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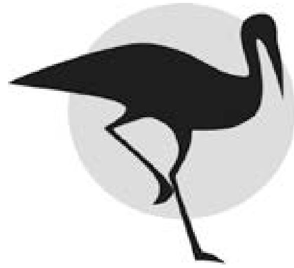

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Medard Boss's Dialogue with Heidegger, Freud, Sartre, Buddha, and Jung: On Being Authentic

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Scott. D. Churchill, Ph.D.
Edwin L. Hersch, M.D.
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Editor's Note: We are happy to welcome back our dialoguers from the 2011 edition of the *Hakomi Forum* in which their initial dialog was "On Being Human," first presented as a conversation hour at the 112th annual convention of the American Psychological Association, Honolulu, Hawaii, in August 2004. Here, they continue the conversation with "On Being Authentic." To repeat what I wrote in 2011, their dialogues are "a creative and rich way the authors, all serious clinicians, model the importance of psychotherapists reflecting on the philosophical principles that inform their work. Too often these principles operate at unconscious and uncritical levels. The exchange is an invitation for others to 'go and do likewise.' Our principles in Hakomi Therapy are rooted in the sciences of complex living systems, Eastern wisdom traditions, and the psychodynamic, humanistic, transpersonal, and somatic influences of the post-1960s. The *Forum* invites articles that further explore the underlying assumptions of our work." Correspondence regarding this article can be directed to Steven Bindeman via email at bindeman1@verizon.net.

Steven Bindeman, Ph.D. was professor of philosophy and department chairperson at Strayer University, Arlington, VA campus until his retirement at the end of 2010. His teaching experience reflects not only his interest in philosophy and psychology, but in film and media studies, science fiction, world music, and comparative religion. He was elected into *Who's Who in American Colleges and Universities*, and has published articles on Heidegger, Wittgenstein, Levinas, the creative process, postmodernism, and numerous book reviews. His book, *Heidegger and Wittgenstein: The Poetics of Silence* (Lanham: University Press of America, 1981) is currently listed as a recommended text under the "Heidegger" listing in the *Encyclopedia Britannica*. He has recently completed a book called *The Anti-philosophers.*

Belinda Siew Luan Khong LLB, Ph.D. is a practicing psychologist and lecturer at Macquarie University, Sydney, Australia. She counsels individuals and families on relationship issues, depression, stress management, and personal growth. She is a member of the editorial boards of *The Humanistic Psychologist*, and *Mindfulness*. Her primary interests include integrating Western psychology and Eastern philosophies—especially Existential therapy, Heidegger's philosophy, and Buddhism—in counseling and research. She has published articles and book chapters in these areas. She was guest editor of a special issue of *The Humanistic Psychologist* on mindfulness in psychology (2009), and co-editor of another special issue: "Bringing Heidegger Home: A Journey Through the Lived Worlds of Psychologists and Philosophers" (2013). Belinda conducts workshops on the integration of meditation, mindfulness, and psychotherapy in Australia and overseas.

Scott D. Churchill, Ph.D. is currently professor of psychology and human sciences at the University of Dallas, where he has taught for over three decades and served as founding director of its masters programs. A fellow of the American Psychological Association, Dr. Churchill is an elected member of its council of representatives, liaison to its science and education directorates, editor-in-chief of its division journal, *The Humanistic Psychologist*, and was recently awarded the Mike Arons and E. Mark Stern award for outstanding lifetime service to the Society for Humanistic Psychology. His professional focus is on the development of phenomenological and hermeneutic methodologies; he teaches classes in a wide range of psychological topics, from primate studies to projective techniques, Daseinsanalysis, depth psychology, and cinema studies. Scott has been providing reviews of film and the performing arts on local television in Dallas for thirty years, and was recently named a fellow of the Dallas Institute of Humanities and Culture.

Edwin L. Hersch, M.D. is a psychiatrist with a psychotherapy practice in Toronto, Canada. He studied philosophy and psychology, phenomenological psychology, medicine, and psychiatry at the University of Toronto, Duquesne University, and the University of California, San Francisco. He has published several articles in professional journals, has a chapter in Phillips and Morley's 2003 book, *Imagination and Its Pathologies*, and has presented numerous papers at various professional meetings, addressing topics such as the philosophical underpinnings of psychological theories. His major work is *From Philosophy to Psychotherapy: A Phenomenological Model for Psychology, Psychiatry, and Psychoanalysis*, published by the University of Toronto Press in 2003. He has conducted extensive research into the interface areas among the fields of philosophy, psychology, and psychiatry as an independent scholar and has practiced clinically in both psychology and psychiatry for more than twenty years.

Doris McIlwain, Ph.D is a personality psychologist teaching two, third-year courses in personality and philosophy of psychoanalysis at Macquarie University. She has three broad areas of research expertise: emotion, movement, and memory. She is currently conducting research on ineffective embodiment in long-term yoga practitioners, therapists, actors, and elite sports people. She researches the implications of the depth and range of emotional experience for rumination and reflection, empathy, moral development, and integrity of self, using as case studies affective profiles of Machiavellian, psychopathic and narcissistic personality types. She was part of the Sydney Silvan Tomkins research group into Tomkin's affect theory, and retains a keen interest in his work. She is published in psychology, philosophy, and humanities journals and has a book on charismatic leader-follower relations. She has a small private practice, and loves yoga, poetry and ceramics.

Louise K. W. Sundararjan, Ph.D., Ed.D. received her doctorate in the history of religions from Harvard University, and her Ed.D. in counseling psychology from Boston University. She is a member of the International Society for Research on Emotions and publishes regularly on that topic. She is a past president of the APA's Division 32 (humanistic psychology) as well as the International Society for the Study of Human Ideas on Ultimate Reality and Meaning. She is a fellow of APA, and chair of the Task Force on Indigenous Psychology.

Abstract

The year is 1991 and the place is somewhere between the six realms of existence and Heaven. In 1990, when Medard Boss, the Swiss psychiatrist and daseinsanalyst passed away, he initiated a dialogue with the four most influential figures of his life: Sigmund Freud, the Buddha, Jean-Paul Sartre, and Martin Heidegger, to explore the question of what it means to be human. This was a theme that interested him throughout his life, and continues to puzzle him in death. He has invited another colleague residing in this ethereal place, Carl Jung, to join the others in a dialogue to explore the theme: on being authentic.

Louise Sundararajan—Chair/ "Medard Boss"
Steven Bindeman—"Martin Heidegger"
Belinda Siew Luan Khong—"Buddha"
Scott Churchill—"Sigmund Freud"
Edwin Hersch—"Jean-Paul Sartre"
Doris McIlwain—"Carl Jung"

Boss: Welcome. It is good to meet with all of you again and engage in another dialogue. Since, in the realms of Heaven there is a confluence between the different streams of time, this means that the notions of past, present, and future all come together within the confines of a single moment. However, for many of those here, it was a full year ago that the spirits of the Buddha, Freud, Heidegger, and Sartre were asked to come together and pay their respects to each other and to me and talk about the nature of being human. During the course of our time together we discussed our different approaches to understanding and overcoming human suffering, and focused on our different views concerning the self, nothingness, discipleship, and the relationship between theory and practice. This time, an additional spirit has come to join us, namely Carl Jung. The theme of today's discussion is on being authentic. We

ask ourselves, how can the inauthenticity of our everyday lives be reconciled with our potentiality for being authentic? In discussing this important question, we may find that related themes demand our attention, namely the process of individuation and the need for personal responsibility. Finally, we may discover the additional need to look further into the nature of change, finitude, temporality, and letting be. All of these themes, of course, relate essentially to the situation of being human.

Issues of Authenticity and Inauthenticity

Heidegger: I must say I am very excited to have these themes introduced into such honored company. The related issues of authenticity and inauthenticity are at the very center of my thinking about the special nature of the being that belongs to Dasein, or human being understood within the context of being-situated in the world. I ask the question that demands an answer: What makes the being of Dasein different from the being of all other beings? The answer I find is this: Only Dasein has the capacity to ask about its own nature. Dasein in fact has a choice to face: it can either own up to, disown, or fail to take a stand on this question. Although only the first choice is the authentic one, it must be recognized that not only are the other modes of experiential (or ontic) being far more common, they are themselves certainly not to be denigrated, as they are no less "essential." It must be acknowledged, however, that the dominant tendency in our lives is a movement towards our own ruination.

Freud: At this initial stage in the discussion I find that I am in sympathy with Heidegger's way of exploring the experience of being human. In my own attempt to appropriate a scientific approach to understanding human existence, I found myself facing a prejudice then existing in the scientific community—an inauthentic prejudice—namely that only physical matter can be approached with scientific rigor. As a natural scientist myself, I found myself with the seemingly absurd and self-contradictory task of investigating consciousness as part of the *res extensa*. In fact, my earlier thesis of the unconscious can only be seen as part of this seemingly impossible task, insofar as what I thought of as "un"-conscious (and thereby "meta-psychological") was precisely the body. In my earliest use of the expression "metapsychology," I was, in fact, referring to that which was "beyond the body." Mental acts, feelings, thinking, and perception—in short, all the phenomena of consciousness—are not to be understood as objective entities in themselves but rather in terms of their specific meanings for a given human individual self. Moreover, they should not be thought of as entities at all, but rather as dynamic processes. This means that neurotic behavior needs to be understood as consisting of goal-directed acts, so that once we discover the self-preservative purpose of such behavior (for example, flight from anxiety) we will be able to locate the repressed childish fears and anxieties that lie at its core. Not only is the unexplored life not worth living, it is—like the occasional blind prejudice that befalls the scientific community—inauthentic as well.

Jung: I too agree with Heidegger that the being of human beings—which includes our conscious selves—is unique. Moreover, I freely acknowledge how very far Freud and I traveled along the royal road of psychoanalysis together. But we parted ways along the axes of scientific understanding and on the focus of therapy. Regarding science, I believe that the increase in scientific understanding since the Enlightenment has led to a blindness regarding the relevance and meaningfulness of religious and mythological truths. Regarding therapy, I believe that Freud focused too narrowly on conflict and neurosis and failed to recognize the potential liberating benefits of directing psychoanalytic practice toward integrative growth. And yes, I agree with Heidegger that we risk inauthenticity when we allow others to draw the line around our dreams, when we hide behind our personae and lose sight of the less differentiated aspects of ourselves, simply because they are incompatible with what it required of us—with what has become the dominant features of our functioning, in accord with what "they" think.

Sartre: Ever since my reading of Heidegger's *Sein und Zeit,* I have been careful to acknowledge the idea that phenomenological ontology is the appropriate way of approaching "the question of Being," since the evolution of modern thought has brought ontology to the phenomenon as the true locus of Being. Furthermore, I assert that no true theory of being can take place without consideration of the being of man—what I call "Being for-itself."—whose being is required for phenomena to be recognized in the first place. Finally, in order to elucidate the ground or foundation for phenomena, I discover two sides of consciousness: on the first side a constitutive consciousness that is the state of being conscious of the phenomenon, and on the second side the being or existence of this very consciousness itself. As to the essence or nature of this Being-for-itself that is consciousness, it can be nothing other than an empty hole, a nothingness; to assert otherwise would be to place an arbitrary meaning on something inherently unknowable. So, this lack, this nothingness, is at the heart of our being, and we are inauthentic to the extent we fail to

own up to this. As long as we fail to take personal responsibility for our life choices, we remain caught up in illusions that are manifestations of our bad-faith. But if we can learn to acknowledge and embrace this incompleteness instead of postulating comforting essences in order to falsely define ourselves, then authentic Being is still possible.

Buddha: I find myself listening to these brilliant ideas from some of the greatest minds of all time, and I ask myself what is the purpose of our discussion here? Personally, I am hoping that together we can shed some light for those who are seeking answers to these perennial questions of life. However, at this juncture, I have a more basic question— are we looking in the right place? From a lifetime of meditating, I have discovered that reason may not be the faculty of man that is especially suited to finding his true nature. Once this true nature is found, it can easily be seen that reason admittedly plays an essential role in its elucidation, but the search itself must be initiated from a different path. The story of how I discovered suffering to be at the heart of human existence I leave for another time. But let it be known that my search for the cessation of this suffering was never an intellectual one. I wonder, then, whether we can engage with the questions of authenticity and inauthenticity through an intellectual discussion? Isn't authenticity a way of being, rather than just a way of thinking?

Boss: I thank you all for sharing with us your foundational and introductory thoughts on authenticity. Upon reflection, it seems to me that Buddha's assertion—that reason is not especially suited to finding man's true nature—is worthy of further consideration. Especially when you take into account his observation that authenticity is to be experienced rather than just debated. I would like to hear from you about this. Let's start with Heidegger.

Heidegger: I want to say that I am in fundamental agreement with Buddha's sentiments. But I feel I need to clarify what I mean by this. The question about "man's true nature"–or as I would put it, Dasein's true nature, should not—nay, cannot—be separated from the history of the "question of Being." By this I mean to say that the question about the nature of man is not an abstract question but rather one that is grounded in history, especially philosophical history. Since these investigations are situated in language, I would say that language is the "house of Being." The different ways in which we have dwelled in this house have been gradually circumscribed by the expanding power of reason and technology to dominate our lives and our thinking and to "enframe" our experience of everything in terms of practicality and calculability. My fear is that we—as products of this modern worldview—are imperceptibly losing the ability to hear what Buddha has to say about ourselves. We will simply translate it into practical terms.

Freud: I find Heidegger entirely too philosophical here. He seems to believe that the concepts with which human beings define themselves are narrowly circumscribed by and grounded in whatever philosophical system is dominant during a specific time. I prefer to view human beings as essentially involved in a struggle for self-discovery. I consider there to be a tension between the demands of culture and the instinctual sexual drives of the individual. Thus, for example, the existence of an incest taboo in a given culture cannot be separated from the traumatic symptoms experienced by an adult female in response to her feelings of guilt and shame with regards to her sexual experiences of early childhood, whether they are byproducts of her fantasy or not. Not only should we not separate adult traits from childhood memories and emotions, we should also recognize how various kinds of adult illnesses are the result of the repression of such feelings, which have a tendency to bubble up from the unconscious. If you shut the front door on them, then they just climb in through the back window. I would also argue against Buddha's observation that we are too intellectual. Our search for a healthy self, free from neurosis, is not primarily an intellectual struggle at all, since the painful emotions and scenes of early childhood have to be revisited—in feeling as well as in thought—if therapy is to be successful.

Jung: I must say, Freud, how intrigued I was to hear you speaking earlier of neurotic behavior as having a goal, since you would always chide me about my own tendency to find larger purposes in our behavior. While I had learned to see human beings as being poised between instinct and the spiritual power of the archetypes, believing that to let either have too much sway was perilous, you in contrast seemed to privilege the animal within us. I even recall you suggesting that symptoms were not a message to anyone, that they were not written on the body in that sense, but were substitute pleasures. You conceded, though, that they achieved some aim, granted some indirect, de-conceptualized expression of some yearning. It is with pleasure that I now hear you suggest they have a goal. Your grip on psychic determinism is, perhaps, weakening at last. We face so many challenges in our path towards individuation, towards authenticity, it is no surprise we mistake ourselves so readily, don't you think, for this persona, that mask? But beyond the perils of this compliant, excessive concern with what "they" think lie darker dangers. For example, in believing ourselves to be more advanced than others. Your mention of Heidegger's idea of owning up to or disowning

one's stance regarding the nature of oneself made me think of the shadow part of my own personality. In fact, I think it is essential to own up to the infantile and primordial elements in oneself, if only to protect against their dominion. But it seems to me that we don't readily enough recognize that a tendency to moralism can be the projection of our own dark impulses onto others. At times we deal with our own shadow, the disowned features of ourselves, by projecting onto others. It seems to me a danger to imagine that we can become so good as to have no dark impulses. In becoming authentic, it is crucial to take a stance on our own shadow; to become aware of it, confront it, and assimilate it. We must embrace our flawed nature before we can have any compassion for others. And no, Buddha, I don't think this is an intellectual enterprise!

Sartre: Embrace our flawed nature? I wonder, what is man's true nature? I have already explained that human consciousness understood as being-for-itself is that being which is its own nothingness. We confront this nothingness when we learn to acknowledge our own bad faith—when we anguish over the ultimate groundlessness of our choices. Finding ourselves condemned to being our own baseless basis for our thoughts and deeds results in a flight toward justification in reasons, causes, and so-called motives. Although we all lie to ourselves, what's interesting is that for our lies to work we have to be careful to hide them from ourselves. An ordinary liar intends to deceive another person and does not need to hide this intention from himself. This kind of lying is a normal phenomenon belonging to what Heidegger calls the "Mitsein," or being-with-others. The ordinary liar hides the truth from another, and by doing so reaffirms the separate ontological existence of the two. In the case of bad faith, however, since the lie is contained within a single consciousness, I must know the truth very exactly in order to conceal it from myself more carefully. The problem is that since consciousness is translucent, that which affects itself with bad faith must be conscious of its having done so in the first place. To escape from these difficulties, people gladly have recourse to the unconscious. Freud uses the idea of the superego or censor to reestablish the duality of the deceiver and deceived at the level of the supposed unconscious part of the mind that executes the repression. Freud substitutes for the idea of bad faith the idea of a lie without a liar. By distinguishing between id and ego, Freud cuts the psychic whole into two parts: I am the ego but I am not the id. But is this distinction—or the whole construction of the apparatus of the unconscious, for that matter—necessary? Since bad faith is an immanent and permanent threat to every human being, we can never completely escape from its corruptive effects. But our ability to radically escape from bad faith through self-recovery still exists; it is in fact what we have been calling authenticity. But unlike the implied essences or archetypes that Jung suggests we must integrate, our particular form of self-recovery is more of an active, creative process. Authenticity is more a matter of engaging in committed, active life choices and taking responsibility for them precisely as the choices and commitments that we voluntarily make. It is not a matter of finding any preformed or pre-determined essential self at all. Rather, our form of being is one in which our existence, or our lived-out actions and choices, precedes our so-called "essence," the latter of which is only to be seen either in hindsight or through the self-deception of bad faith.

Buddha: I seem to have triggered a lot of interest regarding my understanding of the relation between thinking and experience. But perhaps we should try and clarify our thinking about what it means to be authentic. The problem is that when we try to discuss our experience concerning such matters, we confront the limits of language. I would like us to return to Professor Boss's important question in his introduction: how can the inauthenticity of our everyday lives be reconciled with our potentiality for being authentic? Perhaps a more fundamental issue in this context is, how we perceive human nature. To me, human nature is essentially good. In my teachings, I often refer to this fundamental part of human nature as "our original face," but today people might refer to it as our unconditioned self. I believe that our original face is naturally good, but having to exist and survive in the everyday world, it may become conditioned or "contaminated"—perhaps in the various ways that Professors Freud, Jung, and Sartre have already indicated. So, I would like to pose a new question: how did we become inauthentic if we have the potential to be authentic?

Question of Inauthenticity

Boss: That is a good question. Why are we, for the most part, inauthentic?

Freud: I see the human self as a continuing process that operates through the interaction between the three dimensions of the psyche, which I have called the "I," the "it," and the "I Above." (I suppose the Americans might call it the "overseeing I," with their obsession with management!) I often regret that my friend, translator, and former patient, James Strachey, chose to Latinize my own use of the vernacular German, assumedly to make my ideas more palatable to an English speaking medical audience. The Ego? The Id? The "Super-ego"? This sounds like comic book heroes. No, what I was talking about were not three

substances or mechanisms, but rather agencies or processes. My friend, Sartre, was right when he said that in this kind of psychoanalysis—which I would call "wild analysis"—the psyche is made to be what it is not, and it is not what it is made to be!

For we must always work with the "I," with that part of the person who thinks in the "first person"—and not with any "third person" self-objectifications, which are already the source of inauthenticity or bad faith. When the three aspects of the psyche are in harmony, the individual person acts with the greatest amount of freedom. But since this is seldom the case, the usual state of human affairs is one of suffering. And it is, in fact, civilization which is responsible for this misery, since when we organize ourselves into civilized society to escape the suffering which incurs when we fail to impede the selfish demands of our libidinal drive or death instinct, we inflict it back upon ourselves in the guilt and frustration created by the repression of these same needs. It is, indeed, difficult to escape the neurosis that is the byproduct of such conflict.

Jung: Each of us constructs a persona, an inauthentic aspect of our self, which we present to the outside world. There is a danger that we can identify with it too much and mistake it to be all that we are. It is merely a mask. It's not a bad thing to have, and in fact it's necessary for getting along with others. But there is more to individuation than simply becoming aware of our persona. What I call "the first act of courage" is the acknowledgement that we have a shadow side to our self as well. In order to undertake shadow work we need to recognize the power of our shadow projections. Most of these projections are other-directed, negative, and strongly emotional. The main difficulty with shadow work is that it involves confronting parts of ourselves that are neglected, frightening, or shameful. Yet the psychic disequilibrium of the individuation process cannot proceed without this confrontation.

Sartre: Like Jung, I also think that we can mistake ourselves. The essential problem is what I indicated before: existence precedes essence. By this I mean we are thrown into the world as free human consciousness, but without meaningful directions. We are thus opaque to ourselves. We aspire to the clarity of thinghood, but remain mired in our own indeterminate nothingness. If we could accept our own freedom and take responsibility for our moral acts, then we might be able to escape from our fate of bad faith. But for this to happen we would have to reach the ontological self-sufficiency of God, and this is, without doubt, a fruitless enterprise.

