences and insights" (Jung, 1948/1969, p. 7). The fundamental unity of psyche and mind piqued Jung's curiosity. It was a concept riddled with existential ambiguity, and one with which he wrestled; yet it was fundamental to his understanding of intrapsychic processes (Brooke, 1991). This principle is reflected in Jung's writing, "In other words, psyche and body form a unity beyond the limits of understanding, but in the meantime, they are treated as though they were separate for investigative, heuristic purposes" (Jung, 1937/1975, p. 547). Jung considered the body to be a gestalt in the meaning-making process of consciousness. He identified the body within the realm of instincts; however, "Jung consistently warns his students and his readers that body and psyche are one and the same life—that no thing is true until it reaches the body, and that that the symbol always needs physical expression" (Kaylo, 2003, p. 1). Rather than working directly or systematically with the body, Jung chose to work with symbols, understanding that they had a materiality of their own, and profoundly shifted the energy of the body. Jung wrote, "Out of the sympathetic nervous system, out of the belly, symbols are born and our transformation takes place" (as cited in Conger, 1988, p. 79). Jung's use of images and the imagination allowed a creative bridge between felt sensory experience and

comprehension.

While a young psychiatric resident, Jung read Freud's recently published book on the interpretation of dreams. Freud's revolutionary concept of attributing unconscious motivation to human behavior resonated with Jung's thinking at the time. Jung initially studied medicine, but later his interest shifted towards psychiatry. His theory, like Freud's, was greatly shaped by the schizophrenic patients he worked with at the famed Bergholzi psychiatric hospital in Zurich (Ellenberger, 1970). Although not known for somatic interventions, there is an account of Jung using gesture as a way to connect with a schizophrenic patient: "Jung (1961) observed that he was able to communicate with a schizophrenic woman by imitating and reflecting her gestures, a technique later developed by dance/movement therapists" (Wyman-McGinty, 2007, p. 221).

To probe deeper into unconscious processes using the body, Jung expanded on a psychophysical experimental method, the Word Association Test, conducting pioneering research in this area. "In 1906 Jung published the first volume of the studies that he had conducted with several collaborators" (Ellenberger, 1970, p. 668). Renown first came to Jung from this research. He added innovative measures to the test, including the first real use of the galvanic skin response and cardiopulmonary function to yield a more complex picture of the individual response process. He described a technique of connecting the subject, via hand-electrodes, to an instrument measuring changes in the resistance of the skin (Papadopoulis, 2006, p. 20). A list of words was read to the subject one by one. If a word on the list elicited an emotional response, a change in body resistance occurred, causing the needle of the galvanometer to deflect, indicating that a complex had been triggered. Jung used the psycho-galvanometer as a tool for zeroing in on a complex. He

defined complexes as “psychic fragments, which have split off owing to traumatic influences or incompatible tendencies” (Jung, 1936/1969, p. 121) and concluded:

> As the association experiments prove, complexes interfere with the intentions of the will and disturb the conscious performance; they produce disturbances of memory and blockages in the flow of associations: they appear and disappear according to their own laws; they can temporarily obsess consciousness, or influence speech and action in any unconscious way. (p. 121)

Using the Word Association Test, Jung attempted to prove empirically the existence of unconscious complexes. He verified that the complexes identified through word association express themselves simultaneously in somatic ways. His studies revealed that the body’s response to (stimulus) words is immediate, direct, and meaningful. Moreover, Jung demonstrated that all psychic complexes are intrinsically embodied. This was “an awareness that he never lost” (Conger, 1988, p. 64). Jung’s innovative research demonstrated the psychological and physiological were inextricably intertwined, and that one’s complexes live in one’s tissues. In discovering autonomous complexes, Jung effectively uncovered implicit processes. Such processes are created by repeated early interpersonal interactions, and shape the right brain relational unconscious. In fact, “many psychotherapists nowadays are of the opinion that therapeutic change is determined in great measure by implicit processes that are nonverbal and also not even conscious” (Sassenfeld, 2008, p. 3). The Word Association Test forms the bedrock of the modern day somatic intervention of biofeedback.

Frederich Nietzsche also greatly influenced the development of Jung’s epistemology as it related to the body. Jung had an estranged and ambiguous relationship

with Nietzsche; however, he was professionally drawn and extraordinarily fascinated by Nietzsche's work *Zarathustra,* and Jung held seminars on *Zarathustra* for 5 years between 1934 and 1939 (Saban, 2011). In these seminars, he "reflect[ed] on the psyche/soma relationship" (Conger, 1988, xxix). He spoke of the subtle body or somatic unconscious, which he defined as:

> the unconscious as perceived in the body, but also the physiological unconscious, the so-called somatic unconscious, which is the subtle body. You see, somewhere our unconscious becomes material, because the body is the living unit and our consciousness and our unconscious are embedded in it: they contact the body. (Jung, 1934-39/1988, p. 441)

Through the concept of the subtle body/somatic unconscious, Jung cogently described what today one calls somatizations: "the unconscious as is experienced as we descend into the body" (Schwartz-Salant, 1986, p. 31). Jung made a clear statement that the subtle body and its vibration "refers to that part of the unconscious that becomes more and more identical with the functioning of the human body, growing darker and darker and ending in the utter darkness of matter" (Jung, 1934-39/1988, p. 441). Jung maintained that one's unconscious thoughts and feelings can exist in the subtle body, and that the less conscious one is of them, the greater the likelihood that they will be encrusted as physical structure and symptoms. In becoming denser, the patterns press up against the limits of one's conscious mind. The unconscious, represented as a somatization, is a physical manifestation of unconscious processes being expressed, and these symptoms can be a portal to bring unconscious processes into awareness in order to be integrated.

Jung recognized that his patients came to him with "traumata or psychic wounds that were lying in potentia" (Jung, 1912/1970, p. 90). The phenomenon of dissociation is an example of a psychic wound caused by relational trauma. Dissociation is a mechanism by which the psyche modifies its own structure to accommodate the interaction with a frightening but needed attachment figure. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) *(DSM-V)* defines dissociation as "the splitting off of clusters of mental content from conscious awareness" (American Psychiatric Association [APA], 2013). Jung appreciated the profound effect of dissociation, which is a direct effect of relational trauma on the psyche. Almost 90 years ago he wrote:

> A traumatic complex brings about the dissociation of the psyche. The complex is not under the control of the will and for this reason it possesses the quality of psychic autonomy. Its autonomy consists in its power to manifest itself independently of the will and even in direct opposition to conscious tendencies: it forces itself tyrannically upon the conscious mind. (1928/1966, p. 131)

Jung cautioned that as long as the dissociated affects or unconscious splinters of the psyche remain unconscious, they will haunt one like a phantom limb, because their energy is profound and often limitless (Jung, 1928/1966). Jung maintained that these dissociated aspects must be integrated into the personality in order for one to individuate and become more whole. Modern day trauma theorists and Jungian analysts such as Margaret Wilkinson (2006) have expanded on Jung's concept of dissociation and recognize that "early brain development is adversely affected by dissociative experience in the earliest relationships" (p. 96). Kalsched (2013) took this a step further, maintaining that "even worse, this dependent, regressed, and vulnerable [dissociated] part of the

personality [is] now hiding in the somatic unconscious" (p. 187). These dissociative processes are experienced by both the psyche and soma, and are encrypted in both; hence, the seminal importance of bringing the body into the clinical encounter.

Both Jung and Freud favored the intrapsychic elements of the psyche, focusing on autonomy and individuation as goals of psychological healing (Stern, 1985). However, they understood that every human being is exposed to the relative impact of relational trauma, and that personality growth is relational and experienced in the brain and the body. The talking cure, or transference cure, is effective because it is an interpersonal model that considers a person's whole psychobiological gestalt in an intersubjective field. Freud and Jung worked within an interpersonal framework and understood through their own personal experiences and clinical encounters that the language of the unconscious (image, symbol, dream, and metaphor) could facilitate the integration of implicit processes and that this integration was of seminal importance. These tenets laid the groundwork and were the catalysts for all future psychological theories and clinical applications. In addition, the fathers of depth psychology were curious and reflected extensively upon the fundamental unity of body and mind. Due to the historical context and the limits of science in the early 1900s, this connection was not fully explored, yet they appreciated that one's emotional history, capacity to relate to others, belief systems, and deepest sense of self are inseparable from the life of the body.

Contemporary depth psychologists.

As the field of depth psychotherapy evolved, so did its practitioners' curiosity about the inherent wisdom of the body. Depth psychotherapists began to perceive the body as incarnated subjectivity, which inspired the use of techniques that considered the body-

mind unity. Practitioners appreciated that "the somatic domain [is] the source of the earliest relational experience with the primary caregiver" and, therefore, explored the use of the body as a way to bring the unconscious into consciousness (Wilkinson, 2010, p. 14). Through depth psychotherapy, one looks to uncover the unconscious processes and complexes that drive thoughts, emotions, and behaviors. Dreams, reveries, and their images are often used in the process of active imagination to facilitate this process (Papadopoulos, 2006). Jung developed the technique of active imagination in 1916. The process has two parts: "the first half is letting the unconscious come up. The second half consists in coming to terms with the unconscious" (Chodorow, 1999, p. 305). To engage in active imagination, one empties one's mind, or one can start with an affect and observe the images or inner voices that arise. Dream images can also be used in active imagination. The process involves the transformation from affect to image, which taps into the natural healing function of the imagination.

In the late 1950s and early 1960s, Mary Starks Whitehouse, a student of dance and Jungian analysis, merged the two worlds of movement and the imagination and created a form of dance therapy. She called this "movement in depth," maintaining that the body was the unconscious in the flesh (Chodorow, 1999, p. 282). Jungian analysts such as Joan Chodorow and Janet Adler utilized the practice in their clinical work as a bodily based form of active imagination, and the approach evolved into what is known today as authentic movement. Authentic movement is a self-directed process of moving and being moved without any agenda. The client turns inward and focuses on the sixth sense of proprioception by noticing the ongoing inner stream of bodily sensations, throbbings, pulsings, and waves, as well as mental imagery, voices, and sounds. These sensations,

visions, and images are then given form and expressed through bodily movement. After the process, the clients share their reactions (Chodorow, 1999). The therapist/witness also shares feedback and the activity is fully processed to bring it into consciousness. Wounding occurs in relationships; therefore, the witnessing, sharing, and processing between clinician and patient in the relational field are integral to the healing that occurs in the here and now. Furthermore, it is critical to the healing process that the information gleaned from the unconscious is integrated and actualized in real life (Chodorow, 1999).

Somatic depth psychotherapists often utilize authentic movement to reach the symbolic or preverbal material experienced in early primary relationships. "By attending to the world of bodily felt sensations, the mover recreates a situation that is in many ways similar to that of an infant who swims in a sensory motor world" (Chodorow, 1999, p. 290). Modern depth psychotherapists such as Stromsted (2007) maintain that authentic movement can be used to express therapeutically what is embodied yet unspeakable. The process can allow one to connect with the preverbal, deep implicit processes of instinct, affect, and sensory perception, and this is often where relational trauma resides. Thus, authentic movement is a powerful, embodied therapeutic intervention that can facilitate integration of implicit processes that are repressed, split-off, or frozen.

Somatic psychotherapy.

The father of somatic psychotherapy, William Reich, appreciated that every patient brings to the clinical encounter not only the symptoms of his or her psyche but also of the whole organism: one can never leave it behind. Reich was a medical doctor and psychoanalyst, as well as one of Freud's most brilliant students. In 1919, a group of medical students in Vienna held a sexological seminar. It was here that Reich first

became acquainted with Freud's writings. Reich wrote a paper to the sexological seminar, "'Concepts of the libido from Forel to Jung' where he clarified Freud's use of libido as the psychic energy of sexual desire" (Boadella, 1973, p. 10). Many colleagues were impressed with Reich's paper, and a year later, at the age of 23, he applied for membership into the Vienna Psychoanalytic Society, and was accepted. Reich's interactions with Freud greatly piqued his curiosity and determined his choice of profession (Heller, 2012).

Reich believed that individual therapy focused on human reactions and psychic illnesses in neurotic patients, which are shaped by the restraints of a patriarchal cultural structure. He maintained that "the social and economic structure of a society impinges upon the character formation of its members in a direct, very complicated circuitous way" (Reich 1945/1972, p. xxv). One way in which social order affects the organism is through issues of the expression of psychic energy and healthy sexuality. Reich posited that psychic conflict combined with dammed up sexual energy caused libidinal energy to become trapped in the tissues, which led to neurosis and mental pathology. "I concluded from a [clinical case] that the stasis neurosis is a *physical* disturbance caused by inadequately disposed of, i.e., unsatisfied, sexual excitation" (Reich 1942/1973, p. 93). Reich was also troubled by the fact that psychoanalysis did not follow a distinct clinical course and often took years to produce relief of symptoms (Reich, 1945/1972, p. 81). These ideas led to Reich's theory of sex-economy, which grew in the womb of Freud's psychoanalysis between 1919 and 1923: "Reich's first scientific theory, the orgasm formula arose as a logical development and extension of the Freudian libido theory" (Boadella, 1973, p. 11). Reich wrote, "I was looking for the energy source of the

neurosis, its somatic core;" through this search he came to the conclusion that sexual and genital disturbances were at the core of neurosis (Reich, 1942/1973, p. 98). This premise was refuted and rebutted by many of his colleagues in psychoanalytic circles.

Reich's orgasm formula was born in 1923. The premise of this theory is orgastic potency, which "is the capacity to surrender to the flow of biological energy, free of any inhibitions: the capacity to discharge completely the dammed-up sexual excitation through involuntary, pleasurable convulsions of the body" (Reich, 1942/1973, p. 102). Physiological flow happened through a process of tension, charge, discharge, and relaxation of libidinal energy. This became the formula he used with patients in his clinical practice to release psychic energy. Reich believed that sexual release leads to the dissipation of neurosis and pathological symptoms, asserting, "a person who develops truly adequate sexual release cannot maintain a neurosis" (Baker, 2000, xxiii). The study of orgastic potency led to Reich's theory of character analysis, an advancement in psychoanalysis that reflected Reich's determination to move clinical work beyond just talking. Reich's focus on the quantity of excitation inspired him to study the connection between psychic energy (libido) and physical structure. He was intensely concerned with what happens to libido, which he considered a "measurable biological energy" (Conger, 1988, p. xviii).

Building on the orgasm formula, and in response to clients' resistances, Reich later became interested not only in symptom analysis, but also on each patient's characteristic ways of functioning: their character. In his seminal book, *Character Analysis* (Reich, 1945/1972), he proposed that as well as expressing oneself through one's words; one also expresses oneself indirectly through characteristic attitudes and

behavior, and through nonverbal aspects of expressiveness. Nonverbal expression included body language and other related phenomena; for example, tone of voice and facial expression.

One's character contains character armor, which Reich described as blocked energy in the body. This armor is created when one's drive meets with environmental frustration. The blocked energy was thought to lead to muscular contraction, which he described as "frozen history," a physical tension that keeps the drive from expressing itself (Boadella, 1973, p. 42). According to the theory of character analysis, "The neurosis was anchored in this rigidity—the armor which produced and maintained the character" (Baker, 2000, p. xxiii). Where Freud posited that the psyche splits due to overwhelming conflict or unresolved emotions, Reich postulated that that same energy becomes bound in tense muscles; therefore, this character armor is also a defense mechanism. Reich soon left the realm of the psychic processes and entered into biophysics. He proposed that muscular contraction was a physiological defense against integrating emotion, and his therapeutic aim was to extract this armor piece by piece. Reich categorized seven segments of bodily armor: the oracular, the oral, the cervical, the thoracic, the diaphragmatic, the abdominal, and the pelvic, and he worked systematically with the dammed up libidinal energy in each segment (Baker, 2000, p. 44). Muscular armoring, according to this theory, did not allow for the regulation of emotions and hence led to psychological symptoms. "Structure and energy had an inverse relationship: the more massive the layering's of character the less fluid and spontaneous was the patient's behavior" (Boadella, 1973, p. 42).

Reich was curious about the processes that held the muscular contraction; this interest led him to the study of the vegetative nervous system (autonomic nervous system). He discerned that

> excitation of the sympathetic nervous system causes contraction, which is felt as anxiety. Parasympathetic excitation causes expansion, which is felt as pleasure. It is the chronic sympatheteconia, therefore, which causes and maintains the armor, which in turn maintains the neurosis. (Baker, 2000, xxiv)

Reich observed that on both the physiological and psychological levels, the parasympathetic nervous system is associated with pleasurable, expansive movement towards the world and with relaxed, embodied unarmored states. In contrast, the sympathetic nervous system is generally associated with contraction; in other words, a libidinal retreat from the world due to anxiety, and is chronically activated in armored states. Through investigative studies, Reich discovered that this expansion and contraction, which he called "pulsation" was found in all life forms, and in humans is most easily observed in pulse and respiration (Carleton, 2009). Discussing Freud's approach to anxiety, Reich wrote, "Freud failed to see that anxiety was a biological phenomenon and cannot appear in the ego unless it is first prepared in biological depth" (1942/1973, p. 136). The overarching principle of expansion (parasympathetic) and contraction (sympathetic) and the role of the sympathetic response in relational trauma are now the bedrock of many somatically based treatment modalities such as Levine's (1997) somatic experiencing and NARM (Heller & La Pierre, 2012).

In the therapeutic setting, Reich proposed that once the patient's bound up body armor, which is held in the musculature, is interpreted; it can unravel and dissolve,

allowing psychic energy to flow once again. To dissolve blocks or hooks and facilitate the flow of libido, Reich worked with his patients' breathing patterns and posture, and would also touch them in session. Reich used a more explicit and intrusive form of therapy, asking his patients "to feel their body from the inside, insisting mostly on the sensation and the affects that are related to the parts of the body being explored" (Heller, 2012, p. 449). As his theory progressed, Reich began using touch more frequently, sometimes having his clients undress. This was controversial amongst Reich's professional peers and damaged his credibility as a clinician.

Reich was not interested in first order change: alleviating symptoms that reflected an underlying character disturbance; rather, he wished to facilitate second order change: to thaw the character armoring in which the patients' symptoms were anchored. By penetrating the armor, one could theoretically dissolve the foundation of dysfunctional thoughts and distressing emotion. In addition, as one's armor dissolved, it released the orgasm reflex, which led to healthier expressions of sexual energy. Reich maintained that underneath this shield-like defensive armoring lay an adult who could self-regulate in love and play, and individuate towards wholeness. "The principle of therapy is quite simple: merely to remove the chronic contraction which interferes with the free flow of energy throughout the organism and thus restore natural functioning" (Baker, 2000, p. 45).

Through microscopy experiments, Reich inadvertently made observations about the breakdown of organic and inorganic matter. By use of the electroscope and other scientific instruments, he discovered that these preparations of matter in a state of breakdown were emitting a form of energy that was not adequately described or

explained by existing energetic conceptualizations. This inspired Reich, in a way similar to Jung, to use a galvanometer to measure this "bioelectric energy" (Reich, 1942/1973, p. 376). He called this bion research. Later, however, he discerned that this energy was not electrical; the libidinal energy was cosmic life-force energy in the body, which he called Orgone (organism) (Heller, 2012).

In the nature versus nurture debate, "Reich was strongly for nurture," demonstrating his deep understanding of the influence of one's primary caregiver on the organism (Conger, 1988, p. 40). Character analysis, which was later called the vegetotherapy theory, held that neurosis and pathological symptoms were the developmental product of the unmet or neglected needs of the child, dismissed wants of the child, or frustrations imposed by a repressive upbringing. "The entire world of past experience was embodied in the present in the form of character attitudes" (Reich, 1942/1973, p. 45). Through the lens of relational trauma, one could say that invasive or depriving relationships cause chronic muscular rigidities and visceral armoring. Inspired by his son, Reich "was particularly interested in the prevention of developmental trauma and of shock trauma to infants, especially new borns" (Carleton, 2009, p. 26). He was also opposed to the strictly controlled infant treatment made popular at the time by behaviorists. Reich "advocated such things as allowing the newborn to remain close to or on its mother's body, breastfeeding on demand, toilet training only when initiated by the child, and freedom for children to masturbate and explore each other's bodies" (Carleton, 2009, p. 27).

A. S. Neill, the British educator who founded the progressive Summer Hill School, also greatly influenced Reich's thinking on the effects of child rearing. Neill was

an administrator of Summer Hill School, a school system that aimed to respect the desires and meet the emotional needs of children while empowering them. This friendship inspired Reich to focus "on the basic requirements of mother love: good bodily contact and the ability of the mother to empathize with the child's needs" (Boadella, 1973, p. 227). Following this rich understanding of the seminal impact of the mother-child dyad, in 1940, Reich started The Organomic Infant Research Centre. The aim of the center was to educate mothers about the impact of their interactions with their infants, as a preventative measure to thwart relational trauma and character armor formation (Boadella, 1973, p. 228). Reich formulated a theory of child rearing that he called self-regulation: "self regulation was a biological concept which allowed the organism of the infant to develop in the most natural and healthy way" (Carleton, 2008, p. 2). Reich understood that this co-creative dyadic relationship between mother and infant was critical and that "every case of successful character-analysis revealed that character attitudes to have arisen as attempts to defend the child in conflict situations with his parents" (Boadella, 1973, p. 47).

Ironically, Reich's theories of sex-economy, character analysis, vegetotherapy, and the energy of the orgone were formed in reaction to Freud's distancing from the sexual etiology of neurosis, and his move towards an ego psychology (Heller, 2012). Traditional psychoanalytic treatment focused primarily on the interpretation of verbal content; however, Freud understood that cure through intellectual insight alone without emotional discharge was not possible. Reich's character analysis added a more holistic focus on the organism, including the nonverbal aspects of one's expressiveness, since he recognized that deep emotion, whether conscious or unconscious, is held physically.

Reich discerned that blocked energy, which stopped the flow of the life force through the organism, led to psychological symptoms and suffering.

Reich ended his life in a federal penitentiary when he refused to cooperate with the FDA's attempt to label his work with orgone energy as unscientific. Today, due to advances in neuroscience and progress towards bringing the body into the clinical encounter, his theories have once again gained recognition. For example, Reich's theories form the core of NARM and its concepts of life force energy, self-regulation, and the tracking of expansion and contraction (Heller & LaPierre, 2012). However, NARM's clinical orientation towards the body differs from Reich's, as will be explored in a later section.

Attachment theory.

John Bowlby, Mary Ainsworth, and the discovery of attachment schemas.

Emergent attachment theory originated from child psychiatrist and psychoanalyst John Bowlby's groundbreaking research on the mother-infant attachment dyad. Bowlby's research revolutionized psychoanalytic theory. Utilizing an interdisciplinary perspective, Bowlby demonstrated how the infant's first attachment indelibly influences conscious and unconscious psychobiological processes, and hence shapes his or her personal development (Bowlby, 1969). Attachment was considered to be the product of activities of several behavioral systems and instinctive social behaviors, with the biological function of creating a bond between mother and child. Bowlby (1951) explained, "the infant and young child should experience a warm, intimate, and continuous relationship with his mother in which both find satisfaction and enjoyment" (p. 13), and he described the effect on the infant of suboptimal experiences in this dyad. Bowlby's theory of

personality development stemmed from multiple sources: his volunteer work with maladjusted children in England, his studies in science and psychiatry, and later from his training at the British Analytical Institute (Bowlby, 1988). His theory crystallized following his work with the World Health Organization (WHO) in 1950, where he was hired to consult on the mental health of homeless children. Here, Bowlby (1969) chose to focus on separation of the mother from the infant since such separation was a recorded event.

Through his clinical experiences, Bowlby discerned that psychoanalytic theory lacked intrinsic pieces of the psychological puzzle, concluding that the theory was flawed in numerous ways. A primary flaw identified was that psychoanalytical theory relied on a retrospective "historical reconstruction" from the patient (Bowlby, 1969, p. 3). Bowlby maintained that a different source of evidence was required, and he appreciated that much could be learned about personality development through naturalistic observations of young children in real-life situations. His particular aim was "to describe certain patterns of response that occur regularly in early childhood, and thence to trace out how similar patterns of response are to be discerned in the functioning of later personality" (p. 4). This was a radical shift from focusing on pathological symptoms to focusing on an individual's experiences in the early environment with the primary caregiver.

Bowlby denounced Freud's claim that childhood trauma and seductions were imagined, as he was convinced that the field of psychology needed to consider the child's actual experiences (Bowlby, 1988). Bowlby's theory of attachment also negated Freud's (1949/1969) hypothesis that "love has its origin in attachment to the satisfied need for nourishment" (p. 70). Bowlby rejected psychoanalytic explanations for the child's

libidinal tie to the mother, in which need satisfaction was seen as primary. In addition, Bowlby disagreed with social learning theory's claim that dependency was based on secondary drives and reinforcement. He used a control systems theory to negate Freud's drive theory, maintaining that attachment happens "when certain behavioral systems are activated" (Bowlby, 1969, p. 179). These systems are shaped by evolutionary adaptedness and proximity with the primary caregiver in the early environment. The infant seeks and actively creates the goal of attachment through crying, calling, smiling, following, clinging, and sucking to evoke response. Hence, certain interactions are enforced and maintained by his or her response so that the infant can create the goal of a secure base from which to explore the environment (Bowlby, 1969).

In developing his theory, Bowlby mined ethological observations of other species with their primary caregivers, believing that such studies provided a container for his theories. For example, Bowlby was influenced by Konrad Lorenz's (1935/1957) pioneering field observations with ducklings and goslings, in particular the discovery that the young bird will seek the familiar. Bowlby described imprinting as "whatever processes may be at work in leading the filial attachment behavior of a young bird or mammal to become directed preferentially and stably towards one or more discriminated figure(s)" (Bowlby, 1969, p. 167). American psychologist Henry Harlow's studies on the effects of maternal deprivation on rhesus monkeys also informed Bowlby's theory. Harlow's surrogate mother experiment was of particular significance. In the experiment, infant monkeys were given a wire and a cloth monkey as surrogates and were observed to seek close proximity to the cloth mother even though she did not supply food. This observation supported Bowlby's hypothesis that infants are motivated by more than just

the secondary need for nourishment and that in addition they had a need for contact comfort (Bowlby, 1969). Harlow (1958) confirmed, "these data make it obvious that contact comfort is a variable of overwhelming importance in the development of affectional response, whereas lactation is a variable of negligible importance" (p. 677). Bowlby's seminal premise was that contact comfort, a secure base, and the capacity of the mother to create a safe haven led to attachment behavior, whereas meeting the physiological needs alone did not (Bowlby, 1969). The attachment behavior is shown as the infant's desire to remain in close proximity to the mother and is defined as "a person attaching or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world" (Bowlby, 1988, p. 27).

Bowlby observed that maternal separations and deprivations were traumatic for the infant (Bowlby, 1973). Experiences of an emotionally inaccessible, neglectful, or abusive mother elicited feelings in the infant of "protest, despair and detachment" (p. 60). Anger, mourning, and grief are emotions felt in despair. This despair "is followed by a state of neurological sluggishness that Bowlby described as a '*failure to thrive*, or *miasma,"* a surrendering to lack of love (Paris, 2011, p. 46). Once the attachment behavior of separation anxiety was activated, only the mother could terminate it and soothe the infant. Bowlby presented empirical evidence suggesting an etiological relationship between certain forms of psychopathic personality and severely disrupted mother-child relationships (Bowlby, 1973, p. 6). However, Bowlby held that these responses to separation were adaptive and were only problematic when they became rigid (Johnson & Whiffen, 2003).

Mary Ainsworth's research provided the first empirical evidence for Bowlby's

attachment theory and further expanded Bowlby's prescient work. Ainsworth was inspired by Bowlby's WHO report "and was impressed by the evidence on the adverse affects on developmental attributable to the lack of interaction with a mother figure when infants and young children spent prolonged periods in impersonal institutional care" (Ainsworth & Bowlby, 1991, p. 3). An early ethological field study in 1954 involved the observation of 27 children in a Ganda tribe in Kampala, Uganda. In this study, Ainsworth visited the children every afternoon for 7 months and watched their interactions with their mothers (Bowlby, 1969). Describing the study results, Bowlby noted, "Ainsworth's findings make it clear that in all but a small minority of Ganda children attachment behavior is clearly present by six months of age" (Bowlby, 1969, p. 200). Ainsworth was fascinated with a particular feature of the attachment behavior—she noted that beginning at around 2 months, the infant was not passive but would actively seek proximity and engagement with the mother. This was a novel view of the infant and would shape later infant research (Ainsworth, 1963).

Ainsworth and Bell (1970) developed an experimental procedure to observe the variety of attachment forms exhibited between mothers and infants. The security of attachment in 1- to 2-year-olds was investigated in the procedure known as the *strange situation* study. The study involved observing the behavior of the mother-child dyad in a series of seven 3-minute episodes in which the infant is observed interacting, separating, and then reuniting with the mother. The study revealed that the infants could be divided into three groups based upon the level of protest exhibited upon separation from their mother and the range of soothing they could absorb upon reunification with their mother.

The three groups were securely attached, insecurely attached, and nonattached. This work formed the tenets of attachment theory.

The creators and researchers of attachment theory discovered that multiple variables shaped secure attachment:

> it was not the total amount of time that the baby was held by the mother that promoted secure attachment so much as the contingency of the pick-up with infant signals of desire for contact, and the manner in which the mother then held and handled the baby. (Ainsworth & Bowlby, 1991, p. 7)

The study results highlighted that a secure relationship was promoted by the mother's sensitivity, emotional availability, and reflective capacities, an unprecedented finding that shifted psychotherapeutic clinical work away from drive and social learning theory.

Bowlby truly appreciated the effects of early developmental relational trauma on the embodied self, creating a theory of personality development that married psychology, biology, and body-to-body regulation. He wrote:

> If growth is to proceed smoothly, the tissues must he exposed to the influence of the appropriate organizer at certain critical periods. In the same way, if mental development is to proceed smoothly, it would appear to be necessary for the undifferentiated psyche to be exposed during certain critical periods to the influence of the psychic organizer—the mother. (1951, p. 53)

Bowlby recognized that the quality of physical and emotional contact, attunement, and regulation within the parent-child dyad determines whether the child will have an essentially negative or positive attitude towards himself or herself and others. In addition, Bowlby depathologized dependency needs maintaining that there is no such thing as

"overdependency or true independence; there is only effective or ineffective dependence" (Johnson & Whiffen, 2003, p. 105). He postulated that an individual's imprinted attachment behavior remains with that individual "from the cradle to the grave" (Bowlby, 1988, p. 82). However, due to advances in neuroscience, today it is known that "the brain is constantly adapting to new information and new circumstances, e.g., modifying patterns of connection between different parts of the brain and reorganizing neural pathways and functions (neuroplasticity), as well as developing new neurons (neurogenesis)" (Hartmann & Zimberoff, 2011, p. 4). Personality development through relationships is a lifelong process. "No form of behavior is accompanied by stronger feeling than is attachment behavior" (Bowlby, 1969, p. 209). This premise changed the way somatic depth psychotherapists understand the effects of normal and pathological development and illuminated the therapeutic relationship and process in ways that are still unfolding.

