Hakomi Forum

Issue 28–29

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Editorial: Many Members of One Body

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This is a double issue of the *Hakomi Forum,* because when I was working on issue 28 in 2015, I had an accident. The story—complete with pictures—of teaching in Hong Kong and Japan, taking an eighteen hour flight home, falling asleep while driving, hitting a truck, and then going through surgery and extensive rehab can be found in the gracious website report set up by some former students: https://www.gofundme.com/ilovegregjohanson

Thank you again, to all who were so understanding and generous with me, and helped me come through the experience with many unexpected benefits.

In 2015, the Hakomi Institute was also busy working with the publication of important new 2015 books: *Hakomi Mindfulness-Centered Somatic Psychotherapy* published by Norton (Weiss, Johanson, & Monda, Eds.); *The Handbook of Body Psychotherapy & Somatic Psychology* published in an English edition (originally German) by North Atlantic Press (Marlock and Weiss, Eds.); and *8 Keys to Practicing Mindfulness* published by Norton (Manuela Mischke Reeds, Author).

I'm happy that this edition has evolved with a theme related to diversity, cross-cultural issues, and underserved populations, issues that our faculty has struggled with over a number of decades. Thanks to Hakomi Trainer Shai Lavie for making a special effort to reach out to his students and colleagues, and encourage them to contribute. In Lavie's introduction to "Hakomi and the Underserved" there are a number of references to previous Hakomi efforts to address such issues in past years.

Dealing with cross-cultural issues is notoriously tricky. When I started doing clinical work in the late sixties, multi-cultural issues were barely acknowledged, let along addressed. Too often therapeutic approaches were taught as if one size fits all. Feminist thought had not yet impacted masculine models. Hopefully, it is more clear today that all psychotherapy is value-based and value-directed, consciously or unconsciously, though it is alarming that a number of therapists still blithely assume they can suspend their values at will to be with any variety of others. Therapists must know that psychotherapy cannot be value-free, because values are implicit in all preferences followed, and explicit in all processes used. Too many think that they can be sensitive to those of other cultures simply by being nice, listening, and not overtly imposing themselves.

On a deeper level, we know that assumed, mainly unconscious values must be brought into awareness, assessed, and often redirected. For example, much Western-influenced psychotherapy promotes unthinkingly the values of clear thinking, openness to feelings, responsible choosing, effective communicating, and courageous acting. There are basic values implicit in each of these stances that may be assumed without question, especially if one has not lived in another culture long enough to realize one's own is only one among many. David Augsburger, in his ground breaking book, *Pastoral Counseling Across Cultures,* points out:

> *If we reward clear and critical thinking, we are valuing rationality.*
> *But this may be incongruent with a culture's core values.*
>
> *If we support openness to feelings, we are valuing intuition and emotion.*
> *But which feelings, in a setting where face is primary?*
>
> *If we invite moral reasoning, we are valuing equality and justice.*
> *But a culture may prize harmony and unity more than these.*
>
> *If we suggest freedom of choice, we are valuing autonomy and independence.*
> *But dependence and solidarity may be core values.*
>
> *If we reinforce divergent perceiving and thinking, we are valuing creativity.*
> *But repetition and conformity may be preferred.*
>
> *If we advocate conflict mediation, we are valuing mutuality and equality.*
> *But conflict suppression may be the cultural norm.*

So, things are definitely messy and complicated enough to evoke some humility. In his 1990 book, *The Dilemma of Psychology: A Psychologist Looks at His Troubled Profession,* Larry LeShan alerted the community to being sensitive to the importance of diversity and differences on many levels.

> Human nature differs to a very considerable extent from place to place and time to time. A Hopi sheepherder, a knight of the First Crusade, a 1980 Wall Street broker, and laboratory psychologist live in different worlds with different definitions of space, time, and honor, different life goals, different views of love and the meaning of death. . . . (LeShan, 1990, p. 60)
>
> [Certainly,] we need different languages for different realms. . . . The "energies" in an electrical battery, a painting by Picasso, an angry crowd, and my hopes for the future are entirely different kinds of meanings and terms. The same word, used in different realms of experience, means something entirely different. (LeShan, 1990, p. 93)

Just think of practicing in America alone. What diversities between us might be found if we were working with an Eastern Oregon cowboy; a Native American living off or on a reservation; a Native American from a different tribe; a beautician from Houston; an African-American youth from the south side of Chicago; a white, middle-class doctoral student in Boston; a factory worker in Detroit; a street person in Atlanta; a Syrian immigrant in Minnesota; a small business owner in Kansas; an illegal immigrant dish washer from Honduras living in South Carolina, a retired retail worker in Tennessee living in a rural area or a large town; a ten-year-old who has already lived in seven foster homes; a poor woman without means who has been raped; a well-educated woman who has been passed over for promotions; a veteran who has been shot, a transgendered person in the military, plus _____?

Think of differences our European, South Pacific and Asian teams might suggest. We should also think of the differences in everyone who walks into our offices, even those from the same area or even the same family. Every person is so unique, with so many ways of integrating so many varied dispositions. Thus, psychotherapy is never boring. We never work with the same person twice. Hopefully, some of the research literature on the importance of collaboration between therapist and client, so much a part of Hakomi Therapy, can help. But, that does not amount to a formula. Even proposing mindfulness if it is pushing an agenda can be ill-conceived.

Underserved populations often suggest matters of money, resources, language, access, HMOs, prejudice, oppression, and more. On the encouraging side, when I, as an educated white guy, was doing urban agency work with poor African-Americans off the street, I found them quite amenable to doing mindful work when they figured out I was offering to help them mine the wisdom of their own experience, as opposed to telling them what to do. Plus, we have the witness of Harry Stack Sullivan who spent a career convincing his psychiatric colleagues that in terms of the deeply psychotic people they worked with, that we "are all more alike than different."

In any case, I am very thankful to all our authors for venturing to engage in these difficult, complex, though rewarding areas with no clear guidelines, and for being willing to put their creative work in print so that we might all share and benefit from their experiences.

Steven Bindeman begins with some philosophical psychology that deals with Merleau-Ponty, the philosopher who possibly best dealt with the mind-body problem. Issues such as felt meaning, engaging the world through the lived body, and learning to sing the world are explicated, providing an intellectual base from which we can deal with any number of therapeutic matters.

Camillia Thompson also provides intellectual support from Jung and others for being aware of the cultural level or layer of the unconscious, how it manifests somatically, and how Hakomi and RCS can work with both collective and personal parts of the ego.

Belinda Siew Luan Khong deals with a hidden population that is paradoxically over and underserved, namely those who have been assigned a terminal prognosis. Do they have rights to know or not know their condition? Khong explores this question and many others in relation to Anglo-Saxon and non Anglo-Saxon cultures in this fascinating paper that interweaves her personal experience with her dying mother, and her professional exploration of the field. Khong explores new ground that deserves a wide readership in the healing world today.

In her article, Sarah Tait-Jamieson deals with Hakomi in relation to Maori culture, including the process of Maori and European cultures meeting in Aotearoa, New Zealand (land of the long white cloud).

Rebecca Lincoln reports from the context of a non-profit agency that is able to support some underserved populations, and how Hakomi Therapy has worked in that setting.

Vivianne Shands, Kamal Ahmed, Christa Toro and Micah Anderson have studied with Hakomi Trainer Shai Lavie at Sophia University. In "Hakomi and the Underserved" they offer clinical reports of working with various populations.

In her "M.E.T.A. Counseling Clinic" article, Donna Roy gives an in-depth overview of how a resident Hakomi training team has established a counseling center that not only provides space for certified Hakomi therapists to practice, but a place where interns can be supervised for both Hakomi certification and state licensure, offering affordable care to the community in the process.

Susan Shawn, as a long-time Hakomi therapist who has been assigned a terminal prognosis, offers an alive, rich, personal, and professional review of Steven Jenkinson's book on how to die in a wise way, paradoxically without hope that would separate one from the present moment.

Johanson reviews Louise Sundararajan's important, though not widely available, book on Chinese emotions that is a doorway to rethinking Western mainline psychology, and how it could be so much more holistic by integrating its mirror image from the East.

Once again Carol Ladas-Gaskin offers poetry that brings another dimension to our work.

I hope you enjoy and are enriched by this edition of the *Forum,* and that you might consider writing articles yourself that are congruent with Hakomi principles outlined in the "Editorial Policy" guidelines, and/or suggest further ideas for thematic issues.

Merleau-Ponty, Bodily Knowledge and Felt Meaning

Steven L. Bindeman, Ph.D.

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Introduction

"Common sense" tells us that we live in a dualistic universe, divided between physical things and mental things. We have learned to think this way because of the pervasive influence of Descartes and his discovery of the *cogito.* This influence is especially noteworthy with regards to the foundations of science, since a major problem with scientific thinking is that it privileges the physical model over the mental one. This is a problem because neither model can completely contain the whole of reality on its own.

For example, scientists continue to struggle with defining the exact nature of consciousness. While finding solutions for how the mind integrates information and how it focuses its attention is relatively easy; determining why or how consciousness occurs is much harder, since we can't just point to some physical mechanism to explain it. Clearly, explaining consciousness falls outside the range of the physical sciences.

Husserl with his phenomenological approach to experiential reality demonstrated that empirical science simply isn't rigorous enough to account for such a phenomenon as consciousness. Empirical science misses the central defining essence of consciousness because the physical model of the world cannot provide a direct description of lived experience. The dualist model that is behind empirical science has dominated our thinking for over 400 years. However, by practicing Husserl's *phenomenological epoché,* a procedure which requires that we bracket out all such knowledge and limit ourselves to investigating the world only in terms of how it is given to us through our direct experience of it, we can stop putting into play these preconceived ideas about the nature of reality, a result which he calls the *phenomenological reduction*. According to Husserl, our direct experience of the world is a temporal process, involving the ongoing correlation between the passive acquisition of noematic experience (the object as such, as it appears to consciousness) along with the active interpretation of this information through the noesis (conscious acts directed at the unfolding meaning of the object, as it undergoes changes over time). Consciousness is, then, for Husserl, an ongoing relationship between individuals and the world they inhabit (Husserl, 1982, pp. 59–62).

Maurice Merleau-Ponty provides a unique approach to the phenomenological investigation of consciousness, different from the central positions of the three foremost phenomenologists of his time. First of all, instead of echoing Husserl's notion that all consciousness is intentional, namely conscious *of* something, Merleau-Ponty developed the thesis that all consciousness is perceptual consciousness. Secondly, while he agreed with Heidegger that human reality, or Dasein, is constituted by the active intentionality of consciousness in the form of the life-world, he parted ways with him concerning the primacy of perception and its connection to the perceived world, because for Heidegger the Being of beings is primary reality, and this is a notion not accessible to perception. Finally, Merleau-Ponty's position is also against Sartre's view that there is a "pure" consciousness, independent of being and without content or structure. He believed instead that Sartre's dichotomization of reality into being-in-itself and being-for-itself introduced relations between modes of being, which in his view properly belong between consciousness and the world. Merleau-Ponty's model of experiential reality is dialogical and relational rather than metaphysical and dualist.

This experiential orientation leads to the realization that the psychological realm is not just the interior world of conscious life, but is instead something which is constituted by the intentional relationship between the subject and its situatedness in what we all recognize as the real world of common experience. This relationship does not consist in the unification of two otherwise separate poles, either. Instead, the ego and its situation are recognized and defined only in terms of their relationship with one another. "The world is not an object such that I have within my possession the law of its making," writes Merleau-Ponty. "… Truth does not 'inhabit' only the 'inner man,' or more accurately, there is no 'inner man.' Man is in the world, and only in the world does he know himself" (Merleau-Ponty, 1964b, p. xi). We find ourselves *already* in the world, and it is in this world that we come not only to know ourselves, but other people as well. Furthermore, Merleau-Ponty believed that Descartes's metaphysical dualism could not do justice to the discontinuous aspects of human experience, like for example the contingent and nonconceptual character of our ongoing relationship with the world and with other conscious beings. This is why he advocated "a new idea of reason, which does not forget the experience of unreason" (Merleau-Ponty, 1964b, p. 8). He did not wish to lose sight of the ambiguity which he believed was as equally central to understanding the human condition as was clarity (Merleau-Ponty, 1964b, p. 8).

For Merleau-Ponty, we are connected to the world through our bodies. Based on this idea, he identified the two distinct types of space we experience: "lived space" and "objective space." Lived space is the first-person account of the space around each of us; it is the space in which someone's own body is the main point of orientation. Objective space, on the other hand, refers to a more mathematical interpretation of space, one that is defined by the three dimensions of length, breadth, and depth. In his view we relate to space bodily through both of these types of comprehension. When Merleau-Ponty concludes that our bodies are not "in" time and space so much as they "inhabit" these dimensions instead (Merleau-Ponty, 2001a, p. 380), he is suggesting not only that we are aware of our own subjectivity through our own specific body, but also that we know the details of our own "lived space" through this embodiment, because it is our primary connection to space. Our bodies are thus the context in which we experience space, and even more fundamentally, the world. Our individual body also derives meaning from the concept of its own lived space, even while it has no control over the objective space it also inhabits simultaneously.

Merleau-Ponty describes an additional aspect of our bodily engagement with the world through another reference to Descartes's *cogito.* He thus explains that "Consciousness in the first place is not a matter of 'I think that,' but of 'I can,'" (Merleau-Ponty, 2001a, p. 348) suggesting that bodily knowledge and sensual experience of the world come before intellectual and conscious knowledge of it. This does not mean that the mind is somehow not factored into our understanding of the world, but rather that it is tied into our *bodily* understanding of the world. We engage with the world first through our bodies and then through our understanding of bodily limits; this means that we first experience the world directly through our bodily senses, and only then do we experience the world in relation to ourselves. In this way, consciousness is produced from our bodily engagement with the world around us.

Because humans are innately embodied, we therefore have an embodied consciousness as well. Because consciousness and embodiment are inseparable for Merleau-Ponty, our intersubjectvity is made known to us by the fact that our consciousness is recognized both on and through our bodies. This means that to know a body is to know a mind. (This is a key idea for the development of "felt meaning"—see below.) It also means that bodies can be seen as both subjects *and* objects. He therefore asks, "If my consciousness has a body, why should other bodies that I perceive not 'have' consciousness?" (Merleau-Ponty, 2001b, p. 450). This understanding of the correlation between body and consciousness defines intersubjectivity.

The true field of intersubjective experience for Merleau-Ponty, however, is not the body but language. Language precedes human existence and therefore all other engagements with intersubjectivity. When he stresses "we must re-discover 'the social world,'" (Merleau-Ponty, 2001b, p. 454) he is arguing that we are engaged with the social world through the "mere fact of existing" (Merleau-Ponty, 2001b, p. 454). This means inevitably that we are engaged with language too, because language is our primary means of relating to the social world.

Furthermore, if the use of language is a shared activity, then this fact allows us to reconcile what would otherwise be, in any account of intersubjectivity, a conflictual engagement with the other. Because language precedes any single human being's existence, the subject already has a starting point for relating to the other. In this way, language has the capacity to serve as the main vehicle through which we can put a stop to all engagements with the other that are otherwise defined by conflict.

Similarly, Alfred Schutz recognizes how the world of daily life is not merely my own private world, but an intersubjective one. My experiences of this intersubjective world are not just my own, but are open to the verification or refutation by others. In what Schutz calls the "we-relation," two individuals share a community of time and space, and are mutually "tuned-in" to one another. This "tuning-in" constitutes a common interest, a common environment, and a common relevance bestowed upon their ongoing actions.

In his essay "Making Music Together" (Schutz, 1964, pp. 159-178), Schutz references G.H. Mead's example of "two wrestlers (who) communicate with each other by a 'conversation of gestures' which enables either of the participants to anticipate the other's behavior and to orient his own behavior by means of such anticipation" (Schutz, 1964, p. 160). The two wrestlers make up a shared community of space and time coordinates that open up common sectors, which in turn enable the articulation of an indirect form of communication. Both music-making and silence-sharing are indirect forms of communication as well.

The shared community of space and time is thus the foundation for the "face-to-face" relationship, which makes it possible for each person within the "we-relation" to have maximum visual access to the other's body as an experiential field. This common spatial environment serves as a shared frame of reference for the mutual scheme of expression, interpretation, verification, etc. The community of time, on the other hand, serves to provide the illusion of a shared personal moment, within which each person in the "we-relation" can follow the other's actions as they unfold phase by phase.

Both members of the we-relation experience the ongoing process of communication in a vivid present which consists of retentions and anticipations within each person's stream of consciousness concerning what each of them is saying, seeing, and doing. They are both talking and listening, to themselves and to the other, in an ongoing and interpenetrating way. "Similar interrelated activities," says Schutz, would include "the relationship between pitcher and catcher, tennis players, fencers, and so on; we find the same features in marching together, dancing together, making love together, or making music together" (Schutz, 1964, p. 162). None of these relationships would be possible if they were limited merely to conflict.

Schutz defines the musical situation as "two series of events in inner time, one belonging to the stream of consciousness of the composer, the other to the stream of consciousness of the beholder, (which) are lived through simultaneously, which simultaneity is created by the ongoing flux of the musical process" (Schutz, 1964, p. 173). Schutz's thesis is that this sharing of the other's flux of experiences in inner time, this living through a vivid presence in common, constitutes a "we-relation," which is the foundation of all possible communication.

For Merleau-Ponty however, the body is the vessel from which we communicate, since it physically amplifies our words. Consequently, in his view, phenomenology must focus on the body, if for no other reason than to prevent its focus from remaining solely on the mind. In Sartre's existentialist account of phenomenology, for example, the mind plays a central role in defining our relation to the world and to others. This, in Merleau-Ponty's view, is naive because it leads to the mind and the body being seen as two separate entities. His own thesis, that embodiment defines our primary relationships to ourselves, to the world, and to each other, avoids such metaphysical dualism.

But how can the lived body assume the responsibility of being the general medium for our having a world in the first place? The answer is that it can do so because it has its own corporeal intentionality. Here Merleau-Ponty replaces the rigid dichotomy between mind and body of traditional philosophy with the concept of the "intentional arc" (Merleau-Ponty, 1962, p. 136), which binds us to the life-world we inhabit and anchors us within it (Merleau-Ponty, 1962, p. 144). Bodily intentionality is so massive and so sensitive that its agency provides "a certain gearing of my body to the world" (Merleau-Ponty, 1962, p. 250), a gearing that is the "origin of space." More precisely, this origin is found in the body's "pre-objective" experience (Merleau-Ponty, 1962, p. 267) of its own movement. Merleau-Ponty gives the example of the geometer who does not merely project abstract figures into an abstract space, but knows their relationships because of his ability to describe them with his own body (Merleau-Ponty, 1964, p. 67).

The lived body is also the origin of both "spatializing" and "spatialized" space, between space understood as something actively expanding and as something fixed and closed-in. The lived body thus has an empowering force, which lends to space the power to connect things which would otherwise be isolated from each other in the vastness of undifferentiated space. Merleau-Ponty claims that we should therefore avoid saying that our body is *in* space or *in* time; rather, we should say it *inhabits* them instead. "I am not in space and time," he writes, "nor do I conceive of space and time. I belong to them, my body combines with them and includes them" (Merleau-Ponty, 1964, p. 140).

Understanding the lived body as the source of expressive and oriented space has implications for our understanding of *place* as well. Place can no longer be reduced to a position in objective space; it is now seen as something ambiguously experienced by the lived body, which is itself oriented in a constantly changing and shifting way. Place is now understood to have a *virtual* dimension, previously overlooked by classical accounts. As Edward Casey explains in his book *The Fate of Place*: "A place I inhabit by my body is not merely some spot of space to which I bring myself as to a fixed locus—a locus that merely awaits my arrival. …A place is somewhere I *might* come to; and when I do come to it, it is not just a matter of fitting into it. I come into a place as providing an indefinite horizon of my *possible* action" (Casey, 1997, p. 232). Place thus has a virtual dimension due to its imaginative possibilities.

Closely linked with the concept of a virtual dimension is the concept of a phenomenal dimension. Just as the theme of the phenomenal field was introduced by Husserl as an alternative to the empiricist idea of the perceptual world, so does Merleau-Ponty's theme of the phenomenal body introduce the idea of virtual movement into and out of places of possible action as an alternative to the empiricist idea of objective space. Merleau-Ponty's notion of place is that it is a *felt* experience; in fact, the lived body not only feels but *knows* the places to which it is especially attached. This kind of knowledge, moreover, has to do with *familiarity,* which has to do with seeing the body as "the matrix of habitual action" (Merleau-Ponty, 1962, p. 82).

Being-in-the-world is therefore for Merleau-Ponty not a matter of strictly measurable relationships. The human body is not merely a body among many others, it is also our only means for gaining access to the world and facing our tasks. The body's spatiality is not merely geometrical either, but is a spatiality of situatedness, of being oriented towards the myriad of possible worlds which confront it. This is a world of constant uncertainty, which has no absolute basis outside ourselves. If we find ourselves, for example, confronted by the collision between shifting external perceptions and often misguided personal feelings, then all we can do is acknowledge how this is the fate of the human condition.

The relation between the body and sound is also more complex than is commonly realized. Human ears are actually not natural reflectors of sound in the world. They are instead transducers, and they play a key role in the making of sound. Because the perception of sound is not a mirror of nature, it's more accurate to say that perception *makes* sounds, even if it makes sounds differently than a microphone does. Because of the role of perception in sound production, we should say that we hear music with our minds and not just our ears.

In his book *Listening and Voice*, Don Ihde explains that "in the auditory dimension the imaginative mode is a matter of 'voice' in some sense" (Ihde, 1976, p. 12). He goes on to point out that in Merleau-Ponty's discussion of the expressive body "Merleau-Ponty notes that what is taken as an inner silence is in fact 'filled with words' in the form of what will here be characterized as 'inner speech.' Focally, a central form of auditory imagination is thinking as and in a language" (Ihde, 1976, p. 120). This ultimately means that language itself is embodied, and that "meaning in sound embodies language" (Ihde, 1976, p. 152).

How is it then, that when we hear a stream of sounds, what we hear is words? How does the mind know when they start and stop—how does it organize this stream of pressure on the eardrum into language and background noise? The answer is that the ear is a piece of the mind. The ear creates aural figures and aural backgrounds the way the eye makes figure and ground. Merleau-Ponty's conception of the phenomenal body contains the realization that the body is *embedded* in the world. We hear words and not just mere sounds because our minds have been trained to recognize certain repeated sound-patterns in meaningful ways.

Although it would seem that the relation between the sound of a word and its actual meaning is completely arbitrary, Merleau-Ponty doesn't see it that way. He distinguishes between the conceptual meaning of a word and its gestural meaning. He claims that specific sounds have an emotional impact on us and are thus able to convey an indeterminate meaning, a meaning that sets boundaries to and provides a grounding for the conceptual meaning that follows it. He even gives pathological evidence to support his theory, observing that "certain patients can read a text 'putting expression into it' without, however, understanding it. This is because the spoken or written words carry a top coating of meaning which sticks to them and which presents the thought as a style, an affective value, a piece of existential mimicry, rather than as a conceptual statement" (Merleau-Ponty, 1962, p. 182). Similarly, many of the "nonsense" words in Lewis Carroll's Jabberwocky poem from *Alice in Wonderland*, (e.g."Twas brillig, and the slithy toves / Did gyre and gimble in the wabe / All mimsy were the borogoves / And the mome raths outgrabe") as well as many of the passages from James Joyce's *Finnegan's Wake*, (e.g., "Oftwhile balbulous, mithre ahead, with goodly trowel in grasp and ivoroiled overalls which he habitacularly fondseed") lend support to the idea of gestural meaning. Although there is a definite grammatical structure to these selections, many of the words contained therein don't make any sense at all—even though, somehow, they resonate in the mind all the same.

In his book *Dimensions of Apeiron*, Steven Rosen expands on Merleau-Ponty's concepts of depth and reversibility by exploring their mathematical ramifications. Associating Euclidean space with classical ontology, Rosen points out that Merleau-Ponty was in essence proclaiming this classical notion of space to be ontical or experiential in nature, in contrast to the embodied, apeironic dimension (apeiron is the ancient Greek term for "the unbounded") of topological space which Merleau-Ponty called "wild being" (Merleau-Ponty, *1968,* p. 253). A key property of this wild or chaotic space is the reversibility of subject and object. To illustrate this property, Merleau-Ponty made reference to the situation of touching, wherein at one moment my left hand touches an external object and thus plays the role of subject, while in the next moment my left hand is touched by my right hand, which now plays the role of subject while my left hand now plays the role of object.

The same phenomenon occurs with the other senses. Merleau-Ponty thus turns to the faculty of vision and provides the example of the Necker cube, which consists of a drawing of two overlapping squares at an angle to one other, connected corner to corner by short lines. While the "cube" is in reality just a two-dimensional drawing of twelve lines, what we perceive is a three-dimensional cube. Since the cube seems to flip back and forth between two equally valid interpretations, however, this not only makes the picture ambiguous, but suggests that what we are seeing isn't actually there. As Merleau-Ponty puts it, "I organize the cube" (Merleau-Ponty, 1962*,* p. 275). This means that by focusing on different parts of the cube, I change the structure of my perception. What I take as figure (as distinct from ground) determines whether I see the cube as from below or from above.

Ihde, in his book *Postphenomenology*, takes the "bistability" of the Necker cube a few steps further. "There is a third stability," he notes, "a two-dimensional one, which may be gestalted. ...the central parallelogram is the body of an insect; the hexagonal outline is a hoe; and the lines from the parallelogram to the hexagon are the legs of an insect... [what emerges from this is] the hermeneutic tale as the vehicle of letting the 'insect' be seen. ...Were I to use the Merleau-Pontian phrase, I am demonstrating that 'culture is perceived'" (Ihde, 1993, pp. 78-8).

Merleau-Ponty took the issue in a different direction, though, and asserted that reversibility equally applies to speech and what it signifies. Thus the speaking and thinking subject is not just a detached cogito but also an embodied participant in the phenomenological lifeworld. While reversibility merely changes what is being objectified, it does nothing to directly challenge the act of objectification whereby we pass irreversibly from subject to object. A gap still remains between the right hand touched and the right hand touching. The presencing of Being, the ability to glimpse what lies between the opposing perspectives, remains out of reach.

The topological example of the Moebius strip shows a way out of the dilemma. Although mathematicians refer to it as a one-sided figure, we can still experience both its inside and outside simultaneously. Yet even though the two perspectives are different, they become in this instance paradoxically one and the same. Thus, if we continue to trace a line on one side of such a figure, upon returning to the starting point we find that both sides have been traced. What we have, though, is merely a two-dimensional model of one-sidedness within which inside and outside get folded into one another.

For such a phenomenon to occur in three-dimensional space, we would have to produce something on the line of a Klein bottle, a bottle whose tube-like top folds into and opens up inside itself without, however, allowing a hole in its body, clearly an "impossible" object – at least, without access to the notion of a fourth dimension. This "higher dimension," which is needed to complete the formation of the Klein bottle, is also the dimension of prereflective Being. Take the example of the worm Uroburos that swallows its own tail. For this to happen, its mouth becomes the hole that swallows itself. Similarly, the Klein bottle can be understood within its own integrity to possess such an enclosure, so that its hole is canceled out by becoming part of its whole. It thereby becomes a self-containing object that contains its prereflective origin without a break.

Eugene Gendlin's therapeutic practice of initiating a discussion with his clients concerning the notion of "felt meaning" can be seen as another example of a self-containing object, in which the mind-body duality is bridged. We are thus led, with the reversibility operating in wild space, to a realization of the intimate harmony of outside and inside, object and subject, bounded and boundless. As Gendlin explains in his book *Experiencing and the Creation of Meaning: A Philosophical and Psychological Approach to the Subject,* "We are most aware of the dimension of felt meaning when our symbols fail to symbolize adequately what we mean" (Gendlin*,* 1997. p. 64). He goes on to say that at any given moment our focus of attention involves meanings that lie beyond our immediate focus. In other words, only part of the presently held meaning is symbolized explicitly; there are always some inexplicit aspects that have yet to be symbolized, even if they could be so at any moment. Once any of these hitherto inexplicit meanings is made manifest, though, its passage from inexplicit meaning to explicit meaning leads to something that we recognize, experience—even feel. While these implicit meanings remain on the fringe of our thought, however, they still contribute to the meaning development of whatever we were thinking about since they remain within the focus of our attention. In other words, our experience of meaning involves associating symbols with felt meanings (Gendlin, 1997, pp. 66-67).

In his book, *Focusing*, Gendlin identifies six focusing movements. They consist of the following: clearing a space, the felt sense, finding a handle, resonating, asking, and receiving (Gendlin, 1978*,* p. 64). He suggests that the subject should pay special attention to how their body feels at each stage in the process (Gendlin, 1978, p.51). The first step involves silencing what is going on inside your head and paying attention instead to how your body feels, especially in your gut. The second step involves selecting a personal problem, and, without thinking about it explicitly, paying attention to what this problem feels like. Step three requires that you provide a descriptive name for this feeling. Step four asks that you move back and forth between this word and the felt sense it evokes. Step five requires that you ask, what is it about this problem that invokes this feeling? Keep asking this question while trying to sense how it makes you feel, and keep doing this until it leads to a shift or a release inside your body. Step six involves being receptive to this shift, staying with it for a while and acknowledging that you have focused on something real. (See Gendlin, 1978, pp. 43-45). In order to illustrate the difficulty with how the process actually works in practice, Gendlin refers to how one of his best focusing teachers overcame his own problem with focusing: "At first, when I tried to focus, I could never get a felt sense. All I had were words I could feel, but there never was any feeling except right in the words. …I was only looking at the center of each feeling, and in the center was what the words said. It took me three months till one day I noticed there was more to the feeling. It had, sort of, fuzzy edges. They were beyond what the words got. That was the breakthrough for me" (Gendlin*,* 1978, p. 90).

