EDITORIAL: TAKING IT HOME WITH YOU

GREG JOHANSON

There is a sneaking suspicion running loose among mental health therapists that there are a certain number of people who are ready to be helped, and that any technique or method we use with them will basically do the job. Likewise, with people who are not ready, it doesn't matter what we do or how we do it. And, the folks who show up at seminars are probably the self-selected few who could grow using any method from primal scream, to being dangled over a snake pit, to doing an average New York City ten year psychoanalysis. So, don't be surprised if the stuff we learn at workshops falls flat on its face when we take it back home with us.

That's definitely a cynical, rather fatalistic, so-what's-the-use view. It is also highly dangerous to the financial well-being of places like the Hakomi Institute. Think of what would happen if students decided they could just as profitably spend their money on a vacation in the islands as on an in-depth, nuts and bolts hakomi training? Perish the thought! And after all the trouble we have gone through to put together what we consider a quality training.

But the thought doesn't perish easily. One of the most well researched, well documented, undisputed conclusions in the psychological literature today is that "Despite clear demonstrations by process researchers of systematic differences in therapists' techniques, most reviews of psychotherapy outcome research show little or no differential effectiveness of different psychotherapies."[1] The few that do show a difference are suspect because they all confirm the therapeutic bias the researcher started out with. The verdict of the wretched, cursed Dodo bird judging the race in Alice's Adventures in Wonderland appears to hold: "Everyone has won and all must have prizes."

The Dodo Verdict is definitely unpopular with many clinicians who have put a life-time into cultivating a particular way of doing therapy, have attempted a number of to date unsuccessful challenges to the validity of the verdict, and have total contempt for anyone who would suggest (even from research data) that people are equally helped by any therapist, any time, any place.

But, need this be such a big, bad bird? Isn't there something nice about the notion that "Everyone has won and all must have prizes?" It undercuts the dangerous assumption that one school must be right and all the rest wrong. It supports the more realistic assumption that we should be able to learn from each other as opposed to engaging in cut-throat competition. It contains the possibility of promoting community as diversely trained clinicians join together to search out what is best for the client as opposed to their representative schools of thought.

I am willing to dogmatically state that, as clinicians, we better, we ought, we should, put our heads together and pool the wisdom of our respective experiences. There is no cause for complacency in the consensus that psychotherapy is, as a matter of research fact, more effective than no treatment at all.[2]

Bernard Bloom, Professor of Psychology at the University of Colorado at Boulder, notes that the effectiveness rate of psychotherapy is about 75%. Not bad if we are talking about baseball batting averages. Bloom comments, however, that if he had a physical illness and a medical doctor said, "Don't worry. We have this great treatment that has a 75% chance of making you better, and only a 25% chance of making you worse than no treatment at all", that he would be inclined to respond as a patient, "That makes me wonder who is looking for a better alternative to this treatment."

Imagine having cancer. Does anyone think the medical establishment should tolerate complacency in simply putting money in the same old research ruts, and not ex-

ploring every new promising avenue, even if the new avenue does not follow the researcher's particular beginning bias?

Alfred North Whitehead used to counsel students to look at the common assumptions of various schools of thought that are not even conscious enough to be questioned. If we, as psychotherapists, were to look respectfully over each other's shoulders, my personal hunch is that we would discover that we do some of our best work by mistake. I think there is merit in proposals which argue for common mechanisms to various therapies that undergird and support the more obvious differences in technique. Bandura has argued that successful clients end up with a general sense of increasing confidence, efficacy, and control from a variety of therapeutic procedures. Others have pointed to the warmth, empathy, genuineness, support, and understanding that go into making a good therapeutic alliance. Some studies demonstrate that while beginning students in various schools of therapy show quite distinct ways of working, that senior, master therapists of different schools operate in ways much harder to distinguish.[3]

In the May 1986 edition of The Harvard Medical School Mental Health Letter (Vol 2, Number 11), Jerome Frank points to a number of common features that enable therapies to help people. First, he makes the assumption that symptoms themselves are not so disturbing to people. While life confronts us with many predicaments, life is not a problem to be solved. People seek help when the symptoms are coupled with demoralization, a sense of being unable to cope, with accompanying feelings of poor self-esteem, confusion, alienation, and isolation. He then comments:

> All psychotherapies attempt to combat demoralization by replacing confusion with clarity, and providing new concepts and information that enable the patient to make meaningful connections between symptoms and experiences that would otherwise be mysterious. All schools of psychotherapy, including those that use drugs, seek to help patients transform the meaning of their symptoms and problems, replacing despair with hope, feelings of incompetence with self-confidence, and isolation with rewarding personal relationships ... Even when therapy has little specific effect on symptoms, it can enable the patient to tolerate the symptoms by transforming their meanings. (p.4-5.)

> All forms of psychotherapy have the following features that can be viewed as ways of directly or indirectly combating demoralization: first, a confiding relationship with a helping person; second, a setting identified in the patient's eyes as a place of healing; third, an explanation of the causes of the patient's symptoms; and fourth, a procedure for relieving the symptoms that requires active participation by both the patient and the therapist. (p. 5.)

> All therapeutic rituals and procedures ... combat demoralization by strengthening the relationship between patient and therapist. It is a commonplace observation that among therapists with equal credentials and training, some are more effective than others. Apparently as yet ill-defined personal qualities contribute to the therapist's persuasiveness. (p. 5.)

Frank's comments offer a helpful perspective for how hakomi fits with the more general field of psychotherapy. He also goes on to comment on the general approaches of the four roughly-grouped categories of psychotherapy today: existential humanistic, dynamic (psychoanalytic), behavioral, and cognitive. His descriptions help make it clear that hakomi has borrowed from the wisdom of all these schools. We join with the existential humanists in seeking to offer "a totally open, non-defensive encounter in which the therapist strives to experience the patient's world as fully as possible." With psychoanalytic therapists we try to "bring underlying conflicts to consciousness." We agree with cognitive therapists that erroneous views of the world, which determine both experience and expression, can be accessed and identified; and with behaviorists that personality is a plastic, flexible medium, that new beliefs and behaviors can be rein-

forced and nurtured for increased satisfaction.

Work on identifying general, underlying mechanisms that apply across various therapies is helpful, I believe. Again, there is no license here for complacency. The care and goodwill of the therapist is fundamental and pre-requisite, but not enough. We need to strive for more precision in explaining the phenomenon of therapeutic change and how it can be encouraged. I think it is quite helpful that the general trend in psychotherapy research today is toward identifying and evaluating smaller sub-processes of therapeutic interactions, as opposed to evaluating entire therapies in relation to each other.

Here, I believe, hakomi can make a gen-uine contribution to the field, especially in our role as a training institute. Every time we do an in-depth training, the trainers revise the curriculum based on what they see happening with the end product students. What part of the theory or techniques are they not getting? What method seems to need a greater breakdown to make the parts explicit? What underlying assumption seems to be missing when the student employs a series of techniques?

The precision is likewise enhanced when students ask questions in the form, "I know you say to look for this when you do this, but what particular clues are you looking for?" Or students go out and practice and come back saying, "You know, I felt confident about the general direction I was going with people, but then when I realized such and such, a lot of the threads came together for me." Or, "The method just doesn't seem to work or address this situation."

Everyone involved in hakomi needs to share insights into the little clues that help make for precision and effectiveness in using the sub-processes of the work, so that we can communicate and pass them on to others in the field. Many can benefit from the results of our experience, and can integrate the results into their own practices though they might never engage in a full scale hakomi training. Certainly we need to voice the underlying principles of mindfulness and non-violence that promote the effectiveness of processes such as accessing and deepening, or techniques such as contact, tracking, probes, etc.

It continually strikes me that psychotherapy as a modern art-science is very young, under a hundred years old for sure. That is cause for humility. And, we have wasted of lot of those years entrenched in opposing camps, throwing rocks at each other. We need, as Professor Bloom suggests, to be responsibly (not neurotically) bothered by our failures, as an impetus to growth and maturity; all of us. Likewise, Eugene Gendlin says we should pay exquisite attention to our successes with people. How <u>did</u> we and they, together, promote the healing transformation? And, I would add that we would do well to look again at the wisdom of the ages, even if it is 4,000 years old, and give up the presumption and grandiosity in thinking that we alone, in modern times, have got a handle on what it means to be human. I still remember a professor from college prefacing a course in the history of ancient thought by saying, "Now when we read these ancient texts, we are going to have to assume that these people were at least as smart as we are, if we are going to have any chance of benefiting from them."

Gendlin is my current, favorite "cloud by day and fire by night" guide for leading us therapists through the wilderness of psychotherapy research to the promised land of increased therapeutic effectiveness and precision, that can be both specified and used to predict outcome successes. In his paper "What Comes After Traditional Psychotherapy Research?"[4] he lists eighteen suggestions for the re-directing of research in our time. I think they are worth listing, in brief, for the benefit of hakomi therapists in particular and other readers in general. Note that I am giving myself a large measure of editorial license in the way I phrase his own wording which makes his points less precise and formal. So, without blaming him for the folksiness of what follows, the gist of what he seems to be saying is:

1. Let's keep cassette and video tapes of our most clearly successful cases and send them to a central data bank that could build a profile of change measures, and what works, when, how, with whom, under what

conditions.

2. Let's not divide or rank our cases arbitrarily, but for learning purposes, compare the clearly good successful cases with the others, even if it is only two in relation to twentyfive.

3. Don't concentrate on predicting the differences between control and treatment groups; but more positively, that our treatment will increase the measure tested for the treatment group.

4. Don't assume that therapy is actually happening in a treatment group, but monitor the presence of actual therapeutic processes, and check the prediction that high process should differ in outcome from both low process, as well as control groups.

5. The results are inconclusive and unsatisfying from trying to use an entire psychotherapeutic approach as a research variable, because the unit is too large, global, diffuse, and diluted by elements held in common with other approaches. Let's look at more specific techniques or sub-processes within a single interview, and in other settings outside therapy. (But watch what probes you use when the pilot is landing the plane.)

7. Don't assume a technique or subprocess is uniformly well done in a treatment group, but monitor and define how it is done when effective.

8. Even within the research of subprocesses, as opposed to whole therapies, we would do well to specify micro-process variables. In terms of turning awareness inward through Gendlin's focusing, for example, it is necessary to differentiate a "gut feeling" (sad, glad, scared) from the "felt sense" of the as-yet-unclear referent. A different quality of attention and awareness is involved that can make or break the process.

9. Maintain a sharp distinction between measures of process (what we do) and outcome (what results happen.)

10. To encourage the most widespread use and adaptation of a sub-process, let's differentiate the form or style of our work (doing gestalt chair reversal) from the substance of what we are attempting to encourage (sense two sides of a conflict and act out of the side usually experienced as alien) which might be encouraged through a number of forms, depending on the therapist's style of preference.

11. Let's go from prognosis, in terms of identifying individual traits that predict success or failure in therapy, to concentrating on how to change the process of therapy to make it more regularly successful for a greater number of people.

12. If available tests and measures for what we want to research (loneliness, sense of competence) don't address the precise aspect we are trying to get at, we will save a lot of time and useless energy by devising a new measure that does.

13. Let's get research, training, and practice closer together. In Gendlin's words: "When a process is specifically defined for research, the same specific can be used in training. Then it can be used again to assess the practice. The measures are separate, but the microspecifics are the same. Such specifics enable us to instruct paraprofessionals and laypersons. Research precision enables wider applications." (p. 134.)

14. The use and abuse of therapeutic micro-processes is not limited to strictly clinical settings. Society at large can and does incorporate various elements of therapeutic processes. Let's broaden research possibilities for studying micro-processes to anywhere they might be happening.

15. "The Old Strategy: Isolate Variables: Chemical vs. Psychological vs. Social. Replace It With: Control for all Three and Test Them Together. Body, psyche, and social interaction are three variables that we put together. They are already always together ... With different inter-actional conditions one gets different results ... We must not assume that the tested effects of one factor remains the same if one of the others is changed." (p. 135.) Honor the

unity principle. Everything is connected to everything else.

16. When different methods or variables are used together, such as chemotherapy and psychotherapy, or intra-psychic and interpersonal techniques, or stern parole officer and kindly family therapist approaches, we cannot assume they remain independent and unchanged. We must allow for the variable of their interaction, for "each to change the other so they find their natural unity." (p. 135.)

17. Let's not approach the various therapies as a whole and try to isolate out cognition vs. feeling vs. imagery vs. behavior. "In the human individual, they are already together! Everyone thinks, feels, dreams, and imagines; has a body; has a family; acts in situations; and interacts with others." (p. 135.) Let's study the therapies in terms of their different microprocesses which provide different accessing routes to the whole person, and allow the learning interaction of therapists being exposed to different methods to change the therapies.

18. Let's save heavy-duty, formal, time-consuming research methods for verifying hypotheses that have already been well explored and show promise of being significant. Let's spend the majority of our clinical research time "playing in the laboratory", tinkering, exploring a sub-process in common situations with friends, peers, students, clients, or a small number of research subjects. Here is where creative, informal curiosity, and fast feedback, disconfirming a hunch or opening up new leads, can put us on the trail of those good hypotheses that are worthy of more extensive research time and energy. And "let us also regularly write such exploratory ministudies, make them available, and discuss them." (p. 133.)

Here we arrive at the focus of this edition of the Forum. Contained within are a series of reports on how people played in the laboratory back home with hakomi in relation to such populations as cancer patients, anorectics, college students, horses (??), senior citizens, and the Spirit. They are all basically experiential-reflective pieces presented to both share and to stimulate further exploration and discussion. As editor, I hope readers will both dialogue with the writers inside their own heads, and be inspired to "go thou and do likewise", sharing at some point their own experiences and reflections in writing. The editorial policy of this journal definitely allows and encourages this form of communication.

A couple of other research thoughts in closing: One. No amount of research and training will ever take the spontaneous element out of therapy. The principle of organicity teaches that every organic living system has a mind of its own, a self-directing, self-correcting quality that processes any input in a unique way. We will never be able to predict that this input will lead to this result, in this type of person, in this type of situation, every time - though this also does not imply any license to abandon the research trail of what processes seem to work in the best interests of clients most often. Every therapeutic response will necessarily retain an experimental quality. We will always have to track and notice what an individual does with an intervention, adjust, and go from there. And, there will always be the enormous complexity involved in putting two different living organic systems in the room together as therapist and client, and allowing for their unique interaction, as Gendlin suggests.

Second. There seems to be something going on that is not controlled by therapist and/or client. Growth happens in the face of ignorance, stumbling, and fumbling by therapist and client alike. Growth doesn't happen despite the most highly trained clinician employing the most state of the art techniques. M. Scott Peck is so impressed that growth happens at all, in the face of so many obstacles working against it, that he posits some spiritual force called grace to account for it in his book The Road Less Travelled. In hakomi, Ron Kurtz has often referred to the concept of negentropy as expounded by Bateson and Prigogine: the notion that there is a force in life that moves to build wholes out of parts, as well as the more well-known second law of thermodynamics, which posits the opposite. By any name, it seems that we are participating in something bigger than ourselves.

That would be a pretty tricky research variable to isolate. Still, I know from my own experience that therapy seems to go easier and more productively when I am aware of and honor, this reality of the unity principle at work. Perhaps someone could come up with an objective check-list that measures whether a therapist seems to be operating out of an engineering model that assumes a client needs to be fixed or rebuilt somehow, or a gardening-midwife model that assumes the therapist's task is more along the lines of providing the conditions that foster growth already wanting to happen, and helping the person to work through barriers to that growth. Then correlations could be made with the efficacy of the two approaches.

What other research topics are lurking in the bushes of the mind waiting to be noticed and explored by practitioners who may or may not have ever thought of themselves as researchers?

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1. cf. "Are All Psychotherapies Equivalent?" by Stiles, Shapiro, and Elliot in the American Psychologist, February 1986, Vol 41. No 2., pp. 165-180.
2. cf. "Research in the Outcome of Psychotherapy" by VandenBos, G. R. and Pino, C. D. in G. R. VandenBos (Ed.) Psychotherapy: Practice, Research, Policy, Sage, Beverly Hills, 1980, pp. 23-69.
3. cf. London, P., The Modes and Morals of Psychotherapy, Holt, Rinehard, and Winston, New York, 1964.
4. American Psychologist, February 1986, Vol 41, No 2, pp 131-136.

HAKOMI IN THE TRENCHES

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"Let's forget about hakomi and just do good therapy."-Ron Kurtz

The trenches are those places people go home to work in after attending hakomi-gestalt-psychodrama, etc. workshops. The people found there are civilians, the ones who are not necessarily the open, motivated, growth-oriented, touchy-feely, hot-tubbing, brown rice-eating, card-carrying meditators who show up at seminars. How does hakomi work with them? Can you use hakomi in settings where more traditional, confrontational, non-mindful methods are the norm? "I feel guilty in the midst of this hakomi training when my clients come in and I end up doing problem-solving things with them instead of pure hakomi sessions. What do I do?"

These questions commonly come up in the context of hakomi trainings. This paper represents my personal response to the issue as a hakomi therapist who does work in certifiable trenches, and as one of the trainers of the institute.

Letting Go of Purism

My most basic word of wisdom on the whole subject is that we can avoid a lot of trouble and grief by letting go of being purists. Purism or "ideal-hakomiism" is an understandably easy trap to fall into. One who goes through some 400 hours of nuts and bolts hakomi training is taught a particular way of working, that in its clearest, purist form has to do with non-violently turning the awareness of an individual mindfully inward toward the reality of their immediate experience. It is a lesson that is well taught and well learned.

The lesson has been tragically perverted however, if the learner goes away with the notion that hakomi is the, or the one best way of working; that it is an ism, a particular rigid set of techniques to be applied in contradistinction to other sets of techniques running around loose in the therapeutic world. This perversion is an insult to the creative, open-ended spirit of Ron Kurtz, the originator of hakomi therapy, and to the universal principles upon which he has based the therapy.

Hakomi in Relation to Other Therapies

So, here is another instance of the oft heard saying in hakomi trainings, "when in doubt, go back to the principles."[1]

The most basic principle of hakomi, from which all the others fall out, is the unity principle. No amount of thinking or writing will ever exhaust the implications of unity. One implication helpful for this discussion is that everything is connected to everything else. We like to quote John Muir at this point: "When you go to pick up one thing, you find that it is hitched to everything else in the universe."

