

**Rubinfeld Synergy Method, Neurobiology, Attachment Theory
and Trauma Treatment: A Conceptual Integration**

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INTRODUCTION

My interest in analyzing the video of Ilana Rubinfeld's work *Speaking My Truth* represents the trajectory of my professional experience and goals. My professional focus has been to support clients in their awareness and choices.

My professional training began with receiving a BS in Nursing from Cornell University. This five-year program, requiring courses both in psychology and the physical sciences before entering the clinical part of the program at New York Hospital, offered an unusual perspective (Margaret Mead was a guest lecturer). Illness was seen as an interactive dynamic between the organism (person), the agent (bacteria or virus), and the environment. Part of nursing practice was to teach patients how to regain and maintain optimal overall health as they were treated for their particular illness.

In addition, I chose to obtain a Masters in Social Work because of this profession's perspective on the "bio-psycho-social" assessment of the client, and because of its emphasis on the primacy of the relationship between client and therapist. I chose Simmons Graduate School Social Work because it emphasized the psychodynamic process or the meaning the person gave to his/her experience.

In my clinical practice, my work with trauma and addictions sparked my interest to learn more about those physiological components of experience which interfere with a person's awareness and choice. I was drawn to the RSM training program because it embraces a complex paradigm, its scope involves the whole person, and it includes a unique and developmentally organic, interactive contact between synergist and client. Intentional touch heightens the client's self-awareness and his/her experience of a personal boundary. My view is that RSM embraces both the salient biophysical and psychosocial aspects of a client's experience.

INTENTION

It was my intention to analyze a Rubinfeld Synergy Method (RSM) session with the RSM lens and the additional lenses of clinical trauma treatment and of current neurobiology and attachment theory as they apply to the session with the client.

I hope to demonstrate that the basic principles of RSM illuminate the new understanding of neurobiology and attachment theory and vice versa. In the hands of a skilled practitioner (synergist), RSM provides clients with direct support for the somatic and sensory processing of the dysregulated physiological processes triggered by traumatic memory. Also, this process, as demonstrated in the video, is consistent with the current clinical understanding of the treatment of traumatic memories.

RUBENFELD SYNERGY METHOD

History

Ilana Rubenfeld comprehended the holistic body-mind nature of a person's experience. She named her method "Synergy" in recognition of the dynamic process that evolved from the integration of her education, experience, and vision.

Her "Synergy method" (RSM) has its roots in three areas:

- 1) F.M. Alexander's teachings of the revolutionary concept of mind-body integration. His systemic understanding that the positioning of the head and the lengthening of the spine had an effect upon a person's sense of overall functioning was novel. He demonstrated that postural awareness offered the possibility of choice in changing unconscious patterns. (Leibowitz and Connington 1990).
- 2) Moshe Feldenkrais (System of Functional Integration) whose concepts of neuromotor teaching and reconditioning recognized that the complexity of action included movement, sensation, feeling, and thought. He included the body's developmental processes of play, repetition, and exaggeration of movement in learning. (Rywerant 1992).
- 3) The experiential concepts of Gestalt Therapy (Fritz and Laura Perls) which define the locus of psychological change to be in the current experience of the person as he/she interacts (makes contact) with the environment. (Nevis 1992).

RSM also integrates knowledge from Family Systems Theory (Virginia Satir) and from an understanding of the trance states of Eriksonian Hypnosis.

Ilana Rubenfeld has shaped her integration of these theories in 40 years of practice and 30 years of training students in RSM. Her comprehension and processing of her personal experiences and of her professional education and training enabled her to synthesize the multiple components of simultaneous experience that are inside and outside the conscious awareness of a person. Historically, these components had been arbitrarily separated by methodology and discipline into aspects of the body, brain, mind, psychology, philosophy and/or spirituality.

Training

RSM practitioners ("synergists"), during a four year professional training program, learn the essential skills of interpersonal relationship, learn the significance and experience of body mind movements (to facilitate internal awareness and the experience of change), and develop the capacity to listen to and facilitate the verbalization and integration of the body mind awareness of their clients. Synergists learn the process of communicating through the unique combination of simultaneous somatic and verbal contact.

Concepts and Process

RSM is a methodology which perceives a person holistically, as a dynamic interrelated system of body, mind, spirit, and emotion. This perception informs the synergist in how to guide and support a client to reconnect (integrate) the disconnected components of his/her interrelated system as they emerge (are discovered) during the synergy process.

The perspective of the RSM session is organic, systems oriented and dynamic. The methodology is informed by the ontological principles of growth and change. The process engages the conscious (known, felt, perceived) and unconscious (neurally stored but not yet perceived or felt) aspects of the client's experience. It is inter-subjective, collaborative, respectful and empathic. Intention, contact, listening and touch are the cornerstones of the process.

The synergist uses a "listening touch" to guide, enhance and/or ground the client's sensory-somatic awareness and uses verbal skills to explore, understand, and support the client's verbalizations (language of this awareness) and his/her expressions of the thoughts and beliefs (meaning) associated with this awareness. This dual focus allows the flow of body mind information processing within the client's own system. Gentle movement of the body is part of the awareness and integration in this process. The synergist is a guide and a resource as the client becomes attuned to his/her sensory- somatic experience and thoughts.

The synergist supports the client to integrate the disconnected components of his/her body mind experience. The completion of interrupted stories or movements and /or the discharge of constricted energy held in the body can be part of this process. The synergist is attuned to the shift in the client's flow of information processing through touch and verbal communication. The client's resources are explored and identified somatically and cognitively. The synergist then guides or supports the client to imagine, verbalize, and/or move toward potential future action in the "here and now" of the session. Future action is planned or rehearsed, and the client's awareness of his/her experience in the planning and rehearsing becomes his/her (felt and known) resource for recalling the new learning, and/or possibility that was experienced.