In his appendix to *Experiencing and the Creation of Meaning*, Gendlin acknowledges his debt to Merleau-Ponty for developing the idea that "'emotional essence' constitutes our experience of the meanings of words" (Gendlin, 1997*,* p. 287). Gendlin adds that this notion of emotional essence "shows that language, rather than being arbitrary symbols, is a way of being in—and 'singing'—the world" (Gendlin, 1997, p. 287). He then explains how Merleau-Ponty, by developing the theme of felt meaning, is able to point out its function in articulating the experience of novel ideas and expressions (Gendlin, 1997*,* p. 287). When we "sing the world" we move freely between the opposing fields of sensual feeling and abstract ideation.

Merleau-Ponty's emphasis on dialogical relationships is also important to the creation of meaning in both its social and ecological contexts. In a dialogue between people, for example, each of the participants connects with the other's feelings and meanings. Hearing plays as great a role here as speaking, and both are understood to be part of the same effort to bring to light something that makes sense. He even goes further, adding that "to the extent that I understand, I no longer know who is speaking and who is listening" (Merleau-Ponty, 1973, pp. 143-144). Such an authentic dialogue will be recognized as a continuation of something that has already been going on for a long time. Other examples of this kind of dialogue would be the ongoing relationships between reader and writer, painter and viewer, musician and listener. In each of these situations, a shared experience and a shared language are presupposed. In addition, there is no struggle for control between the participants, since the enterprise is a commonly shared one and the roles of artist and audience are recognized as necessary and complementary to one another.

The whole scenario within which such a dialogue takes place is part of the larger issue of the perceptual intertwining which Merleau-Ponty characterizes as "the flesh of the world": I touch the earth while the earth touches me. In dialogue, not only do we see and touch one another, but we are also visible and tangible for others. The world is not merely an object to be observed by consciousness. Our embodied subjectivity is never located purely in either our being touched or in our touching, but in the intertwining of these two aspects. Merleau-Ponty's image of the "chiasm" refers to this intertwining between body and world; it describes how this overlapping and encroachment can take place between touching and being touched, where they are never exactly the same thing. Similarly, every authentic dialogue is intertwined with the thoughts of each participant, in the sense that the thought of each makes possible and is made possible by the dialogue, and by the perceptual domain it makes possible. (see Merleau-Ponty, 1973, p. 14). Discourse, thought, and perception are not autonomous domains. They mutually implicate one another in such a way that our access to any of them involves all of the others. The ongoing possibility of transitioning from one to the other is also part of what Merleau-Ponty calls "the reversibility which is the ultimate truth" (Merleau-Ponty, 1968, p. 155).

If perception and thought are intertwined in dialogue with discourse through reversibility, then perhaps silence also can be shown to be intertwined with discourse as part of reversibility too. In other words, if perception can be focused in different ways (like concentrating on touch or on sight or on any combination of the senses) and if thinking can be engaged in according to different modes (like musing, planning, constructing, theorizing, or calculating), then silence can be engaged with in different ways as well. According to Merleau-Ponty, we recall, the world is involved in a kind of dialogue with me—and I with it. Since I am not merely subjected to the world but am engaged in both speaking to it and listening to it as well, then both speaking and listening require any number of the modalities of silence, involving different shifts of focus and shifts in the cutting off of attention as well.

For Merleau-Ponty, the being of the world can only appear to us as both present and absent; it is never simply present. We therefore interrogate the world and listen to its call as it is jointly constituted by both discourse and silence. Similarly, both the being of man and the being of the world are constituted by passive and active modes of consciousness encroaching upon one another. They do not negate one another as opposites, but when taken together provide depth. In the intersection between man and world, meaning reveals and conceals itself simultaneously. Meaning is therefore not all of a piece but is rather in a state of constant tension between the poles of speech and silence. These poles are not merely coextensive, though. Instead, silence serves as the foundation for discourse just as the world is the foundation for objects. Since felt meaning only takes place when we are at a loss for words, then it too can be seen as part of our ongoing dialogue with silence at the limits of language.

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Complexes of the Cultural Unconscious: Trance States, Hakomi, and the Re-Creation of the Self

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Abstract

This article is a condensed version of my master's thesis for counseling psychology from Pacifica Graduate Institute. The original can be found on ProQuest. It combines two areas of interest: somatic psychology and cultural psychology. It looks at clinical research and theoretical developments related to the cultural layer of the unconscious as it manifests somatically. It draws from both Jungian and Hakomi theoretical orientations, and offers an analysis of core theoretical parallels. In this essay I hope to convince the reader of the importance of recognizing and working with cultural complexes, as the theory has been defined by Singer & Kimbles (2004). As the world becomes increasingly culturally mixed, clinicians need to increase fluency in recognizing cultural influences and helping clients work through them. Cultural complexes function as powerful trance states, taking hold over the body-mind continuum and creating parataxic distortions. Somatically oriented methods such as Hakomi and R-CS offer experiential techniques that can assist clinicians to access the cultural layer of the unconscious, observe these distortions by their somatic signatures, and work directly with parts of the psyche that are both collective and personal.

Introduction

Before pursuing licensure as a clinician, I studied cultural psychology and interfaith dialogue. I came to see that cultural complexes influence most aspects of human life and create unconscious conflicts in tragic and debilitating ways both locally and globally. Clinically, I see these same issues limiting my clients' lives. Conflicts related to race, sexual orientation, ancestral heritage, and gender are but a few of the problems that can be worked with somatically, enhancing awareness of the personal-cultural interface and increasing self-efficacy. Although therapists are trained to see these issues as personal or familial, naming them as culturally originated is a more realistic and expedited path to individuation, the process of psychological growth described by Jung (Jung, 1921/1971, pp. 448–449).

While psychology recognizes humans to be cultural beings who are influenced by the experiences of our predecessors, it has failed to do much with it. Some exceptions include feminist therapies and the DSM IV "Outline for Cultural Formulation" (1994). In the space between the personal subconscious and the deepest, collective layer of the psyche (Jung, 1931/2014, pp. 139–158), Jungian theorists Thomas Singer and Samuel Kimbles (2004) have suggested the presence of a complex-laden cultural unconscious. They argue that to sit with a whole person means seeing an individual as a cultural being who carries not only personal associations, traumas, and desires, but also a layer of collective experiences that are more specific to a time and place than the amorphous archetypal energy of Jung's collective unconscious.

The theory of cultural complexes proposed by Singer and Kimbles (2004) combines the theory of the cultural unconscious, proposed by Jungian analyst Joseph Henderson (1990), with the theory of complexes introduced by Jung (1948/2014, pp. 92–106). It was his discovery of complexes using the word association test that led Jung (1961/1963) to eventually develop his own theory on the structure of the psyche (p. 116).

The Collective Unconscious: Jung's Contribution to Psychology

In 1916, Jung delivered a lecture proposing his idea of a collective unconscious as a reservoir of psychic material that exists below the personal unconscious and holds archetypal energies or patterns (Shamdasani, 2003, p. 232). It diverged from Sigmund Freud's emphasis on the personal unconscious, in which he referred to anything that was not obviously sexual as "psychosexuality" (as cited in Jung, 1961/1963, p. 150). Jung's theory expanded the idea of the unconscious to include not only personal, repressed memories but also a tribal, national, and familial heritage, as well as an archetypal core that was shared by all of humanity.

Similar to the layers of earth, he proposed, the psyche is layered from the ego, the center of consciousness, all the way down to an archetypal molten core (Singer & Kimbles, 2004, p. 3). The collective unconscious contains archetypal energies, innate potential ideas, and activities that structure and give meaning to experience (Jung, 1931/2014, pp. 152–155), and that are a "phylogenetically inherited layer of the unconscious" (Shamdasani, 2003, p. 232). This perspective was expanded upon by Jung to be a "memory of mankind" (Shamdasani, 2003, p. 233). Ira Progoff (1981), psychotherapist and reconstructionist of depth psychological theory, wrote of his understanding of the collective unconscious:

> The fundamental hypothesis on which Jung works is the idea that the potentialities within the individual personality are not left unaffected by the developments of history, and that what happens in time leaves its mark not only on the psyche of the individual, but also on the continuity of the human race (pp. 67–68).

By 1935, Jung was also including a "somatic unconscious" in his structure of the psyche (Jung, 1988, p. 441). As he saw it, "somewhere our unconscious becomes material . . . and that is the place where one cannot say whether it is matter, or what one calls 'psyche'" (p. 144). Jung described the subtle body as the integration within the somatic unconscious of psyche and body, and the intangible realm from which they both arise as different, synchronistic expressions of a single energy (p. 432).

Complexes: The Heart of Analytical Psychology

So central are complexes in analytical, or Jungian, psychology that Jung almost named his work complex psychology. A complex consists of emotion-laden memories and ideas that have formed an "*image* of a certain psychic situation . . . incompatible with the habitual attitude of consciousness" (Jung, 1948/2014, p. 96). The complex coalesces around a structuring and meaning-giving archetypal image or motif. Complexes are a theoretical function of the psyche that are "repetitive, autonomous, resist consciousness, and collect experience that confirms their historical point of view" (Singer & Kimbles, 2004, p. 6). The complex with its archetypal core is a dynamism in the psyche that cannot be seen, but that can be known through its disruption of ego functioning (Jung, 1937/2014, p. 121). The theory of complexes was Jung's original idea developed from his word association experiments performed at Burgholzli from 1900–1909, which were designed as a diagnostic test for psychopathology (Shamdasani, 2003, p. 46).

> As the association experiments prove, complexes interfere with the intentions of the will and disturb the conscious performance; they produce disturbances of memory and blockages in the flow of associations; they appear and disappear according to their own laws; they can temporarily obsess consciousness, or influence speech and action in an unconscious way. (Jung, 1937/2014, p. 121)

Due to minute time lapses in attention, Jung postulated that certain words provoked associations that led to personal historical moments that took psychic energy to maintain in the unconscious due to the defensive purpose of containing psychic material that is unbearable to the conscious ego (Shalit, 2002, pp. 10–12). In the relationship of the complexes to the somatic unconscious, it is important to note that in conducting the word association tests, a psycho-galvanometer was used to measure physiological responses. This means that complexes were first recognized and measured by their *physiological* results (Stein, 1998).

As Jung (1948/2014) commented, the term *complex* was in the common lexicon when he was still living and remains so today, but the nature of complexes is less understood (p. 96). And their function, effectively putting one into a trance state, makes observing them and thus disidentifying from them, nearly impossible because self-observation becomes tinted by the complex. As Jung wrote, "everyone knows nowadays that people 'have complexes.' What is not so well known, though far more important theoretically, is that complexes can *have us*" (p. 96). In compensating for and opposing the conscious attitude, complexes come into conflict with the ego. Clinically, it is the ego's ability to hold in awareness the tension between the energy of the complex and the conscious attitude, so as to slowly integrate the complex material into consciousness that constitutes psychological growth toward wholeness, the work Jung (1921/1971) defined as the process of *individuation* (pp. 448–449).

The Cultural Layer of the Unconscious

Although Jung's focus was on the relations between the conscious, personal unconscious, and collective unconscious, in several documents including his autobiography, Jung (1961/1963) made references to a cultural layer in the unconscious. In his famous house dream, he noted images that were impersonal, signifying "passed stages of consciousness" from "the foundations of cultural history" within his psyche (p. 161). In the same book he stated, "A collective problem, if not recognized as such, always appears as a personal problem" (p. 233). Jung continued, "Psychotherapy has hitherto taken this matter far too little into account" (p. 234). Jung however did not elaborate on the cultural aspect of the unconscious, seeing it as a derivative of the collective unconscious, upon which he focused as the activating clinical influence.

The cultural unconscious was finally elaborated on and clearly defined by Henderson (1990) in 1962, the year after Jung's death. A previous student of Jung's, Henderson (1990) proposed a cultural layer of the unconscious in a paper presented to the Second Congress of Analytical Psychology in Zurich. He expanded the theories on the collective unconscious, defining the cultural unconscious as

> an area of historical memory that lies between the collective unconscious and the manifest pattern of culture [and] has some kind of identity arising from the archetypes of the collective unconscious, which assists in the formation of myth and ritual and also promotes the process of development in individuals. (p. 103)

The cultural unconscious is distinct from the collective unconscious because it is specific to a certain time and/or place, whereas the collective unconscious is more deeply psychologically and biologically (or phylogenetically) rooted.

Cultural Complexes: Applying Complex Psychology to the Collective Unconscious

Henderson's (1990) ideas on the cultural layer of the unconscious sat mostly dormant until they were further developed by Jungian analysts Thomas Singer and Samuel Kimbles, published in an editorial work *The Cultural Complex: Contemporary Jungian Perspectives* (2004). With this perspective, analytical psychology had a clearer understanding of not just the structure of the unconscious but also its functions. The essays chosen for the book laid a case for a cultural layer of the unconscious through which cultural identities are channeled as psychological complexes. This collection of essays helped identify the importance cultural conditioning has on the development of complexes and supported the theory that complexes can operate not only in individuals but also in the collective, cultural body of groups.

What is also relevant to the topic of somatic work is the perspective that cultural complexes are recognized by their somatic signatures. Editors Singer and Kimbles (2004) write, "Individuals and groups in the grips of a particular cultural complex automatically take on a shared body language and postures, or express their distress in similar somatic complaints" (p. 6). This points to a *felt* common or collective shared body. These essays outline the ways cultural complexes show up in the analytical process and the importance of the analyst's vigilance to their influence (Beebe, 2004; Kimbles, 2004; Morgan, 2004).

Speaking to the relationship between the social and psychological, psychotherapist and group analyst Farhad Dalal (1998) wrote of a social unconscious that "is a representation of the institutionalization of social power relations in the structure of the psyche itself" (p. 209). Haim Weinberg (2007), an expert on group psychotherapy, added that the social unconscious is co-constructed by group members, and "includes shared anxieties, fantasies, defenses, myths, and memories. Its building bricks are made of chosen traumas and chosen glories" (p. 312). Beliefs are carried by the collective and demonstrated in body posturing and relational styles. While in Hakomi we may look to character strategies to explain these somatic signatures, I argue the need to also take into account the cultural body that lives within our clients.

According to Singer and Kaplinsky (2010), the addition of cultural complexes to depth psychological theory serves two functions. First, it assists in individual analysis by giving theoretical orientation to working through conflicts around group identity. Secondly, it can assist social theorists and analysts working in the social spheres to hypothesize the functions of a group psyche and its complexes, especially in either intragroup or intergroup conflicts. In short, Singer and Kaplinsky noted that the analysis and working through of both the cultural layer of the unconscious and the function of complexes within this layer can provide analysts a fresh look at group dynamics as they exist in the international sociopolitical theater all the way down to an individual in the consulting room.

Somatic Psychotherapy

Complexes: trances that take over the body.

Freud (1923/1960) recognized, "The ego is first and foremost a body ego" (p. 20), which simply means that sensory experiences are the material from which the ego is developed. Contemporaries of Freud and Jung, psychoanalysts Wilhelm Reich and Sandor Ferenczi were exploring the impact of psychological states, or complexes, on the bodymind and techniques for using the body to treat them (Ben-Shahar, 2014). Their theories were highly influential, if controversial, and have continued to be influential in the development of modern techniques.

Psychiatrist Fritz Perls, whose psychotherapeutic methods brought attention to sensations, perceptions, and nonverbal expressions, was highly influenced by Reich and Ferenczi (van Vreeswijk, Broersen, & Nador, 2012, p. 12). The experiential techniques of this group of psychotherapists focused on accessing and working through unconscious material via the imaginal-sensory body. Their endeavors arguably share a common root in the work of psychiatrist Pierre Janet (1859-1947) on the dissociative nature of traumatic memory (van Vreeswijk et al., 2012). They also bore similarities to the Jungian concept of active imagination in which unconscious contents, including complexes, are assimilated into consciousness "through some form of self-expression" that gives "voice to the sides of the personality . . . that are normally not heard, thereby establishing a line of communication between consciousness and the unconscious" (Sharp, 1991, p. 12). This should all be familiar to the Hakomi informed therapist.

According to Jungian analyst Joan Chodorow (1997), in his work on active imagination, Jung wrote that the ways to the imagination are sensory, through dance, song, and painting (for example). This would suggest that psychic life is intimately connected with the body (Chodorow, 1997, p. 8). This also would suggest that change is not complete, not anchored or integrated, until it is realized in the body as a phenomenological reality. In what would later be published as his *Visions Seminars,* Jung (1934/1976) said,

> *When the great swing has taken an individual into the world of symbolic mysteries, . . . nothing can come of it, unless it has been associated with the earth, unless it has happened when that individual was in the body. . . . [otherwise] you are simply hypnotized into a sort of somnambulistic state or trance. . . . And so individuation can only take place if you first return to the body, to your earth, only then does it become true . . . individuation can only take place when it is realized when somebody is there that notices it.* (p. 473)

Hence, individuation occurs only when unconscious material is filtered through the senses, experienced in the body, and witnessed by self or another. This set of techniques is consonant with what today is known as mindfulness-based interpersonal neurobiology (Siegel, 1999) and is certainly foundational to Hakomi methods.

Hakomi and R-CS: Mindfulness as the Antidote to Trance

Jon Kabat-Zinn (1990) defined mindfulness as "paying attention in a particular way, in the present moment, on purpose, non-judgmentally" (p. 4). Complexes, whether personal or cultural, take over the psyche producing distressing states of consciousness that distort one's senses, leaving one lost in time and dissociated from the body (Wolinsky, 1991). With mindfulness-based experiential psychotherapies and developments in neuroscience, promising advancements in the treatment of psychological disorders have been made.

Kurtz's (1990) description of Hakomi starts with, not the method, but with a phenomenological view of personhood to which the system is adapted, making it a modality that puts a person's holism before technique. The techniques are to study expression, a gesture or thought for example, that stems from experience, and when these are followed "you eventually come to memories, images, and beliefs about who we are, what's possible for us, what type of world it is, what it wants from us, and what it will give and take" (p. 14). In Hakomi, one studies the expression with the assumption that it will lead to the core content. In Jungian analysis, one studies the symbolic nature of dreams, fantasies, and symptoms (Jung, 1921/1971, pp. 427–433, 475). Both desire to get to core beliefs, or archetypal patterns, so that one feels as though they live in relationship with their Self.

In Hakomi the goal is to process deeply unconscious material and change core beliefs through employing the mindful and compassionate qualities of the Self, specific techniques such as probes (Kurtz, 1990, ch. 7) and taking-over (Kurtz, 1990, ch. 8) that lead to providing a missing experience that will begin to create a reorganization of experience that is deeper, wiser, and more free.

In the Re-Creation of the Self Model of Human Systems (R-CS) the assumption is that the *Organic Self* is present, available, and knowing (Eisman, 2006, p. 65). Similar to the Jungian perception of the Self as the transcendent whole out of which the components of the psyche are formed (Sharp, 1991), Eisman (2006) contended that people are born with a sense of wholeness that becomes lost through painful or paradoxical experience. Eisman (2015c, lecture) gave the example of a little girl who knows inherently, as a part of her Organic Self, that she is lovable but cannot make that consistent with a mother who ignores her. As a result, she fragments, creating a self, or what Eisman referred to as a *little i*, who is unlovable. This formation of a little i is a way of protecting the Organic Self. Although R-CS certainly sees the value of psychological maturation and the cultivation of wisdom, the technique holds the Organic Self as omnipresent and so needing no further development. The techniques are to help one recognize a *preference* for the Self who is already there (Eisman, 2006, p. 65).

Re-Creation of the Self and Falling Awake

In R-CS the clinician is trained to recognize trance states that are full physiological experiences created from different selves referred to as *little i's*, which, often in childhood, were fragmented to deal with overwhelming experiences (Eisman, 2006, p. 63), states that Schwartz (1995) refers to as "parts." These selves activate "specific experiential components—the specific postures, thoughts, attitudes, etc.—around which those patterns were formed" (p. 64). An individual has many different selves experienced as states, which Eisman categorized as *the hurt self*, *the strategic self*, *the survivor*, and *the spirit in exile* (p. 64). Schwartz (1995) highlights categories of exiles, managers, and firefighters. From a Jungian perspective, these could be seen as representing archetypal motifs that structure and give meaning to a set of personal and unique experiences (Jung, 1954/2014a, p. 205). In doing so, they are also filtered through unconscious cultural associations and contribute to maintaining collective narratives (Dalal, 1998; Singer & Kimbles, 2004; Weinberg, 2007).

The archetypal states described by Eisman (2006) are detectable across client-specific material. Each has a distinct flavor that clinically one can recognize by interviewing them: "Who is speaking now?" is a common question in the R-CS method (Eisman, 2015c, lecture). Eisman came to recognize there are times this question can also elicit the answer: "Me. This is me." A clear selfhood is identified, and often, Eisman (2006) observed, in this work it is the desire to experience the self that is the pathway to doing so. He taught that an "orientation towards preference is essential to this process" (p. 65). As the clinician and client sink into mindfulness together to become curious about the states that appear, the client can feel for herself what she actually prefers. "The Self's main mission is to prefer and pursue, at any moment, the next self-relevant experience that gives it pleasure of some sort" (p. 65). This is what is known as the *Organic Wish*, and it can be as simple as a drink of water, or as complex as choosing a mate to partner with. And yet these desires are certainly complicated by cultural narratives.

In summary, R-CS assumes that individuals are spiritual beings who are born whole and remain whole (p. 64), that this wholeness knows exactly what it prefers (p. 65), and that a therapeutic alliance (p. 62) coupled with active therapeutic experimentation (p. 69) can help to shift consciousness away from fragmentation and towards the Organic Self (p. 65).

It is interesting to note that Jung (1948/2014) claimed, "There is no difference in principle between a fragmentary personality and a complex" (p. 97). The trance states that experiential modalities such as Hakomi and R-CS aim to change are very similar to Jung's description of complexes as "psychic fragments, which have split off owing to traumatic influences or certain incompatible tendencies" (1937/2014, p. 121). Jungian complex theory and R-CS (Eisman & Roy, 2014) both agree that one does not get rid of these fragmented states of consciousness. Rather, one becomes aware of them *as states* rather than as self by experiencing the affect that the mechanisms of the complex kept one numb or oblivious to (Jung, 1954/2014a, p. 98).

Clinical Findings: Falling Awake

In somatic therapies, as in all rigorous explorations, the results are limited and honed by the instrumentation. The body is an intricate sensory system that is still vastly more mysterious than it is understood. The literature reviewed in the previous section revealed the importance of the body as foundational in the beginnings of psychoanalysis (Freud, 1923/1960; Jung, 1934/1976) and, despite the decades of focus on the cognitive self, as beginning to take precedence in therapeutic modalities once again. Indeed a brief review of Taoist and Buddhist philosophies shows the millennia-rich traditions of self-understanding through mindful and somatic self-awareness (Kurtz, 1990). What somatic and mindfulness-based therapies share is the assumption that mindfulness, as gentle self-awareness, is the antidote to trance.

The power of trance is in its unconsciousness. Complexes create physiological responses in the body that often go undetected because of their unconscious familiarity. The classic example of someone angrily yelling, "I'm not mad!" demonstrates this, but there are many pervasive and obscure ways this shows up. In this simple example, the denial of anger does not prevent physiological alterations that trigger psychological states of mind; the contradiction between the denial of anger and the nonverbal meta-communication of the affective state just goes undetected by ego consciousness. What mindfulness practices can teach is that one is not the cluster of behavioral defenses that rally around one's complexes. The self is the one who watches the theater and observes the drama. The individual embodies a larger consciousness capable of living from the Organic Self.

Cultural Complexes

Personal therapy is not a time to solve larger cultural issues. The side effects of personal work, however, extend beyond individual lives, contributing to social change. As one begins to shift habituated responses to family, work, and community engagements, cultural shifts are inevitable. It is worth noting that this is not the goal of meeting cultural complexes in therapy. The goal is always improving the quality of life for our clients. And, as therapists, we need to be aware of the force of cultural complexes and their presence within us so that inadvertently we do not perpetuate and collude with those that constellate in our clients, which may be inhibiting psychological growth. This is more of a risk when working with people who share our cultural background, but not exclusively. It is also a risk when working with those we differ from because we may fail to see how their affect and behavior is rooted in a cultural complex or in a reaction to the presence of the therapist's cultural complex.

The question then becomes: To what extent does a therapist or client want unconscious, culturally inculcated assumptions about the world to skew not only one's perceptions of self and world, but also the therapeutic process itself? Jung argued consistently that,

> when an inner situation is not made conscious, it happens outside, as fate. That is to say, when the individual remains divided and does not become conscious of his inner opposite, the world must perforce act out the conflict and be torn into opposing halves. (Jung, 1951/2014a, p. 71)

In therapeutic transference–countertransference process, the client's inner conflict is projected onto the therapist, drawing the therapist into the client's psychic battle (Jung, 1946/2014, p. 170). When this happens, the therapist who is not aware of the transference is at risk of reenacting the original psychic wounding. In this case the therapist may derail the therapy by becoming for the client "just like all men," or the mother who taught her the importance of being "nice," or the father who encouraged her to strive but never provided love.

This relational model of therapy "conceives of the therapist and patient as a unit reenacting the patient's past relationships" but with the therapist modifying the dynamic in a way that is reparative to the original wounding (Sullivan, 1989, p. 44). When the therapist is able to do this, and reflects on the transference providing a "'correct' interpretation [it] is helpful because it expresses a deep conscious and unconscious resonance between therapist and patient" (p. 43). Though Hakomi generally affects transference through altering the organization of experience (Stolorow, Brandchaft, & Atwood, 1987) through a "corrective experience" more so than an interpretation, it remains that unprocessed *cultural* assumptions can impact the work our clients can do in the consultation.

In therapy, this cultural shadow can show up insidiously as the undertones of the way one approaches the work. The pattern I often see are women who have internalized patriarchal methods of accomplishment, and thus are driven by an unconscious masculine, and want to jump in and tackle their psyches as if they were confronting the Minotaur at their center, or Orthrus guarding the psychic cattle. The implicit assumption that hard work and a sharp analytical mind can "fix" them is in fact the very attitude that is pathogenic, preventing reparative attachment from forming.

The feminine principles of receptivity, gestation, and relationality (Sullivan, 1989) are foreign to these women, often due to early relational trauma, and thus defended against.

But they can be learned from new experiences. Therapy does this mostly through the therapeutic relationship as a secure base with which to experiment, while always working with and allowing the defenses. Through this gentle approach I see women and men come to detect a preference for being soft, vulnerable, tender, and letting the love in that is freely offered. With this self-awareness they can take this relational/organizational template into their relationships and begin to craft a life that is more balanced and whole.

The Numinous in Somatic Work

Working experientially with clients has the potential to side step the cognitive, rational brain, entering more deeply into holistic experience than ego-based or other more cognitively focused modalities might. For example, a cognitive behavioral therapist may encourage a client to reality test or replace self-talk cognitively, until she has talked herself out of old beliefs and into new ones (Boyes, 2012).

Clinical work takes on a different flavor when the unconscious patterns are worked through directly, somatically and through mindfulness, to bring them to consciousness and experiment with various ways of holding this material. When a person's internal witness is constellated, creating mindful self-observation, entrenched relational patterns can be altered through direct somatic experience with a new relational dynamic. Within this self-witnessing process there is a numinous experience that is not the exception but the norm.

From a Jungian perspective numinous experience relates to contact with the Self, in that the ego becomes aware of being acted upon by a power that is autonomous from and transcendent to it (Jung, 1961/1963, p. 336). This experience is healing because it effects a change in the ego's attitude to one that Jung described as religious in that it leads to "careful observation of, and respect for, invisible forces and personal experience" (Sharp, 1991, p. 117). This change in attitude can perfuse the therapy, deepening the client's engagement with the somatic unconscious and Organic Self.

Conclusion: Somatic and Mindfulness Work With Cultural Complexes

> Cultural complexes are based on repetitive, historical group experiences which have taken root in the cultural unconscious of the group. (Singer & Kimbles, 2004, p. 7)

In my work with clients I see trance states every day, in every client and every session. These states can be rooted in personal or cultural identities and my hope is to help the client integrate her various identities into a whole person. When clients feel that these identities or states of belonging are in conflict it essentially puts their inner state of being at war with itself. It is an autoimmunity of the psyche that creates troubling symptomatology.

With my clients I first work to assist them to recognize the conflicting parts of their organization and the strategies each employs. I use mindfulness and the therapeutic relationship while also paying attention to the transference dynamics each of these little i(s) elicits. The treatment is complete when my clients feel their life is moving forward with purpose. Resourcing that is used when the conflict feels unmanageable allows the psychic energy to move away from managing inner conflict that created a lived stalemate and into the organic wishes of the Self. The parts that belong to the various identities still stand. They are not washed away. But instead of whipping around from one little i to another, the client comes to experience, recognize, and rely upon the Organic Self that exists without conflict.

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“Should We Tell?” Living a Good Life in the Shadow of Cancer: A Personal Reflection

Dedicated to the Loving Memory of My Mother

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Abstract

Terminal cancer poses many medical and existential dilemmas for patients, their families, and for helping professionals. I discuss my mother’s experience with pancreatic cancer, and how cultivating a meditative attitude helped her to cope with her illness. The Heideggerian, Daseinsanalytic, and Buddhist perspectives on mortality, and ways of cultivating a meditative attitude are explored. Research and guidelines about doctor-patient communication across Anglo-Saxon and non Anglo-Saxon cultures point to significant cultural differences in the preferences of medical professionals and patients about disclosure, and the role of the family. Recommendations for improving guidelines on disclosures, and exceptions to disclosures to benefit patients are discussed. I argue that the most important question in dealing with patients experiencing terminal illnesses is not about disclosure or non-disclosure, but how individuals can be assisted in coping with their dis-ease rather than their disease.