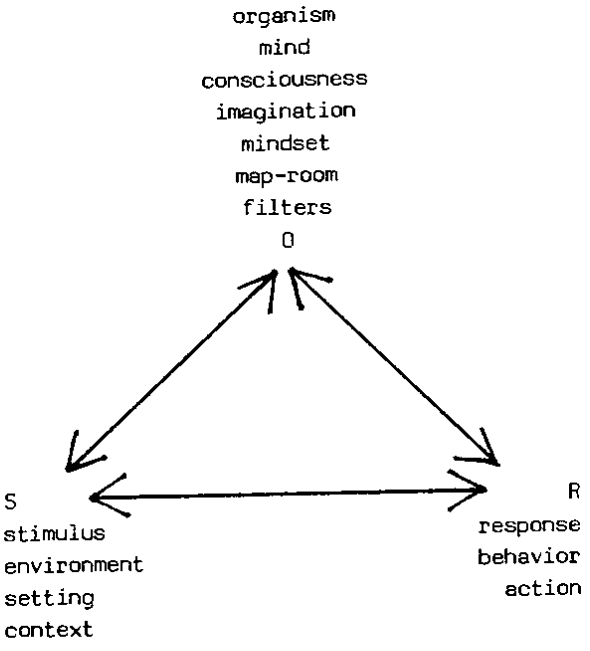
I would like to take this principle back to good old experimental rat psychology to offer a model for understanding how hakomi is related to the wide gamut of other therapies currently available to us.

A lot of psychological research energy in the first part of the 20th century went into attempting to understand and explain behavior in terms of stimulus (S) - response (R) reflexes. But when it turned out that S_1 (big Scottish Deerhound dog) didn't always lead to R_1 (me climbing the nearest tree),

but sometimes led to R_2 (you reaching out to pet the enormous critter), and even R_3 (the four year old neighbor kid terrorizing the poor beast, chasing him through the park), researchers had to give up and admit to an S - O (organismic variable) - R psychology.

A lot of people were and are unhappy with the introduction of the infamous "black box" into the nice, tidy S - R equation. But, no matter how much we debate about the essence of the black box being connected to classic conditioning variables, the collective unconscious, early interpersonal encounter, metabolism, or astrological conditions, it remains undeniably present No stimulus gets into our consciousness and effects a response without first going through the interpretive, formative filters of our mind, imagination, or whatever we want to call our O variable.

What I like to do is take the linear S - O - R and put it in the two dimensional design of a triangle. Here we can get a graphic representation of how each of the elements is in a mutually reciprocal relationship with each of the other elements, and how a change in any one can have effects on the others. Unity. Everything is connected to everything else.



For example, I see someone I don't know coming down the sidewalk toward me (S). I automatically organize around thinking the person will not like me (O). I direct my gaze toward the lawn or the bird in the tree, as if I am preoccupied, so that I can avoid the other's gaze in a socially acceptable manner (R).

A number of things can effect this scenario. If the other person (S) begins to look away, looks at me harshly, or begins to smile broadly in anticipation of a friendly greeting, these environmental changes will all effect my own disposition to respond.

It is also possible that I could catch myself mobilizing around avoiding eye contact, and in a brief moment of awareness, confirm to myself, "Yes, you are basically a person nobody would want to pay any attention to," or "wait a minute, we are all in this together. Nobody is better than anybody else," or "I'm not going to let anybody intimidate me." All these O possibilities could change what happens.

Or a different behavioral response could affect things. I could decide to smile at the other person, even though I'm scared. I could self-consciously go with looking mean and staring the other person down.

If I decided to smile, it is possible that this would evoke a smile in the other person and change my mindset to a degree. "Oh, some people do smile back. Maybe other people are anxious too, or maybe I'm more appealing than I think." This change in mindset could change the way I view the next person I meet. Instead of mobilizing around the notion that this person will not like me, I might have a more open, though still cautious, mobilization around the possibility that this person might or might not like me - I wonder which way it will be? If I initiate a more hopeful possibility in my own eye contact, I will be paving the way for more friendly confirmations from others.

Clearly, various schools of therapy have grown up around emphasizing the importance of the S, O, or R variable. Psychoanalysis, hakomi, and rational-emotive emphasize change in the O. Glasser's reality therapy and behavioral management of consequences, are working on the external environmental stim-

ulus variable. Rolfers and nutritionists are working the internal environmental stimulus variable. A lot of others encourage and teach various forms of behavioral change.

Sadly, at least in the early days, and still too often today, the schools were invariably imperialistic in claiming that their emphasis was indeed the most important, crucial, deserving of study, funding, etc. We have all spent a lot of time, hope, and energy searching for that one, most right way. It was a wonderful relief for me, personally, to hear Kurtz say in various contexts, "Why can't we all be right?" Why can't there be room for all kinds of approaches and interventions? Hakomi clearly honors the unity principle in being more than just happy to work in an interdisciplinary way.

Beyond being happy to work interdisciplinarily, refering clients to body workers. metabolic technicians, etc., I also hope for and encourage hakomi therapists to choose from and employ a wide range of methods and techniques. We don't have to forget what we already know when we walk through hakomi's front door and take off our shoes. And we shouldn't.

We are all, hopefully, on the side of healing, not taking sides in disputes over therapeutic territories. We want to promote and encourage what is needful for a person's well-being and wholeness. Being grounded in the unity principle and affirming the interconnectedness of all things gives one a heck of a large license to do what is needful in a particular instance. And, to do so not with the constraints of some dogmatic therapeutic notion of what is called for in any and all situations (what Greer Boyce calls a universal specific) but with the blessing of knowing we are contributing to wholeness, unity, the spontaneous movement of separated, alienated parts into wholes through a wide range of techniques that might be directed toward the S, O, or R variable.

That statement raises the question, of course, of whether hakomi is anything in particular if it is everything in general. I'll struggle with that a bit more in a number of the following examples. For now, it is fair to say that a wide range of techniques are acceptable if used within the framework of the principles - unity, organicity, mind-body holism, non-violence, and mindfulness.

Breaking Illusory Rules

One person's rules are another's choice or option, notes Kurtz. In hakomi we teach an identifiable method with specific guidelines and procedures. Behind the careful, methodical teaching there is the hope and belief that once trainees have learned the scales, they will be enabled, through personal and professional grounding in the principles, to do jazz, to improvise the necessary variations, to be in good tune with the live melody being played in front of them.

One of the first things we teach is that hakomi is an intrapsychic as opposed to interpersonal therapy. We move as quickly as possible to getting out of a normal conversational mode that would give people the idea that we were going to just talk. We encourage mindfulness right from the start which lets people know that we are about the business of helping them study the organization of their own experience. We don't get caught up in the content of stories people tell. We might contact them in the midst of a story by saying "a little anxious, huh?" in order to perhaps encourage them hanging out a little longer with the anxiousness so that they can learn from it. But never, "so tell me more about times and places you have been uneasy." We don't value chit chat.

So, one of the things I find myself doing a lot in the setting I work in is engaging in what I call "conversational chit chat," (CCC). I see a number of rural people who are unfamiliar with and basically suspicious of therapy. It feels like a failure of some sort to them when they feel forced to make an appointment at my agency. But they finally do.

A farmer comes in whose son is acting out in school and with his friends. He is mad at his wife for not taking care of the family at home. She is mad at him for being in the fields all the time and not giving his son the fathering he needs. The kid has been picked up for minor theft. The wife is

broaching the subject of divorce. He is devastated because he feels he has been doing his part in bringing home the bacon, and he desperately needs and values his family though he can't express that to them well.

So, when he comes in nervous, out of his element, hat in hand, field clothes on, I say "haying today, huh?" He says, "yah." I get chit chatty. "You worried about getting it all in before the next rain?" He responds and we start talking about farming. I show a lot of interest and ask a lot of questions about farming which is his area of expertise and daily life.

In terms of hakomi, I am breaking the rules. But more fundamentally, I'm promoting safety, the first rule. I'm making genuine human contact that he can relate to. I'm letting him know that I'm interested in him as a person and not just a thing, a therapeutic problem. I'm communicating in between the lines that I'm happy to join him in his normal, healthy life as well as in places of pain, that doing therapy is optional for me.

If I strike up CCC with someone, I then have to invent additional transition techniques not found in the HT manual. When I feel the timing is right, I say something like,

T: You know, I'd be interested in talking with you all afternoon about this stuff, but I'm starting to feel a little guilty about taking up your time when I understand you had some concerns that led you here today. Was it something about the family you wanted to explore?

C: Yah, its not going too good with the family.

T: Uh huh. So, it sounds like a little hopelessness in your voice as you say that?

C: (nods)

T: And a little confusion too?

C: Yah.

T: Well, I could guess a little bit about that, but you know, you are the world's expert on what's going on with you, and I kind of like to help a person mine his own wisdom. How would it be if you just hung out for awhile with that sense of hopelessness, and see if it will tell us more about itself? Maybe more about the confusion will come out in the wash too. Is that OK?

C: Uh, yah.

T: OK. So let's just notice how your body is experiencing the hopelessness, by simply hanging out with it like you might hang out with an experience of a sunrise on the horizon. Notice anything else there might be about the quality of the hopelessness ... hopeless about being able to do .... what?

In addition to promoting mindfulness in this example, I am also establishing a contract. Transactional Analysis people teach explicit contract-making right from the start. It is not explicitly taught in hakomi. Implicitly, it has to be there. A lot of attempts at accessing fail because the client has not agreed to that agenda. Here I am telling my farmer what I propose, and getting him to sign the dotted line of agreeing to explore his present experience. He goes along with it. He might not have. Then, I would have had to let go of my game plan and found another one.

Difficult Individual Clients

"Can hakomi work with any kind of client?" is a common question in the trainings. On one level the answer is obviously no, if hakomi is thought of as a specific bag of therapeutic tricks. Then a person has to go from one bag of tricks to another to find the one that fits best for bed-wetting, sexual dysfunctions, recurring nightmares, relational problems, eating disorders, etc. On another level the answer is a non-macho yes, if hakomi is thought of as a framework within which a wide range of techniques can be integrated around a central core of universal principles.

Trungpa says[2] the best thing we can do for some people who are unsteady and almost lost in the chaos of their lives is to provide them with a nice orderly, hospitable place to be, and cook them some nice, orderly, nutritious meals. Is that doing hakomi? Absolutely. It is doing what is needful. It is entering into the organic flow of what is healing. It is supporting the need for order the person is so desperately and unsuccessfully trying to provide for themselves. It is promoting safety, helping get someone out of the thunderstorm, which is a prerequisite for mindfulness down the track.

With some of the people I work with, we have to hang out with the contact stage of the process dealing with safety issues for months on end. With one woman who has overwhelming, undifferentiated tears and sadness at the slightest beginning of turning awareness inward, I have simply been offering an interpersonal relationship that majors in honesty, no tricks, compassion with no physical touching as yet, clarity and realism; all those things that Carl Rogers and Harry Stack Sullivan have taught us so well. My faith is that we are accomplishing something in between the lines that has to do with safety, trust, and hope that will one day lead to the possibility of more mindful self explorations on her part.

With another woman who would have a DSM III diagnosis of mixed atypical personality disorder, mostly avoidant with a lot of dependency, I likewise have not pushed mindfulness as an agenda. The woman grasps and fearfully clings to the very few relationships she trusts, and spends a lot of her energy majoring in her children, and shoring up what little self-image she has. She has a long history of being hospitalized and in therapy. My first objective with her was simply to offer a relational anchor that would keep her from being hospitalized. She claimed that she needed emotional nourishment from people, and that when she got it she could lower her medications. She was going through a very shaky period because of disruptions with her children leaving the nest as well as formerlly close friends leaving town.

A number of therapists would have gotten in a power struggle with her, saying she didn't need to be close and nourished by others; that would enhance dependency. She needed to get in touch with her own power, stand on her own feet, analytically understand where her need for warmth was coming from, and be independent, which of course would scare her and mobilize her defensively.

In good hakomi fashion I went with the flow, saying it was fine with me for us to be close and nourishing with each other within the limits of our situation. I hope she will eventually learn there is not a conflict between being needy and being independent. They can both be true. Neither has to be sacrificed.

We experimented with touch. She held herself in so much that her body was often trembling and in mini-spasms. First, just a hand on the back, asking for meaning, what that was like for her, what the hand seemed to be saying. Then the sorting out of sexual issues, affirming the OKness of feelings, which is a different issue than how one acts out the feeling. Then a hug standing up. Then a hug sitting on the same couch with her twisting awkwardly to insure minimal contact. Finally after many months, her being able to let me hold her in my lap as a child.

Then some processing about the issue of whether I would drop her if she were to become stronger and more independent. Finally, some actual accessing of core material while I held her in my lap after a disturbing incident in her life. We were able to contact a very bright, precocious child who at age three got the very clear message that her developing potential threatened the parents, was not welcome, and would be squashed in no uncertain terms if it became too obvious. The possibility of more "pure" hakomi exploration had arisen.

Are there people we shouldn't try to do hakomi mindfulness with at all? Of course. I don't try to do therapy with a wet alcoholic. I do all the interpersonal, compassionate, confronting, reality-oriented work I can, to get them into whatever program they

need to dry out. I then consider treating whatever is left over.

I'm very cautious about getting mindful with an anti-social personality who comes through the legal system. I don't want to produce a more psychologically-enlightened, therapy-wise, anti-social personality. I follow the rule of thumb that insists we are not going to do anything at all together until his or her report of what happened matches the victim's report which I make sure I have available.

Emotionally disturbed children basically need compassionate, genuine, realistic adult relationships with a large measure of structure, clarity, and consistency provided. Painfully shy people can and should be taught basic social skills and given the opportunity to try them out in the market place with the therapist right along with them, as well as looking into character derivations of the shyness. The greatest benefit to people who have experienced traumatic events who have not been able to debrief them with anybody - Vietnam vets, adult survivors of childhood sexual abuse - derives from being able to tell their story in a group with others who have gone through the same trauma. Character work should come later, not sooner. Adult survivors are routinely mis-diagnosed as histrionic or borderline personalities.

I never have figured out what to do with a seriously paranoid person who has framed me as one of the bad guys. Nor do we want to relax a person with a schizoid process too quickly , either through hakomi, meditation, bio-feedback, or stress reduction exercises, etc. All the standard cautions in the literature should be taken into account when working with specific clinical syndromes.

In general, hakomi is wonderful for slowing people down and giving them an opportunity to sort out the confusion that comes from normal life stresses. It is ideal for working with neurotic clients who are distressed by some aspect of their behavior. Hakomi also can be usefully employed with those who have personality disorders, though here it is trickier, since these people are placing the blame for their problems on external causes beyond their control. Psychotic folks are still struggling with getting a firm sense of differentiation between me and you, and have no room for re-arranging intra-psychic furniture. Here hakomi therapists have to major in interpersonal contact that will help them become real to the person, as well as pay a lot of attention to concrete matters of daily life in the patient's world. The compassion and respect of hakomi's style is helpful here, echoing the wisdom of Harry Stack Sullivan, M.D., who spent a lifetime convincing his psychiatric colleagues that they were more like their schizophrenic patients than different from them.

With many specific disorders (such as sexual dysfunctions, sexual offenders, eating disorders, etc.) hakomi therapists should familiarize themselves, if they have not already, with the known dynamics and general treatment approaches, and make decisions about how hakomi's refined emphasis on mindful exploration of the organization of experience can most usefully fit in. Some hints about that are included in examples below.

What Form Non-Violence?

Some trainees struggle with the issue of what it means to be non-violent, one of the main principles from which hakomi works . "I work in a methadone clinic and we lower a client's methadone dosage if they don't comply with the program." "I work with anorectics and sometimes have to hospitalize them against their will." "I work in a graduated hospital unit where patients have to meet specific requirements to graduate from a restrictive unit to a less restrictive one." What to do, what to think?

An important thing to note about non-violence is that it has little to do with trying to be a nice, sweet, understanding, gentle person. It has to do with going with the flow of healing, those movements which are persuading things toward wholeness, that which the person wants at the deepest levels.

Sometimes the person is not mindful and conscious of what is in the best interests of his or her own healing. I sometimes have to make humble (it is dangerous of course) but

firm leaps of faith in assuming and carrying through with what is best. I routinely counsel spouses and employers of alcoholics that the most caring, compassionate, loving, healing thing they can do, is to not rescue the alcoholic but to let him or her bump up against the reality of his/her situation. People who are acting out-of-control, trying to break windows on an in-patient unit, are not amenable to mindfulness or any kind of talk in general. Structure is called for. The more they can participate in and understand structuring interventions the better, but sometimes they can't participate at all.

In general, hakomi is on the side of healing, and therapists should not be squeamish about using whatever methods seem to be in its best interest . More specifically, hakomi majors in accessing the O variable through mindfulness. I'm always looking for opportunities to do that, even while employing other methods that address the S or R variable.

Anorectics

Let's take working with anorectics for example. Sometimes they have to be hospitalized because they simply do not comprehend how closely they are flirting with death. I would do it in a second on the assumption that there is a part of them, the most important part, that wants life and life more abundant.

It would be best, if I were the primary therapist, that I work with an M.D. colleague who could play the heavy role and do the hospitalizing. Then, in good hakomi fashion, I could consider the hospitalizing act as a life-probe that is reverberating through the person's consciousness. I could use that in exploring the O dimension.

T: "So, your parents thought you should come see me," or "So, Dr. M decided to hospitalize you, even though you didn't think it was a good idea yourself, huh?"

C: Yah. I don't know why they did that.

T: Uh huh. What is that like for you to have someone else make a decision about your life? A little anger maybe, ... confusion? You know best, I'm sure. How would it be if you just hung out with yourself for a few moments to notice what your own experience is telling you?

Here there is the possibility of taking radical control of an anorectic's life, and then using that act as a way of accessing the control issue within the anorectic that is thought to give rise to the whole syndrome.

A Behavioral Contract Group for Adolescents

In general then, one of the good things hakomi training can add to the repertoire of people trained in other methods is that sensitivity to how the person's programs seem to be organizing them around various inputs, and a good ability to access that O material when the opportunity presents. Obviously, there is the prerequisite here of not buying into S or R approaches as the only thing worth doing, the prejudice that exploring the O can only amount to navel gazing. There must be an openness to various roads to healing and a willingness to transcend the dogmatism of colleagues or teachers.

I do some contract work with public schools. Often this takes the form of doing behavioral contract groups with students. I have them do a vocational interest inventory, look at what careers they are wanting and what the prerequisites are. Then I ask them to identify how they are getting in the way of their own desire for success, do a contract around something they can change for their own benefit, do a force field analysis of factors for and against the change, and finally a strategic plan that addresses the factors identified in the force field analysis. Sounds just like your average hakomi training, right?

I use hakomi every step of the way, operating within the structure of the group, always on the alert for opportunities to promote self-awareness. While discussing with one student the ways he gets in the way of his own progress with grades, he mentioned that he will just blank out in class and stare out the window looking nowhere. So I asked:

T: Do you understand the blanking out? Do you know when it most commonly occurs?

C: No.

T: Well, let me give you two possibilities and you check with your own experience to see which one seems most right. OK?

C: OK.

T: Alright. Does your inner wisdom tell you it is a better hunch that you blank out when things get simpler and boring, or harder and more complex?

C: Harder and more complex.

T: OK. And in the same way, does your inner sense tell you that it is OK with you to do as well as you're able, or that you should be doing really well in school?