The video is a demonstration of a RSM session. It is not within the paradigm or practice of RSM to diagnose or treat clinical conditions. However, the video demonstrates that the concepts and process of RSM are illustrative of the concepts underlying treatment of traumatic memories and are validated by neurobiology and attachment theory.

NEUROBIOLOGY AND ATTACHMENT THEORY CONCEPTS APPLICABLE TO UNDERSTANDING THE VIDEO

Concepts from Neurobiology

Advances in clinical studies and brain imaging techniques reveal that the brain's functioning is far more complex and interconnected within the brain itself and throughout the body than previously known. The brain is now seen as the super system of a network system of constant information processing that functions as an interrelated brain-body dynamic. The central nervous system and the peripheral nervous system(made up of the sensory division and the motor division) link the body to the brain and the internal experience of a person to the outside world and vice versa. Nerves (neurons and nerve fibers conducting electrical impulses) and biochemical information (message delivering substances) flow through the body and back to the brain in a non-linear manner via neural pathways and via the bloodstream through neurotransmitter and biochemical release. An intervention at any point in the system will influence and be influenced by events at other points, and information flows from top down (brain to body) and bottom up (body to brain). The biochemical information substances are now known to be more complex and include: neurotransmitters, steroid hormones, and the most recently discovered peptide hormones- neuropeptides and growth factor. The myriad number and specificity of receptor sites reveal that the information processing has its own innate intelligence, beyond what we currently know.

The brain is interactive with and also influenced by the environment (persons and the external environment). Its interaction with the environment determines the manner in which its genetic material unfolds. The brain is capable of growth and change throughout a person's life time (evidence shows through mid-life).

The physical structure of the brain consists of the brainstem, which regulates biophysical processes and takes in information from the senses and the body, the midbrain (limbic system) which generally regulates emotions and the neocortex (top part of the brain) which generally regulates thought and cognition. The brain functions like an analog processor which sorts, collates and stores information, in the form of images and schemata, according to similarities and differences. Rather than having specific anatomical areas of the brain dedicated to specific functions, we now know that there are convergence areas of neurons in the brain for specific functions and these convergence areas intercommunicate and influence each other. The spaces between the gray matter and the white matter are important. Feelings and thoughts are known to be neurally interconnected and not completely separate processes. (Applegate and Shapiro 2005, Damasio 1994, Pert 1997, Ratey 2002).

The mind is a process that depends upon neural information from the brain and information from the body as part of an integrated biological system. It is a representational process of image and perception that informs and is informed by the person's experience. It includes all the brain functions and the additional systems of consciousness, emotions, feeling, memory, thought and information processing. Brain, body and mind are interconnected and interdependent.

Consciousness includes a knowing of self. Damasio (p.128,1999) states that “The full scope of the mind is not confined to images of what is perceived externally or what is recalled relative to what is perceived. It also includes you”.

Damasio (1999) distinguishes between emotions (the process of the biological state in motion) and feelings. He categorizes emotions as: 1) primary (innate) and dependent on limbic system circuitry and 2) secondary, dependent on innate emotions and also linked to a more complex interactive body mind feedback loop which involves mental changes and somatic (bodily) changes. (The latter can also involve conditioned somatic and mental responses to a specific place in the body which he terms somatic markers.) The somatic experience can change the mental process and the mental process can change the somatic experience.

Feelings are the experience of the somatic and mental change inside the person and they can be conscious or unconscious (capable of becoming conscious).

Damasio delineates three senses of self:

- 1) a proto-self which is a neural representation of the moment to moment state of body processes and is non conscious (does not become conscious);
- 2) a core self which is based in a consciousness of the here and now body processes; this self is transient and ever changing (it depends on the functioning of the proto-self as its foundation);
- 3) an autobiographical self which depends on a sense of extended consciousness, i.e., a perception of self over time that is continuous through past, present, and future.

The autobiographical self includes autobiographical memory which combines stories or representations of ourselves over time. These stories form a coherent narrative, and, like all memory, are subject to condensation, compression, and distortion.

Siegel reports that some of the most important information about the neurological links that are involved in interpersonal communication and regulation of our internal physiologic state “...show that the processes involved in self-regulation, the creation of meaning, and interpersonal communication involve overlapping neural circuits. These are the same circuits that mediate emotion and seem to be part of the process that creates autobiographical memory” (p 18. in Solomon and Siegel 2003).

Concepts from Attachment Theory

Attachment theory is based in the biological (hard wired) survival requirement that an infant attach to a caregiver. This attachment begins in the first year of life, during the most significant growth spurt of the brain. Research confirms that the quality of the infant-caregiver relationship between birth and the third year of life shapes the development of the infant’s brain and mind functions. The primary caregiver’s ability to be empathically

connected and attuned to the infant's bodily-based physiological needs and states of arousal is the process that supports the development of positive attachment. This primarily right brain mode processing of attunement allows the infant/child to develop a capacity to self-soothe, self-regulate physiologic hyperarousal states and experience the environment as safe. The caregiver's ability to respond with consistency, his/her own self regulation, affective matching, and mirroring of the infant's state supports the infant to develop a boundary between self and other, and to maintain physiological homeostasis. It is in this context that trust develops, trust of self and trust of the other.

From research and experience, Shore defines the essential task of the first year of life as the creation of a secure attachment bond and emotional communication between infant and caregiver. Some of the qualities of this emotional communication and empathic attunement are intuitive, facial, vocal (tone, rhythm, quality of speech), gestural, postural and nonconscious. He believes that this attunement, through mirroring, synchronistically engages the brain interaction between caretaker and infant. (Shore, in Solomon and Siegel 2003).

A study group of psychoanalysts and developmental researchers (The Boston Change Process Study Group) has identified the salient factor [extrapolated from data on positive child-parent and patient-therapist relationships] that promotes change. "It is that the formative experience (my emphasis), whether in childhood or therapy, registers mainly in the domain of implicit knowing, [that it is] ... procedural rather than symbolic, enactive rather than narrative. It includes 'knowing how to' rather than 'knowing that' and it includes knowing how to be with people"(Wallin,p.12. 2002).