Heidegger: I think that one of the reasons why we become inauthentic is because we get so fixated on the facticity of our everyday lives and with taking the easy way out that we forget to care about anything, and we find ourselves in a state of decadence or fallenness. We turn away from what a heightened awareness of our own death can give us. We pay too much attention to the They.

Buddha: I agree with Professor Heidegger that one of our reasons for living inauthentically is because we have learnt to live this way habitually. I also agree with him that this is because we are unable to confront our fear of mortality. I believe, though, that this is related to the bigger issue of our being unable to accept impermanence or change. Even though intellectually we accept the idea that impermanence is at the very heart of human existence, experientially we live as if permanence is the norm. So we continually busy ourselves with acquiring material things and performing endless projects, activities relating to what I call "edifices to permanence," in order to avoid the knowledge that everything, including life itself, will eventually pass away. In fact, we are rendered inauthentic precisely when we fail to acknowledge this impermanence, which is the true nature of things.

Basis for Authenticity

Boss. That is a good point, Buddha. You seem to suggest that taking and confronting certain aspects of previously avoided issues and taking personal responsibility is the starting point for becoming authentic.

Heidegger: I agree with Buddha about the ways that we avoid accepting impermanence and finitude, but I would add the observation that finitude also entails that our choices are finite. In my earlier writings, I enunciated the concept of "Being-guilty," or "Existential guilt." By that I mean that we are continually confronted with new possibilities that must be taken on and fulfilled. However, the facticity of our situation means that at any given point we can only choose one possibility, and forsake others. Existential guilt arises because of our inability to fulfill these other possibilities. We fail to realize our authentic self since our limited choices leave us with a vague feeling concerning the essential finitude and groundlessness of our lives. I believe that we discover authenticity only when we learn to confront our existential guilt and transform it into an active embrace of our potentialities in a resolute manner, and take responsibility for being our own person. We confront this potentiality through our mood, which is a unique and primary way of disclosing Dasein's Being-in-the-world. Furthermore, only certain moods are authentic.

For example, only in anxiety is Dasein brought face-to-face with itself. Anxiety discloses what Dasein authentically and really is, namely a being that is Being-in-the-world.

Sartre: Anxiety, freedom, choice, responsibility, contingency…these are all terrifying and potentially overwhelming experiences to us. As such, we try in vain to hide, deny, or run from them through the defenses of false certainties, projections, etc. These provide a continuous basis for inauthenticity.

Boss: So, inauthenticity, while having personal dimensions, is also a larger, existential concern. I agree with Heidegger about existential guilt, which I see as being different from the guilt feelings that clients talk about in therapy. I believe we cannot really make our clients feel free of existential guilt, as this is part of the human condition. At best, we can only help clients become aware of this existential guilt, which is the necessity of having to choose amongst different possibilities so that they no longer experience neurotic feelings of guilt.

Freud: However, it may just be the other way around. The job of the psychoanalyst is, perhaps, to free the individual from neurotic sources of guilt in order to make them ready for addressing even deeper issues pertaining to ontological guilt. Our job as medical doctors, psychiatrists, and psychotherapists is to bring the person to a state of readiness for spiritual and philosophical development. I do not think that existential awareness is enough to be able to choose one's way out of neurosis. If you think that, then you fundamentally misunderstand the nature of neurosis. Yes, choice is involved, but there is also reflected in any neurosis the contingencies of individual history. Isn't this what Heidegger has called facticity? I suppose, in this sense, psychoanalysis itself is a kind of "hermeneutics of facticity"–but one that remains more in the subterranean regions of the repressed unconscious than in the light of day. As Sartre pointed out, if having to choose and to take responsibility for our choices is frightening, then we are really dealing with people's defensive postures in the face of taking responsibility. Am I beginning to sound like an existentialist? Oy vey! In my work, I am more concerned with helping clients come to terms with neurotic guilt by dealing with the contents of their unconscious and working through repressed longings and resistances so they can, hopefully, live more authentically.

Jung: I agree with Freud that we can help people to become more authentic by enlarging the scope of personality by making the personal unconscious conscious. However, as Boss says, there is more than the personal at stake. My focus also transcends the personal, since we are also the repository of the remnants of the history of mankind, those inborn virtual images that are the archetypes. Spirit in form, numinous in character. You can use the word spiritual if magic is too strong a word for you. These archetypes are the regulators and stimulators of creative fantasy. We need to attend to their presence within us, as they may also reveal the undervalued, less differentiated aspects of ourselves. My aim, then, is individuation, which can only be achieved via the guided disequilibrium of analysis. There, I seek to bring about a psychic state in which a person may experiment with her nature: a state of fluidity, change, and growth where nothing is eternally fixed nor hopelessly petrified.

Buddha: It is interesting to hear that the basis for authenticity revolves around individual resolve, making hard choices, and learning to integrate different aspects of our personalities. I was particularly interested in the discussion on existential and neurotic guilt. When I mentioned responsibility earlier, I was thinking more about respond-ability: that is, the ability to respond appropriately to each unique situation. The relevant question here is not so much "What are my possibilities, and how do I choose?" but rather "What is an appropriate response to the situation or the phenomenon that I am encountering?" Sometimes this calls for action, and sometimes for non-action. If we understand impermanence or change to be in the nature of things, our responsibility is to learn to respond skillfully to moment-to-moment experiences. This is because I believe that each new moment is pregnant with possibilities and information that earlier moments could not have shown up, and therefore no moment is privileged. I do not think that it is a case, as Professors Heidegger and Boss suggested, of resolutely choosing one possibility and experiencing existential guilt for having forsaken other possibilities. Rather, it is being mindful of what is called for in the given situation and responding appropriately—what I refer to in my teachings as right mindfulness, right understanding, and right action. If subsequently the response turns out to be inappropriate, then the person goes through the process of seeing what is now appropriate in light of changed circumstances. In such instances, the feeling may be one of remorse rather than guilt. Remorse involves self-reflection and a reappraisal of past actions and choices, rather than self-recrimination and self-blame. In short, I think that the basis for being authentic is to remain open and let things unfold naturally, and then respond accordingly.

Heidegger: I concur with Buddha. In my earlier conceptions of authenticity, I focused more on willed resoluteness:

the courage and resolve to break away from what is comfortable and familiar. In my later conception of authenticity, I saw it more in terms of releasement (or what we refer to in German as Gelassenheit). Releasement involves adopting a meditative attitude towards things by reducing the ego and just waiting. By waiting, I do not mean to suggest that we remain inactive, although sometimes restraint is warranted. Rather, as Buddha pointed out, in waiting we allow things to be, and in so doing remain more open to other possibilities.

Being-Authentic

Boss: Thank you for that interesting discussion. I would like to move on to our final question: what do you think being authentic involves?

Sartre: A life of active engagement in the world and with others, of continuously reflecting and acting in acknowledgement of our contingent choices while attending to both our realistic facticity and our ever-present freedom, is certainly a starting point for one's pursuit of authenticity.

Buddha: I see authenticity as a state of being where people are able to cultivate a more open attitude to what they encounter and to experience and respond to what unfolds naturally without needing to change or justify it. It does involve an active engagement with the world, not from the standpoint of one's ego, however, but from the sort of compassion and wisdom that come with understanding the interconnectedness of everything. I see it as similar to enlightenment. I often tell people that before enlightenment, chop wood, draw water. After enlightenment, chop wood, draw water. The difference is not in the activity, but in the attitude we adopt towards what we do. I believe that by learning to let go of our preconceptions and biases through meditation and mindfulness, we engage with the world through egoless responsiveness rather than willed actions.

Jung: For me it is the psychic development that fulfills the individual qualities and peculiarities of your nature—stripping away the false wrappings of the persona and gaining a measure of freedom by attending to the suggestive power of primordial images. It is regaining a fluidity vital for personal and cultural development. No longer will we be a touchy bundle of egotistical wishes and fears, compensated for by unconscious counter-tendencies. We will, instead, be free to relate to the world of objects and others, and concern ourselves with collective problems and shared growth.

Heidegger: When we are born, we are thrown into a predetermined world of family, culture, and nationality. We have not chosen this situation, we have instead fallen into it and we can never be authentic if we remain there. This is the world of the they-self, and it frames our every possibility, unless we escape its hold on us. We can do this only if we discover—by way of the mood of anxiety about the uncanniness of our existence—that it could yet be otherwise. Thus does anxiety reveal to Dasein the possibility of being-authentic, by allowing it the freedom to understand itself outside the control of its own historical conditioning.

Freud: Perhaps the angst of which Heidegger speaks is not entirely unlike the angst with which I must deal with my patients. But I do not think that anxiety alone "reveals" to us the possibility of being-authentic. It only prepares us for such an awakening. And besides, Martin, did you not also speak of a "call of conscience"? And is not this "conscience" of yours more precisely what reveals to us, in our being, our very own possibility for being-authentic? I might remind you that what I called the "Ueber-ich" already contains within it the possibility for a conscience, whether it be one that supplies us with "neurotic" guilt or "ontological" guilt. I shall leave the rest of you to your more lofty considerations of mythic ambitions, ontological guilt, and authenticity. For me, I will depart your company with a gentle reminder that a little bit of self-restraint and a little bit of sublimation, coupled with just a modicum of sexual satisfaction, should be enough to provide for the individual's happiness. And if I have a final wish, it is the hope that such happiness shall never be eliminated from among the higher aims of civilization.

Boss: Thank you for another interesting dialogue. I believe that in exploring authenticity from the philosophical and psychological perspectives covered today, we have contributed significantly to the understanding of what it means to be human. I am looking forward to continuing our dialogue next year, and engaging in furthering our understanding of human existence.

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Perspectives On the Human Condition: Philosophy, Civilization, and Character

Robert D. Stolorow, Ph.D., Ph.D.

Editor's Note: In Hakomi we have been referencing Robert Stolorow's work on the intersubjectivity of therapy and transference, in terms of the organization of experience, for decades. We are happy to welcome him to the Hakomi Forum to share thoughts about humanness that integrate the philosophical, cultural, and therapeutic. "Philosophy as Therapy" was first published on March 7, 2014 in the Psychology Today blog. "Feeling, Relating, Existing" and "Empathic Civilization in an Age of Trauma" on November 22, 2011, and "What Is Character And How Does It Change?" was published on February 16, 2012. All are used with permission

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Abstract

Stolorow reflects on the human condition, especially as it is subject to trauma when key, organizing illusions are shattered. He notes how character is organized in relation to developmental issues, how cultural events are also formative, how philosophically informed therapies can invite transformative awareness that claims one's relativity and embeddedness, and how the vulnerability of traumatized states can be held and lived through in the context of a relational home of mutual empathic understanding.

Philosophy as Therapy
Two Philosophers Seek to Free Us from Illusion

> *There is nothing which requires such gentle handling as an illusion.*
>
> —Søren Kierkegaard

The idea that philosophy as questioning dialogue has a therapeutic aim and impact goes back at least as far as the Socrates of Plato's early dialogues. It is in the *Apology* that Socrates spells out most explicitly the therapeutic aim of his philosophical method, the *elenchus*, as well as the unity of its investigative and therapeutic aims. The divine purpose, he claims, of his practice of philosophy, of his devotion to questioning, examining, and testing the men of Athens, is to persuade them to care "for the best possible state of [their] soul[s]"—to provide *psyches therapeia*.

An analogous therapeutic aim can be shown to underlie the philosophies of Martin Heidegger and Ludwig Wittgenstein and, in a certain sense, to unify them.

For both Heidegger and Wittgenstein, philosophy is a human activity exhibiting a unity of investigative and therapeutic aims. For both philosophers, the purpose of philosophical concepts as formal indicators (Heidegger) or as signposts or reminders (Wittgenstein), is to point us toward the path of transformation rather than to explain. For both, a first step on this path is the recognition of illusions spawned by conventional interpretedness (Heidegger) or scientistic evasiveness (Wittgenstein). For both, such illusions are sedimented in linguistic practices, in the "idle talk" of *das Man* (Heidegger) or the "bewitchment of our intelligence by means of our language" (Wittgenstein). For both, philosophical investigation is a way of bringing what we already prereflectively understand

into the light of thematic explicitness. And what both philosophers bring into thematic explicitness are aspects of our context-embeddedness and of our finitude. Heidegger helps us understand and bear the anxiety that comes with authentic or owned Being-toward-death, and Wittgenstein helps us to bear the irresoluble complexity of an indeterminate multiplicity of language-games and perspectives, each serving particular human purposes, of which the scientific perspective is only one. Through our therapeutic encounters with the philosophies of Heidegger and Wittgenstein, we are able to recognize ourselves as ever more distinctively human.

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Empathic Civilization in an Age of Trauma: Our Tranquilizing Illusions Seem to be Threatened from All Sides

In my work over the last two decades attempting to grasp the nature of emotional trauma (http://www.psychoanalysisarena.com/trauma-and-human-existence-9780881634679;-http://www.routledgementalhealth.com/world-affectivity-trauma-9780415893442), I have shown that its essence lies in the shattering of what I call the *absolutisms of everyday life*—the system of illusory beliefs that allow us to function in the world, experienced as stable, predictable, and safe. Such shattering is a massive loss of innocence exposing the inescapable contingency of our existence on a universe that is unstable and unpredictable and in which no safety or continuity of being can be assured. Emotional trauma brings us face to face with our existential vulnerability and with death and loss as possibilities that define our existence and that loom as constant threats.

I describe our era as an *Age of Trauma* because the tranquilizing illusions of our everyday world seem in our time to be severely threatened from all sides: by global diminution of natural resources, by global warming, by global nuclear proliferation, by global terrorism, and by global economic collapse. These are forms of collective trauma in that they threaten to obliterate the basic framework with which we as members of our particular society have made sense out of our existence.

It is my view that, here in America, our Age of Trauma began with the terrorist attack of September 11, 2001. In horrifyingly demonstrating that even America can be assaulted on its native soil, the attack of 9/11 was a devastating collective trauma that shattered our customary illusions of safety, inviolability, and grandiose invincibility; illusions that had long been mainstays of the American historical identity. The economic meltdown and the fall of iconic companies and financial institutions inaugurated a second wave of collective trauma.

Several outcomes of trauma, whether individual or collective, are possible. If what I call a *relational home*—a context of human understanding—can be found in which traumatized states can be held and eventually integrated (and I will have more to say about this later), a traumatized person may actually move toward a more authentic way of existing, in which existential vulnerabilities are embraced rather than disowned. More commonly, in the absence of such a relational home, he or she may succumb to various forms of dissociative numbing. Alternatively, traumatized people may attempt to restore the lost illusions shattered by trauma through some form of what I call *resurrective ideology:* collective beliefs that seek to bring back to life the illusory absolutisms that have been nullified.

A good example of the way resurrective ideology works was how, after 9/11, Americans readily fell under the spell of the rhetoric of George W. Bush, who declared war on global terrorism and drew America into a grandiose, holy crusade that enabled Americans to feel delivered from trauma, chosen by God to rid the world of evil. Another example, in the wake of the economic crisis, was the attribution of messianic powers to President Obama, expectations of being saved that have led, as they inevitably do, to bitter feelings of disappointment. Resurrective ideology always ends up being destructive.

What is the alternative to resurrective ideology? Earlier I suggested that the healthy alternative is the forming of bonds of human understanding in which experiences of trauma can be held and lived through. What makes such empathic connections possible?

Jeremy Rifkin (http://www.huffingtonpost.com/jeremy-rifkin/the-empathic-civilization_b_416589.html) looks to neuroscientists and social scientists for the answer. Neuroscientists are claiming that human brains possess special neurons—"mirror-neurons"—that allow one to feel another person's emotional situation vicariously, as if it were one's own. Accordingly, it is built into our genetic endowment to be an empathic species, and human evolution is characterized by expansion of our empathic capacities to ever-broadening domains. Indeed, in Rifkin's utopian vision, communications technology is now extending the empathic capacities of human nervous systems so vastly as

to make possible a global empathic interconnectedness, a universal empathic connectivity that can avert a planetary collapse.

My own inclination has been to look not to neurobiology but to our existential structure: how we are necessarily understandable to ourselves as human beings. Because we and all those we love are finite, vulnerable beings, the possibilities of death and loss, and therefore of emotional trauma, always impend and are ever present. I have contended, however, that just as our finiteness and vulnerability to death and loss are fundamental to our existential constitution, so too is it constitutive of our existence that we meet each other as "siblings in the same darkness," deeply connected with one another in virtue of our *common* finiteness. Thus, although the possibility of emotional trauma is ever present, so too is the possibility of forming bonds of deep emotional understanding within which devastating emotional pain can be held and cared for, rendered more tolerable, and, hopefully, eventually integrated. Our existential kinship-in-the-same-darkness is the condition for the possibility of the healing power of human understanding.

Whatever differences we may have, Rifkin and I both apprehend the critical importance of mutual empathic understanding in our current Age of Trauma. Imagine an "empathic civilization" in which the obligation to provide a relational home for the emotional pain that is inherent to the traumatizing impact of our finiteness has become a shared ethical principle. In such a society, human beings would be much more capable of living in their existential vulnerability, anxiety, and grief, rather than having to revert to destructive ideological evasions of them. In such a societal context, a new form of identity would become possible, based on owning rather than covering up our existential vulnerability. Vulnerability that finds a hospitable relational home could be seamlessly and constitutively integrated into whom we experience ourselves as being. A new form of human solidarity would also become possible rooted not in shared resurrective grandiosity but in shared recognition and respect for our common human finiteness. If we can help one another bear the darkness rather than evade it, perhaps one day we will be able to see the light.

What Is Character and How Does It Change?

Traditionally, in psychology, psychiatry, and psychoanalysis, the term "character" has been used to refer to constellations or configurations of behavioral traits. "Anal characters" are said to be compulsive and perfectionistic; "hysterical characters" are described as histrionic; "passive-aggressive characters" show anger covertly by withholding; "narcissistic characters" are excessively self-centered; "borderline characters" form chaotic and primitive relationships; and so on. How might character be understood from a perspective, like mine, that takes organizations or worlds of emotional experiencing as its principal focus (Stolorow, Atwood, & Orange, 2002)? I have long contended that such organizations of emotional experiencing always take form in contexts of human interrelatedness (Stolorow, 2007; Stolorow, 2011).

Developmentally, recurring patterns of emotional interaction within the child-caregiver system give rise to principles (themes, meanings, cognitive-emotional schemas) that recurrently shape subsequent emotional experiences, especially experiences of significant relationships. Such organizing principles are unconscious, not in the sense of being repressed, but in being *pre-reflective*. Ordinarily, we just experience our experiences; we do not reflect on the principles or meanings that shape them. The totality of a person's pre-reflective organizing principles constitutes his or her character.

From this perspective, there can be no character "types," since every person's array of organizing principles is unique and singular, a product of his or her unique life history. These organizing principles show up in virtually every significant aspect of a person's life: in one's recurring relationship patterns, vocational choices, interests, creative activity, fantasies, dreams and emotional disturbances. Psychoanalytic therapy is a dialogical method for bringing this pre-reflective organizing activity into reflective self-awareness so that, hopefully, it can be transformed.

Early situations of consistent or massive malattunement to a child's emotional experiences (situations in which the child's feelings are ignored, rejected, invalidated, devalued, shamed, punished, and so on) have particularly important consequences for the development of character as I have conceived it. One consequence of such malattunement is that emotional states take on enduring, crushing meanings. The child, for example, may acquire an unconscious conviction that unmet developmental yearnings and reactive painful feeling states are manifestations of a loathsome defect, or of an inherent inner badness. A defensive self-ideal may be established, representing a self-image purified of the offending emotional states that were perceived to be unwelcome or damaging to caregivers. Living up to this emotionally purified ideal then becomes a central requirement for maintaining harmonious ties to others and for upholding self-esteem. Thereafter, the emergence of prohibited emotion is experienced as a failure to embody

the required ideal, an exposure of the underlying essential defectiveness or badness, and is accompanied by feelings of isolation, shame and self-loathing. A person with such unconscious organizing principles will expect that his or her feelings will be met by others with disgust, disdain, disinterest, alarm, hostility, withdrawal, exploitation, and the like, or will damage others and destroy his or her relationships with them.

A second consequence of significant emotional malattunement is a severe constriction and narrowing of the horizons of emotional experiencing so as to exclude whatever feels unacceptable, intolerable, or too dangerous in particular relationship contexts. When a child's emotional experiences are consistently not responded to or are actively rejected, the child perceives that aspects of his or her emotional life are intolerable to—and unwanted by—the caregiver. These regions of the child's emotional world must then be repressed or otherwise kept hidden in order to safeguard the needed tie. Large sectors of the child's emotional experiencing are sacrificed, and his or her emotional world may thereby become emptied and deadened. Such sacrificing may also take the form of aborting the process whereby emotional states are brought into language. When this is the case, emotions remain nameless, inchoate, and largely bodily, and psychosomatic problems may develop.