C: I should be doing really well.

All this confirmed for me the observation that while this was a kid who looked laid back on the surface, underneath there was a lot of tension and drive. He had been talking of how high-powered and successful both his father and grandfather were, and how much he admired them. On a hunch, I asked him whether he thought his dad would tell him 1) "It's OK with me for you to simply do as well as is right for you," or 2) "You have to do better than I did even." He answered, "better than me even."

I didn't think that was right. I encouraged him to have an actual conversation with his father about it, and let his mother in on that idea. He reported back that yes, his dad did want him to do better than he himself had done. The reason, however, didn't turn out to be that dad had done well and wanted his son to do even better. It turned out dad had been a flake, even though he was successful later, and wanted his son to get on board at the start. The student was able to relax more and blank out less.

That is an example of accessing some O stuff, encouraging some new behavior R (talking to father), and changing the environment S (parents now being more aware of the pressure son was feeling that was getting in his way).

Family Therapy

I have done a number of multiple impact family therapy sessions for the Children's Services Division of the state. This means spending all day with a family with as many therapists as there are family members.

It is sometimes hard for me to function with the team because some members have been so rigidly trained in structural and strategic methods that they believe the family system is the all-controlling reality and that any individual, intra-psychic work with a particular family member is worse than useless. From a hakomi point of view this is poor general systems theory. A system is a whole that is made up of parts. Any system is part of a larger supra-system and composed of smaller sub-systems. What some, not all, family systems people don't buy is that each sub-system has a relative amount of autonomy in relation to the supra-system, and that changes in the components of a system can affect the system as a whole.

I do buy that, and I'm looking for ways to act on it during a family session, at the same time that I'm participating in the other techniques of family work. One family we met had multiple problems, with acting-out kids and a single mother. In the initial joining part of the all-day impact session, I made contact with the mother by telling her that she evoked in me the image of a person burdened by a pile of bricks weighing her down. "It seems like the juvenile authorities are piling bricks, CSD, the schools, etc., and you are feeling overloaded." She confirmed that as a good image.

The children had come from various fathers. At one point one of the team members suggested that the youngest boy had a need to talk with his mother about his father whom he had never known and knew nothing about. So, we arranged the chairs for a talk. I shadowed the mother.

The boy said, "Yeh, what about my dad?" Immediately the mother stiffened and went into a defensive justification about "Well,

that was a long time ago, and he was the manager of this motel I was working at, and..."

I interrupted immediately and said to the mother, "Slow down for just a moment. How did you experience and interpret his question about his father?" She wasn't a very articulate, intelligent person so I volunteered, "It looked to me like you experienced his question as if he were putting one more brick on the pile, like he was asking you to justify yourself somehow?" "Yah. That's right. That's how it felt."

So, I then suggested that he might not have intended it like that and that she might check it out with him. She looked at the boy and said, "Were you wanting me to defend what I did with your father?" The boy replied, "No, I just wanted to know about my dad", and they went on to have a nice healing conversation.

After it was over I turned to the oldest boy and said,

T: Did you notice how your mother stiffened up and got defensive when he first asked about his dad?

C: Yah.

T: Have you ever seen her do that before?

C: Sure.

T: Does the conversation ever go any place when she gets that way?

C: Not a chance.

T: OK. So, I think one thing you could do in the family as the oldest, and the one who seems to be basically out of the house and most of the conflicts, is to track that in your mother. When you see it happening you can contact it by saying, "Looks like you think you got another brick mom. We better back off for a minute and get clear." Do you think you can spot it and do that when it happens again in the future?

C: Yah, I can do that.

T: Good. That might be more helpful than just yelling at both of them when they get into it.

C: Right.

T: But, if they want to go ahead and fight with each other anyway, just to have fun, you can let them. You are not responsible for solving the whole thing. Just call it by name maybe.

C: Gotcha.

Here I am again encouraging self-awareness in mother, O; encouraging her to try a new behavior, R (checking out her assumptions about people's intentions); and mobilizing the environment, S, to encourage the new behavior (teaching the older son a little tracking and contact skill).

I am also not going along with the common family therapy practice of intentionally leading a family into one of their normal impasses. In hakomi fashion, I am orienting things toward satisfaction, helping them work through mini-impesses as they arise.

At the end of an all-day impact session we all share appreciations. It was gratifying to me to have this poor, welfare mother say to me that she appreciated that I had a way of encouraging the best in people, and not provoking the worst. Two points for hakomi! Not because we have a mill turning out nice people therapists, however. Nonviolence and gracefulness simply get the job done objectively better, with less commotion and drama, and with more effortlessness and efficiency.

Vietnam Vets

When I was first asked to lead a therapy group of Vietnam veterans I was specifically told that this was not a subtle group you could be graceful and gentle with, doing cutesy, mindful things. They were tough, hardened, reclusive, and needed a lot of confrontation, encounter, reality testing, behavioral contracts, rage reduction, etc. That is true in a way. These persons do respond to clarity, honesty, no games, and interpersonal support from other vets.

I also found that they were relieved and curious when I told them that I didn't like to work by giving a lot of advice and solving problems. I had great faith that each person had within him or her (some nurses) the wisdom to direct their own healing if we could support them in tapping it. Being in the military they had had enough of others directing their lives. They appreciated that approach, even while wondering about it.

Before I arrived, the group had developed a common practice of putting tense people on a mat and holding them down while they struggled to reduce rage and relieve pressure. A number of them were relieved and appreciative when I introduced the hakomi experience of creative struggling; having the struggler direct the struggle creatively by checking inside themself to see how it felt most satisfying to struggle, with what kind of resistance provided by the others. That way is empowering, and encourages mutual, negotiated control as well as mindfulness.

One night a guy was there who had a habit of coming to group every four weeks or so when he felt the tension rising within him, and struggling on the mat to let off the steam. He had repeated the procedure for a long time. This night it was my judgment, though the group did not agree, that he was tense but not so much that he couldn't be mindful. So, I suggested that instead of going automatically for physical release, that he turn his awareness inward to check out more precisely what he, himself, thought was needful at the moment.

T: What is the tension like in your body? Is it located any particular place?

C: Yah, right here (pointing to his solar plexus.)

T: OK. Hang out with that spot for a moment and see if it will tell you anything more about itself. What is the quality of the tension?

C: Its like a bright white burning light.

T: Good. Hang out with the light then awhile in the same way.

He had his eyes closed. At this point a group member signaled me and I motioned for him to do his thing. He put his hand on the guy's solar plexus and said:

V: So you can visualize this tension as a bright white light, huh?

C: Yah.

V: OK. Now just let your mind go blank and not see anything, OK?

C: OK.

V: Now, are you blank?

C: Yah.

V: Now just let the first thing you see come into your mind ... Do you see it?

C: Yah.

V: A fire fight?

C: Yah.

V: White phosphorus shot?

C: Yah.

Then he went on to describe a memory of an attack in which his squad was pinned down and about to be shot out by the enemy, where he had rescued the radio pack and called in support fire to save the unit, only to have one of our own phosphorus shots kill his remaining buddies. After relating this the other vet looked at me like, "what next?". I commented to the guy:

T: It looks like that hand on your solar plexus is somehow relieving?

C: Yah. It's like the tension is just flowing out through it.

T: Well, if it feels good, let's just hang out with it awhile and let it feel good. OK?

C: OK.

T: (After a pause.) Maybe we can do a little translation here. If that hand was using words, what would it be saying to you?

C: It is saying, "It's OK to feel the terror."

That was it. We then learned that he had a lot of people around him who got uptight when he started to get uptight. He would still involuntarily hit the deck when a car backfired unexpectedly. They were telling him, "It is not OK to feel the terror. You have to control it so we will feel better."

So, we processed that and helped him know that at least those people in the group with him were OK with him feeling terror, and that it was good for them too to know it is OK. The more this guy integrates that message, the less the steam builds up and needs mechanical release. Vets, like anybody else, are not machines. They are human beings who have this marvelous capacity that other animals don't, to be mindful, to be able to witness the way they organize their experience, and not simply be caught in the organization.

Enough Said

Enough said. Hakomi's non-violent, non-warfare continues in the trenches. It proceeds in an open-ended, curious way, grounded in faith in the ultimate unity of things, even while we wander around in our dualities. What modalities integrate naturally with each other?[4] What encourages things toward wholeness with people?[5]

Hakomi will deepen and broaden as more people work in more settings with more client populations, and share the results with the rest of us. But it will only proceed as there is faith in the underlying principles, which transcend the dogmatism of a particular set of techniques or methodologies, and hakomi is prevented from becoming another thing or ism.

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1. See my editorial by the same name in the second edition of the Hakomi Forum, Winter, 1985.
2. "Becoming A Full Human Being" by Chogyma Trungpa, Hakomi Forum, Summer, 1985, pp 19ff.
3. Cf. "Intensive Family Services" by Greg Johanson, Hakomi Forum, Summer, 1984, p.39ff.
4. Cf. my articles on psychodrama and biofeedback in the Winter, 1985 edition of the Hakomi Forum.
5. Cf. "The Hakomi Method and Couples" by Devi Records-Benz in Hakomi Forum, Summer, 1984.

'ORGANIZATION' MEANS THAT IF NATURE PUTS TWO THINGS TOGETHER IN A MEANINGFUL WAY, SOMETHING NEW IS GENERATED WHICH CANNOT BE DESCRIBED, ANYMORE, IN THE TERMS OF THE QUALITIES OF ITS CONSTITUENTS. THIS IS TRUE THROUGH THE WHOLE GAMUT OF COMPLEXITY, FROM ATOMIC NUCLEI AND ELECTRONS UP TO MACROMOLECULES OR A COMPLEX INDIVIDUAL. NATURE IS NOT ADDITIVE. IF THIS IS TRUE, THEN THE OP POSITE IS ALSO TRUE, AND WHEN I TAKE TWO THINGS APART I HAVE THROWN AWAY SOMETHING, SOMETHING WHICH HAS BEEN THE VERY ESSENCE OF THAT SYSTEM, OF THAT LEVEL OF ORGANIZATION.

ALBERT SZENT-GYORGI
NOBEL PEACE-WINNING BIOCHEMIST

CANCER AND PSYCHOTHERAPY

RON KURTZ

RON KURTZ IS FOUNDER AND DIRECTOR OF THE HAKOMI INSTITUTE. HE HAS HAD A LONG STANDING INTEREST IN THE ISSUE OF HOW PSYCHOLOGICAL, STRUCTURAL, METABOLIC, AND ENVIRONMENTAL FACTORS INTERACT IN DISEASE PROCESSES AND HOW THEY CAN BE ADDRESSED HOLISTICALLY IN TREATMENT PROCESSES. HE WELCOMES DIALOGUE ON THIS AND OTHER ISSUES AND CAN BE CONTACTED THROUGH THE INSTITUTE ADDRESS IN BOULDER, OR AT HIS ADDRESS IN ASHLAND (745 IOWA STREET, ASHLAND, OREGON 97520 - 503/482-2049), WHERE HE IS LIVING, PRACTICING, AND OFFERING INDIVIDUAL TUTORIALS FOR INTERESTED STUDENTS.

The causes of cancer are not easily defined. Metabolic theory holds that cancer results from the collapse and overload of such normal functions of the body as surveillance, digestion and elimination. When the body cannot detect and clean up runaway cells as fast as they are forming, cancer is happening. Either the systms which detect and clean up cancer cells are weak or the need to clean is exceedingly high, or both. All this can occur with little or no psychological content. Emotional problems are not always part of the situation. Where emotional problems are part of the situation, they both weaken defense and are a burden to the systems which clean.

There are several attitudes, beliefs and emotional habits which can contribute to the worsening of a cancer situation. "There's nothing I can do about it." Such an attitude undermines the treatment. The commonly held notion that cancer is always fatal or the use of such a word as "terminal" is devastating to people with this attitude. It begins in childhood and has been called, "learned helplessness." Any effort to "fight for your life" is seen as futile. Hope gives way to frustration, anger and pain. Since energy and determination are important parts of any long-lasting, successful treatment, this attitude must be brought to light and changed.

"I don't deserve it." "Other people are more important and better than I am." These go a little deeper and also undermine treatment. Such attitudes make it difficult to take care of oneself. When others count more, there is discomfort and anxiety about being good to oneself, even about spending the money and making the effort to get well. The person feels, "I'm not worth it." Combine this attitude with, "there's nothing I can do about it," and you've got formidable obstacles to therapy.

There are more beliefs which affect treatment. "I can't be myself and still be loved." "It's too painful to reach out for help or comfort or love." "I won't get what I want." "I am alone." "I have to please everyone else." These beliefs are learned. They almost certainly held some truth for the child who learned them. All these beliefs affect the treatment of a life-threatening disease like cancer.

It is also true that certain habits of feeling and belief directly affect our physical well being. For example, self-hate or the holding back of anger cause physical wear and tear on the body. Emotional conflict and blocked expression leave toxic wastes which the system has to eliminate. For weak, overloaded systems, wastes are a very significant factor. On the other hand, satisfying emotional expression can be "cleansing." It relaxes and can allow a sympathetically dominant state to move towards parasympathetic, just as a pleasant state of rest follows work. Conflict is effort. And, since it's unsatisfying, it presses for more effort.

A feeling common among cancer patients is a sense of loss and a backlog of unexpressed grief over this loss. Again, when unexpressed, those feelings cause wear and tear. They contribute to a bleak outlook

and an "it's not worth it" attitude. The loss can be that of a loved one or even a dream for something better. Whatever loss it is, it is a loss of something held dearly, coloring any hope for the future, creating apathy and depression. Physically, unexpressed grief suppresses both breathing and movement, further depressiing those systems which clean and nourish the body.

It can be the case that these factors have been present all along, contributing to the development of the disease. In that case, they would be strong, central factors in the personality. It can also be true that they are minor factors in the personality and are precipitated by the knowledge that one has cancer. Both cases are possible and both happen.

MIND/BODY SPLIT

The intact complete self is experienced as feelingful, alive and physically real. There is a tangibility and substantiality to experience itself. Such substantiality is natural. It remains with us unless seriously interferred with. In a person prone to serious diseases this interference is most likely a central aspect of his or her early training.

In this early training, love, affection, attention, contact -- all the experiences which lead to security, pleasure and satisfaction in our relating to others -- are made conditional upon strict behavior requirements. The child has to make itself lovable. And to do that, the child goes against its natural inclinations.

The child faced with the conflict between being loved and being itself takes one or the other of two main courses open to it. It either tries to "be good" and we have the beginnings of the conforming and exceedingly nice, "goody-goody" person often seen as a cancer patient. Or it rebels and we have the "I don't need anyone" attitude and the fleeing from one's need for others. In both cases, an important aspect of the complete self is abandoned. In one case, it is the aspect that feels and acts on self-directed needs and impulses. In the other, it is the need for love and closeness that is pushed aside. Both contain the seeds of self-destruction.

It well may be that those with a parasympathetic developmental type will be prone to chose a strategy in which they will make themselves lovable at the expense of self-determination, while those with a sympathetic dominant type will tend to be more assertive and independent at the sacrifice of ever loving or being loved in a total way.

It is as if the child decices, "I cannot be myself and still be loved." One type acquieses, the other fights. Both lose the aliveness, solidity and feeling that come from living fully and truthfully. This loss of self is later echoed as the loss of the dream or the significant other. And, conversely, the recovery of self makes all other losses less devastating.

When the self splits, certain thoughts, ideas, opinions, etc., become alien. The body itself is partially disowned. Sensitivity is dulled and attention is focussed away from bodily experience. The body is split from the mind and the self is no longer felt as substantial, real, alive or whole.

At this level of split, the feeling mechanisms which guide eating, resting and the other bodily functions become dull or suppressed. In this numbed state, we have to be guided by ideas about food, rest, etc. We are much more susceptible to false notions of what's right for us. We are much less able to listen to our inner voices and more dependent on outside guidance. We lose our sense of taste and our ability to reject what is truly alien to us, like the chemicals in processed foods. This dullness, this lost contact with the life of the body, sets the stage for all the self-poisoning that's done in the name of convenience, pleasure, expedience, success or whatever. And this same mechanism dulls us to what is truly good for us, so we miss what nourishment there is.

From all of this, it's easy to see what's needed. Most generally, the recovery of self, the healing of the splits of body and mind. A return to wholeness is needed. And on the level of belief in particular, we have to learn that we can be ourselves and be

loved for it (by someone). We have to accept our need for that love and for closeness to others. We need to be open to our feelings and willing to express them, especially anger, grief and the need for love. We need to become sensitive to our bodies and what experience can teach us. And, we need time--time, a safe place and the support of others to bring these changes about.

The therapeutic method outlined below was designed around the notion of the mind/body split. It works to achieve that basic healing. It seems, therefore, to be particularly appropriate for those with debilitating, life-threatening disease.

THE METHOD

An accepting, non-forceful attitude is the first essential. Non-acceptance is the client's worst habit. To find non-acceptance in therapy would be disastrous. And the acceptance one finds must be genuine. The therapy is a constant act of love. The therapist must be willing to know and accept the other. The best ground for that is accepting oneself. So, the therapist takes his or her own journey within, which when complete, leaves one blessed with self-acceptance and the love of others.

The therapist's acceptance sets an example for the client to do likewise. To look within is painful and requires support the client cannot give him or herself. The client's non-acceptance of self is a habit. Clients level many punishing judgments upon themselves, judgments which maintain the habits of "being nice" or "not needing anyone." A statement like, "I shouldn't be so selfish," is typical. It is easy to see how it could keep one from acting in one's own interest. The "nice guy" style is always purchased at the price of self. A genuine giving of self, born of abundance, is entirely different.

The therapist's job is to provide a strong contrast to these negative judgments, creating a safe, supportive atmosphere. This allows the client to go inside and contact painful feelings, thoughts and memories. These early experiences are the roots of self and the path to the healing of the self. The goal is to go back to one's source and to emerge from it with the self intact. The caring and support of the therapist helps make this possible. Acceptance, then, is the first ingredient.

So the goal is reaching the full experience of self. On the path to that fullness lie all the painful feelings and memoories we have shunted from consciousness. By asking questions, by focussing awareness, the therapist guides the patient inward towards these lost experiences and towards the fullness of <u>experience itself</u>. We emphasize experience, not theories, past history or explanations. It is in this reliving of the past that we realign the present. We go back and get what was lost, accepting it, embracing it as our own -- our love, need, power, hopes and our ability to live fully. Our willingness and willfulness, our softness; we get it all back. It is voluntary, an act of courage. We have to go gently. Force arouses resistance, defenses, new splits. We don't try to defeat the client's defense system. We help the client drop his or her defenses voluntarily. Then it is something accomplished, not done to them, a genuine achievement. As such, it leaves the patient stronger and more confident.