Key words: cancer, disclosure, non-disclosure, guidelines, cultural differences, doctors preferences, patients’ preferences, meditative attitude, Buddha, Heidegger

Introduction

> *Those who do not know how to live, will not know how to die, and those who cannot die, cannot live*
>
> Condrau (1998, p. 105)

It is said that nothing prepares you for the reality of marriage except marriage itself. So it is with death. What is the reality of living with imminent death for the patient, the family, the healthcare professionals and carers? How do we give the patient quality rather than quantity of life while he or she is living? Should we communicate, and if so, how much information should be shared with the patient? Do we continue searching for treatment options when the prognosis is poor? When is enough, enough? How do we discuss funeral and other important issues and concerns with the patient?

These were some of the medical, ethical, and existential questions and dilemmas confronting myself and my family when we were informed in October 2014 that my mother had advanced pancreatic cancer.

My mother passed away peacefully on August 2015. Her death has prompted me to reflect on, and write about dying, death, grief, and loss. During my mother's illness, I did not have the energy nor the time to look at what the literature was telling us about communicating with a patient about cancer. Nevertheless, my discussions with medical professionals and carers piqued my interest. After her death, I researched the literature: studies, research, medical policies and guidelines on this topic. The information I uncovered was illuminating, but at times, disconcerting. So my conversations with my mother became part of a larger conversation, not only about disclosure of diagnosis and prognosis, but the existential question: "how to live a good life in the shadow of cancer."

In this article there are personal elements—I draw upon my mother's experiences, my own experience, the experiences of my family members, and the support that we received from the medical and the spiritual communities. Yet, it is not only an article about personal experiences. While my mother's passing was unique to her and to us, death per se is a universal and, I believe, a relational, shared experience.

The insights from her passing have provided me with a framework to reflect on how we can help others to cope with this human experience more pragmatically and compassionately, as a member of the helping professions or as someone who is otherwise encountering another person's dying and death. I discuss the various themes that unfolded in my mother's life as an illustration of how we navigated the medical and existential dilemmas, and the lived experiences of my mother and the family, with her being an uninformed cancer patient.

On Learning the News

When her doctors first informed us that my mother had pancreatic cancer, there was a sense of disbelief and a degree of denial about the diagnosis, a common response in patients and family when first confronted with the diagnosis of cancer (Johanson, personal communications, 29 December 2015; Kubler-Ross, 1969). My mother had been experiencing symptoms of indigestion, itchy skin, and jaundice, She was continually losing weight, had no appetite, and, most days, little energy. But then she was 88 years old. "Aren't her symptoms, symptoms of aging?" we asked her doctors, hoping for a positive answer. What can be done?" we inquired. They advised "Not much, given her age and her frailty." The prognosis was that she probably has "six to nine months to live."

Her gastroenterologist recommended the insertion of a stent into her bile duct (Cancer Research UK, 2014) so that the bile would flow into the bowel, relieving the symptoms of jaundice, and making her more comfortable. My mother knew that she had jaundice and consented to the procedure. The stent relieved many of her presenting symptoms. We were still hoping for the best.

Managing the Dis-Ease or the Disease?

The specialists advised that given my mother's age, physical health, and the type of cancer, she was not a good candidate for surgery, chemotherapy, or extensive treatment. The "silver lining" was the oncologist's recommendation of a procedure known as intensity-modulated radiotherapy (IMRT). IMRT is "an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor" (Radiologyinfo.org for patients, 2015).

Hence, began the first of many dilemmas for us as her family. There were endless rounds of discussions and debates of what was best for her. "Should we seek further treatment?" "Second opinions?" Some family members did not wish to pursue any further treatments, but to let my mother's condition be. Other family members strongly advocated for second opinions and checking out treatments from overseas. I was more concerned with managing her dis-ease—her emotional states, psychological needs, quality of life and general well-being—rather than her disease. The final word came from her supervising physician, a close relative who had looked after her for many years. He advised that my mother was not in a state to travel, and that any treatment had to be undertaken locally.

According to her oncologist, the IMRT would not cure the cancer. However, the radiation could shrink the tumor, slow its progression, and allow her to enjoy minimal pain for a longer period. Additionally, the treatment could be stopped at any stage should my mother experience any significant side effects. He said that without the IMRT, the tumor could progress faster, and she could experience significant pain as the tumor grew. "But we have need to decide soon," he added, "otherwise the cancer could spread, and the IMRT would not be efficacious."

It was December 2014, a few days before Christmas. The whole family: children, in-laws and grandchildren, were gathered in Kuala Lumpur, Malaysia where she lived, to celebrate her 89th birthday. My mother enjoyed her last birthday tremendously, getting into the party spirit and singing all her favorite Chinese songs to her heart's content. It was bittersweet. We cheered her on. Yet the need to make a decision about the procedure was urgent and we were no closer to reaching a family consensus.

To break the stalemate, and being mindful that time was of the essence, I convened a family meeting. My daughter made some pertinent observations. She reminded her uncles and aunts—"It seems like a no-brainer. The procedure has many upsides, and relatively few downsides. We are not looking at giving Ah Ma (Chinese for grandmother) a long life, but a good life and a good death." The family decided to proceed with the IMRT. My husband and I were given the unenviable task of discussing the procedure with my mother.

Should We Tell?

The Family Preferences

Communicating bad news is an extremely difficult task for everyone involved: healthcare professionals, patients, and families. As a therapist, I have worked with many clients facing terminal illness. My clients and their families sought help in coping with their fear, stress, anxiety, and depression. In Sydney, Australia, where I practice, most patients have already been informed of their condition, even in cases where the cancer was incurable. As I discuss later, the disclosures had to do with needing patients to make an "informed consent" about their treatment.

So, by the time my clients came for therapy, the majority had already learned of "the rocky road" ahead for them. Some clients spoke of the sleepless nights lying awake, in cold sweat, wondering "How much pain and suffering will I experience before the end?" "Will I die as painfully as others that I have seen?" Some were fearful of going to sleep per se, worrying "When will I breathe my last breath?" "Will I still be breathing tomorrow?" Family members spoke of their sense of helplessness as they watched loved ones endure rounds of radiation, chemotherapy, and surgery, coping with the physical, emotional, and psychological tolls of the treatments.

As I worked through these emotions with clients and their families, often with them in tears, and at times outside of office hours—fear, anxiety and depression do not observe office hours—I appreciated that the differences lay, not so much in whether they knew about their condition, but their attitude in relation to their illness.

One client who was diagnosed with advanced lung cancer was unable to accept the prognosis. He attempted to exhaust all options including an experimental drug therapy, which left him sick and exhausted, unable to enjoy his remaining time with the family, including the day he died as he was placed on a ventilator. After his death, although his family accepted that it was his decision to undergo all the medical treatments, they were nevertheless traumatized and much saddened by his inability to spend quality time with them. They shared with me: "We never got to say a proper goodbye. We never got closure."

Another client was diagnosed with bone marrow cancer, which had metastasized. She was given a prognosis of twelve months. She accepted this prognosis, quit her job, took up guitar playing, and spent her time on the beach with her husband and daughters. During her last few days in the palliative ward, she brought her guitar, serenaded the family, the other patients and nurses, and passed away peacefully.

Both my clients had full knowledge of their diagnosis and prognosis. Yet it was their attitude, rather than the information, that made a significant difference to their quality of life. In my mother's case, we were faced with similar dilemmas of whether and how much we should communicate to her about her condition. I was mindful that there were no right or wrong approaches, just "skillful ones" as the Buddha would say. And I felt that the most skillful approach was to take my cues from my mother.

Many of my family wanted to tell her about the diagnosis of cancer. They felt that she had a right to know in order to make decisions about treatments, and to prepare for this last stage of her life. My husband and I advised against telling her that she had cancer. I suggested that we use words like "growth" rather than cancer, as the latter term carried a lot of negative associations.

Again, the family was at a stalemate. Wearing my psychologist hat, I role-played with the family the kind of conversation we might have with my mother. Below is a sample of my discussions with various family members, which went on for several days:

> B (Belinda): What would you tell mother?
>
> FM: (a family member): What the doctor told us. That she has cancer
>
> B: What if she asked how long she has left?
>
> FM: We could tell her that the doctors can't tell, and we don't know how long.
>
> B: What if she asks why aren't the doctors recommending an operation or chemotherapy?

FM: (silence)

B: What if mother gets fearful and starts to feel depressed and anxious?

FM: We will be there for her.

B: Will we be there when she can't sleep or wakes up at odd hours worrying about dying? Can we be there for her 24/7?

FM: (silence).

B: What if she asks whether she will die, how soon, and whether she will suffer in pain.

FM: We will assure her that she won't suffer.

B: Is that the truth?

FM: Wouldn't you want to know if it was you?

B: I think it's about whether mother would wish to know. We need to be guided by her preferences.

FM: It is ethical to tell her the truth.

B: Which truth? The truth about her medical condition or the truth that she may experience great dis-ease and suffering as the cancer progresses? When do we start shading the "truth" and not tell her about the real prognosis, and how aggressive her type of cancer is.

FM: (silence).

B: I think that what we have to ask is: "What hope are we giving mother by telling her that she has advanced cancer and that there is no cure or treatment." What about her peace of mind, knowing that she will die soon? Is it ethical to give her information that she can't do anything about, but has the potential to cause her great emotional suffering? I think that it is a question of compassion, rather than ethics.

The Medical Opinions

Prior to discussing my mother's condition with her, I sought the advice and opinions of various healthcare professionals. Their responses and the anecdotes that they shared were informative and instructive.

Her treating oncologist felt that we should consider telling her about the cancer. Another senior oncologist in Kuala Lumpur advised against it. This oncologist's own aging mother had a brain tumor and dementia, and he had decided not to tell her about her cancer. His rationale was that many elderly people like my mother, who had little education and capacity to appreciate the gravity of her condition, if told that she had cancer, would probably only recall "the pain and suffering of someone she knew, who died from cancer." Those memories and associations," he explained, "would create unnecessary fear and suffering in her mind, especially if the prognosis is bad." The palliative care doctor and my mother's carers also recommended against telling my mother about the cancer, and shared anecdotes about the negative impact of disclosure on their patients' quality of life.

In Sydney, I learned from the oncological team that had previously treated my husband for cancer that his oncologist preferred to disclose to his patients that they had cancer when their informed consent was needed for treatment. When there were no treatment options, he preferred to use words like "growth" or "tumor," as he felt that the term cancer "was brutal" and carried negative connotations. I discovered, however, that this oncologist's compassionate approach was the exception rather than the norm.

I also learned from a general practitioner, a Chinese-born Australian, that in China, the doctors often did not tell the patients the whole truth, but that in Australia, they were ethically bound to do so. However, she agreed that sometimes she wished that she had the option not to disclose all the information, as often the patient, upon learning the diagnosis and prognosis, experienced significant anxiety and fear.

It appeared that there was no consensus among the medical professionals about disclosures. Many professionals who were working on the frontline, with real life experiences of cancer patients, were not supportive of full disclosure.

My Mother's Preferences

I realized that the decision about disclosure needed to be based on compassion rather than ethical or medical considerations. I had one more person's preference to seek out—my mother's.

I received much support from my husband, Charles. He had a good relationship with my mother and she would often share with him what she could not express with her children. She knew that he had had operations for two bouts of cancer, one thirty years before, and another in 2012. During her illness, my husband and I visited with her regularly, and she looked forward to these visits. It was during these times that she was most reflective and we were able to get a good sense of her preferences and her attitude towards cancer and death. The following is a summary of one of her conversations with my husband:

> Mother: You had several major health issues before. What is it like to have a major operation? What is it like to die?
>
> Charles: I don't see it as death. I see it as a long sleep from which one doesn't have to wake up. It is quite peaceful, actually.

My mother shared with me that she found his analogy of death as a long, peaceful sleep, comforting. She said, "I am not afraid of death. I am afraid of pain. So I don't want any operation that will cause me pain and suffering." After our discussion I emailed the family. Below is an extract of my email:

> Mum mentioned to Charles that there was a history of cancer in the family, but the cancer genes were all from our father's side, but none from her own family. The sense that Charles had from the conversation was that mum was concerned about cancer, but was glad there was no cancer in her family. We know that is not true [her own mother died from lung cancer]. However, it showed, as the senior oncologist told us, that the word *cancer* brings on a set of fears based on the patient's previous experiences and memories, and that the knowledge might create unnecessary anxiety at this stage.

These conversations suggested to me that my mother might well have had a sense that she had cancer, but she was hoping that it was not, as there were no cancer genes from her family's side. Additionally, my mother could have asked outright whether she had cancer. She did not. Should we disabuse her of this illusion, or do we continue to let her hope for the best? I decided that the latter approach would be more compassionate, as she needed to be psychologically strong to cope with the procedure.

Gawande (2015) related the story of his cancer patient, Jewel Douglass, who was willing to face surgery, but did not want "to take risky chances" (p. 235). According to Gawande, "I came to understand that she was telling me everything that I needed to know" (p. 240). In a similar vein, my mother was telling us everything that we needed to know: she was not asking for information about her diagnosis or prognosis. She was telling us that she did not want to undergo any treatment that might cause her pain and suffering, regardless of her condition.

In our follow-up discussions about the IMRT procedure, we realized that it was important to give my mother a narrative that was consistent with her philosophy in life in order to motivate her about the procedure and to give her hope that she would have a better quality of life. My mother had indicated that the stent helped to relieve her jaundice symptoms and pain, and that she was pleased that the family was happy for her. This gave us a good opening. Below is another extract of my email to the family:

> Charles explained that she had to see the doctors again, and that if she followed the doctors' advice, like she did with the stent, she would be continuing to give herself and her family the gift of peace of mind. He said that this was consistent with her selflessness and her philosophy of giving to the family despite personal sacrifices to herself. Mother said that she understood and that she would try and follow the doctor's advice, because it made the family happy when she was feeling better.

By framing the need for the procedure as consistent with her attitude of giving, rather than that the procedure was good for her, we hoped that she would be more accepting of any difficulties that she might encounter with the treatment, instead of giving up and saying "Better to die."

The next day I had an extensive discussion with my mother. I asked her what she understood about her medical problems. She said that she had a growth in her pancreas which caused her jaundice and various symptoms, and that the stent had relieved many of the symptoms. I explained that her doctors were recommending a procedure called IMRT to manage the growth. I outlined briefly what the procedure involved, the period of treatment, and some of the possible side effects for which the doctors would give her some medication to ameliorate. I gave her the analogy that the procedure was similar to a CT scan (which she had undergone several times). My mother's response was "I don't mind that. CT scan is not painful."

When I reassured her that my sister and I would accompany her to all the treatments, she consented to the procedure without protest. By keeping the explanation simple, and not burdening her with too many medical details, using an analogy that she understood, I felt that my mother had sufficient, but not overwhelming facts to make an informed decision about her own treatment.

In January 2015, my mother commenced her IMRT treatment, which involved her going to the hospital three times a week for five weeks. During this period, we tried to give her some simple pleasures and keep up her sense of humor. After each treatment, we would make our way to the "3-Michelin stars" hospital canteen, where my mother could select from a "gourmet" meal of "soft rice" or "soft bread," as she was unable to tolerate more complex food.

On the last day of the procedure, she even asked to be taken to her "gourmet restaurant" to celebrate the end of the treatment.

The IMRT proved to be a success. Until her death in August 2015 (a total of eight months), my mother was able to manage her pain with Ultracet, a moderate grade of pain relief medication. According to her doctors, the IMRT had shrunk the tumor and slowed its growth, and therefore the pain medication was working more efficiently. It was only three days before she died that she was put on morphine, as she was unable to take her medication orally.

My mother's experiences suggested that the lack of knowledge that she had cancer did not negatively impact on her response to the treatment. On the contrary, if she had known that the IMRT was a short-term solution for cancer, she might have been discouraged from following it through, rationalizing that the end result would not be any different. I was comforted that in following her lead and talking about growth rather than cancer, we had minimized her fears and suffering.

After the IMRT, unfortunately, my mother had a fall, and suffered a fractured femur, which caused her a lot of pain. The doctors advised that she would need high care at home. Otherwise she could continue to stay in the hospital. My mother had always expressed a wish not to die in a hospital, or to be taken to a nursing home. We were fortunate that one of my brothers had the resources for her to stay at his house, where she was provided with round-the-clock nursing and hospice care.

While the IMRT provided my mother significant relief from continuous pain, the cancer was still casting a long shadow. So we continued to try to monitor her preferences, wishes, and concerns. Most of the discussions we had with my mother were opportunistic. As a result of the home arrangement, we had the space to share her favorite movies, music, and to laugh and talk about things that she wanted to talk about, for example, her growing up during the wars, and her life as a wife and mother.

The important questions were broached tangentially. For example, I queried "When your fracture is better, is there anywhere that you would like to travel to, or anyone that you wish to visit with?" My mother's response was simple, "I don't want to go anywhere. I just want people to come and visit me, and I like to spend more time with the family." Everyone rallied around her. The family—young and old, far and near, her siblings and friends—visited frequently and spent quality time with her. It was a meaningful, poignant time for all of us.

As my mother's condition worsened, my family wanted to find out more about her wishes for the funeral service. I casually raised the subject by mentioning the type of funeral services we had previously arranged for my father and queried which type of service she thought that he preferred? My mother responded "I don't know what your father preferred, but I prefer a simple Buddhist service." She expressed a wish for the service to be conducted by the Buddhist monks from the local Theravadin order that she supported and where my father's ashes were kept. She indicated that she did not want joss sticks, just flowers and simple chants. Her overriding wish was "Keep it simple."

So each day I learned more about my mother's preferences and wishes, and her relationship to death and dying. And the important messages that we were getting from her was to keep things simple, and that she was at peace where she was now. As Gawande (2015) noted, "surveys of patients with terminal illness find that their top priorities include, in addition to avoiding suffering, being with family, having the touch of others, being mentally aware, and not becoming a burden to others, and achieving a sense their life is complete" (p. 155).

In ongoing conversations with my mother, I came to appreciate that questions like "Should we tell?" and "How much do we tell?" were largely immaterial if we took the time, and provided the space, safety, and opportunity for the patient to tell us what he or she preferred. I learned that our primary responsibility as family members or helping professionals was not to get bogged down with what to tell or how to tell it. Regardless of our roles, the gift that we could give to patients was to be present with them, and to listen mindfully to what they were really saying. In this regard, I was thankful that I was able to facilitate my mother feeling safe to do so. I felt that I had become a better therapist from my lived experience in helping her to navigate hard choices. In my mother, I found a good teacher to learn about living and dying.

Doctor-Patient Communication and Disclosure on Cancer

Overview

After my mother's death, I examined the literature: research, studies, guidelines, and recommendations on communication and disclosure or "truth-telling" (Kazdaglis et al., 2010, p. 442) to cancer patients. According to Kazdaglis et al. (2010), "from a health care perspective, it [truth]-telling] may be defined as total openness about the diagnosis and prognosis" (p. 443).

Generally, the literature can be classified into three groups. One group dealt with the disclosure of information to patients and their families—"whether," "when," "what," and "how much" and the exceptions to disclosure. Another group dealt with the guidelines for more effective communication with patients—the "how to." A third group examined patients' and families' preferences in relation to communication.

On reviewing the literature, a number of salient themes emerged:

There was significant variance among the helping professionals in terms of disclosure

There were significant cultural differences in relation to the type and degree of disclosure

The working assumption was that disclosing "the truth" was beneficial to patients

The guidelines for more effective doctor-patient communication were developed from the views of panels of healthcare experts. These panels rarely included patients and their families

The rights of patients appeared to focus on receiving information and making an informed choice about treatment. With a few exceptions, patients did not appear to have the right to refuse to receive the information per se

The majority of the studies involved patients who had already been informed of their condition prior to their participation; studies involving uninformed cancer patients proved to be the exception.

Guidelines and Recommendations

Disclosure of information to patients experiencing cancer or other life limiting illnesses were generally set out in guidelines and recommendations concerning the rights of the patients. For example, here are several:

> Javashvili, G. (n.d): *Ethical and Legal Issues of Palliative Care: Explanations and Recommendations to Healthcare Personnel*
>
> National Health and Medical Research Council (2004): *General Guidelines for Medical Practitioners on Providing Information to Patients*
>
> National Breast and Ovarian Cancer Center (2007): *Breaking Bad News: Evidence from the Literature and Recommended Steps*
>
> Okamura et al. (1998) *Guidelines for Telling the Truth to Cancer Patient*s
>
> Rodin et al., (2009): *Clinician-Patient Communication: Evidence-Based Recommendations to Guide Practice in Cancer*

The guidelines set out the patients' right to information about their diagnosis, prognosis, and treatment, and full disclosure was usually recommended.

The guidelines and recommendations were based on the general principle "that patients were entitled to make their own decisions about medical treatments or procedures and should be given adequate information on which to base those decisions" (NHMRC Guidelines, 2004, p. 14). A common example of the information to be provided to patients included the following from these guidelines:

- the possible or likely nature of the illness or disease;
- the proposed approach to investigation, diagnosis, and treatment;
- the expected benefits, common side effects, and material risks of any intervention;
- other options for investigation, diagnosis, and treatment;
- the degree of uncertainty of any diagnosis arrived at;
- the degree of uncertainty about the therapeutic outcome;
- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all;
- any significant long term physical, emotional, mental, social, sexual, or other outcome that may be associated with a proposed intervention.

The guidelines and recommendations, along with their implications will be discussed at greater length in later sections.

Cultural Differences on Disclosure and Non-Disclosure

Many studies and research have highlighted cultural differences in relation to doctor-patient communication and disclosure. The researchers have also identified differences across cultures with regard to patients' preferences for disclosure and the role of family. In this section, I explore these differences, and discuss whether they reflect real cultural differences.

Medical Professionals' Preferences

According to Kazdaglis et al. (2010), full disclosure by physicians appeared to be based on the assumption "that truth telling is always beneficial to patients..." (p. 443). Their study highlighted significant variance among physicians and cultural differences about "truth-telling" (p. 443). The authors noted that physicians in Western countries— the U.S., Finland, and Canada—were more inclined towards full disclosure. In these countries, the physicians felt that they had an obligation to fully disclose to the patient, as the patient's right to participate in their own treatment was enshrined in law. In the U.S., the debate was not about whether or not to disclose to patients, but "how and when to tell them [the patient] the truth" (Kazdaglis et al., 2010, p. 445).

In other countries without an "Anglo-Saxon cultural background such as Japan, Greece, Turkey, Spain, Italy" (Kazdaglis et al., 2010, p. 445) full disclosure was still not commonly practiced. In Japan, for example, in the 1980s, disclosures about diagnosis to cancer patients were not commonly observed as doctors perceived it "unethical to reveal what they considered a 'death sentence,' and patients were also reluctant to know their true condition" (Sato, Beppu, Iba & Sawada, 2012, p. 226). However, the trend in Japan appeared to be changing towards more disclosure (Okamura et al., 1998).

Patient's Preferences

Tan, Yaakup, Shah, Jaffar, and Omar (2012) found that Malaysian cancer patients "desire honesty from their doctors when it comes to communication of bad news" (p. 3) and that upon receiving the diagnosis, patients often requested more information about test results and treatment options. It was not clear from the study whether the patients' desire for more information was related to diagnosis, prognosis, or both, an important distinction often overlooked in studies about patients' preferences.

In Japan, Sato et al. (2012) found that while the rates of diagnostic disclosures have increased, the rate of prognostic disclosures by Japanese doctors remained relatively low: "…doctors are less likely to communicate life prognosis even when they tell their patients about cancer diagnosis" (p. 228). On the patients' side, Sato et al., (2012) noted important differences in patients' preferences for prognostic information:

> While some of the participants [patients] voluntarily asked for prognosis to prepare themselves for the end of life, others were shocked by unexpected and unilateral disclosure. Some obtained prognostic treatment from books and websites. Some preferred to remain unaware of the prognosis partly because they feared it would become a self-fulfilling prophecy" (p. 225).

According to Huang, Meiser, Butow, and Goldstein (1999), the majority of Chinese migrant patients and their families in Australia believed that "while disclosure of potentially curable disease was considered appropriate, non-disclosure of a poor prognosis was favoured to enable continued optimism and hope …" (p. 212). The authors also found age, personalities, and educational level of the patients to be important determinants of preferences, with younger patients and those with higher education levels reflecting preferences closer to Western values, and older patients and those with lower education levels preferring to leave treatment options to their doctors. Similarly, a study by Laxmi and Khan (2013) found that for Indian patients, age and education were important factors in the preferences for information.

A large study of UK cancer centers from 34 hospitals (Jenkins, Fallowfield, & Saul, 2001), which examined the information needs of 2331 cancer patients, found that "98% of patients needed to know whether the illness was cancer, and that 95% wanted to know about their chances of cure. According to the authors, "this observation should convince health professionals that they should not withhold the truth about diagnosis on the grounds that many patients prefer not to know" and that "information about prognosis should not be avoided either" (p. 50). However, in a breakdown of responses to specific questions such as "what the chances of cure are," the authors reported that while 98% (1909/1943 respondents) wanted all information, 77% (118/161 respondents) wanted "only good news" and 73% (118/161 respondents) would "leave up to doctor" (p. 50). In terms of raw scores, the number of participants who did not opt for full disclosure was significant, especially in an Anglo-Saxon cultural context.

Hagerty, Butow, Ellis, Dimitry, and Tattersall (2005) found that the majority of patients in Australia at the early stage of cancer desired detailed prognostic information, and that these preferences varied according to demographic, psychological, and disease variables. According to the authors, patients of Anglo-Saxon background preferred more prognostic disclosure while those from other cultures (both patients and doctors) were in favor of non-disclosure.

In Australia, the *Clinical Practice Guidelines for Communicating Prognosis and End-of-Life Issues with Adults in the*

Advanced Stages of a Life-Limiting Illness, and Their Caregivers (Clayton et al., 2007) recommended that health care professionals took into account patient and caregiver preferences and provided information tailored to these needs, including "giving the patient the option not to discuss it" (S83). However, the same guidelines recommended that health care professionals disclose full prognostic information to patients—the rationale being "that if information provision is not honest and detailed, patients may perceive that health care professionals are withholding potentially frightening information. …Therefore, it is in the patient's best interests to offer such information rather than withhold it in an attempt to protect the patient from losing hope or being upset" (S87). In my view, the guidelines to *tailor* prognostic information to patients' specific preferences alongside the recommendation to *fully disclose* appeared incongruent and were difficult to reconcile.

Does this variance in cancer patients' preferences for information reflect a real cultural difference? While some of the studies found that culture does play a role, there was also evidence to suggest that these preferences were influenced by age, gender, education level, stage of cancer, and the type of information desired (Hagerty el al., 2005; Huang et al., 1999; Laxmi & Khan, 2013; Sato et al., 2012). Another consideration that might have influenced patients' preferences was that in these studies the majority of the participants already knew about their illness. According to Kazdaglis et al. (2010), their opinions might be biased, and it was possible "that fewer patients want to know in detail about their illness than is believed by health professionals" (p. 444). Additionally, in most Anglo-Saxon and other countries where there was an obligation—ethical or legal—on the part of the medical professionals to disclose, it was not surprising that patients, once informed of their diagnosis, would wish to know more. Overall, the studies showed that patients' preferences for more information may be a function of culture and the various factors discussed.

The Role of the Family

Many studies conducted in non Anglo-Saxon cultures highlighted the importance of familial engagement. This engagement included physicians consulting with the family first as to how much information to disclose to the patient (Huang et al., 1999) and involving the family in the decision-making process (Laxmi & Khan, 2013). This represented "a divergence from usual Western practice …" (Huang et al., 1999, p. 212). Fujimori et al. (2007) also found that the majority of Japanese patients preferred to have their physicians take into account the feelings of their family. Kazdaglis et al. (2010) noted similar paternalistic practices existing in Arab and Islamic cultures, such as Kuwait and Saudi Arabia.

The above findings on the role of the family appeared to be in contrast to the practices in Anglo-Saxon culture where patients, rather than family members, were initially and primarily involved in the information and decision-making process, and physicians were required by guidelines and legislation to fully disclose to patients. Hence, the research findings demonstrated a real cultural difference in relation to the role of the family. However, in my view, the practices in non-Anglo-Saxon cultures, rather than reflecting paternalistic practices, suggested that family interactions were more relational than individualistic. In many of these cultures, family members played an influential role in most important decisions (not limited to medical decisions) affecting the individual, regardless of age and gender. Current Australian guidelines have taken into account such cultural differences by recommending professionals to be "sensitive to the person's culture, race, religious beliefs, and social background" (NBOCC recommendations, 2007, p. 19), and "to show respect for the family and the fact that they may have different views from your own about truth telling and patient autonomy (Communicating prognosis guidelines, 2007, S103).

In summary, there appeared to be real cultural differences with regard to medical professional's preference for disclosure and with the role of the family. However, the cultural difference in relation to patients' preferences appeared to reflect individual differences, and were influenced by various factors, culture being only one of them. Unless these multi-dimensional variables were differentiated and understood, the perception that patients in Anglo-Saxon cultures preferred more information than those from non-Anglo-Saxon cultures will continue to be perpetuated uncritically, and individual preferences overlooked.

It is recommended that more research be conducted across different cultures studying:

- informed and uninformed patients prior to their participation
- patients' preferences for diagnostic or prognostic information or both
- patients' preferences at different stages of their illness
- family members' preferences
- views and attitudes of health-care professionals who are obliged to disclose, versus those who have discretion about disclosure.

In this way, regardless of which culture the professional and patient identified with, the communication between doctor and patient would be "dis-ease" rather than "disease" centered.

Communication and Disclosure of Information

Determining Patients' Prefences

In recent times, clinical practice guidelines have been formulated to assist health-care professionals with ascertaining patient's preferences and to promote more effective doctor-patient communication: "the how to," rather than "the what." This is a welcome recognition that "no one size that fits all." Below are some examples of the guidelines and recommendations developed in various countries:

The *Good Medical Practice: A Code of Conduct for Doctors in Australia* (2014) (The Code) provides, among other guidelines, recommendations on effective communication with patients dealing with end-of-life issues and managing cultural differences:

> Effective communication: "listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences" (p. 8).
>
> End-of-life care: "… respecting different cultural practices related to death and dying" (p. 11).