How does character—that is, the array of a person's prereflective organizing principles and the corresponding horizons of emotional experiencing—change as a result of a successful psychotherapeutic process? In regard to psychoanalytic therapy, there has been a longstanding debate over the role of cognitive insight vs. emotional attachment in the process of therapeutic change. The terms of this debate are directly descended from Descartes' philosophical dualism, which sectioned human experience into cognitive and emotional domains. Such artificial fracturing of human experience is no longer tenable in a post-Cartesian philosophical world. Cognition and emotion, thinking and feeling, interpreting and relating—these are separable only in pathology, as can be seen in the case of Descartes himself, the profoundly isolated man who created a doctrine of the isolated mind, of disembodied, unembedded, decontextualized *cogito*.

The dichotomy between insight through interpretation and emotional bonding with the therapist is revealed to be a false one, once it is recognized that the therapeutic impact of analytic interpretations lies not only in the insights they convey, but also in the extent to which they demonstrate the therapist's attunement to the patient's emotional life. I have long contended that a good (that is, a mutative) interpretation is a relational process, a central constituent of which is the patient's experience of having his or her feelings understood. Furthermore, it is the specific meaning of the experience of being understood that supplies its mutative power, as the patient weaves that experience into the tapestry of developmental longings mobilized by the therapeutic engagement. Interpretation does not stand apart from the emotional relationship between patient and therapist; it is an inseparable and, to my mind, crucial dimension of that relationship.

In a nutshell, interpretative expansion of the patient's capacity for reflective awareness of old, repetitive organizing principles occurs concomitantly with the emotional impact and meanings of ongoing relational experiences with the therapist, and both are indissoluble components of a unitary therapeutic process that establishes the possibility of alternative principles for organizing experience, whereby the patient's emotional horizons can become widened, enriched, more flexible, and more complex. As the tight grip of old organizing principles becomes loosened, as emotional experiencing thereby expands and becomes increasingly nameable within a context of human understanding, and as what one feels becomes seamlessly woven into the fabric of whom one essentially is, there is an enhancement of one's very sense of being. That, to my mind, is the essence of character change.

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Lifestyle and Mental Health

Roger Walsh, M.D., Ph.D.

Editor's Note. We are thankful for Roger Walsh amassing a wealth of literature in this article to support the use of therapeutic lifestyle changes. This is crucial information to use in the integration phase of the Hakomi model to bridge the transformation of core beliefs into congruent habits and lifestyle changes that support the establishment of new neural networks that undergird long-term change. The article was originally published in the *American Psychologist* (2011, Vol. 66, No. 7, pp. 579–592), and is used with permission.

Roger Walsh M.D., Ph.D. is a professor at the University of California Medical School, editor of *The World's Great Wisdom: Humanity's Heritage of Timeless Teachings,* and author of *Essential Spirituality: The 7 Central Practices to Awaken Heart and Mind.* He has made lifelong contributions to the interface of spirituality and therapy, and has been a key contributor to the work of the Integral Institute.

Abstract

Mental health professionals have significantly underestimated the importance of lifestyle factors as contributors to and treatments of multiple psychopathologies, for fostering individual and social wellbeing, and for preserving and optimizing cognitive function. Consequently, therapeutic lifestyle changes (TLCs) are underutilized, despite considerable evidence of their effectiveness in both clinical and normal populations. TLCs are sometimes as effective as either psychotherapy or pharmacotherapy, and can offer significant therapeutic advantages. Important therapeutic lifestyle changes include exercise, nutrition and diet, time in nature, relationships, recreation, relaxation and stress management, religious/spiritual involvement, and service to others. This article reviews research on their effects and effectiveness, the principles, advantages, and challenges of implementing them, and the forces (economic, institutional, and professional) hindering their use. Where possible, therapeutic recommendations are distilled into easily communicable principles, since such ease strongly influences whether therapists recommend and patients adopt interventions. Finally, the article explores the many implications of contemporary lifestyles and therapeutic lifestyle changes for individuals, society, and health professionals. In the 21st century, therapeutic lifestyles may need to be a central focus of mental, medical, and public health.

Key Words

Lifestyle, therapeutic lifestyle changes, mental health, psychopathology, cognitive capacities

Lifestyle and Mental Health

The central thesis of this article is very simple: Health professionals have significantly underestimated the importance of lifestyle for mental health. More specifically, mental health professionals have underestimated the importance of unhealthy lifestyle factors in contributing to multiple psychopathologies, as well as the importance of healthy lifestyles for treating multiple psychopathologies, for fostering psychological and social wellbeing, and for preserving and optimizing cognitive capacities and neural functions.

Greater awareness of lifestyle factors offers major advantages, yet few health professionals are likely to master the multiple burgeoning literatures. This article, therefore, reviews research on the effects and effectiveness of eight major therapeutic lifestyle changes; the principles, advantages, and challenges of implementing them; the factors hindering their use; and the many implications of contemporary lifestyles for both individuals and society.

Lifestyle factors can be potent in determining both physical

and mental health. In modern affluent societies, the diseases exacting the greatest mortality and morbidity—such as cardiovascular disorders, obesity, diabetes, and cancer—are now strongly determined by lifestyle. Differences in just four lifestyle factors—smoking, physical activity, alcohol intake, and diet—exert a major impact on mortality, and "even small differences in lifestyle can make a major difference in health status" (Khaw, Wareham, Bingham, Welch, & Luben, 2008, p. 376).

Therapeutic lifestyle changes (TLCs) can be potent. They can ameliorate prostate cancer, reverse coronary arteriosclerosis, and be as effective as psychotherapy or medication for treating some depressive disorders (Frattaroli et al., 2009; Pischke, Scherwitz, Weidmer & Ornish, 2008; Sidhu, Vandana, & Balon, 2009). Consequently, there is growing awareness that contemporary medicine needs to focus on lifestyle changes for primary prevention, secondary intervention, and to empower patients' self-management of their own health.

Mental health professionals and their patients have much to gain from similar shifts. Yet the importance of TLCs are insufficiently appreciated, taught, or utilized. In fact, in some ways, mental health professionals have moved away from effective lifestyle interventions. Economic and institutional pressures are pushing therapists of all persuasions towards briefer, more stylized interventions. Psychiatrists in particular are being pressured to offer less psychotherapy, prescribe more drugs, and focus on fifteen minute "med checks," a pressure that psychologists who obtain prescription privileges will doubtless also face (Mojtabai & Olfson, 2008). As a result, patients suffer from inattention to complex psychodynamic and social factors while therapists can suffer painful cognitive dissonance and role strain when they shortchange patients who need more than mandated brief treatments allow (Luhrmann, 2001).

A further cost of current therapeutic trends is the underestimation and underutilization of lifestyle treatments (Angell, 2009), despite considerable evidence of their effectiveness. In fact, the need for lifestyle treatments is growing, since unhealthy behaviors such as overeating and lack of exercise are increasing to such an extent that the World Health Organization (2008) warns that "an escalating global epidemic of overweight and obesity—'globesity'—is taking over many parts of the world," and exacting enormous medical, psychological, social, and economic costs.

Advantages of Therapeutic Lifestyle Changes

Lifestyle changes can offer significant therapeutic advantages for patients, therapists, and societies. First, TLCs can be both effective and cost-effective, and some—such as exercise for depression, and fish oils to prevent psychosis in high risk youth—may be as effective as pharmacotherapy or psychotherapy (Amminger et al, 2010; Dowd, Vickers, & Krahn, 2004; Sidhu et al., 2009). TLCs, which can be used alone or adjunctively, are often accessible and affordable, and many can be introduced quickly, sometimes even in the first session (McMorris, Tomporouski & Audiffren, 2009).

Therapeutic lifestyles have few negatives. Unlike both psychotherapy and pharmacotherapy, they are free of stigma, and can even confer social benefits and social esteem (Borgonovi, 2009). In addition, they have fewer side effects and complications than medications (Amminger et al., 2010).

Therapeutic lifestyles offer significant secondary benefits to patients, such as improvements in physical health, self-esteem, and quality of life (Deslandes et al, 2009). Furthermore, some TLCs—for example, exercise, diet and meditation—may also be neuroprotective, and reduce the risk of subsequent age-related cognitive losses and corresponding neural shrinkage (Hamer & Chida, 2009; Pagnoni & Cekis, 2007; Raji et al., 2009). Many TLCs—such as meditation, relaxation, recreation¸ and time in nature—are enjoyable, and may therefore become healthy self-sustaining habits (Didonna, 2009).

Many TLCs not only reduce psychopathology but can also enhance health and wellbeing. For example, meditation can be therapeutic for multiple psychological and psychosomatic disorders (Chiesa, 2009; Didonna, 2009; Shapiro & Carlson, 2009). Yet it can also enhance psychological wellbeing and maturity in normal populations, and cultivate qualities such as calm, empathy, and self-actualization that are of particular value to clinicians (Shapiro & Carlson, 2009; Shapiro & Walsh, 2006; Walsh, in press).

Knowledge of TLCs can benefit clinicians in several ways. Utilizing TLCs may result in greater clinical flexibility and effectiveness and less role strain. It will be particularly interesting to see to what extent clinicians exposed to information about TLCs adopt healthier lifestyles themselves and, if so, how this affects their professional practice, since there is already evidence that therapists with healthy lifestyles are more likely to suggest lifestyle changes to their patients (McEntee & Haglin, 1996). There are also entrepreneurial opportunities. Clinics are needed which offer systematic lifestyle programs for mental health similar

to current programs for reversing coronary artery disease (Pischke et al., 2008).

For societies, TLCs may offer significant community and economic advantages. Economic benefits can accrue from reducing the costs of lifestyle related disorders such as obesity, which alone costs over $100 billion in the United States each year (WHO, 2008). Community benefits can occur both directly, e.g. through enhanced personal relationships and service (Post, 2007), and also indirectly through social networks. Recent research demonstrates that healthy behaviors and happiness can spread extensively through social networks, even through three degrees of separation to, for example, the friends of one's friends' friends (Fowler & Christakis, 2008; 2010). Encouraging TLCs in patients may therefore inspire similar healthy behaviors and greater wellbeing in their family, friends, and coworkers, and thereby have far reaching multiplier effects (Christakis, 2009; Fowler & Christakis, 2010). This offers novel evidence for the public health benefits of mental health interventions in general, and of TLCs in particular.

So what lifestyle changes warrant consideration? Considerable research and clinical evidence support the following eight TLCs: exercise, nutrition and diet, time in nature, relationships, recreation, relaxation and stress management, religious and spiritual involvement, as well as contribution and service to others.

Exercise

Exercise offers physical benefits that extend over multiple body systems. It reduces the risk of multiple disorders, including cancer, and is therapeutic for physical disorders ranging from cardiovascular diseases to diabetes to prostate cancer (Khaw et al., 2009; Ornish et al., 2008). Exercise is also, as the *Harvard Mental Health Letter* (September 2000) concluded, "a healthful, inexpensive, and insufficiently used treatment for a variety of psychiatric disorders" (p. 5).

As with physical effects, exercise offers both preventive and therapeutic psychological benefits. Preventively, both cross-sectional and prospective studies show that exercise can reduce the risk of depression, as well as neurodegenerative disorders such as age-related cognitive decline, Alzheimer's and Parkinson's diseases (Hamer & Chida, 2009; Sui et al., 2009). Therapeutically, responsive disorders include depression, anxiety, eating, addictive, and body dysmorphic disorders. Exercise also reduces chronic pain, age-related cognitive decline, severity of Alzheimer's, and some symptoms of schizophrenia (Colcombe & Kramer, 2003; Daley, 2002; Deslandes et al., 2009; Stathopoulou, Powers, Berry, Smits, & Otto, 2006).

The most studied disorder is mild to moderate depression. Cross-sectional, prospective, and meta-analytic studies suggest that exercise is both preventive and therapeutic, and therapeutically it compares favorably with pharmacotherapy and psychotherapy (Dowd et al., 2004; Sidhu et al., 2009). Both aerobic exercise and nonaerobic weight training are effective for both short-term interventions and long-term maintenance, and there appears to be a dose-response relationship with higher intensity workouts being more effective. Exercise is a valuable adjunct to pharmacotherapy, and special populations such as postpartum mothers, the elderly, and perhaps children appear to benefit (Hamer & Chida, 2008; Larun, Nordeim, Ekeland, Hagen, & Heian, 2006; Sidhu et al., 2009).

Possible mediating factors that contribute to these antidepressant effects span physiological, psychological, and neural domains. Proposed physiological mediators include changes in serotonin metabolism, improved sleep, as well as endorphin release and consequent "runner's high" (Deslandes et al., 2009; Stathopoulou et al., 2006). Psychological factors include enhanced self-efficacy and self-esteem, interruption of negative thoughts and rumination (Dowd et al., 2004), and perhaps the breakdown of "muscular armor": the chronic psychosomatic muscle tension patterns that express emotional conflicts, and that are a focus of somatic therapies (Smith, 2000).

Neural factors are especially intriguing. Exercise increases brain volume (both grey and white matter), vascularization, blood flow, and functional measures (Erikson & Kramer, 2009; Hamer & Chida, 2009). Animal studies suggest that exercise-induced changes in the hippocampus include increased neuronogenesis, synaptogenesis, neuronal preservation, interneuronal connections, and BDNF (brain-derived neurotrophic factor, the same neurotrophic factor that antidepressants upregulate) (Cotman & Berchtold, 2002).

Given these neural effects, it is not surprising that exercise can also confer significant cognitive benefits (McMorris, Tomporowski & Audiffren, 2009). These range from enhancing academic performance in youth, to aiding stroke recovery, to reducing age-related memory loss and the risk of both Alzheimer's and nonAlzheimer's dementia in the elderly (Hamer & Chida, 2009; Quaney et al., 2009). Multiple studies show that exercise is a valuable therapy for Alzheimer's' patients that can improve intellectual capacities, social functions, emotional states, and caregiver distress (Christofoletti et al., 2007; Deslandes et al., 2009).

Meta-analytic studies provide more fine-grained details about the cognitive benefits of exercise for the elderly, and offer four kinds of good news. First, the effects can be large, reducing the risk of Alzheimer's by 45%, and increasing cognitive performance by 0.5 SD (Hamer & Chida, 2009). Second, though women may gain more than men, everyone seems to benefit, including both clinical and nonclinical populations. Third, improvements extend over several kinds of psychological functions, ranging from processing speed to executive functions. Fourth, executive functions, such as coordination and planning, appear to benefit most. This is a welcome finding given that executive functions are so important, and that both they and the brain areas that underlie them are particularly age sensitive (Colcombe & Kramer, 2003; Erikson & Kramer, 2009).

Finally, meta-analyses reveal the specific elements of exercise that benefit cognition. Relatively short programs of 1-3 months offer significant benefits, though six months or longer are more beneficial. There seems to be a threshold effect for session duration, since sessions shorter than 30 minutes—while valuable for physical health—yield minimal cognitive gains. Cognitive benefits are enhanced by more strenuous activity, and by combining strength training with aerobics (Colcombe & Kramer, 2003; Hertzog, Kramer, Wilson, & Lindenberger, 2009). In short, research validates the words of the second U.S. president, John Adams, who wrote that "Old minds are like old horses; you must exercise them if you wish to keep them in working order" (Hertzog et al., 2009, p. 26).

Fortunately, even brief counseling can motivate many patients to exercise (Long et al., 1996) and risks are minimal, although an initial medical exam may be warranted. Yet despite the many mental and medical benefits of exercise, only some ten percent of mental health professionals recommend it. And who are these ten percent? Not surprisingly, they are likely to exercise themselves (McEntee & Halgin, 1996).

Nutrition and Diet

There is now considerable evidence of the importance of nutrition for mental health, and an extensive review of over 160 studies suggests that dietary factors are so important that the mental health of nations may be linked to them (Gomez-Pinilla, 2008). Given the enormous literature on this topic, it is easy to feel overwhelmed. Therefore, the following section reviews this complex literature, but also distills easily communicable principles, since such ease strongly influences whether therapists recommend and patients adopt treatments (Duncan, Miller, Wampold & Hubble, 2010). Two major dietary components must be considered: food selection and supplements.

Food Selection

For food selection, the key principles are to emphasize a diet that:

1. Consists predominantly of multicolored fruits and vegetables (a "rainbow diet"),
2. Contains some fish (a "pescovegetarian diet"). Preference should be given to cold deep seawater fish (which are high in beneficial omega-3 fish oils, e.g. salmon), while avoiding the four species with high mercury levels (shark, swordfish, king mackerel, and tilefish) (Oken et al., 2008).
3. Reduces excessive calories. For societies confronting the "globesity" epidemic, reducing excess calories offers both economic and public health benefits (Delpeuch, Marie, Monnnier & Holdsworth, 2009). For individuals, reducing excess calories offers medical and neuroprotective benefits (Prolla & Mattson, 2001). This neuroprotection is especially important in light of recent findings suggesting that adult obesity may be associated with reduced cognitive function, as well as reduced white and gray matter brain volume (Raji et al., 2009; Wolf et al., 2007). Fortunately, pescovegetarian diets are low in calories.

Multiple human and animal studies suggest that pescovegetarian diets may prevent or ameliorate psychopathologies across the life span (Gomez-Pinilla, 2008; Willis, Shukitt-Hale, & Joseph, 2009). Such diets may enhance cognitive and academic performance in children, as well as ameliorate affective and schizophrenic disorders in adults. They also offer neuroprotective benefits as demonstrated by reductions in the incidence of age-related cognitive decline, Alzheimer's and Parkinson's diseases (Gomez-Pinilla, 2008; Kang, Ascherio, & Groodstein, 2005; Morris, Evans, Tangney, Bienias, & Wilson, 2006). Several studies of the Mediterranean diet—including a meta-analysis of twelve prospective studies with over 1.5 million subjects—found reductions in incidence of both Alzheimer's and Parkinson's diseases (Sofi, Cesari, Abbate, Gensini, & Casini, 2008). Dietary elements that appear to be particularly neuroprotective include fish, vegetables, and perhaps fruit, as well as lower intake of animal fats (Gu, Nieves, Stern, Luchsinger, & Scarmeas, 2010; Kang et al., 2005; Morris et al., 2006). Of enormous public health importance are recent findings

suggesting that due to epigenetic factors, "the effects of diet on mental health can be transmitted across generations" (Gomez-Pinilla, 2008, p. 575).

Supplements

Growing evidence suggests that food supplements offer valuable prophylactic and therapeutic benefits for mental health. Research is particularly being directed to vitamin D, folic acid, SAME (S-adenosyl-methionine), and most of all to fish oil (Sarris, Schoendorfer, & Kavanagh, 2009).

Fish and fish oil are especially important for mental health. They supply essential omega-3 fatty acids, especially EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid), which are essential to neural function. Systemically, omega-3s are anti-inflammatory, counteract the proinflamatory effects of omega-6 fatty acids, and are protective of multiple body systems. Unfortunately, modern diets are often high in omega-6s and deficient in omega-3s (Freeman et al., 2006) .

Is this dietary deficiency associated with psychopathology? Both epidemiological and clinical evidence suggest it is. Affective disorders have been most closely studied, and epidemiological studies, both within and between countries, suggest that lower fish consumption is associated with significantly, sometimes dramatically, higher prevalence rates of these disorders (Freeman et al., 2006; Noaghuil & Hibbeln, 2003). Likewise, lower omega-3 tissue levels are correlated with greater symptom severity in both affective and schizophrenic disorders, a finding consistent with emerging evidence that inflammation may play a role in these disorders (Amminger et al., 2010) . However, epidemiological studies of dementia and omega-3 intake are as yet inconclusive (Freeman et al., 2006).

Epidemiological, cross-sectional, and clinical studies suggest that omega-3 supplementation may be therapeutic for several disorders. Again, depression has been most closely studied (Stahl, Begg, Weisinger, & Sinclair, 2008). Several meta-analyses suggest that supplementation may be effective for unipolar, bipolar, and perinatal depressive disorders as an adjunctive, and perhaps even as a stand-alone treatment (Appleton, Rogers & Ness, 2010; Lin & Su, 2007), though at this stage supplementation is probably best used adjunctively. Questions remain about optimal DHA and EPA doses and ratios, although one meta-analysis found a significant correlation between dose and treatment effect, and a dose of 1000 mg of EPA daily is often mentioned, which requires several fish oil capsules (Freeman et al., 2006; Kraguljac et al., 2009).

There are also cognitive benefits. In infants, both maternal intake and feeding formula supplementation enhance children's subsequent cognitive performance (Freeman et al., 2006; Gomez-Pinilla, 2008; Innis, 2009;). In older adults, fish and fish oil supplements appear to reduce cognitive decline, but do not seem effective in treating Alzheimer's (Fotuhi, Mohassel, & Yaffe, 2009).

The evidence on omega-3s for other disorders is promising, but less conclusive. Supplementation may benefit schizophrenia and Huntington's disease, as well as aggression in both normal and prison populations. In children, omega-3s may reduce aggression and symptoms of ADHD (Freeman et al., 2006; Song & Zhao, 2008).