Speed also hinders the process. To interact quickly is to revert to habit and reflex, not awareness and learning. A slow, gentle pace will arrive much more quickly at the goal than speed, force or great effort. So, the therapist works in a slow, gentle way. Plenty of time is allowed for the client to explore their own experience. The client is encouraged to take time and savor sensations and feelings. It is a meditative approach. Just staying with an experience brings it into sharp focus, revealing its roots and meaning. No fancy techniques are needed, only patience and the courage to stand and not run.

At that important crossroads where we either stand or run, the old habits are geared for shutting down the pain and looking elsewhere. We look away from the real needs and the feelings within. We put on an "adult" face and turn to the world outside

ourselves. This is our usual habit, done without our noticing it. Therapy brings awareness to this choice. It helps the client feel and understand and accept the pushed-out parts of being. It helps the client nourish, support and love that starved, unhappy soul within. Without that contact, without a change of heart that accepts all that once was and can be again, therapy is incomplete. By retrieving and embracing these deepest parts of ourselves real healing takes place.

Two factors central to a life-threatening disease like cancer, the need to be loved just for one's self, one's whole real self, and the need to express one's feelings freely, usually emerge spontaneously in therapy. The following transcript demonstrates this and the techniques that help it happen.

This is a transcript of a therapy session I did in Boulder, Colorado in October, 1979. I am assisted by one of my then students, now trainer, Pat Ogden. The client, K., is a thirty-three year old woman who has Hodgkin's disease. She has been on the Kelly program for two years and has done well but has a persistant tumor in the left side of her neck. Her medical doctor, Dwight McKee, M.D., is also present and assisting. I have annotated the transcript with my comments on the process and techniques.

R: Ron Kurtz, therapist
K: the client
D: Dwight McKee, M.D., K's medical doctor
P: Pat Ogden, assisting

R: So, let's go to work. You flew in from California?

K: Two days ago. Still experiencing a little jet lag.

R: Could you see out the window?

This simple question, asked in that special voice we use with children, evoked something of the child in K. She responded with an immediate delight in the memory of her trip.

K: Yes, it was great!

. . . . . .

R: Why don't you stand up, K, I'll have a look. Hmmm. Oh! Far out! I'm going to ask you a few things, okay?

One of the ways I sometimes begin working with a new client is by having the person stand in a comfortable posture while I see what their body tells me about who they are and what's going on with them. The body directly expresses the emotional history of the client. Focussing on it this way is a directroute to some of the more deep-seated aspects of personality.

K: Umhmm.

R: But first I want you to get nice and comfortable, a comfortable standing posture. Oh, dear. Oh, dear. Would you take a step this way! Yeah, this way. Yeah. (sigh) Whew! Umhmm. I'll tell you something. Can I talk to them (Dwight and Pat) a little bit? You, too! (to everyone). Those hands don't fit the body at all, the lower arm and hand. Maybe the whole arm dosn't fit the body. That would tend to tell me that there's a problem with reaching out and taking in. When the hands are relatively small and the arm's like that (to K.). So, it's like you disowned your arms at some point. Maybe, the left one. See that? Unconsciously answering me, "this one, this one"...

(K's right arm moved slightly, spontaneously, opening and showing the palm a bit.)

Another thing is, you're leaning over to that side, huh? So, let's see what happens. Those are the things I am thinking about working with at the moment. (to K.) Do you have anything in mind to work with at all?

K: I noticed yesterday when I was working with Lorne that, as I would release, as things would come up, my voice would almost disappear. Like instead of being able to get a sound out, it's like,

ahhh... (making a choking sound).

R: Right. One of the things that tumor does, I guess, is it affects that, too!

K: Umhm.

. . . . . .

K: Well, what I experience is that it would just disappear. Everything disappears.

R: Everything disappears?

Often, when I hear a word like 'everything,' I start asking for specifics. This time it proved fruitful.

K: (whispers) Felt like it.

R: What else disappeared?

K: Who...my...you know...who I am. As my voice went, I went.

R: Uh huh. When your voice comes back, who comes back? Do you know? Do you have any idea of who you are when you come back? No? Yes?

K: Yeah, well, it feels more like a, um, a fighting me.

R: Right. Your fight comes back.

My saying, "right" confirms that the fight came back and that I saw it in K's posture and facial expression.

K: Right.

R: Even a change of pusture, to get tougher. It's just like tapping. Ask a question, the unconscious answers, if you're looking for it. Why don't you go into that. The you who came back. Yeah. You don't have to exaggerate. You can just...

K's posture changed very slightly into an angry stance, just as she focused on who she was when she came back. Following what her body is saying, I try to stay in constant dialog with her physical experience. Also, at this point, we are switching from remembering and describing something that happened the day before to something that is going on physically, right now.

K: What, that stance?

R: Yeah!

K: Also, it's really apparent in my jaw. It always is. But in the session, yesterday...

R: The jaw; what happens? When you come back, your jaw...?

K: Comes out.

R: Comes out. And you get tough.

K: Grrrrr!

R: Do that arm! See what happens with that arm!

While growling, K's arm turned outwards. So, again I am focusing on bodily expression. Repeating the movement and doing it in slow motion helps to concentrate awareness and to see how the body participates in K's emotional expression.

K: Like that?

R: Again, a few times. Do it a few times. Do it in slow motion once.

K: It's a real...

R: Opens up?

K: No, it's a constriction.

R: Tightens there?

K: My shoulder. Everything gets tight, in here.

R: So, your pec minors tighten.

K: Umhmm. (laughs) Whew!

Information is piling up for K.

R: So, do it a few times in slow motion! And let yourself get a feeling like...add more and more, like...uh...did you ever see a picture come into focus very slowly, or just adding pieces to it till it becomes a whole? Okay. Do that a few times! Like a jigsaw puzzlie.

Still guiding awareness, building on the experience. All this helps K. stay turned inward on her physical process. The open-ended and somewhat vague suggestions allow K. to find her own way through the process, calling forth her creative energies.

K: Also what happens...I expell me...my breath goes out of my chest, and I hold it out.

R: Then go back, many times! Get every piece of the experience! See what happens in your heel! See what happens in your belly!

K: It's aggressive. I move forward. My weight comes forward.

R: Comes forward. Uhum. Keep going! (K. sighs.) Good! Yeah! That's it. Now rest a bit, then come do it again! See what else shows up!....Alright. Good!

K: (whispers) Getting tight here.

R: Head turning. Head turns a little bit. Keep going! You're doing fine. Check what happens to your shoulders when you do it.

At the same time we are exploring this once spontaneous movement, K is doing more and more of it voluntarily. We are searching for the meaning of this bodily mobilization. Such events are almost overlooked in the flow of words or are handled outside awareness. By staying with these physical events, we stay open to all the possibilities inherent in the nonverbal world of pure experience, the deeper memories, feelings and beliefs that words can so easily mask.

K: Now there's a resistance to doing that.

R: You don't want to do it any more?

K: (laughs) Enough of that one.

R: Okay. Help her resist, Pat! Pat's going to stop you from doing it. So..

K: From doing what?

R: What you were already doing. So, she'll resist for you and you can keep doing it.

In what follows, Pat holds K. and tries to keep her from turning and moving the way she had just been doing. Since K. is now feeling resistance to this movement, Pat 'takes over' the resistance, literally. Since Pat is protecting K. from going too far, K. can get even deeper into the movement and, therefore, its meaning. There are many instances of this kind of 'taking over' in this session. It is one of the main techniques of the therapy, basicaly supporting the defense system. It allows the patient to give up the defense system without a struggle and at his or her own pace.

K: Alright. Let me relax and do it again, okay? .... (sighs)

R: Right. Fine. Okay, let's stay with that. Something emotional happens. A little flash of emotion happens.

K: Felt similar to what was happening when this was being opened up. I would turn and my jaw would come out. It was a real resistance.

R: To....?

K: Having to open up.

R: Right. Yeah. Okay. Sit on the stool! Pat, just handle the hand itself, okay! Keep her from doing that. I'll have to get permission for that because, literally, your body already told us, "enough of that." There's something about doing this that you don't like but I want to get a little more information. So, just see if it's okay to do just part of it, just the hand turning. See if it

feels good to you to try to turn your hand against Pat's resistance.

I switched here to having Pat resist only the hand movement. I was concerned that we were forcing things and would lose K's feelings of being an equal partner in the therapy. If she just started following orders, we would lose her awareness, excitement and, at some level, cooperation. At that point, therapy is failing. So, I reduce the 'experiment' to just one of its important components, the hand turning and direct attention to how that feels. If it feels good, that's a signal that we're on the right track and we have permission to continue.

K: Umm. Some...a part of it feels good, because I'm active, you know. It's a...a..a.... It's something aggressive. It's a feeling that feels good.

R: Okay, work with that! Make it feel better, even more pleasurable!

Here again, I'm engaging K. in the process, this time in the search for an even more satisfying way of struggling with Pat.

K: Well, it's not pleasurable if I can't move it. It's just dead ended.

R: Uhuh. So, let it move a little bit, okay!

K: Yeah, there's some....yeah.

R: Yea, what? (general laughter)

K: Always feels good if I can get somwhere with it. If I'm just clamped down, it's nowhere, there's no satisfaction in that one. But, if the strength and aggression get me something, then it's worth doing.

This interaction has yielded what may be one of a central system of beliefs. It has the sound of an important attitude. It is surely related to the "not taking" we suspected earlier.

At this point, I have noticed a habit of K's which is disrupting the process. I discuss it with her and following that, she changes.

R: Okay. So.... There are two things that are important to me at the moment. One is that you do a little bit and come back out and watch me, or, you come back out and talk to me. It's like you don't stay with your experience very much. You go and get it and you come back and present it to me as if...what?...as it...

K: Okay, now what?

R: "Okay, now what?" Like you're in a hurry.

K: Oh! Always. "Let's get on with it!"

R: Well, the only way to get on with it is to get into it. You have to go inside. The hurrying blocks any possibility of getting very deep. Every time you come back out, you've lost the experience.

K: It's safer though.

R: It may seem safer that way, safer for you to throw the ball to me and say, "now what? now what? now what?" So; let me tell you one little thing about this. If you can contact and stay with your experience without creating words immediately, without analyzing it, without making it explicit immediately...Do you know about this? If you make it explicit immediately, it's like...just like a recognition system. If you're walking down the street and you say, "who the hell is that?" "Oh, that's Charlie." As soon as you think, "that's Charlie," it's never gonna be anyone else. And it may not be Charlie. As soon as you decide who that is, as soon as you label your experience, you cut out all the rest of the possibilties. And, it's in the rest of the possibilities that the change lies, because you're going to do your habitual recognizing anyway. You are going, "oh, that's what that is," instead of, "wait a minute. A little mystery here, let's wait and see what else is there." Like a little fog. Like a Chi-

nese painting. Okay, let's go again. If you want to... I don't want to force you at all. You're half way, huh? Menz a menz.

. . . . . .

K: Yeah. Because on the other side of the aggression is a little girl.

The appearance of 'the child' and the feeling of being a child, a specific child, at a particular time and place, clearly experienced, happens spontaneously in almost all sessions where the process of turning inward is successful. It is one of the surest signs of accessing the unconscious and is the most important therapeutic opportunity.

R: Right. Right. You can feel her now?

K: Yeah.

My saying, "right" and my asking about feeling the child now are the result of observing changes in K's face and posture. Tracking the body this way yields a great deal of valuable information about states of consciousness. K's head is resting in her hands.

R: Almost always, this posture is a child.

K: (softly, thoughtfully) Holding...It's holding.

I now ask Pat to take over the holding that K. is doing, to take the effort out of supporting the head with the hands. Also, K's head leaned a little toward her own shoulder, so I asked her to lean on Pat.

R: Help her do that, Pat! Why don't you sit down too. Let's sit down. That child is the one who can change. That's the part that can change its mind. Yeah. So, you do it first, right, and then you (Pat) just help her do that somehow! Get behind her and support her a little bit! You (K.) see how much of the effort you can give to Pat. You want to even hold her back up a little bit, Pat! Yeah. Right. Beautiful. Good.

This taking the effort out is central to the therapy. It accomplishes several things: it is a way of touching, with all that that means; it is a message about support, namely, "I will help you do what you feel you need to do," and it gives the person an opportunity to drop some of the tension which is stopping full feeling and to drop it at their own pace, while maintaining the position of the body. In releasing their tension, the person becomes more sensitive to the finer signals arising from the mood and memories present. This is the most important factor in the change of state of consciousness.

And stay with that experience of the little girl until...yeah...good...you let yourself into it now, huh? Right. Stay with that experience and that little girl until you know who she is and what she's feeling, and what she wants, and what just happened. Right. Right. If you can, just kind of keep an eye on her; almost keep a part of you just watching her.

This watching of the child is a substitute for complete regression into the child state. Complete regression happens and is valuable, too. In this case, I felt that K's contact with the child wasn't strong enough to get the regressive state. Watching has the additional quality of developing the witness, another important aspect of the therapy, akin to meditation.

Yeah. And anything that comes up out of that experience that's kind of a surprise for you or new or informative, then you tell me that if you can. Good.

K: (soft, childlike) She wants to be taken care of and...uh...

R: Yeah. Good. Take the support! Yeah. She'll (Pat) take care of you a little bit.

K: Umm...uhh...scared.

R: Umhmm. Okay, let's ask her; let's talk to her. You see if you can make her available to me or if you can't, then I'll ask you and you ask her, okay? So, let me tell her first that I hear that you're afraid and I hear that you're scared of something and I want to know if there's anything I can do to make you feel safer. If there anything anybody can do or anything you can do for yourself to make you feel safer?

I'm asking K., as little girl, to look into her experience for what's needed. So having directed awareness inward and found a fearful child, we now direct the search for what is needed to correct the situation. In many cases the main strategy of most people at this point in their process, is to avoid the fear and pain by turning awareness away or by shutting the feelings off with tension. Redirecting the search for nourishment at such critical junctures is another facit of the therapy.

K: Well, something that I felt a lot...

R: Yeah. You want to come out and tell me, huh?

Here, I have spotted the old tendency of K's to leave her experience and come back to report on it. It was this she had been doing through the first part of the session. I redirect her inward again.

K: Yeah.

R: See if you can tell me from there. Just try it once!

Very often this is a novel experience for the person. They are not used to staying with their feelings and reporting on them at the same time.

K: Well, if I'm rocked and loved, what happens is I...it feels like that's what I want, but it doesn't make me feel safer.

R: Umhm. Okay, so you want something and then you get afraid when you get it. Is that right? Like you want to be rocked and loved but somehow it's scary to you.

K: Oh! Yeah!

R: So, Pat, try these words, okay? We're going to do a little experiment, alright? The words will be...you let the words go in and see what goes on, right? Just see how that little girl responds to these words, but wait til Pat says them, alright? I'm saying them to her (Pat), but you wait till Pat says it! Pat, you say, "I'm staying right here with you."

P: See what happens when I say...."I'm staying right here with you."

I've called this technique a "probe." It has the form of asking the person to witness any automatic reactions to something the therapist does or says. Anything that does happen automatically is especially convincing and almost always interesting. It also has the nice quality of giving the person the vantage point of being somehow outside of the reaction rather than being caught in it. It requires that the therapist hear the possible underlying feelings and beliefs and come up with a statement which will set off the automatic reaction. It also requires that the patient be relaxed and turned inward. I try to use only potentially nourishing probes. With this probe, I have guessed that what is scary for K. is that people will go away just when she's getting what she wants. K. holds a slightly stiff position after the probe.

R: So, you don't quite accept that, huh?

K: Right. It's too good to be true.

R: See, the breathing doesn't change. You didn't let it in. You went...(I show K. how she got stiff.)...you know?

When a probe is taken it, it is usually followed by a sigh of relief.

K: Yeah.

R: It's too good to be true. Okay. We'll take that over, too. Pat will say that. Pat will say her words and I'll say, "It's too good to be true." And you can just listen to it, alright? You can just listen to the two of us talking and see how that little girl responds to the two of us doing that. (To Dwight, about Pat) She needs some support. (Then, asking Pat) Is that right?

P: No. I just had to change positions. I'm okay.

R: Okay. You can see what happens. So, you start, Pat!

P: I'm staying right here with you.

R: It's too good to be true.

P: I'm staying right here with you.

R: It's too good to be true.

P: I'm staying right here with you.

This is another example of "taking over." Here, we're taking over the words in K's head. As we did this, K's head started shaking from side to side.

R: Okay, shake your head!

K: "Bullshit!" (This is said in a normal tone of voice and with feeling.)

R: "Bullshit!" You're angry and sad both, huh?

(The sadness was in her face, the anger in her voice.)

K: Yeah.

R: Come out! Say it!

K: (Yelling) This is bullshit! I don't believe any of it.

R: Great. Great. Good Stay with it! Yeah. Good. Sample it! Savor it!

Again, I'm encouraging K. to stay with her experience. Also, I'm giving my approval to her expression of anger. In many cases of people with cancer, anger is not easily expressed in a satisfying way.

K: (Sighs. Then, whispering and tearful.) It's like having a carrot I can never get.

This may be the central feeling/ belief: the frustration and pain of a child who sees what she wants and needs and also sees that chasing it just moves it further away. This might be a parent that wants to be left alone. A parent that gets cold when the child approaches for comfort and attention.

R: Right.... (To Pat) Try, "I'll stay with you a little while." See if that's acceptable!

P: I'll stay with you for a little while.

This probe is less intense and so, possibly more believable. The attempt here is to get some kind of nourishment accepted, thus starting the process of letting in what's needed. This of course will be a major change in the way K. handles this need. K. sighs right here which, as I've mentioned, is a sign that the probe was taken in and that some tension has been released. It's that kind of sigh.

R: Possible, huh? Good. So, savor that! Okay? So, savor somebody being with you for a little while. No? Shook that off too, huh?

K's demeanor changed and I interpreted that. This "dialog with the body" is central to the client's feeling the presence of the therapist.

K: It's not enough, then. It's not enough.

R: (Laughs) So, if it's not enough, you don't want it either.

D: Catch 22.

K: Right.

R: Yeah. So, there's a deep part of you, this child part, a deep part that says, "I don't believe anybody's there to help me. No support."

K: (Softly, sad) Yeah.

R: Unless that child can change her mind and take some support, you're going to be in this pattern forever. So, you'd better talk to her. Say, "Hey, take a little bit anyway, just go ahead to see how it feels to take a little bit of support."

K: (sighs.)

R: Let's see what it does to the pectoral minors. Oh, yeah, you got something on your mind. What?

K: I...my little...uh...girl...it's just real unacceptable, but when I get in who I am now...

R: ...it is acceptable.

K: Well...yeah...it begins to be.

R: That's good enough.

K: Then I can accept...

R: That's good enough. Let's see with that little girl, if we can make it acceptable to her, too. Very important for you to be in harmony.

K. sighs again. All <u>these</u> sighs are part of K's indecision and struggle with her feelings.

Very important that she accepts it. Let's see what her objections are. You remember when she came up out of that..."Bullshit!...Grrrr!"