Extrapolating from the process of attachment, we know that people communicate much more than verbal content when using right brain synchronicity; they communicate their emotional state. This synchronicity is neurological and evokes the emotional feeling state within the other person .This synchronicity enables adults to actually feel what another person feels. (Applegate and Shapiro,2005).

TRAUMA MEMORY THEORY APPLICABLE TO UNDERSTANDING THE VIDEO

Concepts About Trauma

Trauma is an experience of overwhelming threat to our safety and/or survival. The Autonomic Nervous System releases a cascade of hormones that activate the fight/flight/freeze response within. As these hormonal substances are cleared (discharged) from the system and the threat is no longer present, physiological homeostasis is restored. When the normal discharge of the fight/flight/freeze response cannot complete itself, some of the physiologic components of this response are stored in the body as a post traumatic stress reaction.

Levine (1997) describes four components of a traumatic stress reaction:

1. Hyper arousal (increased heart rate and rate of breathing, agitation, difficulty sleeping, tension, muscular jitteriness, and racing thoughts)
2. Constriction (of blood vessels in the skin, extremities, and viscera) and of awareness (hyper vigilance to the perceived threat)
3. Dissociation (a split between some aspects of the body and/or mind)
4. Freezing (immobility) which is associated with the feeling of helplessness.

The bio/ physiological sequelae of trauma are stored in the body as arousal activated (triggered) memory. They are often stored as split-off pieces of the experience (sensations, feelings or emotions – parts of the affective response to the event) that are not integrated somatically with a coherent narrative or sense of self over time. These stored bio/physiological responses can be activated (triggered) by a stimulus (which is usually sensory) associated with the original event, which overwhelms the person's system. In addition some of the affective components (feelings and the meanings that are attached to these bio/physical responses) are also reactivated. Scaer (2001) identifies the foreground features of post traumatic stress reaction as a perceived sense of helplessness and violation of the sense of personal boundary which endures the actual overwhelming threat.

Whether or not a trauma produces a post traumatic stress reaction is dependent upon the interrelated dynamics of: the person (body mind development and previous experiences), the nature of the event itself, and the environment (interpersonal and physical). Fragments of trauma are stored primarily as sensory or emotional memory in the implicit memory system (defined below) of the mind. Any aspect of the five senses and/or the kinesthetic and proprioceptive senses (including visceral and postural senses) can be associated with and trigger the memory. The autobiographical sense of self a person stores in relation to the trauma is stored in the explicit memory system (defined below), even though the original event of the trauma may not be recalled. Additional negative components are added to this sense of self each time the post traumatic stress response gets activated, especially reinforcing the sense of helplessness and the violation of personal boundary (it's happening inside the person, and he/she has no control over it).

Experiences are stored in the brain as memory. There are two distinct memory systems: implicit memory and explicit memory.

Implicit memory is procedural and responsible for the recall of coordinated sensorimotor behaviors, to ("know how"). It has both emotional and perceptual components, and involves both sensory images and body sensations. It is associated with the amygdala region of the brain, is present at birth, is non-declarative (does not have language), and is unconscious. Retrieval (recall) is only in the "here and now" without a subjective sense of self or time.

Explicit memory includes two major forms: semantic (factual) and episodic (autobiographical which has a sense of self over time). Explicit memory is concerned with facts, sequences, and resolution (meaning), of “knowing that”. It does not develop until after the first year of life and is associated with the hippocampus, which does not mature until age 3. It is conscious and narrative (has language) and there is a subjective sense of “something being recalled”. (Siegel in Solomon and Siegel 2003; Rothschild 2000; Scaer 2001).

B. van der Kolk (p.174 in Solomon and Siegel 2003) has distilled the unique characteristics of trauma memory from a century of research: (I quote)

- 1) It is imprinted primarily in sensory and emotional modes...
- 2) The sensory experiences often remain stable over time and are unaltered by other life experiences.
- 3) They may return, triggered by reminders...with a vividness, as if it is happening all over again....
- 4) These sensory imprints tend to occur in a mental state in which the victim may be unable to precisely articulate what they are feeling and thinking...a characteristic dominant during the first year of life...when information processing is nonverbal.

Concepts About Trauma Memory Treatment

In the treatment of traumatic memories, the client’s titration of the stored affective response to the trauma is the basis for safety and integration. The therapist lends her self-regulatory functions as a model and guide to this process. In this state of his/her own self-regulation, the therapist guides the client to selectively focus on the triggered sensory motor sensations and to discover the body mind resources available to metabolize these sensations. As this is accomplished, the co-creation of a narrative can evolve.

Children are at high risk for developing post traumatic stress responses because of their developmental vulnerability. Children are at heightened risk for experiencing a violation of trust and safety, because their sense of boundary is not fully developed. If the parents are associated with the traumatic event, in any way, the child is likely to blame him/her self for the trauma because the preservation of the attachment bond is primary.

Briere (2002) provides a framework for working with adult clients who have been abused as children. He has based his theory of treatment on a self-trauma model, which has a cognitive-behavioral perspective. He expands this theory of self-psychology to include emotions as well as cognitions, “deep” cognitive activation, relational schema, and the role of early attachment experiences on thoughts, feelings and memories.

Although the way of processing material is decidedly different in RSM, I will be referring in the synopsis of the video to Briere’s framework only because it provides the essential guidelines for processing traumatic memories from childhood events and serves as a valid way (in terms of current trauma theory) to illuminate portions of the RSM session.

Briere believes that three aspects of therapy are inter-related and must be balanced during the processing of trauma material:

1. Exploration vs. consolidation
2. Intensity control
3. Goal sequence

Exploration refers to the detailed examination of the sensations and feelings associated with the traumatic memory in a context of relative safety (the interpersonal relationship with the therapist) in order to investigate the “how” and “what” of these sensations.

