A comparison of mindfulness and phenomenological enquiry processes within psychotherapy and their applications for working with complex trauma

A narrative literature review

Margaret Landale

July 2016

A dissertation presented in partial fulfillment of the requirements for the degree of MSc in Mindfulness at the School of Education, University of Aberdeen

Words: 17747 (excluding abstract, acknowledgments and bibliography)

I declare that this dissertation has been composed by myself, that it has not been accepted in any previous application for a degree, that the work of which it is a record has been done by myself, and that all quotations have been distinguished appropriately and the source of information specifically acknowledged.

Signature:
Name: Margaret Landale Date: July 2016

Abstract

One of the key questions in psychotherapy practice is how to support clients who may find it difficult to engage with processes of self-enquiry and self-reflection. Working with deeply engrained patterns of avoidance, shame or dissociation is a challenging process for both psychotherapist and client. This literature review focuses on three areas of investigation. It explores definitions of experiential enquiry processes by looking at traditions and clinical methodologies that might help define these processes. It draws in particular on phenomenological, humanistic and mindfulness traditions to help define underlying ideas and methods. It then draws on the expanding fields of affective neuroscience, trauma and attachment research to provide relevant explanations and theories for the personal dilemmas that clients may face in relation to self-enquiry processes.

Finally this is linked back to clinical applications of phenomenology and mindfulness in contemporary psychotherapy. Clinical process vignettes that incorporate mindfulness or phenomenological enquiry processes within the treatment of complex trauma have been selected to help illustrate ways in which clients can be supported to engage with self-enquiry and overcome deeply held resistance, dissociative patterns and shame issues.

Keywords

Mindfulness, phenomenological enquiry, experiential, humanistic psychotherapy, complex trauma, affect regulation.

Table of Contents

Acknowledgements

My sincere gratitude goes to all the authors who explicitly or implicitly have helped shape my thinking in putting together this review and who continue to inspire, challenge and help me reflect on my clinical work.

I also wish to thank my clients and supervisees for sharing with me their deep enquiries, for allowing me to accompany them on their search for understanding and meaning and for teaching me about humility and compassion.

I would like to thank all my course tutors but especially David McMurty, Heather Regan-Addis, Choden and Fay Adams for all their guidance and for modeling how to bring mindfulness and compassion to the work we do. A special thanks also to my academic supervisor Graeme Dixon, for supporting my idea for this dissertation, for his guidance, questions and invaluable feedback.

And finally this could not have been achieved without the loving support of my wonderful husband and daughters – thank you for believing in me and for putting up with it all!

Introduction

A core intention in the field of psychotherapy is to help clients raise awareness of their inner and, in particular, non-conscious processes. This includes paying attention to embodied and emotional dynamics and experiences as well as cognitive and psychodynamic patterns and behaviors.

In essence this refers to an experiential practice and involves an ongoing active enquiry, not just into the presenting issues a client brings, but also into what is being experienced, how it is being experienced and how it is communicated, particularly in the context of the therapeutic relationship. Yet this basic premise is often met with incomprehension, avoidance or resistance and so another core element of psychotherapeutic work is to help clients face the dilemmas they might be experiencing in an open-minded and accepting manner.

In this context the renewed focus on the body stimulated by the various findings of neuroscience research (Damasio 1996, 2000; Panksepp 1998; Ledoux 1999; Siegel 1999) are especially relevant here. These findings support the notion that embodied and emotional processes impact on our behavior and strongly influence our capacity to think and make sense of our experience. There is a growing consensus that in order to improve therapeutic outcomes therapists need to improve their understanding of the right-brain to right-brain processes of communication so that they can be more attuned to the non-verbal interactions that unfold within the therapeutic environment. (Schore 1994; Herman 1992/2010; Siegel 2003).

Psychotherapy processes are also innately intuitive and present-centered as they require the therapist to be able to work with unfolding phenomena. So it seems pertinent in this respect to review phenomenological psychotherapy traditions and see what they are contributing to the development of psychotherapy skill and practice. Such processes, interestingly, have clear overlaps with mindfulness. At the same time there are distinct differences between mindfulness and phenomenological traditions and one of my aims in this literature review is to explore these similarities and differences in more depth.

We also know that mindfulness especially in its secular forms, has become recognised and validated over recent years as an effective therapeutic methodology (Baer 2003, 2014). Mindfulness and psychotherapy traditions share as a central tenet the intent to enquire into the processes of the mind and to recognise and transcend habitual patterns and conceptualisations. However, enquiring into the inner world of one's own mind is always challenging and for some clients this can seem to conflict with their need to hold onto their sense of self. Both mindfulness and psychotherapy traditions recognise that this inner reflective focus can lead to strong avoidance and resistance in individuals and this is especially relevant for clients who are struggling with issues of self-criticism, self-loathing, shame or trauma. Such clients have often had to build strong inner defenses precisely to avoid pain or the feeling of being overwhelmed, which compromises their capacity for self-reflection (Gilbert & Proctor 2006; Gilbert 2009; Germer, Siegel et.al. 2005). When working with conditions such as anxiety disorders, somatic disorders, severe forms of depression or dissociative disorders, these fears and avoidance strategies are all too present and I will be looking at how the latest research is throwing new light on how to work with clients when such conditions are present. (Rothschild 2000; Ogden 2006; Van der Kolk 2007).

The overall aim of this review is to draw on a broad base of research, theoretical models as well as clinical reflections and discussions to help clarify clinical perspectives and interventions. It is my intention that this will be especially relevant for counselors and psychotherapists who have an interest in phenomenological or mindful processes and who are also interested in how to adapt these safely into their specific clinical context.

The format of the narrative literature review is well established in the counselling and psychotherapy profession. Riessman & Speedy (2007) point out that publications within the psychotherapeutic professions are still more common in the form of books or chapters and less in the format of academic research papers. They write: "…a central area of narrative study is human interaction – the daily stuff of social work, counseling and psychotherapy." (Riessman & Speedy 2007, p.432).

I believe that the study of complex human interactions benefits from narrative, reflective and creative methods, as so much can be understood from an instinctive, intuitive and even metaphorical level. This is a view shared by qualitative researchers with a specific interest in phenomenological methods, such as Finlay 2011; McLeod 1999, 2011; Halling & Leifer 1991.

Baumeister (2013) articulates that the benefits of a narrative literature review are that *"…it can integrate results from very different methods and procedures."* (Baumeister 2013, p.122).

The question I am investigating is broad and there are three areas which seem relevant regarding forms of resistance to self-enquiry which we may encounter in psychotherapy. Using a variety of clinical, theoretical, philosophical and spiritual sources this paper will aim to:

1. Clarify the relevant philosophical and theoretical roots and perspectives of phenomenological and mindfulness traditions and how these have been adapted in psychotherapy.
2. Discuss current models of trauma - in particular complex trauma and how this might enhance our understanding of resistance to self-enquiry.
3. Explore relevant clinical applications of mindfulness and phenomenological enquiry processes in 1-1 psychotherapy - in particular in relation to complex trauma conditions, shame and dissociation.

These themes fall naturally into three chapters, which form the bulk of this literature review.

Chapter 1: Investigation and clarification of the relevant philosophical and theoretical roots and perspectives of phenomenological and mindfulness traditions and how these have been adapted in psychotherapy

This first chapter provides a brief overview of phenomenological and mindfulness traditions and how these have impacted on the field of psychotherapy. It focuses in particular on how humanistic traditions have been influenced by a range of

phenomenological, philosophical and spiritual ideas and practices. In this context I am making comparisons in particular between the qualities and processes of phenomenology and mindfulness and their contemporary adaptations into psychotherapy.

The influence of phenomenology on the developing field of psychotherapy and in particular on the humanistic psychotherapy approaches goes back to Husserl (1931/2012), and his 'phenomenological method'. His ideas were taken up and developed further not just in the field of philosophy but also in psychology and psychotherapy. This paper provides a brief summary of the leading influencers in these fields such as Heidegger who focused in particular on the question of 'being in the world' thus highlighting the inter-subjective reality of human experience and Merleau-Ponty (2014) with his notion of "pre-reflective communication". It also highlights the influences of Buber, Maslow, Gendlin, Rogers and Perls who all contributed to shaping the humanistic psychological approaches.

Humanistic approaches, in particular Person Centered, Gestalt, Focusing and Existential therapy approaches have stayed true to phenomenological philosophy especially with their focus on working in 'the now', including somatic and non-verbal phenomena and emotions. Some of the key ideas of these four approaches regarding phenomenology and experiential practice will be highlighted as these approaches have remained dynamic and keep developing their theory and practice according to the changing paradigms of science and time. In short it is true to say that much of the psychotherapeutic processes that focus on an exploration of personal experiences and relational or social dilemmas are, by definition, phenomenological.

The emergence of mindfulness provides us with another lens through which to see how phenomenology has been integrated into the field of psychotherapy. Jon Kabat-Zinn (1990), who developed the Mindfulness-based Stress Reduction (MBSR) program and thus arguably founded contemporary secular mindfulness-based approaches such as MBCT, DBT and ACT, defines mindfulness as:

"…the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment." (Kabat-Zinn, 2003, p 145).

The practice of mindfulness can be seen as a well designed and adapted skills training for the mind and over the last decades secular mindfulness approaches have become more refined and are now increasingly applied as psychological methods.

There are obvious similarities between psychotherapy and mindfulness (Germer 2005a; Bion 2004). They share an orientation towards the present moment and the intent to develop attitudes of tolerance and inclusion as well as qualities of openness, curiosity and empathy. The humanistic traditions in particular have held strong to the belief that this deepening of awareness will bring greater acceptance, release a person's inner potential and allow greater integration. (Maslow 1971/1993; Rogers 1951/2003; Kurz 1990/2005).

Therapeutic mindfulness skills are also relevant for working with non-verbal, embodied and sub-conscious elements of experience and can help the therapist and client create a safe and compassionate environment that will allow the client to focus on previously rejected or suppressed aspects of their internal experience. (Germer 2005a; Shapiro, Carlson et.al. 2006; Siegel 2010).

Contemporary mindfulness approaches have also had a close collaboration with neuroscience and the study of brain activities and emotions. This arguably has helped establish mindfulness-based approaches in clinical settings.

Chapter 2: Discussion of current models of trauma - in particular complex trauma and how this might enhance our understanding of resistance to self-enquiry.

This chapter reviews complex trauma models and explores how these might explain the difficulties some clients face in relation to self-reflective and self-enquiry processes. There has been a wealth of research into conditions of trauma and effective treatment methods since the 1980s. Apart from involving a breadth of research traditions it has also attracted interest from all the major

psychotherapy approaches. One could argue that trauma has become a unifying field in psychotherapy and this has put the body as well as phenomenological and mindfulness processes at the center of trauma treatment. I have therefore chosen trauma as my central model to explain resistance to self-enquiry. (Van der Kolk, Mc Farlane et al 2007; Rothschild 2000; Ogden & Minton 2006).

In short, trauma refers to a reduced capacity to effectively process stressful events or overwhelming and painful experiences. Usually trauma resolves over time and there is a return of normality. However, if events are too severe or overwhelming this return to normality is prohibited, leading to the development of Post Traumatic Stress Disorder (PTSD). (Levine 1997, 2008, 2010; Rothschild 2000; Van der Kolk 2003; Folette & Palm et.al. 2006; Chu 2011).

Trauma and PTSD involve neurobiological, emotional and mental processes that can be highly restrictive, overwhelming and disorienting. It involves emotional dys-regulation, and it affects our behavior, memory and social engagement systems. This can lead to severely disorganised mental processes and dissociation. (Lanius & Blum et al. 2011, pp 333-334).

Complex trauma conditions such as somato-form disorders, clinical depression, or dissociative disorders have been linked to early attachment scenarios where the needs of the child for secure attachment were not met sufficiently or even violated. The quality of our early care-giving relationships has been recognised as pivotal to our emotional development and necessary for the development of a secure enough or integrated sense of self. (Siegel 1999, 2003; Schore 1994, 2003a, 2003b).

There is also substantial evidence that attachment trauma influences the development of brain structures, the functioning of the ANS as well as emotional regulation. (Siegel, 2003; Putnam,1997; Schore 2003a, 2003b; Cicchetti & White, 1990; Herman 2010).

Current treatments to trauma recognise the need to help improve affect regulation and for the client to develop self-awareness skills, including being able to distinguish between body sensations, emotions and thinking. (Van der Kolk

2001, 2003; Rothschild 2000, 2010; Ogden 2000, 2006). Phenomenological and mindfulness processes are recognised as beneficial for the development of awareness skills and improved affect regulation.

The integration of mindfulness or phenomenological methods requires specific skills in the therapist such as paying attention to their own embodied perception or somatic transference, being able to monitor the client's arousal levels and having the appropriate skills to help the client process any overwhelming emotions or memories that might surface. I would argue that mindfulness traditions in particular have a lot to offer in developing the openness, attunement and awareness that therapists need to work with these conditions.

Chapter 3: Exploration of clinical applications of mindfulness and phenomenological enquiry processes in 1-1 psychotherapy - in particular in relation to complex trauma conditions, shame and dissociation.

The third chapter follows three lines of enquiry. Firstly it looks at mindfulness as a key resource for the psychotherapist. The facilitation of phenomenological enquiry process in 1-1 psychotherapy is challenging and relies on the therapist's capacity to pay attention to the unfolding processes at various levels simultaneously - the therapist's own inner processes including counter-transference, the client's non-verbal and verbal expressions and communication and what emerges in the intra-personal or relational field.

Mindfulness traditions offer grounded guidance and practices to help engage with these processes and support the therapist's intention and skills. (Williams, Teasdale et al 2007; Germer 2005a, 2005b; Shapiro & Carlson 2010; Siegel 2010a).

In this chapter I focus on how a therapist's mindfulness skills can significantly support their phenomenological work - especially in relation to attuned attention, empathic presence and security which are all qualities that are needed for the client to feel safe enough in order to engage with previously avoided or dissociated aspects of their inner world.

I also focus on the phenomena of the therapeutic relationship itself. The links between complex trauma and insecure or disorganized attachment scenarios have led to a view that the therapeutic relationship is a prime catalyst for change. (The Boston Change Process Study Group, 2010). Schore (1994, 2003a, 2003b); Cozolino (2006) and others suggest that the deep qualities of empathic moment–by-moment attunement can influence information processing, implicit memory, affect regulation and neural circuits. This is especially relevant to non-verbal forms of communication and the sensitive balance between following and allowing the client's processes and engaging in a more directional manner. The question 'how to shift from a mindfulness stance to encouraging the client's own mindfulness processes and motivation for skills development' is of interest here and this chapter scans the literature for relevant theory, clinical reflections and illustrations that help bring these processes alive.

In addition this chapter draws on clinical work that includes mindfulness of the body and emotional processes. The sensorimotor psychotherapy approach (Ogden & Minton et.al. 2006) has been developed as a treatment for complex trauma and draws on mindfulness as a core intervention. Other trauma specialists such as Lord (2010, 2013), Fisher (2015), Rothschild (2000, 2010), also provide clinical vignettes that are helpful in illustrating how mindfulness or self-enquiry processes can be safely and effectively integrated within the therapeutic relationship. In addition there is also an example from my own clinical practice that illustrates the therapist's inner mindfulness processes and how this facilitates a deeper empathic attunement to the client.