A particularly important finding is that fish oils may prevent progression to first episode psychosis in high risk youth. A randomized, double-blind, placebo-controlled study was conducted of 81 youths between 13 and 25 years of age with subthreshold psychosis. Administering fish oil with 1.2g of omega-3s per day for 12 weeks reduced both positive and negative symptoms as well as the risk of progression to full psychosis. This risk was 27.5% in controls but fell to only 4.9% in treated subjects. Particularly important was the finding that benefits persisted during the 9 months of follow up after treatment cessation (Amminger et al., 2010). Such persistence has not occurred with antipsychotic medications, which also have significantly more side effects. Although only a single study, these findings suggest another important prophylactic benefit of fish oils.

With one exception, risks of fish oil supplementation at recommended doses are minimal, and usually limited to mild gastrointestinal symptoms. The exception is patients on anticoagulants or with bleeding disorders because fish oils can slow blood clotting. Such patients should therefore be monitored by a physician.

Omega-3s modify genetic expression, and as such are early exemplars of a possible new field of "psychonutrigenomics." Nutrigenomics is an emerging discipline that uses nutrients to modify genetic expression (Gillies, 2007). Since genetic expression is proving more modifiable, and nutrients more psychologically important than previously thought, psychonutrigenomics could become an important field.

Space limitations allow only brief mention of another significant supplement, vitamin D. Vitamin D is a multipurpose hormone with multiple neural functions, including neurotrophic, antioxidant, and anti-inflammatory effects. (Cherniak, Troen, Florez, Roos, & Levis, 2009). Vitamin D deficiency is widespread throughout the population,

especially in the elderly, exacts a significant medical toll, and several studies suggest associations with cognitive impairment, depression, bipolar disorder, and schizophrenia. Mental health professionals are therefore beginning to join physicians in recommending routine supplementation (usually 400-1,000 units per day), and where indicated testing patients' vitamin D blood levels and modifying supplement levels accordingly (Cherniak et al, 2009).

There are further benefits to supplementation and pesco-vegetarian diets. First, they have multiple general health benefits and low side effects. Second, they may ameliorate certain comorbid disorders—such as obesity, diabetes, and cardiovascular complications—that can accompany some mental illnesses and medications. A diet that is good for the brain is good for the body. As such, dietary assessment and recommendations are appropriate and important elements of mental health care.

Nature

Imagine a therapy that had no known side effects, was readily available, and could improve your cognitive functioning at zero cost. Such a therapy has been known to philosophers, writers, and laypeople alike: interacting with nature. Many have suspected that nature can promote improved cognitive functioning and overall well-being, and these effects have recently been documented (Berman, Jonides, & Kaplan, 2008, p. 1207).

For thousands of years, wise people have recommended nature as a source of healing and wisdom. Shamans seek wilderness, yogis the forest, Christian Fathers the desert, and American Indians go on nature vision quests. Their experience is that nature heals and calms, removes mental trivia, and reminds us of what really matters (Walsh, 1999). More recently, romantic and existential philosophers echoed similar claims, which the romantic poet William Wordsworth (1998) famously summarized as:

> *Getting and spending we lay waste our powers*
> *Little we see in nature that is ours;*
> *We have given our hearts away….* (p. 307)

Yet today we are conducting a global experiment in which we increasingly spend our lives in artificial environments: walled inside and divorced from nature. Within these nature-free settings, noise is often annoying, and lighting is often artificial, low intensity (often less than 10% of sunny days), with nonnatural spectra and rhythms. As the burgeoning field of environmental psychology demonstrates, the psychological costs of such settings can be wide-ranging. These costs include disruptions of mood, sleep, and diurnal rhythms. Cognitive costs include short term impairment of attention and cognition, as well as long term reduced academic performance in the young, and greater cognitive decline in the elderly (Anthes, 2009; Higgins, Hall, Wall, Woolner, & McCaughey, 2005; Kuller, Ballal, Laike, Mikellides, & Tonello, 2006). Further psychological difficulties occur in special populations such as Alzheimer's and post-surgical patients (Anthes, 2009; Ulrich, 2006).

Media Immersion and Hyper-reality

In the last half century, a further artificial dimension has been added. Increasingly, we now spend hours each day immersed in a flood of multimedia stimuli, whose neurological impact we are only beginning to understand. However, some researchers have already concluded that "The current explosion of digital technology not only is changing the way we live and communicate but also is rapidly and profoundly changing our brains" (Small & Vorgan, 2008, p. 44). This is hardly surprising given that the average American spends several hours a day watching television, and increasing time with digital media (Putnam, 2000). As Thoreau (1854) lamented, people "have become the tools of their tools" (p. 85).

Fortunately, television and digital media can sometimes be beneficial. Multiple meta-analyses show that while aggressive television content can certainly foster negative attitudes and aggressive behavior, prosocial content can foster positive behavior such as altruism (Mares & Woodard, 2005; Preiss, Gayle, Burrell, Allen & Bryant, 2006). Likewise, digital immersion can benefit certain psychological and social skills in children, as the massive Digital Youth Project demonstrated (Ito et al., 2008).

However, media immersion can also exact significant psychological and physical costs in both children and adults, and a novel vocabulary has emerged to describe multiple "technopathologies." Excessive media immersion, especially when combined with heavy work demands, can create psychological dysfunctions that include disorders of:

Attention: *continuous partial attention* and *attention deficit trait.*

Cognition: *digital fog* and *techno-brain burnout.*

Overload: *data smog* and *frazzing* (frantic ineffectual multitasking).

Addiction: *screen sucking* and *on-line compulsive disorder.*

And, of course, *techno-stress* (Small & Vorgan, 2008; Wehrenberg & Coppersmith, 2008)

Yet the full implications of contemporary media and our

divorce from nature may extend much further and cut far deeper than individual stress and pathology. There is an exploding literature on social effects (e.g., Bracken & Skalski, 2009), and so powerful and pervasive is today's multimedia reality, that for philosophers such as Jean Baudrillard, it constitutes a "hyper-reality"—a simulated life-world that seems "more real than reality." So omnipresent are media manufactured images and narratives, and so divorced are we from the direct events they portray, that we largely live in, believe in, and respond to, this artificial hyper-real world, rather than to the natural world itself (Tiffin & Terashima, 2001).

Evolutionary, Existential, and Clinical Concerns

We have barely begun to research the many implications of artificial environments, new media, hyper-reality, and our divorce from nature. However, the problems they may pose can be viewed in multiple ways. Biologically, we may be adapted to natural living systems and to seek them out. This is the "biophilia hypothesis," and multiple new fields—such as diverse schools of ecology, as well as evolutionary, environmental, and eco psychologies—argue for an intimate and inescapable link between mental health and the natural environment (Esbjorn-Hargens & Zimmerman, 2009). In existential terms, the concern is that "…modern man—by cutting himself off from nature has cut himself off from the roots of his own Being" (Barrett, 1962, p. 126), thereby producing an existential and clinical condition generically described as "nature-deficit disorder" (Louve, 2005).

Clinicians harbor multiple concerns. Evolutionary and developmental perspectives suggest that children in environments far different from the natural settings in which we evolved, and to which we adapted, may suffer developmental disorders, with ADHD as one possible example (Bjorklund & Pellegrini, 2002). Likewise, evolutionary theory and cross-cultural research suggest that for adults, artificial environments and lifestyles may impair mental wellbeing, and also foster or exacerbate psychopathologies such as depression (Buss, 2000).

Therapeutic Benefits of Nature

Fortunately, natural settings can enhance both physical and mental health. In normal populations, these enhancements include greater cognitive, attentional, emotional, spiritual, and subjective wellbeing (Ho, Payne, Orsega-Smith, & Godby, 2003; Pryor, Townsend, Maller, & Field, 2006). Benefits also occur in special populations such as office workers, immigrants, hospital patients, and prisoners (Maller, Townsend, Pryor, Brown, & Sleger, 2006).

Nature also offers the gift of silence. Modern cities abound in strident sounds and noise pollution, and the days when Henry Thoreau (1921) could write of silence as a "universal refuge…a balm to our every chagrin" (p. 291) are long gone. Unfortunately, urban noise can exact significant cognitive, emotional, and psychosomatic tolls. These range, for example, from mere annoyance to attentional difficulties, sleep disturbances, and cardiovascular disease in adults, and impaired language acquisition in children (Clark & Stansfeld, 2007). By contrast, natural settings offer silence as well as natural sounds and stimuli that attention restoration theory and researchers suggest are restorative (Berman et al., 2008).

As yet, studies of specific psychotherapeutic benefits are limited, and sometimes conflated with other therapeutic lifestyle factors. Though further research is clearly needed, immersion in nature does appear to reduce symptoms of stress, depression, and ADHD, and to foster community benefits (Taylor & Kuo, 2009; Taylor, Kuo, & Sullivan, 2001). In hospital rooms that offer views of natural settings, patients experience less pain and stress, have better mood and postsurgical outcomes, and are able to leave the hospital sooner (Devlin & Arneill, 2003; Ulrich, 2006). Consequently, nature may be "…one of our most vital health resources" (Maller et al., 2006, p. 62). Given the global rush of urbanization and technology, the need for mental health professionals to advocate for time in, and preservation of, natural settings will likely become increasingly important.

Relationships

> *Of all the means which are procured by wisdom to ensure happiness throughout the whole of life, by far the most important is the acquisition of friends.*
>
> *—Epicurus (Gordon, 1999, p. 35).*

The idea that good relationships are central to both physical and mental wellbeing is an ancient theme, now supported by considerable research. Rich relationships reduce health risks ranging from the common cold to stroke, mortality, and multiple psychopathologies. On the positive side, good relationships are associated with enhanced happiness, quality of life, resilience, cognitive capacity, and perhaps even wisdom (Fowler & Christakis, 2008; Jetten, Haslam, Haslam, & Branscombe, 2009). Analyses of different domains of life indicate that quality of life is "dominated by the domain of intimacy" and that people with overt psychopathology have a lower quality of life "most

particularly in the domain of intimacy" (Cummins, 2005, p. 559).

These clinical observations can now be grounded in the emerging field of social neuroscience, which suggests that we are interdependent creatures, hardwired for empathy and relationship through, for example, the mirror neuron system (Cattaneo & Rizzolatti, 2009). So powerful is interpersonal rapport that couples can mold one another both psychologically and physically. They may even come to look more alike, as resonant emotions sculpt their facial muscles into similar patterns, a process known as "the Michelangelo phenomenon" (Rusbult, Finkel & Kumashiro, 2009).

Not surprisingly, good relationships are crucial to psychotherapy. Multiple meta-analyses show that they account for approximately one-third of outcome variance, significantly more than does the specific type of therapy (Duncan et al., 2010), and that "The therapeutic relationship is the cornerstone" of effective therapy (Norcross, 2010, p. 114). As Irvin Yalom (2002) put it, the "paramount task is to build a relationship together that will itself become the agent of change" (p. 34). Ideally, therapeutic relationships then serve as bridges that enable patients to enhance life relationships with family, friends, and community.

The need may be greater than ever, because social isolation may be increasing, and exacting significant individual and social costs. For example, considerable evidence suggests that, compared to previous decades, Americans are now spending less time with family and friends, have fewer intimate friends and confidants, and are less socially involved in civic groups and communities (McPherson, Smith-Lovin & Brashears, 2006; Putnam, 1995; 2000). However, there is debate over, for example, whether Internet social networking exacerbates or compensates for reduced direct interpersonal contact, and over the methodology of some social surveys (Fischer, 2009). Yet there is also widespread agreement that "the health risk of social isolation is comparable to the risks of smoking, high blood pressure and obesity…. [while] participation in group life can be like an inoculation against threats to mental and physical health" (Jetten et al., 2009, p. 29, 33).

Beyond the individual physical and mental health costs of greater social isolation are public health costs. In "perhaps the most discussed social science article of the 20th century" (Montanye, 2001), and in a subsequent widely read book, *Bowling Alone*, the political scientist Robert Putnam (1995; 2000) focused on the importance of "social capital." Social capital is the sum benefit of the community connections and networks that link people and foster, for example, beneficial social engagement, support, trust, and reciprocity (Bhandari & Yasunobu, 2009). Social capital seems positively and partly causally related to a wide range of social health measures—such as reduced poverty, crime, and drug abuse—as well as increased physical and mental health in individuals. Yet considerable evidence suggests that social capital in the United States and other societies may have declined significantly in recent decades (Putnam, 1995, 2000).

In short, relationships are of paramount importance to individual and collective wellbeing, yet the number and intimacy of relationships seems to be declining. Moreover, "the great majority of individuals seeking therapy have fundamental problems in their relationships…" (Yalom, 2002, p. 47). Clients' relationships are a major focus of, for example, interpersonal and some psychodynamic psychotherapies (Shedler, 2010). Yet clients' interpersonal relationships often receive insufficient attention in clinical and training settings compared to intrapersonal and pharmacological factors (Pilgrim, Rogers, & Bentall, 2009; Shedler, 2010). Focusing on enhancing the number and quality of clients' relationships clearly warrants a central place in mental health care.

Recreation and Enjoyable Activities

> *Through experiences of positive emotions people* transform *themselves, becoming more creative, knowledgeable, resilient, socially integrated, and healthy individuals*
>
> *—Barbara Fredrickson (2002, p. 123).*

Involvement in enjoyable activities is central to healthy lifestyles, and the word "re-creation" summarizes some of the many benefits (Fredrickson, 2002). Behaviorally, many people in psychological distress suffer from low reinforcement rates, and recreation increases reinforcement. Recreation may overlap with, and therefore confer the benefits of, other TLCs such as exercise, time in nature, and social interaction. Recreation can involve play and playfulness, which appear to reduce defensiveness, enhance wellbeing, and to foster social skills and maturation in children (Lester & Russell, 2008), and perhaps also in adults (Gordon & Esbjorn-Hargens, 2007). Recreation can also involve humor, which appears to mitigate stress, enhance mood, support immune function and healing, and serve as a mature defense mechanism (Lefcourt, 2002).

Further recreational activities include art and other esthetic pleasures, which have long been employed for self-healing. For example, the great 19th century philosopher, John Stuart Mill—one of history's outstanding intellectual

prodigies—spent his childhood force-feeding himself with facts. However, when at twenty he fell into a severe depression, he turned to the arts—music, painting, and especially poetry—for self-therapy and these, his biographer reports, "saved him" (Gopnik, 2008).

Many studies suggest that enjoyable recreational activities, and the positive emotions that ensue, foster multiple psychological and physical benefits (Ho et al., 2003; Gordon & Esbjorn-Hargens, 2007; Lester & Russell, 2008). However, some studies of recreation include and conflate additional healthy lifestyle factors such as exercise, relaxation, and nature, and there are few clinical guidelines. Mental health professionals will therefore need to use their clinical skills to assess and support individual patients' interests. "The bottom line message is that we should work to cultivate positive emotions in ourselves and in those around us not just as end states in themselves, but also as a means of achieving psychological growth and improved psychological and physical health over time" (Fredrickson, 2002, p. 120).

Relaxation and Stress Management

Chronic stressors can exact a major toll across multiple organ systems and levels. This toll extends from psychological to physiological to chemical (e.g., oxidative stress) to genomic expression (hence the new field of "psychosocial genomics") (Dusek et al., 2008). Even though stress is universal, few people are trained in managing it. In addition, humans now face an array of novel stressors for which there are no evolutionary or historical precedents. Many people, therefore, respond unskillfully or even self-destructively, aided and abetted by pervasive unhealthy influences such as advertising, media role models, and novel psychoactive drugs (Buss, 2000). Yet many skillful strategies for stress management are now available, ranging from lifestyle changes to psychotherapy to self-management skills. Beneficial TLCs include almost all those discussed in this article—especially exercise, recreation, relationships, and religious/spiritual involvement—and specific self-management skills can both complement and foster TLCs.

Self-Management Skills

Specific stress management skills include somatic, psychological, and contemplative approaches. Somatic skills span both ancient Oriental and contemporary Western techniques. The Chinese mindful movement practices of tai chi and qui gong are increasingly popular in the West, and research studies suggest both physical and psychological benefits (Kuramoto, 2006). A review of fifteen randomized controlled trials of tai chi's effects on psychosocial wellbeing found significant benefits for the treatment of anxiety and depression, but also noted the mixed quality of the trials (Wang et al., 2009).

Western self-management skills include mental approaches such as self-hypnosis and guided imagery (Trakhtenberg, 2008), as well as somatic approaches, especially muscle relaxation therapies which center on systematically tightening and relaxing major muscle groups. By doing this, patients learn to identify and release muscle tension, and eventually to self-regulate both muscle and psychological tensions. Muscle relaxation skills are widely used for the treatment of anxiety disorders, including panic and generalized anxiety disorders, and meta-analyses reveal medium to large effect sizes (Manzoni, Pagnini, Castelnuovo, & Molinari, 2008)

Contemplative skills such as meditation and yoga are now practiced by millions of people in the United States, and by hundreds of millions worldwide (Walsh, in press). Concomitantly, an explosion of meditation research has demonstrated a wider array of effects—psychological, therapeutic, neural, physiological, biochemical and chromosomal—than any other psychotherapy (Walsh & Shapiro, 2006; Walsh, in press).

Considerable research suggests that meditation can ameliorate a wide array of (especially stress related) psychological and psychosomatic disorders in both adults and children (Arias, Steinberg, Banga & Trestman, 2006; Black, Milam & Sussman, 2009; Chiesa, 2009; Dusek et al., 2008). Multiple studies including meta-analyses, show that meditation can reduce stress measures in both clinical and normal populations (Chiesa & Serreti, 2009; Hofmann, Sawyer, Witt & Oh, 2010). Partially responsive psychosomatic disorders include, for example, cardiovascular hypertension and hypercholesterolemia, hormonal disorders such as primary dysmenorrheal and type two diabetes, asthma and chronic pain (Anderson, Liu & Kryscio, 2008; Shapiro & Carlson, 2009). Responsive psychological difficulties include, among others, insomnia, anxiety, depressive eating, and borderline personality disorders (Didonna, 2009; Shapiro & Carlson, 2009).

Meditation can also be beneficial when combined with other therapies. The best known combinations are Dialectical Behavior Therapy (primarily used for borderline personality disorder), Mindfulness-Based Stress Reduction, and Mindfulness-Based Cognitive Therapy. A meta-analysis of mindfulness based therapies found large effect sizes for anxiety and depressive symptoms of 0.95 and 0.97 respec-

tively, and therapeutic gains were maintained at follow-up (Hofmann, Sawyer, Witt & Oh, 2010).

It is now clear that meditation, either alone or in combination with other therapies, can be beneficial for both normal and multiple clinical populations. However, it is less clear how different meditation practices compare, or how meditation compares with other therapies and self-regulation strategies such as relaxation, feedback, and self-hypnosis (Walsh & Shapiro, 2006).

Yoga may also be helpful for stress and mood disorders. However, studies are fewer, and reviews draw cautious conclusions (da Silva, Ravindran, & Ravindran, 2009; Kirkwood, Rampes, Tuffrey, Richardson, & Pilkington, 2005; Pilkington, Kirkwood, Rampes, & Richardson, 2005).

In addition to its benefits for relaxation and stress management, meditation may also enhance measures of psychological capacities, health, and maturity in both patients and normals (Walsh & Shapiro, 2006). Particularly important to health care professionals are findings that meditation can enhance valued caregiver qualities such as empathy, sensitivity, emotional stability, and psychological maturity, while reducing distress and burnout (Shapiro & Carlson, 2009). On the cognitive side, studies suggest that meditation can enhance some measures of cognition, and may reduce age-related cognitive losses and corresponding brain shrinkage (Pagnoni & Cekic, 2007; Xiong & Doraiswamy, 2009). The universality of stress, as well as the multiple benefits of both lifestyle changes and self-regulation skills for managing stress, suggests that these TLCs and self-regulation skills deserve to be central components of health professionals' training, personal and professional practice, and public outreach.

Religious and Spiritual Involvement

Religious and spiritual concerns are vitally important to most people and most patients. Some 90% of the world's population engages in religious or spiritual practices, these practices are a major means of coping with stress and illness, and most patients say that they would welcome their health professionals inquiring about religious issues (Koenig, 2002). Yet few health professionals do. This may be unfortunate given the prevalence and importance of religious-spiritual practices, their many influences on lifestyle and health, their impact on therapeutic relationships and effectiveness, and the deep existential issues they open (Fowler, 1995; Koenig, 2009).

Considerable research suggests a complex but usually beneficial relationship between religious involvement and mental health. The most massive review to date found statistically significant positive associations in 476 of 724 quantitative studies (Koenig, McCullough, & Larson, 2001). In general, religious-spiritual involvement is most likely to benefit when it centers on themes such as love and forgiveness, and likely to be less helpful or even harmful to mental health when themes of punishment and guilt predominate.

Benefits span an array of health measures. Mental health benefits include enhanced psychological, relational, and marital wellbeing, as well as reduced rates of disorders such as anxiety, depression, substance abuse, and suicide. For physical health, religious involvement seems beneficially related to both specific disorders such as hypertension and to nonspecific mortality rates (Koenig et al., 2001). Strikingly, those who attend religious services at least weekly, tend to survive for approximately *seven years* longer than those who don't, even when studies control for factors such as baseline health and health behaviors (Koenig et al., 2001). Important mediating and contributory factors likely include service to others, and especially social support. Contemplative practices such as meditation offer further psychological, somatic, and spiritual benefits (Didonna, 2009; Shapiro & Carlson, 2009; Walsh & Shapiro, 2006).