The mother-infant relationship and its effects on implicit processes.

The study of infant attachment reveals how the infant's subjectivity and affect are created and regulated psychobiologically, through verbal and nonverbal exchanges with the caregiver in the intersubjective field. For this reason, somatic depth psychotherapists look to attachment theory to inform and inspire their work. Beginning in the preverbal, first months of life, infants are acquiring their own idiosyncratic manners of bodily organization in interactions with their caregivers. The caregiver interactively attunes to the infant's affective state through a rich sensory experience of eye contact, gesture, prosody, tone of voice, and sensorimotor and tactile communications (Cozolino, 2006). The subtle ways in which the parent receives contingency signals from the infant and

makes sense of the meaning of those signals, in addition to the time taken to respond to the signals, shape the infant's implicit processes of the right brain relational unconscious and attachment system (Cozolino, 2006; Schore, 2012). The infant must, therefore, manage the specific exchanges, positive and negative, embodied and expressed by the caregiver. "The infant finds her solutions and a basic core repertoire of body practices is established during such interaction" (Downing, 2012, p. 134). Some practices optimize attachment; others protect and are defensive mechanisms created to mitigate the effects of maternal deprivation, neglect, contingency ruptures, and lack of attunement. On a very basic level, the infant needs the parent to tune in to his or her inner experience in order to attain a deep, profound experience of feeling felt. This rich experience of feeling felt must also occur between the client and the therapist in the clinical dyad in order for the therapeutic alliance to facilitate the client's process and foster change.

The 1990s saw a second trend, inspired by Bowlby and influenced by psychiatrist Daniel Stern, to "develop ways of supporting how an infant grows into the realm of social interactions" (Heller, 2012, p. 608). This research integrated psychoanalysis, developmental psychology, and neurosciences, and supported the emerging field of somatics. Historically, many psychologists and analysts appreciated the value of studying infancy, including Wilhelm Reich, Anna Freud, Margaret Mahler, and Melanie Klein. According to Heller (2012), "child psychoanalysis soon developed in a spectacular fashion, thanks to the works of personalities such as Bruno Bettelheim, Rene Spitz, Margaret Mahler, Francoise Dalto, and several others" (p. 608).

Stern studied infant subjectivity, specifically the interpersonal and intersubjective context of the dyadic system between infant and caregiver (Stern, 1985). Stern, like

Bowlby (1969), was dissatisfied with Freud's theory of psychosexual stages, arguing that Freud's theory did not provide the field of psychology with a direct link to adult psychopathology. Stern (1985) also maintained "reality experiences precede fantasy distortions in development" (p. 254). In addition, attachment movement theorists and clinicians such as Stern discerned that healthy interdependence in relationships, rather than independence and autonomy, are indicative of maturity.

As a young psychiatrist, Stern attempted to reconcile how his patients' social and emotional histories influenced their adult personalities. This early work fueled his curiosity about infant development. Stern's own experience during infancy of being abandoned in the hospital, coupled with his desire to link psychological theory with reality, inspired his groundbreaking research. Stern used a microanalytic research approach, the data from which was then coded. Similar to Bowlby, he was influenced by ethology, "which privileges the careful description of behavior in its natural habitat detailing form, sequence, and timing of behavior" (Beebe, 2014, p. 5). This microanalytic research approach has been extensively reviewed for 3 decades and continues to influence the infant-caregiver microanalysis research of today.

Stern (1985) was interested in the contingency (attunement) created in the dyadic communication between infant and caregiver. He discovered that these contingent social signals between caregiver and infant facilitate the process for the emergence of the infant's self. The infant differentiates between what pertains to the self and what pertains to others, and this allows the infant to have constructive communication. From birth, the body is a primary object of exploration, and the body as differentiated from other is the earliest source of an emerging self. Stern maintained that this process of differentiation is

present at birth and proposed "the infant's major developmental task is the opposite one, the creation of ties with others—that is increasing relatedness" (Stern, 1985, xii). Rather than attachment-autonomy, he favored attachment-individuation. In his seminal book, *The Interpersonal World of the Infant* (Stern, 1985), he classified four "senses of self" (p. 36). The first three senses are preverbal, and emerge together.

According to Stern (1985), the emergent self "is the process of emerging organization as well as the result, and it is this experience of emerging organization that [he] call[s] the emergent sense of self" (p. 45). The emergence of an organization of self is created though the processes of diverse experiences that are associated and connected within the dyad (p. 46). The organization of self emerges through the processes of amodal perception, physiognomic perception, and vitality affects. Amodal perception is the ability "to take information received in one sensory modality and somehow translate it into another sensory modality" (p. 51). This perception creates affect; however, affect is felt and expressed among all of the senses. Physiognomic perception is the manner in which the infant understands through focusing on the caregiver's facial expression. Vitality affects are inherent in all behaviors; for example, "there are a thousand smiles, a thousand ways of getting out of chairs, a thousand variations of performance and all behaviors, and each one presents a different vitality affect" (p. 56). Hence, each caregiver has his or her own essence or manner of interaction with the infant through repetitive tasks. Moreover, through the microanalysis and coding of a mother's interactions with her dizygotic twins, Stern discovered that the mother's vitality affects were different with each infant based on the different contingency signals used by each child with her (as cited in Beebe, 2014).

A core sense of a self is felt from about two to seven months, when infants begin to identify themselves and their sense of volition (self-agency), sense of gestalt (self-coherence), feelings associated with experiences with other (self-affectivity), and a felt sense of passage through time, with past experience and future expectations (self-history) (Stern, 1985). According to Stern, "sense of self is not a cognitive construct. It is an experiential integration" (p. 71). The subjective self appears from 7 months, when the infant is able to experience a sense of intersubjectivity and realizes that he or she is separate from other people but can bridge this gap through social experience. The verbal self appears around fifteen months, when the child is capable of complex interpretation of abstract ideas and the world around him or her.

Stern was one of the first theorists to use words such as *attunement* and *intersubjectivity*. He discerned that the infant needed the mother to attune so that the mother could understand the infant's internal state and match it, to share an intersubjective affective dynamic (Stern, 1985). As well as attuning to the infant, the mother also regulated the infant's level of arousal, affect intensity, and attachment. In this sense the mother is a "self-regulating other for the infant" (p. 102). This creation of self happens through dependence and a dance of attunement where mother and infant are part of a *we*. However, the "infant learns that some states are shareable, and some are not, and that this learning powerfully affects attachment security and the capacity for intimacy" (Beebe, Lachman, Markese, & Bahrick, 2012, p. 266).

Edward Tronick, a researcher of developmental processes, also influenced modern day somatic psychotherapists. Tronick examined the co-created dynamics and dyadic states of consciousness between mother and children by studying nonverbal

communication and bodily based emotional processes. For Tronick (2003), co-creativity "implies that when two individuals mutually engage in communicative exchange, how they will be together, their dynamics and direction are unknown and only emerge from their mutual regulation" (p. 476). He is best known for the "still face paradigm" experiment, where babies are observed interacting with an unresponsive, expressionless mother. After 3 minutes, the babies in the study were observed to become frantically distressed and angry (Tronick, Adamson, Als, & Brazelton, 1975). They were observed to make repeated attempts to bring the interactions into the usual contingency patterns with the mothers. When these attempts failed, the babies withdrew and some oriented their faces and bodies away from the mother with a withdrawn, hopeless facial expression. This experiment is one of the most replicated findings in developmental psychology and truly exposed "that it only takes two minutes to so visibly destabilize the child which shows to what extent a child expects certain forms of interaction as early as the first months of life" (Heller, 2012, p. 626). Two decades later, Tronick revolutionized social interaction research through the development of a new, quantitative approach to studying interactions between mother and infant. He used quantitative, real-time series mathematics to assess rapid, subtle, face-to-face verbal and nonverbal communication systems of the mother and infant. Medical psychologist Beatrice Beebe adopted this research model and has continued to use it for the past 3 decades (Beebe, 2014).

For Tronick, the infant is an individual homeostatic system in a dyadic system and "communication is a moment to moment process" across multiple communication modalities (as cited in Beebe et al., 2012, p. 257). Through this theoretical lens, he viewed the mother and infant as two messy, sloppy systems trying to coordinate or

match. “The point of departure in the system inevitably leads to numerous moments when mother and infant coordinate poorly or are mismatched and find themselves confused, dysfunctional and frustrated” (Heller, 2012, p. 623). Tronick (2003), however, does not classify these misattunements as dysfunctional; he maintains that through repair of the ruptures, the dyad can learn new ways of being together. Times of behavioral matching and synchrony create dyadic states of consciousness. Through the oscillations of these ruptures and repairs, the infant can further organize, create a sense of self, and create meaning. The infant’s sense of self in the world is created through many levels of meaning: cognitive, emotional, and bodily. The weaving of explicit and implicit affect states and levels of meaning are created in the intersubjective field. The infant’s core organizing principles of self are created out of the moment-by-moment, constant, and reiterated relational and interactive experiences in the dyad.

Successful communication is experienced as joint dyadic states of consciousness, synchrony, somatic resonance, and shared meaning. From this co-creative process, the child develops. Through effective communication, the infant can expand deeper into his or her own embodied consciousness, which creates a sense of self. When infants do not share dyadic consciousness and do not experience repair, they experience loss of connection and relational trauma: they contract, and feel a sense of annihilation. These psychobiological implicit experiences of libidinal expansion (being seen) and libidinal contraction (being missed), which were also described by Reich (1945/1972), are an intrinsic part of the NARM theory, which will be explored later in this review. Contactful maternal bonding fosters growth for the infant and is the foundation of brain and body autonomic nervous system wellness (Heller & LaPierre, 2012).

The concept of co-regulating interactions, as mediated by nonverbal behaviors, is of seminal importance to somatic depth psychotherapists who often work with the invisible. For 3 decades Beebe has studied the patterns of experience of the co-constructed interactions of the infant and mother. These interactions form the basis for brain and nervous system development, which shape the infant's core personality. Intrigued by Stern's video microanalysis, Beebe chose to conduct her dissertation research with him, because she was "fascinated with parallels between mother-infant communication and non-verbal communication in treatment" (Beebe, 2014, p. 2). During the late 1970s, researchers such as Tronick and Stern set the stage for the study of infant-mother communication systems. This research demonstrated the role of the initiating social infant and of a bidirectional model of communication in a dyadic systems view (Bell, 1968). Through the study of microanalysis and by working with the mothers during playback sessions, Beebe discerned that aspects of these interactions occur out of awareness, often subliminally; they are "nonconscious," rather than dynamically "unconscious"; therefore, they are implicit and are dominant in personality and psychotherapy (Beebe, 2005, p. 11).

Beebe (2014) also discerned that the infant was interested in more than just nourishment and was capable of primary social relatedness and play from birth. Infants have expectations of regulation and misregulation, which are created through patterns of interactions, and shaped by how each partner in the dyad changes in relation to the other (Beebe & Lachman, 2002). These action tendencies and expectations are both conscious and unconscious, and are encoded in the brain and in the body. Beebe challenged prevailing psychoanalytic theory that espoused that only the mother's response organized

the infant. She maintained that both the infant and the mother have self and interactive regulation and each form of regulation affects the other. Beebe (2014) wrote, "Instead, both infant and mother cocreate the nature of the infant's experience . . . we think of dyadic bidirectional regulation as existing in dynamic relation to the self-regulation of each partner of the dyad" (p. 8). A groundbreaking research endeavor supporting this thesis was Beebe's analysis of a "chase and dodge" film. The analysis clearly demonstrated that the interaction was not only driven by the mother:

> The infant had a virtuoso repertoire of withdrawal and avoidance maneuvers. To every maternal overture, the infant could move his body back, duck his head down, turn his head away, or pull his hand out of his mother grasp. Exercising virtual veto power of the mother's effort's to engage him in a face-to-face encounter. (Beebe, 2014, p. 9)

Often gaze aversion or avoidance was a way for the infant to self-regulate from excess stimulation or arousal from the mother. With the help of a large research team, Beebe documented that the chase and dodge pattern at 4 months became organized within the infant and predicted a form of insecure or resistant attachment at 12 months (Beebe, 2014). Beebe also discovered that, consistent with the Ainsworth's strange situation (Ainsworth & Bell, 1970) and Tronick's still face experiment (Tronick et al, 1975), throwing novelty into the system such as a stranger interacting with an infant "can be seen as a slight perturbation and can amplify aspects of the systems organization" (Beebe, 2014, p. 13). Through studying stranger-infant interactions, she observed that verbal synchrony, or lack of, between stranger and infant predicted attachment at 1 year. Furthermore, in longitudinal studies of these same dyads, the vocal contingency patterns

between infant and stranger predicted aspects of the adult attachment interview (Beebe, 2014).

Beebe's (2014) microanalysis findings suggested that when a mother exhibited lack of predictability, mismatched her infant's affective state, expressed a still face, or did not repair misattunements, then at 4 months (when these contingency patterns were predominant) they were predictive of disorganized attachment at 12 months. For example, if an infant was repeatedly in distress and the mother ignored or smiled at the distressed infant, Beebe called these exchanges "cross-modal discrepancies" (p. 16). Such exchanges resulted in relational trauma. Beebe proposed that a "4-month infant on the way to 12-month disorganized attachment comes to experience and represent *not being sensed, known, or recognized* by their mothers: and difficulty *knowing themselves,* particularly in states of distress" (2014, p. 16). Experiences of misattunement and dyadic mismatching cause the infant to become overwhelmed and unable to regulate. This experience of relational trauma affects the organization of the brain and the autonomic nervous system. Fear motivational systems become activated in the infant's brain, which can predict later dissociation (Schore, 2012). Moreover, Beebe (2014) found that perfect synchrony or attunement were not in fact optimal for infant attachment, as this was felt as vigilant and inflexible; rather, it was interactions with a midrange degree of vocal turn taking that created an "optimal mid range model," which was ideal for healthy personality development (p. 12). This midrange degree of interactions (similar to Winnicott's good enough mother) created space for flexibility and initiative within the experience of contingency.

The essential task of the first year of human life is the creation of a secure

attachment bond of emotional communication between the infant and the primary caregiver. This connection has a profound affect on the processes of the infant's body, brain, behavior, and experience, because it allows the infant to regulate, integrate, and organize its psychobiological processes. The mother-infant relationship has unique archetypal effects on other relationships, and these early patterns set a trajectory of relational ways of being with self and other. Secure attachment or deep connection created through bidirectional, flexible, mid-range attuned communication stimulates the growth of affect regulation circuits in the right brain relational unconscious, allowing the integration and organization of the self to happen. The contingent bidirectional interactions in the mother-infant dyad "leave an enduring imprint of the developmental trajectory of the right brain," where the infant's attachment system and fear motivational system reside (Schore, 2011, p. xvii). When the mother induces extreme levels of stimulation or abuse, or very low and mismatched communication such as neglect without repair, the infant's fear motivational system becomes activated. This relational trauma and dysregulation created by less than good enough attunement creates a spectrum of insecure, avoidant, and disorganized attachment schemas, which manifest in dissociated and imbalanced neural networks. According to Schore, "an enduring outcome of early relational trauma is manifest in a maladaptive highly rigid, closed right brain system" (p. xxiii).

The study of the infant-mother dyad also illuminates the importance of nonverbal dimensions and implicit processes of the self and the clinical dyad. Moreover, this research emphasizes that psychotherapeutic work must address the implicit dimensions of interactions since the organization of experience and self requires more than insight or

interpretation. The theory provides a framework within which to integrate nonverbal communication and to understand how interactions are organized at the nonverbal level in adult treatment. It supports the thesis that it is vital for the therapist to have somatic mindfulness of his or her own body and inner state in the present moment, as well as to track the patients' nonverbal shifts and physiological elements. Specifically, the therapist can track "rhythm matching, modulation of vocal contour, pausing, postural matching, and gaze regulation" (Beebe & Lachman, 2002, p. 63). Tracking implicit and explicit dimensions is an essential therapeutic component since it can support affect regulation and reorganization for the patient in the present moment. In addition, this dyadic systems view supports the understanding "that the organization of the individual is always in a dialogue with the dyad, influencing and being influenced by the nature of the interactive regulation" (p. 29). The clinical dyad involves an ongoing integration of bodily based emotional processes within the self as well as interactive regulation. Through this interactiveness emerges a constant process of reorganization of implicit relational processes and dynamics that shape experience and behavior. Thus, the infant-mother dyad is a prototype for somatic depth psychotherapists as it illuminates the implicit processes of dyadic interactions and amplifies how relational physiological processes can support clients' affect regulation, integration, and organization of self.

Relational developmental trauma.

The effects of relational trauma are pervasive and shape one's way of being and attending to the world. Trauma is any experience "that causes the child unbearable psychic pain or anxiety. For an experience to be unbearable means that it overwhelms the usual defensive measures" (Kalsched, 1996, p. 1). Relational trauma is experienced on a

continuum in the dyadic, intersubjective attachment system between child and caregiver. It encompasses experiences of sexual and physical abuse, violations, intrusions, neglect, and lack of attunement. Psychological relational trauma results in the child experiencing feelings of intense fear, helplessness, loss of control, shame, and threat of annihilation. "Such feelings overwhelm the adaptations that ordinarily provide people with a sense of self-agency, emotional connection meaning and integration" (Renn, 2012, p. 19). Such trauma is often embedded within supposedly protective relationships; the effects are compounded when the exquisitely vulnerable child is also blamed, or the abuse is ignored or denied (Kalsched, 2013). The relational past is "phenomenologically silent," as it lives on in invisible ways in the intrapsychic and interpersonal present (Renn, 2012).

A suboptimal early environment causes the child to create adaptive survival styles (defense mechanisms), which can lead to identity distortions and overwhelming symptoms of anxiety and depression, disordered eating, personality disorders, and addiction. In the intersubjective realm of the parent-child dyad, these misaligned affective exchanges create fragmentation of mental processes, dysregulation of psychobiological functions, and a disorganizing effect on the development of a corporeal sense of self. Such trauma can create internal working models or encode implicit relational knowing, which serve as templates for relationship to self and others (Bowlby, 1969). The embodied relational experience to self and other is categorized as schemas in the neural networks of implicit processes of the right hemisphere (emotional brain), and encoded and contained in the body. These emotional schemas influence one's thoughts, feelings, and behaviors, and often maintain nonoptimal ways of experiencing and relating in the here and now, resulting in what Freud (1926/1989) termed repetition compulsion.

Research on personality development has revealed that children learn about themselves and the world around them by interpretation through the lens of their caregivers (Barrett & Fish, 2014). Thus, the patterns of interaction in the child-caregiver dyad gradually structure and organize the child's vast inner world. Relational trauma has a disorganizing effect on physiological and emotional processes and, therefore, affects the child's self-regulation, sense of self, self-esteem, and personality development.

> Emotional abuse is far more common than physical or sexual abuse, yet just as significant in the development of psychopathology because the child has to employ adaptive survival strategies to deal with negative affect: for example suppressing hate, anger and sadness by being either good or inappropriately happy. (Renn, 2012, p. 22)

The child's identity organization is contingent upon the caregiver's cumulative mentalization capacity to be attuned verbally and nonverbally to the child's current embodied state. In this exchange, the caregiver can modulate the child's affect and thereby can instill affect regulation for the child's internal psychobiological state. Some caregivers are unable to regulate their own negative affect and stress and are unresponsive to the child. Within these intersubjective collisions, the caregiver does not offer repairs to relational ruptures of the attachment bond and this is experienced as traumatic for the young child (Kalsched, 2013). Chronic relational ruptures result in "a self defined in shame" (Wilkinson, 2010, p. 46). Research findings suggest "that it is often not the traumatic event in and of itself that is salient in personality development and adult psychopathology, but rather the characteristic intersubjective/attachment system within which the child experiences the trauma" (Renn, 2012, p. 21).

The caregiver attunes, affirms, and attends to certain aspects of the child's behavior, affect, and expressions, and this interaction is weaved into the child's felt sense of self (Bromberg, 2011). Often the caregiver ignores or disconfirms parts of the child, and these cumulative catastrophic injuries of attachment result in a child splitting off aspects of self to preserve the attachment to the primary caregiver (Heller & LaPierre, 2012). An adaptive survival response to misattunement and lack of regard for the child "is one where the child withdraws from the self-generated spontaneity and instead conforms to the imposed images and narcissistic needs of the caregiver, which shape implicit processes of personality development" (Renn, 2012, p. 22). The parts of the child not greeted or met by the caregiver are split off, and the child introjects the caregiver's actual state (Winnicott, 1990). "In suppressing vital aspects of self experience, the child adopts an alien reality and inauthentic mode of being and relating" (Renn, 2012, p. 22). The adaptive defense of splitting becomes self-organizing and creates a false self (Winnicott, 1990). Winnicott associated the false self with the mind and maintained that often the split-off parts or authentic self languished in the body as psychosomatic illness. The chronic, cumulative, misaligned interactions create aspects of personality development that are autonomous and unconscious. Jung (1948/1969) termed these persistent patterns complexes and wrote:

> Even the soberest formulation of the phenomenology of complexes cannot get round the impressive fact of their autonomy, and the deeper one penetrates into their nature—I might almost say into their biology—the more clearly do they reveal their character as *splinter psyches*. (p. 97)

When dramatic or more profound relational trauma ensues, the child becomes psychobiologically overwhelmed. The maternal haven of a secure base can instead become an instigator of threat, and triggers an alarm in the infant's right hemisphere, the locus of both the attachment system and the fear motivational system (Schore, 2011). The relational stressor activates and overloads the child's sympathetic nervous system, "including arousal of physiological components of the stress response—rapid breathing and heart beat changes and changes in the general homeostatic environment" (Bucci, 2008, p. 60). This sensory and somatic activation creates systemic dysregulation and encapsulates the child in a psychobiological state of terror. When feelings of terror become chronic, the nervous system continually evaluates the risk of threat through the poly-vagal nerve network (Porges, 2011). Stephen Porges, a neuroscientist who specializes in study of the neurobiology of social behavior, termed this process neuroception. He explained, "I have coined the term neuroception to describe how neural circuits distinguish whether situations or people are safe, dangerous, or life-threatening" (p. 11). Neuroception of safety or threat is felt in the somatic unconscious, in the viscera and nervous system, and prepares the person for social engagement or defensive measures of fight, flee, or dissociation.

Often in response to repeated, severe, inescapable abuse or neglect, the child experiences affective flooding and switches from sympathetic hyperarousal into the survival response of defensive parasympathetic, dorsal vagal hypoarousal, which results in dissociation (Kalsched, 2013). Pierre Janet first used the term *dissociation* in 1889 to refer to "the uncoupling of the mental processes, the splitting apart of psychological functions that normally got together" (Wilkinson, 2010, p. 143). The psychobiological

defensive process of dissociation involves the disconnection of the child's mental processes from his or her embodied experience: the cortex of the right hemisphere disconnects from the lower limbic right brain, and the child's perception and intrapsychic thoughts are short-circuited (McGilchrist, 2009; Wilkinson, 2010). The metabolic shutdown state of dissociation does not resolve the basic issue and numbs the child to his or her needs and emotions, given that both subjectivity and intersubjectivity crash. Dissociation becomes a default response for dealing with a broad range of daily stressors and "the real emotional significance of that experience remains hidden all along from the patient, so that not reaching consciousness, the emotion never wears itself out, it is never used up"; therefore, the splitting continues unabated (Jung, 1912/1970, p. 98). Dissociation causes ruptures in the brain's hemispheric bilateral communication. This lack of communication between the right and the left hemispheres powers the relentless dissociation machine, which keeps dissociated aspects of the self apart, perpetuating anti-integration and psychopathology (McGilchrist, 2009).

Dissociation is an adaptive survival strategy that encapsulates the psyche from conscious awareness, effectively holding it in a trance-like state (Jung, 1912/1970). "Dissociation as a defense is responsive to trauma—the chaotic, convulsive flooding by unregulatable affect that takes over the mind, threatening the stability of selfhood and sometimes sanity" (Bromberg, 2011, p. 49). Through the experience of dissociation, certain aspects of the self become ego dystonic because they are unbearable to the mind. These split-off emotional experiences are unconscious and create "multiple self states," which are stored in the psyche-soma; specifically, in the implicit, lower subcortical relational right brain, and in the autonomic nervous system (Eldredge & Cole, 2008, p.

80). The unfulfilled needs and dissociated affects are bound in the body and nervous system in the form of undischarged arousal, which is held as physical tensions, somatizations, or frozen life force (libido). Because these dissociated affects are unconscious and encoded somatically, a coherent cognitive narrative is not often available (Ogden, Minton, & Pain, 2006).

Relational trauma is complex because it often occurs during vulnerable times in the brain's development and organization and in turn affects the developmental trajectory of the child's identity and self-organization (Barrett & Fish, 2014, p. 9). It has profound and far-reaching effects, because the child is confronted with the pain of living before having the inner resources to manage the pain; thus, the trauma colors the entire life of those affected. The majority of exchanges of relational trauma are internalized as nonverbal and unconscious, and shape a person's capacity for regulating affect and stress. Trauma is an intrinsically biological phenomenon: physiologically, it creates embodied states of hyperarousal, hypoarousal, and dissociation. Dysregulation then becomes a homeostatic set point. Lack of a secure emotional base creates a diminished capacity for connection to self, and facilitates foreclosure of self. Relational trauma haunts one's interpersonal relationships like a phantom limb, unconsciously present in one's interpersonal contexts. These implicit, right-brain relational processes shape the affective stance that the world is not safe. Such individuals tend to isolate, shielding themselves from developmentally appropriate relational engagements, and therefore have limited opportunities for corrective emotional experiences (Heller & LaPierre, 2012; Kalsched, 1996). The simultaneous fear and longing for connection creates a narrow window of tolerance for patients who have experienced relational trauma: they keep their lives small

in order to feel safe (Ogden et al., 2006; Schore, 2008). Attachment theory and neuroscience research supports the depth psychological axiom: that there is indeed a cause and effect relationship between early experience and personality development, and that this exchange becomes encrusted in psyche and soma, and unconsciously drives behavior and one's felt sense of self.

Somatic Depth Psychotherapy and the NeuroAffective Relational Model (NARM) as Interventions to Treat Relational Trauma

Who is the self who comes for therapeutic treatment in the clinical encounter? For Jung (1953/1968), "the self, is not only the centre but also the whole circumference, which, embraces both conscious and unconscious, it is the center of this totality" (p. 41). Modern psychotherapy theories support Jung's definition, recognizing that the self is embodied and relational, and "is the totality of what an organism is physically, biologically, psychologically, socially and culturally" (LeDoux, 2002, p. 31). The embodied expression of self encompasses an emotional, complex, dynamic, ever-changing evolution of conscious and unconscious processes. This process of self-emergence and individuation is contingent on interactions with others and reflexivity within the self: "We are all born with an innate capacity to seek companionable shared experiences first and foremost in the implicit domain of being and relating" (Renn, 2012 p. 82).

"The task of psychotherapy, including self-therapy, is to reestablish lost connections: either the connections between different parts of ourselves—as between the conscious and unconscious—or between ourselves and the world" (Paris, 2011, p. 151). To therapeutically facilitate a patient's process is complex: the clinician must honor and

listen to all aspects of the individual and his or her ecology. This can be achieved by utilizing holistic discourse and interventions that integrate both the verbal, conscious, cognitive, explicit domain, and the nonverbal, emotional, somatic, implicit domain. "Verbal, cognitive left brain communication between patient and analyst is not on its own sufficient cure for right brain, affective dissociative distress" (Wilkinson, 2006, p. 105). Therefore, the somatic depth psychotherapist integrates top-down explicit cognitive approaches and bottom-up implicit somatic approaches to facilitate the patient's process (Heller & LaPierre, 2012). Every childhood is more or less traumatic, and early experiences are immortalized in the psychological organization of the child. Those who have endured chronic and intense trauma may lack a felt sense of a corporeal self, overwhelming emotions can exhaust them, and actively self perpetuate nonoptimal ways of being and relating (Kalsched, 2013). Trauma can freeze psychic energy or libido. The energy lingers in an unintegrated form and manifests behaviorally in adaptive survival strategies, complexes, dissociated defenses, dysregulation, and felt experiences of anxiety and depression (Heller & LaPierre, 2012).

Insights from neuroscience research and attachment theory support the depth assertion that a secure attachment to the therapist facilitates individuation of the self. This premise is shared by various techniques of the talking cure (Stromsted, 2007). The secure analytic dyad, where the patient exists in the heart and mind of the therapist, can facilitate awareness and integration of implicit memory, foster self-regulatory capacity, and inspire emergence of reflective functioning to support the process of individuation (Kalsched, 2013). Patients come to the somatic depth psychotherapist for relational support to alter the self and its self-states, to deal with disorders that are primarily emotional in nature,

and to create meaning and understanding of their vast inner milieu. They long to be relieved of felt and expressed identifications, those habituated ways of being and doing that do not reflect who they actually are (Bromberg, 2011). “How many of our own habitual behaviors and feelings are outside of our conscious awareness or are long accepted as parts of ourselves, of who we are, when in fact they are not” (Levine, 2010, p. 171).

The talking cure, explicit processes, and top-down interventions.

Freud’s talking cure revolutionized psychotherapy. He appreciated that although one’s implicit memory is unconscious; it guides and directs feelings, thoughts and behaviors that are largely out of conscious awareness. Freud saw the value in exploring the vast inner world of his patients in order to support the process of changing minds (Ellenberger, 1970). Neuroscience research findings are generally supportive of Freud’s theory. For example, functional imaging studies have shown that functional activity in the brain is altered by psychotherapy, specifically “localized to the pre-frontal lobes” (Solms & Turnbull, 2002, p. 288). Psychoanalysis or somatic depth psychotherapy today is “more accurately characterized as a communicative cure than a talking cure” (Bucci, 2008, p. 74). Dyad communication occurs in microseconds through multiple channels of words, imagery, body sensations, and gesture, implicitly and explicitly in the intersubjective field. With a holistic lens, patients can gain access to their implicit/procedural memory, engage in a process of affect regulation, and further individuate. “The challenge of psychotherapeutic work is to enable all aspects of the individual voices to be heard, ultimately in new way” (Bucci, 2008, p. 74).