Consolidation refers to the foundation of safety which the client experiences within him/her self in the work with the therapist. The therapist helps the client increase his/her awareness of (these inner) self capacities by lending her self-regulation and guiding the client to focus on his/her additional somatic and physiologic resources in the “here and now”. The therapist may guide, validate, soothe or support the client to facilitate his/her capacity to increase this awareness.

Intensity control refers to the level of activation and the therapist’s role in helping the client titrate the balance between feeling too much (so that the client’s system is overwhelmed) and not feeling enough (so that nothing changes for the client).

Goal sequence means that priority is given to the capacity and awareness of the client’s sense of self before processing trauma material. The therapist needs to assess and help the client identify his/her resources and basic level of affect tolerance (or ability to tolerate affect) and self-regulation throughout the therapeutic process.

The treatment process (of Briere’s framework) is focused on the impact of trauma to the child who presents as an adult in treatment and includes:

- 1) An ongoing assessment of client safety and providing support for the client
- 2) A facilitation of client self awareness and his/her sense of a positive identity
- 3) Exploration of the client’s self-other entitlements and boundary issues (This issue of entitlement in relation to others is complicated by early attachment needs as well as any violation to the physical boundary of the child, such as surgery. A child can become confused about what belongs inside of his/her self and what belongs outside.)
- 4) Facilitating the client’s ability to experience increased awareness and competence in affect modulation and affect tolerance
- 5) Transferential work with the therapist to correct experiences of disturbed childhood relationships

Trauma memory treatment is aimed also at helping the client to discharge the biophysical responses and fragments of sensory and emotional memory and to integrate his/her experience into a coherent narrative as part of his/her autobiographical narrative. This involves pacing of the triggered physiological responses to allow metabolism and integration of these responses and separating a sense of self from the traumatic event and from the triggered responses to the event. Neural integration of right brain/left brain processes are necessary for this to happen.

The right hemisphere is "...dominant in growth for the first three years of life... it processes information as non-verbal signals in a holistic, parallel, visual spatial manner. Self-soothing is also a major function of the right hemisphere. (It is)...dominant for non-verbal aspects of language, tone of voice, gestures, facial expression of affect, the perception of emotion, the regulation of the automatic nervous system, the registration of the state of the body, and for social cognition...as well as mediating the retrieval of autobiographical memory.... The left side of the brain develops later-...and is about linear processing using linguistics in a logical fashion... (It) uses syllogistic reasoning...(which is concerned with) cause and effect relationships that can explain the rightness and wrongness of things (Siegel,p14-15,Solomon and Siegel 2003).

The integration of right brain/left brain neural processes during treatment must maintain a delicate balance that challenges the system to metabolize the physiological sequelae of the trauma but that does not overwhelm the system. The sensory motor responses of hyper arousal, hypo arousal, and the helpless state need to be "titrated" in a way that allows the client to release the stored sensations and emotions and to metabolize them. The practitioner "lends" her self regulatory function to the process to support the client's regulation of these intense sensations and emotions. The ultimate goal for the client is to return to a homeostatic state of body mind information flow and to have a coherent narrative about his/her self.

Summary of Above as Pertinent to RSM

All experience begins as sensory experience. Sensory experience (internal or external) can be direct or indirect via associations to previously stored images or schemata in the mind. Both the direct and indirect experiences are "collated" to preexisting schemata in the mind and are woven into the ongoing (autobiographical) narrative of the person's sense of self. The entry point for change in the person's narrative and consciousness of self is at the level of core consciousness, which is usually the background state of a person's consciousness. Heightening a person's awareness by bringing attention to his/her biological and internal sense of self allows the person the possibility of shifting the sense of self in the present state of his/her autobiographical narrative. RSM's use of touch is a direct sensory contact that allows a person to heighten his/her awareness of this internal state. Heightening a client's somatic awareness of self while exploring the client's associated cognitive meanings, supports and enhances the client's ability to integrate a new meaning and a new sense of self. The somatic awareness and "marking" of this experience provides the client with a subjective internal reference point. The specific way synergists use touch to make contact with and listen to clients' body mind stories enhances the possibility of core conscious awareness.

In general, good psychotherapy treatment involves a process of body mind neural integration in which the client's affective components (emotions and feelings) are processed and integrated into a new understanding (meaning). The neural networks involved include those "... dedicated to sensation (associated with the brain stem), affect (associated with the limbic system), cognition (associated with the cortex) and behavior." (p.147, Applegate and Shapiro 2005). Neural interaction is enhanced in the co-creation of the narrative process. Affective arousal from the limbic system and brainstem (sub cortical neural networks) are moderated by cortical processes, "...while affective (right brain) arousal is balanced by cognitive (left brain) processing." (p.149, Applegate Shapiro 2005). The co-creation of a narrative with the therapist is an interpersonal process that allows the client new possibilities of self in the "here and now" of his/her autobiographical story. The RSM process organically weaves the subcortical and cortical processes of a person's story into the narrative by means of simultaneous somatic and verbal communication.

The process of therapy is a function of the client- therapist relationship which is enhanced by the therapist's attunement and ability to create a "holding environment" (psychoanalyst D.W. Winnecott's term) for the client. This is most directly replicated in the listening touch and communication process of RSM. The synergist's ability to replicate the attunement of right brain mode processing with the client is enhanced by engaging the sensory system of both client and synergist.

THE SYNOPSIS OF "*Speaking My Truth*": A Rubenfeld Synergy Session

(Note: Reference within this synopsis will be made in brackets [] to the concepts about Neurobiology, Attachment Theory, and Trauma Treatment which were presented above.

Introduction (5:40-9:22)

This segment of the videotape is the introduction of the session and marks the time that Kara (C) (the client) comes forward to sit on the table and talk with Ilana Rubenfeld (S) (the synergist) until the time that C lies down on the table and S makes contact with her by means of "listening touch".