Chapter 1: Investigation and clarification of the relevant philosophical and theoretical roots and perspectives of phenomenological and mindfulness traditions and how these have been adapted in psychotherapy

1.1 Overview

This first chapter will provide a brief overview of some of the core ideas in phenomenological and mindfulness traditions and how these have impacted on the development of experiential approaches in psychotherapy.

At the heart of this dissertation is the attempt to clarify enquiry processes and their relevance and benefits for the psychotherapeutic endeavor. The traditions of psychotherapy, phenomenology and mindfulness could all be described in essence as fields of enquiry into lived experience and there has indeed been much cross-fertilisation between these traditions especially in the last few decades. A paper like this can't possibly do justice to the complexity and depth of ideas, methods and insights each of these traditions represents. I have therefore chosen to focus on relevant aspects of these traditions that help clarify their contributions to our understanding of experiential methods applied in psychotherapy.

A brief resume of relevant ideas and concepts within the field of phenomenology will be provided followed by an introduction to four humanistic psychotherapy approaches that have actively incorporated phenomenology. This focus on humanistic approaches recognises the fact that the two other main psychotherapeutic traditions - psychoanalytic/psychodynamic and cognitive-behavioral approaches have remained closer to the positivistic, answer and method seeking science paradigms and are therefor less relevant for this discussion.

Finally this chapter will turn to Buddhist and mindfulness traditions and explore their influence on psychotherapy as well as discuss similarities between phenomenology, mindfulness and psychotherapy.

1.2 Mapping the mind - Paying attention to lived experience

The last century saw new formulations and ideas about the human mind, which formed the basis for the rapidly developing fields of psychology and psychotherapy.

A new science paradigm - phenomenology - had emerged towards the end of the 19th into the 20th century, which proposed a turning to the inner realms of the human mind and spirit, researching the 'lived experience' and exploring what it was like being human. At the same time psychology emerged as a new field through the work of people such as the philosopher and psychologist William James (1842-1910), the clinical psychologist Jean Piaget (1896 – 1980), who influenced our understanding of child development and learning, and of course the Psychoanalyst Sigmund Freud (1856 – 1939) who developed his map of the unconscious (Storr 1989).

These new psychological perspectives and theories were doubtlessly inspired and underpinned by the phenomenological philosophies that had begun to emerge in the middle of the 19th century.

Earlier philosophers such as Soren Kierkegaard (1813 – 1855) and Friedrich Nietzsche (1844 – 1900) had begun to challenge the leading Christian and positivist science doctrines of their time. They argued that *" …the real goals of philosophy" were "self-knowledge and freedom". (Burston 2003, p 312).*

The philosopher Edmund Husserl (1859 – 1938) established his school of Phenomenology, developing a *'science of experience'* (Husserl 1931/2012; Spinelli 2005, p 31) or *'a science of how things appear'* (Van Deurzen & Adams 2011, p 13).

Husserl identified that consciousness is never separate from it's objects of attention and he saw enquiry as a process based on physical, emotional and personal as well as environmental and social aspects of experience. He developed the notion that it is our innate intention as a human being to *'make meaning'* of our experience and the world around us. (Joyce & Sills 2010, p. 18). Husserl also promoted the use of intuition as opposed to the rational or

logical methodologies applied and relied on by the positivist sciences. (Van Deurzen & Adams 2011, p13-14).

His ‘phenomenological method’ (Husserl 1931/2012), aimed to provide a tool to investigate how things appear and are experienced in the conscious mind. It applied three ‘rules’ or steps that needed to be followed:
‘The rule of Epoche’: which requires setting aside biases, expectations, assumptions and pre-formed ideas. This is also referred to as ‘bracketing’.
‘The rule of Description’: which requires a focus on immediate or concrete aspects of experience, rather than theorizing, speculating or explaining.
‘The rule of Horizontalisation’ (Equalization Rule): which avoids attaching specific significance or importance to what is being experienced. It aims to hold all aspects of description in equal measure and attach equal significance to it. (Spinelli 2005, p 19-21).

Building on Husserl’s ideas, Heidegger (1889 -1976) developed his Existential Phenomenology, which in turn strongly influenced the work of Sartre (1905 – 1980) who coined the term Existentialism, which subsequently had a major influence on the developing field of humanistic psychology. (Burston, 2003, Spinelli 2005).

Heidegger focused in particular on the question of ‘being in the world’ and highlighted the inter-subjective reality of human experience. He also believed in the human capacity for developing resolute awareness, and emphasized the importance of engaging with deeper and often existential forms of anxiety. (Heidegger 1953/2010; Van Deurzen & Adams 2011).

Merleau-Ponty (1908 –1961) also emphasized inter-subjectivity - going as far as proposing there was no real separation between the self and others, which interestingly is also a key Buddhist concept. He paid particular attention to the embodied aspects of experiencing. (Merleau-Ponty 2014; Van Deurzen & Adams 2011;Brazier 1991). For instance his notion of ‘pre-reflective communication’ sits especially well with the concept of unconscious processes and how these influence, or even determine, our inner as well as inter-relational reality.

At the same time as these phenomenological ideas and methods were emerging, Sigmund Freud (1856 – 1939) developed his psychoanalytic method, which became hugely influential throughout the twentieth century. His early clinical work with hysteria, illustrated for example in the famous case of Anna O. (Breuer& Freud 1974/1991, p. 73 -102), helped him make the link between suppressed memories and how these might surface at a somatic level and this led him to develop his three-tier model of the human mind: the conscious, pre-conscious and unconscious mind. (Freud 1941/2005). Famously he likened the mind to an iceberg, where the conscious mind is only the tip of the iceberg and the pre- and unconscious mind forms the large bulk that is not seen and lies underwater. His later structural model of the mind (or psyche), proposed the three tiers of the Id, which relates to human instincts and drives, especially sex and death drives; the ego which relates to pre-consciously held patterns of beliefs and behaviors that determine how we relate to the world and ourselves, and the super-ego which manifests moral beliefs and judgments. (Storr 1989).

Freud's school of psychoanalysis provided the inspiration for many who were to follow and his theories helped to shape and define processes of enquiry into the human experience and especially in the psychological professions.

In summary it is fair to say that all the above philosophical ideas helped to define the study of human experience and shaped a new phenomenological research paradigm that influenced our perspectives and understanding and became applied in many areas of life and science. These ideas were prevalent also in shaping the psychological professions. They identified obstacles to an objective investigation into human consciousness, such as how to differentiate between object and observer (i.e. Husserl), they recognised that deeper human existential anxieties give rise to self-concepts and patterns of perception (i.e. Heidegger, Sartre) and they proposed that in order to observe or enquire into human nature and the processes of the mind we would need to include embodied and felt phenomena (i.e. Merleau-Ponty, Freud).

1.3 Phenomenology applied in psychotherapy

With these foundations in mind we might agree that psychotherapy with it's focus on pre - and unconscious processes, can also be described as an enquiry into the 'lived experience' - and in this next section I will look briefly at four Humanistic psychotherapy schools that illustrate how phenomenological ideas and principles have been integrated into psychotherapy today: Focusing Psychotherapy, Existential Therapy, Person-Centered Therapy and Gestalt Therapy.

1.3.1 Focusing Psychotherapy

Gendlin (1978/1981) developed his Focusing approach after undertaking extensive phenomenological research into the effectiveness of psychotherapy. He wanted to understand which clients benefitted from psychotherapy and identified that in order for an individual to engage positively with therapy, they needed a capacity for being curios about their own inner experiences. He argued that this inner focus, this openness to engage with an inner enquiry process, was the determining factors for therapeutic outcome. In fact he was quite outspoken about the type of client who in his opinion would not benefit from therapeutic interventions when he wrote:

> *"If they did not somehow know right from the start how to approach themselves inside in that special way, they did not achieve major changes, no matter what they or their therapist did or how earnestly or how long." (Gendlin 1978/1981, p. 5).*

He also observed that this inner focus would need to include or even be based on somatic levels of experience and consequently developed his Focusing approach. The approach deliberately directs attention to the embodied experience, thus aiming to by-pass preconceptions and thinking. It is present-centered and promotes attitudes of openness and curiosity.

This is well summarized by Doralee Grindler Katona:

> *"The focusing-oriented approach…to psychotherapy is an embodied contemplative practice that posits a living body that is an undivided*

whole that knows what is needed next for development. This 'living body' approach draws upon mindfulness, neurobiology, relational connection, and spiritual potential as unified process." (Grindler Katona 2015, p. 157).

A core aim in the approach is to try to connect to the 'felt sense' (Gendlin 1981, 1996). In Gendlin's words:

"The felt sense is a bodily sensation, but it is not merely a physical sensation like a tickle or a pain. Rather, it is a physical sense of something, of meaning, of implicit intricacy. It is a sense of a whole situation or problem or concern, or perhaps a point one wants to convey. It is not just a bodily sense but rather a bodily sense of…" (Gendlin 1996, p 63).

Focusing is probably one of the most directly defined phenomenological enquiry processes in clinical practice. It offers clear practical steps and guidance to attune to our innermost experiences and can be used as a vital resource by client and therapist alike. (Sharma 2011; Gendlin 1996)

1.3.2 Existential Therapy

Existential psychotherapy can be describes as a philosophical method of therapy that operates on the belief that inner conflict within a person is due to that individual's confrontation with the givens of existence. (Spinelli 2006, p 3). It was originally developed by Rollo May (1958/2004; 1999), who had been strongly influenced by Tillich (1878 – 1965) as well as Buber (1886 – 1965). The tradition also draws on the works of Heidegger, Sartre and earlier philosophers such as Kiekegaard (1813-1855) and Nietsche (1844-1900). (Spinelli 2005, 2006; Van Deurzen 2011).

One of the leading voices in the Existential Therapy community has been Irvin Yalom, who argued that psychological problems could be linked back to four essential themes: death, freedom (and responsibility), isolation and meaninglessness. (Yalom 1980).

Existential Therapy has adapted Husserl's phenomenological method within the clinical context to include four steps: '*Attention'*: learning how to pay attention in a sustained way, a quality of 'just attending' rather than going into 'thinking about'. This includes processes of noticing, observing, describing. '*Epoche'*: becoming aware of the thought processes and assumptions we hold about the object of our attention. '*Verification'*: interpretation and rigorous checking that our observations are correct. Importantly this requires a certain level of intuition. *'Becoming aware of assumptions'*: awareness of the lenses through which we view experience or objects. This also includes awareness of our habitual distortions. (Van Deurzen and Adams 2011, p 43).

All the above rules seem of prime importance for the psychotherapeutic encounter. They offer guidelines to therapeutic attention and challenge the therapist to keep monitoring their own mental processes, interpretations and judgments. Importantly they can be linked back to the ideas of phenomenologists such as Husserl and his 'phenomenological method'.

In summary it is true to say that Existential therapy processes aim at cultivating phenomenological and self-enquiry processes, utilising the therapeutic environment and relationship to expand awareness of how we experience things. As with Gendlin's Focusing approach, we are also beginning to see distinct similarities between mindfulness and phenomenological enquiry practices. (Burston 2003; Aich 2013; Felder, Aten et al. 2014).

1.3.3 Person-Centered Therapy

Another humanistic psychotherapy tradition that has its roots in phenomenology is the Person-Centered Approach developed by Carl Rogers (Rogers 1951/2003; Geller 2003; Bazzano 2011).

Rogers (1961) highlighted the importance of the therapeutic relationship and in particular the therapist's attitudes and qualities. He originally identified three basic therapeutic attitudes or conditions: *'congruence, authenticity and transparency'.* (Lietaer 1993, p19).

These have been adapted and extended over the years and now include

six conditions for a beneficial therapeutic encounter: there has to be a meeting of two individuals; the therapist needs to be fully present for the client; and needs to have awareness of the inter-relational field, also referred to as 'organismic experiencing' i.e. being embodied and perceptive of non-verbal processes (Rogers 1961, p 111); the therapist needs to feel and express unconditional positive regard; to be deeply empathically attuned; and be able to maintain congruent communication. (Rogers 1961, Bazzano 2011, p 120).

Rogers was strongly influenced by Heidegger's existential phenomenology, but perhaps more importantly, he was deeply inspired by the philosopher and religious thinker Martin Buber. Buber's dialogical method and the concept of the I-Thou relationship remain highly significant concepts in the person-centered approach. (Buber 1937/2013, 1967; Friedman 1994; Anderson & Cissna 1997)).

The key themes that person-centered therapists have adapted into their clinical work as a direct result of this include that the psychotherapeutic process is seen as an active enquiry into the lived experience of both client and therapist. It is intra-personal as well as inter-subjective and requires a deep capacity for paying attention in an open and unbiased way, especially within the therapist as s/he holds the focus and orientation of the process. It is embodied and empathic as well as intuitive and happens in the present moment. (Brazier, ed. 1993; Embleton-Tudor, Keemar et al. 2004)

Again it is striking how just as in mindfulness there is the intention to focus on the present moment, to pay attention in an unbiased or accepting way and to include somatic and felt aspects of experiencing.

1.3.4 Gestalt Therapy

Another psychotherapy tradition that has been integrating phenomenology into its theory and practice is Gestalt Therapy, which was developed by Fritz and Laura Perls together with Paul Goodman. It drew on Husserl, Heidegger, Kierkegaard, Tillich and Buber as well as being strongly influenced by Zen Buddhism and Taoism. (Perls, Heiferline and Goodman 1951/ 1984; Clarkson & Mackewn 1993).

The word Gestalt comes from the German and is defined as follows:
" A gestalt is a pattern, a configuration, the particular form of organization of the individual parts that go into its make up." (Perls, Heiferline et al. 1951/ 1984, p3).

In clinical practice Gestalt therapy explicitly uses a phenomenological approach to investigate these 'forms of organization of individual parts' in order to help facilitate processes of change. Husserl's three rules of phenomenological enquiry have been integrated into Gestalt practice and Joyce &Sills point to a *"…fourth element – active curiosity …" (Joyce &Sills 2010, p 18)* as essential to this process. They also write: *"A crucial phenomenological perspective is that people are always actively making meaning of their world (called intentionality) and therefore the client is always an active participant in what he is experiencing and how he is experiencing it…"* (Joyce &Sills 2010, p 18*).*

And Crocker writes:

> *"The phenomenological method in Gestalt therapy involves a process that seeks to discover how the client's beliefs, and her understanding of the events and persons in her life, function in the client's own organisation of experience, and therefore how they function as the ground of her cognitive, emotional, and behavioral responses to current and ongoing situations."* (Crocker 2005, p 69).

Gestalt puts much emphasis on designing or co-creating experiments and exploration to help engage the client in the enquiry process and Perls describes an '*awareness experiment'* where the client was asked to: *" …attend mainly to external events – sights, sounds, smells – but without suppressing other experiences. Then…concentrate on internal processes – images, physical sensations, muscular tensions, emotions, thinking…"*
(Perls, Hefferline et al. 1951/1989, p 84).