"For those whose earliest patterns are derived from relational trauma, an experience in therapy must seek to modify such responses by providing a different affective experience through relating with another at the deepest levels both consciously and unconsciously" (Wilkinson, 2010, p. 10). Somatic depth psychotherapists recognize the value of explicit, verbal, top-down interventions in eliciting organizational change in the patient's emotional schemas and in formulating a coherent narrative. Well-timed interpretations by the therapist, and linkage of present behaviors with the past in an attuned relational context can lead to instrumental insights, but "the original wounding first has to be made conscious" (Paris, 2011, p. 125). Insight involves linking feelings to words, and also naming intrapsychic conflicts as they appear. This mindful use of language can lead to regulation of overwhelming emotions and support integration of various self-states (Siegel, 2007). "The working through of the insights that are made possible by such attunement is underpinned by right and left brain processing, by the capacity to feel with another while remaining able to think" (Wilkinson, 2010, p. 61). In this instance, the two hemispheres are functioning in an integrated manner, which supports resilience, agency, and individuation (Cozolino, 2006). The symbolic form of language can support the therapist in discovering the patient's internal working models of attachment and uncover unconscious expectancies about relationships (Bowlby, 1969).

Somatic depth psychotherapy using relational interpretive methods considers how the silent past is revisited in the present and can be reworked through a narrative. "The stories of one's life, told in a context of time and place, with specific detail and imagery, have the power to connect memory and emotion, linking the individual's autobiographical memory to his current affective state" (Bucci, 2008, p. 74). The salient

role of narrative and story integrate different information and energy exchanges of consciousness, sensations, feeling, and behaviors. Research has shown that relational trauma can cause "a deficit in the right brain's orbital systems, as a result of which affective information implicitly processed in the right hemisphere is inefficiently transferred to the left for semantic processing" (Renn, 2012, p. 124). Therefore, troubling emotional experiences do not become organized into an explicit coherent narrative. In therapy, these painful stories are told and as the therapist attunes, a dyadic state of consciousness is created in the resonance. This linkage of consciousness and resonance raises the state of integration for the patient. The patient can integrate emotion and create a more cohesive narrative because the therapist has attuned to his or her inner state with empathy and without judgment (Siegel, 2007). Stories, and the therapist's ability to bear hearing them, can allow patients to discover themselves, to regulate affect, and to heal from traumatic injuries (Cozolino, 2006).

Often patients who have experienced relational trauma struggle in interpersonal contexts. When stressed in relationship, they experience psychobiological dysregulation, which thwarts their capacity to mentalize (Fonagy, 2000). Naming the emotions in the here and now, in a safe container, can support affect regulation. This can create space for self-reflexivity and mentalization of another person's state and intentions. Other interventions can support the patients' propensity for self-reflexivity and mentalization. For example, therapists might ask their patients to share what they imagine the therapists might be thinking or feeling about them. In this way, a patient "may be able to shift out of an habitual nonreflective mode into an intersubjective state of being and relating, which takes into account the other person's motivations and perspective" (Renn, 2012, p. 95).

Through this process, the therapist can highlight the patient's unconscious expectancies about another's behavior. By focusing on the relationship in the here and now in the intersubjective field, the patient is empowered to be authentic and not to fall into a pattern of pleasing the therapist and reprising the false self. This congruent exchange creates a new embodied experience and "a return to a more authentic experience of being brings patients the benefit of seeing that many of their adaptive, defensive patterns, although valuable, are self states and identities that have eclipsed their more unified, true nature" (Newman, 2008, p. 180).

Implicit processes and bottom-up interventions.

Somatic depth psychotherapists work with disorders of the self that are primarily emotional. Such emotional experiences are "not processed through language and logic; as the right hemisphere speaks a language of images, sensations, impressions, and urges toward action, therapeutic discourse must be conducted in a language that the right hemisphere speaks" (Fosha, 2003, p. 229). Emotional, implicit processes mediate many of the patient's thoughts, feelings, and behaviors. Although these processes do not exclusively occur in the right hemisphere, many researchers and theorists link the right hemisphere with the unconscious. "The right hemisphere processes unconscious emotional material" (McGilchrist, 2009, p. 187). Jung and Freud intuited that through the use of images, metaphor, and dreams, patients could gain access to unconscious processes. Such processes are the tracks for one's attachment schemas and corporal felt sense of self.

Somatic depth psychotherapists aim to harness the body's and the psyche's self-healing capacity when working with image and dream. For Jung, images were of seminal

importance for engaging with the psyche in both clinical and personal explorations. He wrote, "The years when I was pursuing my inner images were the most important in my life" (Jung, 1962/1989, p. 199). Jung theorized that images gave shape and form to affect. He maintained that images were often attempts of the mind to represent early or past childhood experiences that have remained encapsulated and unconscious in the psyche: "images . . . are the inborn language of the psyche and its structure" (Jung, 1958/1970, p. 339). Therefore, by inviting and engaging images in therapeutic work in the here and now, one can access early preverbal, unconscious, affective experiences, and work towards symbolically transforming attachment schemas that are felt and lived, but not known. Jung understood what researchers today are realizing, that "one of the remarkable aspects of mental imagery is that we can use it to access at least some aspects of implicit information stored in memory" (Kosslyn & Moulton, 2009, p. 38).

Jung (1962/1989) also discerned that images were often autonomous; therefore, they could represent unconscious complexes, self-states, or splinter psyches. This realization led him to work with images in the clinical dyad at the subjective level. Modern research supports this insight, demonstrating that:

> on one hand, implicit memories often affect imagery, and in this sense, imagery is a mental application of implicit memory. On the other hand, implicit memories can be affected by imagery; in this sense, imagery plays a role in forming implicit memories. (Kosslyn & Moulton, 2009, p. 45)

Jung intuited what current research is revealing: that imagery can be used to access implicit information stored in memory, and that repeatedly working with imagery can affect behavior (Kosslyn & Moulton, 2009). Woodman (2009) contended, "image is the

connector between psyche and soma" (p. xii). She viewed images as portals into the affects of the psyche. In the clinical dyad, images can manifest in metaphor, dreams, bodily sensation, embodied imagination, and artistic endeavors.

Jung and Freud proposed that emerging symbols could connect one with one's unconscious. Metaphor is a symbol that is the "currency of the mind" and plays a dominant role in organizing emotional memory (Modell, 2005, p. 555). The Greek term *metaphore* means, "to transfer," and somatic depth psychotherapists use metaphor as a symbolic intervention for integration and individuation (p. 562). Social psychiatrist Arnold Modell (2003) proposed that metaphor is the "transfer of meaning between dissimilar domains" and, therefore, is a symbolic tool for comparing and contrasting the meaning of current emotional experience with the sub-symbolic unconscious memories of past experience (p. 27). Often, relational trauma and the infant's early affective experiences and memories may remain inchoate and cannot be made explicit. "It seems likely, therefore, that such early affective memories may be stored as wordless affective metaphors" (Modell, 2003, p. 45). Primary metaphor derives from bodily sensations in early childhood and, therefore, has the capacity to express what is embodied and lived, yet not fully understood. "Metaphor allows conventional mental imagery from sensorimotor domains to be used for domains of subjective experience" (Lakoff & Johnson, 1999, p. 45). Metaphor can be a tool to symbolically connect somatic implicit memories with present behaviors, thoughts, and feeling. Through this linkage, meaning and insight can arise, supporting integration (Pally, 2000). The language function of metaphor resides predominantly in the right hemisphere. The right hemisphere "is specialized in pragmatics, the art of contextual understanding of meaning, and in using

metaphor" and it is the foundation for all forms of understanding (McGilchrist, 2009, p. 49).

The symbolic form of metaphor can also regulate affect as it can translate overwhelming feelings into words, which can provide organization (Lakoff & Johnson, 1999). Secondary metaphor is derived from culture; therefore, metaphor is both personal and archetypal, and is a fundamental form of cognition (Modell, 2005). The use of metaphor is a powerful tool to crystallize and interpret the client's current state of being and feeling. Expressing oneself symbolically influences affect regulation, stimulates brain activity, and facilitates change in the embodied self (Paris, 2011). Metaphors contain sensory, imagistic, emotional, and verbal elements, and "more brain centres light up in response to metaphor than any other form of human communication . . . new neural connections are not created as entirely new entities but rather are added to pre-existing conditions" (Wilkinson, 2006, p. 29). Metaphor is a salient weaver of emotional, unconscious memory, and conscious experience (Modell, 2003).

Effective psychotherapy requires the wisdom and support of the body. Kalsched (1996) wrote, "One danger of psychotherapy is that it becomes too 'mental' (wordy) and loses the link with the body. When this happens, psychotherapy loses the psyche also" (p. 65). Somatic depth psychotherapists understand that the body is the unconscious in the flesh, and that relational trauma is embedded physiologically and psychologically. Levine explained:

> Traumatic symptoms are not caused by the event itself. They arise when residual energy from the experience is not discharged from the body. This energy remains

> trapped in the nervous system where it can wreak havoc on our minds and bodies. (As cited in Carleton, 2009, p. 32)

Emerging research has demonstrated that early attachment predominantly occurs at the implicit level of bodily interactions through the infant's sensorimotor system; therefore, the somatic domain is the source of earliest relational experience. Moreover, somatic depth psychotherapists appreciate that meaning, understanding, and regulation emerge from new embodied experiences in the clinical dyad in the here and now.

When working bottom up, the body is a portal that can reveal the patient's relational patterns and belief systems (Stromsted, 2007). By tracking sensorimotor sensations, gesture, breath, and posture in the present moment, the therapeutic dyad can access unconscious and evocative core material. In working with these physiological elements, the autonomic nervous system, which is connected with implicit processes of the right relational brain, can tell its story and learn to regulate. "The right hemisphere's superiority in the emotional realm is explicitly linked to the close physiological relationship with the body" (McGilchrist, 2009, p. 69). A bidirectional interaction occurs between soma and psyche. As Jung (1936/1969) postulated, "The separation of psychology from the basic assumptions of biology is purely artificial, because the human psyche lives in indissoluble union with the body" (p. 114). Effectively tracking and linking somatically based sensations to emotional processes in the here-and-now allows the patient to self-regulate. This supports their ability to be more present—rather than past—focused. In the co-constructed body-to-body dyad, the manner in which the patients discourse is related through prosody, gesture, eye contact and facial expressions is often more informative than its explicit historical context (Renn, 2012). The

psychobiological reorganization of implicit processes with the specific support of the body will be further illuminated in the next section on NARM.

The NeuroAffective Relational Model (NARM).

NARM is a holistic treatment model for the treatment of relational trauma. It braids together physiological, psychological, and relational aspects of a person, and integrates the use of top-down and bottom-up clinical interventions. The theory supports the depth psychotherapy principle that it is in connection to oneself and to one's body, in the presence of a witness, that one can regulate affect, integrate split-off energies, gain a sense of agency, and access inner resources to support individuation. Therefore, NARM is a clinical application of the depth psychological principles of working with the functional unity of the body and the mind in the present to facilitate modulations of implicit processes. NARM is a phenomenological theory that brings a somatic understanding into developmental work. The nervous system is viewed as a communication system, and the theory correlates psychology with nervous system regulation. NARM interventions aim to connect clients with their intrapsychic processes in the intersubjective field. This emergent intersubjective process engages the patient's affect, cognitions, and sensations in the present moment to facilitate regulation of the nervous system and to allow the process of modulating the relational unconscious to support self-organization. Finely attuned, embodied inquiry is thought to support the patient's capacity for connection to self and to others, and can cultivate a deeper sense of aliveness, which "is a state of energetic flow and coherency in all systems of the body, brain and mind" (Heller & LaPierre, 2012, p. 8).

Consistent with depth theory, NARM theory postulates that within each person's mind and body is an inherent impulse towards greater cohesion and integration. Moreover, each person encompasses an open-ended, creative, and emergent spirit, "As we have seen the inherent tendency of the psyche to split means on the one hand dissociation into multiple structural units, but on the other hand the possibility of change and differentiation" (Jung, 1936/1969, p. 122). In both depth psychotherapy and NARM, therapists are not viewed as problem solvers; the work is to invite the patients to reveal themselves so that the patients can become known. It is imperative that the therapist does not get mired in technique but rather comes to each clinical moment with a place of not knowing, yet holding a tapestry of theory in the background.

Consistent with attachment theory, NARM theory holds that in the primary caregiver-child dyad, when certain biologically based core needs are not met at certain developmental milestones, psychological and physiological symptoms result that affect "self-regulation, sense of self, and self esteem" (Heller & LaPierre, 2012, p. 3). Early environmental failures are incorporated into the child's immature embodied structure, which creates adaptive survival styles and current relational patterns that are often unconscious. As an adult, such survival styles can dominate one's life and distort one's sense of identity and "quickly becomes a waste of psychic energy" (Paris, 2011, p. 109). The result is a disconnection from one's true embodied nature, and a reduced capacity for affect regulation, mentalization, and integration. Patients can often be identified with their survival styles, even though these behaviors foreclose on their sense of aliveness. This sense of lack of aliveness is often what drives individuals to therapy.

Patients' symptoms reflect disconnection to their life force, and such symptoms can be used to access their internal world, "all symptoms, are at the same time, crucial symbolic letters that want to be read" (Paris, 2007, p. 209). Similar to Freud's psychosexual stages, these disconnections and distortions occur throughout the developmental stages in the child's self-organization (Heller, 2012). In NARM theory, each stage, and hence each adaptive survival style, is named for the unmet psychobiological core need and is viewed as a missing or compromised core resource (Heller & LaPierre, 2012). Five adaptive styles are recognized. These adaptive survival styles are created in the first 5 years of life, and the identity distortions keep the adult viewing the world and the self through the lens of the child. NARM works to support the inner adult and discover the parts or self-states that lacked attunement or were unmet. The five adaptive survival styles and their traits become an organizing structure of the self. The first, *connection* (pre-birth to 6 months), is caused by a lack of, or no connection with the primary caregiver in infancy. This creates disconnection from self and leads to difficulty relating with others. Dissociation is a coping mechanism. The second, *attunement* (6 months - 1.5 years), occurs when the caregiver fails to attune to the child's inner world. This creates issues with knowing and having needs, and such children often become caretakers. The third, *trust* (2-4 years), occurs when a child has no one to rely upon; hence, the child uses power and control to avoid vulnerability and helplessness. In the fourth dyad, *autonomy* (2-4 years), the parents see the child as an extension of themselves; children withdraw their autonomy to maintain the attachment, which can lead to co-dependence. The fifth style, *love-sexuality* (4-6 years), is created when the child is

rejected by the opposite sex parent; the child may over perform or base his or her sense of self on appearance in an attempt to be loved (Heller & LaPierre, 2012).

Each adaptive survival style has underlying shame-based and counter pride-based identifications. They are both created in response to less than optimal parenting and with shame, the self as bad in indelibly imprinted in the mind. Pride-based identifications develop in response to the shame and "are an attempt to turn shame into virtue, but paradoxically, the more energy a person invests in the pride-based counter-identifications, the stronger the shame-based identifications become" (Heller & LaPierre, 2012, p. 14).

Consistent with the theories of depth psychotherapy and Reich's (1945/1972) character analysis, NARM theory holds that there is a life force, a libido or a psychic energy, "that fuels healthy aggression, strength, self-expression, separation/individuation, fight-flight, passion and sexuality" (Heller & LaPierre, 2012, p. 11). According to this theory, when a child's core needs go unmet, distortions of the life force ensue, and this creates a distress cycle, "In the distress cycle continuous loops of info travel from the body to the brain and the brain to the body" (Heller & LaPierre, 2012, p. 17). Energy (life-force) and information flow; top-down, this is how one's thoughts, judgments, and identifications affect the ability of the nervous system to regulate. Bottom-up processes refer to how the regulation or dysregulation of the nervous system affect one's cognitions and affect. "When a child experiences early trauma a distress cycle is set in motion that initially moves bottom-up *and* later top-down in continuous self-reinforcing loops" (Heller & LaPierre, 2012, p. 17).

NARM interventions respond to this distress cycle with a healing cycle that involves bottom-up and top-down orientations. The interventions track three levels of experience: cognitive, emotional, and physical, to disrupt the continuous interplay and self-reinforcing distress cycle loop. Four primary NARM principles support the healing cycle interventions: support, connection and organization, explore identity, work in present time, and regulate the nervous system (Heller & LaPierre, 2012).

NARM theory acknowledges the relational trauma of the past but does not focus on it, since symptoms of shame, despair, fear, loneliness, and so forth can reinforce the issues and do not address the root cause. In an effort to support a connected, coherent, organized, reflective state, the work emphasizes patient's resources, strengths, and resiliency. The first principle is to support connection to self and self-organization during the session. This can be achieved by holding a neutral place of inquiry and curiosity, while reflecting the patient's internal structure and intrapsychic conflicts and processes. The therapist uses a process-oriented, mindful approach to track how a patient moves out of connection-disconnection and organization-disorganization in the present time. In addition, the therapist will emphasize internal and external resources that have previously helped the patient, since this can have an organizing effect on the patient's psychobiology. Such resources, and their corrective emotional experiences, can uncouple the distorted identity, defenses, and beliefs. The therapist can comment on the witnessed organization experienced through resourcing. This serves to bring the patient's conscious awareness to the feeling and to reinforce it. From a more organized place, the therapist can create a wedge to make the identification more ego-dystonic (Heller & LaPierre, 2012).

The therapist holds a neutral but mindful presence to safely bring to awareness and explore the patient's identifications and counter-identifications in a safe holding environment. This happens through a titrated process, which can help patients see through the fiction of both identifications of their survival style. In naming the conflicts as they surface, patients can become less identified with them, and enter into relation with them. In addition, the therapist will use somatic mindfulness to track emotions and the accompanying bodily sensations in the here and now. The bottom-up tracking of sensations titrates the patient's process. This allows the client to be less emotionally reactive, and to assume the stance of an observer in the present, which supports mentalization and facilitates reorganization. When patients begin to tell the therapist that they feel anxious or scared, the therapist gently guides them away from describing emotional states and instead asks how these emotions are felt physically in the body. "In work that focuses on sensate experience, patients gain some freedom to allow for the completion of blocked responses to trauma" (Eldredge & Cole, 2008, p. 100). The body is viewed as the unconscious in the flesh, and can offer images, words, and sensations to enable deeper connection to the vast internal world.

The NARM therapist also tracks and brings to awareness the pendulation of libidinal expansion and libidinal contraction of the patient's autonomic nervous system. "In the nervous system and elsewhere in the body, every expansion and uptick in aliveness will naturally be followed by contraction" (Heller & LaPierre, 2012, p. 21). The patient is educated about this naturally occurring process; this awareness allows patients to witness their process and facilitates the release of any fear, blame, or judgments about it. The processes of shame and blame serve to guard the survival style, so it is important

to support nonjudgmental observations of the ongoing natural pulsations of the psyche/soma. It is imperative to find the right pace to support reconnection for each patient, and to understand each patient's capacity for mindfulness and self-reflexivity.

> Relational trauma creates a container in which archaic, nonconscious, cognitive-affective mental models are being perpetuated in the here and now, actively mediating and distorting the person's attachment-related thoughts, feelings, and behavior, particularly at times of heightened emotional stress—the silent relational past lives on in invisible ways in the interpersonal present. (Renn, 2012, p. 85)

NARM therapists educate patients on how they continue to recreate their history in the here and now. The focus is less on why patients are the way they are, and more on what they are experiencing in the moment, and how they disconnect from themselves in present time. In the mind, one can anticipate the future or remember the past, but the body only exists in the present moment. Therefore, the body supports the process of truly connecting to oneself in the present moment. The aim is to maintain dual awareness of what was then and what is now. With practice, patients can listen to what they feel in the present moment and be discerning about the real truth in the moment. Through a descriptive rather than prescriptive deconstruction, old identifications and defenses become more obvious and one gains a sense of agency. It is important to work with what is now instead of how patients perceive they wish to be, since the more one is allowed to fully experience who one is, the greater the possibility of perturbing the system.

For NARM, and for somatic psychotherapy in general, maintaining awareness of and supporting regulation of the patient's nervous system is a key principle. In the co-

constructed dyad, “as clients learn to listen to themselves, their nervous system becomes more regulated. As their nervous system becomes more regulated, it is easier to listen to themselves” (Heller & LaPierre, 2012, p. 223). The nervous system is regulated from a top down perspective, as disavowed emotions become integrated, and distorted identifications of adaptive styles are resolved. Tools and techniques for bottom-up regulation are also used; these include containment, grounding, orienting, titration, and pendulation. In the dyad, emotions can be explored as long as they are manageable, and it is important for the patient to name the emotions, if possible, as they emerge. If the therapist witnesses the patient reaching the upper or lower threshold of emotions, then the therapist must titrate the process and ground the patient by bringing awareness back to the body. The therapist can also pendulate to a resource, or focus on the patient’s experience in the present moment through grounding in the body, or orienting to an object in the room. Clinical pendulation is used intentionally to move the patient away from an overwhelming narrative to something soothing and comforting, while the therapist remains highly attuned. “Pendulation is used simultaneously with titration to support the nervous system’s capacity to integrate highly charged affects in a way they bring increasing self-regulation” (Heller & LaPierre, 2012, p. 232).

Jung and Freud seemed to understand that their patients came into therapy with “a force for individuation (left hemisphere) and a force for coherence (right hemisphere)” and that meeting the biological need to feel understood supports these processes (McGilchrist, 2009, p. 203). With NARM, the therapist is highly attuned to the patient’s psychobiological processes, since attunement regulates the nervous system and creates a secure base from which to explore the inner world of the patient. In this embodied

therapeutic relationship, the patient is consciously connected to cognitions, affect, and physical sensations. In a safe holding environment they become more aware of their unconscious attachment schemas, procedural expectancies, adaptive survival styles, distortions and resources. This creates a new experience and "experience can create structural changes in the brain" (Siegel, 2007). This unique and authentic co-constructed dyad, in which patients feel safe to be present with whatever they are feeling, and with their congruent self, facilitates a deeper groove of self-knowing and organization, which is regenerative and priceless. Somatic depth psychotherapy supports the inherent self-healing aspects of the body-mind as it provides the freedom for the adult self to choose what to integrate and who to be, in relation to self and other.

In the somatic depth psychotherapeutic dyad, the primacy of embodied experience is honored and the self is in a dynamic, sacred process of becoming. Somatic depth psychotherapy adds to NARM applications through the understanding that for transformation to happen, the therapist must be willing to somatically attune and deeply resonate with the patient, to the point where the influence is bidirectional, given that the therapist is influencing as well as being influenced.

> For two personalities to meet is like mixing two different chemical substances: if there is any combination at all, both are transformed. In any effective psychological treatment the doctor is bound to influence the patient; but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence. (Jung, 1929/1966, p. 71)

In this co-constructed dyad, the patient and therapist are differentiated, yet there is a third body, a shared self, which is created only through deep embodied connection and somatic resonance. “It is through my body that I understand other people” (Merleau-Ponty, 1962/1972, p. 186). In embodied, mindful, deep connection with other, this generative dyad of bravery can be a transformational experience.

Summary of Literature Review

As this review of the literature shows, the theory of psychoanalysis is the bedrock of all modern psychotherapy. Modern theorists, based upon their own interests, introspections, and experiences, have built upon the legacy of prior theory. Through interdisciplinary research, neuroscience has validated depth psychology’s core premise—that unconscious processes influence all aspects of human experience, especially the creation of one’s corporal sense of self. The literature also illuminates how early relational experiences become encoded in the right-brain relational unconscious, and how through such experiences, psychobiological states are established that organize memory, emotion, cognitions, and a sense of embodied being. Recent data from the neurosciences and traumatology support the notion of the primacy of the relational right hemisphere and its preeminence in the human experience and, therefore, its dominance in psychotherapy (McGilchrist, 2009).

The founding theorists of depth psychology understood the therapeutic value of integrating the unconscious and of linking differentiated self-states, and they worked diligently to develop methods to reach this primal realm. From this perspective, patients come to therapy to facilitate the processes of uncovering, integrating, and modulating the relational unconscious through a new embodied experience. In this co-constructed dyad,

patients can garner what was not given, experienced, or exchanged in their early environment. The modification of habits, symptoms, and personality processes is a complex and gradual process. To address the whole gestalt, interventions must:

> involve the somatic expression of a person's internal conflicts as much as it involves the verbalization of mental representations. Therefore, an approach to treatment that focuses solely on one of the aspects is doomed to be limited in its potential to heal. (Barratt, 2013, p. 45)

Because the body is the very basis of human subjectivity, the field of somatic depth psychotherapy is returning to its roots and recognizing the intrinsic value and innate intelligence of the body in supporting the client's self-organization and individuation. Therefore, to support the evolution of somatic depth psychotherapy, a useful avenue of research could be the exploration of the patient's holistic experience in the clinical encounter. The resurgence of the body in the clinical encounter is a burgeoning field and one that would benefit from more research into the client's embodied, lived experience. Through the phenomenological research proposed for this dissertation, it is hoped that the theory of depth psychotherapy can evolve and deepen its relationship with the body, and perhaps uncover effective clinical interventions that work with the functional mind-body unity to help heal the universal phenomena of relational trauma. To this end, therapeutic work may be inspired and supported by good scholarship.

Chapter 3
Research Approach

The proposed study will utilize a somatic depth psychological approach and a qualitative phenomenological method, both of which value the participants' embodied lived experience. Jung had a deep understanding of phenomenology. His personal and clinical experiences shaped his theory and he was determined to address psychological phenomena on their own terms, "through a means, which does not encroach upon the integrity of the original experience" (Kaylo, 2003, p. 1). For this study, interviews of participants lived experience of NARM therapy will be documented and analyzed using qualitative, phenomenological methodology, and then synthesized using a somatic depth psychological philosophical stance.

Research Methodology

The formal method I have selected for this dissertation research is qualitative phenomenology. In qualitative methodology, "quality refers to the essential character of something" (Kvale, 1996, p. 67). Qualitative research distills a psychologically meaningful comprehension of people's lived world and experience. In this way, the lived aspect of human experience is valued, studied, and then analyzed. The proposed study will involve interviewing patients who have experienced NARM therapy. Qualitative methods of interviewing participants also provide an analytic methodology that can discover the essences (sense of being) and structure of the therapy experience, which will be expressed in psychological language rather than quantification (Creswell, 1998). Hence, qualitative research is an appropriate method for a meaningful investigation of the patients' lived experiences of NARM therapy.

Phenomenological analysis is an effective methodology with, which to analyze

the lived process of clients' experiences of NARM therapy. The key value and primary objective of phenomenological research is to examine and explicate the meaning, structure, and essence of the lived experience of a person, or a group of people around a specific phenomenon (Giorgi, 2009). A phenomenological stance allows one to "study . . . the world as we immediately experience it rather than as we conceptualize, categorize or theorize about it" (Van Manen, 1990, p. 3). This methodology will allow one to gain information about the essence of the client's subjective experience of this psychobiological treatment model. Merleau-Ponty (1962/1972) defined "phenomenology as the study of essences," and essence is a description of phenomena (p. 317). In such research, the aim is to listen in to the essence of an experience, describe it in a detailed way, and examine what it means for the person who has had the experience (Moustakas, 1994).

Appropriate to the phenomenological method, this study aims to understand experiences of NARM therapy from the participants' perspective. The study will detail the content and structure of their therapy experience and describe the essences and essential meanings of the experience (Kvale, 1996). Psychotherapy patients who have participated in NARM will be interviewed, and their open-ended interviews audiotaped, transcribed, and documented. The text or raw data will then be analyzed to garner the patients' lived experience of NARM therapy. Through this analysis, one can draw meaning and discover emergent themes of the data. A primary purpose of a phenomenological methodology is to alter the researcher's understanding and bring forth new and unexpected aspects of the phenomena (Kvale, 1996).

Procedures for gathering and analyzing data.

Amedeo Giorgi's methodological design, the descriptive phenomenological method, is appropriate because in this approach, one first describes the lived experience of the participant, and then the researcher interprets for further psychological meanings (Camic, Rhodes, & Yardley, 2012). Giorgi's method is a descriptive phenomenological method and begins with the initial step of "epoche," which asks that the researcher bracket his or her own subjectivities in order to have a fresh perspective. This orients the researchers to identify their biases, transferences, and agendas and as best as they can put them aside. In addition, "A descriptive attitude implies a certain necessity demanded by saying that one describes what presents itself precisely as it presents itself, neither adding nor subtracting from it" (Giorgi, 1992, p. 122). After ethical assurances of a phenomenological study have been established, and the participants have been interviewed, the researcher reviews the transcribed texts of the interviews.

First the transcribed texts and data are examined in their entirety to get a holistic view of the whole lived experience being studied. When a sense of the whole is grasped, the researcher then rereads the interviews with a psychological perspective with the aim of extracting "meaning units" based upon what is psychologically relevant to the phenomena being studied (Giorgi, 1985, p.10). Meaning units are noted when there is a transition in meaning when the researcher rereads the transcript and therefore exist in the researcher's perspective and understanding. The researcher continues to track the meaning units as they change and transition through the text of the interview.

Once the meaning units have been identified, the researcher goes back and looks for the psychological insights contained in them (Giorgi, 1985). This process requires

reflection on the meanings and essences of the participant's description and is called imaginative variation. Imaginative variation transforms the participant's natural expression into psychological language and involves finding relevant implicit common messages. "The whole purpose of the method is to discover and articulate the psychological meanings being lived by the participant that reveal the nature of the phenomena being researched" (Giorgi & Giorgi, 2012, p. 252). Through this process, it is important that the researcher continues to bracket biases about the subject and truly pulls psychological insights from the participant's descriptions.

In the final step, the researcher synthesizes and integrates insights and meaning units into a description of the essential psychological structure of the phenomena. This synthesis can reveal the lived understanding of phenomena under study so that the researcher can truly encounter and discover psychological meanings. Aside from common themes, it is important to note individual themes that could perhaps feed the current and future research. Through the methodical distillation of the data, a universal salient essence can be found, which will be summarized and reflected upon from a depth psychological perspective.

Participant selection and ethical considerations.