In Canada, the *Clinician-Patient Communications Practice Guidelines* developed by Rodin, et al. (2009) set out some evidence-based recommendations to guide communication with cancer patients:

> Assess the patient's personal preferences for information and current understanding of their condition. For example, ask "Tell me, in your own words, what you understand about your condition?" (p. 45).
>
> In offering prognostic information: "First, ask if the patient wants information about prognosis…" (p. 45).

The Spikes Protocol, a six-step protocol developed in the U.S. by Baile et al. (2000) for delivering bad news to cancer patients recommended, among other things, ascertaining whether and how much information patients wanted regarding their condition. The Spikes protocol is now employed in various countries including the U.S., France (Teike Lüthi & Cantin, 2011), Germany (Seifart et al., 2014) and Australia (NBOCC recommendations, 2007).

In Japan, guidelines for telling the truth to cancer patients (Okamura et al., 1998) emphasized the importance of disclosing diagnostic and prognostic information to cancer patients, and outlined communication skills for providing such information. Comparing these Japanese guidelines for disclosure to analogous ones in Anglo-Saxon cultures, there were some significant differences. For example, the Japanese guidelines did not emphasize checking out patients' specific preferences prior to disclosure, or to consider the cultural background of Japanese patients. Additionally, although the role of family was recognized, it was deemphasised in favour of the patient's autonomy: "In principle, family members should not be told the diagnosis of cancer before patients are told" (Okamura, et al., p. 2). It would appear that these guidelines were premised on the assumption that more disclosure was beneficial to patients. The focus in these Japanese guidelines appeared to be in response to the lack of disclosure to cancer patients in Japan until recently. However, the question remained as to what Japanese patients actually preferred. Fujimori and Uchitomi (2009) found that "in family-centered cultures, such as Japanese culture, patients preferred that relatives be present more than patients in Western cultures did, and comparatively fewer patients preferred to discuss life expectancy in Asian cultures" (p. 214).

As discussed earlier, medical professionals in Anglo-Saxon cultures had a preference for fuller disclosure. In many of these countries, the assumption of benefit to patients appeared to be the prevailing wisdom. The question of whether disclosure per se was in fact helpful seemed to go unchallenged. Kazdaglis et al. (2010) queried whether Anglo-Saxon countries had moved too far and whether patients had lost the right not to have "the whole truth, and nothing but the truth?" (p. 445). The concerns expressed by Kazdaglis et al. (2010) applied equally to the issue of truth disclosure in Japan and other countries where patients' preferences varied from their Western counterparts. If non-Anglo-Saxon countries moved towards greater disclosure, guidelines for tailoring disclosure to individual preferences needed to be incorporated; otherwise the pendulum towards truth-telling could easily swing too far as well.

The main limitation of the guidelines for determining patients' preferences was that the guidelines were primarily developed from canvassing the views of healthcare experts (see NBOCC recommendations, 2007; Okamura et al., 1998; Rodin et al., 2009). As a result, there was a great variation in the recommendations (Schofield et al., 2003) and there were relatively few studies exploring the disparity between patients' preferences and the recommended guidelines (Schofield et al., 2001). For example, Seifart et al. (2014) found that patients' preferences for communication with their clinicians differed from the recommended Spikes protocol. One possible reason for this disparity was because the "real" experts—the patients and family members—were not included in the panel of experts, nor were their views and actual preferences solicited in the development of these practices. This lacuna needs to be addressed, as otherwise it could result in the providers (the health care professionals) rather than the consumers (the patients and their families) determining what constitutes effective and appropriate communication and disclosure.

Exceptions to Disclosures

Generally, the guidelines dealing with doctor-patient communication revolved around diagnoses, treatment options, and outcomes, and centered on a relationship that Gawande (2015) described as "informative" (p. 200):

> We [doctors] tell you the facts and figures. The rest is up to you. "Here's what the red pill does, and here's what the blue pill does"… . "Which one do you want?" It's a retail relationship. …We know less and less about our patients but more and more about our sciences.

While most guidelines in Western, and recently, in some non-Anglo-Saxon countries have recommended more disclosure, studies have shown there is a great variation in patient's preferences, with some patients preferring no disclosure at all. The preference for non-disclosure is less researched or discussed, and is the focus of this section.

According to Kazdaglis et al. (2010) "it is important to reconsider the argument that telling the truth is universally 'good' for the patient" (p. 446). Some guidelines recognized that some patients may not desire any information at all regarding their illness. For example, the NHMRC guidelines (2004) and Georgia recommendations made explicit exceptions for physicians to withhold information or for patients to refuse to receive information (p. 17):

Withholding Information

Information should be withheld in very limited circumstances only:

> - if the doctor judges on reasonable grounds that the patient's physical or mental health might be seriously harmed by the information, or
> - if the patient expressly directs the doctor to make the decisions, and does not want the offered information. Even in this case, the doctor should give the patient basic information about the illness and the proposed intervention.

The NHMRC guidelines (2004) further stated that "it is not appropriate to withhold information because the patient might be disconcerted or dismayed …" (p. 17) and "the doctor must try to ensure that the patient has *sufficient information and understanding* (italics added) to be able to waive his or her right to be informed and still to give valid consent" (p. 17). Similarly, the NBOCC recommendations (2007) advised professionals "to accept the patient's right not to know" (p. 16), while still requiring professionals to give patients sufficient information to make an informed consent in exercising this right.

The Georgia recommendations granted patients the "right to refuse to receive information" as follows:

Refusal to Receive Information

> Patient has the right to refuse to receive information about his or her own health condition and proposed medical service…. This likewise applies [to] incurable diseases. Surely, the doctor shall ensure that the patient has no desire to learn about his or her own health condition and the details of proposed medical care. The best approach in this case is posing relevant questions to the patient during conversation and hearing the patient's opinion (p. 6).

The Georgia recommendations further set out that the exception was permitted when doctors were certain "that disclosure of full information may be harmful for a patient," but that the treating doctor needed "to coordinate [the] decision with the ethics committee and in case of absence of such committee, with other colleagues" (p. 13).

In my view, these exceptions to disclosures posed significant difficulties in their implementation, and appeared to be inconsistent with the principle of respecting patients' rights and autonomy. One can conceive of the difficulties of applying them in practice. Imagine the following scenario:

> A legally competent patient consults with the treating doctor about the results of medical tests after experiencing symptoms that might be consistent with cancer. The tests show that the patient has cancer, the prognosis is bad, and the treatment options are negligible or absent. The doctor offers to discuss the test results with the patient. The patient informs the doctor that he or she does not wish to discuss the information.

What are the patient's rights and the physician's obligations in these circumstances? The NHMRC guidelines (2004) and the NBOCC recommendations (2007) required the physician to still give sufficient information so the patient could make an informed consent about waiving his or her right. This was clearly incongruent with the patient's wish not to be told. In short, the guidelines appeared to say that the doctor had to provide sufficient information about what the patient did not want to hear in order for the patient to exercise the right not to hear the information!

In my view, the type of recommendations set out in the NHMRC guidelines (2004) and the NBOCC recommendations (2007), raised a number of critical issues:

- The option to withhold information did not appear to make distinctions about the severity of the illness. In the case of terminal illness, a discussion on the diagnosis, prognosis, and lack of treatment options was bound to have a negative psychological impact on the patient.
- The guidelines did not appear to differentiate between withholding different types of information, e.g., between diagnosis, prognosis, and treatment options.
- Why was the patient not the best person to decide how much information he or she preferred to receive? Disclosing unwanted information may have the effect of unburdening the doctor at the expense of burdening the patient.
- Why was it inappropriate to withhold information because the patient "might be "disconcerted or dismayed?" (p. 17)? Doctors should be given the discretion to consider the emotional impact on the patient, rather than the obligation to furnish the patient with sufficient medical information.
- If a patient requested no disclosure, why was this request not regarded as the patient having made a decision about his or her own medical treatment and tantamount to informed consent?
- How was the autonomy of the patient respected if it was the doctor, rather than the patient, who decided what was "good for the patient?"

Although the Georgia recommendations appeared to be a more enlightened approach, one can still envisage practical difficulties and possible psychological impact on patients. In the hypothetical scenario set out above, if a patient invoked this exception, the doctor in Georgia was permitted to accede to this request only if he or she was certain that full disclosure was not harmful to the patient, and after consulting with an ethics committee or a colleague. Can any medical professional be that sure? Would it not be too late if the doctor was wrong since we know we can't unhear what we have already heard? Would not the patient be fearful that there was something more seriously wrong and think: "Why does my doctor need to consult with an ethics committee and other doctors?" And finally, how would an ethics committee or another doctor, who presumably would not know the patient as well as the treating physician, determine whether full disclosure was harmful or not to that particular patient? So the considerations in the Georgia recommendations appeared to be based on medical-ethical-legal considerations, rather than on the psychological needs of the patient.

Psychological Impact of Disclosure and Non-Disclosure

Kazdaglis et al., (2010) noted that there was not much research exploring the relationship between disclosing the truth and quality of life. The authors called for more evidence to ascertain whether truth telling had a positive impact on the patient's quality of life "… or is just assumed by health care professionals to be beneficial to patients" (p. 443). Equally, there did not appear to be much research that looked at the psychological impact of non-disclosure.

In Japan, a qualitative study (Maeda, Hagihara, Kobori & Nakayama, 2006) examined the psychological process of uninformed terminal liver cancer patients from the time of their hospitalization to their passing. The study found that the 59 uninformed cancer patients went through "five stages and four gates" (p. 8). The authors used the term "gates" to describe the "obvious and severe" (p. 1) feelings that each patient experienced at the end of each stage. The stages and gates ranged from stage 1 of "anxiety and puzzlement" (and the gate of "anger") (p. 8), to stage 5 of "acceptance" (and the gate of "uncontrollable grief") (p. 8). According to the authors, at stage 5, after the patients passed through the process of deep grief, they experienced a paradigm shift:

> Death seems to loose [sic] its grip on the mind and it is not spoken of anymore, although thoughts of death never disappear. Patients look back over their career and life at what they can be proud of and become close to their family, who has always

> been with them. They have a strong desire for warm hearted times. …In this stage, patients spend time peacefully appreciating the people around them, gradually deepening their level of acceptance (p. 8).

The authors attributed this state of mind to various factors such as "the tradition and culture of the Japanese society as a collectivistic or interdependent culture…" (p. 8).

> [F]amily relationships had priority over any other associations for these patients. Therefore, the patients strived to, above all else, value the thoughts of the family, that nondisclosure of the diagnosis was the best choice for the patient and the family in working to accept death (p. 9).

In relation to the psychological impact on the patients after disclosure, although more research would be helpful, currently there was information about such impact. Okamura et al. (1998) found that anxiety and depression including "…despair of the future, irritability, fear, insomnia and appetite loss" (p. 3) were the most common symptoms experienced by patients after receiving the news about their illness.

In Australia, the National Breast Cancer Center (2005) developed clinical guidelines on *Effectively Communicating Prognosis: Evidence From the Literature and Recommended Steps* for dealing with the psychosocial concerns of cancer patients. Some of these emotional issues included "episodes of intense, unpleasant and distressing emotions (such as anger, feeling out of control, fear and helplessness" ("Emotional issues," para 2), and psychological issues, including depression, anxiety, traumatic symptoms, relationship difficulties, body image, and sexuality.

Discussion on Disclosure and Non-Disclosure

Kazdaglis et al., (2010) advised maintaining a healthy balance between "the 2 ethical principles of veracity (truthfulness) and beneficence (doing good)" (p. 446). Health professionals in Asian and South-East Europe "should be more willing to answer patients' questions truthfully when they indicate a preference to know…" (p. 446); while in the U.S. and the U.K., health professionals should perhaps adopt a more cautious attitude and identify and respect patients "who wish to know less and complying with their choice" (Kazdaglis et al., 2010, p. 446). As human beings, when confronted with information about a terminal illness, it was understandable that patients would experience a range of negative emotions. It was an existential, rather than a medical issue. Healthcare professionals should be more prepared to take into account the needs of patients holistically, rather than just medically.

According to Edwin (2008) it was important to differentiate "therapeutic privilege" from "patient waiver" (p. 160). The former was exercised by doctors in withholding information from patients, whereas the latter was exercised by patients "waiving their rights not to know the truth about their condition" (p. 160). "In the case of therapeutic privilege, it is the doctor who is entrusted to determine that the disclosure of information mandated by the informed consent doctrine would cause the patient harm, whereas in the case of waiver the patient determines that he would be harmed by disclosure" (Edwin, 2008, p. 160). According to Edwin, "the right of those who do not want to know should also be respected" (p. 160).

If physicians were required by law to disclose, then equally, patients should be given a reciprocal right to opt for whether they wished *to receive or not receive* the information. Given research showing that patients desired more autonomy in deciding their own quality of life, guidelines giving physicians the final say in determining whether to accede to patients' request for no or less disclosure are indefensible. Such guidelines need to be reviewed, as the assumptions underlying them do not appear to be respectful of patients' autonomy and self-determination.

I believe that the focus of medical professionals should be about "healing" rather than "curing." To put it more bluntly, the guidelines seem to saying, "*Doctors have a right to protect you from yourself in the short term even if you suffer in the longer term.*" Presumably, some might argue that guidelines are needed to protect patients from less experienced physicians. But burdening more experienced physicians with obligatory requirements, often at the lowest common denominator—in order to avoid the mistakes by more inexperienced doctors—does not necessarily protect patients.

The relationship between doctors and patients cannot be legislated upon, and the parties themselves should be allowed to freely navigate the "highs" and "lows." The inefficacy of an interventionist or a piecemeal approach to social problems is best articulated by Latour (1995)—"We see only… crisis, disputes, interventions, compromises, substitutions, and orderings that get more and more complicated and engage more and more elements" (p. 275). Treating physicians should be given support to exercise their discretion and best judgment, rather than be constrained by laws and policies from doing so, for fear, perhaps, of potential litigation for non-disclosure, negligence, malpractices, or voiding their medical insurances. In general, I believe that it would be more appropriate for guidelines and recommendations on communications with cancer patients to:

- Make a clear distinction between the disclosure of information by doctors, and the receipt by patients, especially in cases of incurable illnesses.
- Give legally competent patients an unequivocal right to make their own decisions, and allow treating physicians to use their best judgment (in consultation with the patient, and if appropriate, family members) to consider what information to disclose, without being hamstrung by law and medical guidelines. The physician's responsibility in such situations is to ascertain patients' real preferences. This discussion should be guided by principles of compassion and respect for the patients' own judgment on what is or is not beneficial.

Being Present with the Patient

In my view, the doctor-patient relationship could benefit from doctors being more patient-centered, i.e., being mindful and present with the patients' dis-ease (their physical, emotional, and psychological states and needs), rather than their disease (their medical condition, symptoms, and treatment options). Mindful presence on the part of the doctor could foster a kind of relationship that focuses on healing, rather than curing.

An illustration of a patient-centered approach was captured by Gawande (2015) in his discussion with a palliative-care specialist, Dr Block, at his hospital:

> For doctors, the primary purpose of a discussion about terminal illness is to determine what people want—whether they want chemo or not, whether they want to be resuscitated or not, whether they want hospice or not. They focus on laying out the facts and the options. But that's a mistake, Block said.
>
> A large part of the task is helping people negotiate the overwhelming anxiety—anxiety about death, anxiety about suffering, anxiety about loved ones, anxiety about finances," she explained. "There are many worries and real terrors."…. There is no single way to take people with terminal illness through the process, but, according to Block, there are some rules. You sit down. You make time. You're not determining whether they want treatment X versus Y. You're trying to learn what's most important to them under the circumstances—so that you can provide information and advice on the approach that gives them the best chance of achieving it. This requires as much listening as talking (p. 182).

Epstein (2007) pointed to two kinds of knowing with regards to doctor-patient communication and relationship: a) knowing *about,* and b) knowing from the inside. According to Epstein, most doctors focus on knowing about their patients, their names, illnesses, symptoms, medical history, etc. Knowing the patient involves the doctor relating to the patient as a fellow human being and understanding his or her emotional and psychological needs. The latter kind of knowing would enable the patient to have a relationship with the physician in which the patient does not feel defined as a patient, but as a unique individual.

This was the kind of relationship that my mother had with her oncologist. Throughout his caring for her, they enjoyed a kind of light bantering, with my mother complimenting him: "Wow, you so handsome. Are you married?" He would respond, jokingly "Unfortunately, yes." Her oncologist encouraged the family to allow my mother to partake all the "less healthy habits" that she had indulged in previously, such as her occasional cigarette, and desserts (my mother had a diabetic tendency). When one family member expressed concerns about my mother's smoking, he queried "Are you concerned about her getting cancer?" He explained that his approach to my mother's condition was "I am about living, not about dying." His sense of compassion, pragmatism and easy humor meant that my mother was not fearful of visits to his clinic, and in fact quite looked forward to the check-ups, and carrying on their humorous exchanges. I believe that his knowing my mother, rather than just knowing about her, contributed to her general sense of well-being despite her failing physical health.

Our Relationship with Death and Dying

Why is our relationship to death and dying so ambivalent? Why do conversations about death and dying among patients, medical professionals, families, and caregivers pose so many dilemmas and invoke a range of emotions.

According to Heidegger (1927/1962), human beings are "Being-towards-death" (p. 301) meaning that mortality is a fundamental characteristic of being human. Yet, people flee from this inevitability by rationalizing death as something that will happen, but not yet (Khong, 2003). Anticipation of death, noted Heidegger (1927/1962), imbues people with the ability to look at their lives as a whole, and to take responsibility for every moment of their lives. Medard Boss (1979), a Swiss psychoanalyst who developed the existential therapeutic approach known as daseinsanalysis based on Heidegger's philosophy, advocated a similar approach towards death. In his teachings, the Buddha also encouraged people to accept mortality. However, death per se does not feature as prominently in Buddhist thinking as it does in Heidegger's philosophy and daseinsanalysis. The Buddha posited another way of addressing our existential anxiety with death: by showing that it is part of an ongoing concern with the larger issue of impermanence of everything, including human existence. From a Buddhist perspective, birth and death are the two end points of life, and it is how we live in the interregnum that is crucial. While Boss (1979) and Heidegger (1927/1962) advised people to accept death as a real possibility and to take responsibility for every moment of our lives, the Buddha counselled people to take responsibility for every moment of our lives because nothing remains the same. In short, it could be said that the daseinsanalytic position is: you have to live responsibly, in order to face *death* resolutely. The Buddhist position is: you have to live responsibly in order to face *life* resolutely (Khong, 1999). The difference between the Heideggerian, daseinsanalytic, and the Buddhist perspectives raises an interesting question: whether the lower rate of disclosure, and the preference for less information in Japan and some Asian countries points to individuals living in a culture that is more accepting of death per se as demonstrated by the Buddha's teachings.

In my view, the debate about disclosure or non-disclosure to cancer patients arises from our difficulty to accept that impermanence (including death) is natural and inevitable. It is ironic yet commonplace—as the Buddha, Heidegger and Boss have shown—that as human beings we are born knowing that we will die, and yet we avoid this most important conversation until we learn that we are dying. The conversation about death and dying has to be ongoing and part of the larger discourse about living.

Cultivating a Meditative Attitude Rather Than Meditation Techniques

When my family agreed not to disclose the diagnosis and prognosis to my mother, we were faced with an existential dilemma: how can we give her a good life in the shadow of her imminent death?

As the matriarch of the family, my mother often voiced concerns about the future of her children, and the financial cost of her ongoing medical treatments. Her concerns caused her a lot of anxiety and would often dampen her moods. My husband and I encouraged her to practice some simple mindfulness exercises. He suggested that instead of worrying about the problems, to focus on two positive experiences daily. To our delight, as her mind was less caught up with old concerns, she got in touch with ordinary day-to-day experiences. One day she said to us, "Today, I felt the warmth of the sun on my skin in a way that I never felt before."

When she found herself ruminating about negative things, I would encourage her to observe the water in the swimming pool, and to look for two drops of water that were the same. She said that she could not find any and then shared her insights "My thoughts and problems are the same. They come and go. I don't need to worry about them constantly." During the period leading to her death, my mother stopped worrying about things that she said she "couldn't change or control."

Over the years, prior to her cancer, I had encouraged my mother to meditate using some simple Buddhist chants. Each time the chants were played, she would calm down and fall asleep. This simple meditation practice stood her in good stead during her illness. At times when pain prevented her from sleeping, listening to the chants would get her into a meditative state, and enabled her to sleep until the pain medication could be administered. Up to her death, her ability to get into this meditative state gave her a sense of equanimity and peace of mind, which I believed no medication could have provided.

Our task about giving her a good life was made much easier by my mother's attitude towards death and dying. She had often acknowledged that at age 89, her days were limited, and although she was not aware of her illness, she reminded us, "It is okay, I am 89. I am ready to go. I am not afraid of death." A meeting with two visiting Buddhist monks from the U.S. made me realized that these were not just mere expressions about aging. She embodied this attitude and state of mind in her being and in her way of living.

One of the monks, Reverend Heng Sure, who spoke Mandarin, asked her how she felt about dying. My mother replied, "When the earth is ready for me, I am ready to go. I have no fear of death. I accept that it is inevitable." She was asked about how she felt about her limited mobility. My mother responded "I used to be upset that I have to be in a wheelchair, but now I accept my condition because my heart is peaceful." It would appear that she was learning to be at peace with herself and with the world.

Later when I played the chants, my mother again fell easily into a meditative state. The monks were amazed at how peaceful she was. The younger monk asked whether she prayed to the Buddha each morning as part of her meditation practice. When my mother replied no, he offered to teach her. Reverend Heng Sure pointed out that there was no need to teach my mother more or new ways of being meditative. He pointed out that my mother had acquired a sense of equanimity: "She is accepting of where she is, and that the family should also accept where she is at too." At the end of their visit, Reverend Heng Sure commented to my nephew: "Your grandmother is beautiful inside and outside (my mother had earlier mentioned to him that she was a former beauty queen). We were pleased that my mother had developed a meditative attitude rather than simply acquired a repertoire of meditation techniques.

Funeral Rites and Services: *Balm for the Living Rather Than for the Deceased*

A few days prior to her passing, my mother was unable to drink, eat, or talk, and the doctors informed us that her life was drawing to a close. The family kept all-night vigils. On the morning of her death, we all gathered in her room. My mother's breathing was barely audible. I led the family in meditation, and at the end of this sitting, we each took turns in sharing with her how we felt about her. I ended by whispering to her that she had been a good mother, that the family was well and thankful for her love and guidance. I added "Mother, we love you. It is alright to let go now." Thirty minutes later, she took her last breath. My mother died so peacefully that we were not certain that she had passed away and we kept checking for signs of breathing. Later, my brother shared with us that he had previously been concerned about death being a painful process, but that seeing how "mother died such a good death, I am no longer fearful of it."

In accordance with her wishes, a simple Buddhist ceremony was held with daily prayers conducted by Buddhist monks. The theme of her service was flowers. The room that housed her coffin was decorated with masses of flowers, and her favorite pot of orchids. One guest was heard to remark "It looked like her garden."

Chief Reverend Dhammaratana, who conducted the evening services and talks at the wake, explained that funeral services were meant more as a balm for the living than for the dead. He said that the chanting and prayers were a way for us to calm our minds and to use that quiet space to remember my mother and to be in a mindful relationship with her. In this way, he added, funeral rites served as objects of meditation for quiet contemplation, and had the psychological effect of helping us to remember her virtues and to accept her passing.

Chief Reverend's wise counsel helped us enormously. As each evening prayers drew to a close, the realization that we would soon have to say our final farewell allowed us to be in touch with our sadness and loss in a way that I believe would not have been possible if we had not cultivated the same meditative attitude towards her death, as my mother did towards her dying. In death, as in life, my mother left us an invaluable legacy.

Conclusion: Living a Good Life in the Shadow of Cancer

My mother had encountered many difficult experiences throughout her life

- She was born in 1926 and grew up in Malaysia during the World War II, under Japanese occupation. Being the eldest of eleven children, her education was interrupted as she had to look after the family, often hiding from the Japanese soldiers and foraging for food in the villages.
- She was married at a young age to my father into a large, wealthy family. It was difficult for her to find her place and a voice in his family, but she was kind and empathetic and became my grandfather's favorite daughter-in-law.
- About twenty years ago, at the age of seventy, she and my father were involved in a land slide. About 22 people, including my father, died in the accident. My mother, who was traveling with my father when the car was washed over the cliff, survived. The rescuers could not believe that a seventy-year-old woman was able to "kick" herself out of the car boot as it floated in the water.

Such was her courage, spirit, and will to live. As my mother put it (in Chinese) before her death "*chet kor is chet por*" (meaning "eating suffering is good nutrition"). My husband believes that the last eight months were perhaps some of the best times of my mother's life. According to him:

> She had a traditional upbringing. She was not an intellectual. What guided her life was traditions.

> All she wanted was to be a “good wife and a good mother.” She withstood all things with her dreams and her values of “what is right, fair and just.” Her basic instinct was giving love, and this was often expressed in cooking good meals. She became a good cook. One of her basic values was “to be free.” She had her family with her constantly. She was able to play whatever *mahjong* (a Chinese game similar to bridge) she could, sit by the pool, and enjoy some cooking and her occasional cigarette. Most importantly she was able to let go and experience *Peng On* (peace of mind).

Part of this paper addressed the question “Should we tell?” My mother’s experiences in living a good life while dying have shown me that this is the wrong question. Questions should more usefully be focused on uncovering patients’ preferences, and helping them to achieve these choices. According to Gawande (2015) “... our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one’s story is essential to sustaining meaning in life” (p. 241).

All of us have a right not to suffer unnecessarily. This is a natural right; it comes with being human. In my view, no additional information about her illness would have ensured my mother a better quality of life during the remaining months. If her doctors were obligated to tell her the whole truth, I would have serious concerns for her mental health and well-being. Although the pain medication had reduced her pain and given her the ability to enjoy her times with the family, I believe that it was the opportunity to shape her personal narrative—as a good mother and a good person—that gave her life continued meaning and purpose.

Kazdaglis et al. (2010) noted “although truth-telling is preferable from a philosophical point of view, when it comes to real life, theories cannot be applied so easily and may not have the results expected” (p. 446). My mother’s experiences point to the importance of medical professionals having the discretion (rather than the obligation) to tailor disclosure to individual patient’s preferences and psychological make-up. And regardless of which culture or jurisdiction the medical professionals are practicing in, they should be supported rather than constrained by the law, policy makers, and guidelines in exercising this discretion and judgement freely.

Life gives us choices even when at times the solution appears to be black or white. In reality, life is lived in shades of grey and this is especially so when cancer casts a long shadow. I believe that my mother was able to transform her life into a rainbow of colors with multi-dimensional hues.

The most valuable insight that I learned from my mother’s passing and something that is consistent with the Buddha’s teachings is: if we accept that we all die eventually, we can get on with living. And so we prepare for the “now” moments, every moment, until there are no more moments, and the journey ends. And the only moment that we can truly be in a “good” relationship with life and death, is NOW.

My mother was not a devout, or a religious Buddhist. I would describe her as a “Sunday school Buddhist,” visiting the monks and temples on auspicious occasions, and making donations when the need arose. But I believe that she died like a Buddha: accepting the transitory nature of life, and being grateful for what unfolds for her and facing her end of life with grace, dignity, and courage.

At her service, I delivered a eulogy, part of which explained her attitude towards life and death:

From a Buddhist perspective, flowers symbolize the cycle of life and death—the young bud matures into a beautiful blossom, then fades away quietly, returning to the earth to nurture new life. Our mother’s life had a similar narrative. She bloomed when she was crowned Miss Kedah. Then she blossomed into a lovely woman, wife and mother to six children, fourteen grandchildren and seven great grandchildren. Like her flowers, she has nurtured generations with her unconditional love, caring, and compassion. Like her flowers, our mother deeply understood the cycle of life and death. Let us rejoice with her in death as we had in life.

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Using Hakomi to Mediate Cultural Differences

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Abstract

In the following article I have begun by describing the process of Maori and European cultures meeting in Aotearoa (land of the long white cloud), New Zealand and how colonization changed Maori life and culture, creating present day conditions. I address the question of how as a non-Maori I work with Maori whaiora (health-seekers/clients), and how I offer Hakomi to them as a way of understanding their experience. Also, I discuss how working with Maori whaiora has changed my Hakomi practice.

Aotearoa, New Zealand

Myth has it that Maui chased and caught the giant fish, Te Ika (fish); Maui that has come to be known as the North Island of New Zealand; the South Island is Maui's waka (canoe). Although Maori refer to themselves as Tangata Whenau (people of the land), whakapapa (oral genealogy) speaks of great waka arriving from mythical Hawaiiki, thought to be a more northern part of Polynesia, seeking new land to re-establish their agrarian lifestyle in approximately the 14th century (King, 2003).

The first European explorers from Holland, France, and England in 1650 did little to disrupt this way of life, merely sighting land or coming ashore briefly. In the nineteenth century European seafarers began establishing whaling and trading between Sydney and Aotearoa. Maori participated in both whaling and trading, some becoming seafaring entrepreneurs (Belich, 1996).

As more Pakeha (non-Maori) settlers arrived, their idea of land-ownership clashed with the Maori idea of kaitiaki o te whenua (guardians of the land), who were responsible for the on-going well being of the land. The Treaty of Waitangi, signed by many Maori chiefs in 1840, exemplifies this cultural misunderstanding; the Maori chiefs were agreeing to kawantanga—governance, which to them meant protection by the Queen of England from war and further European invasion (Considine & Considine, 2012). To the English, it meant Maori were now a colony under British laws and customs whereby land could be bought and sold. Many of the "agreements" that Maori signed since the Treaty saw them lose vast tracts of land to "the Crown" and Pakeha settlement (Considine & Considine, 2012).

For Maori, land is more than a commodity to be bought and sold. Whenua, the word for land in Maori, means both land and burial place of the placenta, indicating the interconnectedness of land and personal identity. Loss of land was the beginning of loss of identity as Maori were separated from lands their tipuna (ancestors) had inhabited and where they were buried, as land confiscation by the crown continued (Considine & Considine, 2012). This aspect of colonization is only now being rectified through the Waitangi Tribunal, established in 1975 to compensate iwi (tribes) for the misappropriation of land.