Experiments in Gestalt aim to help the client differentiate between embodied, emotional and cognitive experiences. Experiments and other interactive psychotherapeutic processes in Gestalt emphasise the need to keep present-

centered and use the therapeutic encounter to be in the here-and-now. (Perls 1947/1969; 1973; Afghan & Shepherd eds. 1973)

Gestalt also puts emphasis on the attitude that the therapist and client bring to these enquiry processes, referred to by Naranjo as 'moral injunctions'. He writes:

> *"1. Live now. Be concerned with the present rather than with past or future.*
> *2. Live here. Deal with what is present rather than with what is absent.*
> *3. Stop imagining. Experience the real.*
> *4. Stop unnecessary thinking. Rather taste and see.....*
> *5. Take full responsibility for your actions, feelings, and thoughts.*
> *6. Surrender to being as you are."* (Naranjo 1973, p 67).

To summarise, the above approaches not only integrate phenomenological enquiry processes but also put much emphasis on the moral and empathic attitudes and qualities the therapist needs to embody. Apart from this there is a distinct focus on paying attention to the manifestations of the lived experience as it is happening, in other words these experiential traditions emphasise the importance of working in the present moment. Again it is noteworthy how much humanistic experiential practices have in common with mindfulness approaches.

1.4 Mindfulness and psychotherapy

Mindfulness is a core practice of the Buddhist traditions, so before we discuss mindfulness and it's application in psychotherapy, it is important to say a few words about Buddhism and it's influence on Western psychotherapy traditions. Buddhism dates back 2500 years and apart from being a religion, could also be described as one of the first in-depth phenomenological philosophy and enquiry traditions. (Batchelor 1998). In the West, Buddhism has had a major influence on the field of psychotherapy especially in the second half of last century when the increased freedom to travel led to an influx of Buddhist teachers in the West.

Leading figures in the psychotherapy traditions such as Jung (Campbell ed. 1976), Fromm (1993) Horney (Morvay 1999), Buber (1967, 2013); Maslow (1971/1993); Gendlin (1981,1996); Rogers (1951/2003); Perls (1947/1969; 1973) and Perls, Hefferline et. al. (1969, 1989) incorporated Eastern philosophies such as Zen Buddhism and Tao in their approaches and there has been an ongoing and fruitful dialogue between Buddhism and Psychoanalysis/psychotherapy. (Molino 1998; Saffran 2003).

Dryden & Still (2006) also argue that Buddhist philosophy has had a particularly strong influence on the field of Humanistic Psychology, helping it to counter-balance the more reductionist psychoanalytic and behavioral schools of psychotherapy. They write: *" Instead of attacking symptoms as essentially negative and undesirable, the emphasis is on nonjudgmental acceptance of symptoms, and a focus on more positive alternatives. "* (Dryden &Still 2006, p7).

Phenomenological and Buddhist philosophy seem to explore very similar themes and questions. The phenomenological nature of Buddhist philosophy is articulated by Olendzki when he writes:

> *"The matter of most immediate concern for the Buddha …was the field of experiential human phenomenology. He put the doctrine of interdependent origination to work to understand and transform his understanding of four major themes; mind and body, the self, suffering, and liberation."* (Olendzki 2010, p. 110).

However, the central tenet of all Buddhist traditions is meditation practice – the in-depth investigation into the nature of the mind which aims to help people become more skilled at transcending it's habitual perceptions and processes. And in this context mindfulness, which lies at the heart of Buddhist practice, offers a wealth of understanding and instruction. This makes it especially useful for psychotherapy.

1.4.1 Secular mindfulness in psychotherapy

The Buddhist tradition of mindfulness has been increasingly adapted into western mindsets and has over recent years become especially popular with therapists and health practitioners.

Secular mindfulness practices were pioneered by Jon Kabat-Zinn (1990, 2003, 2005), who developed his Mindfulness-Based Stress Reduction (MBSR) program drawing on various Eastern traditions such as Yoga and meditation and combining this with western stress management techniques. His eight-week group program identified clear practice elements, which made it possible for outcomes and benefits to be measured and researched. (Baer 2003, 2014; Dryden 2006).

His work inspired the development of other group programs such as Mindfulness-based Cognitive Therapy (MBCT) an alternative treatment for depression developed by Segal, Williams and Teasdale (2002);
Dialectic Behavior Therapy (DBT) developed by Linehan (1993a, 1993b) as a treatment for borderline personality disorder; and Acceptance and Commitment Therapy (ACT), developed by Hayes and Strosahl et al. (1999). DBT and ACT both emphasise acceptance as a core practice element in their approaches. And Linehan distinguishes between 'emotional mind', reasonable mind' and 'wise mind' to facilitate awareness and integration. (Linehan 1993a, 1993b).

The term mindfulness is a translation of *"…the Pali words sati and sampajana which as a whole can be translated as awareness, circumspection, discernment, and retention…"* (Shapiro & Carlson 2010, p4).

Gunaratana (2002) defines the word Sati simply as an activity whereas Germer proposes it *"…connotes awareness, attention, and remembering."* (author's italics) (Germer 2005, p 5).

But it is Jon Kabat-Zinn's definition that offers a clear practical sense of what mindfulness means: *"Mindfulness can be thought of as moment-to-moment, non-judgmental awareness, cultivated by paying attention in a specific way, that*

is, in the present moment, and as non-reactively, as non-judgmentally, and as openheartedly as possible." (Kabat-Zinn, 2005, p.108).

Shapiro and Carlson point to there being a difference between mindfulness as a mental state and an active practice when they write:

> *"…(a) mindful awareness: an abiding presence or awareness, a deep knowing that manifests as freedom of mind (e.g., freedom from reflexive conditioning and delusion) and (b) mindful practice: the systematic practice of intentionally attending in an open, caring, and discerning way, which involves both knowing and shaping the mind*." (Shapiro & Carlson 2010, p 4).

In essence it is fair to say that the practice of mindfulness offers a structured skills training for the mind (Shapiro, Carlson et al. 2006). It pauses the flow of habitual mind activity for example by focusing our attention instead on a specific facet of our experience such as the breath. This focus then becomes the vantage point to which we can return our attention again and again as well as providing us with an anchor point from which we can gain clearer perspectives on our unfolding inner experience. As Wellings put it:

> *"The basic idea is that when we concentrate gently and patiently upon one thing the mind becomes still and pleasurably calm. Once the mind has acquired this skill it can then be used to look deeply into the mind itself and this will give insight into how things really are…"* (Wellings 2015, p. 16).

But it is not just focus and attention that is being practiced in mindfulness; it is also our attitudes or intentions such as open mindedness, non-judgment and beginners mind. (Kabat-Zinn 1990, 2005; Germer, Siegel et al. 2005; Germer 2005 a, 2005b, 2009; Weiss 2008). This is especially relevant for psychotherapists who are interested in helping their clients both to reflect on their experience and interrupt unhealthy patterns of behavior and thinking (Germer 2005 a, 2005b; Lord 2010; Harris 2013). This has proven to be especially effective for example in the prevention of depression, the treatment

of anxiety or to help reduce chronic pain (Williams, Teasdale et al. 2007; Burch 2008; Orsillo & Roemer 2011).

Mindfulness therefore is increasingly relevant and provides a bridge between Buddhism and psychotherapy but it is also noteworthy that it correlates with Husserl's phenomenological method and his three rules. As we saw earlier, 'bracketing', is the practice of setting aside biases, expectations, assumptions and pre-formed ideas. 'Description' focuses on immediate or concrete aspects of experience, rather than theorising, speculating or explaining. And 'horizontalisation' holds all aspects of description in equal measure and attaches equal significance to it.

To clarify this further let's just consider some core elements of mindfulness practice. As a meditator we try as best we can to settle our mind, to let go of expectations, to create an open mindscape from which we can observe the arising of phenomena such as sensations, feelings or thoughts. We practice in the here and now, simply noticing without getting caught in distraction or reaction. We practice acceptance of whatever it is that arises in the field of awareness. Again it seems striking how similar this process is, both in intention and practice, to phenomenological philosophy and method.

Germer is helpful in describing some clear similarities between mindfulness and psychotherapy: *"They are both introspective ventures, they assume that awareness and acceptance precede change, and they both recognize the importance of unconscious process."* (Germer 2005a, p. 21)

And Bion writes: *"…psychotherapy is a kind of mindfulness practice, a willingness to accept the truth of one's own experiencing."* (Bion 2004, p. 496)

Mindfulness and experiential psychotherapy practices also share an orientation towards the present moment and the intent to develop attitudes of tolerance and inclusion as well as qualities of openness, curiosity and empathy. The humanistic traditions in particular have held strong to the belief that this deepening of awareness will bring greater acceptance, release a person's inner

potential and allow greater integration. (Maslow 1971/1993; Rogers 1951/2003; Kurz 1990/2005).

Mindfulness skills within a therapeutic context are also relevant for working with non-verbal, embodied and sub-conscious elements of experience and can help the therapist and client create a safe and compassionate environment that will allow the client to focus on previously rejected or suppressed aspects of their internal experience. (Germer 2005; Shapiro, Carlson et.al. 2006; Siegel 2010).

In addition to the above both meditation and psychotherapy traditions have written about forms of resistance, avoidance or miscomprehension that can arise when we are trying to practice mindfulness or self-enquiry. (Smith 2010; Taylor 2014; Shapiro & Carlson 2010; Segal, Williams et.al. 2002).

1.5 Concluding thoughts

Mindfulness and its integration into psychotherapy is evolving quickly. Research into areas such as affective neuroscience, attachment and trauma are consistently reshaping our understanding of the psychological dilemmas that clients bring to therapy. (Schore 1994, 2003a, 2003b; Saffran & Muran 2000; Ogden & Fisher 2015). And while this understanding is in itself very revealing it leaves therapists grappling with the challenge as to how self enquiry processes can benefit those very clients who are most resistant to paying attention to those inner processes of experiencing which they find painful, distressing or disorientating.

I would argue that mindfulness traditions encompass a wealth of practical instructions and guidance, which can make the application and integration of mindfulness practices in psychotherapy very effective. However, the motivation for mindfulness practice is deeply personal and can’t be enforced. And the complexity of our resistance to these inner processes has been studied and explored throughout the history of Buddhism. (Smith 2010; Nairn 2001; Mathers, Melvin et al. eds. 2009; Adyashanty 2011).

On the other hand phenomenological methods with their focus on description of experience do not rely entirely on an inward focus, they explore more

specifically the phenomena of whatever is being experienced rather than the mind itself. This includes the therapeutic relationship and might therefore make it a slightly more versatile method when working with deep resistances to self-enquiry. Within the context of individual psychotherapy a flexible engagement with both mindfulness and phenomenological practices might be advisable.

Chapter 2: Discussion of current models of trauma - in particular complex trauma and how this might enhance our understanding of resistance to self-enquiry

2.1 Overview

Trauma involves complex neuro-biological processes that don't just determine how we regulate affect and emotions, but also influence how we process information and engage in relationships. This is being supported by a wealth of research into the subject since the 1980s. Apart from involving a breadth of research traditions, trauma has also attracted interest from all the major psychotherapy approaches. One might even argue that it has become a unifying field in the psychotherapy profession.

In this chapter I will briefly review the most prominent ideas and trends for understanding and treating trauma conditions. As my focus in this dissertation is on how we might understand the difficulties some clients face in relation to self-reflective and self-enquiry processes, I have chosen to focus on:

a) information processing, in particular dissociative processes;
b) the effects of trauma on the body, in particular affect regulation;
c) relational or attachment trauma.

All three factors, I would argue, can significantly undermine our sense of self and limit our capacity to pay attention to what we are experiencing in an open and curious way. Raising awareness of these processes through the lens of trauma research can be helpful not only for the therapist but also for the client as it can provide a supportive context to their individual experiences. I have therefore chosen trauma as my central model to explain resistance to self-enquiry.

2.2 Defining Trauma

Early definitions of trauma were based on seeing trauma symptoms as abnormal and trauma was treated as a psychiatric illness. (Van der Kolk,

Weisaeth et. al., 2007). But from the the 1980s our understanding of trauma advanced. The pressure to develop new treatments for the high number of Vietnam veterans that presented with post- traumatic stress disorder (PTSD) led to increased research into this subject. This was also supported by the developing field of neuroscience, which provided insights into the workings of the brain and highlighted that our brains, emotions and biological systems are 'wired' together and represent a complex system for processing traumatic stress. (Siegel 1999; Damasio 1996, 2000; LeDoux 1999).

However, it was not only the interest in understanding the effects of war and disaster that brought trauma to the foreground. It soon became clear that trauma is often rooted in earlier experiences related to our childhood. Judith Herman's research established a link between Borderline Personality Disorder (BPD) and childhood abuse. (Herman 1992/2010). And Helen Bass and Laura Davis's feminist angle on investigating the effects of sexual abuse, identified that trauma was not just related to adult life experiences but could often be related back to early developmental circumstances that had impacted negatively on the individual's development. (Bass & Davis 1988/2008).

The development of ever more sophisticated brain scans and other technologies also highlighted that the neurobiology of stress and the processing of emotions are determining factors in trauma. The psychiatric researcher Bessel Van der Kolk brought neuroscience insights to trauma treatment, paying particular attention to somatic phenomena especially in relation to autonomic arousal and intrusive emotions. He also took an active interest in the non-verbal dimensions of trauma and how memories are not just stored in the brain, but importantly also in the body. (Van der Kolk, McFarlane et al. 2007; Van der Kolk 2014).

In short trauma began to be understood as a person's reduced capacity to effectively process stressful events or overwhelming and painful experiences. Usually trauma resolves over time; however, when the impact of certain events is too severe or overwhelming then the return to normality is prohibited and this leads to the development of post-traumatic stress disorder (PTSD). (Levine

1997; Rothschild 2000; Van der Kolk 2003; Folette & Palm et.al. 2006; Chu 2011).

Individuals suffering from such unresolved trauma or PTSD will be under the influence of complex neurobiological, emotional and mental processes that can be highly restrictive, overwhelming and disorienting. This includes emotional dysregulation and impacts on our behavior, memories and social engagement systems. It can also lead to severely disorganized mental processes and dissociation. (Lanius & Blum et al. 2011, pp 333-334).

At the extreme end of the scale we can also expect complex trauma conditions such as Disorders of Extreme Stress (DESNOS), or dissociative disorders such as borderline personality disorder (BPD) and dissociative identity disorder (DID). (Siegel 2003; Herman 2010; Chu 2011).

Below I am now going to look at dissociation, affect regulation and attachment in order to help map the current territory of trauma theory and how trauma in its various forms can block a client's capacity for self-enquiry. I will refer to trauma conditions in general as complex PTSD to include early developmental factors.

2.3 Dissociation

A core process that therapists might encounter when working with traumatised clients is dissociation. In essence this can be viewed as a strategy of protection to help manage experiences that are too overwhelming or painful. (Chu 2011; Ogden & Mintel 2006; Van der Hart & Nijenhuis et al, 2006; Van der Hart & Steele 1997). Dissociation can thus be seen as an attempt to minimise, compartmentalise or control the impact of highly distressing experiences. (Van der Hart 1997; Van der Kolk 2007, 2014; Fisher 2015). This is however a risky strategy as it can develop into complex PTSD, dissociative disorders such as borderline personality disorder (BPD) or dissociative identity disorder (DID). (Siegel 2003; Herman 2010; Chu 2011).

Michel & Bentel et.al (2007) make a link between complex PTSD and depersonalization (DP) and define DP more specifically as an ego defense in relation to shame. DP, in their view, functions as an attempt to keep the

experiencing self separate from the observing function of the self. (Michel & Bentel et.al. 2007, p 694).