Religion, Spirituality, and Psychological Development

It is important for mental health professionals to recognize that there are multiple levels of religious development. These levels range from *preconventional* to *conventional* to *postconventional* (or from *prepersonal* to *personal,* and *transpersonal*), and are associated with extremely different kinds of religious faith, practice, behavior, and institutions (Fowler, 1995; Wilber, 2005, 2006).

For example, consider the developmental stages of religious faith. At the preconventional level, *mythic-literal* faith involves an unreflective, literal acceptance of culturally provided beliefs. At the *synthetic-conventional* level, people begin to create their own individual, but still largely unreflective, synthesis of diverse conventional beliefs. At later postconventional stages, such as *conjunctive* and *universalizing* faith, individuals critically reflect on conventional assumptions, open to multiple perspectives, confront paradoxes, and extend their care and concern to all peoples (Fowler, 1995; Wilber, 2006).

When developmental differences go unrecognized, problems ensue. For example, the views of one level are taken as normative, and those at this level tend to assume that people at other levels are mistaken, misguided, malevolent,

or disturbed (Wilber, 2005). Many contemporary religious and cultural conflicts appear to reflect these kinds of cross-level misunderstandings (Walsh, 2009).

This developmental perspective brings new clarity to many religious and spiritual issues. For example, it makes clear that religions are not only culturally diverse, but also developmentally diverse, and that mental health professionals need to be sensitive to both kinds of diversity. Religion can be an expression of immaturity, conventional maturity, and postconventional maturity, and of corresponding motives and concerns ranging from egocentric to ethnocentric to worldcentric (Wilber, 2006). Interpretations that view religion as, for example, always regressive or always transcendental, invariably overlook this developmental perspective. Examples of reductionistic interpretations that view religion as *necessarily* regressive or pathological include the writings of the so called "neoatheists," such as the recent extremely popular books *The God Delusion*, *The End of Faith*, and *God Is Not Great*, all of which are ignorant of developmental research (Dawkins, 2006; Harris, 2005; Hitchens, 2007). Unfortunately, the widespread failure to recognize developmental differences—in faith, morality, values, ego, worldview, and more—and their far reaching implications for religion and multiple other areas of life, seems a significant factor underlying many contemporary cultural conflicts (Walsh, 2009; Wilber, 2006)

Of course, religious behavior can sometimes be regressive or pathological. However, religious behavior can also both express and foster healthy, mature, and even exceptionally mature development. In fact, a classic goal of spiritual practices such as meditation is to foster postconventional development through, for example, *bhavana* (mental cultivation) in Buddhism and *lien-hsin* (refining the mind) in Taoism (Walsh & Shapiro, 2006). Contemporary research and meta-analysis are supportive, since meditators tend to score higher on measures of ego, moral and cognitive development, as well as self-actualization, coping skills and defenses, and states and stages of consciousness (Alexander & Langer, 1990; Alexander, Rainforth, & Gelderloos, 1991). Ideally, religious-spiritual traditions offer both "legitimacy" (support for people's current level of psychological and faith development), as well as "authenticity" (support for maturation beyond current levels) (Wilber, 2005). Given the significance of religious and spiritual involvement, it seems important for therapists to be familiar with developmental and other key issues, and where appropriate, to inquire about and support healthy involvement.

Contribution and Service

From ancient times, service and contribution to others have been regarded as virtues that can benefit both giver and receiver (Walsh, 1999). The world's major spiritual traditions emphasize that, when viewed correctly, service is not necessarily a sacrifice, but rather can foster qualities that serve the giver, such as happiness, mental health, and spiritual maturity. Altruism is said to reduce unhealthy mental qualities such as greed, jealousy, and egocentricity, while enhancing healthy qualities such as love, joy, and generosity (Hopkins, 2001; Walsh, 1999). The benefits of service are also said to extend to healing, such that healing oneself and others can be intimately linked. Multiple myths and healing traditions describe "wounded healers": people who by virtue of their own illness learn to heal others, and may thereby be healed themselves.

In our own time, both theory and research point to correlations between altruism and measures of psychological and physical health. Multiple studies, including those that control for prior health factors, suggest that people who volunteer more are psychologically happier and healthier, physically healthier, and may even live longer (Borgonovi, 2009; Grimm, Spring, & Dietz, 2007; Post, 2007). The so called "paradox of happiness" is that spending one's time and resources on others can make one happier (Walsh, 1999).

Altruists of all ages may experience a "helpers-high" (Post, Underwood, Schloss, & Hulbert, 2002). Even required community service for adolescents seems to effect long-term positive psychological changes, while even mandated monetary donations can make college students happier than spending the money on themselves (Dunn, Aknin, & Norton, 2009). Erik Erikson (1959) famously suggested that "generativity" (care and concern for others, and especially for future generations) may be a hallmark of successful maturation. Moreover, altruism has a positive social contagion or multiplier effect. For example, cooperative behaviors cascade through social networks to induce further cooperation in others (Fowler & Christakis, 2010), while at the community level, service is a key contributor to social capital (Putnam, 2000).

In summary, considerable research shows positive relationships between altruistic behavior and multiple measures of psychological, physical, and social wellbeing. However, there are important qualifiers. Major exceptions include "caretaker burnout," such as overwhelmed family members caring for a demented spouse or parent. Furthermore, the

kind of motivation powering prosocial behavior affects outcome. Whereas service motivated by pleasure in helping is associated with multiple positive measures (such as positive affect, self-esteem, self-actualization, and life satisfaction), this may not be true when service is driven by a sense of internal pressure, duty, and obligation (Gebauer, Riketta, Broemer, & Mai, 2008).

Psychotherapists repeatedly rediscover the healing potentials of altruistic behavior for both their patients and themselves. Alfred Adler emphasized the benefits of "social interest," while helping other members contributes to the effectiveness of group therapy and support groups such as Alcoholics Anonymous (Duncan et al., 2010). Likewise, therapists often report that helping their patients can enhance their own wellbeing (Yalom, 2002). Wisely perceived, altruism is not self-sacrifice, but rather enlightened self-interest (Walsh, 1999). As the Dalai Lama put it, "if you're going to be selfish, be wisely selfish—which means to love and serve others, since love and service to others bring rewards to oneself that otherwise would be unachievable" (Hopkins, 2001, p.150).

These benefits of altruism hold major implications for our understanding of health, lifestyle, and therapy. Based on their findings, Brown et al. (2003) wrote an article titled "Providing Social Support May be More Beneficial Than Receiving It," and concluded that interventions "designed to help people feel supported may need to be redesigned so that the emphasis is on what people do to help others" (p. 326). Other researchers quipped, "If giving weren't free, pharmaceutical companies could herald the discoveries of a stupendous new drug called 'Give Back'—instead of 'Prozac'…" (Post & Niemark, 2007 p. 7). Contribution and service to others have long been considered central elements of a life well lived. Now they can also be considered central elements of a healthy life.

Discussion

A culture's technology has far reaching effects on people's psychology and lifestyles (Wilber, 2000), and modern technology is now affecting our psychology, biology, society, and lifestyles in ways we are only beginning to comprehend. Moreover, technological innovations and their lifestyle effects are changing "more quickly than we know how to change ourselves" (Putnam, 2000, p. 402). Many of the resultant costs are doubtless as yet unrecognized, and this raises a disconcerting question: Could some of our patients be "canaries in the mine," warning us of ways of life that may exact a toll on us all? This is a question that health professionals will need to confront increasingly as technological, environmental, and lifestyle changes accelerate.

Interactions Among Therapeutic Lifestyle Factors

Fortunately, individual TLCs appear to counter many medical and psychological complications of contemporary pathogenic lifestyles. This raises a hopeful possibility: Might multiple TLCs be even more effective? There is evidence for this in both animal studies and clinical medicine. For example, physical activity increases neuronogenesis in the rat hippocampus. However, the effect is maximal only when the animals are exposed to a rich social environment rather than living in isolation (Stranahan, Khalil & Gould, 2006). Similarly, in his program to reverse coronary arteriosclerosis, Dean Ornish employed four TLCs: exercise, vegetarian diet, relaxation and stress management, and social support. Each proved beneficial, and effects were additive (Pischke et al., 2008). Might this also be true for psychological disorders? Quite possibly, but as yet we have no clear answer.

Difficulties of Implementing Therapeutic Lifestyles

Given the many advantages of TLCs, why have mental health professionals been so slow to adopt them? The reasons range from patients to therapists to society. Effective public health programs will therefore need to address all these.

For patients, TLCs can require considerable and sustained effort, and many patients feel unable or unwilling to do them. Patients often have little social support, little understanding of causal lifestyle factors, and a passive expectation that healing comes from an outside authority or pill (Duncan et al., 2010). Societally, whole industries are geared towards encouraging unhealthy choices. Patients contend with a daily barrage of psychologically sophisticated advertisements encouraging them, for example, to consume alcohol, nicotine, and fast food, in the never ending search for what the food industry calls the "bliss point" of "eatertainment" through "hypereating"(Kessler, 2009). Unfortunately, you can never get enough of what you don't really want, but you can certainly ruin your health and life trying (Walsh, 1999).

Therapists also face challenges. The first is simply to become familiar with the large literature on TLCs. The second is a professional bias towards pharmacological and formal psychotherapeutic interventions. In addition, fostering patients' TLCs can be time intensive, can demand considerable therapeutic skill, and is not well reimbursed. Therapists may also harbor negative expectations (not with-

out some justification) that patients won't maintain the necessary changes. However, it is crucial to be aware of the Rosenthal effect: the self-fulfilling power of interpersonal expectations. Finally, cognitive dissonance may be at work when therapists' own lifestyles are unhealthy (McEntee & Halgin, 1996).

Taken together, these therapist beliefs and biases may constitute a variant of what is called "professional deformation." This is a harmful distortion of psychological processes such as cognition and perception produced by professional practice and pressures. As long ago as 1915, a sociologist observed that "The continued performance of a certain profession or trade creates in the individual a deformation of the reasoning process….such deformation is largely a matter of adaptation to environment" (Langerok, 1915). Professional deformation can be extreme. Consider, for example, the forced psychiatric hospitalization and drugging of Soviet dissidents by Soviet mental health professionals who believed that the counterconventional beliefs of these "patients" were diagnostic of "sluggish schizophrenia" (Voren, 2002).

However, more subtle forms of professional deformation may be more pervasive and more difficult to recognize. The mental health system's current pharmacological emphasis—at the cost of psychotherapeutic, social, and TLC interventions—may be one example. This pharmacological bias is heavily promoted by the pharmaceutical industry, and Marcia Angell (2009), former editor of *The New England Journal of Medicine*, concluded that "one result of the intensive bias is that….Even when changes in lifestyle would be more effective, doctors and their patients often believe that for every ailment and discontent there is a drug" (p. 12). An obvious question then becomes: Does the widespread underemphasis of lifestyle factors across mental health professions constitute a further example of professional deformation?

Are there additional therapeutic lifestyle factors? Certainly, and examples range from sleep hygiene to ethics, community engagement, and moderating television viewing, all of which have demonstrated mental health benefits (Ito et al., 2008; Preiss et al., 2006; Putnam, 2000; Walsh, 1999).

Wide scale adoption of TLCs will likely require wide scale interventions that encompass educational, mental health, and public health systems. Political interventions may also be necessary, for example, to reduce children's exposure to media violence and unhealthy food advertising. Of course, these are major requirements. However, given the enormous mental, physical, social, and economic costs of contemporary lifestyles, such interventions may be essential. In the 21st century, therapeutic lifestyles may need to be a central focus of mental, medical, and public health.

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Oppression Embodied: The Intersecting Dimensions of Trauma, Oppression, and Somatic Psychology

Rae Johnson, Ph.D.

Editor's Note: Rae Johnson, one our most experienced somatic educators, offers a stellar example of integrating mind/body and behavior with cultural values and social structures in a exemplary study that illustrates Hakomi's unity principle. It is hoped her article will inspire others to follow her lead, since this inclusive quality of holistic work is simply too rare. It was previously published in the USABP Journal, Vol. 8, No. 1, 2009, pp. 19–31, and is used with permission.

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Abstract

Through narrative somatic inquiry, this study investigates the lived embodied experiences and understandings of individuals who identify as oppressed. It explores the somatic impact of their oppression: how they embody oppressive social conditions through their non-verbal interactions, and how oppression affects their relationship with their body. The participants' narratives suggest that a relationship exists between the somatic effects of trauma and embodied responses to oppression, and that the body is an important source of knowledge and power in resolving the traumatic imprint of oppression. These new insights are linked to the developing fields of somatic psychology and traumatology, and implications for diversity work in body psychotherapy is discussed.

Key words: *somatic psychology, trauma, oppression, diversity, embodiment*

The research discussed in this paper explores the somatic imprint of oppression: how we embody oppressive social conditions through our non-verbal interactions, and how oppression affects our relationship with our own bodies. The study integrates somatic perspectives with narrative inquiry (Clandinin & Connolly, 2000) to investigate how oppression is enacted and reproduced through the body, using a "body stories" approach (Johnson,1997; Olsen, 1991; Sullivan, 1995) to access and document the lived embodied experiences and understandings of five women who identify as oppressed. This knowledge is then framed in the context of psychotherapeutic and psycho-educational practice, with particular emphasis on understanding how the somatic imprint of oppression may be linked to our emerging understandings of the body's role in mediating trauma, and how somatic psychotherapists can more effectively incorporate issues of diversity and social justice in their work.

An Introductory Narrative

For many years—well into my twenties, in fact—I would have insisted to anyone who asked that I was not oppressed. I was raised in a family of gentle introverts with a quirky disregard for social norms, and believed that my unique upbringing had successfully inoculated me against the kind of gender and sexual oppression that I knew other queer women experienced. For example, neither of my parents particularly treated me like a girl as I was growing up. Not that they treated me like a boy, either. Rather, they simply encouraged me to be myself—to identify and articulate my preferences, make my own choices, and take responsibility for my actions. My parents taught me by example and instruction to be more self-referenced than socially-referenced. They were always asking me what I thought, so I learned what I thought. As a result, I knew myself much better than I knew the world.

It wasn't until I started school that I began to recognize how different this made me, and how the combination of quiet, polite dependability and self-assured autonomy placed me outside traditional gender categories—I wasn't really like the girls (too strong minded), and I wasn't really like the boys (too reserved). More significantly, I understood somehow that I couldn't choose between being "just like the boys" or "just like the girls" without sacrificing something essential to myself. So I didn't. With the tacit but unquestioning support of my family and a series of friends who were attracted to my capacity to know my own mind, coupled with my relative disregard for what other people thought, I instinctively refused to "do gender" the way I was expected to. Of course, I refused to do many things the way I was expected to—not with any particular desire to rebel, but simply because it never really occurred to me to do otherwise.

The eccentricity that naturally developed from repeatedly choosing my own course when faced with an endless series of small but significant social choices pervaded all aspects of my identity. "Not fitting in" became such an intrinsic element of my day-to-day lived experience that it went relatively unnoticed, and was not understood by either myself or my family to be inherently problematic. Certainly, the effects of having constantly to choose between being true to myself and belonging to a social group were not analyzed, problematized, or politicized in any substantive way. It was just "the way I was," and "the way things were." Sustained by the care and understanding of a small circle of kindred spirits, the cost of my deviance remained unexamined until much later in my life.

Although I deeply appreciate the degree to which privilege undergirds the preceding statements—that I lived in a context where my oppression was not a vivid and painful figure, but rather an invisible but pervasive ground—I must also acknowledge the unique challenges it presents. One of the women I interviewed for this study remarked that she felt that one of the most destructive aspects of covert abuse was its capacity to render its victims unaware of the damage it inflicts, and my own process of reclaiming embodied knowledge lost to oppression echoes that experience.

As I noted earlier, this reclaiming process did not really begin until I was well into my twenties, through deep immersion in psychotherapy training that integrated bodywork and a dramatic exposure to the ideas and practices of radical feminism. As a student in a professional training program in Gestalt Therapy, I was exposed to the full range of bodywork approaches that had influenced the development of Gestalt—bioenergetics, Alexander Technique, Feldenkrais, Rolfing, and massage, for example—and this exposure was as much experiential as it was theoretical. Around the same time, I formed a women's group with a number of my closest friends, and every Tuesday night for two very full years, we wrestled (sometimes literally) with the personal and interpersonal impact of living as women in a patriarchal society. I also began working as a counselor at a shelter for homeless young women, where I witnessed first-hand the devastation of body, mind, and spirit that violence against women perpetrates. My first night on duty at the shelter, I spent an hour cleaning dirt out of the ragged scrapes on a 16-year-old girl's face after she was dragged across the pavement during a gay bashing outside a local dyke bar.

After years of quietly accepting the notion that my refusal to conform to society's expectations was my individual choice (and therefore, my responsibility), I began to realize how very few genuinely satisfactory choices I really had with respect to gender and sexuality. For the first time, I began to question why I was repeatedly forced to refuse a social norm (to behave a certain way, to dress a certain way, to respond to men a certain way) and accept the consequences (alienation and marginalization), rather than feeling free to choose from a range of possible options, or to create my own. Radical feminist theory helped me to frame my discomfort and disconnection as systemic and political, rather than merely an introvert's existential dilemma. Although very few feminists were talking about the body at the time (Price & Shildrick, 1999), my own work with the body in psychotherapy provided a rich source of material that linked clearly and directly with issues of oppression. Light bulbs were going off—but they were going off in my body, not just my head.

These light bulb flashes of insight illuminated a somatic landscape far more damaged by the effects of oppression than I would otherwise have imagined. As I undertook additional professional training in dance/movement therapy, psychodramatic bodywork, crisis intervention, and traumatology, I began to recognize a pattern of impact that echoed what I was seeing in my clinical practice working with survivors of childhood trauma. Specifically, the effects of oppression on the way I used and felt my body seemed very similar to the somatic effects of trauma.

A research study I conducted on movement therapy with survivors of trauma (Johnson, 1996) reinforced for me the importance of recognizing the ways in which the body deals with traumatic experience, and helped me begin to articulate the somatic dimensions of post-traumatic stress disorder (PTSD). Subsequent trauma research (Levine,

1997; Nujenhuis, 2000; Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, 1994, 1996) has affirmed the role of the body in mediating trauma, and describes the somatic impact. These effects may include a sense of disconnection from the body (experiencing the body as somehow unrelated to the self, or an inability to feel all or part of the body) that the literature often refers to as somatic or somatoform dissociation (Nujenhuis, 2000). The somatic impact of trauma may also include a constriction of body movement (and a related discomfort with being physically expressive), somatic re-experiencing of traumatic events (body-based implicit memories in which only the physical sensation is present), a heightened startle response, and a range of somatic complaints (Scaer, 2000).

As I began to make these links for myself, I grew more attuned to the somatic manifestations of oppression in others, and began to attend more carefully for connections between what students and clients told me about their bodies and the social contexts in which they lived. I became increasingly curious about the ways in which the somatic imprint of social injustice might be experienced and understood through the bodies and voices of the oppressed themselves. What follows is the result of my research on the somatic dimensions of oppression, viewed through the lens of the accumulated knowledge of twenty years as a body-centered psychotherapist and somatic educator. To help locate this research in the context of my own professional work, another brief story is in order.

Several years ago, I was facilitating a movement therapy group for women in recovery from addiction. One of the participants brought an intriguing combination of enthusiasm and reticence to the work of the group—she struggled with group dynamics and finding her voice in group discussions, but was game to try any movement experiment I suggested. Her body language was hesitant, and her use of space limited, but there was often a smile on her face and a sparkle in her eyes. During one session, we improvised to music using large chiffon scarves, imagining that our bodies were expressing the qualities of air. As the sound of harp strings floated through the room, I noticed that Julia was moving with more freedom and ease.

When the group sat down together afterwards to discuss our experiences, the grin on her face was impossible not to notice. Beaming with pride, she confided that she had put her arms over her head. I think we were all a little mystified by that statement at first, until she explained that her childhood experiences with a physically and emotionally abusive alcoholic father had so stifled her ability to feel free in her own body, that she had become unable to raise her arms over her head without feeling completely exposed and vulnerable. She had been taught not to take up space, not to reach or strive or rejoice. She had also learned not to expose the vulnerable core of her body to possible attack by others. Although she was now well into her thirties, she couldn't remember ever before feeling comfortable raising her arms over her head in the presence of others. It struck me again how critical the relational dimension of embodiment is, and how the ways we are with others (or fail to be) is so much an issue of the body.

From my perspective, there were incredible forces preventing Julia from being in her own body, in her own way. Although that morning Julia had named her father's abuse as one of those forces, I had heard her name many other factors in the course of our work together: being a street kid, a lesbian, a drug addict, a psychiatric survivor, a woman. I resolved then to focus my professional work on understanding how multiple social forces work through the body to bring oppression into being. The research described in this paper is grounded in that resolve, and I hope to offer new insights, knowledge, and understandings that are relevant to scholars and practitioners alike.

Conceptual Framework

The theoretical foundations of this research are located in the scholarly literature of a number of fields and disciplines, including embodiment and non-verbal communication theories, somatic psychology, and feminist and critical traumatology. Key findings in the existing literature are described below in a sequence intended to guide the reader through the interdisciplinary conceptual framework from which the study rationale and research questions emerge.