In 1907 the New Zealand Parliament passed the Tohunga Suppression Act, intended to replace what were seen as superstitious and dangerous traditional Maori healing practices with modern medicine. Tohungas were not only healers, but carriers of tikanga—traditional wisdom, history and cultural practices—so by prohibiting Tohunga from practicing, Maori oral traditions were severely compromised, which hastened cultural assimilation. Te Reo (Maori language) was suppressed in schools, either formally or informally, Maori children punished or beaten for speaking their native tongue (King, 2003).

After WWII there was an economically fueled drift of Maori from remaining rural land to the city for jobs in factories and freezing works, causing further loss of cultural identity. This process of acculturation was seen as inevitable and desirable by some pragmatists who felt it portended economic progress for Maori (King, 2003).

The 1970s heralded a resurgence of Maori identity in Aotearoa, New Zealand. Land marches challenged to confiscation of Maori land, as mentioned previously, the Waitangi Tribunal was established to restore illegally confiscated land, the Kohungareo (language nest) movement established early childhood centres, which have gradually become total immersion Te Reo education. Kuras, total immersion primary schools followed, and soon Te Reo was part of the secondary syllabus.

Although Maori seats in New Zealand Parliament were established in 1867 by the Maori Representation Act as a way of rewarding Maori loyal to the crown and placating Maori rebels, disparities in the administration of the Maori electoral system meant Maori did not enjoy the same representation as those of European descent (New Zealand Parliament, 2009). Between 1893 and 1975 persons of more than half Maori descent were not allowed to vote in a European electorate, however, since 1975 a person with some degree of Maori descent is able to choose whether to vote in a Maori or general electorate (New Zealand Parliament, 2009). These legislative changes reflect both the effects of inter-marriage between Maori and pakeha and the resurgence of Maori cultural identity. In general parlance today and in the casework I will discuss below, the term Maori refers to anyone who culturally identifies as Maori.

Continuing an historical understanding of the marginalization of Maori, the post war employment boom came to a halt in the 1980s, closing small factories and freezing works. In the Hawkes' Bay where I practice, there are now three generations of numerous Maori families, once employed at the freezing works, who have been unemployed and on welfare benefits with little prospect of employment.

Not unexpectedly, social problems among Maori abound today: Although 14.6% of New Zealand's population are Maori, Maori represent over 50% of the prison population (Ministry of Justice, 2015); the incidence of sexualized violence among Maori women is twice as high as among pakeha women (Mayhew & Riley, 2009); 30% of reported incidents of domestic violence involve Maori; the Maori youth suicide rate was 35.5 per 100,000 of the Maori youth population, which is more than 2.5. times that of non-Maori youth in New Zealand (Ministry of Health, 2012).

So today, while there is a resurgence of Maori language and culture that has produced growth in Maori art, literature, the performing arts, with more young Maori entering university and following professional careers, Maori are still some of the most socio-economically marginalized people in Aoteraroa, New Zealand. Motivated by these social problems, my colleague, Donny Riki has established Te Aratika (the good/honest/right path) to make psychotherapy available to Maori and Pacifica people in the Hawke's Bay. Mental Health Initiative referrals have come to us in this service from two medical practices who have a high percentage of Maori whaiora (those seeking health), and one dedicated Maori medical practice, and through word of mouth in the community, funded ultimately by the Ministry of Health.

A Non-Maori Working with Maori

I am tauiwi, a person not born in New Zealand. I was born in Torrington, Connecticut, U.S.A. of Eastern European Jewish parents and attended a primary school where I was one of two Jewish students enrolled. I encountered ignorance and prejudice about being Jewish from an early age, and so have been sensitive to feeling "different." At University, after intending to major in psychology and finding the prevailing "behaviorism" mechanistic and devoid of attention to human relationships or spirituality, I stepped sideways to anthropology and archeology. I became skeptical about the wisdom of analyzing other cultural systems when one of my anthropology professor's study of the organization of rural power was used by the C.I.A. to destabilize villages in Thailand.

My first experience of travel abroad taught me how much distortion can be created by our cultural lenses: I began reading a *Washington Post* article on the six-day war that described a conflict between the U.S. and the Soviet Union. At mid-flight I was given a *Manchester Guardian* that described the same event as conflict between Palestinians and Israelis!

When I came to New Zealand in my early twenties, suntanned with curly black hair and brown eyes, arriving in Wellington train station and was asked by a Polynesian railway worker, ”which island do you come from?” I replied, “The big one.” However, I was aware that although I could pass for Polynesian until I began to speak, I came from another culture and looked at the world differently. I chose not to pursue an academic career in archaeology because I felt I would be a foreigner offering an interpretation of Maori culture, which I knew little about. Instead, I again stepped sideways, offering a social studies unit on archaeology to the local primary school and went on to train as a teacher. My experiences at Teachers’ College learning Maori waiata (songs) and a canoe trip up the Whanganui River visiting some of the old villages and maraes were a gentle introduction to Te Ao Maori (the Maori world), reminding me how much I don’t know about that world where I am a visitor.

I have taken this attitude into my work as a psychotherapist by following the cultural lead of the client, be they Maori, pakeha, or tauiwi. On the advice of wise kuia (grandmother/elders) and karaua (grandfather/elders) I offer my pipiha (my genealogy and the land marks of my birthplace) to Maori clients and make a place for them to respond. I also offer them a karakia (prayer) to begin and end the session, if they wish.

I have been fortunate to work for two kaupapa Maori (conceptualized by Maori knowledge and oral tradition) organizations. Several months after completing my general psychotherapy training, I had two job interviews on the same day. The morning interview was with Te Rangi Haeata Oranga (the breaking of a new dawn), Hawke’s Bay’s kaupapa Maori gambling help agency. The “interview” was a mihi whakatoa, a meeting to get to know and welcome me. Seated on mattresses, “marae-style” were all the staff and kaumatua (elders) of the agency who introduced themselves with their whakapapa (geneology) and spoke of their work. I was invited to reciprocate. Talk continued in the whare-kai (dining area) over “a cup of tea,” a generous lunch, in keeping with Maori protocol of transitioning from the tapu (sacred) process of mihi to the noa (profane/everyday) business of eating that also happens in the process of powhiri (formal welcome) on the marae. At the end of the morning I felt well-fed and well-met.

I also noted that at Te Rangi Haeata Oranga as well as therapists and kaumatua to hold tikanga, there were social workers, a woman who did regular mirimiri (traditional massage), and opportunity for whaiora to be referred for rongoa (traditional medicine). This attention to the needs of the whole person impressed me as truly wholistic healing, something that is often stated as the goal of health practices, but not achieved.

The second interview was in the afternoon with a firm of psychologists. After I had sat in the waiting room for several minutes, a woman came out with a cup of coffee in hand and said she was just finishing her lunch and would be with me shortly. I was invited into a boardroom with this woman who, with pencil poised, asked questions about my curriculum vitae, what I thought I could offer to the company, and my “learning edges.”

I was offered both jobs, but the choice was a no-brainer for me. Whereas I felt the psychologists were only interested in my mind and my ability to use it in my work, the experience with Te Rangi Haeata Oranga had engaged my complete embodied self. It was a wonderful and welcoming place to begin my career as a psychotherapist and to begin to implement the Hakomi I was learning at professional Hakomi trainings.

Using a Hakomi Paradigm with Maori Whaiora

The Hakomi principles sit comfortably alongside a well-regarded and popular Maori model of health, Te Whare Tapa Wha (the four walls of the house) (Durie, 1998). These four walls or spheres of reality and importance in Te Ao Maori (the Maori world) are Hinengaro (mind), Tinana (body), Whanau (family), and Wairua (spirit). The equal importance of mind and body means that the Hakomi concept of mind-body wholism is not foreign to Maori. The importance of familial connection motivates Maori to seek emotional, social, and economic support from their whanau. When a ceremonial meeting and welcoming (powhiri) takes place on the marae (courtyard of a Maori meeting house that acts as a social and ceremonial forum), speeches are made to make connections to whanau and tipuna, thus easing tensions and animosities. When meeting informally, Maori seek familial connection to each other, and often with pakeha, Maori will name the origin of their pakeha tipuna to seek connection. The wairua is the immortal part of a human being that leaves the body at time of death—best translated as spirit (Best, 1934)—and is similar to the Hakomi concept of essence or essential self (Morgan, 2015, p. 40).

Ron Kurtz, when working in Aotearoa, New Zealand and meeting Maori people, perceived them as psychically whole, embodied, personifying the unity principle: "A Maori person sang a Maori parting song. . . about going away over the sea. As he sang, I could feel his love and knowledge of the sea. I felt like we were there, on the sea, sailing away."

The Hakomi principle of organicity, the idea that things unfold according to a higher order plan, is also consistent with Maori paradigms.

Although Maori were traditionally a warrior culture, in day-to-day life there is a non-violent attitude of going with the flow of life. For example, Maori seem much more accepting of death as inevitable than pakeha, and often if an older Maori person is diagnosed with a terminal illness they will choose not to seek medical treatment. Neither does mindfulness seem an alien concept to my Maori whaiora, particularly if I describe it as "going inside to have a look at your wairua."

Some examples of how I have worked with whaiora using Hakomi principles and techniques will best illustrate this synergy.

Terry (pseudonym) was a client who I worked with during my three years at Te Rangi Haeata Oranga. He identified as Maori, was thirty years old and married with four children. He was referred through another agency in Central Hawkes Bay as a whanau member affected by gambling, his father being the gambler. Terry spoke about feeling let down by his father when his parents split up. Terry was in his early college years at the time, and was living with his father. He was an excellent rugby player, but felt his father hadn't helped him to realize his dream to play rugby professionally, and had steered him into his own profession of shearing. Terry was also sad that his father now rarely visited Terry and his whanau.

I explained that Hakomi was a technique that helped us get in touch with our wairua. I explained that it was like looking inside and talking about what we saw and felt. I asked Terry to sit with his eyes closed or softly focused and just notice any thoughts, body sensations, emotions, or memories he noticed arising in him when he heard the words, "Terry, you are loveable." This initially acted as a fluffy probe, as Terry was taken back to very early childhood. He had just gotten out of the bath and his mother was drying him by the fire. His dad was there, too, relaxing in his chair, and he could feel how much they both loved him. Terry basked in the warmth of this memory for quite a while before returning to ordinary consciousness and becoming tearful. I contacted his emotional response and he remarked, "that's what was missing after my parents split up: love." The probe had hit home and Terry had made sense of it intuitively.

I was also struck by the ease with which Terry was able to become mindful. As a Maori, perhaps his concept of "wairua" was not so compartmentalized as a western ideas of "spirit." This may have allowed him access to his inner landscape, displayed in the present moment, as his psychodynamic history and his experiences of being loved and feeling held. The ease of accessing the past also indicates a Maori way of thinking where time is not so compartmentalized as it is in western society. This is reflected in a felt sense of the nearness of tipuna who are deceased but are said to stand behind their progeny when they are called through the recitation of whakapapa, or in times of need.

Another whaiora, who I will refer to as Mere, has been an Accident Compensation Corporation (ACC) client since 2012. ACC is a government scheme that provides free therapy for people who have sustained physical and mental injuries that includes incidents of sexualized violence. Unfortunately, as indicated above, Maori women are subject to an extraordinary frequency of sexualized violence. Mere was one of those women. She had earlier disclosed and processed with another Hakomi therapist, an incidence of being gang-raped when she was a teenager and had found mindfulness invaluable for dealing with recurrent flashbacks as a way of separating "what happened back then from what is happening now."

She had had a break in therapy and then was referred to me to deal with a memory of her mother being drunk and sexually violating her when she was eight years old. It seemed that Mere had been drawn to me unconsciously to work through her mamae (troubling sorrows) with her now deceased mother, because her transference towards me was strong from the beginning of our work. She commented on my curly hair at our first meeting, saying it reminded her of her mother's hair, and found it hard to make eye contact with me. I suggested that she experiment in mindfulness looking away from me, noticing what happened, then looking at me for a few seconds and noticing her reactions. She reported an anxiousness feeling in her puku (stomach) about me looking at her while she was looking away. Looking at me felt "scary," and when she looked away again, she could feel what she imagined to be my critical gaze looking at her, looking away.

I then suggested we try the experiment with me looking away, looking at her, and looking away again. When I first looked away, Mere said she felt relieved that I wasn't looking at her. When I looked at her she said she felt "confused and lost and nervous." As I looked away, she reported a deep sense of sadness. Mere quickly grasped the parallels to her experiences with her mother, wanting connection and protection but feeling frightened and confused by her mother, the dilemma of disorganized attachment (Wallin, 2007). Safety in our therapeutic relationship was the focus of therapy for the first year.

In a more recent session, Mere came troubled by her lack of courage to speak to the mistreatment and disrespect she felt she endured from family members. She felt her siblings only valued her ability to cook, and ignored her when she tried to give her opinion on whanau matters. She explained, "They takahe (trample) on my mana (honour)." When I asked her to direct some mindfulness to her physical body, she said she felt "floaty, kinda disconnected" from her body. She was staring intently at me and I contacted her intent gaze. She replied, "Something weird is happening. . . your face is changing. I'm seeing my nanny. . .nanny loved me. . . she's telling me kia kaha (be brave), to gather my feathers. . . she's telling me to gather my feathers and weave a korowai (cloak). . .the whanau will see the korowai and know they must listen to me.Again, Mere was quick to make meaning of this experience. She said the feathers she needed to gather were those things about herself that she knew were her strengths: her ability to be a good mother, a good listener, a practical person, and clear-thinking. Mere said that her nanny had those qualities herself, and had passed them on to her. For her, this was a reminder of how present her nanny was, although deceased. When I asked how she was feeling physically, Mere took a deep breath, smiled slowly, and closing her eyes said, "I feel full, I know how to restore my mana," and her ease with herself was palpable.

I sensed that Mere was connecting, through her own physical body and through her nanny's body, to the sacredness of the female body that is inherent in Maori tikanga. As the vessel of procreation, the female body is revered and tapu according to tikanga. When a woman is hapu (pregnant) or mate (menstruating), she does not enter a garden, enter an urupa (cemetery), or bathe in the sea or river. This does not mark her exclusion, but rather the sacredness and importance of her female body, particularly in these conditions (Wallen, 2007, p. 118). With this reminder from her nanny, Mere was embodied as a wahine toa (a strong woman).

Mere was able to draw on this strength later when whanau members were questioning her for reporting violence and intimidation she experienced by her niece, whose children have been removed from her care, and who Mere voluntarily cares for. The children overheard their mother threatening "Nanna" (Mere), and were confused and fearful. Mere knew "It was my chance to stop the cycle of whanau violence," so she put a protection order in place that prohibits her niece from seeing the children except at specified times and under supervision, despite whanau criticism.

Learnings from Te A Maori and Maori Whaiora

I feel enriched as an individual and as a Hakomi psychotherapist for having worked with Maori whaiora, for working with Maori colleagues and kaumatua, and for the opportunity to be exposed to Te A Maori (the world of Maori). From my first experiences with Te Rangihaeata Oranga I have learned the value of manaakitanga (providing support and hospitality) to whaiora and colleagues. This allows us all to relax and be more available to each other in the present moment.

The fact that Maori tikanga (cultural practices) encompass a consciousness of the presence and power of ancestral forces in present life experiences adds a dimension to life that is rich and supportive. Encouraged by the awhi (support) and wisdom of kuia and friends, I have felt the reassurance of my own tipuna in times of stress. When I voiced concern to my Maori friend about taking the role of kaikaranga (the one who calls) to lead a Hakomi student body onto the marae, she wisely reminded me, "Sarah, your ancestors will be there. You are calling to them and they will awhi you."

I have also used my pipiha (account of geographical and genealogical origins) to help me feel grounded and supported when I was being interviewed by a panel of psychotherapists for membership in the New Zealand Association of Psychotherapists, and now often tell new clients, Maori and Pakeha, about my origins when I introduce myself.

This affects how I work with Maori clients, for example how I contact and track their experience. Knowing there may well be the added presence of tipuna in our interactions adds another layer of mutual respect and makes me less liable to make assumptions about the meaning of their experience. I now think of ancestry as another level of consciousness in the hierarchy of experience to be considered when I lead clients, Maori and Pakeha, in mindful study of the levels of their present experience. I imagine that other Hakomi practitioners could find this way of thinking beneficial and enriching.

I have also benefitted from a deeper understanding of the sacred feminine as understood in tikanga, Maori. Initially, when told, "Don't go into the garden if you're mate," when at the marae, I understood it only as a restriction. I now appreciate the respect and veneration for women as child-bearers and mothers that this rule of tapu implies.

Conclusion

Maori are a people who have been socially and economically marginalized in their own country though the process of colonization. While there has been a resurgence of cultural pride and identity beginning in the 1970s, Maori are represented disproportionately in social problems.

My own experience of marginalization has created an affinity with Maori and a caution in assuming I can fully understand their experience. This has led to an attitude of following their cultural lead in the therapeutic relationship. I have explained how I have offered Hakomi as a way of allowing whaiora to make sense of their experiences, how Hakomi and tikanga Maori can create a healing synergy for whaiora, what valuable learnings I have gleaned from my contact with Te Ao Maori, and how they have changed and enriched my Hakomi practice.

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Applications of Hakomi Mindfulness-Centered Somatic Psychotherapy in a Non-Profit Setting

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Abstract

Through the use of narrative and composite case examples, this article explores the question: Can Hakomi, a mindful somatic psychotherapy, be applied when working with individuals who have been marginalized and oppressed?

Introduction

Shivering, he sits looking out the window. It is a rather large window on the sixth floor of a downtown bank building. The window overlooks the traffic on a major street. Across the street one can see the office for a local television station.

This is the first meeting that Desmond and I have. I can sense a kind of timidity in him. It is as if he might run at any moment. I am grateful for my training in Hakomi, as it has given me the skills to slow down and wait in loving presence. I wait for a bit, allowing him to take his time and orient to the room. I offer some gentle comments intended to create safety and establish contact: “a lot to see out there.” He looks at me and looks back out the window. Thinking that looking outside might be soothing (as it is for many of my clients), I take a guess: “Kind of good to look out the window.” He gives another look and looks back out the window. I continue to wait. After a bit, Desmond looks at me and says, “I was in the woods.” He is still trembling. He looks back out the window.

I think through my mental file of what the woods can mean, and then I realize that Desmond, a homeless African American veteran of the Viet Nam war, has probably been literally living in woods. As I simply repeat his words, “the woods?” he looks up and says, “Yeah, I haven’t been this high up in a long time.”

I imagine how confusing and frightening it must be for him to be around people. I begin to think about the courage it took for Desmond to walk past a white security guard who would normally ask him to leave the building. I picture what it might be like to be this high up, in this much space, sitting in a “fancy” office, across from a white woman with a degree. Our lives, our bio-psycho-social worlds, are miles apart. Yet, we begin to find a way to connect, human to human.

The Need for Hakomi with Underserved Populations

People who are marginalized habitually and unconsciously look for signs of being discounted. Many times they have become so accustomed to their needs being disregarded by both individuals and social institutions, they have learned to overlook their own needs. This is internalized oppression. Sometimes even practitioners unconsciously collude with this oppression and in subtle ways overlook their client’s humanity.

Yet, I have learned that by treating people with dignity, respecting their way of being regardless of my privilege, the person can find their own inner resources and sometimes therapeutically deepen into the process to discover the unseen patterns that continue to shape their choices. By respecting their process, and especially their hesitancies at each stage, we as practitioners, communicate our willingness to not marginalize them as people, and to help build safety and trust in a collaborative manner.

Working in a non-profit setting I do not always get to choose with whom I work. The majority of the people who come to see me have not heard of Hakomi, they have not practiced mindfulness, and this may be the first time they have ever seen a counselor. So the question arises: Can Hakomi, a mindful somatic psychotherapy, be applied when working with individuals who have been marginalized and oppressed? My personal experience is a resounding "Yes!"

In the book, *Falling Through the Cracks: Psychodynamic Practice with Vulnerable and Oppressed Populations*, edited by Joan Berzoff, offers a clinical example of Al, a school social worker, frustrated in working with a mother who was living with an abusive husband. The mother was unwilling to take Al's advice to leave the marriage and she was not responding to Al's interventions of acknowledging her strengths and perseverance. Berzoff writes:

> What Al did not know was psychodynamic theory. He did not have a way to conceptualize this mother's unconscious need to repeat what she had not mastered. . . . Telling her that she needed to leave did not take into account where she was developmentally and the degree to which she has separated and individuated. (Berzoff, 2012, p. 3)

She continues to write:

> . . . thus expecting that she could rationally change her behavior spoke to the clinician's lack of understanding of just how great the pulls of unconscious inner life can be, and how, in conjunction with one's place in the social structure, these pulls often determine behaviors that otherwise do not make sense. (Berzoff, 2012, p. 4)

When working with an individual with internalized layers of oppression, we practitioners often, at times, become frustrated and want to give up. Sometimes we are more likely to resort to more directive approaches with clients who have the least ability to apply the suggestions. These tendencies to be directive may originate in concerns of safety for the client, frustration on the part of the practitioner, limited training and knowledge of how to work with the client's inner worlds of internalized oppression and trauma, a fear of intimacy, or a combination of factors.

Hakomi Mindful Somatic Psychotherapy gives the practitioner a choice between directive and non-directive approaches. In my experience, working in the present moment and creating little experiments for the client to "try out," offers the opportunity to introduce effective skills that can help when there is a need for resiliency and stability. At the same time, these little experiments open a doorway to explore unconscious motivators when the timing is right.

Case Example One: Desmond, 68-year-old, Homeless African American Veteran

Let's continue with this case of Desmond, mentioned in the opening paragraph. As I become more familiar and attuned with Desmond's rhythms, he begins to show signs of trust. By the end of this initial session, I have some history:

- I have learned that, with the exception of the support of the homeless shelter who referred him, Desmond does not have social support.
- During his time in Viet Nam he was living in a bunker that collapsed.
- He has been sober from alcohol for a month. Sobriety is a requirement of the shelter, and he is struggling with his addiction.
- He is fearful of attending an Alcoholics Anonymous meeting.

We don't discuss the impacts of being African American. But, I can assess by his age, he grew up at a time when blacks and whites in the South were using separate bathrooms and water fountains. And, African Americans of this generation were given separate—many times disparate—educations. The risk of standing up to oppression could mean death. By the end of this first session, Desmond has begun to look at me a little more and his shivering is decreasing. I ask him if he will come back again and he agrees.

Applying Hakomi to Establish Internal Resources

In the next session, we discuss whether he might like to learn some things that could help him feel less anxious. He says "I would." We discuss the idea of doing little experiments in awareness where he can decide for himself whether something is helpful for him or not. I ask, "Would you like to try a little experiment?" He says, "I would." I give him a brief introduction on how to study his experience (putting the concept of mindfulness in simple language). I invite him to be curious while observing what happens when he presses his feet into the floor. He notices that his anxiety seems to go down some. From this beginning we practice a few somatic resourcing skills in mindfulness, and he observes the impacts.

I know that I will have limited time with him. I am also aware that he has limited resources both internally and externally. I trust in the ability of a human living system to adapt to health and that even small amounts of movement toward health can help the system begin to change. While I am informed by my knowledge of some of his bio-psycho-social world, we work collaboratively with experience occurring in the present moment. I use the principles of Hakomi to help him develop some somatic resources for his experience of anxiety, which I imagine is partly related to trauma, as well as internalized oppression. We are working in a present centered mindful state of consciousness to establish trust and help Desmond develop his own ability for self-regulation of physical and emotional experiences. I offer experiments intended for him to have a direct felt experience of a new somatic resource. While tracking the results of these little experiments in awareness, I observe signs that his nervous system is becoming more regulated. If he becomes less regulated, it will clue me to back off. We go slowly.

I worked with Desmond for another four sessions before he was moved to a shelter in Dallas. I did not get to say goodbye. I did not have time to create the safety needed to engage in psychodynamic therapy that would help him discover his unconscious patterns and core beliefs that likely are part of many of his choices, including his alcoholism. But, I was aware of underlying motivators as I made choices in the present moment. I do not know if those few resourcing skills he learned were able to integrate enough to stick with him, but I have hope that they did. I maintain hope that making a positive loving connection with another human being can evoke positive ripples within his or her being.

Summary of Session Work

In this example with Desmond, I offered some direct, specific suggestions to help his anxiety, yet we tried these things in a spirit of curiosity, an experimental attitude. With this attitude of curiosity, there was room for the process to unfold and wait for what was to emerge next in the session. Desmond could decide for himself if he thought this was something that worked. Given enough time, we might have moved from this more directive present-centered mindfulness practice, toward a more non-directive mindful study of his past infused present, where we could explore how his internalized core patterns and beliefs limited his choices today. Indeed this latter option does happen often with clients who are not able to continue with therapy for several months.

Case Example Two: Marjani, 21-year-old, Arabic Muslim College Student

Marjani is a college student of Arabic descent. She is the second generation in her family to be born in the United States. The first member of her family to attend college, she comes to counseling to address her concerns about social anxiety. Her family is proud of her success in school, but they are also unfamiliar with her experience of attending college. Marjani is well-spoken, and in spite of her social anxiety, is able to create some social connections. She has support from her family, but has few friends.

In addition to the social anxiety, she has worries about her ability to complete college. She is paying for college and working part-time to cover bills. Her funds to pay for counseling are limited. With the support of donations to our non-profit setting, we are able to offer her a fee that meets her budget.

While Marjani is a highly motivated client, she is somewhat hesitant about the counseling process, as no one in her family has ever seen a counselor. She is also concerned that I will not understand her Muslim faith. She acknowledges that living in a rural area, where evangelical Christian is the predominate faith; she has delayed seeking counseling due to lack of interfaith services. It is important to her that I can respect her choices and help her view them in the context of her faith and values. Marjani says that she has heard of mindfulness, as it is frequently reported in the news, but she doesn't know much about it. She reports that she has tried some breathing techniques, but they have only helped a little.

Creating Safety with Differences and Processing

Unlike Desmond, Marjani has both internal and external resources. She has the ability to be self-reflective. I hold in my awareness some understanding of the impact of the power differential both as a therapist and as a white Christian. I am aware that due to the power differential, Marjani may not feel the freedom to speak openly unless I facilitate the exchange. As part of creating safety, I encourage us to actively engage in conversation and understanding about the similarity and differences in our faiths. I pay special attention to understanding what is important to her about her faith. As we move toward mindful study, I want Marjani to trust that she can speak openly and make connections between various parts of herself: her faith values and experiences, her inner bio-psycho-social world, and her somatic memories.

Over time the process of her counseling has taken a course much like that of any other Hakomi therapy client. We establish mini-contracts to try some things out in mindfulness, and experiment. We study her inner critic. She recalls a period of time when she was bullied in middle school. She feels the emotions and somatic impulses associated with the remembered pain of friends withdrawing from her socially. She becomes aware of a choice she made to withdraw as a way of self-protection. Within about two months, Marjani reports that she feels more comfortable walking to class. In about three months, she starts talking about noticing times of self-compassion. In about four months, she begins to talk about taking some risks to reach out to make new friends.

When she began therapy she was attempting to push herself to make new behavioral choices, but she would get stuck. However, by taking time to compassionately observe the stuck places, especially the well developed inner critic, she begins to notice a greater ease with making choices that once seemed impossible to her. She continues to work in counseling and the layers of the unconscious patterns, core organizers and beliefs, continue to emerge. Her ability to offer herself compassion, while she self reflects, is increasing.

Case Example Three: Mark, 62-year-old, Gay, Anglo Saxon Retired Male Surgeon

Let's consider one more example where elements of diversity and oppression may be part of the impact of the client's inner world.

In the waiting room, I greet a slightly graying, well-dressed man. As we walk down the hallway to my office, he carries himself with an air of confidence. Mark has recently retired from his profession as a surgeon. He is a white male, professional, who is able to pay the full fee for counseling. At first glance, Mark appears to come from a life of privilege. The initial intake information shows that Mark has been feeling depressed and he wants help with that. I wonder, to myself, if some of his depression might be related to retirement, but I wait to see what unfolds.

As Mark sits down, he begins to tell me some of his story. He was married for thirty years. Six years into his marriage he had a two-year affair with a man, at which time he considered divorce. However, he was concerned about the impact it would have on his daughters. He reports that for years he struggled with his attraction to men. He was raised in a conservative Christian home where he did not think being gay was compatible with his faith. He loved his wife and enjoyed their friendship. Yet, it never felt quite the same as his feelings for men.

Over time, he had difficulty forgiving himself for the affair and his attractions to men. He began to withdraw from going to church or participating in a faith community. Increasingly, he became more depressed. Five years ago he decided to divorce his wife. He wasn't sure at the time if he would date men or lead a celibate life. But, he knew that he could no longer live a lie. He disclosed that about a year and half ago he began a relationship with a man, whom he has come to love. He says that he feels like he can be himself in this relationship. Yet, he still experiences conflicting feelings that interfere with his relationship.

During this five-year period he has explored some aspects of meditation and he is drawn toward contemplative practices. He is interested to know what Hakomi therapy is, thinking it might be something he likes. He notes that he found me through a Google search looking for "gay friendly" therapists, and found only three therapists in town. He does not want to offend me, however, he is concerned that I might try to tell him that he can change being gay. He says he has lived with that belief long enough. He is also concerned, that as a "gay friendly" therapist, I will be offended if he talks about his Christian beliefs. I wait for him to pause and then ask, "Would it help to know a little of my belief?" He says, "It would."