Another downside to these dissociative mechanisms is the way in which they undermine people's ability to process information in everyday life. This is summarised by van der Kolk & Van der Hart et al. (2007) when they write:

> *"Three critical problems affect information processing in people who suffer from PTSD. First they over-interpret current stimulus as reminders of the trauma; …Second, they suffer from generalized hyper arousal and difficulty distinguishing between what is relevant and what is not….Third, after dissociating at the moment of the trauma, many traumatized individuals continue to use dissociation as a way of dealing with both the trauma-related intrusions and with ongoing stressful life experiences."* (Van der Kolk & Van der Hart et al 2007, p. 305).

We can see dissociative processes that we might encounter in the therapy room as indicators of complex PTSD. This might manifest in the guise of negative self-beliefs, self-destructive or self-harming behaviors, drug abuse or eating disorders as well as in somatisation and amnesia. Dissociative internal patterns are also likely to undermine the client's ability to engage in healthy intimate relationships. Van der Kolk (2001) provides a good overview of these conditions as well as reviewing the treatment approaches.

2.4 Affect Regulation

Psychotherapists working with trauma have also benefitted from extensive research into the workings of the brain and emotions. Advances in technology have meant that we are able to study the workings of the brain and the body in far more depth and findings from neuroscience and neurobiology as well as research into affect regulation have been integrated into trauma theories and have led to the development of new treatment approaches in psychotherapy. (Panksepp 1989; Schore 1994, 2003a, 2003b; Siegel 1999, 2003; Damasio 1996, 2000; LeDoux 1999; Cozolino 2006).

One of the most important insights coming from contemporary trauma research is that trauma is closely linked to high levels of stress and therefore represents a compromised capacity for affect-regulation. Trauma could simply be defined as a chronically activated stress response or as Ogden, Mindel et.al. put it: *"Unresolved survival-related action tendencies include not only chronic postural and movement patterns related to defense, but also the rapid mobilization of the autonomic nervous system in response to trauma related stimuli."* (Ogden, Mindell et al. 2006, p26).

Another insight is that trauma memories are stored implicitly in the body. This relates to our evolutionary bias towards survival and trauma memories are stored at a neuro-biological level to allow for a quick activation of the threat response when trauma related signals are being picked up. Another survival strategy is to store memories in the unconscious or pre-conscious realms, so that despite processes of dissociation the body's alert systems can still 'sense' real or perceived danger. (Chicchetti & White 1990; Levine 1997; Siegel 1999; Rothschild 2000; Fisher 2014).

This is well summarised by Fisher (2003) when she writes:

> *"If traumatic events have been recurrent…we can be left with a host of 'implicit' memories, intense responses and symptoms that 'tell the story' but without words and without the knowledge that we are remembering…Worse yet, if the environment is chronically traumatizing, as are most childhood traumatic environments, the survival response system will become chronically activated, resulting in long-term effects on the developing brain and body".* (Fisher, 2003 p.2).

Contemporary trauma treatment approaches such as Somatic Experiencing (Levine 1997, 2008, 2010) and the Sensori Motor Approach (Ogden & Minton 2000; Ogden & Minton et al. 2006) as well as Eye Movement Desensitization and Reprocessing (EMDR), (Shapiro 1998, 2005) have aimed at developing therapeutic methods for working directly with these implicit memory processes, utilising neurobiological resources in order to help process trauma memories.

2.4.1 'Top-down' and 'bottom-up' modes of trauma processing

We can distinguish here between 'top-down' and 'bottom-up' modes of trauma processing and Fosha makes the point that this can be be done experientially within the safety of the therapeutic relationship. (Fosha 2003, p 229).

In essence top down processes refer to our ability to observe or monitor our experience by noticing and observing body sensations and learning to differentiate between sensations, thoughts and feelings. Bottom up processes refer to tapping into and improving the regulatory functions of our innate biological systems such as the ANS, movements, including micro- movements and breathing. (Ogden and Fisher 2015, p 182-183)

Van der Kolk (2014) points out that we can influence the activities of our threat detection system via the medial prefrontal cortex (top down) or the reptilian brain (bottom up). He writes:

> *"Knowing the difference between top down and bottom up regulation is central for understanding and treating traumatic stress. Top-down regulation involves strengthening the capacity of the watchtower to monitor your body sensations. Mindfulness meditation and yoga can help with this. Bottom-up regulation involves recalibrating the autonomic nervous system…We can access the ANS through breath, movement or touch."* (Van der Kolk 2014, p65-66).

Note that Van der Kolk points here to enhancing the individual's capacity for self-awareness and self-regulation through practices such as breathing, Yoga and mindfulness. The therapeutic relationship can help set these processes in motion yet there is also a degree of self-motivation required which would enable the client to cultivate this in their everyday life.

I would argue that top down processes may also include introducing empathic rationales and models that help put trauma experience and what might be done about it into context. This is especially relevant for clients with complex trauma who often struggle with deep shame issues and harsh self-criticism. Top-down approaches can also form a vital building block for a trusting therapeutic

alliance. It is crucial to have established a trusting and safe therapeutic environment when we are introducing and working with 'bottom-up processes in psychotherapy as these often tap right into existing high levels of affect dysregulation. A good example of this is that working with the breath can be highly challenging for many clients with complex trauma. Rather than being a resource, the breath is linked to traumatic and implicit memories and can re-activate defensive trauma mechanisms. Pacing, truncating and establishing a shared understanding of how to monitor autonomic arousal levels and put on the brakes are all vital conditions that make bottom up processing of trauma safe. (Safran & Muran 2000; Aposhyan 2004; Rothschild 2010).

However, increasing the client's tolerance for bottom up processes is vital for improving affect regulation and the processing of traumatic memories. It allows an experience of ease and connection and helps us feel more attuned to our senses and a more balanced innate inner sense of being. (Siegel 2007, p. 137-139).

2.4.2 Window of tolerance

Another model that is used to help improve affect regulation in trauma is the window of tolerance, which was first coined by Daniel Siegel (1999, 2010b) and then adapted for the sensorimotor approach to trauma by Pat Ogden. (Ogden & Mintel et.al. 2006).

Siegel described the 'window of tolerance' as

> *"….a band of arousal in which we function well. Outside the window we become dysfunctional. We move to the edge of the window on one end and we've come closer to chaos; at the other edge we are nearing rigidity."* (Siegel 2010 a, p 50).

To generalise, in trauma autonomic dis-regulation represents an over reliance on either the sympathetic or parasympathetic branch of the ANS. The 'window of tolerance' suggests that in trauma our tolerance levels for dealing with stress are reduced and our tolerance for processing stress is too limited or narrow. This leads to either hyper arousal (sympathetic branch of the autonomic

nervous system (ANS) or hypo arousal (parasympathetic branch of the ANS). To go back to Ogden, Mindel et.al.:

> *" When hyperaroused, clients experience too much arousal to process information effectively and are tormented by intrusive images, affects, and body sensations. But when hypoaroused, clients suffer another kind of torment stemming from a dearth of emotion and sensation – a numbing, a sense of deadness or emptiness, passivity, possibly paralysis…In both cases…meaning making becomes biased by the perceived danger signals."* (Ogden, Minton et al. 2006, p26).

Sensorimotor psychotherapists will use the 'window of tolerance' model as a map to help explain how trauma impacts on our capacity for affect regulation. They also use it to help the client pay attention to somatic experience and to help improve affect- and self- regulation. (Ogden & Minton 2000; Ogden, Minton et al. 2006; Ogden & Fisher 2015).

This emphasis on aiding affect regulation and widening the window of tolerance addresses the fact that in a state of a hyper or hypo arousal, our capacity to pay attention and reflect on our experience is highly limited.

2.4.3 The ANS and polyvagal operation – central to affect regulation

Another scientist who has been influencing current trauma thinking is Stephen Porges (Porges 2011). He, controversially at first, identified the vagus nerve as central to emotional regulation and developed his Polyvagal theory of autonomic nervous system regulation. He linked polyvagal operation to the parasympathetic and sympathetic parts of the ANS - *immobilization* - high parasympathetic activity, extremely slow metabolic state; *fight or flight* -high sympathetic arousal, accelerated high metabolic state. And thirdly he argued that the cranial nerves also control bonding and engaging behaviors that are crucial for our survival, so the third tier of polyvalgal operation is the *Social engagement system.*

He is one of a growing number of scientists who view the nervous system as central not just to how we orient within our physical but also in our relational,

inter-personal environments. He coined the term *Neuroception* which refers the processing of information via both the nervous system and through our senses. (Porges 2011, p11)

In summary it is true to say that current treatments to trauma recognise the need to improve affect regulation. This is achieved by helping the client to develop self-awareness skills, including being able to distinguish between body sensations, emotions and thinking. (Rothschild 2000, 2010; Van der Kolk 2001, 2003; Ogden & Mintel 2006; Ogden & Fisher 2015).

Experiential therapies which engage either or both phenomenological and mindfulness processes are being adapted within this context and are seen to help improve awareness skills as well as affect regulation and over all can lead to a more integrated sense of self. (Geller 2003; Grossman 2011; Follette, Briere et.al. 2015).

2.5 Attachment

Complex trauma conditions such as somatization disorders, clinical depression, or dissociative disorders have been linked to early attachment scenarios where the needs of the child for a secure attachment were not met sufficiently or may even have been violated. The quality of our early care-giving environment has been recognised as pivotal for a healthy emotional development and necessary for the development of a secure enough or integrated sense of self. (Putnam 1997; Siegel 1999, 2003; Schore 1994, 2003a, 2003b; Gerhard 2004).

Attachment, in other words, is vital for our survival. For the first years of our lives we depend utterly on others to take care of us. This does not just relate to our physical needs being met, but importantly is relevant to how we learn to be in relationship with others and how we develop a sense of who we are in those early years. Emotional processes are closely linked to help us navigate these early attachment environments. (Ainsworth &Bell 1969, 1970; Bowlby 1997; Klein 1987/1997; Stern 1998).

As Van der Kolk & Weisaeth et.al. put it: *“The capacity to regulate internal states and behavioral responses to external stress defines both one’s core*

concept of oneself and one's attitude towards one's surroundings." (Van der Kolk & Weisaeth et al. 2007, p. 64.)

Evidence that attachment trauma influences the development of brain structures, the functioning of the ANS as well as emotional regulation has built over the years, not just in relation to how we manage stress and regulate our emotions but importantly also in relation to our innermost identity and sense of self. (Siegel, 2003; Putnam,1997; Schore 2003a, 2003b; Cicchetti & White, 1990; Herman 2010). This is put well by Cozolina when he writes: *"…the self emerges from relationships."* And he continues:

> *" It is safe to assume that the self consists of many layers of neural processing that develop from the bottom up as we grow. The first system of internal body sensations are joined by sensory-motor systems, added to by emotional and cognitive processing, and later topped off with abstract ideas and beliefs. All these systems are woven together in the context of our relationships."* (Cozolino, 2006, p. 338).

2.5.1 Attachment Theory

Perhaps surprisingly the question of how attachment scenarios might shape the development of our personality and mind only began to take hold from the middle of last century. We can link attachment theory back to Bowlby (1997) who, as a child psychiatrist and analyst, became interested in how the care-giving environment impacts on a child's development. He sought to put psychoanalysis into a wider context by incorporating evolutionary theory and ethology. (Cassidy & Shaver (eds.) 2008).

Holmes defines attachment theory as an *"….evidence-based account of intimate relationships, charting the reciprocity upon which individual's survival, developmental progress and emotional flourishing depend."* (Holmes 2015, p 209).

Bowlby's close collaboration with the researcher Mary Ainsworth (1969, 1970) further defined and substantiated attachment theory. Ainsworth focused on researching the behavior of young children when they were separated from

their care-givers and put into ‘strange situations’. She also developed the adult attachment interview (AAI), which is widely used in clinical settings. Her research contributed significantly to mapping attachment styles or patterns, differentiating between secure, insecure organized and insecure disorganized patterns of attachment. (Cassidy & Shaver eds. 2008; Holmes 2015).

Cicchetti & White (1990), focused their research on children with abusive family backgrounds and found that these children tended to rely on active rather than reflective coping strategies and that they had a diminished capacity for mentalising and verbalising their feelings.

The difficulties of processing emotions within abusive or neglectful attachment environments are also observed by Lord when she writes: *”When there is trauma in parent – or caregiver – child relationships, the child’s capacity to tune in to others, be trusting of others, experience emotions in their bodies, regulate emotions, know or express what they feel, and have perspective about their situation and their emotions could be impaired.” (Lord 2013, p.1000).*

And Janina Fisher reflects on this from her clinical perspective of working with clients suffering from dissociative identity disorders (DID): *“Without interactive regulation from securely attached parents, small children must depend on their ability to alter consciousness when soothing is needed and the body’s innate ‘fault lines’ for compartmentalizing overwhelming experiences.”*
(Fisher 2015, p. 2).

This is also reflected on by Gerhard when she writes:

> "*Children who have developed insecure strategies for dealing with their emotions cannot tolerate feelings and so cannot reflect on them. Their emotional habits for managing feelings kick in too quickly. Avoidantly attached children are likely to automatically slam on their emotional brakes when strong feelings start to arise, so that they don't have to be aware of feelings they don't know what to do with*." (Gerhard, 2004, p.28-29).

2.5.2 Attachment and the therapeutic relationship

Within the therapeutic context, our understanding of how a client might have learnt to cope with these early impacts on their emotional development is paramount to the building of a safe base within the therapeutic relationship.

The relational analyst Allan Schore has written extensively on the importance of recognizing these patterns of affect regulation and how they might be addressed within the therapeutic relationship. He argues that:

> *"Affect, both its regulation and dysregulation, play a central role in the infant-caregiver and patient-therapist relationship. Affect dysregulation is associated with stresses within the therapeutic alliance, and therefore it is important to understand the etiology and operations of early-developing yet enduring defense mechanisms that are mobilized by relational stress."* (Schore 2003, p. 63).

In this context it is also important not only to aim at building a secure and empathic therapeutic alliance but also to be prepared to work with the manifestations of attachment disorganisation and distrust. These processes can be seen as elemental aspects of working therapeutically with complex trauma conditions. The client's habitual processes of affect dysregulation and the implicit insecure attachment patterns inevitably form part of the fabric of the therapeutic relationship. Therapist and client will have to learn to navigate rapture and repair cycles repeatedly and successfully in order for the client to internalise the experiences of a safe relationship.. (Safran & Muran 2000; Safran 2012).This was also highlighted by Dozier, Cue et.al (1994) in a study investigating the manifestations and impact of attachment dynamics on the therapeutic alliance.

It is generally understood, that the client needs to feel safe enough to enact some of these patterns within the therapeutic space so that they become more transparent and can be investigated and brought to awareness.

One important factor for this is the therapist's capacity to pay attention to and regulate their own emotional processes in relation to the client - also referred to

as somatic counter-transference. This process is illustrated by Wallin when he writes:

> *"Observing our own bodily experiences is no less important than observing the patient's. Because the brain's mirror neuron system ensures that we actually resonate automatically with our patients, our somatic states may well represent unconscious responses to the patient's non-verbal communication."* (Wallin 2007, p.296).

The therapist's capacity for this deep empathic attunement to the client's experience can help engage the client in processes of self-enquiry rather than repeating cycles of self-judgment, shame, dissociation or avoidance.