There are many ethical issues to consider when working with human participants. The study will include six participants who have experienced some form of relational trauma and who have been in NARM therapy. I will select research participants based on accessibility, qualification, and self-interest, a specific criterion being that they are in or have been in therapy with a NARM therapist. Appropriate volunteers will be solicited through a letter of invitation to participate in the study. My current or past clients will not

be included in the study. The recipients can respond by phone or email to indicate their interest in participating in the study. The purpose of the study and the main features of its design and duration will be discussed with the participants at length. In the invitation, potential participants will be asked to provide me with the right to tape record the interview and to publish the interview data in a dissertation and in other publications. I will select six participants from the individuals who respond positively to the inquiry.

Once I have selected six participants, I will hold a phone or in-person conversation with each participant to answer any questions. Participants will also be given the opportunity to ask questions or raise concerns. This initial conversation will cover the basics of informed consent, the timeframe for participation in the study, and a potential date and location for the first taped interview. Informed consent forms will be provided, requiring a signature before the interviews begin. The forms will clearly state the overall purpose of the study, the main features of the design, the expected duration of the interview process, the limits of confidentiality, and the participants' right to withdraw from the study at any time. In addition, the consent form will specify how to reach me, and I will also provide outside referrals should participants at any time feel distress due to the interview process. Furthermore, all efforts will be taken to insure the participants' confidentiality, and also the confidentiality of the NARM therapists with, which they work. Specifically, the informed consent form will state that the researcher will be a container for information regarding the NARM therapists and that no identifying information about the NARM therapist will be revealed in the data. The informed consent form will notify the participants that these findings will be published; however, their identity will be protected. Since I consider the participants as co-researchers, they will be

offered an opportunity to review the work before publication in order to make additions or changes to the transcript.

There are emotional risks involved in participating in an in-depth interview. For example, one could unearth repressed or dissociated experiences that could lead to overwhelming emotions. Since the body will be incorporated into the interviewing process, a participant's autonomic nervous system might get overwhelmed. As the researcher, I must remain aware of this possibility and be prepared with interventions to orient and ground the participants. There is also a risk that a participant may feel uncomfortable and wish to withdraw from the study, and yet feel pressure to continue. Hence, it is important to reassure participants that their safety and sense of wellbeing are a primary concern. In addition, the research proposal will be reviewed and approved by the IRB at Pacifica Graduate Institute, and the American Psychological Association ethics criteria and standards will be followed and adhered to.

Limitations and Delimitations of the Study

There are certain parameters and delimitations that have been set on this study. First, the participants are limited to a small population of persons who have been in a specific treatment model, NARM therapy. The cultural, historical, and educational background of the participants will inevitably influence the expression of their experience and limit the implications of the study. In my research, I have found no previous data relevant to this population or to the research question. Hence, this study will provide basic data as a foundation for future clinical research.

Another known limitation is my minimal experience as a researcher with a phenomenological method. For instance, without prior experience of using participants

and collecting data, I have no experiential reference point. I am disadvantaged simply by never having tackled a research study of this magnitude. A related problem regards the question of objective interpretation. I have a particular philosophical stance about the phenomena of the clinical encounter and of what my research might reveal about it. My hope is that by adhering to the research methodology and by consciously bracketing my biases, objectivity will be maintained. However, my own emotional involvement and limitations of my personal psychology will pose a challenge as I intend to record my results with a modicum of impartiality.

The reliability, validity, and generalizability of this research is limited in that it will be connected to a certain population, from a particular vantage point, at a specific time and place, and from a particular researcher. In addition, once I delve into the actual research process, more limitations will undoubtedly surface. Nonetheless, my hope is that this study will make a modest yet scholarly contribution to the understanding of the somatic depth psychological clinical encounter.

Organization of the Study

In the first chapter, I address the depth psychotherapy mythopoetic processes of change and suggest that depth psychotherapy embrace its roots and incorporate the body, as it is the basis of human subjectivity. I then explicate my own experiences as a clinician and explain how that has inspired me to research relational trauma as it is a core phenomena. I further illuminate how neuroscience validates the depth psychology premise of a relational unconscious and how these processes create one's nucleus of self and relational patterns. The research problem suggests that relational trauma is pervasive and shapes the intrapsychic and interpersonal symptoms that patients come to

psychotherapy for. Therefore, research into the lived embodied experience of the psychotherapy client is needed and the research question then orients the research.

In Chapter 2, I review the literature on relational trauma and how it affects the whole gestalt of a person soma and psyche. This review is done through the theories of depth psychology, somatic psychotherapy and attachment theory. Explicit and implicit psychotherapeutic interventions are discussed ending with NARM a model that is inclusive of both.

In Chapter 3, the research approach describes the depth psychological theoretical lens with, which the research is approached. I then define qualitative phenomenological methodology and outline the methodological steps I will apply to my data as defined theoretically by contemporary phenomenologist Amadeo Giorgi. Research procedures for gathering data from my six participants are highlighted, and then I discuss my qualitative procedures for gathering my data.

Chapter 4 of this study will present the oral interviews of the research participants transcribed in written form (and presented in a tabular analysis in the appendices). Chapter 5 will summarize the dominant themes in the collected data and discuss the clinical applications, possible ramifications, and implications to the field of somatic depth psychotherapy, and will propose recommendations for future research. Final thoughts will be offered. References and appropriate appendices will complete the dissertation.

Chapter 4
Presentation of Findings

Overview

This chapter is a presentation of the results of the phenomenological analysis of the lived experience of being in NARM psychotherapy. To explore NARM as a psychobiological intervention, the researcher interviewed six individuals who generously volunteered their time, thoughts, and embodied experiences of such therapy. To gather information about their direct experience of engaging in NARM therapy, participants were asked a set of 20 questions in an interview. Each open-ended interview lasted from an hour. 15 questions emerged as the most relevant to the phenomenological research. The answers to these questions from the six participants were analyzed using Amadeo Giorgi's phenomenological research methods.

A pseudonym was used to protect the anonymity of each of the six participants. All of the participants indicated through the interview process that they had experienced some form of relational trauma through neglect, emotional abuse or lack of attunement in their early environment. As a researcher I was struck by the richness of each person's narrative. For each of them, the NARM therapy experience had been robust and dynamic. Unequivocally and invariably, all the participants said that their experience of being in NARM therapy had illuminated a deeper understanding of their core organizing psychobiological principles, adaptive survival styles, and, connection patterns to self and others. In reading the transcripts numerous times I was deeply touched by their experiences and humbly amazed at the facilitative process of the therapeutic encounter. I have chosen to include quotes from the interviews, which re-present the lived experiences of being in NARM psychotherapy in the participants' own words. Doing so offers each

reader the opportunity to get a flavor for the individuality of each participant and their particular experience. The flavor and, I hope, the profundity of their experiences will come to life as each reader listens to these personal descriptions.

The details and richness in each participant's description of their experiences made it challenging to parse out and distill common themes. With time, as I analyzed the raw data from the interviews, themes began to emerge. This chapter will be divided into six sections—one section for each of the participants. Each section will begin with a brief biographical sketch of the participant. This will be followed by a presentation of the particular themes that emerged from their individual interviews. Specific quotes from the interview will be used to illustrate the theme.

Chapter 5 will examine and analyze the common themes and essential constituents of the NARM therapy experience in greater detail. That chapter will conclude with a synthesis of the general structure of the lived experience of being in NARM therapy. Finally, Chapter 6 will present a summary of the research, discuss implications for the field of clinical and somatic depth psychology, and offer suggestions for further research.

Nico

The first interview I conducted was with Nico, a married man in his 50s, who was an engineer and is now a licensed marriage and family therapist in private practice. I emailed him to ask if he was interested in participating in the study and he emphatically responded, "yes." We conducted the interview two days later. I was nervous, as this was my first interview. I was also excited at the prospect of learning about his experiences and the possibility of discovering things about his experience that would be meaningful.

During the interview I questioned myself—was I prodding too much, too silent, and, so forth. As the interview progressed, we both sank into the process and the questions and answers became an organic flow. In person, Nico was warm, engaging, and very open to the interview process. He had been engaged in NARM therapy with two different therapists for a few sessions. I explained to Nico that I would be asking him 20 questions during the interview. The structure around these questions would be open-ended.

12 separate themes were culled from Nico's interview. Each of these themes is illustrated using natural meaning units (NMUs) Each NMU is differentiated by an individual heading in this section. Under each NMU are quotes of Nico's from the interview.

The patient connects to his inner experience of emotions, thoughts and sensations.

"When I got to that material I remember, 'Oh yeah there's something to work on here and that was much more intense material.' So yeah, it kept me connected to what was going on inside."

The therapist finely attunes to the patient.

"I had one session with Tom in, which he totally misattuned to me. He acknowledged this at the next session and apologized."

"Yeah, it was the repair Tom did after he misattuned in that session. And that was actually very healing. Yeah, a little more emotional 'cause that was something that didn't happen well in my family."

"And so I felt very seen, which was quite a profound feeling. Really it was that kind of relief that 'Ah, somebody is seeing me.'"

"He got it. He wasn't defensive. He really got it, so he was able to acknowledge it and acknowledging that repaired it. Being seen more accurately made all the difference. Yeah. So acknowledging that the past session wasn't well attuned and then he was very attuned to me in that session, so between the two it really repaired that."

The therapy experience is present focused.

"It would mostly be that I felt present. There would be times when I'd be reaching back in history and exploring where things came from. But I always felt in the moment. Current and present. I never got lost in the past, didn't get projected off too far in the future and things like that. It felt very much present-centred."

"Yeah I had the same experience with Maureen and we're exploring things and I'm getting to see this on one hand and this in the other but feeling it in the present moment. So yeah it's definitely a characteristic with NARM that really seems to come through. Oh yeah, "I need to work on this" were current, more or less current, but they came from the past. It was lived in the past, it was relived in the present, more or less present, and then it was felt and experienced and integrated in the wound in the very present."

"Yes, I was definitely tracking it at the therapist's request. Yeah. Of course, the therapist was tracking it, too. And he would often see something even deeper than I was feeling it at the moment. Sometimes he would help me deepen into it."

"Yeah, by having the time to really spend experiencing my body then I could start to connect with it and see it and not gloss over it. Right. Just not notice because I am on

to some other idea or other thought or some other . . . Comes into awareness, puts the magnifying glass on it makes it bigger and easier to see."

"Facial expressions, yeah he was reading those clearly. He would comment on them."

"I wasn't always completely aware of it. It would be something I was on the edge of and his noticing helped me go deeper into that usually in those cases. He'd really then start to track that, be with that and pause enough to deepen the experience."

Images facilitate the patient's process.

"I commissioned a local artist to paint a picture for my waiting room that has two kids looking at each other and then they have these masks on, or out in front of them are these two masks. There's like the shadow mask here and the persona mask here. And I had thought of it in terms of, shadow and persona and now I sort of look at it as Tom's shame-based and pride-based identifications these masks that we put on and then we get overly identified with them and think that's who we are."

"And so I use that image to talk to people about this quite—and they really get it that oh my God, yeah, it's really hard to have a relationship when you're looking through two masks and seeing them through their two masks.

The patient experiences a new embodied authentic sense of self.

"Yes and I would say mostly that's been in relationships. I just feel a whole lot more at ease and in command of myself and my feelings. Less anxiety, confidence, happier more grateful. Really, really grateful for the great relationships that I have."

*"*Well I really let go of my fear of being alone, that I am not going to die, I am not going to go into some anxiety if I am alone. It was huge. It feels like it's gone. Maybe it'll rear its ugly head again but it's gone right now."

"I am enjoying it more as solitude and a real sense of security that people in my life that care about me will actually be there. That's a really good thing."

"So, I am also letting go of my passive-aggressive self. I still notice it wants to flair up once in a while. I see it now. And then I can decide do I want to do this or not. Hmm, so it's more conscious and mostly I let it go."

"Can be more honest and deep and—and safe. So it's richer, yeah. Yeah, safe is the key word. Yeah, I would say I don't feel pressured now . . . where there used to be a lot of pressure. My life was a pressure cooker in the old days, yeah. I certainly don't feel that "on edge" stuff. I feel a lot more relaxed. Yeah not waiting for the punch to come or the shoe to drop."

The patient's personal resources are highlighted.

"I had done the video for Tom, adding –subtitles—for class—he really got how much I put my heart in that. And I felt really seen because putting my heart into my work is something I really like to do and it's really strength of mine. That was a really healing event to have him really see that and speak to it and then acknowledge it."

Metaphor supports the patient's process.

"Yeah, I do recall there were metaphors and I tend to like metaphors a lot so that was helpful."

"You want to use the simplest map that will get the answer that you need. You don't want to use a way complicated map if the top-level approximation model would answer it. So metaphors are like that simple approximation of reality."

"That's what I like about them I think. Yeah they create a map that simplifies a complex situation. "You are here." Exactly! Yeah, crystallizes it into a really clear single point, which has a real beauty."

"Sitting with it and you know speak in some metaphor, analogy that—that deepens it or some other aspect, how it might come into play in my life also deepens that particular one."

The therapy experience is titrated.

"I did need to cause some of the stuff that Tom was digging for in the way of feelings takes a little while to connect with and for potency to grow for me. So yeah, I did need to slow down a little."

"He was pretty good at facilitating that. Not rushing, going deeper and exploring around the edges of it. The time and sort of recognition of what was actually coming up."

Relational patterns are explored.

"It really became much clearer . . . the autonomy pattern. The connectivity, the connection patterns. That was pervasive in my adult relationships with other people."

" It's the fears underlying those would come into play in the relationship. Yeah. The fear of abandonment and the connection style, and the fear of not being able to be truthful and real if it disagreed with them would be something that would get them angry."

"Yeah. I see it a lot clearer, which means I have to act on them. I can't just act out the pattern anymore. A bunch of crap. It makes life harder. Yeah, then it integrates. And so much nicer."

The experience of the therapist having an agenda.

"He was trying to manipulate me to get angry and to feel stuff that I wasn't feeling in the moment and. you know he had an agenda. He says he has no agenda but he had one that session. Yeah so I was pissed off about that."

"It really was good 'cause it really got me clear that, Oh, when somebody has an agenda that it doesn't match your own, it really feels miss-attuned and it's really aggravating.' So it really helped to emphasize his point about not having an agenda."

NARM engages with the whole gestalt of the patient.

"I don't know, just watching the first introduction he put out—came in an email to me about 11:30 at night—I sat there and started watching. I couldn't stop. It was past two in the morning when I went to bed. Well the integration of the SE work with the nervous system and sensing and the character structure type work and identifications of who we are, and how we can use top down and bottom up . . . . ."

"So like I say, SE is another tool so that we can use both of these things together and that's what NARM does. It was right in alignment with what I was thinking was around how you heal people. Through being able to work top-down and bottom-up depending what's needed at that moment. It really spoke to me."

"So NARM feels like there's room for that. For the whole thing, the whole person. Yeah, it's not just a niche therapy. It feels like it's all encompassing and a generalized

thing, it can go deep where it needs to but it can also get around all over the whole map, not just some portion of the map."

After I finished the interview with Nico, we sat and chatted for another 45 minutes and I felt that the interview had supplied meaningful data and I was excited to pursue the other interviews.

Kim

Kim is a single woman in her 40s and she is a licensed marriage and family therapist. After getting her license, she worked at Los Angeles County mental health. She is currently in private practice. Kim was kind enough to come to my office on Christmas Eve to do the interview. She was very eager to share her stories in great detail. Kim had been in NARM therapy with the same NARM therapist for two years. She describes her therapy experience as transformative. Following are Kim's 11 themes illustrated with the natural meaning units (NMUs) from her interview:

The patient connects to his inner experience of emotions, thoughts, and sensations.

"So I feel like it just supported the slowing down, checking in, seeing what are you experiencing, what are you noticing."

"And then I think with NARM specifically it's really supporting what is your inner experience right now, in a different level than just tracking the sensations or being aware, so just in the slowing down and in the invitation and in the being asked 'what is your inner experience?'"

The therapist finely attunes to the patient.

"I am like, Yeah and it's all in the attunement. I mean it's just incredible resonance and the masterful use of his language and you just feel so seen and attuned to and supported and loved, deeply, deeply."

The therapy experience is present focused.

"Yeah I think it was always like what you're experiencing right now. Even though referencing the past as you talk about XYZ when you were young, what do you feel now, or trying to support the adult me now, today, to be the strength in whatever the situation we were talking about."

The body and its expressions and sensations are tracked and incorporated.

"Yeah, always. Always. We did some things very specifically with my body, like some eye exercises, and then always 'What do you notice?' If you're calmer, what is your experience, are my visions better, brighter? Directing the grounding. Initially because I had such a tendency to space out and fog out, there was a lot with the eyes and the vision getting clearer." "There would be warmth, and I was learning at SE originally, and he would highlight that in terms of Polyvagal theory, or go okay your social engagement system is coming on."

"My facial expressions were commented a lot in that same like, 'Oh what just changed?' when I would get almost giddy if I would have the anger and I would be like 'Whoo.' He would always comment on that."

"Tone of voice, he would note if my voice changed to deeper cause my voice can tend to get tiny and small so he would definitely track and comment if my voice changed, when it became deeper. Yeah, he would comment on that."

Images facilitate the patient's process.

"Imagery a lot. Yeah the Shrek face was the guy I was dating and with my ex-boyfriend…really in the expression of my anger like images, what might you want to do." "And then I remember several different times with anger specifically, having that be supported and using a lot of image, imagining. I remember this one guy, that same guy that I was dating, who was very, very attractive by our standards, and then like wanting his face to be like Shrek-face and just destroying it kind of. Just really working with it and very much encouraging all that impulses."

"And I think 'cause he could feel it that there was like rage. Then allowing the image with my ex-boyfriend. It was kind of like revenge, wanting him to have pain, like I wanted him to turn into a puddle of pain or something. So really in the anger around is where I would say it came up."

The patient's movements are enacted and processed.

"Yeah there was. I just remembered specifically that one time with the pushing and the arm and the pillow and then . . . . . "

"Pushing like really pushing against him with some things in anger and this part. Yeah, I mean he always had a pillow so it was like you're pushing the pillow instead of him, but some specific physical things like that, but not a lot necessarily. And then always 'What do you notice?'"

The patient experiences a new embodied authentic sense of self.

"Yeah I think my sense of self really developed in a different way because of embodying my experience more."

"This inner awareness supported my self-developing in another way and then the healing was in letting go of those identifications where it's like 'okay I don't even know it's the water I swim in' and those identifications, or the management strategies. It's like I don't even know another way to do it until I started doing NARM."

"Then I was like 'Oh okay', 'Oh I do that?' 'Oh I take on all of the responsibility for that?' 'It's me that's doing this, this, and this instead of other person?' or 'What if they're changing? No.'"

"Yes! K1 can say without question it changed my life. It just changed and brought me back to me really."

"Or just glad to know I'm here now, not there. Just this authentic self, so much more."

The patient's personal resources are highlighted.

"Yeah always, even where it was a true expression of emotion. Even the collapsing was never judged. It was always just 'It's okay to let that emotion be there or naming the emotion.'" "But yeah really whenever I would show up it would be such a quick tracking of adult-child. When the adult would come through sometimes, it would just be there half a second and then it would go. But he'd catch it and he's like 'It's really interesting 'cause it's there and now it's even gone again.' Even as just attention would be brought to me or to it, then it would get 'Uh-huh someone is seeing me!' and it would go a little bit. He was really supporting that adult."

"Any time I would do things that were not in my survival style or challenging my survival style, he was really, really supportive. Highlighted, yeah."

"Like just I would have to stand up to someone, a teacher. I was studying the model then and so he was like 'It's was an opportunity to not use your survival style' and he would bring it in that intellectual, which helped me a lot. It helped me to have that context."

"Yeah, always resourcing always ground yourself if you need to, take a moment, slow down."

Metaphor supports the patient's process.

"There was some other crazy one of like destroying things with my jaw. And an Albatross, that was maybe a metaphor, actually that was definitely a metaphor, kind of in the autonomy survival style, being burdened and there was this albatross on my back, and then working with that weight. Then at some point it turned into this flesh and I destroyed it with my teeth."

The therapy experience is titrated.

"Yeah he did, and grounding. And stretching out, like if I would say I feel calm, 'Any other words for calm?' He would help to just take your time with that, let yourself really experienced that. That's the slowing down. That it was because of what was happening in the body integration."

"And then grounding and then I would learn to do it myself. I remember definitely a pattern of just when we'd be onto something and then really getting spacey or . . . Yeah I would get spacey, really spacey or foggy or like vision changes and then really being able to notice that myself and then slow down and take time and connecting it to good news instead of 'Oh you're spacing out and now you're stupid,' you know whatever else you could think. Yeah just on to something. Your ego's being challenged —he

doesn't really say it like that but just like 'Um-hmm curious about that, what just got opened up, what stirred,'. . . and then really it's taking time with that to let it… and he would do a lot of resourcing in those moments."

Relational patterns are explored.

"Yeah. When I went in the first thing I worked on was . . . I was going through breakup and we had broken up, but we really spent another year trying to break up and that was when I started therapy with Mario." "So that was really one of the first topics and how much I, surprise surprise, I took responsibility for everything and his pattern was more towards blaming, 'You're the one who's not connecting, you're the one who's this that and other' and how I just willingly accepted that as true, 'It must be me.' And then as I got more connected then the relationship really ended. "

"Then just in the process of allowing myself to leave County Mental Health where I was the loved supervisor and it was big deal to be the golden child again in my workplaces, I was the golden child as well much of the time, and I am getting hot even talking about it. It's like "Oh my god" It's the golden child thing. But just saying no, I want to do my private practice. I don't want to work in this environment that's awful and stressful and depressing, and I want to do the work that I cares about and love. I got to do pieces of it there but not everything. It was a big move and it was because of NARM."

Susan

Susan is a single woman in her 40s. She has her doctorate in psychology and is a practicing psychologist with a private practice. She has been in NARM therapy with two different NARM therapists over the course of 2 years. Susan was very open and forthcoming during the interview and the interview flowed very easily. Through Susan's

interview, 12 separate themes emerged and they are followed by natural meaning units natural meaning units (NMUs) from the transcript.

The patient connects to his inner experience of emotions, thoughts, and sensations.

"Inner experience meaning what was going on inside, my sensations and stuff? Yeah. First because I think part of the NARM process makes you tune in. In case you're not, the question is what are you experiencing and that reminds me to tune in."

"And when I did in the presence of the therapist, because they just hold the space so nicely, then I was able to feel the void and how scary that–was—It was very healing."

"Because I was able to tune into it and I assumes—what they explained—is as a little kid it feels like death. I spent my whole life not wanting to go in there."

"Exactly, so the ability to sink in there trusting the person that's there holding the space and stuff and feeling that void and how that felt and then after a while, maybe a minute or so, feeling the void and then this just incredible, big, huge void like a big nothingness, and then the warmth came in. It was just . . . To take the time to slow it down enough to be able to feel that is just so powerful."

The therapist finely attunes to the patient's experience.

"You are really catching the nuances in the body. I think in talk therapy they catch the nuances of the words you're speaking, but the SE, NARM therapist catches the nuances in the body."

"You feel really seen. Not in a creepy way, not in an 'I feel exposed' way, it doesn't feel like you're . . .There's a difference between feeling seen, exposed, like naked,

you're watching everything to protect myself, or seen as like in that attachment piece, I think when I feel really seen and it feels so good and that's how it is."

The therapy experience is present focused.

"In the first interpretation, yeah. I am noticing everything that's happening in the moment. The other one is also—He comes at it from what's going on now in my life and how that's manifesting and then that ties back to why that is. There's a link, yeah. But you're dealing with what's going on in my life now."

"Like why don't I feel . . . I don't know. The last thing I was dealing with him was why don't I feel connected to people? So that's in the present time. Then it's explored through the lens of the past but still . . . But it's really the lens of the present but you explore the past because that's where it came from."

The body and its expressions and sensations are tracked and incorporated.

"Fred and Marcia both track it differently, but they both definitely track it. With him it's subtle too. You may not even be able to describe the difference. I think he's a little bit more descriptive. I think it's because he's more—he notices everything and then he reports back. What are you noticing now I noticed your body went down?"

"Whereas she tracks it and she lets you know that there's a difference but she might not verbalize it in the same way."

Images facilitate the patient's process.

"We're doing some sessions with Marcia and it was when I was moving and stuff and it's just so stressful and stuff and the image of her holding me showed up, which would have never showed up because I am the most independent."

“And I thought, ‘How interesting,’ and that it didn't repulse me. I didn't go ‘Ew, what the hell was that about?’, which allowed me during session, when I explored it with her. With the whole stress of the selling of the house and moving and then moving again because the carpets were ruined and this whole mess, I noticed that I felt alone in it because even with my friends I'm not fully connected to them. It keeps me from being fully connected.”

“ I’ve got some very good friends, but there was that feeling of alone with going through this stressful time. And then that image showed up of her holding me and allowing me to be supported by her, which was so interesting.”

The patient’s movements are enacted and processed.

“Yeah. Movement in the sense where they had me make a movement.”

“Yeah. It was—sometimes—beginning with Fred I explored a fight movement and he actually put a pillow and I pushed against it and also. In a fight kind of response. Yeah. I think that's the feeling that I can recall.”

“It really takes advantage of that piece and so we can then really, from a body sense experience how liberating one feels after you're able to fight back for example. As an example of that. In addition to the attunement piece, there is also that piece. Finishing stuff.”

“Or even working through some stuff, like looking through old fight or flight that you didn't get. You were bullied as a kid and never feeling like you can respond to that, or bullied by a sister, which is my first experience I suppose.”

"Again, slowing it down enough to allow you to experience what it would be like to fight back and noticing what your body does when you're fighting back and noticing how you feel after . . ."

The patient experiences a new embodied authentic sense of self.

"I think it's happened a few times, but the one I really remembers is that one session where he said, 'The more you embrace your womanhood, the more separation from your psychological father,' and I really kind of felt like I arrived. "

"After the sadness that showed up from the thought of—and that's what he's always talking about. You break that attachment connection. So the sadness of breaking the attachment connection but then all of a sudden and I had this image of just I really just arriving. Yeah. It was really cool."

"In the one with Fred, it was really realizing how connected and how maybe I was trying to preserve my attachment with my dad by keeping myself down, because I thought that's what he viewed me as. And that's that attachment connection that we try to hold onto."

"It was the emerging more empowered, stronger. Yeah. Stronger in a different way and empowered . . . I've always been strong but more in a defended way. This is more stronger like filling my shoes."

The patient's personal resources are highlighted.

"The personal resources that I recall most recently because they were explored are what I had to do to survive the deficiencies in my childhood. That's really interesting, also a different way of exploring resources."

"We've explored more my resources as an adult, everything that I have done. But I think that's another advantage of this type of therapy. You're exploring actually your defences as a wonderful resource that now maybe is working against you but none the less, it's a resource. It's not seen as a bad thing."

Metaphor supports the patient's process.

"Because metaphors do of course show up that help with the whole—with everything that's going on."

"I think metaphors are so powerful and so often they just show up. It's not random. It's—your body kind of creating that image. Because they're not random at all."

The therapy experience is titrated.

"I think any time I started the session with 'I noticed that I gets upset when this happens,' and then he slows it down. What are you noticing in the body as you're thinking about that happening and that ties into maybe a memory from the past or even just slowing it down and what you're noticing."

"I think that is at the core of the healing is you look at slowing it down. It slows down the nervous system enough to do what it needs to do, which is what Peter talks about. How do the animals in the wild release that fight or flight? They almost got killed but they didn't. That's how you release that energy and they take the time to do that and we don't."

"I think the slowing down process is the key to the healing because it slows the nervous system down enough to do what it naturally is supposed to do."

"We talk in talk therapy about our issues. But it doesn't shift that quickly or that profoundly or . . . You know what I mean? I can observe it but just from what I feel is I'm

noticing my body doing something, which in talk therapy you don't . . . It may be happening but because you're talking, then you're on to something else and the nervous system gets stuck again, because you're on to something else."

Relational patterns are explored.

"With others meaning just anybody, like friends and—I think not completely yet just because we've just gotten into this but I think that that sense of when I found myself feeling alone, even though I had friends that said 'Hey, I'll come over and we'll do this' and stuff, it was noticing how I keep myself from being fully connected to people. So that's part of exploring the relational because I don't let myself do that. Yeah to feel fully connected to people."

The experience of touch therapy.

"When we went to—when we explored it—this is maybe a little bit off NARM, but we did table work. She put her hands under my shoulders and she said, 'Let my hands support your body.' My body actually started to do this kind of contorted movements because it was almost like it didn't know how to let her support me from a body standpoint, which was interesting."

"You know when they say the body has a mind of its own? I actually experienced that because I could —not—It was the most bizarre thing I've ever felt. It's like her hands are already under me so you feel them because I'm already . . . Gravity is pushing me my body against her hands because they were right in between. And when she said I'm going to talk to your body and ask it to let—it—I can't remember exactly how she said it. Something about letting . . . And then all of a sudden my body started to kind of do this like it didn't know how to—like it was confused."

"Literally my body just started to contort, like it doesn't know what to do. It was just kind of leaning into it and I didn't know how to do that."

Jaime

Jaime is a married woman in her 40s who holds a master's degree in spiritual psychology. She teaches contemplative practice and somatics. We had planned our interview for a Sunday. On her way to my office she got lost, which delayed our starting time a bit. Jaime had been in NARM therapy for the past two years with the same NARM therapist. Her sessions with the therapist were often longer than traditional 50-minute therapy sessions. She had to travel quite a distance to get to her therapist's office, so found it more convenient to schedule longer rather than more frequent sessions. Eleven separate themes emerged from the analysis of the material from Jaime's interview. They are listed below and illustrated with natural meaning units (NMUs) from the transcript:

The patient connects to his inner experience of emotions, thoughts, and sensations.

"The therapist would ask if I was aware of how I was feeling it. I remember him saying to me, 'Can you notice what's happening right now?'"

"For me, when I am connected to my inner experience in the sessions its definitely within my body, so the felt sense, sensations and emotions, but also I am connected to the inner experience of thoughts that are going through my mind as well and be able to notice them."

The therapist finely attunes to the patient.

"The therapist, attuning to me and was saying 'Well, that must have been really sad.' And in that acknowledgment it really brought it more into the now. Yeah, it was sad

and feeling that sadness right now in the moment and leads to other remembering the sad then."

" It was good of the NARM therapist to recognize that and, in the subtle way of noticing how it was still, it's feeling that sadness in the present moment so it was still alive today and being able to feel that."

"He would continue to ask was I okay with this? I was also very aware of him being very attuned to me, which was very comfortable, comforting, where in the past I remember when I was younger and not being attuned to so well. I could really feel him being attuned to me."

The therapy experience is present focused.