K: Umhm.

R: What is she angry about? Let's ask her. What are you angry about? Yeah. Let's ask her.

K: I ask her?

R: No, no. You were asking that little girl part. You want to go back into that pattern. See if you can contact her again?

K: Yeah. Alright.

R: Good. (To Dwight) I'd like you to support that leg there, Doctor. Oh, that's okay. Whichever way you want it. Let's put some pillows under it. It feels a little better slightly closed, I think. Is that right?

K: Then I have to lean on her more.

R: That's good. That's okay. It's okay. Tell her it's okay, Pat.

All this was in connection with getting K's position back to where it had been before, with her leaning on Pat.

P: It's okay.

R: Okay. Now we'll go to that little girl, alright? We'll try the same sentence, "I'll be with you for a little while."

P: I'll be with you for a little while.

R: Yeah..."and I'll try to make you feel better."

P: ..."and I'll try to make you feel better.

K: (Whispers.) No...It's like, if I believe it...

R: ...you open yourself up to being hurt.

K: Right. It's vulnerable and...uh...it's not worth it.

K. is at a choice point about opening up. She has come back to it. Perhaps she hasn't felt it since she was the child she's experiencing. It is at such choice points relived that therapy and change take place.

R: (Gently.) So, how can I not hurt you?

K: Has to do with my belief. There's nothing you can do. I don't think. I don't know.

R: If you're opening yourself to hurt, you're imaginging something's going to happen. What's going to happen?

K: You won't be there.

R: Yeah. So (nodding to Pat), you say, "I will be there..."

P: I will be there.

R: You won't be there.

Pat and I are taking over the struggle with K.

P: I'll stay right here with you.

R: No, you're not. You're gonna leave me.

P: I'm not gonna leave. I'm staying right here with you.

R: No. You're not gonna stay. You're gonna leave. I know you're gonna leave me.

P: I'll be right here.

R: You won't be there.

P: I'm not leaving.

That's about a ten-second pause here. With such "arguments" it's a good idea to allow the more positive voice to have the last word.

R: (To K.) Just for a moment or two, stay in your body, and see which muscles participate.

K: My jaw's real tight.

R: Right. Something that keeps it out. Okay. So, what you want to do is relax your jaw a little bit and try to let it stay relaxed. Okay. See if you can inhibit the impulse to tighten your jaw...good. (To Pat) Now say, "I'll stay right here with you for a while."

I'm asking that K. inhibit her habitual response to open up. In doing that, she makes earlier responses available to the process. The energy has to go somewhere.

P: I'll stay right here with you for a while...

R: (softly) and I won't go away suddenly...

P: I won't go away suddenly...

R: I won't leave while you're sleeping...

P: I won't leave while you're sleeping...

K: (emotionally) I don't believe it.

R: Just don't tighten the jaw okay! (K. moans.) So, let's get it clear, okay? In the past, the kind of things we're saying didn't happen. We just want to make them possible in the future....So... (to Pat) "I'll stay right here with you."

The first thing we had to do here was to help K. differentiate between the voices as representative of the past and possibilities for the future. We're at the very edge of change.

P: (slowly and softly) I'll stay right here with you. I won't leave suddenly. I won't leave while you're sleeping.

R: (whispering) Great. Yeah, great. I'll be right here when you wake up.

There's a relaxing in K., a letting down, and a sadness that's present.

P: I'll be right here when you wake up.

K: (tearful) I just flashed on a time...the only time I can remember that that was true.

R: The only time that was true...

K: I had my tonsils out and my mother spent the night with me in the hospital.

Here's a powerful, specific memory. The kind that shapes lifetime beliefs.

R: Oh. Only once...had your tonsils out.

D: While you had an operation on your throat.

Dwight has made a connection between the operation to have the tonsils out and the tumor of the neck. K. makes it also.

K: That's right. In the hospital. Uhggh!

R: Well, just say this...(at this point, K. starts crying)...we'll wait till you're available...till your phone lines are open.

There's a long pause here while K cries. Pat is holding her.

K: My phone lines are open.

R: Great. You don't have to have your tonsils out for me to be with you. You don't have to have an operation for me to be with you. (K. sighs deeply.) Great.

K: A friend said...a friend said to me recently, "You don't have to get any sicker."

R: Right. "You don't have to get any sicker." You don't even have to stay sick. (K. sighs. Then, to Pat...) Try that one!

P: You don't have to get any sicker for me to be with you. You don't have to stay sick. (K. sighs again.)

For me, all these sighs are signs that the nourishing statements Pat and I are making are being taken in.

R: Good. Let's try it upright. Come up with the back! That's it. Try it from here. "You don't have to stay sick.

I've had K. change her posture to a more upright one. This is a move away from the posture of sadness and immobility and into one which can more easily absorb these new ideas.

P: You don't have to stay sick. (K. inhales and holds her breath.)

R: That's iffy...borderline.

K: Yeah.

R: What's the little voice say. What's the little part say?

K: I'm not sure I believe it. (This is said in a bright voice, as if the excitement and happiness that should come with these beliefs were about to burst through.) Even...(K. sighs) it's like a, you know, in fishing, a weight, a sinker dragging a line down...

R: like a sinker, huh?

K: I hear it and I almost believe it and then there's this ughhh!

R: We've got to attend to that part. That part protected you, kept your mother around. It did nice things for you. Got your mother to stay there all night one time. So, let's talk to it. Hey, you have other ways to do this. Don't worry! We'll make sure you'll have company when you're well.(To Pat.) Try this one, try, "I'm not your mother, and I like you better well."

P: I'm not your mother, and I like you better well.

K: That's great. (a long, deep sigh.)

R: Finally!

Apparently, we hit the right probe. We needed to differentiate ourselves from K's mother. Often you have to do this.

K: 'Cause that unhooks me. But, see, that's not the little girl anymore.

R: Oh, yeah, she's around. I'm sure she's around. Do it again! Do it again! In fact (to Pat), why don't you say the same thing while you hold her. (To K.) Let her hold you!

K: As the little girl?

R: Yeah.

P: I'm not your mother and I like you better well.

R: (To Dwight.) You say it too! "I'm not your father..."

D: K, I'm not your father and I like you better well.

K: Um...(tearfully) that's great.

R: K, I'm just Ron Kurtz and I like you better well. (K. cries softly.) Don't run from that! Let that come! Especially pay attention to the jaw and pec minors! See if they soften!

K: They do.

R: They soften? That's good. That's good.

K: Yeah...'cause it frees me.

R: I'll tell you what I want...oh, stay right there! Let me see in this position. You don't hve to force anything; (to Pat) just keep a hand somewhere. She's already leaning. She's leaning in space. So, just tell her..."it's okay to lean. It's okay." (Pat takes K. in her arms.) Yeah. I'm sorry. I missed what you were saying. I was thinking. What did you say?

D: "It frees me."

I was busy watching K. and getting ready for more nourishment and I missed a key statement. Luckily, Dwight had it.

R: Oh, "it frees me." Yeah. "It frees me."

K: Umm. (The sound of relief.)

R: Frees you from the strategy, that plan...that way of doing things.

K: Right.

R: So, I want you to close your eyes and you can stay like that and I want you to start to reach out into space with that hand. Yeah....

As K. reaches out with her eyes closed, I put my hand out also and, towards the end of her reaching, her hand touches and comes to rest in mine. H ere, I am creating the physical statement, "reach out and I'll be there." K's in a very sensitive state and very much in touch with her feelings about reaching out.

See...that's another way.

K: My jaw's tight.

R: Okay. Let's do it again.

K: Don't quite believe it.

R: Yeah, I know. See if you can inhibit the tightening of the jaw. (K. sighs deeply.) Great...and reach....Don't let that jaw get tight, alright.

K: (deep breath) Ahhhhh...was it...my first feeling...was it really there...is there really a hand there and then...uh...kinda spaced out.

R: Spaced out...that's good. Spaced out is good.

K: ...withdraw from...

R: Sometimes spacing out is like you're going through a process of changing, you know. Like you get a little confusion at first, like toxins coming out, kinda confused. Then it settles down in a new place, sometimes. They're all strategies of avoiding the pain of people leaving...getting people to stay with, that strategy, and avoiding the pain of people leaving. Tighten up against what you're going to feel like when it happens.

I'm planting some suggestions here, a la Erickson.

So, let me put another one in there... just...(I start commenting a little abstractly on myself here.) I'm such a perfectionist...do a clean job...don't leave the scissors in or anything, you know. (Laughs.) So, I want you to be very careful to watch what happens when I say this, okay? First of all, I want you to listen to my voice very carefully, to what it sounds like, okay?. "You're not six years old anymore."

This probe is designed to free K. from the limitations of her child, who like any child, is dependent on her mother. I'm telling K. in effect that she can reach out to people other than her mother. Directing her to my voice was to avoid the possible pushing away connections one could make to such a statement.

K: (Curiosity) Yeah?

R: You want to hear more...

K: Yeah.

R: Is that what that, "yeah" was about...you got curious about that. "You're not six years old anymore" means, even though you need people, you don't need your mother anymore. (K. sighs.) Great. (Laughter.)

K: Thank the lord. Ahh! (K. blows nose.) Yeah. There's a difference.

R: Good.

There seems to be great relief at this point.

Well, I think we can sew this one up. (Laughter.) That's enough work for today. That's fine.

McKee is a surgeon. I am moving very quickly away from the emotionally open state K. is in, by laughing and by a change in tone of voice and, of course, with the words I'm saying. I want to leave the work we've just done "untouched" for a while. Even a minute or two is good. This allows it to "set." I don't want all those nice things we've accomplished to be messed with for a while. The stuff that follows allows K. to come back to normal, everyday consciousness. I'm skipping most of it. It took about two or three minutes.

. . . . . .

D: Seems like you have a lot more choices and options and awareness than you had.

K: Yeah. Umhm.

R: Yeah. Let me talk to them a little bit, okay. (To Pat and Dwight.) That was meaning practice we started with. You notice that? You know, like what is the meaning of all these things you're doing. We just started with a little movement of the arm. Access through meaning, that's nice.

So, the session ends with a moment of teaching. The whole thing took about an hour.

BUT WE CAN GO NO FURTHER IF IT IS NOT APPRECIATED THAT THERE IS SOME KIND OF ENERGY FIELD OR ORGANIZING PROCESS--CALL IT CONSCIOUSNESS--THAT IS OPERATING BEYOND THE REALITY WE ORDINARILY PERCEIVE.

RICHARD MOSS, M.D.
"THE I THAT IS WE"

THE STILLNESS IN STILLNESS IS NOT THE REAL STILLNESS. ONLY WHEN THERE IS STILLNESS IN MOVEMENT CAN THE SPIRITUAL RHYTHM APPEAR WHICH PERVADES HEAVEN AND EARTH.

TAOIST TEXT

THE CONTEXT FOR HAKOMI IN THE TREATMENT OF EATING DISORDERS

LEE MOYER

LEE MOYER, PH.D., IS A PRIVATE PRACTICE CLINICAL PSYCHOLOGIST WITH A SUBSPECIALITY IN EATING DISORDERS. SHE HAS PRESENTED PAPERS ON GROUPS FOR EATING DISORDERS TO NATIONAL ORGANIZATIONS INCLUDING THE WESTERN PSYCHOLOGICAL ASSOCIATION IN 1982 AND THE AMERICAN PSYCHOLOGICAL ASSOCIATION IN 1984. SHE IS A FORMER PSYCHOLOGICAL CONSULTANT TO ANRED, A NATIONAL ORGANIZATION FOR SELF HELP FOR EATING DISORDERS. LEE IS NOW IN THE CERTIFICATION PHASE OF HAKOMI TRAINING. LEE'S EFFORTS ARE DIRECTED TOWARDS REFINING HER HAKOMI SKILLS WITHIN THE RUBRIC OF A CLINICAL PSYCHOLOGY PRACTICE, AND INTRODUCING HAKOMI TO THE "STATE OF THE ART" TREATMENT FOR EATING DISORDERS.

This article is designed to be the first of a two-part series in the use of Hakomi in the treatment of eating disorders. I would like to describe the wider context of treatment in this first article, followed by a later article describing the applications of Hakomi principles and techniques for the treatment of women with eating disorders. [1]

I will generalize throughout this article. It is important to remember not all clients will fit the typical description. The purpose is to provide a "ball park" description that the therapist refines to include the unique features of each client.

Eating disorders include primarily anorexia nervosa and bulimia. Anorexia nervosa is the starving disease: young women starve themselves and become emaciated in the relentless pursuit of thinness. Bulimia is the binge-purge syndrome: women are often normal-weight individuals who vomit or use purgatives or laxatives after binge-eating. Sometimes they alternate between bouts of overeating and deprivation diets.

Bulimia and anorexia nervosa are complex disorders that are caused and then maintained by various social, psychological and biological factors. Eating disorders are now epidemic among college-age women. Because research and treatment advances are relatively recent, therapists and clients are often relatively unfamiliar with many areas of treatment. I hope this article will provide an awareness of the complexities involved in the treatment of eating disorders and an aid in evaluating if, and what kind of, additional training may be helpful in developing an approach to psychotherapy with this population. I also hope this article will contribute to an understanding of a context in which Hakomi can be an effective therapy with bulimics and anorectics.

It is important to realize that no single treatment is apt to be sufficiently comprehensive to address the problems inherent in anorexia nervosa and bulimia (Lacey, 1985; Bruch, 1985; Johnson, 1985). Exposure to diverse treatment methods--individual, medical, nutritional, and family--are usually needed.

The reader may be disappointed that there is so much to consider regarding treatment context; [2] however, the treatment of eating-disordered clients requires a broad multidisciplinary perspective. It is believed that without careful evaluation and multidisciplinary support, people with eating disorders often seem to terminate prematurely and deteriorate in their eating behavior, with further diminished self-esteem and serious discouragement (Lacey, 1985; Hall, 1985).

A description of the evaluation procedure and its rationale are outlined here. Evaluation almost invariably relies on consultation with other treatment specialists.

MEDICAL EVALUATIONS

A nonmedical therapist working with an eating disorder client needs a good working relationship with a physician skilled in evaluating medical problems with eating disorders. James C. Sheinin, M.D., has written a good article for physicians unaccustomed to evaluating eating-disordered individuals.[3]

Electrolyte disturbance is probably the most dangerous complication of vomiting and laxative abuse. Occasionally, clients attempt to induce vomiting with an emetic like Ipecac. They may also use diuretics. Again, the biggest danger is electrolyte imbalance, which may cause weakness, tiredness, constipation, and depression. In extreme cases, they may result in cardiac arrest and sudden death. These abnormalities are related to degree of low weight and the frequency of self-induced vomiting, combined with laxative, emetic, and diuretic abuse (Garfinkel and Garner, 1982; Adler, et al, 1980; Andersen, et al, 1985).

A physician will need to assess whether weight gain is essential before effective psychotherapy can proceed. A weight loss approaching 25 percent of original body weight will often signal the need for hospitalization for anorexia. Hospitalization may also be necessary for bulimics who show a high degree of dietary chaos.

DIAGNOSTIC ASSESSMENT

Eating disorders are spectrum disorders. Clients range from severe personality disorders (often borderline and hysterical) to relatively adjusted individuals. Borderline personality features are especially common among laxative users (Wooley, S. and Wooley, O., 1985).

Bulimic clients especially sometimes have histories of multiple substance abuse, various impulse-dominated behaviors such as shoplifting, promiscuity, self-abusive behavior, or unremitting binge-purge cycles. Clients with severe character disorders, borderline or narcissistic, who have been bulimic or anorectic for several years may not be able to give up their symptoms for a long time until extensive therapeutic work has been accomplished. These clients tend to respond most favorably to highly structured, directive, supporting interventions aimed at life management. Symptoms generally remit only after the client feels securely held by a treatment setting (Wooley, S. and Wooley, O., 1975).

Therapists need to evaluate whether symptomatic eating behavior is only one aspect of a much more complex treatment picture. The therapist will need to consider not only the degree of psychological disturbance but also his or her own level of skill in determining whether Hakomi is the most appropriate immediate psychotherapy intervention.

ASSESSMENT OF DEPRESSIVE SYMPTOMS

Depression frequently coexists with eating disorders. Assessment has two major complications. First, evaluation of depressive symptoms is complicated by the direct effects of starvation and electrolyte imbalance. Secondly, there is reason to believe that primary affective disorders frequently coexist with eating disorders (Piran, et al, 1983; Cantwell, et al, 1977). A primary affective disorder is a depressive state characterized by vegetative symptoms such as mood variability, persistent fatigue, sleep difficulty, frequent crying episodes, irritability, restlessness, and appetite disorder.

Frequently, a primary affective disorder is responsive to antidepressant medication. Both tricyclic antidepressants and monoaminoxidase inhibitors have been reported to be successful as an adjunct to treatment with eating disorder clients (Needleman and Waber, 1976; Pope, et al, 1983). This is a controversial area, but generally, trial on antidepressant medication should be reserved for clients where there is reason to believe that depressive symptoms would persist after weight and eating patterns are normalized (Garfinkel and Garner, 1982).

Given that depression frequently co-exists with an eating disorder, evaluation needs to address degree of suicidal ideation, the extent of suicide risk, and to what degree intervention addressing suicide potential needs to be a part of treatment.

FAMILY ASSESSMENT

In most treatment programs, family therapy is a requirement for treatment of any anorectic or bulimic who is 18 or younger (Wooley, S. and Wooley, O., 1985; Schussetz, et al, 1985; Sargent, et al, 1985). Especially when the client lives at home, recovery may be impossible without addressing patterns of family interaction.

Parents generally have guilt, anger, and feel overwhelmed by the eating disorder. They want help but are tired of the efforts and need relief and guidance. Issues concerning the whole family often include communication skills and effective parenting (Schwartz, et. al., 1985). There is often a facade of "super-togetherness" and stability that covers deep discontent on the part of one or both parents (Garner, et al, 1985).

The parents often need help with their own anxieties to permit their daughter more freedom. When the daughter shows true signs of developing independence, parents often comment, "If only she could again be the girl she once was," overlooking that she was unable to face growing up and living as an adult (Bruch, 1985).

Often family therapy or an assessment of family dynamics is helpful in assessing underlying beliefs. Often there is an understanding of the daughter's need to provide happiness for her parents who could not tolerate her growing up and leaving home. There is often a need for dealing with disillusionments with parents who have interfered with individual self-expression and with conflicts that have stood in the way of individuation.

TESTING (OPTIONAL)

The Eating Disorder Inventory is the first valid and reliable test specifically for eating disorders. It gives a differentiation into bulimic and anorectic categories; it also gives measurements of categories such as ineffectiveness and fear of maturation, which are central theoretical constructs of the illness (Garner, et al, 1983).