S's initial contact with C communicates S's full energetic presence and resonance with C. Non-verbal communication is foreground to verbal communication and linear understanding. S's face is expressive and soft; her body position is nodding and affirmative, and her responses and observation "match" and are "in tune" with C's statements and non-verbal communications. S elaborates C's statements by acknowledging, "that's special" and reflects back small phrases to C. S adds her own self-regulatory function to the exchange with a calming tone and postural steadiness (grounding). This behavior and communication is the process of attunement which replicates the positive bond essential in early childhood [Attachment Theory]. S's tone, facial expression and body communicate acceptance as in, "You are fine; I am pleased you are here, and I am in tune with you". This process creates a "holding environment" for C and establishes the foundation of safety and trust necessary for therapeutic work; [Trauma Memory Treatment].

S is also observing C from a unified body mind perspective of a person's functioning; [Neurobiology]. An assessment of C is done organically by noticing her somatic (body) response to her verbal story and visa versa. Her somatic presentation is noticed: body posture including patterns of skeletal holding, muscle holding and tension, how she moves and from what place the movement originates in her body. This somatic presentation is the embodiment of early patterns and past history.

(5:40) S uses body focused (movement/action) inquiries and statements: "When you heard the word volunteer, what propelled you...?" (Ratey (2002) describes consciousness as analogous to four theatres in the brain with each theatre being farther removed from our actual experience. He recommends asking questions which are directed towards what a person actually does (actions, functions) to come closer to the person's experience of themselves.) [Neurobiology].

(6:57) S guides C's verbal statements to awareness of her body as she reflects back C's statements and also adds "In your body..." Damasio defines our core experience as what is biologically happening in our bodies. He states that attention needs to be directed towards what we are experiencing in our bodies, since it is usually only available to us as background information. This is particularly important because our core experience is the only place in a person's narrative that he/she can change. [Neurobiology].

(8:10) S mirrors what she has heard with a positive affirmation: "This was so rich ...you told me a lot about yourself..." S focuses the information to the "here and now": "Right now in your life..." [S's communication now and throughout the session is consistent with the manner and tone of early bonding positive attachment. In places where I state that she directs the client, this is done in a gentle manner much the way a good parent defines limits or boundaries for a child.]

C spontaneously adds additional information that is about the voices of spirit/God which are awakening her, sending her messages at night. Even though the information is positive, the "presenting problem" or her distress is that she is awakened each night and cannot get back to sleep. She is awake and drawing and writing (about the messages). The lack of sleep, awakened earlier each night (last night at 3 AM) is getting her "mad".

(9:00) S mirrors C's aggressive word "mad" softly and with humor, expanding the feeling into action suggesting: "need to slap him around...thank you very much...enough is enough..." S is presenting the possibility of integrating aggression with gratitude and limit setting.

S has also learned from C that she is aware of not experiencing a "center" in her body any further down than her heart chakra, which is connected to the spirit/God. C is consciously working on transforming herself and coming from a place of her truth, rather than conforming.

Beginning (9:22:14:50)

This segment of the tape begins with C lying down on the table. It marks the time when S first makes physical contact through touch until the time of deepening of the work when C's past memory of trauma gets physiologically triggered.

(9:24-10:40) As C lies down on the table, S verbally encourages her to do what her body is already doing: "Arrange yourself any way you want". S engages in what she terms "prattle" (a permissive hypnotic technique sounding like insignificant chatter that distracts the brain and deactivates a traumatic response. (10:27) C's eyes are fluttering, indicating that she is in a light trance state.

(10:40) First Touch. S makes contact with C's head. S and C are now making direct sensory contact which allows them to "get acquainted" with each other on a sensory level. S is able to make contact with the body mind of C and heighten C's awareness of this. S can feel the holding and fluidity in her skeletal system, the pulsing in the circulatory system, as well as C's somatic and energetic response to her touch. C learns who the S is through her sensory system. The attunement to one and other on this sensory level is the attunement of a mother and child and allows C to sense her awareness of safety in the relationship with S. [Attachment Theory]. There is a "holding" in C's body, and her breathing is shallow.

(10:45-11:35) S continues to prattle while gently engaging and disengaging contact with C's head and offers a hypnotic suggestion of "needing to sleep, to get rest for energy ...and presence."

(11:55) S makes contact with C's feet. This allows for awareness of a top to bottom sense of connection for C (if present) and allows S to assess the flow of energy peripherally from C's feet to hips (bottom up) by gently moving them [Neurobiology]. There is holding and little movement in the feet, legs, and hips. S verbalizes safety and acceptance of C's "here and now" state by her tone and words, "yes-all right" [Attachment theory].

(12:19-13:19) S gently guides C's attention to inner awareness of her lower body by first asking her "what are some of the messages you are getting at 3 AM in the morning?"- as she approaches her left hip. C tells S that she has had two dreams about her dog Angel and her cat Spanky. S uses this information (which is already in C's unconscious/body dream state) to support C's (potentially safe) conscious energetic connection to her left hip. S directly asks C which one of her pets is in this hip as she simultaneously makes contact underneath and above the left hip joint. C answers "Angel" and the held quality in her hip softens. S sweeps this energy down C's leg and foot; there is freedom of movement from left hip to foot.

(13:19-14:01) S continues to direct C's attention to inner awareness of her lower body by stating, as she approaches the right hip, "...now we are going to cat Spanky". As she is making contact with C's right hip, S asks, "What are you going to say to him?" C answers with "Spanky is spunky." There is a similar release of holding and a movement from right hip to foot. As S "shuffles" toward the left shoulder, she asks C what she would like to say to Angel. C answers "She's a sweetie-a good girl". [Neurobiology: S has begun a right/left

neural processing by using attention, focus and touch on both sides of C's body. S has helped C somatically mark in her hips the possibility of integrating opposite affective energies in her body: the softer energy (heard in C's tone of voice and name of dog Angel) and more aggressive energy (heard in C's tone of voice and name of cat Spanky). S asks the conscious mind of C what she wants to say to Spanky. C now has the energetic availability of her hips, legs, feet (as evidenced by the freedom of movement), and the possibility of integrating opposite energies in her body.]