2.6 Concluding thoughts

In summary it seems indisputable that trauma conditions contribute significantly to the likely resistance or fear that patients will experience when faced with self-enquiry processes in psychotherapy. With this in mind I would argue that it is an essential requirement for therapists to have a broad perspective and skill level to work with these processes experientially and effectively. A key part of this must include their ability to assess a client's resistance to looking within from the different angles outlined above. Questions such as: is this client manifesting symptoms of complex PTSD, originating in early experiences; how is the client regulating affect; are they using dissociative strategies of self-protection and how are they engaging within the therapeutic relationship are all vital questions to explore. Most importantly trauma research helps provide a supportive rationale which will help both therapist and client to engage with these deep and complex conditions.

If we consider raising self-awareness, adjusting arousal levels to a more balanced or sustainable level and generally facilitating insights and new experiences of being in relationship as an ultimate goal in psychotherapy, then the next question is how this manifests in clinical practice.

In the following chapter I will therefore focus on clinical processes that make this possible – in particular mindful and phenomenological enquiry processes.

Chapter 3: Exploration of clinical applications of mindfulness and phenomenological enquiry processes in 1-1 psychotherapy - in particular in relation to complex trauma conditions and dissociation.

3.1 Overview

This third chapter will firstly look at the therapist's inner resources for working with phenomenological or mindful enquiry processes. The safe facilitation of enquiry processes in 1-1 psychotherapy can be challenging and relies on the therapist's capacity to pay close attention to the unfolding processes at various levels simultaneously: this includes their own inner experience including somatic counter-transference, the client's processes, especially non-verbal manifestations such as affect regulation, implicit memory and dissociation as well as relational patterns of self-organisation.

Using a clinical composite from my own practice I will illustrate how the therapist's mindfulness skills can significantly support phenomenological work - especially in relation to attuned attention and empathic presence which are qualities needed for the client to feel safe enough in order to engage with previously avoided or dissociated aspects of their inner world.

Secondly, I will focus on the phenomena of the therapeutic relationship itself. The links between complex trauma and insecure or disorganised attachment scenarios have led to a view that the therapeutic relationship is a prime catalyst for change. Schore (1994, 2003a, 2003b), Cozolino (2006), The Boston Change Process Study Group (2010) and others suggest that empathic moment–by-moment attunement can influence information processing, implicit memory, affect regulation and neural circuits. This is especially relevant in regard to non-verbal forms of communication and the sensitive balance between following and allowing the client's processes on the one hand and balancing this with more directional or interpretative interventions on the other.

Thirdly, this chapter explores how to encourage the client's own self-reflective processes and how to improve their motivation for new skills development.

Clinical illustrations in the literature will be used to help bring these processes alive. I have chosen material that focuses in particular on enhancing mindfulness of the body and emotional processes.

3.2 Mindfulness - a key resource for the psychotherapist

As illustrated in chapter two, we find that complex trauma conditions might explain some of the difficulties clients have with inner reflection processes. Given the complexity of some clients internal worlds, especially when dealing with processes such as dissociation, ingrained self criticism, shame or mistrust, it is clear that the therapist's authenticity and capacity for empathic attunement are vital for building a safe enough therapeutic alliance that would allow the client to overcome some of their instinctive resistance to self-enquiry.

In order to create a safe and supportive therapeutic milieu, however, the therapist also needs to be able to regulate their own affect and emotional responses, particularly in regards to somatic counter-transference and be able to maintain a sustained focus on the presenting processes, i.e. working in the here and now, tracking and aiding affect regulation and helping the client recognise and process surfacing implicit memories. It also requires a confidence to temporarily suspend the thinking, rationalising mind and rely instead on the use of non-verbal communication or simple descriptive, awareness enhancing commentary. (Germer 2005; Ogden, Minton et al. 2006; Weiss 2008; Rothschild 2000, 2010; Ogden & Fisher 2015; Fisher 2014, 2015;)

I would argue that both mindfulness and phenomenological traditions can contribute significantly to the therapist's safe handling of trauma processes. This is relevant in a number of ways: the therapist's attitude and capacity for empathic attunement, acceptance and unconditional regard; the therapist's quality and level of attention or focus which includes being able to observe and reflect on embodied processes such as affect regulation and somatic counter transference; and the therapist's ability to work in the present and follow the minute signals, expressions and manifestations of moment by moment experience. In other words, self-enquiry or self-reflective processes need to be modeled securely by the therapist.

I would further suggest that therapeutic work with its complex processes and dynamics benefits greatly from the wealth of philosophical and moral ideas and intentions provided by phenomenological traditions. Phenomenological enquiry processes are at best attentive and open-minded, manifesting the aim to follow unfolding processes rather than trying to direct, influence or control.

However, this does require mental discipline and skill. Mindfulness traditions have long maintained the importance of training the mind so that it can sustain the process of paying attention in the present moment without judgment. In other words, intention is not enough, we also need the right skills to support it.

Mindfulness traditions therefore offer a wealth of practical teachings and skills training to support and enhance our capacity to be mindful – and thus sustain a phenomenological mindset. (Kabat-Zinn 1990, 2003; Segal, Williams et al. 2002; Bishop, Lau et al. 2004; Germer 2005b; Williams, Teasdale et al. 2007; Orsillo &Roemer 2011).

Given the above, there is clear consensus that a therapist's mindfulness skills can at the very least be supportive if not critical to their work with clients. Cigolla, F., and Brown, D., (2011) conducted a small study using the method of interpretative phenomenological analysis (IPA) where two male and four female therapists agreed that regular mindfulness practice was informing their "way of being" and had become part of their work by *"…modeling and embodying it in the therapeutic relationship and explicitly by encouraging a present-centered and accepting attitude"* (Cigolla & Brown, 2011 p 716).

And Germer goes as far as suggesting that: *"Doing psychotherapy is an opportunity to practice mindfulness in everyday life. The therapy office can be like a meditation room in which we invite our moment-to-moment experience to become known to us, openly and wholeheartedly."* (Germer, 2005a, p.11-12).

The following composite (Landale 2015), based on my own clinical reflections on working with complex issues of mistrust, offers an insight into the therapist's internal processes mindfulness:

"After announcing to G that my fees will increase by £2 we sit in silence. I notice her face has gone pale and withdrawn. Her jaw moves slightly as if gritting her teeth, her shoulders are hunched and her right hand keeps pulling the sleeve of her jumper. She looks out of the window. The silence seems to grow heavy as the minutes creep by.

I notice that my breathing feels restricted as if a weight is pressing down on my chest. I also feel slightly sick at the pit of my stomach. I am beginning to feel cold. I feel I have made a mistake, I should have taken care of her, not demanded more money. What difference does £2 really make to my income? I catch these thoughts and in an attempt to bring myself back into the room and make contact with her I say: "We have been sitting here in silence since I told you about the fee increase."

Silence. G's face seems to be closing off even more, she does not look at me, and the silence seems to grow heavier still. My head fills up with fragmented thoughts. I notice that I have started to think about what I am going to cook for supper and when to buy the missing ingredients for it. Bringing myself back into my body I notice tension in my shoulders and experience restlessness in my legs. I also become aware of the coldness is in my stomach - something icy - as I breathe into it I notice something else lurking there. Irritation? I feel restless, the silence feels increasingly difficult for me and I say: "I imagine your silence is telling me that you are angry with me for increasing my fees". As soon as I have spoken these words, it feels all wrong. Rather than enduring the only way she knows how to relate to me right now, I am trying to push things on, force her to speak to me because I find the silence and the feelings it evokes in me, unbearable.

I decide to give in to the silence, to accept it as a powerful form of communication, this is it! Letting go of my expectations of what should happen, accepting what is so right now, I settle into my seat. I become aware of my breathing. Slowly I can feel my mind calming. I can hold G in my awareness, a sense of being with her, stepping right into the silence with her, joining her in this heavy, cold silent territory.

> *As I watch her ashen face, take in how tense she looks, hardly breathing and held in, thoughts arise about her experiences as a child and how she had to manage her mentally ill mother, her only attachment figure. I remember what I know about the serious neglect she endured and I feel a deep sadness as I engage with G's silence in this context.*
>
> *I say: "I am thinking of you as a small girl and how it was impossible to complain or make a fuss or be angry when things were taken from you, or when you were left without." She shoots me a quick glance and as she averts her eyes again, I can see tears welling up in her. As the tears are beginning to run down her cheeks, the silence between us seems to become softer, warmer."* (Landale 2015).

The above composite illustrates how the therapist's mindfulness can facilitate a deeper attunement to the client. Unexpressed feelings are being sensed and processed by the therapist. The ensuing communication helps the client to feel seen and her inner turmoil becomes something she can in the following sessions give more attention and expression to.

I have also chosen the vignette to illustrate the mundane and ponderous processes involved in working phenomenologically or engaging mindfully with lived experience. Patience, a willingness to re-orientate again and again, paying attention simply to what is happening without getting lost in thinking or analysing, giving up control and challenging one's intentions to change the client are processes that can feel at times tedious or insignificant. However, it is by paying careful attention to the small facets of experience, that we stumble upon meaning and can create moments of deeper connection or insight.

Siegel (2010a) argues that the development of mindfulness skills provides a key resource for therapists wanting to work in a more embodied and present centered way. He proposes that the therapist's authentic presence is vital for building a safe therapeutic alliance and writes:

> *"The subjective side of attunement is the authentic sense of connection, of seeing someone deeply, of taking in the essence of another person in that moment. When others sense our attunement with them, they experience 'feeling felt' by us."* (Siegel, 2010a, p.34).

This 'authentic sense of connection' can be hard to establish or maintain, especially when working with complex PTSD. Cozolino (2006) reflects on a moment in which he found himself challenged by his client Jasmine. Having commented on a situation she had been facing with her boss, Jasmine experienced Cozolino as judgmental and critical of her and reacted with rage. He reflects on his inner process in response to her outburst in the following vignette:

> *"I hung on in silence as she fell back on the couch, threw pillows at the wall and pretended to curl up like a child. I tried to remain centered and not allow my feelings of anxiety and defensiveness to interfere with my availability to her. I focused on my breathing and tried to stay in an open and receptive state of mind. The word borderline may have flashed through my head but my role as her therapist was to stay connected, accepting, and not to punish Jasmine for punishing me. I knew better than to focus on her attacks. ….. We sat in silence for a few minutes. Finally when it felt right to reach out to her I said quietly "I'm sorry you feel so rejected, so alone. I know your work is difficult and you are under a lot of pressure."* (Cozolino, 2006, p. 258).

This vignette illustrates the importance of the therapist's self-regulation. Cozolino's awareness of his own 'anxiety and defensiveness' allowed him to focus on his breathing to aid his affect regulation and he avoided getting caught in diagnostic labeling ('borderline'). He also importantly 'knew better than to focus on her attack' and avoided being drawn into her rage. By being mindful of and regulating his own inner processes he found the right level of attunement that allowed for a repair of the temporary rapture in the therapeutic alliance.

The importance of the therapist's self-regulation is also reflected on by Lindy (2007) who writes that the therapist *"…must monitor personal subjective*

responses while finding sufficient neutral ego resources to carry out sound clinical work, and especially to help the survivor find words to express nuances of subjective meaning in an empathic context." (Lindy 2007, p. 526).

As we have seen from the above vignettes, the therapist's awareness of their own processes in relation to their client is essential, as much of psychotherapeutic work is, in effect, experiential and contemplative.

3.3 The phenomena of the therapeutic relationship

As we have seen earlier, complex trauma conditions typically have their roots in the individual's early attachment environment. This will have inevitable repercussions for the therapeutic relationship especially in relation to the client's transference. It is important to remember that the client's trauma memories are linked to those early care-giving relationships on which they depended for their development and associated deep defense patterns are therefore likely to surface in relation to the therapist.

The therapeutic relationship can be viewed as a vital ground for working with complex trauma conditions. Neuroscience suggests that the brain is a social organ and its plasticity allows for new neural circuits to be developed under the right relational conditions. (Siegel 1999, 2003; Schore 1994, 2003a, 2003b; Cozolino 2006).

A group of researchers and eminent psychotherapists, The Boston Change Process Study Group, state that an authentically attuned therapeutic relationship can *"…create state shifts and organismic reorganization."* (The Boston Change Process Study Group, 2010, p.7).

This view is also expressed by Siegel when he writes:

> *" New neural connections in response to experience can be made across a life span. As new synapses are formed in response to experience, we create the foundation for memory. In this way experience, memory, and development are overlapping processes."* (Siegel 2003, p.2).

As we have seen above, the didactic processes that might underpin such organismic changes are largely non-verbal and rely more on energetic exchanges, empathic attunement and appropriate mirroring. Heitzler, a body psychotherapist specializing on trauma describes this when she writes:

> *"The client's experience of the therapist as the safe containing object is measured…by the client's energetic perception of the therapist's embodied presence and the sense of congruence between the therapist's verbal and energetic messages. This level of relating depends on the therapist's moment-to-moment attunement to her own bodymind responses – to the client, the trauma and the transferential relationship which is constellated in the room."* (Heitzler 2009, p.181).

This is very hopeful indeed but let's not forget that, given the dissociative, dysregulated and complex transference processes that represent complex trauma, this can by no means be an easy process. Chu makes reference to this when he writes:

> *"This is the therapeutic dance, a seemingly endless cycle of disconnection and reconnection that occurs repeatedly, sometimes in the course of even a single therapy session and certainly over the weeks, months and sometimes years in the early phase of treatment."* (Chu 2011, p.121).

Given the intricacy of this work, many therapists believe that the processing of trauma in psychotherapy can take time. Indeed, to allow the client to go at their own pace and accept any resistance to remembering or processing trauma can be seen as being vital for building a safe therapeutic environment. This means also that therapists continually monitor their awareness of how a client organizes her/his experience. A shared awareness of habitual self-beliefs and patterns of relating are of foremost importance for forming a sustainable therapeutic alliance. (Saffran & Muran 2000; Wallin 2007; Holmes 2010; Muller 2010; Fisher 2011; Taylor 2014).

With some complex clients this need to accept the client as they are can be very challenging, especially when part of their self-protection system is build on mechanisms such as rejection, heightened mistrust or strategies of idealisation.

Mindfulness traditions put great weight on acceptance and often link this with compassion training. Such qualities also provide significant support for the therapist to help them weather some of the complex relational dynamics. (Lord 2013; Gilbert & Proctor 2006; Gilbert 2009; Germer 2009; Neff 2011; Germer & Siegel 2012; Siegel 2010a).

3.4 Encouraging the client's own mindfulness processes and motivation for skills development

This next section will look at some of the clinical processes that illustrate how we might help our clients overcome their resistance to self-enquiry. The clinical processes I have chosen will represent working in the moment, following embodied and/or felt experience and 'bracketing' preconceptions in order for meaning to arise naturally.

First let us look at how to prepare the ground for such enquiry processes. There is consensus that trauma clients may find it challenging to focus in on their present moment experience due to the dissociative inner patterns we have discussed previously. Attending to 'here and now' experience can become easily overwhelming or even be re-traumatising for some clients. (Bromberg 1998/2001; Taylor 2014; Rothschild 2000, 2010; Van der Kolk 2007; Levine 2008, Ogden, Minton et al. 2006).

3.4.1 A phased approach to trauma processing

Most contemporary trauma approaches use a phased approach. This idea was first articulated by Judith Herman in her influential book Trauma and Recovery. Herman identified three specific phases for trauma processing: safety, remembrance and mourning. (Herman 2010 p.155-156).