THE PSYCHOEDUCATIONAL COMPONENT OF TREATMENT

Many psychotherapists and clients are least familiar with this area of treatment, yet the importance of the therapist's understanding of these psychoeducational factors cannot be overemphasized. Some clients improve simply through understanding more about the social and biological contradictions with which they have been struggling (Garner, et al, 1985).

It is important to understand the enormous pressures on women to diet in the pursuit of a thinner shape and how these have become more unrealistic and destructive. The health benefits of slenderness have been profoundly overemphasized. Dieting, the major treatment for obesity, may also be the major cause for obesity (Wooley and Wooley, 1985) and it certainly seems a major cause for bulimia (Garfinkel and Garner, 1982).

Studies on psychotherapy have indicated that treatment has often led to an increase in well-being, with little impact on overt eating symptoms. For example, because of binge eating and vomiting, the client often has little idea of normal dietary intake (Lacey, 1985). In the recovery process, due to this distortion of appetite and satiety, the body needs to be retrained to experience satiety. Knowing this provides hope and gives the client a road map (Wooley and Wooley, 1985). Physical symptoms accompanying recovery must also be discussed and understood. These symptoms include dramatic weight shifts due to the rehydration and an apparent disturbance in the regulatory mechanism for food retention, which seems to correct itself with time. These psychoeducational principles in the treatment of bulimia and anorexia nervosa need to be incorporated

with any psychotherapy method. I find it most useful to present the psychoeducational principles within a context of a group specifically for eating-disorder women.

It is important that the effects of social and biological pressures be integrated in treatment so that the client does not experience the profound loss of self-esteem, self-criticism, and blame that come from being unable to control her weight by "will power." It is important that she understand the extent to which she is fighting an impossible battle, largely based on misinformation. The therapist working with eating disordered individuals will need some specialized knowledge. The scientific literature relating these points is reviewed in some detail, followed by specific practical recommendations for overcoming bulimia and related disorders (see Garner and Garfinkel, 1985, pp. 513-572).

GENERAL ISSUES IN PSYCHOTHERAPY

Bruch and Selvini-Palazzoli (1974) described how early disturbances in mother-infant relationships contribute to the development of eating disorders. The mother seems typically rigid, overprotective and unable to respond to her daughter as an individual (Hall, 1985). The mother seems to lack the ability to empathetically "tune in" to her infant's needs, for example, for food or comfort. Needs and feelings are responded to inappropriately. The infant does not develop the essential groundwork for body identity with "adequate perceptual and conceptual awareness of her own functions" (Bruch, 1985).

During childhood, eating-disorder families generally do not know how to encourage exploring and sharing inner experience. When anxiety or depression occurs, it is minimized, ignored or smothered. Sometimes, childhood stresses meet with unempathetic responses. For example, "You're too sensitive--there's nothing to be upset about." "You're okay--don't worry about it." Such responses dismiss the child's anxiety. Often a child senses that what is important is not her own experience but rather not being a burden to others. The foundation of the child's budding self or inner experience is not contacted, recognized, confirmed or taken seriously (Goodsitt, 1985). As a result, there is a diminished sense of self. Obedience and overconformity characterize childhood behaviors (Bruch, 1985).

The child grows up perplexed in trying to differentiate between disturbances in her body and in the world outside (Bruch, 1985). Ego boundaries are diffuse. There is little sense of separateness. Feelings of helplessness and lack of control predominate (Hall, 1985). With puberty, the future eating-disordered individual feels helpless under the impact of new bodily urges including increased hunger. In her fear, she overcontrols her needs. The effect is self-starvation often leading to bulimia (Bruch, 1985).

Intrapsychically, the eating-disordered individual typically feels terribly ineffective, incapable emotionally, labile, tension-ridden, desperately needful, unable to be alone with inner feelings (Goodsitt, 1985). She commits herself to never being a burden and tries to maintain her parents' well-being. She has a compliant, pleasing facade and cannot allow her wishes and needs to become important. With the onset of the eating disorder, these needs and wishes break through and she takes control of at least a narrowly defined world (Goodsitt, 1985). These general issues may provide some groundwork in forming a sense of "the child" and her core beliefs. In my own work, accessing "the child" has been a most powerful intervention.

ADDRESSING THERAPY ISSUES WITH HAKOMI

I would like to share some early thoughts of how I see Hakomi especially suited for addressing some of the problems described above. The principles underlying Hakomi address some aspects of eating-disorder disturbance in a profoundly direct and healing way. It is beyond the scope of this paper to apply the principles to the treatment of eating disorders, yet it seems important to mention two which seem the most

obviously important--mindfulness and mind-body holism.

Early childhood experiences have resulted in the child's failure to tune into inner experiences and learn about herself. Most eating-disordered behavior is compulsively determined by the urgent need to drown out tensions that exist because the client is not aware of her needs and desires and, therefore, cannot fulfill them (Goodsitt, 1985).

Helping the eating disorder client to get in touch with her inner experience helps her to ground and center herself, to integrate external behavior with inner feelings and beliefs. Helping the client to learn mindfulness. focusing internally, turning her attention to present experience, and to observing this experience nonjudgmentally without interference is helping her discover the very roots of who she is (Kurtz, 1984, pp. 165-166).

Mind-body holism is also important. Hakomi works at the mind-body interface. Eating disorders are desperate emotional statements that express themselves with the body. The anorectic and the bulimic tend to value and judge themselves in terms of their bodies. An inability to tolerate any body imperfection is a core issue. There is confusion and mistrust of bodily functions (Bruch, 1973; Frazier, 1965; Garfinkel and Garner, 1982; Garner and Bemis; Goodsitt, 1977; Selvini-Palazzoli, 1978).

The frequent tendency for anorexic patients to overestimate the size of their own bodies was originally observed clinically by Bruch (1962) and since then has been well-documented (Casper, et al, 1979; Crisp and Kalucy, 1974; Freeman, et al, 1983; Garfinkel, et al, 1977; Garner, et al, 1976; Goldberg, et al, 1977; Piereloot and Houben, 1978; Slade and Russell, 1973; Strober, 1981; Strober, et al, 1979; Wingate and Christie, 1978). Despite the obvious importance to clients with eating disorders, body image and body awareness concerns are rarely explored in any of the literature on psychotherapy for eating disorders. Body perceptions, by their very nature, do not readily lend themselves to articulation.

In one promising article by Wooley and Wooley (1985, pp. 414-420), body image therapy was designed to increase movement repertoire and develop feeling symbols through imagery, movement and therapeutic art exercise. In one exercise, for example, clients were asked to envision moving inside their mother's body, then to move as their mothers did. While moving "in the mother's body" they felt more out of touch with internal cues. These techniques are experimental, fairly powerful and likely to prove an important component to the treatment of eating-disordered women. They seem compatible with and easily integrated into Hakomi techniques.

ADAPTING HAKOMI TO SOME PITFALLS OF EATING-DISORDER PSYCHOTHERAPY

There are several pitfalls to working with the eating-disordered population which also apply to Hakomi. In my consultation with therapists, there is often confusion and frustration. Therapy seems to be proceeding with little problem or even with great success. Early in therapy the client cancels and does not return. Understanding the typical internal process can help avoid some pitfalls.

Most therapists tend to overestimate the capacity of the eating-disordered client to use therapy. Most are fooled by the client's apparent self-sufficiency and often by her ability to deny the the seriousness of her illness (Orbach, 1985; Goodsitt, 1985). The typical therapist will need to be more directive in teaching the client how to explore her feelings and how to use therapy.

The eating-disordered woman often fears that she is basically inadequate and scorned by others. Yet her mistrust is hidden from the therapist under the facade of pleasing cooperation. Her inability to identify, much less express, her feelings makes therapy more complicated. The therapist will need to be sensitive to safety issues in a complex way. The client may not feel safe but be unable to recognize these feelings. Worse, should the therapist correctly track fear and attempt to contact it, the client may hide her confusion to avoid appearing inadequate. The combination of inability to recognize feelings and

need to appear in control can often confuse and "double bind" the therapist.

The therapist might have problems with contact statements. Often being woefully unaware of inner experience, hearing the therapist describe her experience or feelings may seem a repetition of her own mother, who always told her what she felt.

Rather than attempt to contact experience in the beginning, it may be important to teach the client to recognize experience. Rather than a contact statement such as "Annoyed, huh?" a teaching recognition statement often seems more effective. "If I were in that situation, I might be annoyed or angry, but perhaps it doesn't bother you or maybe you have some other feelings." The multiple-choice nature of this approach contacts the confusion in a nonviolent, accepting way. It lessens the need to appear competent and hide inadequacy. It lessens the chance that she will again hear her mother telling her how she feels. It gives permission to explore the possibilities and compassionately articulates a sense of separateness with the therapist.

Eating-disordered individuals are more likely than most clients to experience crippling anxiety related to uncertainty and feelings of inadequacy. Many clients seem to benefit by being forewarned of feelings of discouragement and bewilderment in the early stages. This contacts her confusion and need for direction. During the first session, it is helpful to anticipate verbally that the client does not feel comfortable with psychotherapy and may wish to run from it. It is helpful to let the client know that this is common and, when this happens, you encourage her to bring this important feeling in (Goodsitt, 1985).

Eating disordered individuals frequently fear negative feelings and experience them as calamitous. There is an underlying fear that the therapist will withdraw from the client and that exposing these feelings will produce the same kind of response it did in parents. Frequently, an eating-disordered client fears that in sharing and talking she will lose what little control she has managed to create for herself. Sharing can be experienced as a loss rather than a relief. The expression of sudden emotion can be quite overwhelming.

Especially when strong or negative emotions are expressed, it seems important that the therapist anticipate that the client may now or later feel overwhelmed and articulate this to the client (Hall, 1985). While the client is under duress, I find it helpful to make it clear you want to help her feel better about herself (Goodsitt, 1985).

It is important to be flexible about the finishing time. Especially with eating-disordered individuals, it can be devastating to begin to express feelings, particularly negative ones, only to be curtailed by an abrupt ending. Unfinished business should be clearly acknowledged at the end and brought up by the therapist at the start of the next session. How the client feels, how the week went, whether or not the client wishes to bring up any issue from the last session can be structured early in each session.

I've also found it helpful to leave sufficient time near the end of the session to talk about the experience of this session--how it met expectations and fears. It is important to encourage the client to express feelings rather than go away with them; otherwise fears and feelings of inadequacy may become sufficiently powerful for her to dread returning (Hall, 1985).

I am currently exploring working with the child with eating-disordered clients. I would like to share a technique that involves storytelling as a probe. In this transcript segment, the client is in either a child or dual state of consciousness. The therapist is telling a story when the client's body becomes visibly rigid; her expression suggests she is upset. This transcript suggests some ways to handle safely issues when inner awareness is very limited.

T: Your shoulders seem all stiff when I talk about the little girl going into the forest.

C: (lightly, seeming to disregard the intensity of her reaction) I was wondering

what's going to happen. (less into a child consciousness)

T: You're wondering what comes next. I'm curious if something in the story might be upsetting you.

C: (no verbal response, expression difficult to track)

T: (not allowing too long an uncomfortable silence) Perhaps you are scared for the little girl in the story. Maybe you found the dark forest upsetting or perhaps there's some other feeling.

C: (efforting, uncomfortable)

T: (again, brief period of silence) It's not clear.

C: (nods)

T: (still talking softly to the child) I want to try my best to help you feel safe, so I'd like to try a game. Is that okay?

C: (nods, seems back to child state)

T: I'd like to try having the little girl have a magic protector. We can decide what kind.

(Client and therapist come up with just the right kind of magic protector.)

T: I'm going to go back to where we left off with the story and have the little girl meet the magic protector, and we'll see if something interesting happens. We'll see if that changes anything in your shoulders. Maybe they'll get less tense or more tense or maybe they'll stay the same. I'll watch so I can learn some things about you and how you feel about this story. And I'll tell you what I learn while you enjoy the story.

(Therapist tracks and stitches bodily responses to incidents in the story, especially when client seems to be frightened.)

Although it takes time to build the rapport to begin "working with the child," this has been the most promising intervention for me. Perhaps this approach addresses developmental lags in teaching about feeling safe, feeling fearful, and the way they manifest in the body. In my experience, intellectual explanations about safety seem to fall on deaf ears. This approach seems to slowly teach internal awareness that eventually prepares the client for deeper work (perhaps work with body image). Progress may be quite slow and erratic. The therapist will need much patience and ability to back off, but I find that this teaching of internal awareness and the importance of safety is often the central issue which touches all other core issues.

SUMMARY

Hakomi has an important place for the intrapsychic component of treatment for many individuals with eating disorders. The context for Hakomi is best seen in a perspective that includes prior evaluation important in treatment that is necessarily multidimensional. The evaluation addresses medical complications, diagnostic implications, and possible presence of endogenous depression which seems to warrant evaluation for trial on antidepressant medication. Suicide risk and need for psychoeducational intervention should also be evaluated.

Contacting the experience of an eating-disordered client may require some knowledge of her "typical" internal experience. Many clients have little inner awareness, feel terribly inadequate, but maintain a facade of pleasing compliance. An eating-disordered client generally responds best to the therapist who anticipates her discomfort and need to be in control and helps her by structuring the psychotherapy session.

I believe Hakomi has a unique ability to address the profound cultural lacks that create eating disorders in the first place. The application of Hakomi principles and techniques to the treatment of eating disorders seems best described in a separate paper. This is an evolving project for me. I am grateful for the communications of other therapists who have used Hakomi in the treatment of eating disordered individuals.[4] I welcome communications in the future and am glad to share what I know.[5]

It is not unusual to find a woman recovered from an eating disorder more alive and developed as a person than had she never developed the eating disorder. With all the complexities and challenges of treatment, recovery can truly be watching the birth of a person.

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1. Because bulimia and anorxia nervosa occur primarily among women, such clients are referred to as female throughout this article.

2. I believe this paper deserves some comment on the organization of experience. This is necessarily the organization of a psychotherapist that includes Hakomi within the rubric of clinical psychology. I realize a paper may be written that does the reverse.

3. Reprints of the article, "Medical Evaluation and Management of Patients with Anorexia Nervosa and Related Eating Disorders," are available through James C. Sheinin, M.D., Division of Endocrinology and Metabolism, Dept. of Medicine, Michael Reese Hospital and Medical Center, University of Chicago, Pritzker School of Medicine.

4. Ron Kurtz had shared a technique of taking over critical voices which seems quite useful (5/85, personal communication) and best described in Part II of this article.

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TENDING BODY AND SPIRIT: COUNSELING WITH ELDERS

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The following piece is taken from the book: Tending Body and Spirit--Massage and Counseling with Seniors. I wrote the book primarily for seniors, caregivers, and massage therapists who have little background in basic counseling skills and who wish to become more aware and effective in talking with Seniors about their concerns. In general, in adapting the use of the Hakomi Method with Seniors, I found it best to rely on the Principles, further develop my use of contact and tracking, try techniques like probes and taking over in simple, limited ways, and be satisfied with little 5 minute processes. I hope you'll find the examples useful.

Stuart: "You know, a large part of the massage therapy is having a chance to talk with you about things that are on my mind. For me, it's at least as important as the massage. I hope that's okay."

Cedar: "It's okay with me. I like talking with you. I know that body and spirit are very interconnected and talking about things is like massage for the spirit.

Stuart: "Yes, that's right. It's a relief and I always get a new perspective. I'm really glad it's okay with you.

Cedar: "It's fine with me. I consider talking and listening part of the massage, in fact."

I'm glad that people like Stuart feel good about sharing their concerns with me. Recognizing the oneness of body and mind and providing space to attend the spirit can be a vital part of massage with Seniors. It is an opportunity to be present to their feelings, worries, dreams, beliefs, and fears as well as the aches, circulation, relaxation, muscle tone, and flexibility of their bodies. Massage is an ideal context for this attention to the spirit: they are relaxed, they have your complete attention, there is a particular length of time set aside for them, and they don't have to talk--silence is perfectly fine in massage.

Tending to the spirit is also very delicate: Seniors often want to be very private about what's going on inside. They are doing a lot of inner work, but feel wary about sharing their deepest concerns, concerns bigger than whether or not they like the food in the dining hall or the receptionist at the desk. Most of this generation learned to keep things to themselves and to be embarrassed to be seen as weak or out of sorts.

Ruth was feeling a great deal of grief over the death of her best friend in the retirement home. I could see she was holding it in. I didn't push. But as I was working on her back, she began weeping--her grief poured out in tears. She was very embarrassed.

Ruth: "I'll be a whole person again next week. I'm so sorry. This is embarrassing for you to see me like this. I'll get control of myself in a minute here."

Cedar: "Ruth, I'm really sorry that you feel so uncomfortable about crying in front of me. I know you've been trying hard to hold it back. But I want you to know that feeling this kind of grief and crying about it seems very natural to me after losing your best friend. You loved her. I guess you were surprised to find so much sadness stored in your back. I'm not surprised and I feel honored that you would share this with me. I don't think you're an unwhole person." (Here I'm letting Ruth know that I understand her strong feelings, and trying to create an atmosphere in which she can feel safe about sharing the feelings. As I have said before, Seniors, or anyone else who has not often revealed deep feelings, tend to think of their feelings as bad, or weak, or unnatural, or out of control. The first order of business as a listener is to create an atmosphere of safety and acceptance. You don't need to push for the feelings. They will naturally emerge when your client or friend feels safe and accepted.)

Ruth: "I should never have let myself feel so much for her. I should have known better at my age." (She feels safer and accepted and goes on, now aware of her own internal unacceptance of her feelings.)

Cedar: "You're feeling a lot of pain--almost too much to bear at your age." (Again, I simply let her know that I understand her feelings--not trying to offer a solution or a bandaid. I trust the organic healing process that naturally takes place out of discovering and exploring the truth.)

Ruth: "Yes." (Here she gives a long sigh. She now feels safe enough to go deeper.) "There are a lot of people here who don't feel at all anymore. I guess it's too painful to feel. Sometimes it is." (Now she begins to look at the bigger picture--and her dilemma.)

Cedar: "Seems too painful." (Again I contact the intensity of her feeling. Just demonstrating that I understand. I'm not adding a new idea, don't want to interrupt her process. So, I use her own words and a very short sentence--a fragment. And indeed, she goes on.)

Ruth: "Yes. But I don't like being around the others. They're so dull. That's why I loved her so much. She felt things."

Cedar: "So, you've got a dilemma here. How to feel things but not get overcome." (Here I want to make contact with the dilemma she has, not the solution--she'll find that.)

Ruth: "Yes. But I'm glad I could still love her this much at my age. I'm glad." (She reconciles her own dilemma--knowing that no matter how painful the loss, it's still worth feeling and loving. There's probably more grieving to come, but the process is no longer "stuck" inside her back.)

Tending to the spirit is very delicate. Your goal is to extend a sincere invitation to share, not a demand; to communicate your willingness to listen and be compassionate, not to give advice; and to demonstrate your ability to understand and respect their experience. Being present, and making contact with another's experience is a privilege and a skill.