(14:15) S gently shuffles back towards C's head. As she makes contact with C's head and neck, S describes a lovely way to work with dreams, which she learned from Fritz Perls, is to speak about the dream in the present tense, as though it is happening now.

Middle of Session (14:50-39:50)

This segment of the tape is the active “working through” of the traumatic sensations and memory and marks the time that begins with the activation of a physiologically stored traumatic memory through the time that S supports and guides C's actively “ working through” this memory. This is evidenced by C's physiologically relaxed somatic state. This includes C's metabolizing of the energy stored in her body; establishing boundaries that identify self as separate from family; completing unfinished business attached to the trauma and creating a positive identity of self in relation to the trauma. [Trauma Theory] C's integration of this work is enhanced and facilitated by S's ability to feel the physiological shifts that are either outside C's conscious awareness and/or trigger a traumatic response. The somatic information available to S through listening touch allows her to make interventions that supersede C's ability to know consciously or to verbalize what is happening. Early intervention geometrically increases the positive effect on the interconnected biological system. [Neurobiology]

S skillfully utilizes C's dream material to facilitate C's ability to practice boundary work and action (speaking her truth). S supports C somatically and cognitively in this process. S consciously loops the practiced action back to C's traumatic memory. S paces this work by monitoring C's physiologic and somatic responses. [Trauma Treatment: pacing and titration]. C has the opportunity to connect consciously and somatically to the “here and now” experience of her narrative [Neurobiology: core consciousness]. S can observe and feel (and C can internally sense) the fluidity of C's skeletal structure at the end of this segment. [Neurobiology: Brain-Body- Mind Feedback Loop]

(14:50) S makes contact underneath the left shoulder-scapula and asks C: “What does your dog Angel, your Angel in the form of a dog, your dog say right now?” [S has synthesized the presenting problem (spirit/voices awakening her with messages), the dream content (her pet Angel), and her body (touch).] C answers, “I need to be taken care of” in a soft, low voice. S asks if C is aware of what just happened to her breathing. (15:20) S gently directs C to, “Tell me your dream in the present tense”- as S supports C to release held energy in her chest and shoulder.

(15:26) C becomes extremely sad: “I'm coming home from Omega (Her voice becomes lower) “...I don't know if I can say it” [Activation of physiological response to former

trauma]. S supports and assesses C's ability to tolerate and verbalize this feeling state [Trauma Theory]. S supports her physically and verbally to "stay with your sadness" as she makes contact with her abdomen and guides the movement of energy up and out of her chest. C's sensory physiology becomes more activated as she feels the sadness (wants to cover her eyes because the light is bothering her). (15:43) C covers her eyes and with physical support of S proceeds to tell her dream. "Everybody is happy- I ask them about Angel- where is Angel- she died- it's my fault- because I didn't take care of her."

(16:23) S, making contact with C's occipital ridge, reflects the incongruity of parental behavior with her words and tone, "...Some greeting-huh... no warning- nothing...Angel died...it's your fault...you didn't take care of her..." C becomes physiologically flooded and S soothes her by gently placing her hands over her eyes, stroking her face, and saying, "I know... I know" [Attachment Theory and Trauma Consolidation].

(16:56) S shifts the energy to deactivate the traumatic response (distraction) by asking C if she is ready for and then telling her a joke. S's hands are making contact with C's eyes and face, and as S tells the joke, she moves to C's left shoulder and touches her head and stomach. [Attachment Theory and Trauma Treatment: soothing and consolidation]. The joke includes a cat Puffy, a child, mother, death, and procedural information about steps along the way to "telling someone bad news". S is speaking in tone and content to the child in C [Attachment theory: attunement]. (18:44) C smiles- she "gets the joke". C is better stabilized and perceptibly breathing in her chest. [The basis of self is body. Self before trauma is fundamentally awareness of a self in a body separate from the traumatic response [Neurobiology and Trauma Treatment].

(19:01-19:54) S begins a cognitive interweave of factual information into C's activated affective state. [Trauma Treatment: Self-other issues, Boundary issues, Parental Responsibility.] S is monitoring C's somatic response that she can see (C is nodding yes) with what she can feel in her hands. S states that "You left the dog with them-They let your dog die" and explores the concept of guilt with C. "They must be Catholic (and includes some universal information about the Catholic version of guilt- blaming the other). "You left the dog with them-bad mistake" [Trauma Treatment: Boundary Work].

(19:54) Supporting C under her right shoulder and scapula, S says, "It sounds like your family is very good at making you feel guilty."

(20:11) S does a cognitive interweave of this information about family trance- "It's your family trance- Your dog is dead and it's your fault. What a phrase, not even a pause..." with C's present affective state. S then asks C to consciously identify how this trance is showing up in her life..."So how do they make you feel guilty in your life?"

(20:24) S cues C to her bodily response to this information. S has both hands under her upper back (from top of C) and states, "your body is very happy about all of this...it is."

(20:46) S making contact with C's occipital ridge identifies the repetitive aspect of family trance in C's relatively more relaxed somatic state, "They've done it again...this dream for goodness sake...it's in your unconscious...it's so much in you." [Trauma Treatment: More

cognitive and factual information woven into C's affective state; C's heightened awareness with support of S's somatic assessment and boundary definition.].

(20:49) S moves to support C's right scapula and shoulder, and in this physiologic state directs C, "Be in your dream...I'll suggest a sentence...do whatever you want (with it): You've done it again." A lessened degree of C's traumatic response gets activated and C needs a towel over her eyes. S supports her to continue in her dream content (there is a visible softening in her chest area). "Tell them what they have done...be really clear..." C cannot find words...breathes deeply...[Trauma Treatment and Attachment Theory: C has increased affect tolerance with the support and self-regulation of S].