"I don't know if I was ever in the place of so caught up in the past that I wasn't aware that Oh you know that happened then and this is now. Even in a big event that I remembered, and when I was needing to complete these biological responses, these defence mechanisms, I am very much aware that right now in this moment it isn't happening to me."

"And I was also aware of the therapist being aware of my awareness of being present. I could talk about it how my body feels and my need to kick. My awareness of it's from this thing that happened a long time ago, and even in the movements of doing it still being connected to the present moment. Throughout the sessions I have always been aware of that."

The body and its expressions and sensations are tracked and incorporated.

"In a recent session, I started to talk about something and I was very aware of this sensation in my body. It's like a vibration, but I can almost feel myself lifting up and

going much more into my head. It's a strange sensation but I am familiar with it. It's almost like disconnecting, beginning to disconnect from my body. And I became aware of that and I just go, 'oh I just need to pause for a moment, and I get settled back down then.'"

"Because I was quite aware of my physical sensations that are going on and the emotions associated with them, so I quite often say to the therapist, 'This is what I'm noticing,' and then we'll track those. Again, we'll slow down, track those sensations for a while and just notice what happens and then at other times I would notice the therapist would ask if I was noticing anything particular in my body."

Images facilitate the patient's process.

"One image came up and I was one of those, which is actually if I look back a powerful image because the cathedral was probably the representation of my body and I was this image that was protecting the cathedral for some reason. And then the image was attacking my attacker because I had been attacked a long time ago. So in this particular biological responses of incomplete was then of attacking my attacker. Through the imagery."

"Yeah, that image helped me facilitate the movement. And the image also facilitated me not having—See the biological responses were complete, but the image also helped me also just to feel the energy move more completely when I didn't physically need to move anymore. So it was really, really powerful. Those images were very powerful."

The patient's movements are enacted and processed.

"There's actually sometimes when there was incomplete defence mechanisms that came through in movement in my arms and legs, which moved quite a bit, and my jaw. You know like in biting. And these were all very protective, self- protective movements that needed to complete that were incomplete in my body systems. So when I started to move they were movements of completion."

"Absolutely, and also realizing in the past it had been confusing to me sometimes feeling like quite an empowered person anyway, but there's been moments in my life where I haven't acted where I would have liked to have done and it was sort of confusing to me why didn't I speak up or why didn't I make a movement?"

"And after this it made a lot of sense to me that oh, somehow those incidences were connected to these incomplete biological responses where I was frozen somewhere in my past."

"As I came out of that freeze response, immobility response, I was able to move that energy that was frozen that it split off, empowered. And once that begins to integrate, move in my body, and then there was such a greater sense of self-agency in that strength, of self-empowerment."

The patient experiences a new embodied authentic sense of self.

"Again it was subtle but it was definitely there, and it was in moments of feeling self-acceptance and in this experience of self-acceptance there was a wonderful expansion. And in that experience of an embodied sense of self that was new, very subtle but new and at the same time familiar."

"Yes, just lit up from the inside. You know. People might not even know that you experience it unless they attune to you, but it's very much that and has a great sense of peace to it as well. So in a NARM sessions when I touch into that. That I think is the most precious gift I receive from the sessions. It's really about connecting to who we are on deeper and subtler levels."

The patient's personal resources are highlighted.

"Keeping it slow, physical connection in presence and verbally attuning, asking if I was okay. I could sense he was observing me, feeling me very, very carefully and also keeping me socially engaged. That was really, I was noticing that as well."

"Yeah. The therapist would ask if I was aware of how I was feeling it. I remember him saying to me, 'Can you notice what's happening right now?'"

Metaphor supports the patient's process.

"There's one that comes to mind right now. Let me sit for a moment and see if another one comes up."

"Recently there was another one we talked about that was in the acceptance of death or like a disease that will take, that is terminal. Just in the acceptance of that, because there's really nothing one can do about that, or death that's imminent. There's an acceptance in that and in the acceptance of it there's a freedom. So we're using death as a metaphor, actively dying as a metaphor to accept what's happening inside and around us."

"That helped in the processes. That metaphor, yeah, that went along with that, acceptance of the self and things that were happening, just in life in general. And we used that in my situation just because of my connection with death or dying."

The therapy experience is titrated.

"There was one other thing that just went through my mind that was very important–oh and just continued to keep things slow because the incident I am talking about was a big, big movement of energy and anger that was coming through my body. So he really made sure that I kept that, slowed down enough; because if that comes through too fast it is overwhelming."

"But it was really pretty useful having the therapist there, helping to slow it down I am sure. That he was facilitating that slowdown. I was aware of needing to slow it down but also very aware of his participation and making sure I kept it slow."

Relational patterns are explored.

"And it's interesting that my relational patterns of today are similar to relational patterns from the past."

"One of the relationships that we're looking at today are like oh yeah, this person's certainly not attuning to my needs within that particular relationship. Still continue to . . . I somehow chose somebody who is similar to my parents in the way that they weren't directly in a relationship. It was more their needs than my needs and of course I continued on with 'I knows their needs must be more important.' Just because those are maybe one of the things that come out of having your needs attuned to when you were younger."

"What came to light more was this. In relationship, when there's a struggle or conflict or something difficult going on was really interesting for me to understand about myself is how I enable that to continue. So I might find myself complaining about it or

complaining about another person or in the relationship, then I will realize then yeah but I am enabling it by continuing to participate in it."

"'Oh yeah, I may want to stop doing that. If I wants these things to change, then it's really I need to change myself.' It's not the other person. Of course. And we know that, but when it comes really down to feeling that emotionally and in the body and so forth . . . Yeah, it's different."

Mario

Mario is a single man in his 60s who has a doctorate in anthropology. He is a mindfulness practitioner and counselor. I reached out to Mario and asked him if he would be a participant in this research. He committed immediately, but it took us a few weeks to schedule the interview. We met at his office. Mario has been in NARM therapy for four years. His first NARM therapist began to travel more frequently, so he just recently started working with a new therapist. Mario was very open and had a lot to share about his experience. Less than halfway through our interview, I began to see themes emerge. As I analyzed the material from his interview, I discovered new themes that had not been expressed by other participants. These new themes, although they had only been identified by Mario, seemed to capture something of the essence of the NARM experience, which seemed important. 12 separate themes emerged from the analysis of the transcript from Mario's interview. Each theme is listed separately below and illustrated with natural meaning units (NMUs) using Mario's own words.

The patient connects to his inner experience of emotions, thoughts, and sensations.

"I have four years of client experience. I did three and a half years with Jordan and just a few sessions with Liz. When I am a client, I have the capacity to be the client, to hear any intervention, to cognitively get a sense of what that intervention is about, to reflect internally on how I am receiving it, to notice how that response is occurring within my body, within my physiology. It connects immediately to an emotional response internally that I don't necessarily articulate."

The therapist finely attunes to the patient.

"And the issue about being seen and heard and reflected back is very potent when you really get it's not about judgment; it's about the illumination of what the dynamic is."

"I could never have gotten it at the level of really core process in some ways that, without having him simply refuse to judge, evaluate, explain, but to hold the space of the process that we needed to go through."

"So the attunement piece you're asking about, the attunement piece here was always very—it was always there and that—but . . . There's a big but to it. Jordan's very sharp. And my experience with him as a NARM practitioner or as the NARM Master was that he held his space about what he felt was therapeutically appropriate no matter what I asked for. So if I am asking for something that he doesn't feel would be therapeutically right, he wouldn't do it even though . . . So it feels sort of like a misattunement—But it's not."

"It's actually connecting to the—either tuning to the not wanting to reinforce any of the distorted identities and what I was asking for, on a number of different

circumstances, would be exactly that, would have had the consequence . . . Asking for something to reinforce a feeling that I had or to clarify something or to judge or explain or something like that actually would have been more reinforcing the identities, the distorted identities."

The therapy experience is present focused.

"The past never got brought up. The only time—the only time it would be brought up is if I've made a connection and—and in a subsequent session something is going on and Jordan would make a connection to one of our earlier sessions that I brought up in an earlier session, which is very different than fishing for something in the past."

"Sometimes the past gets brought up, as 'Is that a familiar experience?' Or—but never questions like 'What's your earliest memory of that?' or things like that."

"Yeah, and that's kind of the most disruptive piece, I think, in a lot of ways, telling the stories. Well, if part of the distortion is one wanting to be understood, then telling a story about why it is the way it is it's always going to the past. It's never being in this moment and what it is like in this moment. So what are you experiencing now? How do you experience yourself as a whole in your life today?"

"I mentioned a while ago and seeing how going to sensation rather than going to emotion or identity, while it seems like it is present moment, it is really skirting the present moment because really what is being asked about is the feelings, not about the sensation. So bringing the identity piece into the present moment, the present time, and the whole."

The body and its expressions and sensations are tracked and incorporated.

"Yeah, so there is—I mean there are tension patterns. I'm pretty in touch with how they manifest. A little bit of the head stuff and the collecting down at the back of the neck, how that comes when certain things would be discussed. Noticing it very subtly and notice how—I know my particular patterns of neck-shoulders, gut, particularly gut, holding, that holding pattern. Those are very familiar patterns and so there's a certain awareness of how that's being held."

"Like I feel the patterns and I no longer just feel the pattern, but I can connect it to how that was a pattern of protecting myself and how that is tied to early developmental periods. It's no longer, 'Oh, you're holding your gut.' It is clear that something is going on. When things are going well in life, I notice that I'm not—I'm not holding it. When there's a tension thing that is arising relationally, then all of a sudden I can feel myself slipping back into the old pattern."

"The shift from sensation and neural physiology to emotion and identity and psycho-biology—that's a huge change, because it's like you can spin sensation stuff out forever and never get anywhere."

The patient's movements are enacted and processed.

"Yeah. Movement all the time, stuff that's going on and noticing that. 'I noticed that we did this.' 'I notice that you are clearing your throat more.' Some of these types of patterns." "That kind of core. But more about movement. It's very easy to get distracted with the minutiae of movement side of any process. So my sense has been we do so much, various things that we do to regulate and to hold space and to communicate that where somebody who is just dealing with the somatic piece and not holding onto the

underlying emotion and the identity that's connected to it, whatever the theme is that's being explored, that when that—the movement is really not consequential at that moment."

The patient experiences a new embodied authentic sense of self.

"Part of what I was describing around trust, where seeing how part—what I pride myself in—of being able to rise to the occasion and do it is very much tied to this identity piece about if I can do this, then you'll love me, that-those pieces. There is a whole series of experiences that have to do with enmeshment and attachment relationship with my mother. That was a very strong piece."

"He had to be really gentle around that because that was really touching on very core identities around autonomy, very core identities around attunement and trust. They were just so all mixed in. And that was transformative to release that. That was huge."

"We really were working on the theme, kept—would come up about my relationship with women truthfully and my mother particularly and the sense of what the work that had to get done for me to get in a very cellular way the difference between caring and that sense."

"And once I could feel the difference energetically, emotionally what the difference felt like in my body, I got the meaning of what it was. Once I could do that, then the whole set of identities that were connected to those patterns were right there. They became available to look at. Prior to that they weren't available. That was huge. A very huge piece. Yeah."

The patient's personal resources are highlighted.

"The kinds of having been so like really seen at my worst by him, having him say to me at some point, who else would he come to coordinate his trainings, or with the finances–like 'I completely trust you about these things, those sorts of stuff.' That combination of having that sense of—that's really where I got the sense of not being judged."

Metaphor supports the patient's process.

"The metaphors around energetics, about the bottom up top down energetic movement, how that is and how that's connected. That becomes a very lovely way in. If I notice, the elevator would go back up again, that sort of thing. Those two parts, noticing it . . . I mean that's very helpful to notice. And sometimes the rapid pendulations that take place with it. There's a movement energetically where the elevator is going up but there's also a restriction pattern that's taking place simultaneously."

"There is some noticing, being able to notice the metaphor of the energy, that the way back in to the other pieces that are un-invisible at the moment. It's that crack in the egg issue. Once you get that crack in it—metaphor is really helpful that way—then you can begin to see what's behind it."

The therapy experience is titrated.

"Therapy experience was always kept slow."

Relational patterns are explored.

"Well, what becomes really clear to me is how, when there is any kind of emotional threat in more intimate relations, that I go cognitive. There's a feeling state

that's there and the protective patterns to go to begin to go into understanding linguistic—like ‘well you said this,’ which doesn't work so well.”

“But what I thinks has been really profound is being about to approach looking at adaptive survival styles that and not pathologizing how one does it in present time. It's really easy to say, Yeah, it was—you did these things as a child to make yourself feel like you were safe or to actually make yourself safer, but now as an adult it no longer works for you.”

“That has a quality of saying well this is really fucked up and that's kind of clinically not about me, pathological in that sense. And the shift away from that framework to really be much more descriptive rather than interpretive, really looking at it from a standpoint ‘Oh, look at the pattern; look at how this is. How do you experience yourself in this moment around that?’ That sort of piece really begins to—really make the non-pathological much, much more pronounced on the way.”

Therapist and patient meet adult to adult.

“And the moment you begin to take the position that the therapist knows where you are and the therapist knows where you need to be to go, there is—you are shifting the whole relational field from two adults exploring to the therapist knows you don't know, which puts you in a child's position. That's huge. That's a huge piece. It is not completely unique. It's not unique to NARM.”

“The moment the clinician steps into the adult child framework and there is this- - You’re taking away the clients agency in that process.”

Tamara

My last interview subject was Tamara—a married woman in her 30s. Tamara is a schoolteacher who has been in NARM therapy with one NARM therapist for the past three years. She explained before we began that she has been in a variety of different forms of therapy since she was 22 years old. She found her NARM therapist through a friend's recommendation. She told me she was a bit nervous at the beginning of our interview. She describes herself as an introvert. She wanted to participate, to share her experiences with me for this research because NARM therapy had been instrumental in helping her in her personal relationships. 10 separate themes emerged from the analysis of the transcript of Tamara's interview. Each is listed below and illustrated with natural meaning units (NMUs).

The patient connects to his inner experience of emotions, thoughts, and sensations.

"I can definitely say that I was connected to my inner experience. And this was facilitated through various questions such as 'What are you experiencing right now as you say that?'"

The therapist might say, 'I notice there was a shift. Can you tell me more about that?' It feels like the questions that the therapist asks are always connecting me to my inner thoughts, emotions and physical sensations."

The therapist finely attunes to the patient.

"I completely felt seen in an unjudgmental way and I really felt met adult to adult. There was just such a level of curiosity in the attunement that I really think brought out more of me in session because I felt so safe, because I felt so attuned to, so held and I felt

really, really tracked. I felt that the therapist really facilitated me feeling safe in that very deep, rich attunement and tracking process."

The therapy experience is present focused.

"Well, the past was often spoken about, but it wasn't the focus of the treatment. It was very helpful because I would be talking about interactions today and then a lot of times I would get an insight about something that happened in the past and I would be able to link that, or we would be able to link that, how this was created in the past and I am still bringing it into the present."

"But certainly the past—we didn't spend a lot of time talking about the past. The therapy is more about what's happening to me in my life right now and then sometimes it was linked to how this behaviour or pattern was created in the past."

The body and its expressions and sensations are tracked and incorporated.

"I would sit with what was going on in my body. So if I was feeling emotions such as grief or sadness, the therapist would ask me what—where do you feel that in your body? Let's say if I felt it in my throat, my throat felt constricted; she would often say to me, 'Just sit with that. Let's see what the intelligence of the body has to say.' That happened numerous times."

"Maybe I was feeling heartbroken and I would feel a deep pain in my chest. And again, we would sit with—just sit with what's going on in the body and then see what emerges from the body. Because then the body would give me different words or more succinct words and images that would get me in touch almost like another layer of what I was feeling."

"Then a lot of times, the therapist would say—I noticed when you said that, you put your hand on your heart, or I notice when you said that, your foot kicked or . . . Not only were sensations tracked but also what were my gestures? What was my body doing as I would say or feel certain things? That was noted and then further explored as well. And then deep buried emotions would emerge, emotions that I was not so in touch with in my everyday life."

Images facilitate the patient's process.

"I remember one session in particular where I had an image of myself that we worked with being at the edge of a cliff and that was very moving for me."

"Then sometimes images of people might be brought in and I could converse with that image or say things that I wasn't able to say to the image before."

"Also sometimes when I would feel an emotion and then go to the body and get quiet with the body, an image would emerge like of me being a young girl and just twirling around in my dress in the sun and feeling the sun on me. Or sometimes like an image of a random flower might emerge. So images did emerge for me in session and they were explored."

The patient experiences a new embodied authentic sense of self.

"I think that in all of the sessions, because I was so connected to my inner world and was invited to reveal myself in a very rich way, that did allow me to be connected to a new sense of self because there has always been something kind of holding me back, whether it's wanting to please people or I think that I have to act this way or that way. I often don't say thing to keep the peace."

"But in my therapy I can just show up and be me, and that is a new sense of self. I am not looking to please the therapist, which I know was a behaviour I learned from my home. I just know that I can show up and whatever comes is meant to come and not being afraid to express my true self feels liberating. That is a new part that has not had much space in my life."

"So actually, in session I think showing up like that and having that experience of really being seen for who I am not through who I think I am supposed to be based upon my past relationships is a new way of being and it allows me to push the envelope a little bit more in my real life and do that more in my real life because I have that embodied experience of feeling that new piece. I have a memory of that and then I am able to bring it out into the world."

The patient's personal resources are highlighted.

"I would say that my strengths were explored and highlighted quite often and I think they were used as a resource too, if I did feel strong emotions. I can recall the therapist bringing in a solid relationship of mine when I got overwhelmed with emotion."

"I remember my strengths and personal resources being highlighted or even something that I would think, judge myself as being bad, the therapist would always bring to my attention the flip side of the coin. Like the good part of that behaviour, that it is not just all negative or that maybe it served a purpose. That was quite enlightening actually."

Metaphor supports the patient's process.

"There was one session I can recall where I was so overwhelmed with being everything to everyone. My family was really pulling at me and my work and I just was

feeling this huge pressure and the therapist brought up the metaphor of me being superwoman and how on some level that must serve me and that it was ok to take that superwoman suit off and she made of movement of doing that and in that moment I remember feeling and taking such a sigh of relief and crying."

The therapy experience is titrated.

"Often I would come into session going a million miles an hour. And I began to notice throughout the sessions how the therapist would really slow me down through asking me questions that inspired me to really think and feel and often she would ask if an emotion came up, 'Is it ok to sit with this emotion right now' or say 'give your self time to feel what you are feeling' and I would notice that then my body had time to connect more with what I was feeling. I do not have exact words for that experience, but it felt kind of like a settling in."

Relational patterns are explored.

"I think that in my personal relationship, especially with my spouse, what I realized was that we would have an interaction—or I'll give you an example. Let's say during the week, I would feel that my spouse was not giving me attention and I would kind of play this tape in my head about that. But then what I would do is I would witness me playing that tape and instead of acting on it and confronting him, I would stay quiet and just watch what happened."

"Then what would happen is, because I was able to witness it and watch it, he would come to me and say, 'Oh my God, I was so stressed out this week.' So it really had nothing to do with me that I perceived he wasn't giving me attention. It just had to do with these old patterns of relationship that I was enacting."

"I also recognized that I would have an expectancy of what he was going to do and that he would catch it as if it was a cold and actually fulfil that expectancy. But it began when I was able to witness and have mindfulness about what the expectancy was and not hold onto it, the whole dynamic would shift."

Summary of Findings

This study explored the lived experience of NARM therapy patients by interviewing six participants, four woman and two men, between the ages of 30-66, about their therapy experience. The participants came from varying backgrounds but included several individuals who had either studied psychology or who were practicing therapists or counselors themselves. The length of the participants' time in NARM therapy varied from a few months to four years.

A thoughtful examination and analysis reveals the general structure of the NARM therapy experience and brings to light 11 key common constituents from the six interviews. The following empirical findings recur through all of the shared experiences and these major themes are enumerated below:

1. The patient connects to his inner experience of emotions, thoughts, and sensations
2. The therapist finely attunes to the patient
3. The therapy experience is present focused
4. The body and its expressions and sensations are tracked and incorporated
5. Images facilitate the patient's process
6. The patient's movements are enacted and processed
7. The patient experiences a new embodied authentic sense of self

8. The patient's personal resources are highlighted
9. Metaphor supports the patient's process
10. The therapy experience is titrated
11. Relational patterns are explored

Without exception, all of the participants emphasized that working with a NARM therapist had been profound and in some cases life changing. Many of the participants spoke directly about gaining embodied insights of identifications, behaviors and adaptive survival styles that were no longer serving them. With this increased awareness they spoke about feeling a shift or a deeper connection to their sense of self. This deeper connection with a sense of self positively affected their interpersonal relationships. Many of the informants were educated about the process of psychotherapy so they were able to articulate the nuances of this type of therapy. The inclusion of both psyche and soma was a universal theme articulated by all of the participants.

Each of the 11 common constituents will be discussed in greater detail in the following chapter. From these constituents a structural description of the lived experience of being in NARM therapy has been cultivated and will be presented.

Chapter 5
Discussion of the Common Themes

Overview

The raw data from the interviews was analyzed using Giorgi's method of phenomenological analysis. 11 common constituents were identified. These constituents were presented in the previous chapter using the words of the research participants to illustrate each. The common constituents based on the lived experience of being in NARM therapy of the research participants are (a) the patient connects to his inner experience of emotions, thoughts, and sensations, (b) the therapist finely attunes to the patient, (c) the therapy experience is present focused, (d) the body and its expressions and sensations are tracked and incorporated, (e) images facilitate the patient's process, (f) the patient's movements are enacted and processed, (g) the patient experiences a new embodied authentic sense of self, (h) the patient's personal resources are highlighted, (i) metaphor supports the patient's process, (j) the therapy experience is titrated, and (k) relational patterns are explored.

This chapter examines these key constituents in detail. The way each of these constituents was experienced and described by individual participants will be discussed and analyzed to highlight and make its essence explicit. From a refined synthesis of common constituents, a structural description of the lived experience of being in NARM therapy will be developed. A poststructural discussion follows.

The Common Themes

The 11 constituents, which identify the general characteristics or key elements of the experience being explored, will be examined using a depth psychological lens. A

general description of each key element or theme will be followed by a description of each participant's experience of this element.

The patient connects to his inner experience of emotions, thoughts, and sensations.

This theme is a universal characteristic of psychotherapy. Most patients come to therapy to eradicate symptoms that are causing mental and physiological dysphoria. Due to their distress, they are willing to explore and excavate their psyches (Cozolino, 2002). In a psychotherapeutic relationship, the therapist supports the patient's self-reflexivity. The therapist facilitates the patient's process to help the patient become more aware of the visible and invisible psychobiological underpinnings of his or her distress. To support this deeper exploration, the therapist asks questions, which help make what is implicit, explicit. Hearing the patient's answer, the therapist then reflects the patient's narrative and process in a way that facilitates awareness of what has been hidden from consciousness (Renn, 2012). The therapist also notices, "listens to," and inquires about nonverbal cues such as prosody of voice, gestures, breath, and facial expressions (Ogden et al., 2006). Within the therapeutic dyad the patient and therapist use a bidirectional model of communication to create a mindful nonjudgmental container in, which to explore the patient's intrapsychic and somatic processes (Beebe & Lachman, 2002). The analysis of NARM therapy revealed an additional and perhaps more subtle aspect of the therapeutic relationship. In NARM the therapist facilitates the process of helping the patient connect to his or her inner experience through subtle yet powerful nuances. This intentional therapeutic exploration is done in a space of potentiality in service to the self.

Nico.

Nico's life was going quite smoothly while in NARM therapy. Initially, he was not feeling the urge to be connected to his inner experience. The first question I asked Nico in the interview was about his process of being connected to his inner experience of emotions, thoughts, and sensations in his NARM therapy sessions. He was just settling into the interview process as he answered. He stated, "I would say I was. It wasn't always easy. There were times when I didn't know what I wanted to work on since my life was going so well that I just was at a loss." This changed when some emotional material was brought up in his NARM therapy sessions, which connected him to his inner milieu. In his words, "When I got to that material I remember, Oh yeah there's something to work on here and that was much more intense material. So yeah, it kept me connected to what was going on inside." Nico was a little vague about his inner experience and his answer to this question. When he slowed down in the interview, he shared that he realized he had some potent issues to work on, and with that realization he felt more connected to his inner landscape.

Kim.

Kim stated very clearly that the NARM therapist intentionally titrated her therapy process. This enabled her to be connected to what she was experiencing and noticing in the moment in her inner experience, "So I feel like it just supported the slowing down, checking in, seeing what are you experiencing, what are you noticing." She further explained that the combination of a titrated experience and utilization of specific

questioning by the therapist served as an explicit “invitation” to connect and explore her inner state.

Susan.

Susan, like Kim, said that she was connected to her internal world through specific questions and language that facilitated the process of having to “tune in.” She added that the safety that is characteristic of and infuses the NARM therapeutic container allowed her to plug into an inner void, a dark place that she had avoided because it felt like death. By slowing her process down in the safe container, she was able to open to and experience the inner void. As she did so, she was filled with the sensation of warmth. She recalled, “Exactly, so the ability to sink in there trusting the person that's there holding the space and stuff and feeling that void and how that felt and then after a while, maybe a minute or so, feeling the void and then this just incredible, big, huge void like a big nothingness, and then the warmth came in. It was just . . . To take the time to slow it down enough to be able to feel that is just so powerful.” Her experience, like that of the other research participants, indicates that the therapist’s intentional use of language and slowing down of Susan’s process supported her being more deeply connected to her inner experience.

Jaime.

Jaime had the same experience. She exclaimed that there were particular questions that the therapist asked that supported the process of connecting to and exploring her inner experience in her NARM therapy sessions, “The therapist would ask if I was aware of how I was feeling it. I remember him saying to me, ‘Can you notice what's happening right now?’ In answering this question and others that also asked about

the specific moment in the session, Jaime was inspired to access her cognitions, feelings, and bodily sensations. As she became present to what she was experiencing in the moment, she became conscious of the deeper emotional, somatic, and mental layers of her experience.

Mario.

Mario, reflecting on his experience, stated that being directed by the therapist to bring his attention inward, he could hear the therapist's interventions. This facilitated a process of synthesis of cognitions, affects, and physiology through his whole being, which connected him more deeply to his emotions. He was aware of his inner processes and the responses of his psyche and soma during sessions. Although Mario was connected very deeply to himself, he often did not share all that he was experiencing in the session. In his words, "It connects immediately to an emotional response internally that I don't necessarily articulate."

Tamara.

Tamara emphatically declared that during her NARM session she attended to her inner experience through the precise language of "What are you experiencing right now as you say that?" This succinct question elicits an illumination of what the patient is experiencing in that moment. She further indicated that not only was it the questions but also other finely tuned statements in, which the therapist noticed Tamara, such as, "I notice there was a shift." With that comment the therapist brought to Tamara the awareness of her energy shift, which inspired her to further explore the emotions or thoughts connected to that energetic shift.

Summary.

The NARM patients recalled the process of being connected to their intrapsychic and interoceptive processes through subtle yet powerful nuances. For four of the participants, the language used by the therapist, the questions, which asked the patient to notice what they were experiencing in the moment, was one such seminal nuance, which facilitated a deeper experience of their psychobiological state. “What are you experiencing as you say that?” or “What are you noticing right now?” are some examples of this type of question.

This particular type and use of questioning is very different from a more general question like “what are you feeling?” The intentional language and questions of the NARM therapist seem to provide a bridge for the patient to his or her vast inner experience of cognitions, affect, sensations and internal object relations. In addition, this way of asking questions and choice of specific words is used to inquire about and elicit nonverbal experiences of body sensations and expressions. This technique of open-ended questioning with clarifying language inspires the patient to be descriptive. As the patient answers, the therapist gains a richer sense of the whole gestalt of the patient’s subjectivity, and this process of awareness deepens within the intersubjective field between therapist and patient. As Tamara reflected, when the therapist noticed a shift in her energy, it inspired her to check in and become a witness to her inner processes. This skill is needed to support integration. As Susan mentioned, the safe, nonjudgemental space held by the therapist inspired her process of exploring an internal space that felt scary. When visited within the supportive NARM container, rather than feeling terribly scared, she became filled with warmth.

There is a subtle depth to this nuanced style of therapeutic questioning. Tamara stated that it is imperative for the therapist to have authentic curiosity and for the intersubjective space to feel like a secure base from, which to explore the patient's inner experience. The NARM patients' statements revealed that the utilization of the art of language by the therapist supported their agency and connected them to what was most pertinent for *them* in the now. This particular use of language and titration of the therapy process created space, which supported a deepening of self-reflexivity from, which insights about the patients' defences and identities emerged.

The therapist finely attunes to the patient.

Receiving fine attunement verbally and nonverbally from the therapist is a key pillar for the psychotherapy patient. This happens moment-by-moment in microseconds and has the capacity to create a secure attachment in the intersubjective dyad (Beebe & Lachman, 2002). Research has shown that being seen and feeling heard supports self-organization, integration, and affect regulation, which are key elements in the patient's process of change (Siegel, 2007). Various themes with regard to attunement and resonance emerged through the data in the interviews. The data clearly illustrated that fine attunement created the element of safety, which inspired the patient to unfold and further facilitated a rich emergent intersubjective process. As was expressed in the responses of the research participants, attunement is more than accurate reflection; it is a co-created, complicated dance between two dynamic emergent systems, a dance that encompasses implicit and explicit nuances.

Nico.

For Nico, the experience of being attuned to by the therapist was not simply black and white. He stated that although he recalled being attuned to in most sessions, he had one session where he did not experience attunement. This left him feeling anxious, angry, and confused. "I had one session with Tom where he totally misattuned to me." This dyadic mismatch was experienced as a rupture in the therapeutic alliance between Nico and his therapist. In the following therapy session it was addressed. This repaired the therapeutic alliance. Nico expressed it this way: "Yeah, then he was quite attuned in the next session, and then I felt a whole lot better, a whole lot more relief. Yeah 'cause not being seen felt very anxiety producing, from somebody who is as good as he is at seeing things." It was clear that the exchange when the therapist acknowledged the lack of attunement touched Nico. When he spoke about this experience in the interview, he got emotional; he recalled that being seen and heard did not happen in his family. This interpersonal exchange with his therapist was especially meaningful in light of this. In Nico's words, "Yeah, it was the repair Tom did after he misattuned in that session. And that was actually very healing. Yeah, a little more emotional 'cause that was something that didn't happen well in my family. And so I felt very seen, which was quite a profound feeling. Really it was that kind of relief that Ah, somebody is seeing me."

Kim.