Ron Kurtz and Hakomi Therapy have been my best teachers as far as learning to make contact with people in an inviting, non-violent and respectful way.

The Hakomi Therapy manual goes into great detail about making contact and assisting people to process their experience. I recommend this book highly. However, in this chapter I simply wish to communicate the importance of making contact with your client's experience and inviting them to share it if they choose. The value of compassionate listening cannot be overestimated. Seniors in our society feel particularly isolated, misunderstood, and unrespected. Your presence in listening, understanding, and respecting can dramatically increase their self-understanding, self-respect, inner richness, and peace of mind. This is enough. You don't ned to solve problems, or release emotion. If these happen as by-products of your contact, fine, but these are not necessary.

I would like to go through some examples of statements that tend to invite sharing and statements that tend to close the door.

Making contact basically involves noticing what's going on in the present moment, and demonstrating with words or touch that you understand. So, you would be watching your client's body for little signals (they may be very small indeed): a little wince, a furrow in the forehead, a slight smile, looking around the room. All of these signals reflect feeling, thought, or meaning. The little feelings or thoughts may not be very important or significant in themselves, but they are an opportunity for you to make contact and demonstrate that you understand, that you are really present and aware. Gently aware, not intrusively. Once you have demonstrated your awareness, a new space will open and your client will feel invited to share deeper levels of feeling and thought. Sharing won't be hard work on your part, it will just open up and flow naturally. And all you need to do is to keep making contact with what is present.

First, here are some simple examples of making contact with what is present:

1. You hear a sigh--you say, "Feels good."

2. You see a furrow in the forehead--you say, "Thinking, huh?"

3. You feel tightening up--you say, "Hurts a little?"

4. S/he says "We had to wait half an hour for lunch again today!"--You say, "You're a little upset?"

5. You see a little tightening around the mouth as they begin to speak, tone of voice is tentative--you say, "It's a little hard to talk about, huh?"

6. You see something happening in their body but you don't know enough to even make a guess--you say, "Something's happening inside."

7. You make a guess, for example, "feeling sad?" and they shake their head, "No", you say, "That's not quite right, huh?"

8. Their voice sounds shaky--you say, "A little shaky?"

In all of these examples, you are simply making contact with whatever you notice. You may be making a little guess about the meaning, i.e. upset in #4, or simply reflecting back what you notice as in 'shaky' in #8. If your guess is right, your client or friend will feel contacted, and invited to go deeper. If you're wrong as in #7, you simply make contact with being wrong "that's not quite right, huh?", and you are on the right track. As you can see, you can make contact with many kinds of things that you notice. We tend to just listen to words, but it is just as effective, or even more effective, to make contact with feelings, tone of voice, facial expressions, physical movements, any change you notice, sound, breathing change, kinds of tension. When you are making contact, you want to make your contact as simple and short and clear as you can. You don't want to interrupt or invade their process, make the sentence so long that they have to stop and ponder it. I have found Ron Kurtz' "feels good, huh" kind of contact to be very easy and effective. It's short and direct. I don't have to think hard to put the sentence together myself so I can respond really quickly to what I notice. It's a statement with a little question at the end that leaves enough space for your guess to be off target and still be okay. Contact invites more self-disclosure.

Next, I want to give some further developed examples of making contact, i.e. what happens next?

While I'm massaging Adeline I notice a little wetness in the corner of her eye. "A little sad, huh." It's a gentle invitation. Adeline sighs a bit and I can see her settle down a little deeper into the sadness. Before I had contacted it, the sadness was standing around on the very edge of her awareness. Now she notices it. She knows that I notice it. It's no big deal. I don't think she's wrong for feeling sad. I don't need to say anything more. She goes on. I have already gently slipped into her experience with her.

"My husband had a stroke last night and they had to take him to the hospital and they wouldn't even let me go with him and now he

can't speak and I can't be with him. I don't know how he is. They're going to take me this afternoon to see him. I'm afraid he'll die."

"You're really worried and upset." (Again, I'm simply acknowledging her feelings. That's the most important thing right now. She doesn't need solutions or advice. Right now she needs to know that I understand. In the simplest and clearest of contact, your client or friend hardly even notices that you've said anything. They don't have to stop and think, they are just enabled to go on, perhaps at an even deeper level.)

Sometimes your client may need a further invitation to share his or her experience.

"A little sad, huh."

"Oh, a little, but I'm okay. Don't you worry about it."

"You're not sure whether it would be right to say anything more about it."

"No, I don't think it would."

"Well, I want you to know that it's okay with me if you don't talk about it and it's also okay with me if you do. Sometimes talking about something that you're sad about really helps.

Here, my client was worried about burdening me with her sadness. This is a common feeling among Seniors. Through making contact with that feeling, more space was created for her to decide for herself. She got permission and reassurance from me. In this case she decided not to. I didn't push. Two weeks later she did choose to talk with me. It is vital that people have choices.

Here's a third response to the same contact statement: Massaging Al, I notice a tear in his eye and a little shaking in his chest. "A little sad, huh." "No. It's mo contact lenses." "Oh." I took a tissue and wiped the tears away. It was obvious that nothing else needed to be said here. Either it <u>was</u> his contact lenses or his sadness was so private that he may not even have noticed. Sadness was not his experience. (In subsequent weeks, the tears would often come and seemed to be related to something I was saying about my children--he always wanted a weekly report). One week I said, "What I'm saying touches you in some way"

"Yes. I always wanted children but we couldn't have them, my wife and I."

"You're sad about that."

"Yes," and then out poured the tears.

A few weeks later he noticed that I was sad. "You're sad today," he said. I felt touched myself.

There are other sentences which I found useful in inviting people to talk about things or in getting them interested in themselves and their feelings. Sentences like, "I'm curious about how you are handling this pain (or adjustment or problem or...)" are great general door openers. "If I were you, I imagine I would feel, or be..." conveys your conviction that whatever they are feeling is natural and reasonable. They tend to think of some feelings as "bad," mean, or selfish. "What's it like for you to be growing (older or be sick)" lets them know that you want to know, that you're really interested. "I want you to know that I respect what you did as a chemist (or that it's okay that you feel this way or that your feelings are natural or ....)." I've found this kind of sentence can alleviate some concerns.

It's just as good to make contact with positive feelings, thoughts or signals as "negative" ones. For example, I'm massaging Elaine and I hear a sigh.

"Feels good."

"Oh yes."

"What feels most good about this?"

"It feels good to relax. I feel so tense these days."

"What kind of tension are you feeling?"

"Oh, I can't sleep very well. I must be worried about something but I don't know what it is." ("What kind of tension" was a good question here because if I had asked her what she was tense about, she would have had a hard time answering because she didn't know. When people, especially Seniors, don't know the answer to a question, they feel uncomfortable and the conversation stops. When that happens, I say, "It's not clear to you," or "Feeling stuck," or "It's had to put into words." Now they can answer again. Every time you can recognize the truth at the moment (and this often requires jumping out of the content and making contact with the process), you have taken a giant step.

There are also sentences which can interrupt or stop a conversation with Seniors. You notice a tear while massaging and you say, "Are you feeling sad?" A question this direct can feel threatening. They don't know how you'll respond if they say "yes," and "sad" instead of "a little sad" sounds BIG and they may be only slightly, if at all, aware of the sadness. If you say, "It looks to me like you're sad," they feel they've been found out, discovered, seen, without their permission. The response will most likely be to say, "No, not at all," and to hide their feelings even more. Then there's "Gee, you're sad. What are you sad for?" This one seems to imply a judgment that being sad is somehow wrong and they need to explain themselves. Or, "You seem to be sad. You just need to have a good cry." This is the wrong time for advice or sharing your personal experience that might or might not be helpful later, but it's not helpful when your client or friend has not yet shared his or her feelings with you.

Other things that aren't very helpful include:

"Oh, it's okay. Don't feel sad. I'll make it better." or "I'll take care of you." It's their experience and it does feel bad to them and you may or may not be able to help them feel better. Or, "It's not so bad. You'll get over it." Don't argue with them. They may or may not get over it. An argument is not going to do anything but set up a contest about what their experience is. And it's their experience, not yours. Or, "I think you're probably sad because your son hasn't come to see you lately." Interpretations are invasion or conjecture and tend to push the person back into their head to figure it all out.

You can also make contact with touch. You don't always have to use words. Nancy was sad. She had begun crying softly but was holding back more tears by sucking in her breath. One choice was to say, "You're holding the tears back, huh." Another was to say nothing and simply wipe the tears. I chose the second. As I began to wipe, she began to breathe more smoothly, and let the tears flow. After some crying she said, "You know, nobody ever dried my tears before." Touch is a powerful way of being with someone else's experience.

Try some of these verbal and non-verbal contact statements with friends. Experiment with saying the same sentence with different tones of voice. Get lots of feedback on what kinds of contact invite more sharing and which shut down sharing. No matter what sentences you use, your intentions will be reflected in your tone of voice. A nonintrusive and inviting and compassionate intention will be felt.

In this next section I want to give you a few actual vignettes of massage sessions to demonstrate some of the issues that Seniors may be dealing with. They are excerpts from longer sessions.

GEORGIA

Cedar: "How are you?"

Georgia: "Oh, fair."

Cedar: "Something's not quite right, huh?"

Georgia: "No." (long silence)

Cedar: "You're not sure what it is."

Georgia: "Well, I'm not doing so well in my adjustments here. I expected it to be an intellectual community and there's less and less of a percentage of them and more and more vague ones."

Cedar: "You're disappointed?"

Georgia: "Yes, and you're treated, well, not as bad as convicts, but like captives."

Cedar: "You're angry too."

Georgia: "Oh, yes! When it's time to eat, they call 'Come and get it.' And they say 'Okay dear, it'll be alright. Don't worry'--and then they don't do what they say. I'm not a kid. I know when I'm being lied to. It's so hard to change from being responsible and in charge to being on the sidelines. I thought I'd be fine because I understand the process from my social work days, but I'm finding understanding isn't enough. I'm not even sure it's a help. I'm not handling it well. I don't know how to do it.

(Georgia was having a hard time adjusting to her new life. As we began to talk, the feeling of things being "not quite right" was vague. By making contact with the uncertainty, she found space to uncover and share what was really on her mind. She had no solution by the end of the session but she had a lot more clarity.)

JEAN (facing an upcoming operation for cataracts)

Jean: I'm a wreck. I wasn't this nervous even when I had my hip replaced.

Cedar: "You're surprised you're so nervous?"

Jean: "Yes."

Cedar: "I guess your eyes are real important to you."

Jean: "Yeh, more important than walking even."

Cedar: "I can understand that. You're a little worried about something."

Jean: "Yes, not being able to see."

Cedar: "You're afraid it might not work and you couldn't see at all.

Jean: "Yes, I know they can't give any guarantees. The doctor says he's done it four or five hndred times."

Cedar: "But you're still nervous."

Jean: "No, I'm not nervous."

Cedar: "What is the feeling you have? What kind of tension?"

Jean: "I don't know. You're the massage therapist. You tell me." (My question "What is the feeling you have?" is too direct. Jean doesn't feel safe anymore as you can tell by her response. I got back in contact by acknowledging how hard it is for her to know what's going on.)

Cedar: "It's pretty hard for you to identify exactly what it is that's going on?"

Jean: "Yes..." (Silence, she sighs and feels safe again).

Cedar: "What would be the worst thing about being blind?"

Jean: "Not seeing, of course."

Cedar: "How do you see now?"

Jean: "Well, it's blobby, like there's a cloud on the ceiling now. But I can see the TV perfectly."

Cedar: "So parts of your seeing are a little like being blind now."

Jean: "Yes, I guess so. I know cataracts don't get better. So it'll just get worse, so the only way I'll see better is the operation."

Cedar: "But you're wondering if it's worth the risk?"

Jean: "No, what do I have to lose? I'll get gradually bind if I don't--so the worst is that I'll be blind a little sooner. Hmmmm."

(In talking about her feelings and the reality of her eyesight, Jean arrives at her own answer.)

GEORGE

George: "My legs hurt a lot."

Cedar: "Have you checked with your doctor?"

George: "Yes, he told me to take some aspirin."

Cedar: "So, does aspirin help?"

George: "No."

Cedar: "How often do you take it?"

George: "Well..."

Cedar: "There's a problem, huh."

George: "Well it gets stuck in my throat and I'm very scared that I'll suffocate."

Cedar: "So taking aspirin is scary?"

George: "Yes, so I don't."

Cedar: "I remember my mother used to crush aspirin in a spoonful of honey when I was a kid."

George: "That's a good idea."

(Here, it seems as if simple problem-solving is in order. There's a solution already, but there seems to be a problem with the solution. George not taking the aspirin doesn't make sense until he recognizes that he's scared. After that my suggestion is helpful.)

JOHN

For a number of weeks John repeated story after story about his work as a chemist. I was getting tired of hearing the same stories. I wondered what he needed from me in regard to his work. One week I simply said, "John, I want you to know that I really respect your work as a chemist." John smiled, and said, "You do? Oh, that's good to know." He sighed and the stories stopped and conversation in the weeks following got much more present. (He seemed to need to know that I saw and respected the larger picture of his life in addition to how I knew him now.)

STEVE

Steve: "I moved all the way out here from Kansas and I didn't know anyone here except my sons, and you know you're the biggest part of the week. I wait all week to see you and you're the one I can talk to. Since my 90th birthday, I'm living for you."

Cedar: "It's a very strong feeling you have."

Steve: "Yes." (First he begins to bite his lip, and then he begins to rub his eyes.)

Cedar: "There's something else you need to say, but you're not sure whether to say it?"

Steve: "I know it's crazy to think about marriage at my age, but I do. That's what I think about. That's the word I wanted never to say. I know it's crazy."

Cedar: "Well, we both know it's crazy because I'm married and I'm so much younger than you, but that's really the kind of feeling it is. The feeling is strong, like marriage. And it's okay with me for you to have that feeling. I feel honored. And it's nice that we both know that marriage is crazy."

Steve: "I want to know if you feel that way about me."

Cedar: "No, my feelings are those of friendship. I really appreciate you and I learn a lot from you."

Steve: "Yes, I knew that was the way it was. (long silence) You know, I think we really have had a meeting of minds just now."

(During any long term weekly massage

relationships, sexual feelings and attachment sometimes occur. These are delicate issues and they can be handled straightforwardly and respectfully.)

BILL

Bill: "You know, on my birthday all these people wrote wonderful things about me. I couldn't believe it."

Cedar: "I don't know whether you mean that you couldn't believe that you are that wonderful or that they noticed it."

Bill: "Well, I couldn't believe they saw these wonderful qualities in me."

Cedar: "You couldn't understand how they would know."

Bill: "Yes, I'm not a dentist anymore and I'm not working and raising a family."

Cedar: "Those are the ways you always felt respected and worthwhile--the things you did?"

Bill: "Yes."

Cedar: "So, it's hard to imagine that people could still see the same good qualities about you when you're not going to work every day."

Bill: "Oh, yes."

Cedar: "Well you want to know how I know?"

Bill: "Yes."

Cedar: "I can feel how much you care about people, how sensitive you are. Like I can feel your spirit."

Bill: "Well, I can feel yours too. You're a very special person."

Cedar: "So you know how to sense qualities in other people without their doing anything."

Bill: "Yes, I do."

(Bill is here doing some inner work about who he is and the meaning of life stripped of the sense of identity he had through being husband/father/dentist.)

STUART

Stuart: "I used to hide a lot when I was a little kid, because I cried. The other kids hurt my feelings a lot and I cried."

Cedar: "It was painful being a kid." (Long silence, in which I continue to massage.)

Stuart: "I don't want to burden you with anything. I don't want to be a burden to you."

Cedar: "You're worried."

Stuart: "Yes, I don't want to make you sad." (More silent massage. I know something important, but delicate is on his mind. I'll wait for more information.)

Stuart: "My son always says, Oh, Dad, you're not going to die..." (More silence.)

Cedar: "It seems like there's something on your mind that you're not sure whether it would be okay to talk about with me."

Stuart: "Oh, yes."

Cedar: "So, I want you to know that it's up to you, but that I really like talking with you and I don't find your feelings a burden. I also want you to know that I think it's perfectly natural and reasonable that you would be feeling a little scared and sad about dying."

Stuart: (Big sigh.)

Cedar: "It's a relief to hear that?"

Stuart: "Oh, yes, I just can't talk with my sons about it."

Cedar: "What's it like for you to think about it?"

Stuart: "Well, I know it's going to

happen..." (He goes on for quite a while.)

(Death and dying is an especially delicate topic--and it's very important to let your client or friend bring it up. Here I take the clues and make a guess and state the guess in a very open ended way so that he can feel safe about talking about his feelings, but not pushed. As you can see, he finds the space he's been needing.)

ADELINE

(Adeline's eyesight is fuzzy. She has a cataract and this bothers her although it's not yet bad enough, according to her doctor, for an operation.)

Cedar: I notice her forehead furrowed. "Something's going on up here, huh?"

Adeline: "Some things are pretty hard work."

Cedar: "What do you mean?"

Adeline: "Oh, thinking I mean."

Cedar: "You're thinking right now? What's it like inside your head?"

Adeline: "I'm trying to see better."

Cedar: "You're working hard at it."

Adeline: "Yes, I always do."

Cedar: "What kind of work is this?"

Adeline: "Well, it's ...well ..."

Cedar: "A little hard to describe."

Adeline: "Yes. Well, it's like maybe if I will it enough, I'll see better."

Cedar: "What is it that you're willing to see now?"

Adeline: "Oh, everything--you, the room, you know. I just want to see it all clearly."

Cedar: "Can you tell me about what seems so important?"

Adeline: "I don't want to fall, books, T.V."

Cedar: "Yes, I can certainly understand that, but I'm wondering what is important to see clearly right now? What is it you want to know right now by seeing?"

Adeline: "Well, you mean with you?"

Cedar: "Yes."

Adeline: "Well, I don't know."

Cedar: "Do you want to study this a little more?"

Adeline: "Sure."

Cedar: "Let's try an experiment. I'm going to say a sentence to you and I want you to notice what spontaneously happens inside--especially what it's like for your eyes and forehead when I say ...'You can get what you need to know even though your sight is fuzzy.' (This sentence was said as an experiment to help her explore a deeper level of the meaning of seeing to her. It was not intended as a solution or advice.)

(Silence while she studies her inner respnse.)

Adeline: "Why, my eyes relaxed. That's interesting."

Cedar: "You noticed your eyes relaxing." (More studying details about how her eyes relaxed and what meaning this might have for her.)

Adeline: "Yes, (sigh, silence) ...You know, now I'm curious about what blind people need to see and how they get it."

Cedar: "You're interested."

Adeline: "Yes."

Cedar: "You have some guesses?"

Adeline: "I'm going to think about this."