(21:46-23:05) **Reworking of Trauma Memory.** C says "They made me feel responsible....S "uh-huh, for...[S offers somatic support and empathic connection for C to continue to integrate the cognitive and physiologic pieces of her traumatic memory. Trauma Treatment] C shares her memory of being made to feel responsible for two surgeries that failed. S asks age of C [Trauma Treatment: self-other entitlement]. She was age 7, so S makes distinction between self-responsibility at age 7 and the absurdity of the doctor's post-operative requirement of silence for one month. C is moving her right hand and gesticulating as she speaks. Rather than being asleep as she was told, C was awake and saw and felt everything. C makes the connection that the light that is bothering her eyes reminds her of the operating room light. S takes towel away from her eyes and lets C place her own hands over her eyes. S soothes her with her tone of voice and physically with her hands on C's stomach and on C's hands over her own eyes. S: "Of course"- and S reminds her (here and now) of "thanks goodness, it's not the operating room... you can cover your eyes". C cries more strongly and more deeply. S continues to support and soothe; "Oh my, my" and place her hands on C's hands on her eyes and stomach. [Attunement to support metabolizing of traumatic affect with direct contact to somatic markers. Neurobiology, Attachment Theory and Trauma Treatment]

(23:32-26:20) S supports completing unfinished energetic work with the doctor. C explains that she has dealt with this before and understands why it had to happen. S agrees that C understands but that a 7 yr. old needs something more. S begins co-creating a narrative from the feeling state and perspective of a 7 yr. old [Trauma Treatment: Physiologic state that has been activated and therefore is still stored in the body]. S adds the missing aggressive action piece. [Trauma Treatment: shift from "freeze state" to discharge of energy in action] S asks "...7 yr old Kara...have you really given this doctor the business...? I know you've told the story, but you haven't given him the 1-2". S while supporting C under the right shoulder(right hand had become active in retelling the story) asks "...what would you say in N. Dakota if you wanted to be really mean... and give something back?" C answers, "F.....A...H...." S enthusiastically supports....."That's great". C has both hands on her abdomen and is laughing. S is making contact with C at head and neck to C7, a place of neurological integration.

C continues to tell the story of post-surgery, gesticulating with her right hand about how she would forget to be silent for that month and say something; that her family would look at her in shock, and she would run to check her face (surgical site) in the bathroom mirror. She knew the doctor was bad from the beginning. Her Mother and Dad told her she'd be put to

sleep for the operations - they assumed. She went back at age 8 for a second operation that failed, and she tried to tell her Mother that the doctor was a “fucking asshole”.

C has found an ally in S who supports, empathizes, coaches and cheers the re-scripting of this narrative in the present context of C speaking her truth and being more present in her body.

(26:34-27:31) S questions C’s statement about her parents’ not knowing what happened to her during her surgery. S weaves factual information into the story at this point. S is at C’s feet and there is a tightening in C’s hips. C explains, “I thought they lied to me”. S agrees “of course...there goes trust 101”. S states clearly, “They assumed; they didn’t know”. [Trauma Treatment: important boundary work because a child will not trust herself in such a situation because of the attachment need to perceive parents as trustworthy and will think that there was some reason that they lied to her.]

(27:48) C describes how she asked the nurses to tell her when she was going to go to sleep. S has hands over C’s eyes [Neurobiology-Damasio: a somatic marker for the trauma event] and soothes her physically and verbally modeling good parenting, “You needed to sleep...sleep is very important...there are certain times in your life when you need to have your sleep... during procedures like this, you need to sleep”. [Trauma Treatment: correction of disturbed relationship with doctor and parents through transference relationship with therapist].

(29:13-30:00) C recalls more details of doctor’s cruelty. S, at C7, takes the lead in creating an image of a prize for this doctor and asks C to join in. C offers, “Biggest A...H.... in the world”. C is laughing as S offers the prize and S recounts the reasons for C that this doctor deserves this “fitting” prize for: strapping me down, telling me not to talk, not letting me sleep...when I was supposed to sleep. [Trauma Treatment: Correction of disturbed relationship with doctor].

(30:00:31:44) C identifies a knot in her stomach [Neurobiology and Trauma Treatment: Somatic marker associated with traumatic memory of surgery]. S with her hands on C’s abdomen, states that the body remembers all of this and want to get rid of it. C identifies that she has told the story of her surgery before but being quiet for so long is a new piece. [Trauma Treatment: increased self-awareness].

(31:54-33:44) S begins weaving the uncompleted action (speaking) associated with the trauma memory into the present tense dream content and somatic awareness of C. This is an “action narrative”. S includes contact with C’s left shoulder and left hand and both hips and head and neck throughout the creation of this narrative. She is monitoring the somatic state of her body and cueing C to notice this also. [Trauma Treatment: increasing awareness and competence in affect modulation] S directs C’s focus to “here in your dream, they say dog Angel is dead and it’s your fault...What does your body want to say to these people... Are you going to be quiet or are you going to say—How could that be my fault?” S guides C to connect with a core sense of herself by monitoring C’s somatic response to this narrative. S suggests that C say something just as crazy as what they said and cues C to her body’s response: “Your body like this-it’s getting warm-a little more of this.” C responds, “Maybe you killed Angel”. S states, “Good, your body is celebrating.” C continues, “I wasn’t even

here. I had nothing to do with it- You killed my dog Angel”. S states, “Your body is celebrating; notice how you feel...say it again...say it again....”

S is helping C to increase her awareness of her somatic response to her truth in the co-creation of this narrative. There is a relaxation in her body. [Neurobiology: Mind-body Flow of Information Processing.]

(34:04-35:00) From this somatic state of flow and relaxation, S is in somatic contact with her occipital ridge and directs C to do the same with the doctor, the operation and her whole family. S suggests the statement, “It’s not my fault...can you say that to them (C’s head rolls easily from side to side)...to A...H...Lamb (name of MD)” C responds with “F.....A...H...Lamb. I was never allowed to say that”. After S releases her contact with C’s head and her head rolls easily from side to side, C initiates an assessment of this doctor’s cruel behavior. He kept her awake and strapped her down for two surgeries during which children are routinely (and need to be) put to sleep. C has a tone of maturity and a perspective as she adds: - “what you did was barbaric”. S agrees with C; tone of voice matches C’s maturity. S supports C with contact to head and abdomen.