Kim recalled that she experienced deep levels of resonance and being felt and seen, "I mean it's just incredible resonance and the masterful use of his language and you just feel so seen and attuned to and supported and loved, deeply, deeply." In addition, she stated that the therapist was finely attuned and brought her attention to her energetic

shifts when he said, “Oh notice how your energy changes.” This is evident in this example shared with me by Kim. The NARM therapist would highlight when he witnessed a shift in Kim and brought her attention to her energetic shifts.

Susan.

Susan added another layer to the attunement piece when she reflected that the NARM therapists not only tracked and reflected words expressed through cognitions and thoughts but also focused and attuned to the nuances of her body and physiology. She stated, “I think in talk therapy they catch the nuances of the words you're speaking, but the SE, NARM therapist catches the nuances in the body.” She also commented on how she felt authentically seen and compassionately observed by the NARM therapist. There's a difference between feeling seen, exposed, like naked, you're watching everything to protect myself, or seen as like in that attachment piece, I think when I feel really seen and it feels so good and that's how it is.”

Jaime.

Jaime shared that she felt attuned to when the therapist reflected her feelings of sadness in the present moment. This attunement supported Jaime in linking what she was feeling in the present moment to sadness from the past that was still alive. When her therapist said, “Well, that must have been really sad,” Jaime felt that “in that acknowledgment it really brought it more into the now.” In another instance Jaime recalled she felt attuned to when the therapist checked in with her through an open-ended question to see if she was ok with an intense experience that was happening in the therapy. She reflected, “I was also very aware of him being very attuned to me, which

was very comfortable, comforting." She realized the poignancy of this attunement as she recalled that she was not attuned to as a child.

Mario.

Mario recalled a few deeply touching experiences of attunement with the NARM therapist. Mario reflected that he experienced a seminal element of the resonance of attunement from his NARM therapist. He recognized that when the therapist was attuned through reflection it was simply to bring awareness to Mario's intrapsychic processes or interpersonal dynamics without judgment, "bringing awareness about being seen and heard and reflected back is very potent when you really get it's not about judgment; it's about the illumination of what the dynamic is." Mario's experience suggests that the neutral and noninterpretive attunement from the therapist inspires embodied consciousness of the client's processes, which are then witnessed together in a nonpathologizing manner. Mario further explained that this highly attuned, nonjudgmental, intersubjective field created a space for his individuation process, "I could never have gotten at the level of really core process in some ways that, without having him simply refuse to judge, evaluate, explain, but to hold the space of the process that we needed to go through."

There was another layer of attunement that Mario experienced. The therapist understood Mario's adaptive survival styles and therefore would not engage in dynamics within the dyad that reinforced Mario's defense mechanisms or distorted identities. The therapist intentionally chose not to collude with Mario's defenses, as he did not want to reinforce them, Mario expressed it this way, "So if I am asking for something that he doesn't feel would be therapeutically right, he wouldn't do." Initially, Mario experienced

this exchange as a misattunement. As time went on, he realized how the intricacy of this level of attunement supported releasing identity distortions and defenses and supported integration.

Tamara.

Tamara recalled that the therapist's authentic curiosity in her NARM therapy dyads created a felt sense of attunement, "There was just such a level of curiosity in the attunement that I really think brought out more of me in session because I felt so safe, because I felt so attuned to, so held and I felt really, really tracked." She reflected that she felt seen and heard without any feeling of judgment from the therapist. This facilitated Tamara feeling safe and inspired her to reveal more of herself.

Summary.

The felt sense of attunement is a multidimensional essence that is experienced cognitively, emotionally, and somatically. It is foundational support to the therapy experience and a key constituent in the intersubjective dyad. One of the common elements at the heart of feeling attuned to as described by the NARM patients is the therapist's ability to hold an authentic sense of curiosity, which creates a nonjudgemental, accepting exploration of the client's intrapsychic processes and somatic dynamics. This active curiosity creates a space of potentiality for phenomena to arise. Language was mentioned again as the mediator of noticing and being with the patients in an open-ended, non-goal oriented way. In addition, as Susan stated, what separates a somatic therapeutic approach from other approaches is the way the therapist tracks, notices, and attunes to the patient's body and reflects the patient's somatic expression. Adding this

somatic component opens the exploration of the implicit and nonverbal aspects of experience.

Attunement is a seminal pillar in the intersubjective dyad. In Nico's case, this attunement caused him anxiety and a relational rupture. When Nico expressed his feelings about not being seen, it led to a relational repair that was contrary to his experiences growing up in his family. This seemed to create a novel and healing relational experience. Mario's experience suggests that the NARM therapist attunes by understanding the patient's adaptive survival styles and distorted identities and does not collude with them so as not to reinforce them. The patients described feeling felt by the therapist. This energetic, sensual exchange creates a resonance in the intersubjective dyad. Even when patients express strong emotions, this attunement creates a container in, which they feel held in this accepting, open field. This attunement supports emotional organization and regulation.

The therapy experience is present focused.

Psychological research has shown that what the patient has experienced in his early environment with his primary caregiver shapes his implicit and explicit layers of memory and creates his embodied sense of self (McGilchrist, 2009). Research has shown that early environmental failures and broken attachments contribute to the symptoms and issues that patients come to therapy to modulate (Heller & LaPierre, 2012). Therapists know that each successive present moment in life is a different instantiation of the past acting on the present (Paris, 2007). Therefore, it is important for the therapist to have an understanding of the patient's attachment schemas and core organizing psychobiological principles. In the NARM dyad, the focus is not on the narrative of the patient's past, as

this is not the focus of the treatment. This is one of the universal elements of NARM as described by the research participants in this study, which distinguishes it from other therapies.

Nico.

Nico recalled that his experience of NARM therapy was very present focused. He was aware that he never projected too far into the future or got lost in the past. “There would be times when I'd be reaching back in history and exploring where things came from. But I always felt in the moment.” He claimed that this experience was the same with both NARM therapists and that he thought keeping the content of the sessions on his present life is a pervasive characteristic of NARM therapy. He eloquently spoke of linking past and present. “It was lived in the past, it was relived in the present, more or less present, and then it was felt and experienced and integrated in the wound in the very present.”

Kim.

Kim spoke of an experience that was similar to Nico’s. When Kim mentioned something from the past, the therapist would facilitate bringing it into the present by asking the question, “what do you feel now?” In Kim’s words, the therapist would “support the adult in me now, today, to be the strength in whatever the situation we were talking about.”

Susan.

Susan recalled that there was always a clear link from the past to the present. In her therapy sessions she was always dealing with what was going on in her life right now. She gave an example of not feeling connected to people recently. “Like why don’t I feel

. . . I don't know. The last thing I was dealing with him was why don't I feel connected to people? So that's in the present time. Then it's explored through the lens of the past but still . . . But it's really the lens of the present but you explore the past because that's where it came from." This feeling of a lack of connection with others that Susan feels in her present life was a familiar feeling and a pattern that she experienced in the past. In NARM therapy she explored the ways in, which this lack of connectedness haunted her relationships today, in the present.

Jaime.

Jaime recalled a particular instance in NARM therapy in, which she needed to complete a biological response from a past traumatic assault in that session. "I don't know if I was ever in the place of so caught up in the past that I wasn't aware that, Oh you know that happened then and this is now. Even in a big event that I remembered, and when I was needing to complete these biological responses, these defense mechanisms, I am very much aware that right now in this moment it isn't happening to me." She also recalled that the therapist in this instance was aware of Jaime's awareness of being in the present as she expressed her body's desire to kick.

Mario.

Mario emphatically declared, "The past never got brought up. The . . . only time it would be brought up is if I've made a connection." He continued, stating that sometimes the past was brought up if the therapist made a connection to one of their earlier sessions or when questions such as, "Is that a familiar experience?" were asked. He then exclaimed that he thought focusing on the past "Can be the most disruptive piece, especially if it reinforces identity distortions adaptive survival styles and defenses."

Tamara.

Tamara reflected that although the past was discussed and explored, it was not the focus of treatment. She recalled that linking the past with the present was helpful as she could witness how interpersonal patterns and identity distortions that were shaped by her early experiences were still happening in the present. "I would be talking about interactions today and then a lot of times I would get an insight about something that happened in the past and I would be able to link how this was created in the past and I am still bringing it into the present."

Summary.

Experiences of relational trauma can cause people to remain stuck in interpreting the present in light of an unchanging past. As the NARM patients described, the past is constantly present in their current agendas, and it is the engine and energy that informs the implicit patterns of their lives and experiences in the present. As they stated, the past insidiously infiltrates and creates the lens through which they perceive the world around them. Their history and all it entails is activated in their lives in the present. However, as the NARM therapy patients explained, the past and its effects are noted but not reified. As a result, it is not the focus of discussions. Nico described how, in NARM therapy, understanding the way the past is re-lived in the present allows one to integrate it into the wound that it shaped. This understanding and the experience in the present in NARM can create a space to assimilate new experiences. Kim stated that she understood how the past influenced her, however, by focusing on and staying in the present in her therapy, her adult self and its sense of agency was supported. With the therapist holding this stance, Kim is not a victim to her past, but an adult in the present who can make decisions and

engage in behaviours that she could not do as a child. For other NARM patients in this study, being focused on their present life circumstances in a session opened the possibility to connect to their past and gain insight into how they re-enact this same behaviour, relational pattern, or adaptive survival style in the present. Jaime reflected that in the present she was able to access a procedural memory through physical movement and complete a biological impulse, which now created a new felt sense of the experience. Of course the past can never be undone; however, as the data exemplified, the therapeutic present moment offers a potential space for implicit memories to be explicitly remembered and re-worked in real time. By focusing on the present moment in the intersubjective dyad, the patient has the opportunity to have a corrective experience.

The body and its expressions and sensations are tracked and incorporated.

Due to recent advances in neuroscience, psychotheraputic theories are incorporating the body and its implicit wisdom into the psychotherapeutic encounter (Barrett, 2014). This involves observing the body and its gestures, incorporating the patients' sensations and interoception, and moving the body kinesthetically either through dance or physical movements that complete physiological responses (Ogden et al., 2006). Somatic approaches offer a supplement to cognitive insight oriented interventions. In utilizing bottom up approaches in the clinical dyad, the therapist supports the patient in feeling the self in embodied awareness (Levine, 2010). Consciousness of the body and access to its processes can support the integration of psyche and soma, as the nervous system and brain are inextricably intertwined and energy and information flow between them (Van der Kolk, 2014). The NARM therapy patients' interviews revealed that the body was prominent and explicitly incorporated and explored in all of the sessions.

Nico.

Nico reflected that in his NARM therapy sessions he tracked his body at the therapist's requests and that the therapist was tracking it too. He recalled, "And he would often see something even deeper than I was feeling it at the moment. Sometimes he would help me deepen into it." Nico might make a facial expression, tilt his head, or take a deep breath. The therapist would notice, and they would take time to explore and see where it would lead them. He continued, "Yeah, by having the time to really spend experiencing my body then I could start to connect with it and see it and not gloss over it."

Kim.

Kim reported that her whole body was incorporated in the sessions—her eyes, sensations, tone of voice, and energetic shifts in her physiology. Regarding her eyes, she stated, "We did some things very specifically with my body, like some eye exercises and then always, what do you notice? If you're calmer, what is your experience, are my visions better, brighter?" In this kind of exploration the therapist would always invite Kim to ground herself physically, especially if strong emotions were coming up. When Kim mentioned that she felt a sensation of warmth, the therapist would note that perhaps her social engagement system was coming online. Regarding the tone of her voice, Kim stated, "Tone of voice, he would note if my voice changed to deeper cause my voice can tend to get tiny and small so he would definitely track and comment if my voice changed, when it became deeper. Yeah, he would comment on that."

Susan.

Susan reflected that both of the NARM therapists tracked the body and its sensations. However, she felt that each therapist used different techniques to do this. "You may not even be able to describe the difference. I think he's a little bit more descriptive. I think it's because he notices everything and then he reports back. What are you noticing now I noticed your body went down?" Susan noted a common thread that runs through many of the NARM patient's experiences—the therapist noticing an energetic libidinal shift in the patient in a nonjudgmental manner.

Jaime

For Jaime, both she and the therapist monitored the interoceptive sensations of her body. "Because I was quite aware of my physical sensations that are going on and the emotions associated with them, so I quite often say to the therapist, 'This is what I'm noticing,' and then we'll track those. Again, we'll slow down, track those sensations for a while and just notice what happens and then at other times I would notice the therapist would ask if I was noticing anything particular in my body." She described one particular instance when she was very aware of a sensation that almost took her out of her body. "In a recent session, I started to talk about something and I was very aware of this sensation in my body. It's like a vibration, but I can almost feel myself lifting up and going much more into my head. It's a strange sensation but I am familiar with it. It's almost like disconnecting, beginning to disconnect from my body. And I became aware of that and I just go, oh I just need to pause for a moment, and I get settled back down then."

Mario.

Mario spoke about his body's familiar tension patterns, which collect at his neck, head, shoulders, and gut. He described what they now mean to him. "Like I feel the patterns and I no longer just feel the pattern, but I can connect it to how that was a pattern of protecting myself and how that is tied to early developmental periods. It's no longer, oh; you're holding your gut. It is clear that something is going on. When things are going well in life, I notice that I'm not —I'm not holding it. When there's a tension thing that is arising relationally, then all of a sudden I can feel myself slipping back into the old pattern." Mario described how he recognized that his body got into bracing patterns when he needed to protect himself. He believed these patterns were created in his early developmental periods in response to his experiences in his early environment.

Tamara.

Tamara described the body as another portal through, which she could explore her emotions and feelings. "So if I was feeling emotions such as grief or sadness, the therapist would ask me 'what—where do you feel that in your body?' Let's say if I felt it in my throat, my throat felt constricted; she would often say to me, 'Just sit with that. Let's see what the intelligence of the body has to say.' That happened numerous times." Tamara professed that after she tuned into her body and its sensations, she could reach another dimension of what she was feeling that came through in images and words. Her body's gestures were also noted and explored as these movements had messages or information of their own: "What was my body doing as I would say or feel certain things? That was noted and then further explored as well. And then deep buried emotions would emerge, emotions that I was not so in touch with in my everyday life."

Summary.

The body and its nonverbal expressions and sensations were explored in various ways with all of the NARM therapy patients. Nico explained how he would track his sensations at the therapist's request. He also noted that the therapist would often notice a nonverbal expression, and then they would explore that. This approach would deepen Nico's process. Eyes, tone of voice, and shifts in energy were all indicators of Kim's inner processes. The NARM therapist noted these, which opened exploration into deeper understanding. Susan stated that she felt both therapists tracked her body. One of her therapists would notice a nonverbal expression, which they would explore. From this careful tracking she became aware of when she was disconnecting from her body. The therapist's careful tracking and mirroring inspired her to ground. As a result of the careful tracking of the nonverbal language of the body and expression, Mario is now aware that when he feels his body contract or brace, it is an indication that his emotions have been triggered. With this new awareness, he believes these are protective patterns that were created in his early development. When Tamara took the time to connect with her body and its sensations and gestures in a session it became a portal for unconscious emotions to come to the foreground. In the NARM therapeutic container somatic mindfulness was a tool used to explore the patients processes and was also used to regulate and support the nervous system as the patients explored their symptoms, adaptive survival styles, and identities.

Images facilitate the patient's process.

Images and imagery are their own symbolic form of language. They give shape and form to affect, cognitions, and sensations (Jung, 1958/1970). Images can emerge

from metaphor, dreams, and sensorimotor sensations. Images can be invited into a therapy session directly. When used in the clinical encounter, the symbolic form of image can facilitate awareness of unconscious processes, inspire physical movement, and allow emotional processes to deepen (Woodman, 2009). The experiences of the NARM therapy patients with images exemplify the myriad ways images spontaneously emerge and serve to facilitate the process of being in service to self.

Nico.

Nico stated that images were incorporated into his NARM therapy sessions. He could not recall any specific experience of this during the interview. He did describe an image that he has in his office, a painting. That image helps bring a deeper understanding of the psychological processes he has explored with his own therapy patients. "I commissioned a local artist to paint a picture for my waiting room that has two kids looking at each other and then they have these masks on, or out in front of them are these two masks. There's like the shadow mask here and the persona mask here. And I had thought of it in terms of shadow and persona, and now I sort of look at it as Tom's shame-based and pride-based identifications, these masks that we put on, and then we get overly identified with them and think that's who we are. And so I use that image to talk to people about this—and they really get it that oh my God, yeah, it's really hard to have a relationship when you're looking through two masks and seeing them through their two masks." In this therapeutic encounter Nico used the image of the masks to illuminate defences and adaptive survival styles in his patient.

Kim.

Kim stated that she worked with images and imagery numerous times in her NARM therapy sessions. There was a particular instance in, which she worked through her feelings of disavowed rage towards her old boyfriend using an image. “I remember this one guy, that same guy that I was dating, who was very, very attractive by our standards, and then like wanting his face to be like Shrek-face and just destroying it kind of. Just really working with it and [the therapist] very much encouraging all that impulses.” Working with the image Kim expressed the anger that she felt towards an old boyfriend and imagined and worked with a meaningful course of action.

Susan.

A powerful image of the therapist holding Susan emerged outside of session. Susan was moving from her home and felt alone and unconnected to her friends, “and then, the image of her holding me showed up, which would have never showed up because I am the most independent.” Susan found this image quite shocking. She described her intrapsychic processes in this way, “And I thought, ‘How interesting,’ and that it didn't repulse me. I didn't go Ewww, what the hell was that about?” Susan reflected that she brought this image up in session and explored it with the NARM therapist. “With the whole stress of the selling of the house and moving and then moving again because the carpets were ruined and this whole mess, I noticed that I felt alone in it because even with my friends I'm not fully connected to them. It keeps me from being fully connected. I’ve got some very good friends, but there was that feeling of alone with going through this stressful time. And then that image showed up of her holding me and allowing me to be supported by her, which was so interesting.” As she was feeling alone,

an image of the therapist holding her outside of session came to her spontaneously. Susan allowed the image to soothe her loneliness.

Jaime.

In her interview, Jaime recalled an image that came to her in a session. It was an image of energy that was protecting her body. In this imagined scene she was protecting herself. “And then the image was attacking my attacker because I had been attacked a long time ago. So in this particular one biological responses of incomplete was then of attacking my attacker through the imagery.” The imagery helped Jaime facilitate the movement of protecting herself; something she had not been able to do when she was attacked a long time ago. “But the image also helped me also just to feel the energy move more completely when I didn't physically need to move anymore. So it was really, really powerful. Those images were very powerful.”

Tamara.

Tamara recalled numerous ways in, which images were used in her NARM sessions. One of the images she worked with was of herself standing at the edge of a cliff. She described the experience of this image as “very moving for me.” Then at other times the therapist would ask Tamara to conjure up the image of someone that she had issues with that she needed to have a conversation with. She described another way images would present themselves. “Also sometimes when I would feel an emotion and then go to the body and get quiet with the body, an image would emerge like of me being a young girl and just twirling around in my dress in the sun and feeling the sun on me. Or sometimes like an image of a random flower might emerge.” What Tamara described

was the way images would appear as she deepened into her somatic, sensory experience. Becoming quiet with her body seemed to invite images.

Summary.

The NARM patients' images are sometimes invited by the therapist, can just emerge from the patient, or are used to convey concepts. When the image emerges, it is often accompanied by an emotion, desire, or need. Whatever is associated with the image can then be explored. Sometimes as the image is explored, unconscious, disavowed, and repressed emotions may surface. Kim's experience of the Shrek image of her boyfriend created an image that represented what she had not allowed herself to see or feel. Engaging with this image allowed her to express a disavowed feeling of anger. Opening to and working with an image allowed Jaime to imagine and experience a successful biologically based self-protective response to an old trauma. As this re-imagining occurred, she experienced a corrective experience of relief. An imaginal experience provided Susan with a much needed sense of support that was contrary to her consciously held image of herself and her way of dealing with the stress of moving. Through this experience she discovered that an imagined likeness of a person could be used to safely work through interpersonal conflicts. The experiences of the participants in this study also revealed that images emerge from the body and its procedural memory and inspire imagined or real physical movements.

The patient experiences a new embodied authentic sense of self.

The psychobiological self is embodied and relational. It is an emerging dynamic process of energy and information flow (Siegel, 2010). One of the existential issues of being human is the conflict between living authentically and dealing with external

familial and cultural expectations and influences. This process of becoming one's self often lacks congruency. These conflicting influences can result in distressing psychological symptoms. Staying true to one's innate psychology and temperament is often challenging. Symptoms can be messages of an underlying experience of incongruence at the level of the patient's felt sense and process of self (Paris, 2007). Although existential angst is part of the human condition, many patients come to psychotherapy to understand and be relieved of these distressing psychological symptoms. If the patient has experienced relational trauma in addition to existential conflict that is part of being human, there will be disavowed or unintegrated parts carried forward from childhood experiences that remain unresolved. The therapeutic encounter can provide a safe container in, which these memories can be remembered, expressed, experienced, and worked with in healing ways (Bromberg, 2011). As the participants described in their interviews, the experience of psychotherapy provided a novel alchemical experience in, which they each were authentically connected to their ever-evolving process of self.

Nico.

Nico was connected to a new authentic sense of self in his relationships. In his words, "I just feel a whole lot more at ease and in command of myself and my feelings. Less anxiety, confidence, happier, more grateful. Really, really grateful for the great relationships that I have." He also spoke about a novel sense of self, which occurred through a process, which involved letting go of distorted identities, fears, and behaviors that no longer served him personally or in his relationships. He described the process: "Well I really let go of my fear of being alone, that I am not going to die, I am not going

to go into some anxiety if I am alone. It was huge. It feels like it's gone. Maybe it'll rear its ugly head again but it's gone right now." This shift in perception continues to have an effect on Nico's relationships today. "I am enjoying it more as solitude and a real sense of security that people in my life that care about me will actually be there. That's a really good thing." He also discovered a passive-aggressive behaviour pattern. "So, I am also letting go of my passive-aggressive self. I still notice it wants to flare up once in a while. I see it now. And then I can decide do I want to do this or not. Hmm, so it's more conscious and mostly I let it go."

Kim.

Kim stated emphatically, "Yes! I can say without question it [NARM] changed my life. It just changed and brought me back to me really." She further explained that by learning about her identities, she could own them and then let them go, which created space for the new to emerge. "This inner awareness supported my self-developing in another way and then the healing was in letting go of those identifications where it's like, 'okay I don't even know it's the water I swim in' and those identifications, or the management strategies. It's like I don't even know another way to do it until I started doing NARM." She described that through awareness and letting go of nonoptimal identities and behaviors she had a felt sense of, "Just glad to know I'm here now, not there. Just this authentic self, so much more."

Susan.

Susan recalled a profound experience in, which she felt connected to a new aspect of herself. Psychologically, she broke free from her introjected object relations. "I think it's happened a few times, but the one I really remember is that one session where he said,

‘The more you embrace your womanhood, the more separation from your psychological father,’ and I really kind of felt like I arrived.” She stated that the therapist made this statement at exactly the right time. His statement created new awareness about how she modified her identity and behaviors to keep the internal attachment with her father. “In the one with Fred, it was really realizing how connected and how maybe I was trying to preserve my attachment with my dad by keeping myself down, because I thought that's what he viewed me as. And that's that attachment connection that we try to hold onto.” This insightful embodied realization was paradoxical for Susan. “After the sadness that showed up from the thought of—and that's what he's always talking about. You break that attachment connection. So the sadness of breaking the attachment connection but then all of a sudden and I had this image of just I really just arriving. Yeah. It was really cool.” Susan became aware of and then released some introjected object relations, which enabled her to feel empowered in a novel way. “It was the emerging more empowered, stronger. Yeah. Stronger in a different way and empowered . . . I've always been strong but more in a defended way. This is more stronger like filling my shoes.”

Jaime.

Jaime described a new sense of self that was actually more familiar than her previous sense of self. Self-acceptance was the key. “Again it was subtle but it was definitely there, and it was in moments of feeling self-acceptance and in this experience of self-acceptance there was a wonderful expansion. And in that experience of an embodied sense of self that was new, very subtle but new and at the same time familiar.” For Jaime, the process was very personal. “Yes, just lit up from the inside. You know. People might not even know that you experience it unless they attune to you, but it's very

much that and has a great sense of peace to it as well. So in a NARM session when I touch into that, that I think is the most precious gift I receive from the sessions. It's really about connecting to who we are on deeper and subtler levels."

Mario.

Through participating in NARM therapy, Mario gained consciousness around his identity and about his patterns in relationships. He discussed insight of a nonoptimal pride based identity that he was present to: "What I pride myself in—of being able to rise to the occasion and do it is very much tied to this identity piece about if I can do this, then you'll love me, that piece." Mario went on to explain that he also discovered insights about his relationship with his mother and the way it affected his psychological early development. "There is a whole series of experiences that have to do with enmeshment and attachment relationship with my mother. That was a very strong piece." He noted the sensitivity of the therapist in working with his adaptive survival styles and identities. "He had to be really gentle around that because that was really touching on very core identities around autonomy, very core identities around attunement and trust." Mario described his process of working with his core organizing psychological principles. "We really were working on the theme, it kept coming up about my relationship with women truthfully and my mother particularly and the sense of what the work that had to get done for me to get in a very cellular way the difference between caring and that sense. And once I could feel the difference energetically, emotionally what the difference felt like in my body, I got the meaning of what it was. Once I could do that, then the whole set of identities that were connected to those patterns were right there. They became available to look at. Prior to that they weren't available. That was huge. A very huge piece. Yeah.

They were just so all mixed in. And that was transformative to release that. That was huge." Mario gained insight into patterns of behavior that were tied to his distorted identity in relationship to women. His sense of identity shifted emotionally and energetically. This shift affected his embodied self in relationship with women. An embodied insight into his identities and patterns allowed him to release them and connect to a new congruent sense of self.

Tamara.

Tamara often felt connected to a new sense of self during her sessions. She described her experience in her sessions in this way: "I can just show up and be me, and that is a new sense of self. I am not looking to please the therapist, which I know was a behaviour I learned from my home. I just know that I can show up and whatever comes is meant to come, and not being afraid to express my true self feels liberating. That is a new part that has not had much space in my life." Tamara described that feeling this congruent sense of self in sessions translated into her everyday life, "I can show up a little bit more in my real life and do that more in my real life because I have that embodied experience of feeling that new piece. I have a memory of that, and then I am able to bring it out into the world." Tamara experienced a congruent sense of self in her therapy session by feeling safe enough to test out the waters in therapy, which then rippled into her daily life.

Summary.

Therapy patients need to process novelty—new patterns of associations amongst conceptions of self. All the participants described experiencing that in some way in their NARM sessions. Nico experienced a process of letting go of his fear of being alone. In

doing so, he was able to embrace his own company. He also released a passive aggressive behavioural pattern, which allowed him to be more authentic in his interpersonal relationships. Kim was more general in her response and reflected simply that she experienced a deeper connection to the whole gestalt of herself. She discovered this happening over time in the course of three years of NARM therapy. Susan experienced being connected to a new sense of self by breaking free of nonoptimal object relations and as a result, she claimed more of her true essence. Mario gained embodied insight of how his early relational experiences of attunement and trust with his mother affected his relationships with women today. In having a felt sense of this pattern intellectually and energetically he could release it. From this different embodied perspective he was able to engage in relationships with women more authentically. Jaime described that the gift of NARM was her experience of being connected to a new sense of self that she was familiar with on some level. She felt expansive as she connected with this sense of self. Tamara explained that she could be her authentic self in therapy without any censorship. Given her autonomy adaptive survival style, this was a novel experience for her. Feeling this sense of authentic embodiment in session inspired her to live it in her everyday life.

The patient's personal resources are highlighted.

There are numerous ways the therapist can tap into the patient's internal or external positive personal resources and capitalize on positive affect in the clinical dyad (Heller& La Pierre, 2012). Somatic psychotherapies highlight resourcing mechanisms as a way to bring the patient into a state of safety and comfort. This can be done through dyadic social engagement that focuses on somatic mindfulness with the use of inquiry, tracking, contact and direct suggestions (Levine, 2010). Personal resources, which can

exist in all domains—cognitive, emotional, and physiological—can tap into positive affective states in the moment or a positive memory. Utilizing resourcing mechanisms in the clinical dyad supports nervous system regulation for the patient, which creates an organized secure base for the patient from, which to explore relational trauma (Heller & LaPierre, 2012). As the informants described their experiences, the therapist named or worked with psychological or physiological positive resources to connect patients to their positive inner feelings of safety, strength, comfort, and optimism in an effort to restore the patient's psychobiological state to balance. These are not abstract mental states of well-being, but embodied experiences of positive feeling. The embodied aspect of this experience is an important distinction between NARM and other forms of therapy.

Nico.

Nico's internal personal resources were highlighted in his therapy. He described it in this way, "I had done a video for Tom, adding subtitles—for class—and he really got how much I put my heart in that. And I felt really seen because putting my heart into my work is something I really like to do and it's really a strength of mine. That was a really healing event to have him really see that and speak to it and then acknowledge it."

Kim.

Kim described a few exchanges, which her therapist intentionally directed her to a positive resource. She recalled the therapist's invitation to use a somatic resource, "always resourcing, always ground yourself if you need to, take a moment, slow down." The therapist would also highlight an internal resource that she had cultivated. One example she described was when she did not use her adaptive survival pattern: "Any time I would do things that were not in my survival style or challenging my survival style, he

was really, really supportive. Highlighted, yeah. Like just I would have to stand up to someone, a teacher. I was studying the model then and so he was like, it's was an opportunity to not use your survival style and he would bring it in that intellectual, which helped me a lot." Similar to that premise, Kim noted how the therapist supported her adaptive positive resource of her adult self in sessions, "When the adult would come through sometimes, it would just be there half a second and then it would go. But he'd catch it and he's like, its really interesting cause it's there and now it's even gone again. Even as just attention would be brought to me or to it, then it would get Uh-huh someone is seeing me! And it would go a little bit. He was really supporting that adult." Another way that Kim felt that she experienced the impact of highlighting her positive personal resources was when the therapist adhered to a neutral stance, "Yeah always, even where it was a true expression of emotion. Even the collapsing was never judged. It was always just It's okay to let that emotion be there or naming the emotion."

Susan.

Susan reflected on the distinct manner in, which she experienced acknowledgement of her personal positive resources. She described that the therapist acknowledge her internal explicit adult accomplishments. However, what was critical for her was in how they explored the perspective that her internal personal resources enabled her to survive the failures of her early environment: "We've explored more my resources as an adult, everything that I have done. But I think that's another advantage of this type of therapy. You're exploring actually your defenses as a wonderful resource that now maybe is working against you but none the less, it's a resource. It's not seen as a bad thing. That's really interesting, also a different way of exploring resources."