I confirm for him that as a therapist, Hakomi or otherwise, it was not my job to determine an agenda for him. He appears to relax a little. I also acknowledge, that for him to explore his internal conflicts, it is important that we create an atmosphere of welcoming, and make room for multiple dimensions of this dilemma. I add that resolving these kinds of deep conflicts in values is a personal process and that my role as a Hakomi therapist is to provide a container and a method with which he can explore different parts of himself. We discuss how this way of working might create possibilities for him to find an internally satisfying resolution, or gentler ways to be with his conflicts. He responds that he initially was not feeling hopeful about counseling, but after talking he has more hope in the possibilities. We continued to work together for two years.

Learnings from Working with Mark

In my work with Mark, I learned some things. I was surprised that it took him some time before he was able to stay in mindfulness. He had experience with meditation and I mistakenly expected this experience to translate more easily. In retrospect, the difficulty of staying in mindfulness makes sense. In Hakomi, we ask the client not only to be mindful, but to be vulnerable while mindful. We ask clients to report on their internal world. As a gay man growing up in a culture and faith that imposes compulsory heterosexuality, Mark held deep internalized shame. Allowing me to enter his world by reporting what he discovered in mindfulness was risking yet another person judging him.

Initially, Mark would intellectualize his experience, talk *about* and interpret his experience inter-personally with me, rather than mindfully staying with his experience intra-personally, and reporting about it without coming out of it. Working with him meant giving him time to trust me. He needed to be certain that if he let me know about internal places of shame, I would not judge him. It also helped to not give up coaching him on how to mindfully study an experience and to stay with it a little longer before skipping to the next. This required me to make room for and honor his protective behaviors, such as intellectualizing.

Many of Mark's behaviors were congruent with early developmental issues of power and freedom. It would be easy to assume that these issues were related to family of origin, and some were. However, some of his struggles with relationship to power and freedom were also impacted by oppressive cultural values and social structures. Initially, Mark was not aware of the depths of shame he experienced as a child and teen when he felt an attraction to males of the same age while simultaneously receiving messages that this was wrong. Mark had only explored in a limited way his internal conflicts of giving up a position of privilege: wealthy, white, Christian, male, and perceived as straight—with coming out as gay, possibly giving up some of his societal role power. All these issues, in addition to his exploration of his faith and values, were important parts of the counseling.

Considerations for Hakomi Faculty and Therapists

Students in training for Hakomi Mindful Somatic Psychotherapy often come from some level of privilege and have varied experiences with meditation and personal transformation. In general, not always, familiarity with meditation and personal transformation is afforded to people of privilege who have the time and money to attend to needs of self-actualization. Part of our challenge as therapists is to find ways to translate our learning experiences, which occur within a fairly homogenous training group, to a more diverse population. We are equipped to work with many people, if we remember to begin with loving presence, non-violence, and curiosity. It is also our responsibility to continue to learn about systems of oppression and its impact on the individual as a living, growing, adaptive system.

Conclusions

Working in a non-profit setting, I see a variety of people. Some of these people are medically and emotionally stable and ready to explore the unconscious beliefs and patterns that influence their lives. Others need support, safety, and stabilization before we navigate the road to psychodynamic depth work. Hakomi can be effective for both populations of people. It is my experience that it is working with the principles of Hakomi that we most quickly forge a relationship that helps a client find their internal resources, and lay the groundwork for the possibility of deeper exploration. Hakomi provides a way to respectfully assist clients in learning skills that resource them and create stability.

Hakomi also provides the opportunity to delve more deeply into the client's inner world and explore the underlying influences that drive one's choices. If therapists can suspend interpretation of these influences and allow individuals to come to their own discoveries, they can allow more of the individual's whole world and life to influence the therapy process. I do not know all of the influences in Desmond's, Marjani's, and Mark's bio-psycho-social worlds. I believe, by creating safety and trust in their organic unfolding, they can find room to study these influences. It is my experience that as a mindful somatic approach to psychotherapy, Hakomi has provided me with tools and knowledge to assist the wide range of clients that practitioners encounter in non-profit settings.

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Hakomi and the Underserved

Vivianne Shands, Kamal Ahmed, Christina Toro, and Micah Anderson

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Kamal Ahmed has actively worked with youth since his teenage years at a local cultural community center in Oakland, CA. An avid athlete since age five, Kamal creatively integrates lessons from sports—and other activities that are familiar to youth—with key meditation concepts to help young people deepen into their physical, mental, and emotional experience. Kamal plans to graduate from Sofia University in 2016 and is currently pursuing his licensure. Email: kamalomar10@yahoo.com

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Introduction

by Shai Lavie, MFT, Certified Hakomi Trainer

The Hakomi Method has generally been taught to middle-class, educated people who have the money to pay $150-200 (in current dollars) per day for a workshop or longer training. Most of us attending these workshops and trainings have done so without seriously reflecting on the level of privilege that allowed us to do so: an income well above minimum wage (or significant savings), a solid educational background (with all the family and social support that makes this possible), a significant amount of free time, and without the recurring experience in our lives of people from the dominant culture doubting our abilities simply because of our racial or ethnic background. The privilege to participate in Hakomi becomes a cyclical system: After we as practitioners learn the method, we usually charge our clients handsomely in private practice settings. In short, it is usually clients who are also quite privileged who have the opportunity to benefit the most from our Hakomi skills.

We can ask: who is left out from this equation? If we think about the range of people living in the United States of America (not to mention the rest of the world) we can start to imagine the array of people who are usually excluded from benefiting from the Hakomi Method: farm workers, military personnel, low-income people living in the inner city, low-income people living in small towns, factory workers, undocumented immigrants, people in prison, refugees from wars overseas, Native Americans living on reservations, and so on.

And yet, there are exceptions. Some in the Hakomi community have taken significant steps to bring Hakomi to underserved populations. In the process, these practitioners have learned to modify the method to best serve the unique needs of their clients (Barstow, 1986; Dall, 1995; Hartman, 1985; Johanson, 1986, 1992, 2012; Johanson & Taylor, 1988, Moyer, 1986; Ortiz, 2009; Whitehead, 1992; Williams, 2012.)

In the following few pages, a few counseling psychology graduate students share their experiences of bringing their Hakomi skills to particular underserved populations.

My hope is that more people in the Hakomi community will bridge their work towards people who would normally not be able to access it. It is good to step out of our safe ivory tower of educated, middle class America and use our skills in service to the bigger human community, with its diverse needs and concerns. Then Hakomi can help fuel the engine of larger planetary healing and interconnection. Let's listen to the voices of four Hakomi students, and hopefully gain inspiration from their work.

Vivianne Shands, Student at Sofia University

As a third-year student at Sofia University, working toward earning my Master of Arts in Counseling Psychology, I have had the honor of working with undocumented immigrants and their children as part of my practicum program. My placement is with Western Youth Services, a community-based mental health organization that contracts with the County of Orange to provide short-term counseling for individuals who seek services at county-run family resource centers (FRCs).

My coursework at Sofia includes studying Hakomi techniques with Shai Lavie, LMFT, and I have incorporated Hakomi techniques into my work with my practicum clients, often to great effect. Hakomi is an empowering technique, handing over control and expertise to the client while guiding them to contact their own internal resources. The resourcing provided by Hakomi has been especially effective with survivors of domestic violence such as Danielle (a pseudonym), whose story I will share here.

Danielle is a twenty-nine year old Hispanic female with two children who lives in central Orange County, California. She is a stay-at-home mom and an undocumented immigrant. She came to the United States at the age of eight, following her mother who had left her in the care of her grandparents in Mexico five years earlier. As a child she suffered emotional and physical abuse and attachment trauma from the long separation from her mother. As a teenager, she turned to methamphetamine to help her cope, but quit cold turkey at the age of nineteen when she recognized that she was "destroying her life."

She came to the local FRC seeking counseling after she decided to end a relationship and move back in with her physically and emotionally abusive ex-husband. Though she had made this decision, Danielle indicated that she still felt confused and was unsure which man (the new boyfriend or the ex-husband) she should choose. She felt a lot of pressure from both men to make a choice and stick with it. Danielle said she felt like she was "in love" with the new man, but felt obligated to return to her ex in order to keep her family together.

Two years prior to the start of our work together, Danielle was seen at the FRC for counseling by a different therapist, and had been enrolled in the "Personal Empowerment Program" (PEP), after it was revealed that she had been the victim of domestic violence. Danielle attended PEP twice. With the help of PEP and her prior therapist, Danielle created a safety plan and began to take steps to end her abusive marriage. However, she was unable to carry out her plan and continued to stay in the relationship with her husband despite the physical and psychological abuse. Later, she met the new man at her gym and became friends with him. After some time, she realized she had feelings for the new man and began an affair. When her husband found out, she ended the marriage, moved out, and obtained a divorce. However, after some time, she started talking to her ex and he convinced her that she needed to end the new relationship and return to him for the sake of their children.

Since we started our work together, Danielle has again moved out of her ex-husband's house and has begun to explore what it is like to be alone, without the new boyfriend in her life. Danielle reports having intrusive memories of the domestic violence and several other indicators on a PTSD assessment. Nevertheless, Danielle has shown a strong ability to use mindfulness during her therapy sessions. She has demonstrated the ability to quickly calm herself when activated without prompting or instruction.

Danielle did not express much affect during sessions. She would talk about the situation with the two men, her children, and other issues that were causing her stress or anxiety in a conversational way, rarely showing any emotion. The first few sessions I mostly listened and reflected her experience through contact statements. I also introduced the concept of mindfulness and led Danielle in a resource-focused meditation at the end of each session. We focused first on her breathing and then on a gentle stroking motion that I noticed Danielle often did with one of her hands. She described the experience as "calming" and described her hands as "friendly, like holding hands with one of your friends as a child." We would return to these resources repeatedly through our work together, using them to find calm, and to contact her internal strength.

Danielle felt confused, especially about what she described as a tendency to feel guilty and responsible for other people's feelings, even when she knew that they were not her fault. Likewise, she felt confused about her reluctance to be affectionate with her husband, who was pressuring her to show her love for him and demonstrate her commitment to him. Danielle also felt guilty about this lack of affection. During our fourth session, I asked Danielle if she would like to explore this mindfully, and she agreed.

I invited mindfulness and directed her attention to the caring feeling of her hands holding each other. I then experimented with a probe, saying to Danielle, "You are safe here. It is okay to ask for what you need." She visibly stiffened in response to this, and reported that she felt frozen, like she could not move. This was an indication that she was experiencing the hypo-arousal in response to some sort of trauma, which I suspected might be linked to the domestic violence that she had experienced at the hands of her husband. I invited Danielle to mindfully describe the frozen feeling, occasionally directing her attention back to her hands, which were still holding each other gently in her lap. Danielle said that the frozen feeling was mainly across her chest and in her throat.

I then suggested that perhaps it would be interesting to have one of her hands show their friendship to her chest or throat, and I suggested she might place her hand where she thought it would feel best. She lifted her hand to her throat and was visibly overcome with emotion. It seemed as if she could not speak. I contacted that experience. She nodded. I asked if she was having some memories and she again nodded. She then said she was remembering her husband choking her, and another wave of emotion washed over her. I contacted this, and asked if she was feeling angry. Her brow furrowed deeply and her jaw clenched, and she nodded. I described this anger as "righteous" and contacted the strength I saw, that I knew she must have had, in order to survive such an experience. I also noted that it must be difficult to be affectionate with her husband after this happened. Another wave of emotion broke through, tears falling as she nodded in agreement and understanding.

Throughout this experience, I directed Danielle's attention to the feeling of her hand, and the comfort and friendship she found there. After she came out of mindfulness and opened her eyes, I asked her to orient herself in the room, inviting her to look around and notice a few things. I then let her consider what had just happened and we sat in silence for some time. After a while, she said that she had not thought about that in a long time, and that she could now remember everything in vivid detail. She moved out of her husband's home that week.

Later in our work together, I noticed that Danielle often said "you know" as a kind of tag line or placeholder in her conversation. After listening for a while I pointed it out and asked her if we could try an experiment, substituting "I know" for "you know" as she told me about how her week went. Danielle laughed and said that she felt self-conscious about it, but slowed down and became thoughtful as she spoke, catching herself saying "you know" and replacing it with "I know." After a while she became quiet and said "it's like I have become aware of myself, and I wasn't before."

In another session, Danielle was finding it difficult to adjust to life without a relationship, sleeping alone in a bed for the first time in many years. During the first separation from her husband, she had the new boyfriend for comfort and company, but this time she was reluctant to continue that relationship. She described being alone as scary and I asked if she would like to explore that fear mindfully. She agreed.

After guiding her into a mindful state, I asked her to invite the fear of being alone in like a guest into her living room. She began describing the fear again as the tightness in her chest. As she felt into the fear, she began to take deep, steady breaths. I contacted her breathing, noting that she was becoming calm. As she focused on her breathing, she seemed to grow taller, more powerful. Her strength radiating from her. I reflected this to her, watching in awe as she seemed to almost glow from within, the power and essence of her being shining through. After some time she said that she felt "empty" and "peaceful," and that she knew she could be alone and it would be okay. "It is strange," she said. "it is emptiness, but at the same time, I know it is not empty because . . . I'm here."

Using mindfulness and Hakomi techniques was incredibly powerful, enabling Danielle to feel her own strength, to experience her own ability to calm and comfort herself, to allow herself to feel the anger of her abuse and to have it be acknowledged, validated, and witnessed by another. It was extremely important to help Danielle access her own strength and to have an experience of her own presence. It had seemed to me that Danielle did not have a strong sense of her own self, her boundaries, and her own wants and needs. Instead, she relied on others to guide her, going along with what they wanted, and forcing herself to be submissive or self-sacrificing. She spoke frequently of how she was supposed to sacrifice her own self for the sake of others. In working with Danielle, my goal was to help her come in touch with her own needs and wants, as well as her own internal strength and resources.

Hakomi is a valuable tool for working with Hispanic women. I have repeatedly heard stories of sexual abuse, extreme neglect, physical abuse, and financial abuse from my clients. Danielle had suffered abuse from childhood and was raised in a family culture and religious tradition (Catholicism) that emphasized women's self-sacrifice and suffering for the good of the family. She struggled at the boundary between two worlds: The traditional Catholic values in which she was raised and which the women in her family still upheld, and the Southern California culture of female liberation in which she had grown as an adolescent. Her Catholic faith taught her to listen to men and ignore herself, yet her familiarity with silent prayer helped to prime her for the mindful self-inquiry that is the core of Hakomi. She simultaneously pushed back against the role imposed upon her as a female and wished to fulfill it as well. Hakomi helped her to connect with herself in a way she previously had not, and to see that though she often felt pulled in two directions, the right choice became clear when she found the calm and comfort of her own internal resources.

Kamal Ahmed, Student at Sofia University

My name is Kamal Ahmed and I live in San Jose, CA. I'm currently a marriage and family therapist trainee at Sofia University (formerly: Institute of Transpersonal Psychology) and am attaining my clinical hours to become a licensed therapist. I work with the Mind Body Awareness (MBA) Project located in Oakland, CA. I facilitate groups and individual sessions with at-risk and incarcerated youth in Alameda and San Mateo County. I also work as a school counselor for Evergreen School District in San Jose, CA. But the cases I'll share here come from my work with the young men who are locked up in juvenile hall and probationary camps.

I've been using mindfulness-based practices for the past three years and Hakomi-specific methods for less than a year. I've learned basic theoretical and foundational Hakomi principles from certified Hakomi trainer Shai Lavie, LMFT. Hakomi, based on my experience, has given the youth I work with the opportunity to be the experts of their lives and experiences. This is a big deal for these young men, who are locked up because most of their day-to-day activities are already determined by authority figures and court-mandated programs.

Here are two cases where I've been able to use Hakomi.

Antony is an eighteen-year-old African American male from a low-income area in East Palo Alto, CA. We've worked in both group and individual settings. In group, he was guarded and alert. His eyes would usually be searching. He had trouble keeping his eyes closed during weekly deep breathing exercises. When he did have his eyes open during meditation, he would fidget or mentally check out. He had a lot to share with me and felt comfortable telling me, during our first session together, that four of his six siblings were killed due to street violence. His affect (facial expressions and body cues) and the content were disconnected as he retold these tragic accounts. Curious about this disconnection I said, "I notice you don't seem affected by this when you talk about it." He replied, "They kind of had it coming to them because they weren't on their toes" (i.e., they weren't careful). Anthony would mention that he had to be three steps ahead of people in order to avoid getting played, or manipulated by others. What a scary place to be in, I thought to myself. (And as I write this and reflect on this young man's reality, I notice my eyes beginning to well up.) I knew I needed Anthony to feel safe with me.

The first few sessions we spent getting to know each other. I'll explain more later on how I make a deliberate intention to do this for each of my clients. I did this by being playful and witty with him. For example, when he disclosed the many ways he "was playing the staff" to get what he wanted. I brought it to the here-and-now and asked, "You're really smart and impressive, Anthony. I'm wondering, have you played me before?" He laughed and said, "No! Why would I play you?" I responded with some lightheartedness with a bit of seriousness, "You sure? How do I know you're not playing me now?" I would usually feel comfortable pulling his leg from time to time. We carried that playful dynamic throughout our work together. One session, I noticed Anthony being his usual self, entering the room hyper-vigilant, although he appeared to be happy and excited. I quickly felt a need to help resource him. After a few seconds together, I wanted to try something new with Anthony.

I asked him to scan the room and pick one thing that was pleasant to look at. He scanned the room until his gaze stopped on a space poster that was hanging in the room. I asked, "What about that picture catches your attention?" He answered, "I guess it just looks peaceful." I joined him in this, wanting to validate his thoughts, and said, "It does seem peaceful, huh? How do you know it's peaceful?" He laughed at the question and said, "It just looks peaceful, man!" (He seemed a little anxious, but a lot less than when he walked in). I then said, "What tells you that it's peaceful? Does this image remind you of a peaceful person? Or place?" He then started taking my questions seriously as he noticed me becoming more serious. He said his grandmother was a peaceful person. We processed what his grandmother meant to him and also shifted internally to focus on the physical sensations of the word *peaceful*. Anthony noted his shoulders falling, breathing more deeply, and feeling relaxed. It was only a matter of seconds before Anthony felt this sense of bliss with me before he snapped out of it and laughed about how different it felt.

I've used Hakomi-based methods with another youth named José. José was part of my group at MBA and I also worked with him individually. He was a jubilant character who enjoyed making others around him laugh. During one of our sessions, José disclosed to me that this was his eighth time being incarcerated. Eight times! I expressed shock through my reaction. He laughed and agreed that it was too many times.

I asked him if there was a part of him that enjoyed being there. He looked at me with a straight face right before he cracked and let out a laugh, as he thought I wasn't serious for asking such a question. I stayed the course and asked him to give the question some thought. Given the relationship and mutual respect we had with each other, I was able to work with him in this way. José thought about it for awhile and said, "I guess I kind of like being here because I'm respected and nobody messes with me. Actually, I run things here. Don't you notice how staff and everyone respects me?" I said, "Yeah, they see you as a leader, don't they?" He nodded.

It occurred to me that this was a missing experience for him: this sense of being seen as powerful. I thought to myself, "What if he could feel this sense of power from within himself so he doesn't have to seek it outside himself?" In order to get the ball rolling and get more information on this missing experience, I needed to immerse him in his experience of power.

José accepted my invitation to examine this sense of power using mindfulness. As we settled into the moment and became more present, I asked him to recall what he shared with me, which he did. I asked him what he noticed. After a few moments, he quickly ran his hand up and down his torso and said, "I feel a lot of things going on here." I invited him to stay with the movement and as he did, he said, "I can feel the power." I asked him where he felt it, and he said it was in his chest. I noticed his spine straightening and I offered, "You can feel that power moving around your core now, can't you?" He silently nodded.

I then invited him to hang out with those sensations and the word *power* for some time. He then mentioned a shooting sensation moving up and down his arm. He slowly opened his eyes while maintaining some inward awareness, smiled and said, "That was a trip, dude!" We laughed and I explained a little bit more about what we were doing. He liked the idea of being able to access this power within himself instead of habitually relying on external validation.

In our next session, I was surprised to find out that he got an early release from probation camp and was able to go back home. We had merely scratched the surface with the aforementioned intervention. I could see how there was much more work needed in order for José to foster and build his sense of self-acceptance and self-validation. However, the previous experience seemed to make an imprint on him. I hope he can continue to cultivate his true power as he moves forward on his journey.

The attitude and skills of Hakomi have been valuable and supportive in my work with these adolescents: primarily loving presence and the healing relationship. It's not uncommon for these youth to continuously receive negative messages about who they are based on what they've been accused of, the neighborhood they're from, and/or the color of their skin. These vicious messages are fed to them through several channels, such as: family patterns and beliefs, the education system, the criminal justice system, the community, and media. Hence, loving presence, comprised of compassion, curiosity, and attunement is truly a gift to many of these young men.

Leading with this quality of presence has taught me to accept them as they are: as worthy human beings, regardless of what they've done wrong, or who they've been conditioned to believe they are. In order to provide a place for my clients to become aware of the inner workings of their lives, they must feel safe and loved, unconditionally. This, in and of itself, can be a significant source of healing.

This non-combative and accepting approach highlights one of the five Hakomi principles: non-violence. Hakomi posits that the client is the greatest expert on their own experience. When some aspect of my therapeutic agenda is met with resistance, instead of opposing or forcing change, the non-violent approach is to support and honor the client's defenses for the wisdom they contain. Likewise, giving the youth the space to speak of things when they feel ready, as opposed to when we might feel they should be ready, carries two benefits: First, their trust invariably increases as their organic readiness is honored; second, since they do not need to resist the therapist, they can begin to contact and understand their internal experiences, and discover resources that can help them manage themselves better in the highly dangerous worlds in which they live.

In terms of adjusting Hakomi techniques to best work with this population, I still have much to learn, since I'm still studying and learning the basics of the approach. However, there is one thing I would emphasize—a powerful, not to be underestimated tool—the power of the authentic relationship.

Earlier, I mentioned how I make a deliberate intention to connect with the youth I work with. I'd like to share a bit about that. I'm a firm believer in bringing the entire self into the therapeutic process with these young people. A large percentage of the youth I work with have negative relationships and attitudes towards adults, and rightfully so. Most adults in the past have either failed to be present in their lives and/or have lost hope in them. Yet, despite these negative recurring experiences, there is still a hungry part of them, I believe, that still desires meaningful and gratifying relationships, though they carry deep suspicions.

Youth typically respond well once they feel they're understood and respected. Once they sense that they can trust you and sense that you're there simply because you genuinely care about them, most will soften up and let you in.

This can be done in a number of ways. A few that have worked for me are the following: explicitly or implicitly (through non-verbal communication which translates into interest and curiosity) expressing my desire to connect with them, using skillful self-disclosure, and by encouraging an inter-subjective relationship with them.

In order to have an inter-subjective relationship with a client, therapists ideally bring their personal self along with their clinical self. Many youth need healthy and positive adult relationships. This is done when we're able to show them who we are as human beings, and not just as objective outside helpers, though we are not asking for the mutuality of best friends. To put it bluntly, they know if we are there for them or if we are there for a paycheck.

Here is an example of how this inter-subjective relational approach served me well in a session. One evening, I was facilitating a group of four teenage boys at a maximum security unit in Alameda County. It was our second session. During our weekly check-in, a youth disclosed that he might receive a third strike on his record, and could possibly serve time for the rest of his life. His chance of beating the case, according to him, were slim. Two of his older brothers were doing life in prison and his mother was already going through a lot of suffering because of it.

As he was sharing this, I scanned the group to see where the group members were at. Everyone was silent as he was speaking. One youth was shaking his head as he was hearing this extremely painful and gut-wrenching ordeal. Another youth had a wide-eyed gaze fixed on the one sharing. I sensed the group connection in the room while I slowly turned my awareness inward. My immediate thoughts were: I could ask questions in order to facilitate further exploration and/or could provide a resource, or any number of commonly used clinical interventions. However, these possibilities didn't sit well with me.

Then I asked myself, "What would I want if I were in this young man's position? What am I feeling toward him as he is sharing?" After he finished for the time being, I said, "I'm really glad you shared that with us. As you were talking, I felt a sense of fear of sitting with the unknown. I wonder how it feels to hold that…it feels like it's a lot to hold. I really care about you and I don't want you to carry all of it alone. I want you to know that I'll be here for you through this, and I know other people in this group will be too."

I paused and looked to the group for signs of affirmation. The two youth I mentioned previously nodded their heads. I continued, "If you need anything please let me or the group know…We're here for you." He was silent while another youth counseled him on focusing on what he can control. The other youth suggested to him to take it day by day. To make sure my words sank in, I said, "I really want you to hear what I'm saying bro…" He stopped me before I finished and said, "I hear you loud and clear. I just never had anyone tell me that since I got here. I felt like I had to go through this all by myself."

Moving forward, I hope to employ Hakomi methodologies that help him explore his inner dimensions with the group. But before doing that, I knew I needed him to know that I care about him to establish the necessary safety and trust. This connectedness, which goes beyond successes in the therapy, will make working with his defenses easier whenever they may show up. This is an example of why bringing the personal self as well as the clinical self is crucial with this, and perhaps all populations.

Christina Toro, Student at Sofia University

My name is Christina Toro. I am currently a counseling psychology student at Sofia University and a marriage and family therapist trainee, completing my practicum training with Partnerships to Uplift Communities (PUC) in Los Angeles, California. PUC is a nonprofit organization dedicated to creating charter schools with the goal of increasing college entrance and graduation rates for underserved students in Los Angeles and the San Fernando Valley. I work with the clinical counseling program at PUC that provides counseling services to the children and families at the schools. I am working at a middle school where my clients range in age from 10–14. All of my clients are Hispanic/Latino and are predominately of a low socioeconomic status.

I began learning about Hakomi principles and techniques nearly a year ago at Sofia University from certified Hakomi trainer Shai Lavie, LMFT. When I began my traineeship several months later, I was able to begin practicing Hakomi techniques with some of my clients.

One of these clients is Ariana (name changed for confidentiality). Ariana is an eleven-year-old Hispanic female, in the sixth grade. Ariana is intelligent and self-aware. She shows a great deal of insight into her emotions and how they are connected to sensations in her body. She is motivated to make changes, and is open to the therapeutic process. Ariana is caring and empathic, always considerate about how others feel. She is a high achiever and a self-described perfectionist. She holds herself to a high standard of performance in almost everything she does. Both Ariana and her mother describe her as sensitive.

Ariana says she gets hurt by the behavior of others, particularly when she perceives them as putting her down or bullying her. Ariana often describes herself as nervous or worried. Ariana has a great deal of anxiety surrounding peer relationships and social situations. She can become extremely distressed in situations where she feels others might be judging her. Ariana began sessions with me expressing that she does not want to feel so nervous or sad so much of the time, and that she wants to feel more in control of her emotions.

I first began working with Ariana by creating safety or the "bubble" as it is described in Hakomi. In the beginning, as I gathered information and got to know Ariana, I offered a lot of validation, normalization, and reflecting back my understanding of what she was sharing with me. These are things I did to create the "bubble" and offer what I hoped would be the foundation of a safe therapeutic environment. I also used contact statements in order to build the therapeutic relationship. I found that when appropriately timed, statements even as simple as, "that's hard huh?" evoked a lot of emotion and I believe allowed her to feel more deeply understood.

We then began to "practice" mindfulness in order to ease her into these new concepts at a pace that seemed to feel comfortable for her. I was careful to track Ariana closely to gain awareness into the pacing that worked for her. I tried to pay close attention to signs of discomfort to be sure I was not moving too quickly. Ariana began with some interest in mindfulness already, which was different from the other clients I work with. This allowed for the pace to move along more quickly.

We practiced mindfulness through a few different exercises. We practiced relaxed breathing in sessions. We did guided meditations and progressive muscle relaxation exercises together. Ariana used art to imagine her "calm place," a candy store, and we applied this to a guided imagery meditation. I attempted to be careful to use language and explanations of mindfulness that were both culturally and age appropriate for Ariana. I did this by using some of her own language. She liked describing herself as being mindful because she said she had used this word in a class where her teacher started the class with a "mindful minute." The word meditation seemed to hold a little bit of charge for her because of a concern that meditation was "for Buddhists" and she is Catholic. This led to a deeper discussion on the relationship between meditation and religion that seemed to lead to an easing of her mind. I also avoided the use of the word meditation going forward, again attempting to use her own language, and because it did not seem important or necessary to our work together.

Ariana was open and eager to do all of these exercises and would often come into sessions asking for more. I believe these activities helped Ariana to deepen her understanding of mindfulness and were helpful in evoking mindfulness during later Hakomi work together. I also believe this stage of introducing mindfulness offered her resources to use as coping mechanisms for dealing with her feelings of anxiety and nervousness. Ariana has reported using these activities during times of high stress and nervousness.

All the while that I have been working with Ariana, I have also been trying to track her non-verbal cues closely. Being that she is a self-described perfectionist, I have found myself particularly on the lookout for discrepancies between what she says to me and what her tone of voice, averting of eyes, movement in her body, etc. are saying. This is because I want to be aware of times she might be "people pleasing" with me. I have already sensed from her a bit of a desire to "do therapy" perfectly. She is compliant so I want to be extra careful that any of my guidance in sessions is in her best interest and at her pace. Also, I sense that if I am inaccurate or wrong about something, she will not correct me. For these reasons, I know tracking and attunement to her is especially essential so that I can know when to self-correct any misses.

Lastly, I used the experiment in mindfulness of a verbal probe with Ariana. On the first occasion of using this technique, after eliciting mindfulness, I used the probe, "You are okay the way you are." Ariana reacted by first physically opening into a big smile. This was followed quickly by averting her gaze and curling in on herself a bit. When I shared what I observed with her and asked her about her experience, Ariana said that it made her feel happy to hear me say those words, but that she does not believe them at other times.

This experimental probe showed what I believe to be Ariana's organic yearning to be accepted for who she is. It then seemed to have the effect of engaging her defensive strategy to protect herself, shown by her rejecting the statement. At a later session, I attempted this probe again with a bit of an alteration to make it more relational, saying, "I like you just the way you are." This led to a similar reaction of smiling and then stating that not everyone feels that way about her. She then shared the story of an incident of severe bullying that seemed to be the catalyst of her deep yearning to be accepted for who she is. This is a typical barrier that positively phrased experimental probes in Hakomi are designed to evoke.