1. In short, embodiment theories and nonverbal communication research tell us that:
    a. We become who we are through our bodies (not just our minds) (Hanna, 1970; Merleau-Ponty, 1962),
    b. Our embodied experience is necessarily also a social experience (Merleau-Ponty, 1962; Price & Shildrick, 1999; Weiss, 1999).
    c. The nonverbal component of social interaction (rather than institutional structure) is the locus for the most common means of social control (Henley, 1977; Henley & Freeman, 1995).
2. Traumatology theory and research tells us that:
    a. Trauma is significantly mediated through the body and manifested in embodied experience (Scaer,

2005; van der Kolk, 1994).

b. Oppression can be located on a continuum of trauma and be understood as chronically traumatic (Burstow, 2003).

3. Somatic psychology proposes that it is possible to transform individual experience through a process of somatic psychotherapeutic intervention and psycho-education that supports the cultivation of an integrated, embodied consciousness (Hartley, 2004).

Given that embodiment theory and research suggest that the body is a significant locus for experience through social interaction, and critical trauma theorists argue that oppression is traumatic, it is reasonable to assume that oppression may manifest in embodied experience in ways that parallel the somatic effects of trauma. Establishing this link through empirical research provides direction for somatic psychologists who engage in teaching, research, or psychotherapy with individuals who have experienced oppression. (For the purposes of this research, oppression is defined as a system of multiple social forces that unfairly privilege the members of some groups over others and subsequently limits access to resources and opportunities for members of socially subordinate groups.)

Although this study represents a preliminary foray into a rich and complex area, it does offer the beginnings of new knowledge. Specifically, it starts to uncover how oppression affects the way some individuals experience and relate to their bodies and the bodies of others. It also suggests that what we "know in our bodies" is critical to our understanding of social justice, and to psychotherapeutic and psycho-educational approaches to diversity work.

Emerging from the conceptual foundation and research rationale described above, my study asked the following questions:

1. How is social oppression experienced in and through the body?
2. How do we bring our bodies to the navigation of power differentials in relationships with others?
3. Can somatic psychotherapy/psycho-education provide a means for becoming more conscious and skilled in the ways we embody power?

These questions will be revisited throughout the text in both the literature review and in the discussion of the research data.

Review of the Literature

Scholars working in the area of critical social theory are making significant contributions to understanding the role of the body in social experience (Cohen & Weiss, 2003; Price & Shildrick, 1999; Shilling, 1993; Turner, 1996), and offer important insights into how the body and society interact, affect and/or create one another. In particular, the work of social theorists emphasizes the role of the body in reproducing society, both through conscious modification and unconscious use. Despite the significance of these contributions, few of these ideas have been applied to practices developed to enrich the lived embodied experience of individuals. At the same time, most of the emphasis in somatic psychology to date has focused on the subjective internal experience of the body, with little reference to how that experience translates to the social and political realms (Hartley, 2006; Knaster, 1993). By linking key findings of critical embodiment theorists with somatic theory and emerging trauma research, I believe there exists significant potential for somatic psychology theory and practice to become a source of social as well as personal transformation.

Evolving Perspectives on Embodiment

In contrast to the primal and Eastern conceptions of the body/mind (Godagama, 1997; Yuasa, 1987) in which the body/mind is conceptualized holistically, the Hellenic intellectual tradition separates body and mind, and devalues the body and its perceptions as unreliable and illusory (Murphy, 1969). In a philosophical legacy extending from Plato and Socrates through to Descartes, the physical senses are regarded as imperfect instruments in perceiving the objective truth of external reality. Only the mind is considered capable of accurately discerning and understanding the true essence of existence, and bodily experience is actually thought to inhibit and impair our attempts to understand the nature of reality. This perspective has been profoundly influential on the Judeo-Christian theological tradition, as well as on later philosophical schools of thought.

Phenomenology offers perhaps the most significant Western philosophical challenge to Cartesian dualism. In particular, Merleau-Ponty's work offers an embodied, existential form of phenomenology that emphasizes the role of the body in human experience, and attempts to resist the traditional Cartesian separation of mind and body. In *Phenomenology of Perception* (1962), Merleau-Ponty argues that consciousness, the world, and the human body are intricately intertwined and mutually engaged, and that physical reality is not composed of the unchanging objects of the natural sciences, but is a correlate of our body and its sensory functions. His elaborations of body image and embodied intersubjectivity provide key concepts in understanding how becoming fully embodied depends on being

with other lived bodies. His notion of inter-corporeality acknowledges that the individual lives in a multi-personal field, and that this field conversely inhabits the individual. Embodied experience and the relational world are so deeply intertwined that inter-corporeality grounds and sustains our ability to relate to the world. The discovery of mirror neurons about a decade ago (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996) provides fascinating evidence of the possible neurobiological basis for inter-corporeality, and ongoing studies in mirror neuron research include discussions on the possible implications and applications of this embodied intersubjectivity (Decety & Lamm, 2003). The conceptual significance of inter-corporeality to this research is the implication that we remain exposed to the other through embodied experience, and can take the other's different perspectives into ourselves through our bodies. In short, what happens to us on a body level in relation to others (including the embodied dimensions of oppressive social interactions) is both meaningful and profoundly important to our self-identity.

Somatic theory as articulated by Hanna (1970, 1986–1987) and others (Greene, 1997, 1998; Johnson, 1983, 1985, 1997) offers further insight into the question of how we bring our bodies to our social relationships with others. Somatic theory draws upon existential, evolutionary, and phenomenological perspectives to suggest that what we experience as reality depends on the quality of somatic perception we bring to our engagement with the world, and that privileging the subjective experience of the body corrects an historical imbalance that marginalizes this dimension of human experience. Using a somatic perspective allows us to understand one of the implications of this imbalance as a narrowing or constriction of consciousness that results in less freedom, fewer choices, and less functional patterns of embodied engagement with the environment (Hanna, 1970). In tracing the philosophical developments that support somatic experiencing, Hanna argues that the need for a return to the lived experience of the body is related to the evolution of the human species, in response to industrialization, rationalization, and the commodification of the body. From this perspective, somatically informed psychotherapeutic and psycho-educational practices could be understood as facilitating the awareness of body experience in support of its modification toward a more functional and intentional relationship between body, mind, and environment.

The Body and Critical Social Theory

Despite phenomenologist's (and somatic theorist's) conceptual linking of the individual and social worlds through the experienced body, the body is rarely directly referenced in sociological writings (Levin, 1988; Ritzer, 1996), and has only recently become a legitimate topic of study in its own right (Shilling, 1993). Gradually, however, the incorporeal abstraction characteristic of Cartesian dualism is beginning to be contested by feminist, queer, and other critical social theorists, who have made connections between disembodiment and gender oppression, as well as other forms of marginalization.

For example, in their preface to *Feminist Theory and the Body*, Price and Shildrick (1999) assert that "The association of the body with gross unthinking physicality marks a further set of linkages—to black people, to animals, and to slaves" (p. 2). Feminist theorists are also noting how embodiment has historically been characterized by binary norms—male/female, well/ill, heterosexual/homosexual, black/white—and that these norms are both threatened and confirmed by the existence of bodies that fall outside them.

Queer theorist Judith Butler (1991, 1993) provides a key concept in understanding how bodies are implicated, not only in the social production of difference, but in notions of identity as well. Drawing on Irigaray's (1985) notion of multiplicity beyond the binary and Foucault's social construction of the body (1990, 1991), Butler's notion of performativity—identity as constructed through a process of bodily reiterative acts and gestures—suggests how our experienced and experiencing body is us. Through performativity, the body "text" shifts from being comprised mostly of stable, unchanging nouns to becoming significantly about verbs. One of the important implications of performativity with respect to this research is that it provides a conceptual foundation for how somatic interventions (both psychotherapeutic and psycho-educational) might transform the somatic impact of oppression by providing alternative ways of performing embodied experience.

Critical race theorists are also addressing the somatic impact of oppression by examining how it promotes a dissociative relationship between self and body. For example, Laura Doyle (in Cohen & Weiss, 2003) suggests that traumatic oppressions such as slavery and racism work to colonize the body of the abject subject, so that access to our own bodily experience as self must be filtered through the lens of those colonizing others. French feminist psychoanalyst Julia Kristeva first posited the concept of the abject body in 1989, and proposed the idea of "abjection" as the turn against the maternal body. This highly ambiguous, ambivalent distancing represents rejection without separa-

tion. Like many somatic psychotherapists, Doyle suggests the art of language as a way of "touching" into the body without pain, and her analysis of the somatic impact of oppression aligns with (and complexifies) how many traumatologists currently understand the dissociative dimensions of trauma.

By mapping the intersections of critical social theory and the body, scholars and activists are moving issues of embodiment to the center of cultural and political analyses. For example, poet and activist Eli Clare (1999, 2001) articulates the links between disability, class, race, queerness, environmentalism, and child abuse by placing the lived experience of the body at the center of these experiences. In critically examining personal experiences with cerebral palsy, class oppression, and identification as a transgendered individual, s/he argues that attempting to avoid the body as the identified source of problematic difference simply perpetuates and entrenches those differences, and that reclaiming the body as self is a profound act of political resistance.

Trauma, Oppression, and the Body

Over the years, psychological researchers and theorists have developed differing understandings of how human beings respond to and are affected by trauma, ranging from early Freudian connections between neurosis and child abuse, to "shell shock" during the World War I, to more recent brain research. Increasingly, the social contexts of interpersonally-inflicted or relational trauma are being examined, in order to identify some of the underlying roots of this persistent source of human distress and suffering.

Judith Lewis Herman (1992) was one of the first to make connections across different forms of violence, and draw parallels between the private violence experienced in the lives of women and children and the public violence of war and terrorism. She asserted that there are important relationships between our personal experiences and the political context in which they occur, and that the legacy of various forms of trauma touches every facet of our society. Subsequent theorists and researchers in the field of traumatology also suggest that much of the violence and abuse resulting in PTSD exists on a continuum (and within the larger context) of social oppression (Scaer, 2005). For example, some scholars have frame violence in the Native American, African American, and LGBTQII (lesbian, gay, bisexual, transgendered, queer, intersexed, and inquiring) communities as a maladaptive response to racism and heterosexism (Bent-Goodley, 2001; Leventhal & Lundy, 1999; Wahal & Olson, 2004).

While it may seem self-evident that the explicit and implicit violence that attends various forms of social oppression can be traumatic for those who experience it on a regular basis, little scholarly research exists to support such a link. Feminist theorist Bonnie Burstow (2003) is one of few trauma specialists making explicit conceptual associations between trauma and oppression. She cites theorists working in the area of trans-generational trauma and community trauma to argue that individuals from oppressed and marginalized groups are violated in ways that have lasting psychological effects. She writes, "The point is oppressed people are routinely worn down by the insidious trauma in living day after day in a sexist, racist, classist, homophobic, and ableist society" (Burstow, 2003, p. 1296). Burstow describes trauma not as a disorder, but as a reaction to a kind of wound, and argues that there is a physicality to trauma that must be recognized even when no overt bodily assault occurs. In particular, she notes that the trauma of oppression often results in some degree of alienation from the body, and there is now some support in the research literature to suggest that systemic oppression and socially constructed imperatives about the body combine in ways that support marginalized subjects to experience their bodies as if they were outside them (McKinley & Hyde, 1996).

While the conceptual framework within which this research is grounded is aligned with theoretical perspectives that problematize a purely medical approach to trauma (Burstow, 2003; Herman, 1992), it is important to recognize that traumatologists now identify trauma as a physiological as well as a psychological and social experience (Levine, 1997; Ogden et al., 2006; Rothschild, 2000; Scaer, 2005; van der Kolk, 1994). Rothschild (2000) notes that, "Even when the traumatic event causes no direct bodily harm, traumatic events exact a toll on the body as well as the mind" (p. 34). Within the field of trauma research, the somatic effects of trauma have now been well documented (Rothschild, 2000; van der Kolk, 1994; van der Kolk et al, 1996).

In particular, somatic dissociation is strongly associated with reported trauma (Van der Hart et al., 2000; Waller et al., 2000), and there is now considerable evidence that somatic dissociative symptoms are prominent in the response of individuals undergoing trauma and in its immediate aftermath. While a universally agreed upon clinical definition of dissociation is not yet available, its features include "...a disruption in the usually integrated functions of consciousness, memory, or perception of the environment" (DSM-IV, p. 477). Extending that disruption to the somatic level, the dissociative mechanism that

serves to protect the individual from distressing material also serves to disconnect them from an overall sense of kinesthetic awareness. Although somatic dissociation can be measured as a normal phenomenon, potentially occurring throughout the population, it is also highly correlated with trauma (Speigel, 1994). Research also indicates a relationship between PTSD and other somatic complaints, although the physical complaints of trauma survivors (i.e., headaches, stomach or digestive problems, immune system problems, asthma or breathing problems, dizziness, chest pain, and chronic pain) are often treated symptomatically, rather than as indications of PTSD. Van Ommeren, Sharma, Sharma, Komproe, Cardeña, & de Jong (2002) found that the number of PTSD symptoms (independent of depression and anxiety) predicted both number of reported somatic complaints and number of organ systems involving such complaints. Neurobiological changes (i.e., alterations in brainwave activity, in size of brain structures, and in functioning of processes such as memory and fear response) and psycho-physiological changes (i.e., hyperarousal of the sympathetic nervous system, increased startle response, sleep disturbances, increased neuro-hormonal changes that result in heightened stress and increased depression) have also been noted (Jaffe & Segal, 2005).

The trauma literature reviewed here emphasizes the somatic dimensions of trauma in order to establish the importance of the body in mediating trauma, and highlight the ways in which critical trauma theorists are reconceptualizing oppression as traumatic. This research extends that knowledge by describing how oppression manifests in and through embodied experience, and to what extent it manifests across established categories of trauma response.

Method

Participants were chosen for this study based on four criteria: a) they expressed an interest and willingness to explore their somatic experience of oppression both verbally and non-verbally; b) they claimed to have sufficient perspective on their experience (either psychological and/or chronological) that an exploration of it would not likely be detrimental to them; and c) they reasonably expected that participation in the study would afford them increased personal insight into their experience. Participants were recruited mainly from the student body at the University of Toronto in Toronto, Canada. Many students at this culturally-diverse university face significant social and economic barriers to higher education, and experience ongoing oppression and marginalization.

Each of my participants engaged in two, private, in-person tape-recorded interviews with me, each lasting approximately 60 to 90 minutes. The interviews focused on their personal experiences of oppression, and how these experiences had affected: a) their relationship to their own body and the bodies of others, and b) their non-verbal communication patterns. During certain parts of the interviews, some of my participants also engaged in one or two somatic "experiments" drawn from well-established somatic psychotherapy techniques. These experiential exercises included a guided Focusing® exercise (see Gendlin, 1987), as well as an interactive "boundary" exercise to explore issues and patterns in the use of personal space. This experiential component was intended to allow us both to have an opportunity to develop somatic connections to the material raised during the interview/discussion—to get a feeling in our bodies what was being described in words—and to assist us both in understanding the nature of the participant's experiences of oppression.

Five narratives were developed from the interviews, and although the length of the original narratives does not permit their inclusion in this paper (each is about 20 pages), highlights from the narratives are interspersed throughout the discussion of the research findings. The participants referenced in the findings include Crissy (a mixed race aboriginal woman with a history of addiction and disordered eating), Natalie (a woman in a primary relationship with an Indian man who has struggled with body image issues for most of her life), Zaylie (a bisexual mixed race black woman who currently works as a physiotherapist and as an exotic dancer), and Pat (a middle-aged lesbian whose recent experience with a Bartholin cyst evoked feelings reminiscent of an earlier abusive relationship).

Findings

A number of common threads were woven throughout the participants' body stories that allowed for a discussion of larger meanings in the context of the research questions, and permitted links to the existing scholarly literature that were grounded in the conceptual framework of the thesis. While several themes emerged from the information held within the narratives, this paper will focus only on two:

1. The relationship between embodied responses to oppression and the somatic impact of trauma.
2. The body as a source of authoritative knowledge as well as personal and social power, and as a site for resisting oppression.

In my discussion of these themes, I will highlight how they provide insights into the research questions, how they

extend what is already known about the role of the body in oppressive interpersonal interactions, and what these stories contribute to the theoretical literature and to professional practice in body psychotherapy.

Embodied Trauma

One of the questions posed by this study was how oppression was experienced in and through the body. The narratives offer a number of important insights by the participants into the ways in which experiences of oppression have affected the felt sense of their body. In particular, participants described experiences that focused on: a) embodied memory, b) somatic vigilance, and c) withdrawal or alienation from the body.

Embodied memory. Several of the participants offered insight and understanding into how the body may "hold" or remember experiences of oppression. For example, when I asked Crissy to reflect on the bodily impact of oppression in her life, she offered a vivid description of the sensation of her body being shaken in response to an oppressive experience. Drawing on the implicit knowledge accessed through the Focusing® technique, she talked about feeling as though her body was being violently shaken by an external force, and feeling a "jolt of fear" course through her body. This sensation of being shaken leaves her feeling confused, helpless, and frozen, as if "stuck between fight and flight." Moreover, Crissy notes that these sensations of disruption and disorientation are very familiar to her, and often accompany experiences of feeling oppressed. By linking this description to the traumatology literature (Rothschild, 2000; Van der Kolk, 1994), it is possible to understand Crissy's embodied memory of oppression as resembling the somatic impact of trauma, and exemplifying one aspect of traumatic intrusion, which is characterized by "physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event" (APA, 1994).

Pat's explanation of her experience with a Bartholin cyst may also suggest a link between the somatic impact of trauma and oppression. As she described the physiological and psychological impact of having a vaginal cyst, Pat talked about uncovering the deeper symbolic layers of what the cyst represented about her childhood experience and the power imbalance in her relationship with her older brother. She described how her vagina held some memories of her relationship with her brother that needed to be held until she developed the psychological strength and capacity to look at these particular issues of oppression. By connecting with the felt experience of her body, Pat was able to access layers of grief and loss that are "laid down in the body." While Pat's training as a psychotherapist has provided her with a conceptual framework for making the links between trauma and the body, it is in relation to my asking about the effects of oppression on her body that she offers this example. Further, she clearly indicates that she understood it as a form of embodied memory, and as a symbolic somatic manifestation of an earlier traumatic wounding.

Another example of the impact of oppression on the felt experience of the body is provided by Zaylie's recounting of her experience engaging in the Focusing® exercise during our second interview, in response to my query about how oppression has affected her body:

> When you first asked me . . . what came to me was that my body is hungry and dry and parched. Then the more I thought about it, I started to feel uncomfortable . . . that there was this kind of tar coating all of my insides that was stopping me from absorbing anything. Like everything that would come into me would just pass through.

Zaylie describes this tarry substance as something she ingested from the outside world, and that now exists within her body as the residue of her experiences of oppression. She further acknowledges that this residue prevents her from absorbing emotional, psychological, and relational nutrients; from being affected by positive experiences with others. It is not just that her body lives with the residual effects of oppression, but that oppression interferes with her capacity to engage with and be nourished by the world. Although Zaylie does not describe this experience as an intrusive traumatic memory, it is clear from her description that repeated experiences of oppression have left an imprint on the felt experience of her body that could be understood as a form of damage. This echoes Burstow's (2003) assertion that trauma is a reaction to a kind of wound, and that the physicality of trauma must be recognized even when no overt bodily assault occurs. Recent research into the somatic effects of trauma (Ogden, 2006; Van der Kolk & Courtois, 2005) underscores the role of the body in mediating traumatic experiences, and the participants' descriptions of their embodied experience of oppression provides important insights into how oppression as a form of trauma may be held and remembered in the body.

Somatic vigilance. All of the research participants spoke about how highly sensitized and attuned they feel to the reactions and responses of others, and although their narratives also describe the ways in which they now take advantage of this heightened awareness in a positive way, it was clear in my conversations with them that their relational

sensitivity was initially born of necessity resulting from difficult and problematic experiences with others.

In her narrative, Zaylie referred to a type of somatic vigilance with respect to men, and spoke about needing to be able to read their non-verbal communication, especially when in close physical proximity. Given that she also names sexism and sexual assault by men as part of her experience of oppression, it is perhaps not surprising that her vigilance is oriented to them as a potential source of danger. Natalie also made reference to her vigilance in noticing men in her environment, and notes her discomfort as something felt in her body. Pat observed that she is especially attentive to the bodily dimension of interpersonal interaction, and acknowledges that she becomes increasingly self-conscious when she feels that others do not respond to her nonverbal cues with some degree of kinesthetic empathy. As a young child, Crissy's somatic vigilance was focused on her mother, and her narrative describes the ways in which she learned to be highly attentive to her mother's smallest nonverbal cues in order to help Crissy anticipate and avoid an angry outburst of verbal abuse. This increased alertness to the body signals of others has continued into adulthood, and Crissy noted that she remains highly sensitive to nonverbal indicators from others that might suggest interpersonal conflict or difficulty.