Jaime.

Jaime recounted her experience of the therapist tapping into her physiological personal resources through a somatic lens. She expressed how the therapist facilitated her connection to inner feelings of strength and comfort: "Keeping it slow, physical connection in presence and verbally attuning, asking if I was okay. I could sense he was observing me, feeling me very, very carefully and also keeping me socially engaged, I was noticing that as well." Jaime explained that the therapist skillfully highlighted Jaime's social engagment system when he witnessed it, which supported her psychobiological organization in session.

Mario.

Mario depicted his experience of personal resources in that the therapist honoured and trusted his talents in spite of the perception that Mario believed that the therapist had witnessed him at his worst. The kinds of having been so like really seen at my worst by him, having him say to me at some point, who else would he have come to coordinate his trainings, or with the finances—like, I completely trust you about these things, those sorts of stuff. That combination of having that sense of—that's really where I got the sense of not being judged." This exchange of Mario's whole gestalt being seen and yet still the therapist trusted Mario tapped into Mario's personal positive resources.

Tamara.

Tamara shared that her personal strengths were most certainly acknowledged and delved into. Even behaviors, patterns, or characteristics that Tamara judged about herself were given a different perspective. "I remember my strengths and personal resources being highlighted or even something that I would think, judge myself as being bad, the

therapist would always bring to my attention the flip side of the coin. Like the good part of that behaviour, that it is not just all negative or that maybe it served a purpose. That was quite enlightening actually." When Tamara felt crushed with affect, the therapist brought in the image of an external personal resource. "I can recall the therapist bringing in a solid relationship of mine when I got overwhelmed with emotion. Or when I had strong feelings, she might ask me if I could recall almost the opposite of what I was feeling, which I noticed would bring some relief." In these interventions an external resource was called upon in session to support Tamara feeling safe.

Summary.

The NARM participants all had experiences of the therapist highlighting or utilizing an internal or external positive resource. For Nico, a positive cognitive personal resource was being seen, acknowledged, and validated by the therapist. Being seen in this way supported his sense of a coherent self. Kim shared that the therapist used positive physiological resources to ground and regulate her nervous system. Susan recalled that the therapist suggested that her adaptive survival style was actually an internal positive personal resource, which allowed her to cope with the failures in her early environment. Jaime stated that the therapist noted her internal physiological resources while in session. This enabled her to stay psychobiologically organized. Similar to Nico, Mario described the process of his whole self being witnessed. The therapist's reflection and highlighting of his internal positive resources inspired self-love. Tamara's internal cognitive resources were highlighted. The therapist facilitated Tamara seeing those aspects of herself that she thought negative through a nonpathologizing lens. She also recalled the way her therapist would enlist an external positive emotional resource from her past when Tamara was

overwhelmed with emotion. Accessing this experience from her past resulted in affect regulation and re-connection to self in the moment. The NARM patients' descriptions of their experiences of positive arousal, which showed up in various forms, amplify this dynamic. The therapist's neutral stance towards something the patient perceived as negative supported an integrative sense of self. The informants indicated they experienced safety, comfort, and affect regulation by utilizing resourcing mechanisms in their sessions. This allowed them to explore their traumas, symptoms, and identities from an organized felt sense.

Metaphor supports the patient's process.

When used in the clinical dyad, metaphor is a symbolic tool that can connect the patient's present affective state with unconscious memory. Through this linkage, meaningful insights often emerge (Modell, 2005). The allegorical quality of metaphor has the ability to synthesize intense emotions into words, which can provide affect regulation and organization for the patient (Paris, 2011). The multidimensional and divergent qualities of metaphor can offer support for the patient's integration as it weaves emotions, soma, and cognitions (Pally, 2000). The NARM therapy patients recounted the use of metaphor in their sessions and explained how the use of metaphor supported their therapy process.

Nico.

Nico emphatically claimed, "Yeah, I do recall there were metaphors, and I tend to like metaphors a lot, so that was helpful." He further explained from his engineer's perspective how metaphors supported the therapeutic process. "You want to use the simplest map that will get the answer that you need. You don't want to use a way

complicated map if the top-level approximation model would answer it. So metaphors are like that simple approximation of reality. That's what I like about them I think. Yeah, they create a map that simplifies a complex situation. Yeah, crystallizes it into a really clear single point, which has a real beauty." Nico also recounted how metaphor amplifies and deepens one's understanding. "Sitting with it and you know speak in some metaphor, analogy that—that deepens it or some other aspect, how it might come into play in my life also deepens that particular one."

Kim.

Kim recalled a specific metaphor that symbolized a coping mechanism she used in her life. The metaphor emerged and she used it in an imagined movement with her jaw, "there was some other crazy one of like destroying things with my jaw. And an Albatross, that was maybe a metaphor, actually that was definitely a metaphor, kind of in the autonomy survival style, being burdened and there was this albatross on my back, and then working with that weight. Then at some point it turned into this flesh and I destroyed it with my teeth." Using this metaphor allowed Kim to imagine ripping apart an adaptive survival style that she no longer needed and was a burden.

Susan.

Susan explained how metaphors exemplified the unified gestalt of psyche and soma, "because metaphors do of course show up that help with the whole—with everything that's going on." She believed that metaphors originate in the body. She described the potential of metaphor in the following way: "I think metaphors are so powerful and so often they just show up. It's not random. It's—your body kind of creating that image. Because they're not random at all."

Jaime.

Jaime described a process in, which the metaphor of the acceptance of death was used as an analogy for acceptance of what is: “Recently there was another one we talked about that was in the acceptance of death or like a disease that will take, that is terminal. Just in the acceptance of that, because there's really nothing one can do about that, or death that's imminent. There's an acceptance in that and in the acceptance of it there's a freedom. So we're using death as a metaphor, actively dying as a metaphor to accept what's happening inside and around us.” She explained that this metaphor was particularly effective for her as she works with dying patients, “That helped in the processes. That metaphor, yeah, that went along with that, acceptance of the self and things that were happening, just in life in general. And we used that in my situation just because of my connection with death or dying.”

Mario.

Mario reflected on the use of metaphor as a way to highlight energetic shifts. “The metaphors around energetics, about the bottom up top down energetic movement, how that is and how that's connected. That becomes a very lovely way in. If I notice, the elevator would go back up again, that sort of thing. Those two parts, noticing it . . . I mean that's very helpful to notice.” Here he described the process of using the metaphor of the elevator going up and down to reflect his energetic and emotional pendulations and contractions, “And sometimes the rapid pendulations that take place with it. There's a movement energetically where the elevator is going up but there's also a restriction pattern that's taking place simultaneously.” Mario reflected that when using metaphors to note shifts in the patient’s energy, it can illuminate nonverbal implicit processes, “There

is some noticing, being able to notice the metaphor of the energy, that the way back in to the other pieces that are un-invisible at the moment. It's that crack in the egg issue. Once you get that crack in it—metaphor is really helpful that way—then you can begin to see what's behind it."

Tamara.

The use of metaphor crystallized Tamara's feelings of overwhelm. "There was one session I can recall where I was so overwhelmed with being everything to everyone. My family was really pulling at me and my work and I just was feeling this huge pressure and the therapist brought up the metaphor of me being superwoman and how on some level that must serve me and that it was ok to take that superwoman suit off." When the therapist had Tamara enact an imagined movement of taking that superwoman suit off, it acutely resonated with Tamara and she cried with relief.

Summary.

One important theme emerged from the data; in NARM therapy metaphor is a seminal symbolic tool in the intersubjective dyad. As Nico stated, metaphor can represent an amalgam of cognitions, affect, and sensations, which can crystallize where the patient is at a particular moment. For Kim and Tamara, metaphor emerged as a way to work cognitively and imaginatively with adaptive survival styles and embedded patterns and behaviours. Susan proclaimed that metaphor provided words and expression to the somatic unconscious. Jaime stated that the right metaphor, one that the patient has a personal association with, could support processes of gaining meaningful insight. Tamara's recollection illuminated how metaphor could animate emotions. The metaphor, worked with through movement, supported the expression and release of affect. Mario

highlighted how the use of metaphor can bring awareness to the patient of unconscious processes.

The therapy experience is titrated.

Titration is an intentional course of action in, which the therapist intentionally slows down the process that is emerging in the clinical dyad. This term was originally used in chemistry and "refers to introducing the smallest amount of incompletley processed traumatic material to bring about a given affect" (Paulsen & Lanius, 2014, p. 368). Peter Levine used it in his theory of Somatic Experiencing, and it also is a seminal tenet of NARM therapy (Levine, 2010). The mechanism of titration carefully and slowly allows phenomena to express at an appropriate level of intensity for the patient. Titration is used to avoid unnecessary distress, flooding, and potential re-traumatization (Levine, 2010). The NARM therapy patients all mentioned the use of titration of their process in some form. All of their responses to various questions demonstrated that this common theme was of seminal magnitude.

Nico.

Nico explained that his therapy experience was titrated. It often took him time to make associations. He described this process as one that kept his therapy experience gradual: "I did need to cause some of the stuff that Tom was digging for in the way of feelings takes a little while to connect with and for potency to grow for me. So yeah, I did need to slow down a little." He stated that the therapist was efficient in managing the pace of the session. "He was pretty good at facilitating that. Not rushing, going deeper and exploring around the edges of it. The time and sort of recognition of what was actually coming up."

Kim.

Kim reflected on the different way she experienced titration in her NARM therapy. The first one she described was the way her NARM therapist used questions and directions."Yeah he did, and grounding. And stretching out, like if I would say I feel calm, any other words for calm? He would help to just take your time with that let yourself really experience that." Titration assisted Kim in her endeavors of grounding and her ability to be with emotional material. Using titration supported her process of integration with the body. Over time, she learned to ground as a way to slow down her process on her own. Kim recalled specifically that when they would touch on meaningful material, "Yeah I would get spacey, really spacey or foggy or like vision changes and then really being able to notice that myself and then slow down and take time." Through Kim's perspective, the therapist's curiosity encouraged deep reflection. This required time, and is another stanchion of titration. "Your ego's being challenged—he doesn't really say it like that, but just like, Um-hmm curious about that, what just got opened up, what stirred, . . . and then really it's taking time with that to let it . . . and he would do a lot of resourcing in those moments." In this way, internal somatic resources were incorporated as elements of the titration process.

Susan.

Similar to Kim, Susan shared how mindful inquiry and directions from her NARM therapist activated a co-regulated intersubjective field of titration. "I think any time I started the session with, I noticed that I get upset when this happens, and then he slows it down. What are you noticing in the body as you're thinking about that happening and that ties into maybe a memory from the past or even just slowing it down and what

you're noticing." Once again the process of integration was mentioned as a by-product of keeping the therapy experience slow, titration of the experience. Susan described the effect that titration had on the integration of psyche and soma. "I think the slowing down process is the key to the healing because it slows the nervous system down enough to do what it naturally is supposed to do. We talk in talk therapy about our issues. But it doesn't shift that quickly or that profoundly or . . . You know what I mean? I can observe it but just from what I feel is I'm noticing my body doing something, which in talk therapy you don't. . . . It may be happening but because you're talking, then you're on to something else and the nervous system gets stuck again, because you're on to something else." Susan fine tuned her description to include the nervous system. "I think that is at the core of the healing is you look at slowing it down. It slows down the nervous system enough to do what it needs to do, which is what Peter talks about. How do the animals in the wild release that fight or flight? They almost got killed, but they didn't. That's how you release that energy and they take the time to do that and we don't."

Jaime.

Jaime worked through a traumatic experience in one of her NARM therapy sessions, and she proclaimed that slowing down her proceess was of seminal importance so as to not get overwhelmed with emotion: "There was one other thing that just went through my mind that was very important—oh and just continued to keep things slow because the incident I am talking about was a big, big movement of energy and anger that was coming through my body. So he really made sure that I kept that, slowed down enough; because if that comes through too fast it is overwhelming." Jaime further highlighted that certain questions that the therapist asked assessed if the patients somatic

and emotional reactions were manageable: “But it was really pretty useful having the therapist there, helping to slow it down I am sure. That he was facilitating that slowdown. I was aware of needing to slow it down but also very aware of his participation and making sure I kept it slow.”

Mario.

Of all of the participants, Mario spoke the least about his thoughts on titration, yet he explained that the therapist always paced his sessions.

Tamara.

Tamara the school teacher explained how she would come into therapy reeling from her everyday life. The intentional art of questioning used by the therapist helped slow down Tamara’s experience. “Often I would come into session going a million miles an hour. And I began to notice throughout the sessions how the therapist would really slow me down through asking me questions that inspired me to really think and feel and often she would ask if an emotion came up, “Is it ok to sit with this emotion right now or say give yourself time to feel what you are feeling?” Similar to the other participants, the therapist used titration to assess the pace of the therapy and determine if it was working for Tamara. This allowed the time necessary for emotions and cognitions to integrate with her body. “I would notice that then my body had time to connect more with what I was feeling. I do not have exact words for that experience but it felt kind of like a settling in.”

Summary.

Having a titrated therapy experience occupied a central position for each participant. Susan, Kim, Tamara, and Jaime all mentioned that the therapist asked certain

questions that assessed their current state. This created containment for the process and supported organization of self. For Nico, the titration process unpeeled layers of affect and gave him time to connect with these emotions. Kim mentioned that the invitation to settle and ground her psyche and soma supported regulation and integration. She stated that if the therapist witnessed her disorganization, he asked questions, which helped slowly uncouple her judgments and thoughts. This titrated process provided a strong enough "here and now" experience, which is critical when working with relational trauma. Susan specifically added that the effect of slowing the process down supported the psyche soma connections. The titration process allowed her body to meet with her mind. She believes that this integrative process is at the root of healing. As Jaime worked through a traumatic event, she noted how the therapist proceeded in a titrated way that allowed her to manage her emotions and prevented emotional overwhelm. Tamara also mentioned the therapist's use of open-ended intentional questions and ability to assess and contain her process, helped create a more secure felt sense in the present.

Relational patterns are explored.

This theme might seem fairly straightforward—the idea that relational patterns were explored—but what was striking was the shift in present-day relational dynamics, which occurred through this embodied exploration in NARM therapy. The quality of a person's life is directly correlated with their relationships. The patient's interaction and exchanges in her early environment with her primary caregiver are imprinted in the child's psyche and soma. These dyadic intersubjective experiences affect her implicit representational models and embodied felt sense of self, which, shape behavior, experiences, and expectancies in interpersonal relationships. In response to less than

optimal early circumstances or relational trauma, children learn to discount their emotions, create coping mechanisms to deal with their environment, and to disown the parts of their personality that have attracted disapproval (Renn, 2012). These normal human responses create internal working models of shame, identity distortions, and adaptive survival styles (Heller & LaPierre, 2012). Even though these subjective beliefs and habituated ways of being are often unconscious, they are the templates for one's relationship to self and others. As Bowlby (1969) discovered, its impact on the structure and organization of self is felt throughout the life span. The participants all shared their exploration of their attachment schemas and templates and the awareness they gained of their relational patterns through NARM therapy.

Nico.

Nico became aware of his autonomy survival style through NARM therapy. This survival style is a self-organizing principle, which involves pleasing others at the expense of oneself. This can lead to quiet resentment that does not get expressed. "It really became much clearer . . . the autonomy pattern. The fear of abandonment and the connection style, and the fear of not being able to be truthful and real if it disagreed with them would be something that would get them angry." Nico also discussed his connection style pattern and his understanding about the trouble people experience using this adaptive survival style have connecting to themselves and others. "The connectivity, the connection patterns. That was pervasive in my adult relationships with other people." These relational patterns according to Nico created fear, which would affect his relationships. Through his experience in NARM therapy he gained awareness of these patterns. "Yeah. I see it a lot clearer, which means I have to act on them. I can't just act

out the pattern anymore. A bunch of crap. It makes life harder. Yeah, then it integrates. And so much nicer."

Kim.

In her response, Kim was very specific about relational patterns that were uncovered and worked through in her therapy. In her first example, she described a romantic relationship. She reflected on the way she re-enacted patterns that were created in her early environment in that relationship. "I was going through a breakup and we had broken up, but we really spent another year trying to break up and that was when I started therapy with Mario. So that was really one of the first topics and how much I surprise, surprise, I took responsibility for everything and his pattern was more towards blaming, You're the one who's not connecting, you're the one who's this that and other and how I just willingly accepted that as true, It must be me. And then as I got more connected then the relationship really ended." In another instance Kim described her relational process at County Mental Health. She shared how that experience supported a core organizing principle of being the chosen one: "Then just in the process of allowing myself to leave County Mental Health, where I was the loved supervisor and it was big deal to be the golden child again in my workplace, I was the golden child as well much of the time, and I am getting hot even talking about it. It's like Oh my god; it's the golden child thing. But just saying no, I want to do my private practice. I don't want to work in this environment that's awful and stressful and depressing, and I want to do the work that I care about and love. I got to do pieces of it there but not everything. It was a big move and it was because of NARM." As she thought about it, she realized that through her NARM

therapy she became aware of identities that she embodied that affected how she interacted in her relationships and at work.

Susan.

For Susan, relational patterns were not an area that she had delved into in great detail in her therapy. In her therapy she did recognize a pattern of how she kept herself disconnected from others. “With others meaning just anybody, like friends and—I think not completely yet just because we've just gotten into this but I think that that sense of when I found myself feeling alone, even though I had friends that said, Hey, I'll come over and we'll do this and stuff, it was noticing how I keep myself from being fully connected to people. So that's part of exploring the relational because I don't let myself do that. Yeah to feel fully connected to people.” Susan reflected on a pervasive relational pattern of not needing others or leaning into others for support.

Jaime.

Jaime reflected on two epiphanies that she had about her relational patterns. The first one was that she chose a partner who did not attune to her needs. She saw this as a re-enactment of the relational patterns in her early environment with her parents. She reflected, “And it's interesting that my relational patterns of today are similar to relational patterns from the past. One of the relationships that we're looking at today are like oh yeah, this person's certainly not attuning to my needs within that particular relationship. Still, I somehow chose somebody who is similar to my parents in the way that they weren't directly in a relationship. It was more their needs than my needs and of course I continued on with, I know their needs must be more important. Just because those are maybe one of the things that come out of not having your needs attuned to when you

were younger." She also described a shift from child consciousness to the adult consciousness she experienced through her NARM therapy. She described a process of taking responsibility and having more agency in her relationships. "What came to light more was this. In relationship, when there's a struggle or conflict or something difficult going on, what was really interesting for me to understand about myself is how I enable that to continue. So I might find myself complaining about it or complaining about another person or in the relationship, then I will realize then yeah, but I am enabling it by continuing to participate in it." She continued describing this shift to adult consciousness in relationship: "Oh yeah, I may want to stop doing that. If I want these things to change, then it's really I need to change myself. It's not the other person. Of course. And we know that, but when it comes really down to feeling that emotionally and in the body and so forth . . . Yeah, it's different."

Mario.

Mario described a protective pattern that he enlisted when he felt threatened in relationships: "Well, what becomes really clear to me is how, when there is any kind of emotional threat in more intimate relations, that I go cognitive. There's a feeling state that's there and the protective patterns to go to begin to go into understanding linguistic—like, well you said this, which doesn't work so well." As Mario described, when he felt emotionally vulnerable, he defaulted to cognitions, which numbed his painful emotions.

Tamara.

Tamara shared that she became conscious of the expectations and projections in her interpersonal relationships. "I think that in my personal relationship, especially with my spouse, what I realized was that we would have an interaction—or I'll give you an

example. Let's say during the week, I would feel that my spouse was not giving me attention and I would kind of play this tape in my head about that. But then what I would do is I would witness me playing that tape and instead of acting on it and confronting him, I would stay quiet and just watch what happened." Here Tamara specifically described how through her awareness of a pattern she could become a witness to her process and not just react. She further explained how the dynamics of her intimate relationship changed as a result of becoming conscious of this pattern. "What would happen is, because I was able to witness it and watch it, he would come to me and say, Oh my God, I was so stressed out this week. So his withdrawal had nothing to do with me. It just had to do with these old patterns of relationship that I was enacting. I also recognized that I would have an expectancy of what he was going to do and that he would catch it as if it was a cold and actually fulfill that expectancy. But when I was able to witness and have mindfulness about what the expectancy was and not hold onto it, the whole dynamic would shift."

Summary.

All of the participants recognized adaptive survival styles or identifications that were shaped through their exchanges with their early environment that created their relational schemas and the way they re-enacted these patterns in their present relationships. Nico described becoming more conscious of his autonomy survival style and the way it affected his authenticity in relationships and affected a pattern of passive-aggressive behaviour. He also recognized his adaptive survival style of connection. The way he engaged in his relationship to self and other was a result of this adaptively created bubble of fear. As these coping mechanisms became crystallized in his awareness and his

fear dissipated, he reflected on how he could no longer just re-enact patterns. This created a space for his more congruent self to integrate. As a result, his relationships were richer. Kim spoke of relational templates that she had re-enacted. She noted one in particular—taking full responsibility for all aspects of a personal love relationship. As her awareness expanded, she saw how she repeated the attachment schema of the golden child in her job at County Mental Health. As she became more connected to her own needs and gained awareness of these coping mechanisms, the identifications that she took on in her relationships shifted. Susan explained that she had not delved into relational patterns in great detail. However, she had become aware of her connection style pattern. She came to realize that using this adaptive survival style kept her from fully connecting to others. She noticed this when she was moving. When she felt overwhelmed as she moved, she saw that she did not reach out to others to soothe her. Instead, she chose isolation. She saw how this relational schema infiltrated her NARM therapy. She described a time when she experienced disconnection outside of session. An image of her therapist holding her came to her. This led to touch therapy on the table where she had epiphanies about being able to yield into a person's touch. Jaime and Tamara experienced similar eureka moments with regard to their interpersonal relationships. They realized that they re-enacted early attachment schemas in their present relationships. They discovered that through awareness and connection to self, they could shift out of child early attachment schemas in their present. Changing their expectations and behaviours shifted their relational dynamics.

The patient's movements are enacted and processed.

Somatic psychotherapies recognize that moving the body can be another support in the therapeutic process, as it plugs into the body's natural wisdom to execute action (Ogden et al., 2006). Movement is another bottom-up clinical intervention that works with the body's felt sense or internal body sensations to process emotions and memories (Chodorow, 1999). Working with movement can involve the therapist commenting on and working with gesture or inviting the patient to enact physical movements. Often in the face of overwhelming trauma, one's physiology becomes frozen, and the pain and suffering are embedded in the energy in one's biology (Reich, 1945/1972). Through utilizing movement, the patient can act out impulses or responses, which supports discharging frozen energies and creates a different felt experience during and after the movement. As described by the NARM patients, cognitive and emotional processes were embodied and re-worked physiologically through movement.

Kim.

Kim described a time in her therapy when she was feeling angry. Her therapist had her push against a pillow to express the energy of anger. As she did so, she experienced the implicit emotional processes that were embodied in this anger. "Yeah, I mean he always had a pillow, so it was like you're pushing the pillow instead of him, but some specific physical things like that, but not a lot necessarily. And then always, What do you notice?" Kim stated that the therapist always asked her about her embodied felt sense after she had completed defensive or protective movements.

Susan.

Susan described a similar process in, which the therapist encouraged her to use the body to work with energy that had not been resolved or discharged. “Yeah. It was sometimes—beginning with Fred, I explored a fight movement and he actually put a pillow and I pushed against it. In a fight kind of response. Yeah. I think that's the feeling that I can recall.” She elaborated on the value of allowing the body to successfully complete an impulse or movement. “It really takes advantage of that piece and so we can then really, from a body sense, experience how liberating one feels after you're able to fight back, for example. Finishing stuff.” She explained how working with these physiological, procedural memories allowed her to have a corrective felt sense in her body of what she originally experienced. Tapping into implicit procedural memories allowed Susan to have the embodied empowering experience of what it felt like to fight back. Through asking Susan what she noticed after she completed this biologically based defensive moevment, the therapist is linking her new empowered interoceptive awareness with her felt sense of self.

Jaime.

Jaime recalled a time when moving her body led to the successful completion of unfinished physiological processes: “There’s actually some times when there were incomplete defense mechanisms that came through in movement in my arms and legs, which moved quite a bit, and my jaw. You know like in biting. And these were all very protective; self-protective movements that needed to complete that were incomplete in my body systems. So when I started to move, they were movements of completion.” She linked this frozen immobile initial response to her attack with the sense of

disempowerment she felt throughout her life: “And also realizing [that] in the past it had been confusing to me sometimes feeling like quite an empowered person anyway, but there's been moments in my life where I haven't acted where I would have liked to have done and it was sort of confusing to me why didn't I speak up or why didn't I make a movement.” She further explained that finishing an uncompleted biological response enabled her to integrate that frozen energy. “As I came out of that freeze response, immobility response, I was able to move that energy that was frozen that it split off, And once that begins to integrate, move in my body, and then there was such a greater sense of self-agency in that strength, of self-empowerment.”

Mario.

Mario commented on movement through a different lens as he discussed how the therapist noticed and commented on his movement. He stated “Movement all the time, stuff that's going on and noticing that. I noticed that we did this. I notice that you are clearing your throat more. Some of these types of patterns.” Mario made a salient point. He believes it is not enough just for movement to be enacted or noted. It needs to be linked with emotions for it to be useful in therapy. He further described how people could sometimes go to sensation or movement as a defense against feeling, “So my sense has been we do so much, various things that we do to regulate and to hold space and to communicate that where somebody who is just dealing with the somatic piece and not holding onto the underlying emotion and the identity that's connected to it, whatever the theme is that's being explored, that when that—the movement is really not consequential at that moment.”

Tamara.

Tamara described how she had spoken about when she got mugged as she was walking to her car during her time in college. “I can recall the two men grabbing my bag and me wanting to run after them but I was so shocked that I could not move.” Tamara reflected how the therapist asked her if there was any thing she wished she could have done in response to her attack: “I really wish that I would have run after them and gotten my bag back as I had a very sentimental necklace in there that my mother had given to me.” Tamara described that the therapist asked her to move her feet really fast as if she was running after them now: “I moved my feet for a good 5 minutes in session and then I mimicked grabbing back my bag and then I surprised myself with a kicking motion towards the men.” Tamara said that after those movements she felt a sense of accomplishment and calm that felt great.

Summary.

The female NARM patients recalled movements in, which they pushed against a pillow, kicked with their legs, and bit with their jaws. Kim was able to express anger that she could not express in her romantic relationship when she pushed against a pillow. Susan explored a fight movement. She explained that she felt the liberation and the pleasure of the completed action afterward. Jaime described movements of kicking and biting that were protective movements. Embodying, feeling, and expressing these movements completed a physiological response to being attacked. She explained that when the attack happened, she was immobilized, and her energy was frozen. She believed that as she enacted these protective movements in therapy, her energy thawed and integrated. This affects her sense of agency today. Tamara described movements of

running and kicking her feet in response to an attack and afterwards feeling an energetic corrective shift of deep relief. In all of these experiences, the NARM female patients revisited a procedural memory and then used movement to create a new embodied memory one in, which they experienced agency. Mario explained how the therapist commented on his nonverbal movements. He described the importance of including emotions as one explores using movements.

Summary of the Common Themes

It might be helpful to briefly recapitulate the common constituents that were identified in the lived embodied experience of being in NARM therapy before moving on to the structural description of the experience.

The patient connects to his inner experience of emotions, thoughts, and sensations.

The informants reported that they were connected to their vast inner landscape of affect, cognitions, and somatic dynamics through specific open-ended questions that the therapist used to inquire about their direct multidimensional experience in the present moment.

The therapist finely attunes to the patient.

The presence of the therapist's genuine curiosity and neutral stance coupled with a mindful exploration of what was happening for the patient in a nongoal oriented way facilitated an intersubjective field of resonance. This elicited a rich sense of being seen, heard, and feeling felt for the whole gestalt of the patient.

The therapy experience is present focused.

Each of the informants expressed that the present moment and all it entailed was at the center of their therapy. When the past was brought up, it was linked to how it informs the NARM patient's experience in the here and now. This supports the skill of dual awareness.

The body and its experiences and sensations are tracked and incorporated.

The participants reported intentional embodied inquiry and exploration of their body and its gestures, expressions, sensations, and movements.

Images facilitate the patient's process.

The informants found that images spontaneously emerged from psyche and soma, were also invited and then amplified to express affect, discover affect, and were engaged with to express what the patient needed in the present.

The patient's movements are enacted and processed.

In the NARM therapy, dyad movement was experienced as an intervention that worked with the body's felt sense, energy, and internal physical sensations to process affect and to re-work unfinished physiological responses from the past in the present moment.

The patient experiences a new embodied authentic sense of self.

There was a felt sense among the participants of having gained awareness of their intrapsychic, interpersonal, and somatic dynamics. Through this multidimensional consciousness they gained an authentic connection to themselves, which created an embodied novel felt sense of self.

The patient's personal resources are highlighted.

The participants explained that their cognitive, emotional, and internal and external physiological resources were highlighted. Accessing these resources facilitated an embodied experience of safety, comfort, and psychobiological organization.

Metaphor supports the patient's process.

The NARM patients found that metaphor emerged from psyche and soma and was a seminal symbolic tool that synthesized and linked implicit affect, cognitions and sensations with words.

The therapy experience is titrated.

The informants expressed that the NARM therapist intentionally paced the emergent process in the clinical encounter. This allowed them to notice their process. They stated that this titration of experience prevented feeling overwhelmed and supported affect regulation, which they thought facilitated body and mind integration.

Relational patterns are explored.

In the NARM therapy encounter, awareness of the way the participants re-enact their attachment schemas in the present was illuminated. As a result of this insight, they were able to become a witness to the invisible dynamics that are at play in their relationships with self and others. This new awareness created a shift in their present relational dynamics.

Techniques.

A structural description, which illuminates the general patterns of the lived, embodied experience of being in NARM therapy, follows. It is an amalgam of all of the informants' data distilled though the common constituents that are described above. The

structure conveys what is typical and psychologically essential about the phenomena of the lived embodied experience of NARM therapy. It is expressed in psychological language.