With many of my other clients I am still in the stages of safety and trust building, as well as establishing their capacity for mindfulness, since experiments in Hakomi rely on mindfulness. I use different mindfulness exercises, like guided imagery, guided meditations, progressive muscle relaxation, and metaphors and art to practice and expose my clients to mindfulness in a way that feels age appropriate and hopefully fun.

One thing I have learned about applying Hakomi from working with Ariana and the population I work with is that I must move at the client's pace. Often this pace means slowly, particularly when introducing Hakomi concepts and techniques. I have found that mindfulness-based concepts, even just a focusing on breathing, are very new, and often strange feeling concepts for the kids and families I work with. A respect of these feelings that may arise in them, as well as a respect for each individual's pace and timing, seems the most important piece of having success in applying Hakomi techniques with this population.

In order to be respectful of each individual's pace, I have found the Hakomi technique of tracking to be useful. I try to closely track for signs of discomfort or resistance. If I miss these, I will often find the attempted experiment to be unhelpful. This is likely because I have moved too quickly. I have found the concept of appropriate pacing to be a dance I have yet to perfect. There seems to be a fine balance between moving into what may feel like resistance in order for a new experience or understanding to emerge and slowing down in order to not push a client too quickly into what might be becoming my own agenda. This is where tracking myself and mindfully checking on my own process is important.

I believe this approach has been helpful. At a certain point all but one of my clients has become open to and interested in at least some aspects of mindfulness. I am not entirely certain that initial resistance to mindfulness and somatic techniques is solely cultural, as I believe many people might find mindfulness to be a new and strange concept for many reasons. I do think the idea of following the client's lead and giving them as much time as they need to be comfortable is a helpful approach.

Another important learning I've had in using the Hakomi approach with the population I am working with is the willingness to have open and honest conversations about religion and spirituality, combined with a willingness to deeply explore mindfulness. The majority of my clients identify as Catholic and openly discuss their religion and beliefs in sessions. Many of my clients turn to their belief system as a form of support and healing. I have found that some are concerned that practicing mindfulness might be against their religious beliefs. I feel this is a valid concern, but one that can easily be put to rest with some education and explanation of what mindfulness is and what it is not. I have found that practicing and evoking mindfulness does not necessarily mean I should use words like *meditation* or *mindfulness*. Therefore, the use of language and explanations that are culturally relevant, as well as age appropriate, is important in working with this population.

I have often found it helpful to use a metaphor that the client can relate to in order to explain mindfulness. I like to pick something that I have learned the client loves, perhaps a sport or music, and help the client paint a picture of what being really in the moment with that thing feels like for them. I often use art to help explore this moment and feeling. This allows me to attempt to explain mindfulness to each client based on his or her own experiences. My hope is that this makes the concepts I introduce later more understood and relatable in some way.

I have found working with this population to be extremely rewarding. I am continuously amazed at my clients' abilities to be open, vulnerable, and willing to try new things. I think it is extremely beneficial to be exposed to mindfulness at such a young age. It is my hope that any bits and pieces of mindfulness and Hakomi that they may take away will support them again and again throughout their lives.

Micah Anderson, Student at Sofia University

> Don't turn your head. Keep looking at the bandaged place. That's where the Light enters you.
> — Rumi

Introduction

I work with incarcerated youth through the Mind-Body Awareness Project. As a therapist in training, I have had the benefit of being introduced to the teachings and methods of Hakomi, and I have found that many of the interventions have been useful in the juvenile hall in our group sessions, despite the original focus of Hakomi on individual therapy. Techniques such as contact statements, accessing and deepening, and immersing the client(s) in mindfulness, are all integral parts, in some form or another, of my weekly groups with the youth. While all these methods provide an increasingly important lens from which I engage the youth, *tracking* in particular is one that I have had to learn from the beginning, even before I knew the Hakomi name and context of it.

Let me share a little about this specific population. My clients spend the majority of each day in isolation, sitting in a cell alone. They are separated from their families, communities, and friends. They come from pasts ridden with aggression as the only way to survive. Many live in places where violence is imminent at any moment, even from a simply perceived threatening look from the eyes of a stranger. Sentencing is often incomplete or in the midst of being processed where years, even decades, of freedom are hanging in the balance. Regret and fear are tangible realities for these youth, despite their defensive mechanisms to cover them.

The Clinician Tracking His/Herself

The ability to track all this swirling experience by the facilitator is essential to maintain the "bubble," so that safety and openness is promoted and preserved. In Hakomi, tracking has been described as a "kind of loving attention" (Weiss, Johanson, & Monda, 2015, p. 159). While I agree with this, I feel that while running groups in juvenile hall, tracking must be infused with a raw authenticity; the therapist's own as well as the group participants'.

Reflecting back on the many groups I have facilitated in juvenile hall, I notice that the ones in which the flow was the most natural and the bubble strongest, were the ones where I was compassionately aware of my own inner experience—or to borrow a Hakomi term, where I *tracked* my own inner experience—as well as the group process.

The more engrained the habit of tracking myself becomes, the better off I am. It is the doorway to lessen reactivity and to improve how I engage emotions, especially difficult ones, whether I am with a client or with family and friends. When I bring gentle, authentic awareness to my present experience as I am feeling it—as an impartial witness—I can be more embodied, which helps me be more present for the client. I know within the context of juvenile hall, tracking has become an integral part of my ability to serve the youth in the best way possible. Triggers can easily arise within me, and I need to keep kind awareness of them so I don't react or judge them, but simply notice them and go back to the task at hand, namely the healing of the client or group.

Tracking clients for verbal and nonverbal cues is the next logical step in this progression. The statistic from Daniel Goleman that 90% of emotional states can be tracked by non-verbal cues is remarkable (Goleman, 2005, p. 152).

Tracking the Group

Tracking information the client is giving off is important, specifically in juvenile hall where clients in the group may not always feel safe to share openly. Sometimes these nonverbal clues might be all a clinician has to go on. Bringing awareness to what is being said and expressed in the group verbally and non-verbally supports a much deeper and fuller understanding of the client and their group dynamics. I like to keep in mind that what the client *isn't* saying can be just as important as the words they are speaking.

When serving the youth who are incarcerated, I find there are other key elements to track such as (but not limited to):

- Who stops to speak or say hello when entering the room, and who walks in without much to say, or much interaction or eye contact of any kind.
- Where attendees sit in the circle, who they sit next to (or away from), and how far they sit away from each other. Do they move their seat or desk?
- Interactions between the group members during the group itself, specifically on a meta-level. Tracking subtle interactions here is important.
- There are also two sub-groups that are impor-

> tant to pay close attention to when tracking the group: peers and leaders. Entering a class in juvenile hall, a facilitator must be mindful that there is always a back-story with the youth who are in the circle; a back-story of friendship and camaraderie and/or possibly one of resentment, anger, and mistrust.

Peers can bring a wonderful opportunity for the group to move quickly towards cohesion, empathy, and authenticity. With peers, often a level of trust has been reached beforehand that can be used by the facilitator. One can capitalize on the peer relationship to promote deeper sharing, supportive words, and feedback from each other.

While the term *leader* may initially be thought to mean the group facilitator or clinician, a leader might also be the strongest personality of the group, and he/she should be treated as such. It is of extra importance to track and engage this member. When the most charismatic member of the group can be engaged on an authentic level, promoting his/her buy-in, other members of the group see this example and tend to follow suit. Tracking who this member is takes time, and there is not a sure-fire way of knowing it. He/she could be a quiet one, or the most rambunctious one. In either case, it is someone who demands respect in such a way that the other youth yield to him or her.

Tracking a Leader:A Case Example

In one of my groups it was clear who the leader was. Miguel (name changed) was Latino, and the only member who had come to our groups in weeks. I immediately engaged him as the leader, as he was the one who invited the other members to attend the group, all who claimed to be new or returning after a period of time.

We started with a check-in. On the side, I asked Miguel to start as a model, and he agreed. Introductions and agreements were stated (which included confidentiality, and a conversation on mandated reporting), plus agreement on one-mic (meaning one person speaking at a time, and respect)

After I asked Miguel to check-in, he took a breath (something we promote before someone checks in), and claimed he was “chillin.” He disclosed how he had spoken with his girlfriend the previous night and learned that she had had a miscarriage of their child, a boy. He became emotionally triggered. As he spoke, the other group members quieted down. Miguel’s triggered emotions increased and he became visibly shaken, at times fighting off tears, but I tracked through his eye movements and tone of voice that he was also regulated, while withholding more underlying emotion. I didn’t push the withholding at this time.

While tracking Miguel, there was suddenly a subtle understanding between us both that he recognized *my* awareness of his suffering, and that it could jeopardize his standing with the other members of the group. I believe we both understood this, but no words were exchanged. After it happened, he quickly changed topics, directing resentment towards one particular staff member as well as other members on the unit. Other group members soon joined in his chorus of anger against this particular staff member, and the mood quickly shifted from what it was a few moments before.

I asked the group to try to adhere to the “one-mic” agreement, trying to get them back to where we were a few brief moments before, contacting the change in his mood. “Go back to what you were talking before with your baby-mama” (a term used to signify a woman with whom one has a child, but to whom one is not married). He firmly declined to do so, continuing on about his anger with the staff.

I knew that he had brushed up against something too tender, and that he was retreating in order to maintain his standing in the hierarchy of the room, as well as his own composure. I yielded to him, recognizing this as a strength in terms of knowing his own boundaries.

Tracking Resistance

As mentioned before, the embodiment of authenticity is foundational to MBA’s work with incarcerated youth in disarming resistance when it inevitably arises. Resistance can be tracked in many ways through fidgetiness, silence, humor and/or talkativeness, or raw aggression When resistance shows itself in the room, we go directly towards what is arising in the moment, by tracking and then contacting the resistant behavior. “Really triggered right now, huh?” “So, something really upsetting about that?” “Seems like the humor is really taking over?” “The silence is here saying…?” This mirrors what we, as mindfulness practitioners, do. Each and every thing that arises in our field of awareness is possibly worthy of further curiosity and investigation, and could be something that leads deeper into transformation, no matter how difficult or ugly it seems to be.

Resistance should never be ignored, but engaged with skillfulness and presence. No matter how it may manifest; through aggression, humor, silence, or something else, resistance arises for a purpose. It is a protective mechanism intentionally or unintentionally put out by a group member to cover or hide real emotional wounding and trauma, and must be handled with care. Resistance can be used as a doorway for authenticity, conversation, and ultimately transformation. Just as an empathic break in the therapeutic alliance can offer a chance for the clinician to model repair, forgiveness and healing, resistance offers similar opportunities.

Tracking Resistance:A Case Example

In a recent group in a San Francisco Bay Area juvenile hall, I had three young men who were mandated to attend. One, an African-American male of 16, made clear eye contact, smiled, and was talkative when he arrived in the room. He amiable, he was happy to be coming. The other two who entered after him were young Latino males, both reserved, and both making little eye contact. I introduced myself to both of them before they entered, as I was standing at the door, welcoming the attendees. I immediately sensed a bit of resistance from both of them, feeling that one, if not both of them preferred not to be in the group. After sitting down and starting the group with an introduction of myself, I contacted this still tangible energy with a question, asking, "So let's keep it real here. Who isn't feeling being here right now?"

This question promoted a discussion around authenticity. It ended up the African-American male *was* excited to be in the group, one of the Latino youth claimed to be neutral ("I'll wait and see…"), and the other one, disclosed he did not want to be in the group. "I really would rather not be here," would prefer to be participating in the recreation period, which was taking place outside the room we were in.Thisf face on a week to week basis;

I made eye contact with him, took a breath, in that order, and told him I was impressed with his level of authenticity that he had since he entered this group, adding that I appreciated him "keeping it real" with me. I told him, as I often tell those who come to MBA's hybrid class/process groups, my only expectation of them is that they speak their truth and remain authentic, even if it means saying something they think I might not want to hear. I finished with, "don't give the right answer, give the *real* answer." This small approach and intervention, which took place within the first 2 minutes of our sitting down, immediately started orienting them towards a culture of self-awareness and trust.

Tracking During Meditation Instruction

Another time tracking is essential is when we lead meditations for the youth. An MBA group is a combination of group process in the form of a "check in," possibly a didactic portion,exploring, and often, a facilitator led mindfulness-based meditation. There is also a curriculum, which in certain groups is used and can run up to 10 weeks, offering and setting for the. These weekly modules are focused on topics such as mindfulness, forgiveness, empathy, and emotional awareness.

For guided meditations, it is essential that the facilitator tracks the participants while offering instructions. Before starting a meditation, we always explain what is about to happen, which I believe is a trauma-informed approach. For example, we tell the youth that closing their eyes is best in terms of closing out visual distractions, but if at any point they become triggered, they have option of opening their eyes so they can check the room. While leading a meditation, one must track the energy in, or often outside, of the room, andnameges. I find it best to mention any distraction, contacting it, if you will to use a Hakomi term, in the mediation instructions themselves. For example, if I notice youth becoming fidgety, I will contact this in the instructions saying something like, "if you start to feel the need to move, or if you are getting fidgety, I invite you to notice what it is like to watch the urge for a few seconds rather than move immediately." This manner of contact can be done when noticing people dozing, or opening their eyes, or if one is attempting to lead a meditation in a loud unit, which is commonplace.

To conclude, I have found that tracking youth in the juvenile hall in groups or individual sessions is an essential skill for clinicians engaged with this population. With histories of trauma,, struggle, and survival incarcerated youth are a population who embody a massive reservoir of resilience and strength. In the experience of this writer, they are low-hanging fruit, ready to blossom and deepen into their authenticity, awareness, and renewed hope.

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The M.E.T.A. Counseling Clinic: Hakomi-Infused, Mission-Driven, Affordable

Donna Roy, LPC, CHT

Donna Roy is a licensed professional counselor, certified Hakomi therapist, and certified Hakomi trainer. She has a thriving private psychotherapy and consulting practice in Portland, Oregon, where she also administers and teaches M.E.T.A. trainings, is an adjunct faculty member in Portland State University's Department of Counselor Education, and directs the M.E.T.A. Counseling Clinic. She has special training in couples, marriage and family therapy, experiential dreamwork, attachment therapy, and clinical supervision.

Donna comes to counseling with a rich international background. She lived and studied in Germany, was a Peace Corps volunteer in South Korea in the 1970s, and worked in Bangladesh with Save the Children as part of her master's degree in intercultural administration. She directed refugee programs on both the east and west coasts of the U.S., and co-owned an intercultural communication consulting and training business for a number of years. After a twenty-year career in international non-profit management and intercultural communication, Donna had an epiphany about fulfilling another lifetime dream: to become a psychotherapist. She did this via a personally customized route that included an MS in counseling and multiple years training in Hakomi and altered state dreamwork.

In 2008, Donna and colleague Jon Eisman formed M.E.T.A., LLC, an umbrella organization whose mission it is to train counselors and psychotherapists in Hakomi and mindfulness-based therapy approaches. Donna also authored a chapter entitled, "Body-Centered Counseling and Psychotherapy," included in Capuzzi and Gross's textbook, *Theories and Interventions in Counseling and Psychotherapy*, published by Prentice Hall.

"I am increasingly thankful for the amazing self-reflective techniques that [my therapist] is helping me cultivate."

Introduction

The M.E.T.A Counseling Clinic, located in Portland, Oregon, is a program of the Hakomi Institute of Oregon and Mindful Experiential Therapy Approaches, (M.E.T.A., LLC), and has been providing mindful, somatic, experientially oriented counseling services and internships for graduate students and state registered interns since 2010. The Hakomi Institute is an international non-profit organization training counselors, psychotherapists, and related helping professionals since the 1980s. M.E.T.A., LLC, is a regional affiliate of the Hakomi Institute, and the clinic is its affordable community service arm.

In 2009 in Portland, low cost or free counseling services existed in recognized university settings and some non-profit and governmental organizations. Private practice settings offered counseling options for clients with the ability to pay higher fees. Clients with mental health insurance coverage had access to approved treatment for specific periods of time, depending on their health care coverage. Trainings in Hakomi mindful somatic psychotherapy were offered through M.E.T.A., LLC, and in some Hakomi-related classes at Portland State University (PSU). This article outlines the creation, development, and future possibilities of the M.E.T.A. Counseling Clinic.

The Local Community Context

Though the Portland community has typically had alternative health services for those with the ability to pay, and, to a certain extent, for those who meet free service criteria, Hakomi's particular brand of mindful, somatic psychotherapy has not been an option for many. In general, this has been due to the financial realities of the private practice model in which most Hakomi therapists work, the lack of Hakomi-trained therapists in conventional mental health organizations, and conventional "evidence-based" mental health modalities being the delivery system norm.

In 2010, the closing of the local YWCA clinic—a program that provided low cost counseling to many for years—changed the conventional low-fee counseling service landscape, even though some other low-cost services remained.

The local counselor education environment has also been evolving. Getting a graduate degree in counseling has been a growing trend in Oregon. PSU, for example, recently had 400 applicants for 50 openings in their master's graduate counseling program. The local National College of Natural Medicine (NCNM) is now offering a master's degree in Integrative Mental Health for ND students. Though being licensed is not a requirement to practice general counseling in the state of Oregon, counseling training programs have been increasing. Graduate program accreditation standards continue to require local internship sites that meet certain experiential and credentialing criteria. And, general trends in counselor education programs support integrating teaching methods (such as Hakomi) that use mindfulness as a direct psychotherapeutic intervention.

All this added up to fertile ground for a training clinic offering affordable, skillfully delivered, well-supervised client services delivered by interns trained in mindful somatic therapy approaches.

The M.E.T.A. Counseling Clinic Model

The M.E.T.A. Counseling Clinic grew out of my vision and aligned with Hakomi and M.E.T.A. principles. I am a Hakomi trainer, co-director of M.E.T.A., LLC, have a background in non-profit management and development, and had a long-time dream of starting a low cost, M.E.T.A./Hakomi-based clinic. Around 2010, I saw how my vision would help address the local counseling service gap. Fundamentally, I was interested in creating a counseling clinic that was mission-driven as to sustainability, affordability, and quality of mindfulness-based services.

This meant operating from a business model that prioritized fee-based funding, was committed to excellence and integration of state-of-the-art methods, and also committed to avoiding the reliance on external funding sources and shifting priorities.

The idea of affordability was woven into the model. The original budget was based on client fees of $35-$45 per session. It was assumed that potential clients would be people interested in mindful, experiential therapy and, though able to pay some, not able to afford typical private practice rates. Providing free services was not included as part of the clinic mission since this would not offer financial sustainability. The expectation was that clinic staff would refer clients unable to pay the clinic fees as needed to local free service options—just like therapists do in private practice.

Another contributor to assuring sustainability *and* affordability in the model was the central role of unpaid interns, as it allowed for fairly reliable expense projections. Unpaid internships are normal within the graduate counseling program environment in Oregon, though finding internships that prepare interns for private practice contexts is unusual. The M.E.T.A. Counseling Clinic internship was expected to be attractive to interns wanting to open private practices after graduation.

The M.E.T.A. Vision and the Clinic Connection

The M.E.T.A., LLC, vision is (1) to provide integrative trainings in change-enhancing, client-centered, mindful, somatic, experiential clinical approaches (such as Hakomi) for established therapists, those transitioning into the field, and other allied health professionals; (2) to inspire and enhance a community of like-minded counseling professionals; (3) to offer advanced personal growth training opportunities; and (4) to offer practical applications of M.E.T.A. theories and techniques through an affordable and self-sustaining training clinic.

The M.E.T.A. Counseling Clinic was formed as a service business organized around people and their needs, with its success, like that of any business, requiring a professional presence, knowledge of the people served and the service focus, needs, and context; a clear plan to meet the needs; resources; and leadership capacity.

The local reputation of M.E.T.A., LLC, as a training organization for counselors and mental health practitioners was the foundation on which the clinic was built and a solid professional and theoretical foundation for intern candidates.

The need for an affordable and mindfulness-oriented clinic seemed clear; the closing of the YWCA clinic was an indicator of a service gap in the local community, and the need for quality internship sites was an educational reality among counseling students. That Hakomi was increasingly recognized as an evidence-supported method was indicated by the growing interest in Hakomi/M.E.T.A. trainings among clinical professionals and the field-wide growth of research in mindfulness-informed treatment.

I relied on my entrepreneurial spirit in forming the affordable clinic. In service to the start-up, I invested in the business by having my private practice and training role sustain me financially in the first year of the clinic. I also took responsibility for the clinic interns and their clients under my license as a professional counselor. This required a certain amount of risk tolerance and self-trust.

Formal training in intercultural organizational management and related collaborative leadership was also useful, as well as understanding varying graduate school internship expectations and Oregon rules for being a clinical supervisor. I was able to officially supervise interns, was a Hakomi trainer, and taught both graduate students at PSU and M.E.T.A. students. I believed in this clinical orientation as a powerful change agent. Finally, I had the full support of my business partner, senior Hakomi trainer, Jon Eisman, and plenty of interest amongst M.E.T.A. students from the beginning.

All of these factors increased the chance of success and supported the initial year of experimentation and clinic development.

The Start-Up and Implementation

Once the decision was made to start the clinic, staffing and development of related policies and systems were the priorities. Though I knew about Hakomi and counseling and had run non-profits and developed programs, I had never formed and opened a counseling clinic and so had a steep learning curve.

Starting with committed, creative, Hakomi-savvy interns seemed important, and looking at current M.E.T.A. graduate students already training with M.E.T.A. made sense. With this idea in mind, while coaching a student in a Hakomi comprehensive training using the quintessential Hakomi technique of "taking over," I saw one student's willingness to step in, be seen, and take feedback as the kind of capacities needed in clinic interns. So, I approached this student (Jenn Samsom) and invited her to be the first clinic intern.

With the support of Jon Eisman, M.E.T.A.'s founder, Jenn and I began to outline steps needed to get the clinic up and running, spending many hours in meetings, researching other clinic systems and processes, and creating forms and processes for the fledgling operation. Within a few months, two other M.E.T.A. students, Catherine Griffith and Amy Hulan, were also on board and cohort #1 was full with three interns.

The team moved forward, planning and creating and developing a sense of both connection and mission. The process mirrored in many ways what is required to set-up a private practice, with the additional training clinic factor.

Some of the topics and questions reviewed and wrestled with included the following.

Administrative Systems:

    What systems will we need to create and maintain?
    What kind and how much documentation will we need?
    Who will create this?

Public Relations:

    What will a clinic web site need to include?
    Who will create it?
    What other ways will we promote the clinic and its services?

Logistics:

    Where will the clinic be housed?
    How will we furnish and monitor the facility?
    What will be needed related to client access?
    How will security be managed?

Funding:

    How will the clinic pay for itself?
    How will supervision be covered the first year before client fees can pay for this?
    What will be the projected income and expenses?
    Will it be profit or non-profit?
    What will be the fee structure and related policies?

Target Clients:

    Whom will we serve?
    How will we recruit clients?
    Where will referrals come from?

Services:

    What specific types of counseling services will we offer?

Clinical Oversight:

    What will be the specific system of accountability for the interns and their clients?
    What will grad schools need regarding their students?
    How will we ensure quality of service?

Intern Criteria and Responsibilities:

    What will be the experience and training prerequisites for the interns?
    What will the interns do besides direct counseling?

Staff volunteered many hours in clinic visioning and planning. In a collaborative process, they created clinic systems and policies related to documentation; client and staff communication; public relations; intern scheduling, roles and expectations; fees and financial tracking and management; new client free consultations; service tracking and follow-up; use of the facility; and client recruitment, information, and referral.

The clinic services chosen were individual, couples, family, and group counseling, integrating basic M.E.T.A./Hakomi techniques and principles. This meant the clinic interns needed to be either already M.E.T.A./Hakomi trained or be willing to train with M.E.T.A. concurrently with the internship, since most graduate programs do not sufficiently prepare students in this advanced work. The intention here was to ensure a high caliber of services based on mindful, somatic methods—and to offer truth in advertising to the public.

This involved critical thinking about the ethics of charging tuition for M.E.T.A. trainings to graduate students chosen to intern with us. In service to this, the decision was made to give a twenty percent discount to accepted interns for one year's worth of M.E.T.A. training, and to give full informed consent from the beginning about this requirement for interning at the clinic.

The first year, I projected a budget based on income from about eight clients per intern by mid-fall of the first year. I knew M.E.T.A. would need to front funds for all the initial expenses for the clinic and Jon and I used income from trainings to support this. Costs such as new clinic furniture, a phone system, intern keys, supplies, and rent were donated by M.E.T.A.. I volunteered my time to cover the cost of individual and group supervision and all administration. One office in M.E.T.A.'s office building was designated for exclusive clinic use.

The Evolution

The clinic opened its doors in the fall of 2010, with its first cohort of three interns. The process of developing systems and policies continued throughout the first year. As staff encountered new questions and needs, they explored the related issues and made informed decisions. The two-hour weekly group supervision sessions often lasted for two and a half hours and included clinical exploration and administrative planning.

Within about two months of starting, all interns had the client load they wanted and needed. By the end of the year each intern had met or surpassed her goals for client and supervision hours. During this first year, more than thirty clients received services, two mindfulness-based groups were offered, and operating costs had been met.

Marketing clinic services was a major priority and was woven into intern duties from the start. This included distributing clinic postcards, speaking to groups, staffing community educational and networking events, reaching out to local organizations and schools, getting listed on various referral services (like 211), etc. Promotional activities were intern-initiated and focused on client recruitment and the professional development of the interns.

By year two, two changes happened regarding clinical supervision: the budget supported paying me for my supervising role, and Anne-Marie Benjamin, LPC, CHT, was hired as an adjunct supervisor. Adding a second supervisor allowed more oversight for the interns as well as richer educational support. Anne-Marie invested in the clinic development by volunteering many extra hours in collaborative problem-solving and clinic administration. She also offered regular intern in-services regarding Hakomi character maps. Having a second committed supervisor was a critical factor in maintaining organizational health and supporting intern development. Supervision groups continued to be central to clinic operations, with supervision processes oriented toward mindful, experiential, and relational engagement having to do with client and clinician needs.

In year three and as a result of the increase in numbers of interns and client sessions offered, overall income to the clinic increased. However, increase in rental costs and supervision offerings meant a small financial loss during this year. To respond to this and reduce the decline in client sessions over the summer, when interns traditionally completed their internships, the decision was made to begin some internships in July rather than September.

In year four, client usage of services increased significantly, averaging ten hours per week per intern, while client attendance also stabilized significantly. The overall health of the clinic continued to improve, ending the year in the black financially and with a waiting list for the 2014-15 cohort.

In year five, the interns averaged eleven-twelve clients per week, with more couples seeking counseling, as well as more clients from the LGBT communities. We welcomed a third adjunct supervisor, Stephen Keeley, LPC, to the team, as Anne-Marie began to reduce her time with the clinic due to her busy practice. The budget once again was balanced at year-end and there was a wait list.

Today's Clinic: 2016

In year six, with the clinic's viability proven, and in support of its sustainability, Stephen shifted into a partially volunteer, more involved supervisor and administrative role, in addition to his paid supervisory functions. This volunteer contribution to clinic development and administrative oversight was an investment in the clinic's future, and aligned with its organizational culture. This also paralleled Anne-Marie becoming more advisory, given her full and demanding private practice and professional commitments.

The intern cohort increased to six this year, and multiple changes took place. A significant one was adding regular continuing education in-service meetings. This involved Hakomi skill practice and clinically and private practice-related guest presentations. Clinic supervisors, other M.E.T.A. clinicians, and the interns themselves offered the in-services.

As the reputation of the clinic itself has grown locally, the need for active marketing has decreased. Though this has allowed interns to concentrate more on clinical skill building and system assessment and improvement, this has meant less emphasis on developing private practice promotional knowledge and skills.

As of April 2016, interns have between nine to twelve clients each. Since this group started their internships with many clients from the existing wait list, one consequence is that the wait list has grown and is currently at forty. This is both good and bad. It certainly indicates a need and interest in affordable, mindfulness-based therapy, but it also uncovers a limitation in service availability. Since we do not want to keep clients on a wait list, the clinic policy is to offer a place on the wait list and to also refer to other local clinicians. Though there are plenty of skilled M.E.T.A. grads, not enough have low fee openings to accommodate the demand.

The Move of 2016

In January, M.E.T.A., LLC moved its trainings into a new facility. This new, larger facility is accessible, offers a spacious training room and group room, as well as seven medium to large, sound-proofed therapy offices. The clinic has taken two of the offices, allowing double the previously dedicated clinic space in a shared professional environment adjacent to the trainings. This offers more capacity and accessibility in serving clients, as well as a more stable, professional, community-based, local professional presence.

General Clinic Outcomes Over the First Six Years

Over time, as more and more graduate students and registered interns have sought us out, M.E.T.A. instituted a clearer and more formal internship application and orientation process that includes a written application, pre-internship training with M.E.T.A., a group interview, and multiple pre-internship orientation events.

Between 2010 and 2016, the clinic accepted and trained a total of 25 interns (both graduate school and state registered) from counseling programs of PSU, Lewis and Clark College, California Institute of Integral Studies (CIIS), Southwestern College, Goddard College, Prescott Collage, and Pacifica, each year adding one intern to the cohort. These interns have had backgrounds in clinical mental health or couples, marriage and family therapy.

They completed six to twenty months of training with M.E.T.A. before or during their internships, either in our M.E.T.A./Hakomi comprehensive training and/or our Hakomi and RCS and attachment professional skills trainings. During the internship, they received two hours per week of group supervision and one hour per week of individual supervision.

Between 2010 and 2016, about 300 clients were served using Hakomi mindful somatic therapy and other M.E.T.A. modalities in individual, couples, family, and group counseling. Client presenting needs ranged from personal growth, to grief, to couples relational dynamics, to parenting, to mental health struggles with depression, anxiety, addictions, bipolar disorder, PTSD, complex trauma, and acute life stress.