Since human somatic responses to danger (even when that danger is not necessarily physical) are hard-wired into our autonomic nervous systems (van der Kolk, 1994), it makes sense that participants would report feeling increased body alertness around potential sources of harm, whether that source is a group of men standing on a street corner, or a conference table full of white, middle-class physicians (as is true for Zaylie when she attends case conferences at the hospital where she works). The experiences of participants as related in their narratives illustrate the ways in which this somatic vigilance became established for them as a habitual pattern of response. Although the catalysts for this response are experiences of oppression, participants' descriptions of the response itself are similar to those found in PTSD (APA, 1994).

Somatic withdrawal and alienation. In describing the somatic impact of oppression, all of the participants spoke about the profound disconnection from the felt experience of their bodies. In many cases, this disconnection was something that participants only realized recently through the process of addressing the impact of oppression. At the same time, participants also described this withdrawal from the felt experience of the body as strategic: something that allowed them to survive the painful feelings generated by their experiences of oppression.

Pat spoke to the experience of somatic disconnection at some depth, and notes that her regaining of body awareness has proved crucial to her sense of healing and empowerment. She described the inability to fully inhabit her body as one of the core pieces of traumatic fallout, and a "certain state of collapse" in her body that reflected a similar state of collapse in her psyche. At the same time, her use of various bodily mediated substances—smoking, alcohol, food—can also be thought of as coping strategies that induce the desired effect of bodily detachment and numbing. Crissy's elaboration of her years of drug and alcohol abuse echo a similar strategy. Interestingly, Zaylie describes how she learned an effective dissociative strategy through the process of dance education, in her description of how dancers are trained to view their own body as an object, as explicitly taught in "white" dance forms such as ballet.

The descriptions of somatic withdrawal and alienation provided by participants appear to correlate in some ways to the PTSD "avoidance" criteria described in the literature on trauma. These criteria include feelings of detachment from self and others, which on a body level might refer to what Nijenhuis (2000) and others describe as "somatic dissociation." The experiences described in the narratives also bring to mind the work of McKinley and Hyde (1996) on objectified body consciousness, who suggest that systemic oppression and socially constructed imperatives about the body combine in ways that support marginalized subjects to experience their bodies from the outside, rather than from within.

Overall, it seems clear from the stories told by participants that some relationship between the somatic effects of trauma and embodied responses to oppression exists. While some of the somatic dimensions of oppression cited in the narratives lent themselves quite easily to a comparison with the body's known responses to trauma, the descriptions do not map precisely onto PTSD or chronic PTSD criteria. Although the psychobiology of trauma is an emerging and rapidly-developing field, and the somatic dimensions of traumatic experience increasingly recognized (Ogden et al, 2006; van der Kolk, 1994), empirical correlations between trauma and oppression (and oppression as a form of chronic trauma) have not yet been established. However, theoretical links do exist (Burstow, 2003) and the descriptions of experiences of oppression by participants

in this study suggest that further research to articulate the specific somatic effects of oppression as a form of trauma is worth pursuing.

Body Knowledge and Power

Despite the embodied wounds inflicted over a lifetime of unjust and inequitable power relations, each of the participants in this study also experienced her body as an important source of knowledge and power, and as a site for resisting oppression. Although safely regaining access to this source of power often required the same patient creativity that Laura Doyle (in Cohen & Weiss, 2003) describes, each of them recognized the importance of doing so. Natalie described a process of increasing reconnection to her body as she grows older, and echoes Pat's observation that she didn't know how somatically dissociated she was until after she regained more feeling, sensation, and awareness in her body.

Crissy talked about how yoga has helped her address the disconnection she once felt from her body, and Zaylie found that "black" dance forms provide her with a similar path back to her body. For Zaylie and Crissy both, dance forms that reconnect them with their cultural heritage provided a medium for embodied expression that helps them reclaim the power of their bodies for themselves. Zaylie engages in African and Caribbean dance forms, as well as hip hop. Crissy is involved with traditional North American aboriginal dance forms. Zaylie noted that dance has provided her with an extensive movement vocabulary, and that she consciously uses her learned capacity to articulate concise non-verbal messages as a way to resist or deflect oppression.

For Natalie, yoga provides a means for connecting with her body in a gentle and compassionate way that helps to soften some of the critical voices that have become embedded in her body image over the years. Crissy's movement classes serve a very similar purpose, and allow her not only to engage with her body in positive ways, but to facilitate that engagement for others. Pat and Natalie both acknowledged that finding ways to experience themselves as athletically capable has helped to foster a growing sense of their bodies as powerful, although it is perhaps worth noting that neither has yet undertaken this reclaiming through team sports.

In nearly every case, this reclaiming of the body as a source of personal and social power seems to have evolved through a process of intuitive selection and fortunate circumstance. In all cases, it has also proceeded through a process of education, whether that learning occurs independently and informally, or through more established frameworks. However, except for Zaylie (whose capacity for embodied knowledge has been consistently cultivated over many years of movement training), the way back to the body has not been an obvious or accessible path. Certainly, participants acknowledge that safe forums for such explorations are rare, and that public health and education systems have not been sites for reclaiming their bodies as primary sources of experience, knowledge, and power.

Discussion

The knowledge generated by research participants on the somatic impact of oppression contributes to existing knowledge in several fields. The themes that emerge from the embodied narratives in this study underscore the significance of the body as a source and site of social injustice (Henley, 1977; Henley & LaFrance, 1984; Henley & Freeman, 1995; Price & Shildrick, 1999). The embodied experiences of oppression described by participants also reflect the more complex, nuanced understandings of social oppression as multifaceted (Johnson, 2001) and provide new insight into the way experiences of multiple forms of oppression are mediated in and through the body, by making connections to the trauma literature that acknowledges the traumatic nature of oppression. Specifically, the findings illustrate how oppressive interpersonal relations elicit traumatic reactions, and point to how the emergent nature of the experienced body (Grosz, 1994) provides a medium for transforming oppression. The narratives in this study also offer vivid illustrations of the way in which the body is a potential source of personal knowledge, agency, power, and creative expression.

This section discusses the contributions of the research in relation to scholarly knowledge and professional practice. First, the contributions to knowledge in the related fields of embodiment theory and somatic psychology are discussed. Contributions to traumatology are also examined. Next, the implications for practice are discussed as I draw on the experiences of research participants described in the narratives to suggest how these new understandings of embodied experience could inform current practices in somatic psychology and body psychotherapy.

Contributions to Embodiment Theory

Embodiment theories are currently situated across a number of fields, including anthropology (Csordas, 1999), sociology (Shilling, 1993; Turner, 1996) and women's studies (Price & Shildrick, 1999). Social theories of the body offer

important insights into how the body and society affect and/or construct one another. They elaborate the role of the body as a site of personal identity, how our social status is reflected in our relationship with our body and the body language(s) we speak, and the role of the body in reproducing society through conscious modification and unconscious use. Critical social theorists (Butler, 1999; Clare, 2001; Grosz, 1994) have theorized the body as crucial in the articulation of social difference, and an important basis for social oppression as well as a site for resistance. However, few theories of embodiment have been linked to practical applications that might transform the daily lived experience of individuals within particular social contexts (Weiss, 1999).

The narratives of lived experience related by the participants in this research provide unique insights into how oppression is embodied, how the subjective felt experience of oppression is understood and expressed in the body, and how the body can provide a medium for transforming personal experience and social interaction. These stories put flesh and blood onto the bones of embodiment theory while simultaneously challenging the tendency of some embodiment theory to focus on the body as an abstract social concept or surface for cultural inscription (Fielding, 1996).

For example, all of the participants described the impact of oppression on their bodies as occurring on an inner, visceral level as well as on the surface. Zaylie spoke about the sensation of tar coating her insides, and Natalie talked about her body as feeling "cocooned." Crissy revealed that she used to dust her skin with baby powder to make it seem whiter, and Pat noted how she uses her arms to gesture into the "relational space" between two people as a way to navigate boundaries. In short, these narratives suggest that the embodied experience of social oppression occurs on all of these levels (inner, surface, and relational) at once. The implication for embodiment or somatic studies is that any abstraction of the body provides an incomplete understanding of a lived experience that is complex, multi-layered, and unique.

The research further suggests that embodiment theorists might productively focus on the body's capacity to transform (rather than simply enact and reproduce) oppressive experience. Participants spoke clearly and convincingly about how they began to reclaim their bodies as a source of knowing about the world, and how becoming more attentive to the messages they conveyed to others through the language of the body provided an opening to shift their relationships with others toward a more equitable balance of power. For example, Pat notes that coming to terms with the past and current wounding of her body feels very much like a victory, and that the journey of healing and reclaiming her body has provided a model for being in relationship with others that addresses abuses of power in a way that Pat feels has the potential to provide a larger healing for social oppression.

Contributions to Traumatology

Recent traumatology research has established that trauma is significantly mediated through the body and manifests in embodied experience. The psychobiology of trauma is an emerging and rapidly-developing field, and the somatic dimensions of traumatic experience are increasingly recognized (Ogden et al., 2006; Rothschild, 2000; van der Kolk, 1994). The effects of trauma are generally grouped into categories that assist in recognizing and understanding how trauma impacts embodied experience (APA, 1994). At the same time, empirical correlations between trauma and oppression (and oppression as a form of chronic trauma) have not yet been established. However, sound theoretical links do exist (Burstow, 2003). What has not been researched until this study is how oppression manifests in and through embodied experience, and to what extent it manifests across those established categories of trauma response.

The insights and understandings of research participants offered a unique glimpse into the complex ways that oppression is mediated in the body as a traumatic experience. Overall, it seems clear from the information participants provided that some parallel relationships between the somatic effects of trauma and embodied responses to oppression exist. The findings of this study provide the first known basis in research for this connection, and suggest that further research to articulate the specific somatic effects of oppression as a form of trauma is worth pursuing.

Contributions to Somatic Psychology

Somatic psychology relies on the internal felt sense of the body as the basis for working with and understanding lived human experience (Hartley, 2004). In working with the body, somatic practitioners address not only the mechanical, physical body, but also the engaged body; the body that feels and connects us with our emotions, sensations, memories, ideas, and beliefs. Although somatic psychology is essentially holistic in orientation, and recognizes the integrality of the environment with the soma, somatic psychologists have largely not taken up social issues, with a few exceptions (Hanna, 1970; Johnson, 1995; Mindell, 1996). While somatic psychotherapists are well situated

to address these issues, current somatic approaches almost universally ignore the cultural, social, and political dimensions of embodied human experience. Despite a commitment to a holistic perspective that includes soma and environment, (Greene, 1997), most of the emphasis in somatic psychology to date has focused on subjective experience through the body rather than on embodied relationship, or how interactive embodied experience with others translates to the social and political dimensions. It has been my experience in training and practicing in the field for over twenty years that somatic psychotherapists rarely provide clients or students with directed opportunities for exploring power differentials among individuals as members of groups, communities, and societies. Issues of social justice, diversity, and equity are almost never directly addressed (Knaster, 1996).

The narratives in this research study offer important new understandings to somatic psychology theorists and practitioners about the significant impact of oppression on embodied experience. Participants were unequivocal about how important social interactions were in forming an embodied identity, and the damage that inequitable power dynamics had on their inner felt experience of the body. Pat describes how she grew up feeling that her body wasn't ever good enough, Natalie mourned the loss of opportunity for her body to develop its full capacities, and Crissy's struggles with body hatred and shame threatened her very survival. Given that these debilitating effects resulted from interactions within social, cultural, and political realities, this research suggests that a shift in somatic psychology to emphasize the sociocultural dimensions of somatic experience would address the somatic impact of oppression more directly.

This research also provides valuable suggestions to somatic psychologists about some of the aspects this shift toward the sociocultural dimensions of somatic experience might include. Participants described a range of somatic effects of oppression, from body image to movement vocabulary. Their narratives also addressed issues of embodied boundaries, body language, and trauma. By making links between these issues and the felt experience of the body, somatic psychologists could harness their expertise on transforming the subjective experience of the body to more directly address its sociocultural context.

Implications for Practice

As somatic psychologists, therapists, and educators working in complex multicultural environments, we have increasingly come to recognize the significance of the diversity and equity issues embedded in the process of personal change. There is also a growing appreciation of the notion that we each bring a unique perspective on these issues into our clinics, offices, and classrooms, based on the intersecting dimensions of our own personal history and professional development (Kellner, 2006). Our clients, of course, bring a similarly complex set of understandings, assumptions, and practices.

This section will focus on how the research informs our practical understanding of the ways in which the body is implicated in the navigation of these complexities, and how the embodied knowing of the research participants might inform the ways in which we address (or fail to address) diversity and equity in our practice. While the contributions of this research to scholarly knowledge discussed in the previous section fell across a range of disciplines (embodiment studies, somatic psychology, and traumatology), the contributions of this research to practice will focus on somatic psychotherapy.

A number of questions emerge from the research with respect to implications for practice. In particular, I was struck by Natalie's observation during her interview that although she values an increased awareness of how her body engages with social power dynamics, she still feels at a loss about what to do with this awareness. If critical reflection is not connected to strategic action, how do we embody change? Or as Natalie pointed out, how does she help to make the world different for her children? To that end, many of the topics in the review of the literature provide some conceptual grounding for applying the research findings to the practice of teaching and learning. And although none of the participants in this study described the exact process through which they engaged in reclaiming embodied experience, it might be useful to theorize briefly about that process here, to help elaborate more precisely how somatic psychotherapy might incorporate both critical and embodied perspectives.

Somatic theory (Gendlin, 1978; Hanna, 1970; Johnson, 1983; Yuasa, 1987) suggests that cultivating embodied consciousness produces/elicits an altered state of consciousness, and Hanna (1970) suggests that this shift in consciousness can serve as a locus for resistance against oppression. More specifically, some somatic practitioners argue that being comfortably anchored in a solid felt experience of the body in relation to other bodies is so phenomenologically different from the experience of "othering" or being "othered" that it provides a compelling counterpoint to hierarchical models of social power—a place from which to experience the world differently even when the social

structures through which that experience is shaped have not yet changed (Johnson, 2003).

Pat described this phenomenon in her narrative through her observation that feeling connected to her own body fundamentally changes her relationships to others in a positive way, and it has been her own body journey that has made issues of social justice real for her. Somatic theory (Greene, 1997) as well as social theory (Foucault, 1991; Johnson, 2001) would understand this process as having profound implications for social structures, based in the premise that social structures are created (and reproduced) through a web of interpersonal relations. When those relationships change—body by body—so, slowly, do the structures.

Extending that process to the practice of therapy suggests that interventions that support the embodiment of clients simultaneously encourage the cultivation of more grounded and equitable relations with others. I contend, however, that the embodiment cultivated through these somatic psychotherapy strategies is not re-embodiment, that is, not a return to some idealized, natural, or "authentic" state of connection with our corporeal selves (i.e., we used to be connected to our bodies as children, but the adult demands of modern society have forced us to disconnect). Rather, this integration of somatic experience and conscious awareness should be viewed as a cultivation of a capacity for deeper and richer forms of consciousness. Yuasa (1987) calls this "bright consciousness"; Hanna (1970) describes this as the evolution of the soma. They suggest that conscious embodiment is new territory for us as a species, not a reclaiming of old ground. However, this should not align the project of embodiment with a modernist grand theory of progress—rather, the specificity and multiplicity of embodiment might be more congruent with a postmodern sensibility that recognizes the unique, fluid, and contingent nature of embodied experience.

By integrating these understandings with the concept of performativity (Butler, 1993), it is possible to suggest further implications for practice that speak to the question of how critically informed somatic psychotherapy might address the embodied effects of oppression. If the unequal social categories upon which oppression is predicated (Johnson, 2001) are culturally constructed through "regulative discourses" (including nonverbal communication as discourse) (Manusov, 2006), it is the repetition of acts shaped by these discourses that maintains the appearance of a coherent identity. In short, if oppression depends upon naturalized social categories of unequal power and status, the idea that identity is performative (that is, it depends not on naturalized differences but on reiterative acts), then changing those acts disrupts the categories upon which social inequity depends. Given the value of nonverbal communication in the development of critical consciousness articulated by participants in this research, it follows that anti-oppressive somatic psychotherapy that incorporates psycho-educational material on nonverbal communication could provide clients with an opportunity to experiment with such changes, and develop a more refined and effective degree of somatic literacy (Linden, 1997).

While the cultivation of conscious embodiment and the development of somatic literacy form the two key implications for practice based on the knowledge and insights of participants in this research study, several additional implications also emerged from the findings. The first suggests a particular quality of therapeutic relationship, based on Zaylie's description of the residual somatic effects of oppression. As she talks about having "this kind of tar coating all of my insides," she further acknowledges that this residue prevents her from absorbing emotional, psychological, and relational nutrients—from being affected by positive experiences with others. It is not just that her body lives with the residual effects of oppression, but that oppression interferes with her capacity to engage with and be nourished by the world. It follows that if Zaylie's experience of oppression has impaired her capacity to be affected by positive (and potentially transformative) experiences as well as protected her from damaging experiences, the importance of genuine engagement between therapist and client in the therapeutic encounter is underscored. Taking the time to establish a safe and nurturing environment in which the unique ways in which individuals embody oppression (and learn ways to protect themselves from oppression through the body) may be even more important than usual for clients struggling with its somatic effects.

This particular finding also has another possible implication for practice. Laura Doyle (in Cohen & Weiss, 2003) suggests that the art of narrative becomes a way to safely slip back into the subjective body. For the abject subject, words offer a way of touching the body and being touched by it without pain. Given the remarkable degree to which participants were able to disclose very personal and deeply troubling wounds, this study is able to provide some affirmation of the value of narrative in psychotherapeutic practices designed to help clients access similar material.

Conclusion

This article describes the embodied experiences of individuals who have faced various forms of oppression, and

connects those experiences to implications for somatic psychology theory and practice in an increasingly diverse social world. Although the stories they tell offer examples of the trauma and disconnection that result from the misuse of interpersonal and social power, they also offer the promise of hope and change. Despite the embodied wounds inflicted over a lifetime of unjust and inequitable power relations, each of the participants in this study still experience their body as an important source of knowledge and power.

This research provides some evidence of the relationship between the somatic effects of trauma and embodied responses to oppression. While empirical correlations between trauma and oppression (and oppression as a form of chronic trauma) have not yet been established, sound theoretical links do exist (Burstow, 2003) and the data from this study suggest that further research to articulate the specific somatic effects of oppression as a form of trauma is worth pursuing. The study also points to how the emergent nature of the experienced body (Grosz, 1994) provides a medium for transforming oppression, and the narratives in this study offer vivid illustrations of the way in which the body is a potential source of personal knowledge, agency, power, and creative expression. It suggests that the hope of social justice can be realized in part through reclaiming our bodies as the necessary ground of our (inter)subjectivity (Csordas, 1994).

Although this study offers only the beginnings of suggestions about how the project of transforming the lived experience of oppression through somatic psychotherapy and psycho-education might proceed, I hope that it will serve as an intriguing and inspiring point of reference for researchers, practitioners, educators, community activists, and others who are interested in engaging the body's capacity to resist and transform oppression.

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Apologies That Heal

Cedar Barstow, M.Ed., C.H.T.

Editor's note: Cedar Barstow continues to reflect and develop her approach to clinical and community ethics through right use of power by considering here the nature of apologies.

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Abstract

The importance and effectiveness of apologies are explored within both healing and leadership contexts. Ineffective approaches are noted as well as guidelines for making them more helpful and useful.

"David, tell Randy you're sorry."

"Sorry."

The mother takes 7-year-old David to another part of the playground. By the sound of the "saaaaawry," I'm guessing that David was being obedient, but he didn't really know what he did, didn't feel like it was his fault, and wasn't sorry at all. As adults, we hear (or even give) apologies like "I'm sorry you felt hurt." "If I did something that hurt you, I'm sorry." "I apologize, but I was really distracted by something else." "I'm sorry, but you should know that I really love you and you shouldn't take it so personally. It's just the way I am." "I'm sorry, but you are really making too big a deal of this. It is just a little thing." "I apologize, but give me a break." "I'm sorry for the problem you had. My assistant is normally on top of things." When we give such an apology, we can say, as 7-year-old David did, "But I apologized!" However, when the apology (as in the examples above), is an inauthentic or inadequate apology, it doesn't heal, it doesn't resolve, it doesn't soothe, and the hurt remains unmoved.

Authentic and effective apology is at the core of healing, clarifying, and restoring interpersonal, organizational, and cross-cultural relationships. A real and well-thought-out apology can, like forgiveness, interrupt the cycle of anger, revenge, and hatred. However, making a genuine apology causes the giver to be extremely vulnerable. You are admitting directly to another that you did something that caused them harm. This is humbling! Doing so is also challenging because it's like leaping off a cliff into the unknown. You are not in charge of how your apology will be received. Your efforts could be harshly rejected; your hopes for healing thrown back in your face.

A client of mine spent some months working with his shame about having abused his younger sister. From a most humble place, he wrote her an apology in the hope that this could be a first step in restoring their relationship. Several weeks later, the letter was returned to him with "Rejected. You will not be forgiven." written across his words. He was devastated. Over time he began to look at what he *could* do rather than grieving for the loss of his relationship with his sister.

His sister couldn't accept his apology, but he could demonstrate that he had learned and changed by volunteering at a women's crisis center. He also could be proud that he had broken many generations of family history by not abusing his own daughters. He was proud of these actions, and they had shifted his inner wound from the shame of feeling unforgiveable to the fact of being un-forgiven. He could now move on.