This has been expanded on as trauma treatments developed and Chu defines these three phases as:

"1. Establishing safety, stabilization, control of symptoms, and overall improvement of ego functioning.
2. Confronting, working through, and integrating traumatic memories.
3. Continued integration, rehabilitation, and personal growth."
(Chu 2011, p. 112).

Most trauma approaches preface this by introducing trauma rationales and psychological education elements at the onset to give clients more of a sense of involvement in their treatment. Given that a complex trauma scenario often implies fractured trust in care giving relationships, the need for the client to have agency or feel empowered to make choices is of great significance. (Chu 2011; Ogden, Minton et al. 2006; Van der Hart, Nijenhuis et al 2006; Germer 2005b).

Phase one of trauma treatment entails helping the client to feel safe with their own internal experience, including somatic aspects of experiencing and learning to pay attention in a non-judgmental way. Mindfulness practices can be very helpful at this stage (Van der Kolk 2014; Ogden, Minton et al. 2006). Lord (2013) for example introduces a form of mindful dialogue as a way to help her clients pay attention internally in a new way. She writes:

> *"With clients who are open to mindfulness practice, we begin each session with a meditative dialogue process, a form of collaborative interaction that combines meditative practices of sitting and listening to the space between the breaths with postmodern collaborative practices of 'not-knowing."* (Lord 2013, p.998).

What we can see here is a natural collaboration between mindfulness and phenomenological enquiry practice. It also establishes connection and equality between therapist and client, all of which, one might argue, helps to create safety, develops skills and lowers the client's anxiety of these processes.

3.4.2 Somatic resources

Another focus that has become increasingly validated as beneficial or even essential for the processing of trauma is to work directly with the body as a resource. Levine, for example, developed his 'somatic experiencing' method

based on the fact that trauma is related to unresolved stressful experiences, the memories of which are somatically active and which, he argues, therefore need to be processed by accessing natural embodied resources and mechanisms. A key part of his model is SIBAM which proposes that working interactively with body sensations (S), images (I), current behavior (B) and affect (A) will bring meaning (M) which furthers integration and new insights. (Levine 1997; Payne, Levine et al. 2015). Whilst Levine's approach is quite directive at times, it does also rely on phenomenological enquiry processes.

Another trauma approach which explicitly applies mindfulness techniques to help the client access and develop 'somatic resources' is the sensorimotor approach. (Ogden & Minton et.al. 2006)

> *"During assessment, the therapist teaches clients how to evaluate their own somatic resources by directing awareness to body sensations, areas of tension and relaxation, movement, pain, discomfort, structure, and alignment. Clients thereby discover which physical capacities are resources and which need to be challenged and changed."* (Ogden & Minton et al. 2006 p. 208-209).

This quote illustrates how right from the beginning a focus on somatic resources as a necessary step towards stabilization is being introduced. Sensorimotor therapy as a relatively new approach has managed to incorporate much relevant neuroscience and attachment theory into its model whilst also including cognitive as well as psychodynamic techniques. In essence though the sensory motor approach centers on mindfulness as a process of self-enquiry. This is evident in the following statement:

> *" In a sensorimotor approach, mindfulness entails orienting and attending to the ebb and flow of present internal experience. Awareness and attention are directed toward the building blocks of present experience: thoughts, feelings sensory perceptions, inner body sensations, muscular changes, and movement impulses as they occur in the here and now."* (Ogden& Minton et al. 2006, p193).

The therapist's role here is to help the client broaden the field of their awareness and help them expand their capacity to tolerate previously avoided aspects of their internal experience. It is seen as vital for the client to be able to pay attention to their somatic ongoing experience and to develop their observing function. (Ogden & Minton 2000). This is supported by questions such as:

> *"What do you feel in your body right now?*
> *Where exactly do you experience that tension?*
> *How big is the area of tension – the size of a golf ball or the size of an orange?*
> *What sensations do you feel in your legs right now as you talk about your abuse?*
> *What happens in your body when you feel angry?"*
> (Ogden, Minton et al. 2006, p. 194).

The sensorimotor approach was developed by Pat Ogden following years of close collaboration with Ron Kurz, the founder of Hakomi therapy (Kurz 1990/2005). Kurz's Hakomi Method is one of the earliest explicitly mindfulness-based psychotherapy approaches. *"Hakomi is a psychodynamic and experiential approach that systematically uses the ancient tool of mindfulness and integrates the body in the psychotherapeutic process.* (Weiss 2015, p 13).

3.4.3 Mindfulness and phenomenological enquiry processes

The following vignette illustrates the experiential use of mindfulness within Hakomi therapy. We enter the process at a point where Jane the client has identified that, for her, having needs equals disappointment. Rob Fisher writes:

> *"I asked Jane to turn her attention inside and let her own words echo – 'Needs are the same as disappointment' – and notice what experience emerged. In this kind of mindful exploration, the therapist can track external signs of experience in the fine changes in the client's face, emotional temperature, breathing and voice quality.....Jane said, 'I feel really hot!' ….I encouraged her to stay with the heat and the redness and asked her to notice the mood that went with it. She said, with surprised*

consternation, but also curiosity, 'Oh, I'm ashamed…of my needs!" (Fisher, R. 2015, p 9).

We see here that by directing Jane's attention inwardly, so that she could listen to the echoes created by what she had just articulated verbally, allowed her to get in touch with her underlying feelings of shame. It was important at this stage for the therapist to remain closely attuned to the client and help maintain curiosity and avoid her contracting, shutting down or becoming overwhelmed. Let's pick up on the vignette again: *" 'Let's make lot's of room for shame', I said, we can hold it gently. Just let a little bit of it be here. Go ahead and stay with it, let's see where it takes you."* (Fisher R. 2015, p10).

Despite this encouragement to stay with her feelings of shame, Jane seemed to be contracting and shutting down at this point. It is important not to lose track or connection with the client at this point and Fisher, noticing that Jane seemed to have shut down and had shifted her body away from the back of the couch, comments: *"You are sitting really straight, and it seems that your feelings just went away. Let yourself be with that uprightness, feel all the muscles involved, and notice what they remember."* (Fisher R. 2015, p 10).

This is a good example of staying with the phenomenological process as it unfolds by simply shifting attention to an aspect of Jane's inner experience, which she might find easier to follow. By directing Jane's attention to the experience of uprightness Fisher stayed focused somatically, simply encouraging mindfulness of body sensations. This prompt then brought up a memory for Jane where her father had encouraged her to jump from a height into his arms and then deliberately dropped her to teach her "*never to trust anyone*" (Fisher R. 2015, p10).

This memory released feelings that had lied buried deeply. It also seemed to provide the necessary background for Jane to understand how much this had impacted on her ability to trust, namely that she had grown up feeling it could never be safe for her to have needs or rely on anybody. It was important, however, not to move too quickly back into thinking and Fisher kept encouraging a mindful embodied focus. He writes:

> *"As her feelings began to ebb, I commented, 'You learned not to rely on anything or anyone, huh? Not even the back of the couch. How about we start by supporting your back, so that it doesn't have to hold you up all on your own?"* (Fisher R. 2015, p 10).

The therapeutic alliance remained strong throughout this process and the finely attuned mindfulness interventions helped Jane to remain aware of her own experience and make small gentle adjustments to her posture at this point. Fisher encouraged her to explore taking support from the back of the couch thus applying the notion of 'bottom-up' regulation that we explored in chapter two.

> "*While she explored the simple, metaphorical act of learning, I encouraged her to slowly and mindfully notice the subtle internal reactions. As she did so, I could see her gradually relax her body, as she realized she could lean a little on the couch without losing herself."* (Fisher R. 2015, p 10).

Fisher's vignette describes how, by paying close, attuned, mindful attention to embodied processes, we can safely help the client get in touch with implicit memories, help regulate the ensuing affect and provide guidance for new inner adjustments. The challenge is not to go off into thinking, interpreting or narrating at this point but rather to stay focused on the small embodied facets of what is unfolding.

Another therapist who has contributed to our understanding of working with the body in the context of trauma is Babette Rothschild (2000, 2010) who also puts much emphasis on helping clients develop their own resources. Developing body awareness and the ability to monitor arousal levels are key to her work. She also teaches clients to 'put on the brakes' and highlights the importance of client and therapists having a shared understanding of how the client can put on the brakes and come back to safer ground if the arising of trauma memories threatens to destabilise them.

This carefully created process of paying attention to inner resources and making the therapeutic relationship safe is subtle and deeply attentive as illustrated by this vignette:

> *" (Gail… has been wanting for some time to face dealing with a car accident that happened when she was 18. She is now prepared to confront it.)…*
>
> *T:* Are you ok with how we are sitting? *(I am sitting in a chair, while G has chosen a spot on the floor.)*
> *(Establishing safety by attending to boundaries, position, and distance.)*
> *G:* No, you're too far away and we're uneven in height.
> *T:* How do you want to change that? *(G comes closer and moves from the floor to a chair.)*
> *(Giving the client control where possible.)*
> *G:* This distance feels good.
> *T:* How do you know this feels good*?*
> *(Connecting body awareness to cognitive evaluation.)*
> *G:* Because I don't feel myself leaning forward or leaning back*."*
> (Author's italics) (Rothschild 2000 p.120).

This vignette shows how awareness of the body starts with what arises in the present moment. The therapist gently guides the client's attention to an observable phenomena manifesting in the inequality in their sitting together and thus encourages the client to start right where she is at this moment in time. She then allows the client to take charge and adjust her distance. This process can feel insignificant in the light of the bigger work about to be done but highlights how it is through paying attention to the ordinary aspects of experience that we create a safer and more steadily held focus for the emotional processes we need to engage with.

By helping her client to focus in on these small nuances of her embodied experience and encouraging her to make these small adjustments, the therapist modeled openness, attention to detail and also acceptance. When Gail began to recall the traumatic incident Rothschild kept encouraging her to slow down,

pay attention to the minutiae of her somatic experience and regulate emotional arousal by pacing herself and thus feeling in charge of the recall of her memories.

Another group of therapists, Van der Hart, Nijenhuis and Steele (2006) apply similar processes of attuning to body sensations to help raise tolerance of affect when working with dissociative disorders. The following vignette illustrates how a patient with an anger phobia is helped to attend closely to her embodied experience to help her focus on a situation, which was likely to provoke an angry reaction.

> "*Therapist:* I notice your breathing is faster than it was just a moment ago. Are you aware of that?
> *Rosemary*: I wasn't, but now I am.
> *Therapist:* Just notice that and see what happens. *[Encourages presentification; does not yet direct the patient to make meaning of the experience, but rather only to observe. This builds tolerance of the sensations and related affects.]*
> *Rosemary:* I feel I want to run away. *[defensive avoidance in the form of flight]*
> *Therapist:* What is that feeling of wanting to run away like in your body right now? *[stays with the patient's experience of the mental actions without moving towards cognition]*
> *Rosemary:* My legs are shaky. I am tense all over, like I could just jump up and go.
> *Therapist*: Would it be alright to allow those sensations to continue for a moment without interrupting them? *[continues to support tolerance of mental actions without behavioral action; encourages completion of the sensations]*
> *Rosemary:* Yes, I guess so.
> *Therapist:* And what do you notice?
> *Rosemary:* I imagine running really fast, away from something.
> *Therapist:* Running away from what?
> *Rosemary:* Umm, feeling angry I think. When my legs stop shaking I feel kind of angry, like I could yell, 'get away from me!!' *[patient engages in*

adaptive feeling after completing the avoidant action of shaking of shaking in her legs that accompanies defensive flight]." (Author's italics) (Van der Hart and Nijenhuis et al, 2006, p 288-289).

Even though the authors don't explicitly use mindfulness as a therapeutic tool, the similarities are striking. The therapist closely attends to the unfolding processes and kept directing Rosemary's attention back to what she was experiencing somatically. This seems to me similar to bringing our attention back to the breath or whatever other support or focus we might have chosen in mindfulness practice.

Another important element of this vignette is Rosemary' s imagination providing a way to help her deal with her emotions: 'I imagine running really fast, away from something.'

Working with the client's imagination is an common element of experiential and humanistic psychotherapy traditions. (Ferrucci 1990; Assagnoli 1990; Achterberg, Dossey et al. 1994; Rossman 2000; Landale 2002, 2009). It is also used to process trauma memories and in particular to help develop inner resources. (Rotschild 2000; Griffin & Tyrrell 2003; Hackmann, Bennett-Levy et al. 2013). The 'safe place' imagery (Van der Hart 2012) for example is recognised as being effective in helping the client access feelings of safety and well-being as well as stabilising arousal levels.

3.5 Concluding thoughts

This chapter explores some of the clinical processes involved in working with phenomenological processes in psychotherapy. I would argue that a sustained practice of mindfulness is a tremendous support for both therapist and client as the work focuses on how to help the client gain new resources and insights into old patterns and dilemmas. However, as we have seen throughout this dissertation, traumatised clients can find it especially difficult to support themselves using self-reflection or mindfulness and in this respect it becomes essential for the therapist to both model and guide these subtle processes.

The first foundation of mindfulness - mindfulness of the body - is increasingly recognised as a vital resource in trauma treatment as well as in general psychotherapy practice. It seems that once that foundation is laid, emotional and cognitive integration can follow more naturally. The subtle changes created through mindful and empathic phenomenological work can be seen as powerful catalysts for change and successful outcome.

Reflections and Conclusion

This literature review investigates experiential and self-enquiry processes and the difficulties that therapists might encounter with these processes in their psychotherapy practice. It aims at counselors or psychotherapists working with an integrative or humanistic orientation as well as therapists who have a particular interest in working with experiential or phenomenological methods, including working with somatic processes or seeking to integrate mindfulness in their clinical practice.

In the first chapter of this review I considered some of the key philosophical ideas that led to the development of experiential psychotherapy approaches and compared these with current mindfulness-based approaches. This comparison illustrated the influence that phenomenological traditions have had on experiential methods within psychotherapy and, in this context, secularised mindfulness can also be viewed as a contemporary phenomenological method that can be adapted effectively to psychotherapy. Indeed the synergy between mindfulness and phenomenological practices would benefit from further exploration to clarify philosophical roots, intent and method.

I am also aware that the secularisation of mindfulness and its separation from its spiritual roots throws up particular dilemmas. I have not discussed these in detail in this paper but it is worth noting the lively dialogue on this issue within the mindfulness community as well as humanistic psychotherapy traditions. (Siew Luan Khong, B. 2007; Watson, G. 2008; Johanson 2009; Rosenbaum 2009).

The second chapter sets out to clarify our current understanding of how some clients resist self-enquiry, particularly when trauma is involved. I am aware that using diagnostic labeling such as complex trauma may contradict base premises of phenomenological and indeed mindfulness traditions such as non-judgment and letting go of preconceived ideas, yet this simply reflects the inevitable tension between structure and process. In this respect it seemed beneficial to review the findings of trauma research as they offer meaningful explanations to therapists, which in turn might help them contextualize the

shame or fear issues that some of their clients experience. Such a rational understanding also helps the therapist to navigate the significant levels of mistrust and resistance they may encounter when they challenge their clients' ingrained self-beliefs and behaviors.