During this time, interns offered eight groups with the following themes: mindful eating; mindful movement; the brain, body, and relationship; mindful parenting; interpersonal neurobiology; non-violent communication and mindful awareness; and mindful awareness in daily life. This year a Hakomi mindfulness process group was initiated that is meant to be a regular offering.

A significant (and somewhat unusual) clinic policy is that clients are able to stay with their clinic therapist after the internship, if the clinician is opening a private practice and the client wants to continue therapy with them. Since most interns from these first six cohorts opened private practices post internship, most of their clients transitioned with them into their private practices for $5-$10 over the standard clinic fee. This has supported both client continuity of care and therapist private practice start-up. For most interns, this internship doubled as a business incubator; for many clients, as a bridge to a private practice clinician.

All of the clinic graduates who went into private practice in Oregon continue to build successful practices based on highly professional values and skills, and customized career goals.

Client Feedback:

Interns regularly ask clients how therapy is going for them, and some use ongoing evaluation formats. At the end of this sixth year, a simple survey was taken addressing the relative importance of certain clinic factors to client satisfaction. Below are questions and some partial findings related to two areas on a 1-5 likert scale: therapist skill/attitude and clinic fees:

How important are the following aspects of the clinic's services to you?

> Therapist skills and attitude: 40% said important and 60% very important
>
> Affordable fees: 20% said important and 80% said very important.

How satisfied are you with the following aspects of the clinic?

> Therapist skill and attitude: 40% said satisfied and 60% said very satisfied
>
> Affordable fees: 20% said satisfied and 80% said very satisfied

How has being a client of the clinic benefited you? What do you appreciate about being a clinic client?

> *I am so grateful to finally be able to receive this type of counseling service at a price I can afford!*
>
> *[My clinic intern] has been incredible to work with . . . her body-centered approach to therapy is integral to the gains I've made in the last year. Her endless compassion and encouragement are amazing as she's guided me through learning how to heal and gain greater self-acceptance.*
>
> *[Our intern's] perspective and insights have been so valuable for our relationship with each other and ourselves. [This] counseling has definitely made a hugh impact.*

2016-17 Clinic Plans

Plans for the 2016-17 internship include increasing the number of interns in the cohort to eight, starting in June. (Interviews were held in October and invitations offered in November; eight interns were chosen from PSU, Lewis and Clark, CIIS, Prescott College, and Saybrook.) More interns will begin to address the growing demand issue and hopefully reduce the size of the wait list. This expansion means the cohort will be divided into two groups of four for group supervision purposes, with myself and Stephen alternating group supervision weekly. Individual supervision will also be shared.

Future Clinic Possibilities and Questions

Some important questions and areas of exploration for the future of the clinic include the following:

> (1) Should the clinic become an Oregon Health Plan provider in order to offer more client choice? Would this add unnecessary complexity?
>
> (2) What is the ideal size of the clinic in terms of quality and financial viability? What is the ideal scale of an established clinic?
>
> (3) Should the clinic itself become a non-profit or stay as an arm of M.E.T.A., LLC?
>
> (4) What research through the clinic would be useful and practical? What capacity would need to be built?
>
> (5) How can we serve a more diverse clientele? How can we increase the number of bilingual and bicultural interns and ones with disabilities?
>
> (6) How should the clinic continue to evolve its training model to foster solid cohort cohesion, clinical innovation, and training excellence?

The M.E.T.A. Counseling Clinic is clearly meeting a local community mental health need with quality services and a viable business structure. It has a firm foundation in Portland, a solid theoretical and educational foundation, significant interest among counseling interns, and high client satisfaction. However, identifying the optimal clinical internship model for effectively serving clients, training interns with sensitivity and skillfulness, supporting supervisors and staff, and being fiscally self-sufficient is an ongoing process. With its successes so far and the strong professional and personal commitment of the people involved, the clinic future seems promisingly secure.

Reviewing the Work of Stephen Jenkinson

Susan Shawn, BA, CHT.

In early February of 2015, a doctor told me that I had Stage IV kidney cancer, and that I had about two months to two years to live. In my travels in this new-to-me realm of "imminent death," I encountered Stephen Jenkinson and his book *Die Wise***.** I devoured his eloquent language, his wisdom, and experience that he shares so thoughtfully and carefully. His teachings fit seamlessly into the Hakomi principles and deserve to be introduced in the *Forum* for others who may be approaching death, or those who have clients, family, or friends who may be.

Jenkinson has an MA in theology from Harvard University and an MA in social work from the University of Toronto. He speaks around the world, is consultant to palliative care and hospice organizations, and is the founder of the Orphan Wisdom School in Canada.

For Jenkinson, high tech health care has become an undeclared war on dying itself. "If you can, you should" (p. 23) is the mantra in our death phobic culture in North America, meaning you should do whatever you can to continue living, no matter what, no matter how much violence you do to the dying person, their body, and their very soul. Dying wise goes against attempts to control and domesticate dying including palliative care. It is a way of redeeming our way of dying that is the right of everyone, a moral obligation, a political act, an act of love, spiritual activism, and yes, immensely hard labor. Therein lies his manifesto.

Instead of a sedated, managed, defeated dying (cope, hope, dope), Jenkinson is talking about purposed, meaningful dying that roots us into our life in a way that nothing else can do. He doesn't say not to use pain meds if they are needed, but to be mindful of each choice, each prayer, and what it accomplishes in a death phobic culture.

So, what would dying look like from a Hakomi perspective? We seek non-violence, organicity, a body-mind connection that is trustworthy, mindfulness in and of the process, and unity. That is precisely what Jenkinson is teaching once you read between the lines. He also includes: village mindedness; caring for our ancestors and our dead, weaving them in our lives; breaking the trance of our death phobic culture; seeing dying as an angel, rather than an executioner, something you live, wrestle with, share, and can teach to others.

Die Wise is not an easy book to read, especially for someone with a terminal diagnosis. He offers not even a thread of wiggle room. For example, people who are dying often ask for "more time." He thoroughly demolishes that idea. If you get more time, you get more time to die, more death, "temporary citizenship in the Land of the Living" (p. 133). He titles one chapter *The Tyrant Hope*. What he means is that if you are living focused on hope, you are living in the future, and are not present to your life that you actually still have. His alternative is to live hope free, which is a subversive move towards lucidity, a revolution of sorts.

He talks about word voodoo: the idea that if you say it, you can make it happen, so no one talks to the dying person about their approaching death. No one will name it for fear they might make it happen. I've walked with some good friends during their dying time who carried this view. There was no way to be with them in any level of honesty and devotion. Jenkinson offers no place to hide.

Even the notion of "quality of life" as a deciding factor in dying is up for grabs with him. He believes that *quality of life* is a principle strategy in our culture's project of dying—not dying. It enforces the addiction we have to competence, mastery, and autonomy. It doesn't serve the dying, who are anything but competent, and quite literally out of control. "If there were no palliative care, what would the arc of dying look like?" he asks. What if we respect the process itself, and listen deeply to what might be needed here? This is right up Hakomi alley.

Our culture says, according to this man who has worked in the "death trade" for decades, that we can die not dying. Dying, instead, in his view, must be allowed to change literally everything. As a person living this through right now, I have to say it really, really does change everything. Staying mindful to this cataclysmic shifting is challenging, and hard work. Jenkinson is a trustworthy guide.

The wisdom we seek can be found in suffering, from being broken-hearted, which for him is a skill. Wisdom comes from learning grief and from practicing grief. Who asks us to be fulfilled in our dying, or to even thrive in our dying, or to be good at it? We need a faithful witness to our dying, not someone who will banish what is hard and demanding.

In Ron Kurtz's language, we need someone with loving presence who can make being vulnerable and incompetent, safe; someone from whom we can receive comfort; someone who is not there to fix what cannot be fixed; someone who is aware that death goes beyond just humans, to trees, rivers, stones, even mountains. We need to proceed as if there is merit in knowing death well.

Jenkinson asks huge questions with a rare precision. He asks the question: When in human history did the death phobia begin? It's not so in other cultures. How "natural" is it to be afraid of dying?

What if this insistence on dying being a trauma *is* the traumatizing thing about dying in our culture? High tech dying turns you into a victim. That's not true for all cultures. In my opinion, high tech tends to do this to birth as well.

A large portion of Jenkinson's book is about our dead: they are "a rumor, unclaimed and unknown." Their bones are somewhere else. It is the orphan story of the Americas, which is a type of homelessness. The alchemy of belonging comes when we plant our dead and their bodies sustain that place. In our history we have slavery, people fleeing, flight as culture, no bone yard in common. People internalize "home" when they are homeless. That leads to a culture of autonomy, self-sufficiency, lonely multi-cultural cities. The outcome for the dead is, mostly, unknown. Even our gods are homeless, not of a place. Even our foundational story, the garden of Eden, speaks of the loss of home, the loss of eternity, of death. Indigenous cultures tend to have gods who live on the same land that they do, embedded into the very earth.

When my mother was dying in our home, about two weeks out, she suddenly declared that she wanted to go home. No amount of saying that this was her home now, no amount of saying she was going home in her dying, appeased her. She had told me my entire life that she wanted to be cremated, and that's what we had planned. But now she wanted to be buried, she wanted to go home, to Ohio I guess, where her family and her ancestors were buried.

Part of our fear of dying for Jenkinson is that the dying begin to understand that their very reality is pending. "They are on the Lost Nation highway, even as dying, not yet dead," disappearing from the memory of those left behind (p. 279). Amnesia is built into our care of our dead. They don't need us anymore. They are mysteriously completed and self sufficient, above the fray. That is power, in a culture like ours. How will I be remembered, if at all, I wonder? Do I just disappear from life, from the human sphere into the realm of "the dead" that almost no one even thinks about?

Now that I am dying, I find myself turning to face those from whom I come, my ancestors, my own "dead," trying to learn from them. We don't treat our dead with any degree of hospitality, usually.

"Dying means to be wrecked on schedule" (p. 300). Being sad is not being depressed, not something to fix. We need courage to stop trying not to die and to relax into it. Dying can be achieved, not endured as we tend to see it. It can be learned. We can die wise. Dying is the time to untie the links of strength and competence that bind us to our bodies. Stopping eating is to "vote no" for keeping on (p. 309). It turns the tide.

To die wise, we can "faithfully report on our ebbing days, the sway of it" (p. 310). My husband will likely not have an escort when it's his turn, a sorrow that brings me to my knees. Children need to know, too, to begin to get a feel for it.

"If you are attending a death, bring a soft focus, a slow gait in your thinking and your speech. Stay willing, be supple in your understanding, ask your eyes to stay open, wonder what is needed of you" (p. 314). As Hakomi therapists, we have practice in working in the non-verbal realm, so this will help a great deal.

Dying people are busy trying to find their way out of their bodies and out of their lives, and there is scant language for this (p. 315). I remember my mom late one night describing being in a tunnel, about half way through. She had a new doctor "on the other side, who had done all the paperwork," and now she wanted to know if she could turn around and come back. Exhausted, I told her that I didn't know, but I would see her in the morning, or not, depending on her choice. We said goodnight and goodbye. And she was all sparkle in the morning; she did figure it out. She lived another few months after that. When my beloved companion David died, he was radiant and said that he could see the light all around.

"When dying is understood as justice, mercy, a sign of compassion that is stitched into the fabric of life itself, that can bring us into a world-loving, community-serving love of life" (p. 350). Then we can die wise.

"Grief isn't an intrusion into the natural order of things. It *is* the natural order of things" (p. 367). It's the ability of seeing the story of the thing, the whole story. We are grief impaired, grief illiterate. We learn instead how to manage it, resolve it, get over it. It's not just the feeling of sorrow, or guilt. It is knowledge and understanding that each of us is obligated to live, for our life. "How you die grows kinship, a chance to practice unlikely gratitude, a way of loving," and love is a way of grieving (p. 378). Jenkinson steps into the unity principle easily and often. He is an unusual man, with language that delves deep into the heart of things, a poet, a storyteller, and a fearless angel of death.

The DVD *Griefwalker* is a lush, marvelous video of Jenkinson and his work, his language, his teaching. Again, there is no hiding place, no way to avoid death in this. He helps us take a long, deep drink into what it is and what it could be, how we got here, and what needs to change for it to be more organic.

His workbook, *How It All Could Be,* brings a whole series of questions to the table. Here is his dedication:

> This was made for all those who have come to me questioning, sorrowing, fighting and trying to lay low while their lives go as lives go, for the families and friends of those who didn't live to see this done, for all those who asked for it. It was made with gratitude to the teachers and great rememberers out on the dangerous and darkening roads, where it all lives.

It's a study guide to *Die Wise*, a shower of questions that incite deep reflections, conversations with shared ideas, delving deeper still into this concept, this manifesto of dying wise. He teaches that you wrestle the angel of death "by grief, by wonder, by courting uncertainty, by falling in love again with being alive, this time with the taste of its end strongly on your tongue." It's part study guide and part workbook, part meditation, and part kitchen table conversation. He wants us to work at this. It's quite grand, and I recommend it to those who read his book.

As for me, I have only been using alternative medicine, and I am now, a little over a year later, a stage III cancer patient. We don't know what that means exactly, but I am learning to live hope free. I'm putting language to this journey in my blog www.SusanShawnAlive.wordpress.com. I keep my eyes open, and I'm learning how to die wise, as best I can.

References

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Jenkinson, Stephen. (2008) *Griefwalker: A film about the redemptive power of deep love for life, when life glimpses its end.* Produced by www.alivemind.net. National Film Board of Canada.

Jenkinson, Stephen. (2009). *How it all could be: A workbook for dying people and for those who love them.* Published by www.orphanwisdom.com. Impression Printing, Canada. ("Something that can be useful in the sorrowing heat of the moment, and in the time before and after.")

Book Review

Understanding Emotion in Chinese Culture: Thinking Through Psychology by Louise Sundararajan, Ph.D, Ed.D.

Gregory J. Johanson, Ph.D.

Understanding Emotion in Chinese Culture: Thinking Through Psychology is a wonderfully strange, marvelously unique and profound book that only Louise Sundararajan could have written. On a personal level: Sundararajan was born in China, married an Indian husband, and works in a forensic unit of a psychiatric center, thus dealing with cross-cultural issues daily. Academically and professionally Louise received her PhD in the History of Religions from Harvard University, and her EdD in Counseling Psychology from Boston University. She chairs the Task Force on Indigenous Psychology, which has over a hundred members from around the globe. She served as past president of The International Society for the Study of Human Ideas on Ultimate Reality and Meaning, and is also past president of the Society for Humanistic Psychology (Division 32 of the American Psychological Association). She is the recipient of the Abraham Maslow Award for 2014, from Division 32 of the APA. She is a Fellow of the APA, and also a member of the board of directors for the International Society for Research on Emotions. She has also published extensively on topics related to culture and emotions, and thus brings a lifetime of research to this book.

This is not an objective book review. It is written based on the way it has impacted me personally and professionally. My first reaction to Sundararajan's significant offering is that it should be re-issued as a paperback immediately, the price lowered (from $130), and the title reversed. While it is not unreasonable to want to learn more about Chinese emotions in a world where China is such a huge economic reality, comprising about twenty percent of the world's population; the real thrust of the book for me is in the sub-title, "Thinking Through Psychology," or more properly, *rethinking* it. Though Sundararajan writes in a holistic (as opposed to polarizing) fashion, there are numerous places in the text where such phrases as "by contrast (to Western)," "conventional wisdom," "received wisdom," "mainstream psychology," "academic psychology" etc., are used, and Eastern experiential subtleties are introduced that confirm for me how limited, clumsy, and partial our Western approach to psychological science has been. While she argues for a creative integration of East and West, I am left with a strong sense that every serious Western student should use this book on emotions as an entry into rethinking the basis of our psychology today. Thus, I would like to see the book be more widely available.

Having said that, the book demands a lot of the reader. Sundararajan is a senior scholar who has published much in the field of affect herself, and is well informed on the general field of psychology. There is a veritable wealth of references throughout the book. These revolve around some 25 distinctions she puts in table form in chapter one (p. 7), dealing with two types of cognition; relational cognition generally privileged in the East, and nonrelational cognition generally privileged in the West. She considers these two types of cognition to be East/West mirrors that must be integrated to support a paradigm shift into holistic psychology.

On her way to her concluding chapter, "What Is an Emotion? Answers from a Wild Garden of Knowledge," she presents the distinctions one at a time, constantly weaving them together into a coherent whole. Thus, there is a lot of built-in redundancy that helps integrate the wealth of intellectual input. Plus, she writes within the Confucian tradition of poetics that uses stories, poetry, sayings, and songs in the service of lived experience. Ideas are complexly nuanced while exploring elusive questions of how emotions are understood. There is deconstruction of simplistic stereotypes. Maintaining the relationship between opposites is considered more important than resolving the differences between them. Cross-cultural horizons of psychology are broadened.

Since there is a detailed wealth of material in the book, in the rest of this review I offer somewhat random, somewhat disjointed notes, often in Sundararajan's own voice, from an inadequate skimming of the book. I hope the items emphasized have resonance for those impacted by Hakomi mindfulness-centered somatic psychology in particular. I hope these notes will move people to consider engaging the larger work.

Sundararajan begins by affirming, “This book is about lived experiences in search of a correct name” (p. vii). Paradoxically, it is not good to know too much too fast, which can keep us from being open to new possibilities.

The development of indigenous psychology that honors non-Western cultural wisdom is a special concern for Sundararajan (Sundararajan, Girishwar, & Marsella, 2013). Indigenous psychology is a

> psychological inquiry that subsists in the gap between the canonical terms of mainstream psychology and the phenomenal world that has as its point of reference a Mecca that falls outside the pale of the epistemological universe of Western psychology. For experiences to remain nameless; or worse yet, to have to take on ill-fitting terms and concepts that falsify and distort them is the agony that drives the endeavor of this book (p. vii).

Addressing theoreticians she notes, “psychology is all about theory and constructs—the so-called empirical evidence, facts, and behaviors are all consequences of theory” (p. xi). Though she references numerous studies citing empirical evidence, she asserts that “terms—such as validation, truth, and facts—have no purchase in this book. This book is not about apodictic truth so much as cross-fertilization of ideas, especially ideas from different lines of inquiry or different levels of analysis in psychology” (p. vii).

She continues, “I offer an explanatory model of culture to explain the well-documented cross-cultural differences in cognitive styles. More specifically, I use the framework of symmetry and symmetry breakdown, derived from physics, to explain how cultures that differentially privilege relational and non-relational cognition are mirror images of each other” (p. viii).

In her chapter on Confucianism she “shows how in contrast to Plato and Aristotle who privileged reason and logic, Confucius considered the cultivation of emotions (*qing*) the goal of education, and used poetry as a primary means for the this goal” (p. vii). In the Daoist influence on Chinese emotions, she notes that “spontaneity is considered the hallmark of true feelings” (p. ix). As she considers the autonomy and independence of Daoism alongside the Confucian concern with group living, dealing with how these two traditions coexist, she notes, “Daoism shares with Confucianism an interest in intimacy in relationships except that in Daoism intimacy has shifted to the transcendent context of communion with Nature” (p. viii).

In chapter one Sundararjan outlines a chain of consciousness, symmetry, and a progression of measurement from order to entropy that includes Market Pricing/ratio scale; Equality Matching/interval scale; Authority Ranking/ordinal scale; Communal Sharing/nominal scale; Oceanic Merging; and Dao (p. 16). In general, the West privileges the heroism related to market pricing and authority ranking,

> whereas the East transcendence. In Daoism transcendence entails moving up a notch in symmetry, via consciousness, to open up a new frontier in conceptual space. This new frontier OM (Oceanic Merging) . . . [is a] relational cognition with ultra-symmetry. “Oceanic Merging” . . . is defined as “the perception of being united in love with everything” (Bolender, 2010, p. 107). . . .Without differentiation, knowledge representation becomes impossible—this takes us right to the realm of mysticism where the real Dao transcends all representations
> (p. 65).

She does point out that “the Daoist version of nonhierarchical interdependence has relevance for modern management that privileges decentralization, flat structure, and employee discretion. A far more important contribution of the Daoist version of interdependence lies in its ecological vision” (p. 70), which counsels humans to find their place *in* nature as opposed to *over* nature.

“Approaching cultures as styles of being present entails a shift from the undue emphasis on explicit beliefs in cross-cultural psychology to lived experiences, which are multi-faceted and rich in meanings that are encoded and decoded experientially through affect” (p. 1). The book hopes to demonstrate “how folk theories of non-Western cultures can function as potential competitors and valued interlocutors in the theory construction of emotions” (p. xi).

Learning to mindfully savor, as opposed to intellectually analyze, is part of an Eastern contribution to theory construction. In her chapter on savoring she writes that, “In contrast to emotional regulation prevalent in the West, the Chinese privilege refinement of emotions”
(p. ix).

In addition, “one of the best fruits of the relational cognition is the arts, which constitute the core of the Confucian curriculum. In contrast to the world of objective reality which is the primary focus of science [mind to world transactions], art resides in a world of subjective reality, a reality made possible by mind to mind transactions" (p. 53).

In terms of moral-emotional development, "feeling plays a more important role than thinking.
. . . Being moved is essential to emotional development" (p. 87). And, our "innate vulnerability to being moved by the suffering of another can be interfered with by rational deliberation, such as utilitarianism (p. 86)." "The unbearing mind brings into sharp relief the difference between the two pathways to morality—cold (non-relational) cognition privileged by the West and hot (relational) cognition privileged by the Chinese" (p. 88).

As might be expected, Sundararajan calls attention to how mindfulness can help work with overly rational objectifying aspects of Western thought and education. "Metacognitive skills consist of decoupling components that have melded into cognitive schema through habitual living" (p. 119)

> Challenging the received wisdom that attention and appraisal are tightly intertwined, mindfulness has demonstrated the possibility of decoupling attention and cognitive appraisal "by allowing inputs to enter awareness in a simple noticing of what is taking place" (Brown, Ryan, & Creswell, 2007, p. 213). This decoupling goes with inhibition of appraisal: In mindfulness practices, emotion scripts are held in check while awareness of the emotion's impact is gracefully accepted. As Germer (2009) puts it: "Mindfulness is the ability to feel our pain—if there is pain to feel—and stay out of the drama" (p. 132). These metacognitive skills lie at the core of the Daoist notion of refined pleasure (p. 119).
>
> Research on mindfulness makes a twofold contribution to Chinese psychology of emotions. First, it calls for a moratorium of cognitive appraisals. Brown and Cordon (2009) claim that appraisals are "self-generated accounts *about* life" (p. 227) that interferes with living. Echoing the concern about filtering in Chinese poetics (see Chap. 7), Siegel (2007) claims that filtering events and experiences through cognitive representations of self and others "twist our capacity to read our own cues" (p. 70) and "obscure direct experience" (p. 99; p. 197).

As is so central to Hakomi Therapy, it is crucial to use right brain interventions in psychotherapy that can only be responded to by bringing awareness to experience: "How do you experience the sadness in your body?" This, in contrast to asking left brain questions such as "Why do you feel you are sad?" that ask for *a theory about one's experience*.

> Second order awareness (awareness of awareness), is referred to in mindfulness literature as mindful awareness or "reflexivity" (Siegel, 2007, p. 98). Mindful awareness can be differentiated from simple awareness, which is on a lower level of consciousness. According to Siegel (2007), mindful awareness "permits the decoupling of automaticity" (p. 144), whereas mere attention to the present moment is not able to do so (p. 164).

Returning to the subject of savoring: as with mindfulness, it is not the same as self-reflection. "Savoring is the mind talking to itself about how X makes it feel. Self-reflection, by contrast, is simply attending to X, where X happens to be oneself. This formulation of savoring makes it clear why self-analysis, self-criticism, and many other kinds of self-reflections do not qualify as savoring" (p. 165).

"There is a long tradition in the West, from Plato to Sartre (with the exception of Heidegger), that considers emotions to be somehow distorting reality. The Chinese believe, on the contrary, that emotion (*qing*) discloses something that is true about the person and the world. . . . Feng claims that it is *qing* that grounds us in reality; it is humans who distort reality when they fail to be true to their *qing*" (Feng, 1983, p. 192).

"The compound '*gan-qing*' literally means 'simulating-responding' which entails not a simple S-R (stimulus-response) relation, but rather a resonating feedback loop based on an intrinsic affinity between all things in a sympathetic universe" (p. 192).

"Together, *qing* and *gan* make one important claim about what it is to be human" (p. 192).

> Feelings are an integral part of human nature, the essence of which is affectivity. In contrast to the reactive response to occurrences or events that constitute the primary framework in mainstream psychology, the Chinese notion of *qing-gan* resets the focus by underscoring the affective dispositions of responsiveness as being primary (p. 192).

[In] "the framework of *gan-ying* . . . emotions emerge as 'unfolding reactions to a responsive social environment'" (Parkinson, 2010, p. 160) (p. 197). Emotions are not just subjective reactions within one's head that leave out the world.

"In the [Western] appraisal framework, knowing is not doing. . . .By contrast the Chinese account shares with the transactional framework the assumption that knowing is doing (Woodward, 2009)—one learns about the world not through knowledge representation of it, so much as by world engaging actions" (p. 197). This helps us understand why watching TV can actually make growing children lose IQ points. Instead of trying to make sense of a cartoon character going over, under, around, and through something on a two dimensional screen, the child's curiosity needs to lead it in exploring their world by literally going over, under, around, and through physical things that then provide a bodily, experiential, implicit referent for what they might one day see on a screen.

"The innate capacity to be impacted (*gan*) more than one can conceptualize is capitalized by the impact-focus approach to emotion" (p. 197).

> As an ensemble of undulating affective states, *qing* (emotion) is the manifestation of the human capacity to be impacted affectively (*gan*). . . .The Chinese notion of *gan* (affectivity) puts a premium on the expression and sharing of one's personal take on impact. In contrast to the Western notion of emotion as a disruptive force to be regulated by reason and cognition (Chap 10; Averill & Sundararajan, 2006), the Chinese consider the human capacity for responding to impact affectively as a positive quality to be enhanced through expanding consciousness. (p. 200)

"Chinese poetics also owe much to Daoism for its unique appraisal profile, in which the relatively simple and automatic processes are privileged as the hallmarks of spontaneity and genuineness, whereas the more cognitively elaborate appraisals are distrusted for being calculative and infested with value judgments" (p. 121). This Daoist view is supported by various research studies that asked Holocaust helpers, or others who voluntarily put themselves in danger to help others, "Why did you do that? What were you thinking that led you to do that?" The non-predictable answers for Western researchers are often: "I didn't go through a thought process. I didn't do a cost-benefit analysis. I just did it because it was right." Sundararjan notes that: "Processing strategies . . . that privilege attention to experience over attribution of cause can make a significant contribution to emotion research" (p. 121).

When Sundararjan considers William James' question, "What is an emotion?" she argues it is more productive to ask how do we model emotions? In her book, she then considers the perspectives of Chinese folk models of emotion. Here, the conclusion is that "the Chinese privilege relational cognition which puts a premium on symmetry, as evidenced by a tendency to capitalize on harmony, resonance, and mind-to-mind transactions. By contrast, the West tends to privilege non-relational cognition that capitalizes on symmetry breakdown which is necessary for tasks of differentiation and cognitive control" (p. 201). The East is more relational; a non-linear dynamic process that makes reality available. The West is more object centered, oriented to cause and effect, mechanistic, mind-to-world transactions, where appraisal and purposive action predominate, and the emotional distortion of reality is assumed.

While this East/West summary evokes deep humility in me as one schooled in classic Western psychological theory, Sundararajan maintains a balanced view: "Since all cultures need both relational as well as non-relational cognition, differences between cultures is not a matter of presence versus absence so much as that of prevalence in one or the other modes of cognition" (p. 201).

She concludes by affirming that, "this formulation of cultural comparisons is consistent with Shweder's (1991) vision of cultural psychology: 'To discover other realities hidden within the self, waiting to be drawn out into consciousness'" (p. 69).

There are many more realities she deals with related to intimacy, love, authenticity, freedom, spontaneity, creativity, the emptiness that comes from savoring negative experiences, and more. The width and depth of the more is available in the full text, along with inspiration to follow her lead in rethinking psychology, and hopefully adding to, or bringing more appreciation to, the richness of a more holistic approach to psychology and psychotherapy.

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Poems

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Sinixt People

Stillness and lemony scent as we
head up the old trail.
River flows to the right –
geese calling out, mosquitoes sparking and whining.

The Sinixt pit dwellings come into view among the rushes –
immense earth bowls the People lived in
year round on the edge of the River,
the home of the Salmon and the Beaver.

One legend speaks of an Elder
of the clan who teaches the People
to dig houses underground to survive
the drought of that time.

Another legend tells us of their travels
South near the (now) border following game –
stories of an Old Woman wintering alone in a cave
who was saved by the Mice and the Frogs.

3,000 years ago, the smoke
from their cooking fires drifted
across the valley floor
toward Frog Peak,

Many years ago we
discovered a large frog pictograph
on the rocks of a cave
near the Columbia River.
Across the river today

Six-hundred acres stand protected
by a tall Woodsman,
while the mysteries
of the People's courageous lives are unveiled.

(Carol Ladas – Gaskin © 2015)

Absolute Attention is Prayer

I thought I could hear
the cherry trees singing
all the notes from white to pink.
Their arms are stretched wide open
budding bright buds, flowers breathing light,
leaves color of plum, unfolding their hands.

Magnolias lift their
white, pink cups
to the shining crows
adjusting their feather tips
skimming over the folded leaves
praying in the branches.

The giant blue heron floats
down, then drifts
upward into the fir branches.
Her mate floats in silently.
They rest in the fragrance
of the trembling blossoms.

In my mind:
the peacock shudders;
his shimmering thousand eyes
converge upon her.

In my mind:
Swallows stitch my life
from tree to tree down the promenade
a hem stitch, doubling back on itself.

Today the swallows are hiding.
Perhaps their wings
are folded in prayer.

(Carol Ladas – Gaskin © 2004)