(The next week, Adeline returns to say, "You know, I'm beginning to get above it.

I'm learning to see with my heart.")

Adeline got interested in her eyesight, did some exploring on her own and found a new perspective. It is often important to explore a situation in the present. Here I help her notice details, another experience of her eyesight right now. Getting in touch with present experience helps people get interested in their own process. When people like Adeline become curious they get "unstuck" and more available to a new perspective.

My hope is that these vignettes will be of assistance. Specific listening skills are important to develop. But in the "big picture" what matters most is creating a safe context for Seniors to be in touch with themselves, if and when they choose.

When you feel respected, understood and invited to go further, you can take a big breath and go visit your inner self. Encouragement to visit yourself with the same respect, compassion and curiosity that you feel coming from outside you is the greatest gift that you as a caring person can give, often an even greater gift than giving the right advice or solving a problem.

FAIRIES AND ULTIMACY

YVONNE NOTARO

YVONNE NOTARO IS A STUDENT AT JOHN F. KENNEDY UNIVERSITY IN ORINDA, CALIFORNIA. AS PART OF A CLASS, SHE TOOK PART IN A HAKOMI WORKSHOP LED BY RON KURTZ. THE STUDENTS WERE ASKED TO WRITE A PAPER THAT INTEGRATED THEIR EXPERIENCE OF THE WORKSHOP WITH REFLECTIONS ON ONE QUOTE FROM A LIST PROVIDED. YVONNE CHOSE THE FOLLOWING QUOTE BY DA FREE JOHN AND INTERWOVE IT WITH HER PERSONAL THOUGHTS AND EMOTIONS FROM THE WORKSHOP.

"Then existence is not problematic. It is creative. It is a process of the confrontation of conditions, but it is humorous, already Enlightened. Nothing ultimate is at stake."

--Da Free John, Talk: The Religious Ambivalence of Western Man

The above quote speaks to my experience of learning about the Hakomi method on a weekend in February at JFK in Orinda. Hakomi emanates a feeling of nonjudgmentalness. It is no coincidence that mindfulness as a mode of observation plays an important role in the approach. Practicing mindfulness is a way to observe the body, behaviors and patterns from a nonjudgmental stance. It is simply noting what is happening. In this way one can bypass the usual protectiveness and defenses created out of fear of being problematic, untogether, crazy, and other loaded words that we use to describe ourselves from our everyday consciousness. Mindfulness creates an environment in which we can see ourselves more fully. It is a necessary step before change, to be able to see what exists. From the viewpoint that "existence is not problematic" we can fiind peace with who we are, and take note of what is, in a very direct way.

In the exercise we did where a partner gently lifts the shoulders to hold some of the weight on them, I was able to stay with my experience without feeling wrong for having the feelings I was having. Part of me was being an observer and was simply taking note of what was happening. I felt great heaviness in my legs and it was hard not to collapse. Having a little weight taken off me, I felt like having my partner take all my weight (and all my burdens). At her suggestion I sat down and my reaction was to curl up and be as small as possible. By helping me carry some burden of responsibility, she helped me get in touch with how heavy things were and how I just wanted to be little and be held. In this stage of being a little girl, I felt how I was very fearful, how I had taken in the fearful images of my mother. I also felt how I had not been able to express my fear and how I had felt pushed to grow up and be strong. Now at this moment in my life,in which I am confronted with myself after having separated from my husband, the feelings of fear that are covered up by my attitude of "I have to be strong" are once again a theme.

Because I was able to experience all this partly from a mindful stance, I was just allowing the process to unfold. I didn't feel restricted by any judgments that I was wrong, my mother was wrong, my husband was wrong, etc. I was simply noting in what environments I had been and what effect they had had on me. I also saw that my marriage had been a replication of my youth in the sense that my husband expected me to be strong. Finally I was out of the bind of my youth and my marriage, but my body was holding itself in the old way and I wasn't quite able to shake loose from the past and benefit from what the present had to offer me.

"Existence is creative." If one doesn't have to put lots of energy into the problematic nature of oneself and everyone else, it opens the door to creativity and new ways of

being. That evening while I was still in touch with my feelings of wanting to be held and not wanting to be alone and strong, I acted differently than usual. That evening I had a date and after the movie we saw together, I decided that rather than saying "Good night, that was a nice evening," I agreed to his suggestion of coming into my place for a bit. While he held me, I cried. Allowing myself to do this was quite different from the usual, "I'm fine, thank you" air that I exude. Also I had to later creatively get myself out of a situation in which my date was reacting sexually to my closeness, while I was at another level of wanting to be held as a child, which is quite different from being with a man as a sexual and attractive woman.

"It is a process of the confrontation of conditions." Usually the word "confrontation" sends shivers of anxiety and fear through my body. In the atmosphere of mindfulness, though, confrontation simply means something like "meeting." There is the sense of becoming acquainted with the conditions, getting to know them, exploring them as a scientist would approach his objective material. Getting to know the conditions that made us who we are becomes like going for a hike and discovering nature. Rather than having the emphasis on oneself, one can look more objectively at what the conditions were that shaped me the way I am and what were the choices I made along the way. By understanding the conditions, it is easier to look at the choices one has made, from a nonjudgmental perspective. Instead of overloading myself with criticism over having chosen a husband who reinforced my "strong" stance, I could see how at that time my awareness was limited and it took me five years to find out that the environment I was in with him was halting my growth, as we were stuck in our patterns and unable and unwilling to break out of them together.

"But it is humorous, already Enlightened." Not only is confrontation not something heavy and fearful, it is being talked about as something light, funny and complete. By distancing oneself from right and wrong values in which the individual is always being judged, it opens up this lighter path from which one can actually laugh at aspects of the human condition. The struggle of existence is seen as a game, something light, already complete at every step. There is a feeling of wherever one is, whatever one experiences is right, already Enlightened. It takes off the pressure of having to be a certain way, having to work hard and having to accomplish.

"Nothing Ultimate is at stake" is the ultimate expression that cuts right through my belief system of right and wrong values. It makes right and wrong be one and the same with slightly different faces.

In being with the process of two other women during the weekend, the sense of "nothing ultimate is at stake" was a theme. Both women were in trouble with their marriages. One was contemplating the idea of a separation, the other had decided, but was still living with her husband. Both women seemed tortured by the choice. Right and wrong were pulling them apart. I was impressed by the result of the process which seemed to have put the choices and the values in the background and themselves as alive individuals in the foreground. There was more of a sense of "this is who I am, and if this is what I have to go through, I'll do it."

During a sesion that I facilitated with one of the women, I felt uncertain about whether I was doing "the right thing." I was trying to stay with Hakomi methods and not fall into the more familiar terrain of psychosynthesis. After the session, the "client" (S.) commented on how she really felt my presence and my caring. I had completely forgotten about the most basic aspect of my being. She reminded me that when love is present, nothing ultimate is at stake.

I am just shocked about how much of my life I spend in the right-wrong and accomplishment modes. S's issue in the session I did with her was also concerned with this subject. The most central phrase had to do with forgiving herself for "allowing" herself as a 5-year old to be sexually abused by her older brother. She had internalized the value system of her parents, and was beating herself up for "having gotten herself into" this awful situation. What triggered the

turnaround was when she asked me to say in French (the language her mother spoke to her as a child, and the language I grew up with) "S., you can forgive yourself." The little girl in her needed to hear from her mother that she had not been "wrong," or at least that if she had been, she could now leave that burden behind her.

I am determined to allow myself to grow out of my right-wrong judgmental paradigm. I can see how my parents grew up in this paradigm, since they were influenced so much by the second world war in which good and evil came so close to their survival. It is time for me now to not inherit their reality, but to embrace the vision that comes with the words of the quote. The vision I have is in the realm of the fairies, in which lightness, love, curiosity and exploration are the important themes. For sure, for fairies nothing ultimate is at stake.

> THE BASIC WORK OF HEALTH PROFESSIONALS IN GENERAL, AND OF PSYCHOTHERAPISTS IN PARTICULAR, IS TO BECOME FULL HUMAN BEINGS AND TO INSPIRE FULL HUMANBEINGNESS IN OTHER PEOPLE WHO FEEL STARVED ABOUT THEIR LIVES.
>
> CHOGYAM TRUNGPA
> "BECOMING A FULL HUMAN BEING"

> WE DON'T NEED TO IMITATE NEARSIGHTED SCIENCE, WHICH PEERS AT THE WORLD THROUGH AN ELECTRON MICROSCOPE, LOOKING FOR ANSWERS IT WILL NEVER FIND AND COMING UP WITH MORE QUESTIONS INSTEAD. WE DON'T NEED TO PLAY ABSTRACT PHILOSOPHER, ASKING UNNECESSARY QUESTIONS AND COMING UP WITH MEANINGLESS ANSWERS. WHAT WE NEED TO DO IS RECOGNIZE INNER NATURE AND WORK WITH THINGS AS THEY ARE. WHEN WE DON'T, WE GET INTO TROUBLE.
>
> BENJAMIN HOFF
> "THE TAO OF POOH"

HAKOMI AND THE HUNT SEAT EQUESTRIAN

CADY ERICKSON

CADY ERICKSON IS AN ACCOMPLISHED EQUESTRIAN WHO HAS RIDDEN IN MANY SHOWING AND HUNTER COMPETITIONS IN OREGON. SHE HAS COMPLETED THE INTERMEDIATE PHASE OF HAKOMI TRAINING, AND UTILIZES THE WORK BOTH IN HER CASEWORK WITH SENIOR AND DISABLED PERSONS, AND IN HER MASSAGE PRACTICE AT INTEGRATIVE THERAPIES IN EUGENE, OREGON.

The principles, data base, and techniques of Hakomi can fit not only a therapeutic model, but non-therapeutic models as well. In this paper, it will be demonstrated how Hakomi overlaps specifically with the equestrian model. Techniques common to Hakomi include tracking, safety, contact, probes, and deepening. Let's take these techniques on a trip to the stables and see what we find.

From the very moment you first approach your horse, you begin to track. You check his overall attitude (nervous, sullen, etc.), his stance, his body movements, and such details as appearance, reflected, for example, in his coat or hooves. You continue tracking as you begin to establish safety with your horse. Soft words, a slow, non-violent approach, and perhaps an outstretched palm for sniffing. If your horse feels safe enough, you will move right into contact.

Slowly touching your horse (tracking all the while), gives you a sense of what is up for him in the moment. Is there muscle soreness or any bruising? Is he alert and oriented, or unresponsive, or skitterish? If safety has not been established at this point, you will know by the response of your horse when you make contact--does he flinch, is he curious, or does he whirl and kick?

Tracking, contact, and safety continue throughout the process of saddling your horse in preparation to ride. Once you are in the saddle, you do what equestrians call "picking up the contact," i.e., you take the reins into your hands.

It is at this time that the equestrian experience can begin to deepen. As you pick up your contact, you track the response. Your first probe will be based upon this response and the other information that you have gathered so far. Imagine that as you mount your horse, he sidesteps away from you. Your probe, based upon this response, might then be specific distribution of your weight in the saddle, accompanied by a slight pressure from your right leg. You would then track to see how he reorganizes around this new information. As with any probe, you first ask your horse to prepare, put out the probe, then track and make contact with the response.

True to Hakomi, the experience with your horse continues to deepen throughout your work together. The level of consciousness begins to change from one of ordinary consciousness to mindfulness. Usual thoughts, habitual patterns, and distractions all fade, as concentration and inner focus, the hallmarks of the deepening process, increases. You and your horse become an integral team. As you proceed together, from walking, to trotting, to cantering, you're deepening the combined experience. You might further deepen by including an indirect outside rein, some lateral flexion, a two-track ("tracking" also being an equestrian term), and perhaps a fence--first one, then two, continuing to deepen in height and/or complexity. Distinctions being the two of you are transcended as you become compassionate spirits, working together on your potential for growth and learning.

The process described above highlights the Hakomi perspective of "parts into whole". All of the separate parts of your work with the horse fit into one experience. Work "on the flat," striding, impulsion, bending,

etc., all begin to flow into an integrated whole that spells harmony and communication.

However, for you and your horse to move into this functioning unit, your focus must remain relaxed. If you start to become tense about where the process is going, or feel that you have to do it for the horse, or to the horse, you may go blank, misjudge a probe, or have a breakdown in communication. The results could merely increase ineffectiveness, or they could spell disaster. You need to remind yourself to keep a wide focus, to remain calm and open, and to know that it is alright to become stuck. If you feel the need for a new track, or the need to clear up some confusion, you can always jump out of the system, or do housekeeping. This might mean returning to an earlier probe, or simply remembering to make contact and track the response. Work with your horse (or client), as a team member, and you both will have success.

Thus far, it has been mostly the techniques of Hakomi that have been presented. Let us take a look now at how the principles of Hakomi apply to the equestrian.

The unity principle and its implications to the equestrian were presented in the discussion of parts into wholes--"all aspects and components are inseparable from the whole and do not exist in isolation" (as stated in the Hakomi Manual). Mindfulness is reflected in one's constant attention to present experience. You and the horse must both be in the moment--you cannot be thinking about what is for dinner with a four-foot fence two strides ahead!

Nonviolence is reflected by the equestrian in a gentle style which produces the best results. You ease into the saddle when mounting, you never slap down on your horse's back after a jump, you avoid jabbing him in the mouth with the reins, you keep a loose lower back that moves with him when he moves, etc.

If you happen to meet with resistance and try to fight it, instead of accepting what is, you will only encounter his defense barrier and create more resistance. For example, imagine that your horse starts to back up whenever you want to trot forward. If your response is to dig your spurs into his side in anger, you will likely create, and thus meet, resistance in the form of a buck, flattened ears, or perhaps a quick "360." However, if you take over the motion, support the defense system, and back up with your contact, your horse will become aware of how he is organizing and, therefore, you will have a likelier chance to break his habitual pattern. He will tire of backing up, realize the ineffectiveness of his response, and reorganize around that new information. In this manner, the principle of organicity is exemplified, i.e., the horse is another living system that is capable of transcending itself in the face of changing information.

Lastly, the principle of mind-body holism is evident throughout your time with your horse in your focus of attention as to how probes (both verbal and nonverbal) are experienced on a body level in your horse.

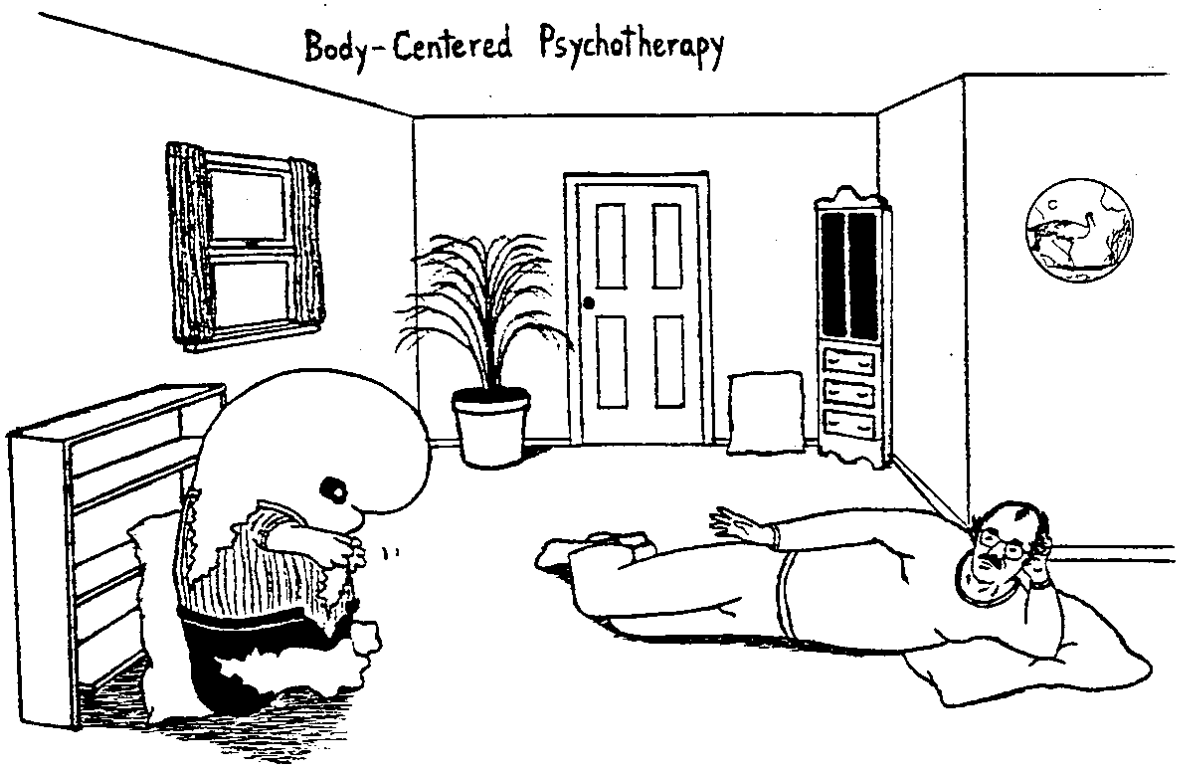
The sensitivity cycle is another facet of Hakomi that is easily accessed by the equestrian. Let's take a quick run through the cycle, beginning with the first phase of insight. You are approaching a 3'4" vertical fence. You remember to remain calm with the "background noise" lowered. You experience clarity regarding angle, distance, organization, and collection. Once you have gathered enough information to act, you move into the response phase. You implement your ideas by jumping the fence. Having jumped the fence safely, precisely, and effectively, you feel pleased with doing such a good job, and thus you pass into the satisfaction phase of the cycle. You then feel done with that particular fence and thus finish the cycle with the completion phase. At this point, you look ahead to the next fence and the cycle repeats. Note that this same cycle can happen on a larger scale also; for example, one could consider a course of fences in its entirety.

Before we end our journey, and leave the stables behind, let us briefly consider the Hakomi character types. It is a largely unresearched, unsubstantiated assertion, but

it would seem that horses assume character types as well as people. The form of a horse can reflect personality as much as does the body of a person. As a general rule of thumb, and so as not to box a horse into any specific category, some correlations might run as follows: Thoroughbreds are Expressive/Clinging; Drafthorses are Tough/Generous; Ponies are Dependent/Endearing; Arabians are Sensitive/Creative; Wild Mustangs are Self Reliant; and Quarterhorses are Burdened/Enduring.

In sum, human systems function similarly to animal systems--they select information from their environment that they then assimilate and organize in a particular manner. And it is in this way that any two self-organizing systems can both learn from, and grow with, one another in a therapeutic atmosphere.

> WHAT WE OBSERVE IS NOT NATURE ITSELF, BUT NATURE EXPOSED TO OUR METHOD OF QUESTIONING.
>
> W. HEISENBURG
> "PHYSICS AND PHILOSOPHY"



"I think you've gone deep enough now, George ..... George?"