I asked a few of my friends to remember a time when they needed to and did offer someone an apology. Usually, we rightly focus on the feelings and needs of the hurt person, but I wondered what the apologizer got from the process. This is what I heard: "I got to let go of at least some of my guilt." "The apology was accepted. It repaired the relationship, and the friendship actually got better." "In the process

of getting to being able to apologize, I went through all my defenses and finally got to see something about myself that I didn't like and face the truth about a familiar and hurtful pattern I had been denying or at least had been unaware of. This was hard work. Once I got it, the apology was easy." "Honestly, I don't know if I got anything at all. It was really like just getting it out of the way." "It was unbelievably relieving for me." "It took such courage. I try so hard to be 'good,' and it was painful but freeing to be able not only to see but to take responsibility for doing a bad thing." "I learned that it's really okay to make mistakes. What isn't okay is not to apologize for them and learn from them." Apologies open big doors. As John Kador (2009, pp. 43–44) puts it, "Apology is the bravest gesture we can make to the unknown.
. . . Apologies unmask all the hopes, desires, and uncertainties that make us human because, at the moment of genuine apology, we confront our humanity most fully. At the point of apology we strip off a mask and face our limitations. No wonder we hesitate."

Now, what is the value of apology to the one who has been wounded? Opportunity for restoring relationship, de-escalating conflict, re-balancing power, recovering dignity, letting go and moving on, stopping a cycle of resentment and revenge, and increasing trust in the human capacity for goodness and truth. This is a strong litany. From the biggest perspective, "Quarrels often escalate into serious conflicts on the fulcrum of apology. . . . Throughout human history, endless cycles of revenge and untold suffering have resulted from the denial of effective apology. It's a tragedy because apology has the power to defuse almost all human conflicts" (Kador, 2009, p. 45).

In my book, *Right Use of Power: The Heart of Ethics,* and in my ethics programs, I talk about resolving difficulties as one of the most important and challenging skills to learn as leaders and human beings. I describe five things that most people need to hear for an injured relationship to be restored. Not all of these things will be essential in all situations, but at least one—and probably more—will be needed. Here they are:

1. Acknowledgement, 2. Understanding, 3. Regret, 4. Learning, and 5. Repair (Barstow, 2006, p. 160). Making "…a genuine apology or an authentic expression of. . . .regret" is the complete description of number three. With a deep bow to John Kador for his excellent book, *Effective Apology—Mending Fences, Building Bridges, and Restoring Trust*, I want now to suggest how one can make an apology (#3) with greater wisdom and skill.

Kador (2009, p. 124) also names five dimensions in making an effective apology: 1.Recognition, 2. Responsibility, 3. Remorse, 4. Restitution, and 5. Repetition. Here's more about each of these.

Recognition. Apology requires recognition that what you did was wrong or harmful. The injured person needs to know that you understand your offense and that you are apologizing for the right thing. "I'm sorry I hurt you" is not sufficient because it is not sufficiently specific. "I'm sorry I spoke to you in a disrespectful way" is better. You need to face and name your offensive action. Doing so calls for humility and vulnerability. It is more effective when both parties agree on the facts of what happened, but sometimes when there is disagreement, you need to give up your need for this aspect of closure. "Apology is basically giving up our struggle with history. Contested facts invariably lie at the heart of botched apologies" (Kador, 2009, p. 52).

Responsibility. In this dimension you take full responsibility for your offense without being defensive, making excuses, offering long explanations, or blaming anyone else. "You misunderstood me. What I meant was . . . . ," or ". . . . and what's your part in this?" won't get you anywhere and might even make matters worse. "I take responsibility for being angry, using mean words, and hitting you" is clear and direct. In my program, dimension two is *understanding* ("They want to know what happened or what your intention was.") I personally have experienced times in which an explanation of my intention or my process was helpful. However, I agree with Kador that explanations can defuse an apology and that the best time for giving an explanation or stating your intention is later on, if at all. "In general, explanations burden apologies. . . .When victims first consider an apology, they don't care about intentions. All they care about are consequences. Explanations have an unfortunate tendency to serve the needs of the wrongdoer more than the wronged" (Kador, 2009, p. 67).

Remorse. Here you use the words "I'm sorry," or "I apologize." It seems there isn't any substitute for these exact words accompanied by appropriate feeling. The little boy on the playground used the right words, but he didn't accompany the words with the much-needed non-verbal cues that would have demonstrated genuine feelings of remorse, humility, vulnerability, and respect. "I wish it hadn't happened," or "I wish I could do it over again" just don't have the needed affect at the moment when "I apologize" is needed.

Restitution. You need to make amends. You need to offer an appropriate action. "I was careless with your bicycle,

and I will take it to a bike shop tomorrow to get it fixed and tuned up." Restitution should go one step beyond the actual harm done, as in this example of having the bike tuned up in addition to simply having it fixed. In my program—number five, *repair*—I talk about the question, "What is needed here for relationship repair?" While this can be a useful, heartfelt question because it conveys a desire to reconnect and restore the relationship, in the apology process it is usually advisable not to ask the injured person what restitution they want because they may not know or may ask for something greater than what you can offer. It is most often best to make an offering yourself.

We sometimes hear the words, "Don't admit you made a mistake because it will be held against you in court." Offering some restitution would seem dangerous because it clearly admits guilt. However, this understanding is not supported by facts. "An expression of regret combined with an offer of restitution actually reduces punitive measures and lowers the odds of litigation. Restitution is not cost-free, but it is almost always less costly and destructive to the relationship than protracted litigation" (Kador, 2009, p. 99). "The last thing a plaintiff's lawyer wants to introduce in court is evidence of a contrite physician who issued an apology" (Kador, 2009, p. 219).

Repetition. Here you say what you have learned, how you have changed, and how things will be different in the future. This action in my program is aspect number four, *learning*: "They [the injured party] want reassurance that you've learned something and will act differently in the future." Repetition in making an effective apology goes further. It is a commitment to not repeat the offending action. For example, "I've learned that I have poor boundaries. I revealed confidential information about you. I will not do this again. I hope over time you will be able to trust me again." This commitment to change is critically important to the success of the apology.

Some General Considerations

Ifs or Buts. Don't use them! Statements like, "I apologize if I said anything offensive," or "I'm really sorry, but I only said this because you said that" neutralize or worsen the injury by making the apology conditional; in effect they deny responsibility (Kador, 2009, p. 203–204).

Assumptions: You may be attempting to express your empathy, but "I know exactly how you feel" doesn't really add to the process. It is much better to enter the dialogue by expressing interest in and concern about how the person is truly feeling. For example, "I wonder how I'd feel if . . ." is better than "If I were in your shoes, I'd . . ." (Kador, 2009, p. 209–210).

Form. Begin your apology with "I." This word makes it clear that this is a personal response from you. Don't ramble on. Being simple, clear, and concise is more powerful and effective than an overly long apology (Kador, 2009, p. 211).

Timing. When the offense is small, immediacy is best. A simple, "I'm sorry I stepped on your foot" will be enough. Without this simple apology, the relationship "bag" gets full of remembered incidents that can be interpreted as a lack of awareness or respect by the other party. This will then require a larger apology and a more complex process for increasing trust. When the offense is great, however, time to think it through, cool off, or do some psychological processing is needed.

Form. Apologizing in person is usually the most successful. An email, which can be easily misunderstood, does not convey emotion well. However, when a CEO or a government official needs to apologize, a written apology may be the only available way.

The other side of offering an apology is accepting one. On the receiving side, you must discern whether the apology is genuine and also whether it feels satisfactory. Accepting is just accepting. It doesn't automatically include trusting or forgiving. Rebuilding trust happens over time. Forgiveness is a separate process. When you do accept an apology, it is important to make an acknowledgment. Responses like "It was nothing." or "Don't worry about it." or "You don't need to apologize." or "It's too late." have the effect of dismissing the intended communication. They trivialize a vulnerable moment. Before learning about the apology process, I had thought that when I said, "It was nothing," I was being kind, generous, and forgiving." I now understand it to be disrespectful. When the apology is genuine, it is best to say, "I accept your apology." The interaction needs to be complete and acknowledged. A friend's "I'm sorry I'm late. I know that caused you some extra work." deserves my recognition of her humility and awareness of her negative impact. "Thank you. I accept your apology" works well as a response.

An apology can move mountains. A half-hearted one can make things worse. A sincere and well-crafted apology can restore relationships.

Apology as High-Road Leadership

When you are looking for a good leader, one of the most discerning things to ask is whether or not the leader can

apologize and take responsibility for repairing relationships and situations. It seems, however, that the path to making an apology is strewn with obstructions. Here are a few: Leaders may fear that an apology will make them seem weak rather than powerful. Those in positions of power are often removed or even protected from hearing negative feedback and so don't know when an apology is needed. Leaders don't understand the anatomy of apology and thus don't do it effectively. Leaders can over-identify with their up-power roles and forget their capacity to cause great harm. When given role power, leaders tend to lose touch with their natural empathy and compassion. Leaders can understand and use power as control, manipulation, force, and exploitation; in this understanding of power, the leader is not even aware that making an apology is an option.

Just as increased responsibility accompanies increased power, so the power of apology increases when genuinely offered by a leader. In actual practice, making an apology reduces the likelihood of legal action, as noted earlier. Effective leaders make genuine apologies. Effective apologizers model what could be called "high-road leadership."

Here's an inspiring story from Canada as described by Jocelyn Orr (personal communication). "Sitting in the Hakomi training circle during the Right Use of Power segment taught by Cedar Barstow, we were instructed on The five aspects of a good apology (recognition, responsibility, remorse, restitution, repetition). I realized that the hearing I had attended as moral support to one of my clients, had quite closely followed these guidelines.

My client and I sat together in a small room with two other women; one a lawyer representing Canada (who referred to herself as 'Canada' throughout the hearing), and another who was the time and record keeper. The agenda was clearly outlined to my client and the process began by Canada's opening remarks. Canada spoke in the first person and she gently and kindly articulated *Recognition* of the terrible wrongs that she, Canada, had inflicted upon my client. She spoke in general terms but acknowledged that the meeting we were about to participate in was to recognize the specific injuries inflicted upon this woman. Canada took full *responsibility* for what my client had suffered, and she expressed *remorse*. We then went forward with the hearing, which required my client to speak of her personal abuse and suffering. Often Canada would stop the process to ask clarifying questions or to gently give the survivor whatever time she needed to gather herself and continue. Canada had specific questions, but my client was generally free to tell her story in her own way and time. Canada concluded the meeting with closing remarks, which again expressed *recognition, responsibility* and *remorse* for the terrible experiences and loss of childhood my client suffered. She spoke of the inadequacy of this form of *restitution*, but stated that this was the best she, as a nation, could do at this point in our history. 'No sum of money will ever fully compensate you for your suffering, and for that I am so very sorry,' she *repeated*. I was brought to tears by the experience. As my client and I left the building, she expressed her feelings to me: 'You know, the money is really of no consequence. Having this experience is what I really needed. I feel my country has apologized to me, and I feel a greater degree of healing as a result.'"

For leaders—and we are all leaders in some aspects of our lives—who are dedicated to right uses of power, the practice of apology has pro-active value. Kador (2009, pp. 223–224 and 239) describes three evolutionary shifts that accompany the practice of apology.

First, "Practicing apology challenges ingrained attitudes about power and accountability." As a leader you must come to see that power requires your accountability. Granting you executive immunity is simply a way of helping you avoid your responsibility.

"Dealing with emotions of apology" comes next. As a leader you must learn to recognize when you have caused harm, be willing to bear knowing the harm you have caused without getting lost in shame, and be capable of the ego vulnerability of offering an apology even when you don't know how your apology will be received. Finally, you must be able to self-correct. This is true, non-defensive self-awareness.

The third requirement is cultivating "a disposition favorable to personal transparency." Learning the emotional and practical aspects of apology serves more than the particular relationship it is attempting to repair. Apology also significantly shifts our understanding of power toward a new paradigm in which we use it with wisdom and skill to heal and repair harm, evolve situations and relationships, and promote the common good.

Apologies may be as simple as expressing remorse for stepping on someone's foot or as deep and complex as apologizing for national abuses of power to minorities or other down-power groups: American Indians, blacks, military women who have been raped, aboriginal peoples, children who have been abused by the clergy, or victims of genocide. Apologies can be as interpersonal as between mother and daughter or as multi-personal as a representative of an

organization apologizing for the offenses of many in the organization.

Here are two personal stories. The first is a simple interaction between my seven-year-old goddaughter and myself; the second has a larger context.

Batia Rose, age 7, my goddaughter, usually has my full attention for several hours after school on Tuesdays. This Tuesday, however, I had a few things I needed to do, and so we didn't get as long as usual to play with the dolls. From her point of view, the dolls need to get fed and dressed and have a chance to play. We use blankets to make a house. We light candles around the room. It is elaborate. This Tuesday we got the house made, lit the candles, and got the dolls dressed, but there was no time to play. Batia was upset. "Why did we do all this when we didn't have time to play? I don't want to just sit and look at how beautiful it is!" "You feel kind of cheated, huh?" "Yes. I want my time to play." She lay down on the floor, sobbing. I sat and waited. After a while I could hear her quieting herself. "You're calming yourself down. That's a good thing to do." Pause. "Cedar, I have an idea for next time." "What is that?" "Well, next time you have things you have to do, you could tell me how long it will take and how much time we'll have left." "That's a really thoughtful suggestion. That way you won't be taken by surprise like today. I'll be happy to do that next time. And I am sorry that you felt hurt today because I didn't tell you what was happening." Our relationship was quickly repaired.

Marian is a Native American elder from a tribe in New Mexico. We met at a gender reconciliation workshop led by Cynthia Brix and Will Keepin. Gender reconciliation is brave, intense, and vulnerable work. The personal hurt and anger shared needs a safe container. Marian sat across the room from me. The warmth of her smile and the compassion in her eyes was potent. She radiated safety. She offered a native prayer in support of the earth and the best of humanity.

I sought her out at lunch for a conversation I was longing to have. I asked her if I could talk with her about something that lay heavy on my heart. She nodded and I spoke. "For 25 years I have been a member of a group of people who do outdoor ceremonial dances in which we call the four directions, drum and rattle, and dance together around a central pole. Obviously we are including things that have come from what we understand about native traditions. I know that many Native Americans rightly feel that white people co-opt and trivialize their sacred ways. If you came to our ceremony, I don't know how you would feel. But drumming and our understanding of the four directions are important and meaningful to us. We are grateful. I don't know if I have any right, but I want to ask for your personal permission to use these things." I paused. Marian nodded. "I promise that I will never trivialize these things. I tell you that the Native American influence has been a great gift to us. The drum has taught us about honoring and entraining to the heartbeat of community. Feeling the energies and guidance of the geographical directions has re-connected us to the beauty and wisdom of the earth." Long pause. Another nod.

"There's one other thing. Can I say more?" "Yes." "My ancestors arrived in New England in the mid-1600s. They received help and learned how to live on this new land from local natives. My ancestors were white people who then treated your people as less than human. My ancestors stole your people's land, disobeyed treaties, killed your people, imprisoned your people, and destroyed your cultures. And we have not yet made it right. We came to America to escape persecution and then went against our own values of freedom and pluralism. I offer you my personal apology." Pause. I see tears in Marian's eyes. "I re-dedicate myself to helping people learn how to use their power and influence to repair situations both big and small that have caused harm and suffering." Marian nods. "Thank you for receiving these words, Marian."

Marian speaks through tears. "I am one who goes out to see what's going on outside the reservation. I come back and sometimes tell the elders about what I see and experience. We know that what we find out there, we will also find in our tribe, and what we find in our tribe, we will also find out there." "What stories will you be bringing back from this workshop?" I ask. "I will tell stories that they will hear. I will tell them that I met this woman (you). I will tell them what you just said. They may be surprised. Hopefully, they will receive and accept your words. Thank you."

In our book, *Living in the Power Zone*, my husband, Reynold Ruslan Feldman, and I refer to the power zone as a range of responses to situations that are discerning, healthy, appropriate, and skillful. There are a number of power parameters that we suggest our readers explore. For example, how do you tend to respond on four continuums: 1. being directive vs. responsive, 2. persisting vs. letting go, 3. being task-focused vs. relationship-focused, or 4. being firmly boundaried vs. flexibly boundaried? (page 73) Effective, respectful, and skillful leaders have honed their ability to respond to situations by discerning what is appropriate

along each continuum. Less effective and skillful leaders get stuck in habitual responses that are appropriate for some situations but not for others. For example, they place such high value on being responsive as leaders that they can't shift to being directive when the task or team requires it. Leaders who abuse their power get stuck in responses from the extremes of each continuum. For example, leaders who are extremely task-focused (or profit-focused) become manipulative, forceful, and exploitive. Leaders who are extremely relationship focused abuse their power by taking advantage of friendships, crossing boundaries, controlling, shaming, and/or letting a task fall apart. Both task and relationship are necessary. It is habitual behavior at the extremes that causes great harm and suffering.

Apologizing is another power parameter. Some leaders (especially women) over-apologize. They may do so for accidentally brushing against someone. They apologize for sitting in a chair that later someone else wanted. They apologize for opening a window to let in some fresh air. They apologize as a strategy for deflecting conflict or making sure everyone likes them. Many years ago, as a new administrator, I thought that if I apologized first, others would join me and share the responsibility. Oops! In my organization, when I apologized, I was happily given all the blame and all the responsibility. My apologies diminished both me and my power.

There are other leaders who make it a policy to never apologize, convinced that apologizing shows weakness and lack of vision. Leading from this policy can permanently rupture relationships, compromise the leader's humanity, and lead to a deteriorating work environment.

Always apologizing and never apologizing are ineffective and damaging. Leaders who use apology wisely and well have learned how to discern when they have done something hurtful; know how to offer an apology simply, directly, and humbly; and are ready to self-correct and move on. Yes!

Here is an excellent summary of this article from Kador (2009, pp. 201-202):

In wholehearted apology, the kind that recipients find immediately satisfying, the offender

- Offers a detailed factual record of the events related to the offense, specifying the offense in plain language without a hint of defensiveness;
- Accepts undiluted moral responsibility for the offense on the offender's own behalf
- Categorically expresses regret for the conduct;
- Takes practical responsibility for the offense; and
- Signals that the offender has learned the error of his or her ways and promises not to do it again.
- In halfhearted apology, the offender
- Hints at the offense at the heart of the injury and argues the facts;
- Attempts to share responsibility;
- Shades the issue of personal regret;
- Resists taking practical responsibility for the offense beyond words; and
- Disregards the issue of repetition.
- In non-apology, which may take the form of an apology but has no apologetic meaning, the offender
- Disputes the facts and defends the offender's actions;
- Sidesteps accepting responsibility except in the most impersonal, non-causal way;
- Avoids expressing personal remorse;
- Rejects providing restitution; and
- Suggests that in the same circumstances the offender will pursue the same offensive conduct

Right Use of Power facilitator, Magi Cooper, works with men who are in habitually abusive relationships. They are familiar with half-hearted or non-apologies described in the list above. With these clients, Magi uses a variation of the apology process described in this article that she finds to be remarkably effective. It has three parts: "This is what I regret (describe behavior and impact)." Then, "This is what I am going to do about it so it doesn't happen again (describe specific actions)." And lastly, "Is there anything you need from me right now about this?" Her languaging is colloquial and the steps are simple and easy to respond to. The process gets to the core of the matter.

Apology is a topic worthy of deep and thoughtful attention. Sincere and well-considered apologies can heal personal relationships, improve organizational dynamics, and de-escalate conflict, interrupt harmful generational patterns, lead to forgiveness, and even stop wars. Learning to apologize well is worthy work of the heart and essential to using personal and role power wisely and well.

References

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Poems

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Salmon Song

My ancestors sang their bones
up this same dark river
skin flayed and scarlet
a banner of passion abandoned
on the river stones.
Bones of my ancestors carry me
threading a needle through time.
Flesh of my ancestors feeds me
a flame licking upstream.
Spirit of my ancestors carries me
a seed in the arms of the wind.

Searching for the Pattern

Sagebrush, pungent now after the rumbling thunder storm,
rests easily in the vast silent landscape, silvery under the bowl of stars.
Even the waterfall at the creek is invisible to the ear.
The Milky Way floats in space outside the cabin door.

I hesitate to break the silence with this old silver flute,
yet finally take it to my lips, this neglected friend,
With fingering unfamiliar after all these years, I reach
for each note searching slowly, blindly for the pattern.

Between the long whole notes, during the rest notes,
a chorus rises out of the desert night — wild coyote music.
They sing out from the creek, the flute replies.
Another chorus calls from the cliffs.

We call out in the dark — listening, calling into the distance.
the pattern slowly unfolds in the calling, the pausing,
the listening, the return, the calling,
the pausing, the listening, the return.

The Key

The key
is in the breastbone
where the heart
rises up to meet the day.

There is a Stone

There is a stone
wearing a coat of green moss
near the lake.
It is listening to the water's edge.

Tree

Outside the window,
breathing in the wind,
bending without breaking,
cellular awareness,
a sensing of roots,
and deep water strength;
the air,
the endless space,
surrounds and permeates
your every fiber,
nestles in beside your needles
and holds you.