In essence this literature review has been written for clinicians and the final chapter provides examples of phenomenological and mindful processes in psychotherapy. This is especially relevant as such processes show how therapists can safely guide the client's attention to focus inward – an especially sensitive area when they are helping clients focus on the embodied aspects of their experience, which play such an important role in trauma.

The clinical vignettes also demonstrate the importance of the therapist's ability to facilitate right-brain to right-brain communication where they are dealing with emotional and non-verbal processes. In this respect I strongly support the idea that an integration of mindfulness into experiential psychotherapy practice relies on the therapist's own mindfulness practice and I would go as far as saying that mindfulness offers profound and practical support for therapists who work experientially. It offers a vital skills training of the mind that seems essential for these processes to be effective.

In conclusion I would argue that phenomenological enquiry processes require therapists to have a vibrant mixture of openness and flow combined with an inner clarity and focus. This is not an easy state of mind to achieve or maintain yet it is vital for deeper awareness, empathic attunement and the integration of otherwise complex emotional processes. Again this lends itself to further discussion and it is possible to argue that in the third chapter I should have focused entirely on the therapist's mindfulness skills as a catalyst and safeguard for phenomenological work. However, this would have been highly subjective and as there is relatively little literature to substantiate a discussion it did not fit the remit of this literature review.

As this paper shows, the applications of phenomenology and mindfulness within psychotherapy are manifold and long established. However, the ongoing pressure on therapists to provide proof of therapeutic outcome, and the trend to

apply scientific and academic measurements can make it harder for therapists to value the intuitive, creative and unstructured processes that lie at the heart of the therapeutic endeavor.

Another area of tension in this review is that I have had to be highly selective of the material to include. Each of the chapters could have been a dissertation in its own right and the comparison between phenomenological and mindfulness traditions does not do justice to the wealth of insight and methodologies these traditions present. However, I chose the literature that felt most relevant for clinical practice and can only apologise for omitting other writers whose insights offer an additional wealth of understanding.

Indeed even with my clinical focus I have had to be selective. There is a wide range of examples illustrating experiential trauma processing and I have had to choose illustrations that are relevant for the discussion in this paper. However it has been harder to find clinical vignettes that represent the frustrations, difficulties and ruptures that are the real challenges in complex trauma work. In this context I had hoped to include another of my own clinical composites but decided that this would have taken me too far away from my narrative.

Future outlook

I am confident that this review provides a platform for further work and exploration of psychotherapeutic insight and practice.

In the first instance the topics in this literature review lend themselves to being edited into smaller papers or a series of blogs and I will re-design my website to include information on the themes covered in this paper.

I have also started to plan two new CPD workshops. The first is on how therapists can work mindfully with implicit trauma memories and the second will look at phenomenological enquiry processes and somatisation in trauma processing.

Finally I have been invited to speak at the BACP conference in October this year under the heading ‘Trauma and its effect on body and mind’. At this conference I will have the opportunity to present some of the findings from this paper.

However, my main commitment is to advancing clinical practice. This review has provided me with essential insights into the integration of mindfulness and phenomenological practice but the bottom line for me is that experiential work depends on experiential learning. My ambition for the future is to help practicing therapists develop their ‘in the moment’ skills and awareness, especially as regards mindfulness, embodiment and empathic attunement.

References

Achterberg, J., Dossey, B., & Kolkmeier, L., (1994). *Rituals of Healing*. New York: Bantam Books.

Adyashanti, (2011). *Falling Into Grace.* Boulder: Sounds True

Afghan, J., & Shepherd, I.L., eds. (1973). *What is Gestalt Therapy?* New York: Harper and Row.

Aich T.K., (2013). Buddha Philosophy and Western Psychology. In: *Indian Journal of Psychiatry* 2013 Jan; 55(Suppl2): S165-170. DOI: 10.4103/0019-5545.105517.

Anderson R, & Cissna, K.N., (1997). *The Martin Buber – Carl Rogers Dialogue*. New York: New York State University of New York Press.

Ainsworth, M.D.S., (1969). Object relations, Dependency and Attachment: A Theoretical Review of the Infant-Mother Relationship. *Child Development,* 40, 969-1025.

Ainsworth, M. &Bell S., (1970). Attachment, Exploration and Separation: Illustrated by the Behavior of one-year-olds in a strange situation. In: *Child Development,* 41, 49-67.

Aposhyan, S., (2004). *Body-Mind Psychotherapy*. New York: Norton.

Assagioli, R., (1956/1990). *Psychosynthesis – A Manual of Principles and Techniques.* London: Mandala.

Baer, R., (2003). *Mindfulness training as a clinical intervention: A conceptual and empirical review.* Clinical Psychology: Science and Practice, 10(2), 125-142.

Baer, R., (2014). *Mindfulness-based Treatment Approaches – Clinicians Guide to Evidence Base and Application*. 2nd edition. London: Academic Press.

Bass, E & Davis, L. (1988/2008, 4th ed). *The Courage to Heal.* US: The Courage to Heal Press.

Batchelor, S., (1998). *Buddhism Without Beliefs.* London: Bloombury.

Bazzano, M., (2011). The Buddha as a Fully Functioning Person: Toward a Person-Centered Perspective on Mindfulness. In: *Person-Centered and*

Experiential Psychotherapies, 10:2, 116-128, DOI: 10.1080/14779757.2011.576560.

Baumeister, R., (2013). Writing a Literature Review. In: *The Portable Mentor: Expert Guide to a Successful Career in Psychology*, 2nd ed. Printstein, (ed). DOI: 10.1007/978-1-4614-3994-3_8.

Bion T., (2004). *Quantum Change and Psychotherapy*. In: JCPL/In Session, Vol. 60(5), 493-501. Wiley Periodicals, Inc. DOI: 10.1002/jclp.20003.

Bishop, S., Lau, M., Shapiro, S. (2004). *Mindfulness: A Proposed Operational Definition*. Clin Psychol Sci Prac II: 230-241, 2004. DOI: 10.1093/chipsy/bph077.

Bowlby, J. (1997) *Attachment and Loss, Vol. 1+2*. London: Pimlico.

Boston Change Process Study Group (2010). *Change in Psychotherapy: A Unifying Paradigm.* New York: Norton.

Brazier, D., (1991). *Phenomenology in Counselling and Psychotherapy*. Submitted by Dharmavidya on Mon, 18/03/1991 - 13:59. Downloaded from http://www.zentherapyinternational.com/?q=paper/1991-dhdjbrazier-phenomenology-counselling-and-psychotherapy, on 15/01/2016

Brazier, D., (ed.), (1993). *Beyond Carl Rogers*. London: Constable

Bromberg, P., (1998/2001). *Standing in the Spaces: Essyas on Clinical Process, Trauma and Dissociation.* New York: Psychology Press.

Buber, M., (1937/2013). *I and Thou.* London Bloomsbury Academic.

Buber, M., (1967). *A Believing Humanism.* New York: Simon&Schuster.

Burch, V., (2008). *Living well with Pain and Illness*. London: Piatkus.

Burston, D., (2003). Existentialism, Humanism and Psychotherapy. In: *Existential Analysis* 14.2. July 2003. (Downloaded from Existential Analysis.org.uk on 2nd Feb 2016).

Campbell, J.,ed. (1976). *The Portable Jung*. New York: Penguin Books.

Cassidy, J. & Shaver, P., (eds.) (2008). *Handbook of Attachment: Theory, Research, and Clinical Application* (2nd ed). New York: Guilford Press.

Chicchetti, D. & White, J., (1990). Emotion and Developmental Psychopathology. In: Stein, N., Leventhal, B. &Trebasso, T. (Eds.)

Psychological and Biological Approaches to Emotion (pp. 359-382). Hillsdale: Erlbaum.

Chu, J., (2011). *Rebuilding Shattered Lives – Treating Complex PTSD and Dissociative Disorders.* Hoboken, New Jersey: Wiley.

Cigolla, F. and Brown, D. (2011). A way of being: Bringing mindfulness into individual therapy. In: *Psychotherapy Research,* 21:6, 709-721, DOI: 10.1080/10503307.2011.613076

Clarkson, P. & Mackewn, J., (1993). *Fritz Perls.* London: Sage.

Cozolino, L., (2006). *The Neuroscience of Human Relationships – Attachment and the Developing Social Brain.* New York: Norton.

Crocker, S., (2005). Phenomenology, Existentialism, and Eastern Thought in Gestalt Therapy. In: Woldt, A.L & Toman S.M. (eds.) *Gestalt Therapy - History, Theory and Practice*. Thousand Oaks, CA: Sage.

Damasio, A., (1996) *Descartes' Error – Emotion, Reason and the Human Brain*. London: Papermac.

Damasio, A., (2000). *The Feeling of What Happens*. London: Vintage.

Dozier, M., Cue, KL & Barnett, L, (1994). Clinicians as Caregivers: Role of Attachment Organization in Treatment. In: *Journal of Consulting and Clinical Psychology*, Vol 62 (4), Aug 1994, 793-800.

Dryden, W.,and Still, A., (2006). Historical Aspects Of Mindfulness And Self-Acceptance In Psychotherapy. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, Vol. 24, No.1, Spring 2006.

Embleton-Tudor, L., Keemar, K., Tudor, K., Valentine, J., and Worral, M., (2004). *The Person-Centred Approach, A Contemporary Introduction.* Basingstoke: Palgrave Macmillan.

Felder, A., Aten, H., Neudeck, J., Shiomi-Chen & Robins, B., (2014). Mindfulness at the Heart of Existential Phenomenology: A Century of Contemplation and Elaboration. In: *The Humanistic Psychologist*, 42:1, 6-23, DOI: 10.1080/08873267.2012.753886.

Ferrucci, P., (1990). *What We May Be – The Vision and Techniques of Psychosynthesis.* London: Mandala.

Finlay, L., (2011). *Phenomenology for Therapists – Researching the Lived World*. Chichester: Wiley-Blackwell.

Fisher, J., (2011). Attachment as a Sensorimotor Experience: The Use of Sensorimotor Psychotherapy. In: *Attachment: New Directions in Relational Psychoanalysis*, Vol. 5, July 2011: pp 99-107.

Fisher, J., (2014). Putting the Pieces Together: 25 Years of Learning Trauma Treatment. *Psychotherapy Networker* May/June 2014. Downloaded 19/10/2015 from: http://www.janinafisher.com/resources.php

Fisher, J., (2015). The Treatment of Structural Dissociation in Chronically Traumatised Patients. In: Anstrop &Benum (in press). *Trauma Treatment in Practice: Complex Trauma & Dissociation*. Oslo: Universitetsforlaget.

Fisher, R., (2015). A Hakomi Case Illustration: Psychotherapy Beyond Conversation – the Psychodynamic Use of Mindfulness and the Body. In: Weiss, H., Johanson, G. & Monda, L. eds., (2015). *Hakomi Mindfulness-Centered Somatic Psychotherapy – A Comprehensive Guide to Theory and Practice.* New York: Norton.

Follette, V., Palm, K., &Pearson, A. (2006). Mindfulness and Trauma. In: *Journal of Rational-Emotive & Cognitive-Behavior Therapy.* Vol. 24, No1, Spring 2006. DOI: 10.1007/s10942-006-0025-2.

Follette, V., Briere, J., Rozelle, D., Hopper, J. & Rome, D., eds. (2015). *Mindfulness-Oriented Interventions for Trauma*. New York: The Guilford Press.

Fosha, D., (2003). Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment. In: Solomon F. & Siegel D. eds. *Healing Trauma – Attachment, Mind, Body and Brain.* New York: Norton.

Freud, S., (1941/2005). *The Unconscious*. London: Penguin.

Freud, S., & Breuer, J., (1974/1991). *Studies on Hysteria,* Strachey, J., & Strachey A., eds. London: Penguin Books.

Friedman M., (1994). Reflections on the Buber-Rogers Dialogue. In: *Journal of Humanistic Psychology,* Winter 1994, vol.34 no 1 46-65. DOI: 10.1177/00221678940341004.

Fromm, E., (1993). *The Art of Being.* London: Constable.

Gendlin, E., (1978/1981). *Focusing.* New York: Bantam.

Gendlin, E., (1996). *Focusing-oriented Psychotherapy – a Manual of the Experiential Method*. New York: The Guilford Press.

Geller, S., (2003). Becoming Whole: A collaboration between experiential psychotherapies and mindfulness meditation. In: *Person-Centered and Experiential Psychotherapies*, Volume2, Number 4, pp 258-273. DOI: 1477-9757/03/04258-16

Gerhardt, S., (2004), *Why Love Matters*. London: Brunner-Routledge.

Germer, C., (2009). *The Mindful Path to Self-Compassion.* New York: Guilford.

Germer, C., Siegel, R., (2012). *Wisdom and Compassion in Psychotherapy*. New York: Guilford Press.

Germer, C., Siegel R. and Fulton P., Eds. (2005). *Mindfulness and Psychotherapy.* New York: Guilford Press.

Germer, C., (2005a). Mindfulness – What is it? What Does it Matter? In: *Mindfulness and Psychotherapy*. New York: Guilford Press.

Germer, C., (2005b). Teaching Mindfulness in Psychotherapy. In C. Germer, R. Siegel and P. Fulton (Eds.) *Mindfulness and Psychotherapy* (pp 113-119). New York: Guilford Press.

Gilbert, P., and Proctor, S., (2006). Compassionate Mind Training for People with High Shame and Self-Criticism: Overview and pilot Study of a Group Therapy Approach. In: *Clinical Psychology and Psychotherapy* **13**, pp. 353-379.

Gilbert, P., (2009). *The Compassionate Mind*. London: Constable.

Griffin, J and Tyrell, I., (2003). *Human Givens*. Chalvington: Human Givens Pubilshing Ltd.

Grossman, P., (2011). Defining Mindfulness by How Poorly I Think I Pay Attention During Everyday Awareness and Other Intractable Problems for Psychology's (Re)Invention of Mindfulness: Comment on Brown et al. (2011). In: *Psychological Assessment 2011, Vol.23, No4, 1034-1040*, American Psychological Association 1040-3590/11$12 DOI: 10.1037/a0022713.

Gunaratana, B.H., (2002). *Mindfulness in Plain English.* Boston: Wisdom Publications.

Hackmann, A., Bennett-Levy, J., and Holmes, E., (2013). *Oxford Guide to Imagery in Cognitive Therapy.* Oxford: Oxford University Press.

Halling, S. and Leifer, M. (1991). The Theory and Practice of Dialogal Research, *Journal of Phenomenological Psychology,* 22, 1-15.

Harris, W., 2013 Mindfulness-based existential therapy: connecting mindfulness and existential therapy. In: *Journal of creativity in mental health*, 8:4, 349-362, DOI:10.1080/15401383.2013.844655.

Hayes, S.C.,Strosahl, K.D., Wilson, K.G.(1999). *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change.* New York: Guilford Press.

Heidegger, M., (1953/2012). *Being and Time*. (Trans. Joan Stambaugh). New York: State University.

Heitzler, M., (2009). Towards an Integrative Model of trauma Therapy. In: *Contemporary Body Psychotherapy – The Chiron Approach*. Ed. Hartley L. London: Routledge.

Herman, J., (1992/2010). *Trauma and Recovery.* London: Pandora.
Holmes, J., (2010). *Exploring in Security*. London: Routledge.

Holmes, J., (2015). Attachment Theory in Clinical Practice: A personal Account. In: *British Journal of Psychotherapy* **31**, 2 (2015) 208-228 doi: 10.1111/bjp.12151.