The lived, embodied experience of being in NARM therapy comprises a psychobiological therapeutic approach in, which the patient is invited to explore the inner experiences and dynamics of their cognitive, emotional, somatic, and relational processes of self in the present moment. There are numerous top-down verbal and bottom-up nonverbal mechanisms that support this therapeutic action. The patient's sense of emotional safety is primary and is facilitated by the therapist using open-ended questions, accepting language, and a neutral stance. This creates a secure foundation from, which to explore the cognitive, emotional, somatic, and relational processes of the patient's experience. The therapist uses mindful inquiry to assess the patient's current emotional state and paces the patient's experience to support emotional and physiological regulation. As the phenomenon of the dyad unfolds the patient's external and internal positive personal resources are highlighted, and this mechanism of resourcing is utilized to connect to the processes of self that are more organized to support the patient's affect regulation. Somatic mindfulness of the patient's body and its "here and now" felt sense, sensations, gestures, and movements are foundational in this exploration of self, as they offer insight into implicit processes. This mindfulness supports nervous system regulation. The patient is invited to move his or her body in the present moment to have an embodied felt sense of completing unresolved physiological actions from the past in the present moment. Within the therapeutic dyad, images and metaphors emerge or are invited. These images provide access and information to the patient's emotions, thoughts,

identifications, and attachment schemas. Engaging with these symbols in the "here and now" facilitated a shift in the patient's felt sense of self. Through this exploration of self, NARM patients gain awareness of their adaptive survival styles and the identities they use to manage their early environmental failures and experiences of attachment. Through this embodied awareness they come to understand how their childhood relational experiences affect their identity, behaviors, symptoms, and relationships today. Through this illumination of processes of self, the patient can be mindful yet not identified with their coping mechanisms and defenses. This leads to a new sense of agency and fosters resiliency. This new connection to a more regulated, organized, solid sense of self affects the patient's capacity for aliveness, vitality, and authenticity as they individuate. In conclusion, this research suggests that the embodied lived experience of being in NARM therapy is life changing.

Poststructural Discussion

In this poststructural discussion, the researcher reflects on the processes of the lived embodied experience of being in NARM therapy and links the elements that constitute the experience with some of the theoretical underpinnings that were discussed in the literature review. This chapter will conclude with some final thoughts on the transformative powers of using a clinical holistic focus one that values the whole gestalt of the patient in the therapeutic dyad. A somatic depth psychotherapeutic lens will be used throughout.

The clinical process of being in NARM therapy.

After synthesizing and analyzing all of the interviews, the data illuminated that the lived experience of being in NARM therapy is a dynamic, multifaceted, complex

exploration of processes of self. The research demonstrates that the NARM therapeutic experience utilizes both explicit interventions of verbal, deliberate, top-down, effortful, nonlimbic, objective, and slow acting processes as well as implicit, nonverbal, automatic, bottom-up embodied, relational, contextual, and fast acting processes in the present moment. The modification of the embodied expression of self and its conscious and unconscious psychobiological dynamics is created through nuanced diverse verbal and nonverbal elements. The constituents that emerged from the research demonstrate that NARM theory and its clinical applications have integrated principles of depth psychology, mindfulness, attachment theory, neuroscience, infant research, and somatics. Salient aspects of these theories are woven together to work holistically with the psychological, physiological, and relational aspects of self.

Most of the psychobiological constituents that emerged from this research were extensively explored in the literature review. The first constituent that was identified was the *patient connects to his inner experience of emotions, thoughts and sensations* is the basis for all psychotherapy. This connection is more nuanced in NARM than in more traditional psychotherapy. The NARM therapists invited their patients to connect to their direct experience of self in the present moment. All of the informants experienced connecting to their direct experience of self in the present moment when asked "what are you noticing *now* in your experience as you say that?" The accepting language and open-ended questions that the therapist used were of seminal importance. Each participant described the way this use of language supported an adult-to-adult exploration that simply illuminated the patient's-intrapsychic and interoceptive dynamics. In the clinical

encounter, as the patients narrated their symptoms or interpersonal issues, the therapist used this type of inquiry to help them connect to their direct experience of the moment.

Participants stated that a key component of NARM was the incorporation of the body and its felt sense and sensations. The body is intentionally supported in NARM. Through this embodied inquiry, the body becomes a gestalt in the meaning making process. The data demonstrated that the NARM therapist facilitated the process of keeping the patients nervous system regulated as the dyad explored their manifestations of relational trauma. Thus, somatic, emotional, and cognitive internal dynamics were all explored in the dyad in service to a deeper connection and understanding of self and its implicit and explicit processes.

The next constituent identified was *the therapist finely attunes to the patient.* The research showed that the communication exchange between the patient and therapist was a moment-to-moment process across multiple verbal and nonverbal communication channels. In the NARM dyad, patients unanimously explained that the therapist held an authentic curiosity and mirrored their internal state without judgment. This gave them a secure base from, which to explore their inner terrain. The NARM patients explained that they had a rich experience of feeling felt through social signals and shared intersubjective affective dynamics in the therapeutic dyad. Infant attachment research data has shown that this is imperative for the emergence and organization of self (Beebe, 2014).

The patients noted numerous times when the NARM therapist interactively attuned to the patient's narrative and affective state through a rich sensory experience. The therapist noted or inquired about facial expressions, prosody of voice, eye contact, and gestures. This way of interacting is characteristic of the mother infant dyad. The

NARM therapist not only reflected back content, she also reflected the music behind the words. This combination of neutral validation of the patient's experience and a finely tuned awareness to energetic shifts in patients created a sympathetic resonance in the intersubjective field. Through ruptures and repairs of attunement, one of the participants in this study had an embodied experienced of being deeply seen, felt, and heard as all of his parts were accepted. Attunement included the therapist's understanding of the core organizing principles of the NARM patient's adaptive survival styles. Attuning in this way did not reinforce the patients' defenses. This supported their adult consciousness. The dyad explored the patient's processes of self in a phenomenological non-goal oriented way. With the experiences of feeling felt and neutrally witnessed, the patients could attune to themselves and expand into their own embodied consciousness more deeply.

The therapy experience is present focused was a constituent that permeated all the interviews. Participants described the way their NARM therapist repeatedly connected them to their direct experience of the moment. Using a process oriented, mindful approach, the NARM therapist tracks connection and disconnection and organization and disorganization of the patient's psychobiological processes of self in present time. Patients gave examples of the ways their NARM therapist noted when their adult self would emerge in a session and, a second later, disappear. Informants recalled ways the NARM therapist inquired about *where* in the body the patient felt strong affect. This use of somatic mindfulness supported the process of patients connecting to themselves in the present moment. Implicit procedural memories were re-worked in the present so the patients had corrective embodied experiences in the here and now. According to the data,

masterful use of language and inquiry supported the process of viewing the invisible past from the lens of the present and then bringing awareness to the way the past was being relived in the present.

The constituent described as *the body and its expressions and sensations are tracked and incorporated* and the use of somatic interventions was of seminal importance in the intersubjective field in the NARM therapy dyad. The inclusion of the body as a collective structure of meaning and the ground for intersubjective and intrapsychic reality moved clinical work beyond just talking. Many of the NARM patients discussed being aware that the NARM therapist tracked their nonverbal expressions and helped them explore their experience. Through this exploration patients recognized that their nonverbal expressions were often unconscious somatic representations of internal conflicts and embodied attachment schemas. In certain cases, exploring bodily-based processes led to discovering unconscious emotions. These emotions were perhaps encrusted emotions, which had been held in the somatic unconscious.

The data from the informants demonstrated that effectively tracking and linking somatically based sensations to emotional processes in the here and now supported self-regulation. Participants recalled the way they used the body to ground. This supported the experience of an organized felt sense of self in the dyad. The patients contended that somatic interventions bridged the gap between the body and the mind. This supports integration of self. Others described the way the therapist would note energetic shifts or changes in libidinal energy. Bodily contractions and armor were explored and often linked to early relational trauma. These experiences indicated that old relational wounds were activated in NARM therapy. As the NARM patients described, therapeutic

interventions in, which bottom-up processes were linked with top-down processes supported a healing cycle in, which nervous system regulation with more organizing emotions, thoughts and self-identities were intertwined. This embodied felt sense of the healing cycle supported the NARM patients being present with their nonoptimal habits, identities and symptoms with a more regulated nervous system. An organized psychobiological state allowed them to be present to, and less identified with their distorted identities and adaptive survival styles.

Images facilitate the patient's process was a constituent that was evident in all of the participants' interviews. The NARM patients described the way images emerged and were utilized as symbolic non-verbal language in a variety of ways. Jung (1958/1970) believed that symbols or images can be used to access implicit memories and shift the energy of the body. Some patients described feeling more empowered after working with an image. The informants described feeling a sense of agency that supported them attending to the world from their adult self instead of their wounded child after working with images. Images and imagery emerged and soothed implicit affective experiences that originated in the failures of the patient's early environments and were still embodied in the present. Participants also described the way images emerged to process and express split off emotions. This often inspired movements that facilitated working with their implicit procedural memories. Images were also invited in and worked with to process the participant's interpersonal relationships. Consciousness of implicit emotions and processes of self were gained through working with images. In numerous cases this consciousness was accompanied by an embodied felt sense shift. This shift can affect implicit structures, which is a critical component of therapeutic action.

The bottom up theme of *the patient's movements are enacted and processed* illuminated Reich's (1945/1972) original theory of libidinal energy in relationship with the body. According to Reich, shock or relational trauma can become trapped in the musculature. NARM and other somatic theories including Somatic Experiencing and Sensorimotor Psychotherapy incorporate movement as a therapeutic intervention to discharge unresolved energy. These somatic theories contend that engaging in protective and defensive movements that are presumed to be associated with immobilization supports the biological completion of emotionally charged states, which are a result of shock and relational trauma (Levine, 2010; Ogden et al., 2006). Patients described the way executing an incomplete fighting action energetically discharges this "frozen history." Unfrozen, the emotion can then be integrated. This leads to a feeling of empowerment. Relational trauma disrupts how one moves through the world. NARM patients described the way pushing against a pillow allowed them to access and thaw unresolved emotions that had been anchored in procedural memory. Participants further recalled that enacting physiological procedural unfinished movements also shifted the emotions and cognitions associated to them. After these executed actions, the NARM therapist always invited patients to notice their felt sense of embodiment in the present moment. The use of movement was instrumental in reaching the energetic source or somatic core of the NARM patient's symptoms or affect as one's psychology is expressed through one's embodiment (Freud, 1923/2001). The patients described the way a new implicit procedural memory was created through movement. As a result they experienced a new felt sense of hope, agency and libidinal expansion of the life force.

The constituent, *the patient experiences a new embodied authentic sense of self,* is of paramount clinical importance. This theme is what generally inspires people to come to therapy (Bromberg, 2011). In the NARM dyad, specific deconstructive language supported exploration of self as the therapist and patient uncovered internal working models of attachment, unconscious relational expectancies, and identity distortions that the patient embodied. The patients described the way mindful insight facilitated being present to, yet less identified with, their distorted identities and adaptive survival styles. Neutral insight created a space for aspects of self to emerge that were not met in their early environment. Connections to dysfunctional introjected object relations broke as the NARM patients became aware of how they embodied certain nonoptimal behaviors and identities to keep the attachment to their early caregivers. Consciousness created choice and dis-identification from distorted identities and nonoptimal relational patterns. The NARM patients expressed no longer being at the mercy of the effects of their relational trauma. From this, a new organized adult consciousness emerged—one that fostered a felt sense of agency, resiliency, and a more solid sense of self.

As the research exemplified, NARM is a resource oriented therapeutic theory. This is highlighted in the constituent; *the patient's personal resources are highlighted*. Utilizing physiological resources is another key element derived from somatic psychotherapies that infuses the NARM intersubjective dyad (Levine, 2010). As the data exemplified, physiological resourcing mechanisms include grounding, titration, orienting, discharge and working with the patients social engagement system. The intentional act of incorporating the body as a resource supported the patient's safety and comfort. Through safe embodiment the patients experienced feeling organized in session. This allowed

them to regulate their affect through safe exploration. Psychological resourcing was also employed when the therapist would highlight the patient's adult consciousness. Patients' adaptive survival styles were also explored as personal psychological resources. This fostered a sense of resiliency. Their explicit accomplishments and innate talents were highlighted to support the feeling of positive embodied affect. The data clearly demonstrated that the mechanism of resourcing supported psychobiological regulation for the NARM patient in the clinical encounter.

The nuanced power of the symbolic tool of metaphor crystallized, regulated, synthesized and amplified the NARM patients' experiences. The constituent of *metaphor supports the patient's process* is derived from this. Metaphor emerged in the dyad. Linking and creating unity through affect, cognitions, and sensations, it was a tool of integration. Because the present moment is a necessary element of NARM therapy, metaphoric language provided words for the patient's "here and now" experience. Metaphor also supported affect regulation as it provided meaningful language for intense emotions. Metaphor and movement worked in tandem to access procedural implicit memories of relational trauma, thus re-contextualizing the embodied experience of the attachment injury. The NARM patients also discussed the process of meaning making that occurs through the use of metaphors with, which the patient had personal associations. This use of personally meaningful metaphors supported integration. NARM has a specific metaphor that is used to explain the patient's memories of relational trauma, thus—"I noticed the elevator went up or I noticed the elevator went down."

The constituent, *the therapy experience is titrated*, was a paramount element. Titration prevented overwhelm, flooding, and potential re-traumatization for the NARM

patients. The pacing of the therapy sessions was done using a variety of mechanisms. The NARM patients stated that the therapist intentionally stretched out their process through deep inquiries. This allowed them to explore the edges of their experiences and associated dynamics instead of diving in. The therapist also invited the patients to really experience what was happening using directives and questions such as "give yourself time," "notice what you are experiencing right now," and "is it ok to feel that emotion?" The research participants shared that this deep slow inquiry regulated their affect and nervous system. They described the way the therapist's direction to utilize somatic mindfulness and physical resourcing was grounding and orienting. They felt stabilized and contained. The directives suggested by the therapist of noticing and being with the body gave the body and mind time to integrate.

The constituent, *relational patterns are explored*, was also identified. As the literature review indicated, personality development and growth are relational and are shaped by implicit, invisible psychobiological structures. These structures organize a person's behavior and experiences in the present and mediate expectations of interpersonal relationships (Paris, 2011). All of the NARM patients experienced gaining insight into their attachment schemas. This insight resulted in changes and shifts in their present-day relational patterns and interactions. Patients became conscious of their adaptive survival styles. They also obtained an understanding of their re-enactments of relational projections, predictions, and expectancies in the present. Patients realized how *they* enabled these implicit relational patterns to persist. With this new awareness they experienced a shift from child into adult consciousness. This adult consciousness supported their felt sense of agency and modified their unconscious re-enactment of

adaptive survival styles and identities. The NARM patients described the way a variety of embodied shifts in perception inspired a greater connection to themselves. These shifts affected the dynamics of their present-day relationships.

The transformative power of the lived embodied experience of being in NARM therapy.

The research showed that therapeutic change consists of a dual process, an integration of implicit, nonverbal modes of communication and explicit verbal modes of communication for the somatic depth psychotherapist. Depth psychotherapists have always valued the nonverbal and symbolic in their efforts to bring consciousness to bear on invisible processes of the self. Incorporating the body and somatic mindfulness in therapeutic practice adds another layer to the intersubjective depth psychotherapeutic dyad. Through mechanisms of titration and resourcing, the somatic depth psychotherapist has tools that facilitate safe embodiment. With a regulated and organized self, their patients can experience a mid-range level of activation in the present moment as they work with narratives, symbols, movements, impulses, and felt sense of the body in an effort to modify implicit memory and facilitate individuation.

Chapter 6
Summary and Conclusions

Overview

This final chapter reviews the nature and findings of this research study. This review is followed by a presentation of the implications of this research for the field of psychology. First, a brief reiteration of the structure of the research is presented. This is followed by a summary of the findings and their inherent limitations. Next, the chapter discusses implications of the results for the field of clinical psychology in general, and depth psychology specifically. Concepts for future research in this area will be suggested. Lastly, the researcher expresses final reflections on the material.

Summary of Nature and Structure of the Study

This study explored the lived embodied experience of being in NARM therapy from the perspective of psychotherapy patients. As presented in the literature review, there is considerable material articulating the theoretical formulations of how the psychobiological self, and its coping mechanisms, identities, symptoms, and behavior, are organized through the exchanges and interactions in one's early environment (Bowlby, 1969). These relational interactions create the patient's internal world of subjective experience and are encoded and stored in layers of implicit memory. They are conceptualized as processes of self, attachment schemas, and self-other representational models (McGilchrist, 2009). Implicit memory creates the way one attends to the world. As it is not declarative, semantic, or episodic, it can be clinically challenging to access and engage implicit memory within the therapeutic dyad (Cozolino, 2002). Freud's work brought clinical insight to unconscious processes. As the literature review demonstrated, every theory is an evolution of the one before it (Heller, 2012). The forefathers of depth

psychology had clinical intuitions about how to work with the invisible nature of implicit memory and the relational unconscious though myth, images, dreams, and metaphoric language. Depth psychologists utilize therapeutic actions that incorporate emotional, embodied, creative, and relational processes in the clinical encounter (Paris, 2007).

Over the past 100 years, psychological theories have focused primarily on explicit narratives and cognitive behavioral interventions to manage a patient's dysphoria (Barratt, 2013). Neuroscience demonstrated that right brain implicit processes are dominant in early psychobiological development. This finding illuminates the value of therapeutic actions that engage with implicit memory in the clinical encounter (McGilchrist, 2009). Implicit memory includes emotional memory, perceptual memory, procedural memory, and bodily sensations. It follows, then, that a key aspect of therapeutic action consists of working with mechanisms and clinical applications that engage the patient's implicit memory (Siegel, 2010). Moreover, clinicians need therapeutic tools that support the modification of implicit memory and its largely unconscious, powerful, yet outdated mechanisms that have created distorted identities, habitual adaptive survival styles and nonoptimal relational expectancies. This study was conducted to increase understanding of the NARM therapy patient's experience of the cognitive, emotional, somatic, and relational processes in the clinical dyad. Additionally, this research was conducted to illuminate how patients' lived embodied experience of NARM therapy transformed their felt sense of self, adaptive survival styles, identities, and self-other relationships which are derived from the silent past.

The phenomenological study is comprised of data from in depth interviews with six individuals who had engaged in or are currently engaged in NARM therapy. The

research participants included four women and two men ranging in ages from 30 to 66. The interviews with participants averaged an hour.

After transcribing the participant's interviews, the researcher asked each informant to verify, and, if desired, change the verbal data. Once each informant validated the transcript, the researcher analyzed it using Giorgi's phenomenological method. This entailed determining the natural meaning units in each interview and organizing these thematically. The researcher then identified the common generalized constituents. From an analysis of these constituents of the experience, a structural description of the lived embodied experience of being in NARM therapy was cultivated.

Eleven common constituents.

The researcher found 11 themes that are essential elements of the lived embodied experience of being in NARM therapy.

1. The patient connects to his inner experience of emotions, thoughts, and sensations
2. The therapist finely attunes to the patient
3. The therapy experience is present focused
4. The body and its expressions and sensations are tracked and incorporated
5. Images facilitate the patients process
6. The patient's movements are enacted and processed
7. The patient experiences a new embodied authentic sense of self
8. The patient's personal resources are highlighted
9. Metaphor supports the patients process
10. The therapy experience is titrated

11. Relational patterns are explored

Structural description.

Finally, the researcher developed a structural description of the lived embodied experience of being in NARM therapy, synthesized from the constituents, presented again here:

The lived, embodied experience of being in NARM therapy comprises a psychobiological therapeutic approach in which patients are invited to explore the inner experiences and dynamics of their cognitive, emotional, somatic, and relational processes of self in the present moment. There are numerous top-down verbal and bottom-up nonverbal mechanisms that support this therapeutic action. The patient's sense of emotional safety is primary and is facilitated by the therapist's use of open-ended questions, accepting language, and a neutral stance. This creates a secure foundation from which to explore the cognitive, emotional, somatic, and relational processes of the patient's experience. The therapist uses mindful inquiry to assess the patient's current emotional state and paces the patient's experience to support emotional and physiological regulation. As the phenomenon of the dyad unfolds, the patient's external and internal positive personal resources are highlighted. This mechanism of resourcing is utilized to connect to the processes of self that are more organized to support the patient's affect regulation. Somatic mindfulness of the patient's body and its "here and now" felt sense, sensations, gestures, and movements are foundational in this exploration of self, as they offer insight into implicit processes. This mindfulness supports nervous system regulation. Patients are invited to move their body in the present moment. This facilitates

an embodied felt sense of completing unresolved physiological actions from the past in the present moment.

Within the therapeutic dyad, images and metaphors emerge or are invited. These images provide access and information to the patient's emotions, thoughts, identifications, and attachment schemas. Engaging with these symbols in the "here and now" facilitates a shift in the patient's felt sense of self. Through this exploration of self, NARM patients gain awareness of their adaptive survival styles and the identities they used to manage their early environmental failures and experiences of attachment. Through this embodied awareness they come to understand how their childhood relational experiences affect their identity, behaviors, symptoms, and relationships today. Through this illumination of processes of self, patients can be mindful, yet not identified with their coping mechanisms and defenses. This leads to a new sense of agency, which fosters resiliency. This new connection to a more regulated, organized, solid sense of self affects the patient's capacity for aliveness, vitality, and authenticity as they attend to the world. In conclusion, this research suggests that the embodied lived experience of being in NARM therapy is life changing.

Limitations of the Study

The qualitative approach used in this study does not allow for empirical statistical generalizability of these findings. Giorgi's descriptive phenomenological method is systematic and methodical. The 11 common constituents found in the research will not be valid for every patient who experiences these phenomena; however, the results should illustrate the essence of the experience. Another limitation of this study is the lack of socio-economic or cultural diversity among participants. All of the participants were

Caucasian and college educated, and some had even higher levels of education. Looking at participants with different cultural profiles might have produced other results. An additional limitation of this research is a result of a group of participants overly weighted with psychotherapists and people who had studied psychology at a graduate level. Given this familiarity with psychology, it is possible that participants had inherent biases about the efficacy of psychotherapy in general.

Implications for Clinical Psychology

A better understanding of therapeutic processes of change in service to the self is beneficial to clinicians and patients involved in psychotherapy. As mentioned previously, for so much of twentieth century, psychotherapy followed a medical model of linear progression beginning with diagnosis, which is addressed by treatment that focuses on cognitive, behavioral and insight-oriented therapies. However, humans are complex systems with emergent properties and therefore need therapeutic models that meet this complexity. Science and the resulting medical therapeutic model is just one story. It does not offer applications that are designed to work with these ambiguous processes of self.

Neuroscientific disciplines delivered powerful support for the agenda of incorporating bodily-based emotional, relational, and implicit processes in the clinical dyad (Ogden et al., 2006). As a result of these findings, clinicians need applications that bring the consciousness system to bear on implicit nonverbal factors, procedural expectations, unconscious coping mechanisms, and patterns of interactions. Through embodied awareness, patients can transition from “traumatic psychobiological self-states into more coherent, organized, and reflective self-states” (Renn, 2012). With the emergence of somatic psychology, it is vital for clinicians to understand how to work

with somatic mindfulness and utilize the body as a portal to implicit processes, which support affect regulation and provide a means to discharge energy.

A few findings from the research highlight mechanisms that were utilized in the NARM clinical encounter which are important for clinical psychotherapy in general. A foundational finding from the research indicated that an integrative approach, one that utilizes a holistic divergent discourse, is efficacious in treating relational trauma and its deeply entrenched archaic representational models that organize the self and relational experience. Moreover, in an effort to listen to all aspects of the patient's ecology, psychological theories can embrace interventions that engage with the material and processes of the patient's explicit declarative systems of the left hemisphere as well as the implicit/procedural information of the right hemisphere to support neural network integration. Clinical mechanisms that support the transfer between right-left-right hemisphere sequences are vital to therapeutic action. The applications for working with the gestalt of the patient were illustrated in the research. This premise of working with the whole patient is necessary for clinicians to understand how to facilitate the patient's individuation.

The therapeutic technique of finely tuned attention to the deductive top down process of language is a salient clinical factor to consider. As archetypal psychologist and scholar James Hillman (1995) wrote, "To become conscious of anything we have first to get the words right, because words are loaded with implications" (p. 12). The masterful mindful use of language is a clinical tool that aids the patient's experience of feeling felt. Using language in this way sets up an open potential plane for a process of exploration and reflection of the patient's internal subjectivity. It is of clinical significance to

understand that the therapist's presence is communicated through accepting language and open-ended questions. Language also inspired the patients to give focal attention to their embodied self in real time. In an effort to support patients, agency inquisitive language was used to promote self-reflection about how they re-enact relational patterns and nonoptimal identities. The clinical application of vivid metaphoric language illuminated implicit processes. The use of metaphor allowed patients to re-conceptualize relational trauma and allowed the concepts to be deeply accepted at the level of the embodied felt sense.

This research suggests that contemporary clinicians need to understand that an embodied felt sense of safety and security must be established in the therapeutic encounter before focal attention and awareness can be employed to explore and reflect on habitual nonoptimal implicit ways of experiencing and relating. The research indicated that it was imperative to keep the patient's nervous system, regulated and organized. Therapeutic actions that supported psychobiological organization and regulation were highlighting the patient's resources and the therapist intentionally pacing the patient's experience. The mechanisms of either psychological or physiological resourcing connected the patient to their more organized subjective processes which prevented re-traumatization, overwhelm and dysregulation. The patient's exploration and reflection of non-optimal habitual processes of self and self-other relational patterns was done through the lens of the present. Seeing in this way supported the process of focusing on *how* the past affects their life today. In this contained and stabilized state, the patients could hold dual awareness of that was then and this is now. This is a key component of therapeutic action.

The research indicated another salient aspect of therapeutic action for clinicians—the necessity for the therapist to offer a description of the patient's dynamics rather than an interpretation of or prescription for. This lens created a non-goal oriented space in which the patient's internal subjective world and its representations of identities, adaptive survival styles, and interpersonal relational patterns were explored expressed and elaborated. An inter-subjective field of a neutral observation process allowed patients to be conscious of their identities and intrapsychic processes, yet not identified with them. With the perspective of an adult-to-adult exploration, the therapist intentionally aimed not to reinforce the patient's defenses. As a result, patients felt an expanded sense of agency.

Bringing the patient's implicit structures into conscious focus in an emotionally meaningful way is a critical component of therapeutic action. Focal attention on the nonverbal phenomena of images, movement, and somatic sensations supports access to and awareness of invisible unconscious processes. Awareness facilitates integration and choice. This research indicated that offering explicit insight into the patient's identity distortions, adaptive survival styles, and attachment schemas supported reflection on the processes of re-enactments. This suggests that it is clinically vital that patients also comprehend how *they* often recapitulate their past early environmental experiences in their present lives. The data indicated that the clinician must articulate the thesis that as children the patients were victims of the failures of their early attachments. However, with adult consciousness, they can make choices. They are not doomed to be identified and trapped in nonoptimal behaviors and symptoms that are not longer in service to the embodied self. The research indicated that through this empowered lens patients gained a

felt sense of agency. This new embodied felt sense of agency then guided their actions, behaviors, symptoms, and interpersonal relationships.

Implications for Depth Psychology

The results of this research are directly applicable to the principles of somatic depth psychotherapy. Freud and Jung understood that relational trauma affects how one moves through the world. They were curious about theories and applications of therapeutic action. Depth psychology values and accesses implicit memory and its representational models and brings them into the therapy setting (Paris, 2007). As the research demonstrated, there are numerous reasons for depth psychology to go back to its roots and re-visit clinical somatic applications in the therapeutic dyad. The data highlighted the use of somatic mindfulness and its various applications—grounding, orienting, titration, pendulation, and discharge supported nervous system regulation. With a felt sense of safe embodiment and affect regulation, the patient's inner subjective world of identities, psychobiological issues and attachment schemas are available for reflection without overwhelm and disorganization.

Depth psychology has used the therapeutic application of authentic movement in the clinical dyad to engage with the implicit procedural memory and its embodied manifestations (Chodorow, 1999). In response to overwhelm caused by relational trauma, one's psychic energy can be become frozen or encoded somatically (Levine, 2010). The research clearly demonstrated that there are movement interventions that somatic theories now utilize to discharge energy and excess nervous system arousal. Therefore, it is important for somatic depth psychotherapists to understand the way movement can facilitate biological completion and nervous system discharge. This somatic application

was facilitated in a titrated way as the therapist guided the patient in attending to visceral sensations or subtle motor impulses associated with incomplete physiological responses. This embodied experience was accomplished through movements of self-protection and defense. This somatic mechanism is a key component to understand. Through movement, the therapist supported the facilitation of corrective interoceptive experiences, discharged frozen energy, and integrated the fight response. As the life force is integrated, patients gain a greater capacity for resilience in the future.

Suggestions for Future Research

This modest research study just touches the tip of the iceberg of a rich source of further analysis. Qualitative studies involving a larger number and more diverse group of participants, which investigate the efficacy of integrative psychotherapy theories, would yield more diversity and detail to these initial findings. This would add to our understanding of the processes of change. I also encourage quantitative studies that compare different somatic therapeutic theories and their applications to determine their efficacy. I support a direct investigation into a deeper understanding of explicit and implicit memory systems and how they interact. I recommend longitudinal studies, which investigate the efficacy of top-down bottom-up psychotherapy theories in affecting the quality of a person's life after the therapy has been completed.

Final Thoughts

As a somatic depth psychotherapist, I began this research with a deep curiosity about patients' embodied therapy experience based on a theory that utilizes verbal top-down and nonverbal bottom-up interventions to treat the pernicious impact of relational trauma. I was compelled to explore the elements of the therapeutic dyad, which offered

access to the implicit memories of the relational unconscious, which affect habitual invisible ways of experiencing and relating. Curiosity about therapeutic actions that incorporated the body. I also encourage quantitative studies d this exploration. I am deeply grateful to the scholarly and clinical ancestors who contributed and paved the way for a clinical integration of interdisciplinary theories.

I am humbled and grateful for the understanding that has been gleaned from this qualitative phenomenological research. However, I am aware that therapeutic action is unpredictable and unique, influencing and transforming both participants in the intersubjective field. I am also realistic and acknowledge the limits of the somatic depth psychotherapy dyad. I accept that psychotherapy cannot cure the multifaceted issues and symptoms caused by relational trauma. However, embodied self-knowledge can be a bridge from child consciousness to adult consciousness. This can enhance the patient's capacities for resilience, self-agency, and inner resources. Embodying a more solid, organized self can enhance the patient's capacity to manage inevitable life stresses and relational ruptures with a greater capacity for affect regulation. The silent past will always effect the invisible present. However, I believe that the somatic depth psychotherapeutic dyad is a potential space from, which a novel experience of self can emerge.

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