Husserl, E., (1931/2012). *Ideas: General Introduction to Pure Phenomenology*. Abingdon: Routledge Classics.

Johanson, G., (2009). Nonlinear Science, Mindfulness, and the Body in Humanistic Psychotherapy. In: *The Humanist Psychologist,* 37:2, 159-177, DOI: 10.1080/08873260902892121.

Joyce, P. & Sills, C., (2010). *Skills in Gestalt Psychotherapy and Counselling.* 2nd Edition. London: Sage

Jung, C.G., (1963/1990). *Memories, Dreams, Reflections*. London: Fontana.

Kabat-Zinn, J., (1990). *Full Catastrophe Living,* New York: Bantam.

Kabat-Zinn, J., (2003). Mindfulness-based interventions in context: past, present, future. *Clinical Psychology: Science and Practice,* 10(2), 144-156.

Kabat-Zinn, J., (2005). *Coming To Our Senses.* London: Piatkus.

Katona, D.G., (2015). Focusing-Oriented Psychotherapy – A Contemplative Approach to Healing Trauma. In: *Mindfulness-Oriented Interventions for Trauma.* Eds Follette, V., Briere, J., Rozelle, D., Hopper, J. & Rome, D. New York: Guilford Press.

Klein, J., (1987/ 1997). *Our Need for Others and its Roots in Infancy.* London: Tavistock Publications.

Kurz, R., (1990/2005). *Body-Centered Psychotherapy*. Mendocino: Liferythm.
Landale, M., (2002). The use of imagery in body oriented psychotherapy'. In: Tree Staunton ed., *Body Psychotherapy*. London: Brunner-Routledge.

Landale, M., (2009). Working with psychosomatic distress and developmental trauma in: Linda Hartley ed., *Contemporary Body Psychotherapy – The Chiron Approach*, London: Routledge.

Landale, M., (2015). *The Present Moment – Cultivating Embodied Attunement and Empathy Through Mindfulness*. Retrieved on 13 May 2016 from: http://www.brightontherapypartnership.org.uk/present-moment-challenges-mindfulness/

Lanius RA., Blum RL, Frewen PA. (2011). *How understanding the neurobiology of complex post-traumatic stress disorder can inform clinical practice: a social cognitive and affective neuroscience approach*. John Wiley&Sons, Acta Psychiatr Scand 2011:124:331-3848. [Available from: DOI:10.1111/j.1600-0447.2011.01755.x]

Ledoux, J., (1999). *The Emotional Brain.* London: Orion Books.

Levine, P., (1997). *Waking the Tiger – Healing Trauma.* Berkeley: North Atlantic Books.

Levine, P., (2008). *Healing Trauma.* Boulder: Sounds True.

Levine P.,(2010). *In an Unspoken Voice – How the Body Releases Trauma and Restores Goodness.* Berkeley: North-Atlantic Books.

Lindy J., (2007). Psychoanalytic Psychotherapy of Posttraumatic Stress Disorder – The nature of the Therapeutic Relationship. In: Van der Kolk, Mc Farlane & Weisaeth, Eds. *Traumatic Stress – The Effects of Overwhelming Experience on Mind, Body and Society.* New York: The Guilford Press.

Lietaer, G., (1993). Authenticity, congruence and transparency. In: Brazier, D., (ed.), (1993). *Beyond Carl Rogers*. London: Constable.

Linehan, M. (1993 a). *Cognitive-behavioral Treatment of Borderline Personality Disorder.* New York: Guilford Press.

Linehan, M., (1993 b). *Skills training manual for treating borderline personality disorder.* New York: Guilford Press.

Lord, S., (2010). Meditative Dialogue: Cultivating Sacred Space in Psychotherapy – An Intersubjective Fourth? In: *Smith College Studies in Social Work.* Volume 80, issue 2-3, p. 269-285. DOI:10.1080/00377311003754187.

Lord. S., (2013). Meditative Dialogue: Cultivating Compassion and Empathy with Victims of Complex Childhood Trauma. In: *Journal of Aggression, Maltreatment & Trauma*, 22:9, 997-1014, published online 01 November 2013. [Available from: DOI: 10.1080/10926771.2013.834018].

Maslow, A.H., (1971/1993). *The Farther Reaches of Human Nature.* New York: Penguin.

Mathers, D, Melvin, E. & Ando O., ed. (2009). *Self and No- Self, Continuing Dialogue Between Buddhism and Psychotherapy.* Hove: Routledge.

May, R., (1958/2004). *Existence.* Lanham US, Rowman & Littlefield.

May, R., (1999). *Freedom and Destiny*. New York: Norton.

Mc Leod, J., (1999). *Practitioner Research in Counselling*. London: Sage.

Mc Leod, J., 2nd ed.(2011). *Qualitative Research in Counselling and Psychotherapy*. London: Sage.

Merleau-Ponty, M., (2014). *Phenomenology of Perception.* Abingdon: Routledge.

Michal, M., Bentel, M., Jordan, J., Zimmermann, M., Wolters, S., & Heidenreich, T., (2007). Depersonalisation, Mindfulness and Childhood Trauma. In: *The Journal of Nervous and Mental Deasease.* Vol. 195, No. 8, p. 693-696. Lippincott Williams & Wilking.

Molino A. (ed). (1998). *The Couch and the Tree – Dialogues in Psychoanalysis and Buddhism*. New York: North Point Press.

Morvay, Z., (1999). Horney, Zen, and the Real Self: Theoretical and Historical Connections. In: *The American Journal of Psychoanalysis*, Mar. 59(1):25-35. DOI: 10.1023/A:1021488721166

Moustakas, C., (1990). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage.

Muller, R., (2010). *Trauma and the Avoidant Client.* New York: Norton.

Naranjo, C, (1973). Present-centeredness: Technique, Prescription, and Ideal. In: Afghan, J., & Shepherd, I.L., eds. (1973). *What is Gestalt Therapy?* New York: Harper and Row.

Neff, K., (2011). *Self Compassion.* London: Hodder& Stoughton.

Ogden, P. & Minton, K., (2000). Sensorimotor psychotherapy: One Method for Processing Trauma Memory. In: *Traumatology*, 6(3), 1-20.

Ogden, P., Minton, K., & Pain, C., (2006).*Trauma and the Body.* New York: Norton.

Ogden, P. & Fisher, J., (2015). *Sensorimotor Psychotherapy – Interventions for Trauma and Attachment*. New York: Norton.

Olendzki, A., (2010). *Unlimiting Mind*. Boston: Wisdom Publications.

Orsillo, S., Roemer, L., (2011). *The Mindful Way through Anxiety.* New York: Guilford Press.

Panksepp, J., (1998). *Affective Neuroscience – The Foundations of Human and Animal Emotions.* New York: Oxford University Press.

Payne P, Levine PA and Crane-Godreau MA (2015) *Somatic Experiencing: Using Interoception and Proprioception as Core Elements of Trauma Therapy.* Front. Psychol. **6**:93. doi: 10.3389/fpsyg.2015.00093

Perls, F., (1947/1969). *Ego, Hunger and Aggression: The Beginning of Gestalt Therapy*. New York: Random House.

Perls, F., (1973). The Gestalt Approach & Eyewitness to Therapy. New York: Science & Behavior Books.

Perls, F., Hefferline, R., and Goodman, P., (1951/1989). *Gestalt Therapy: Exitement and Growth in the Human Personality.* London: Pelican Books.

Porges, S., (2011). *The Polyvagal Theory – Foundations of Emotions, Attachment, Communication and Self-Regulation*. New York: Norton.

Putnam, F., (1997). *Dissociation in Children and Adolescents: A Developmental Perspective*. New York: Guilford.

Riessman, C. &Speedy J., (2007). Narrative Inquiry in the Psychotherapeuitc Professions. In: *Handbook of Narrative Inquiry – Mapping a Mothodology*, ed. Clanini, D.J. Thousand Oaks, CA: Sage.

Rogers, C., (1951/2003). *Client-Centered Therapy – It's Current Practice, Implications and Theory*. London: Constable & Robinson.

Rogers, C., (1961). *On Becoming a Person*. London: Constable.

Rosenbaum, R., (2009). Empty Mindfulness in Humanistic Psychotherapy. In: *The Humanist Psychologist,* 37:2, 207-221. DOI: 10.1080/08873260902892196.

Rossman, M., (2000). *Guided Imagery for Self-Healing.* Tiburon CA: HJ Kramer.

Rothschild, B., (2000). *The Body Remembers.* New York: Norton.

Rothschild, B., (2010). *8 Keys to Safe Trauma Recovery.* New York: Norton.

Rubin, J., (1996). *Psychotherapy and Buddhism*. New York: Plenum Press.

Safran J. and Muran, J.C. (2000). *Negotiating the Therapeutic Alliance – A Relational Treatment Guide.* New York: The Guilford Press.

Safran, J., (2003). *Psychoanalysis and Buddhism.* Boston: Wisdom Publications.

Sartre, J.P., (1958/2003). *Being and Nothingness.* Abingdon: Routledge.

Schore, A., (1994). Affect Regulation and the Origin of Self: The Neurobiology of Emotional Development. Hilldale: Erlbaum.

Schore, A. (2003a). *Affect Dysregulation and Disorders of the Self.* New York: Norton.

Schore, A. (2003b). *Affect Regulation and the Repair of Self.* New York: Norton.

Segal, Z., Williams, M., and Teasdale. J., (2002). *Mindfulness-based Cognitive Therapy for Depression*. New York: Guilford.

Shapiro, F., (2005). *EMDR Training Manual part 1&2.* Watsonville, CA: EMDR Institude.

Shapiro, F., (1998). EMDR: *The Breakthrough "Eye Movement" Therapy for Overcoming Anxiety, Stress, and Trauma*. New York: Basic Books.

Shapiro, S., Carlson, L., Astin, J., and Freedman, B., (2006). Mechanisms of Mindfulness. *Journal of Clinical Psychology*, Vol. 62(3), 373-386. 'Wiley InterScience' Published 2006 [Available from: DOI 10.1002/jclp.20237].

Shapiro, S. and Carlson L., *(2010). The Art and Science of Mindfulness.* Washington DC: American Psychological Association.

Sharma, R., (2011). Carrying Forward: Explicating Gendlin's Experiential Phenomenological Philosophy And Its Influence On Humanistic Psychology. In: *Journal of Humanistic Psychology,* 51(2) 172-194. DOI: 10.1177/0022167810363919

Siegel, D., (1999), *The Developing Mind.* New York: Guilford Press.

Siegel, D., (2003). An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma. In: Solomon F. & Siegel D. eds. *Healing Trauma – Attachment, Mind, Body and Brain.* New York: Norton.

Siegel, D., (2007). *The Mindful Brain.* New York: Norton.

Siegel, D., (2010 a). *The Mindful Therapist*. New York: Norton.

Siegel, D., (2010b). *Mindsight.* Oxford: Oneworld Publications.

Siew Luan Khong, B., (2007). The Buddha's Influence in the Therapy Room. In: *The Hakomi Forum* – Issue 18, Summer 2007. Downloaded on 3rd March 2016 from: http://www.hakomiinstitute.com/Forum/Issue18/4_HF_Buddha_in_the_therapyroom.pdf.

Smith, R., (2010). *Stepping out of Self-Deception, the Buddha's liberating Teaching of No-Self*. Boston: Shambhala.

Solomon F. & Siegel D. eds. *Healing Trauma – Attachment, Mind, Body and Brain.* New York: Norton.

Spinelli, E., (2005). *The Interpreted World – An Introduction to Phenomenological Psychology*. 2nd ed. London: Sage.

Spinelli, E., (2006). The value of Relatedness in Existential Psychotherapy and Phenomenological Enquiry. In: *The Indo-Pacific Journal of Phenomenology, Vol. 6*, Special Edition, August 2006.

Stern, D., (1998). *The Interpersonal World of the Infant*. London: Karnack Books.

Storr, A., (1989). *Freud*. Oxford: Oxford University Press.

Taylor, M., (2014). *Trauma Therapy and Clinical Practice – Neuroscience, Gestalt and the Body.* Maidenhead: Oxford University Press.

Van der Hart, O., Stele, K., (1997). Time Distortions in Dissociative Disorder: Janetian Concepts and Treatment. In: *Dissociation*, 1997, 10(2), 91-103.

Van der Hart, O., Nijenhuis, E. and Steele, K., (2006). *The Haunted Self – Structural Dissociation and the Treatment of Chronic Traumatization*. New York: Norton.

Van der Kolk, B., (2007). The Complexity of Adaptation to Trauma: Self-Regulation, Stimulus Discrimination, and Characterological Development. In: Van der Kolk, B., Mc Farlane, A. & Weisaeth, L., Eds. (2007). *Traumatic Stress.* New York: Guilford Press.

Van der Hart, O., (2012). The Use of Imagery in Phase 1 Treatment of Clients with Complex Dissociative Disorders. In: *European Journal of Psychotraumatology* 2012;3: 10.3402/ejpt.v3i0.8458. DOI: 10.3420/ejpt.v3i08458

Van der Kolk, B., Mc Farlane, A. & Weisaeth, L., Eds. (2007). *Traumatic Stress.* New York: Guilford Press.

Van der Kolk, B., Van der Hart, O., Marmar, C., (2007). Dissociation and Information Processing in Posttraumatic Stress Disorder. In: Van der Kolk, B., Mc Farlane, A. & Weisaeth, L., Eds. (2007). *Traumatic Stress.* New York: Guilford Press.

Van der Kolk, B., Weisaeth, L. & Van der Hart, O., (2007). History of Trauma in Psychiatry. In: Van der Kolk, B., Mc Farlane, A. & Weisaeth, L., Eds. (2007). *Traumatic Stress.* New York: Guilford Press.

Van der Kolk, B. (2001). The Assessment and Treatment of Complex PTSD. In: Yehuda R. ed., *Traumatic Stress.* American Psychiatric Press.

Van der Kolk, B., (2003). Posttraumatic Stress Disorder and the Nature of Trauma. In: Solomon F. & Siegel D. eds. *Healing Trauma – Attachment, Mind, Body and Brain.* New York: Norton.

Van der Kolk, B., (2014). *The Body Keeps the Score*. London: Penguin.

Van Deurzen, E., & Adams M., (2011). *Skills in Existential Counselling*. London: Sage.

Wallin, D., (2007). Attachment in Psychotherapy. New York: Guilford Press.

Watson, G., (2008). *Beyond Happiness – Deepening the Dialogue between Buddhism, Psychotherapy and Mind Sciences.* London: Karnac.

Weiss, H. (2008). The use of mindfulness in psychodynamic and body oriented psychotherapy, *Journal for body, movement and dance in psychotherapy*, London: Taylor &Francis.

Weiss, H., (2015). Characteristics of Hakomi. In: Weiss, H., Johanson, G. & Monda, L. eds., (2015). *Hakomi Mindfulness-Centered Somatic Psychotherapy – A Comprehensive Guide to Theory and Practice.* New York: Norton.

Wellings, N., (2015). Why Can't I Meditate? London: Piatkus.

Williams, M., Teasdale, J., Segal, Z., and Kabat-Zinn, J., (2007). *The mindful way through depression.* New York: The Guilford Press

Yalom, I., (1980). *Existential Psychotherapy*. New York: The Perseus Books Group.