(35:11-38:00) As she supports her left shoulder, S informs C, “it is time to tell your family to stop assuming...didn’t ask questions...passed silence on to you...You are breaking that (family trance) mold”. S explores how C’s family processes their need for information as she has her hands under her head and neck area). C explains, “They would be afraid to talk back”. S asks, “What would they do?” C-“They just sit there; they sit in their fear.” S is making contact gently and tenderly with sides of C’s face and over her eyes (not covering them). S reminds C of what fear does to your body. “They were fearful people...they gave up their power...They gave it all away.” [S is energetically and physically soothing the site of C’s surgery as she identifies boundaries and behavior of the parents. S cues C to remember what happens in her body with fear: [Trauma Treatment: Boundary work, Self-awareness, Positive self-identity]. C remembers that her father told her to pray. S validates that it was wonderful to have God help her relax for her surgery, and that C was able to tell the doctor to get his elbow out of her stomach. [Trauma Treatment: S also weaves in cognitive information about lack of appropriate responses to danger when prayer is the only action available.]

(38:28-39:50) S rolls C’s head easily from side to side, indicating fluidity of head and neck movement, and body is softened and fluid. S weaves C’s presenting problem into this relaxed state...”So what do you need to tell these voices that come in the middle of the night...a kind good voice...?” C responds with certainty and enthusiasm, “I got it! They could let me sleep now...talk to me during the day.”

S moves torso gently and cues C- “Your body is really with that...That is the truth...not asking it to go away---talk to me another time---I need sleep.” [Neurobiology: S is helping C mark this relaxed body state with this cognitive awareness. Body interweave.]

Ending of Session (39:50-50:12)

This segment of the tape is the ending of the session and marks the time that **S** summarizes the body mind experiences that were new for **C** (new learnings as core body experiences) and guides **C** to become aware of the somatic theme of the session by asking **C** “what is the message from your body?” **S** helps **C** integrate these experiences cognitively and somatically as **C** sits up, stands, and walks around the room.

(39:50) **S** with her hand on **C**'s stomach and close to her head summarizes, “Today we have discussed right here and now... [Neurobiology: **S** emphasizes the core conscious experience of self] ... that you have a very good voice- you can use it- can say anything you want-can change anything you wish [Neurobiology: a change in consciousness of self occurs in the present conscious experience of self]- even saying F.....A...H ...MD and lightning didn't strike you.”

(40:13-42:28) **S** asks “What is the message” **C**- “It's ok when I speak; bad things don't happen when I speak.” **S** directs **C**- “Let every cell of your body know that”. **C** repeats the phrase as **S** sweeps down both sides of her body with her hands. **S** differentiates the past experiences from the future: “They did...They don't have to” and emphasizes the present core experience in her body “...I will be reminding every part (your body) to hear that...say it again.” As **C** connects to her present somatic state she shifts her self statement to, “I have the right to speak [self-entitlement] and good things can happen when I speak.” [positive identity]. **S** validates this by stating “that is the truth” and demonstrates (somatically and verbally) that all of **C**'s body is connected and fluid and cues **C** to notice this-[Trauma Treatment: increased awareness of affect modulation] : “Your body says whoop-dee-do. Your body is all connected.” [Neurobiology: Integration of cognitive awareness and somatic awareness]

(42:28-43:07) **S** instructs **C** to open her eyes very gently, and **C** repeats as she gazes into **S**'s face [Attachment Theory]: “good things can happen when I speak”. **S** agrees by mirroring her and expands her statement by weaving it back to somatically include: “especially when it comes from your heart.” This is an integration of **C**'s somatic awareness at the beginning of the session. **C** comes to sitting.

(43:43-46:38) **S** maintains full presence with **C**. **C** becomes self-conscious as she becomes aware of the camera and group looking at her; her breathing becomes shallow and her body tightens. **S** distracts **C** (from the reactivation of pieces of the traumatic memory) with humor, warmth and empathy as she describes how other graduates were concerned about how they looked when filming workshops. [Neurobiology and Trauma Treatment: She has distracted **C**'s activation of the piece of trauma memory concerning her family's shocked response to her speaking and has woven a universally true story in which **C** can feel herself included , while in the present state of affective activation.]

(46:38-50:12) **S** reminds **C**, “It will take a long time... to knowing you can speak... that you can express yourself and to be really appreciating who you are.” [Neurobiology: new experiences are integrated over time. Trauma Treatment: self awareness and positive identity].

C states, "I can speak and good things can happen." S directs C to say that to a few people as she walks around the room (practice of the new experience of self with movement and verbalization). At the very end of the session, S offers to make a sculpture (prize for the doctor) with C any time she wants. [Trauma Treatment, Positive Identity, Boundary Work: this is an additional lending of S's support (post session cue) to help C from being pulled back into the family trance: feeling guilty for saying something that her family would never say and never allowed her to say.]

CONCLUSION

Trauma is a bio-physiological phenomenon and treatment has to include a bilateral neural processing of the stored processes of this event. In this RSM session the synergist had direct somatic contact with both sides of the client's brain-body and she was able to move her contact with the seen and felt movement or holding of the client's energy (biochemical and neuron information flow). She was also able to synchronistically sense the client's need for support and guidance for this process. Since the inability to verbalize what is happening is a definitive component of traumatic memories, this sensory contact is significant. A core theoretical tenet of the treatment of trauma memories is to initiate a process of activation and regulation of physiological responses that allows the client to achieve homeostasis in a manner that parallels the infant's learning of self-regulation through relationship with a therapist. The latter concept also resonates with attachment theory. The synergist's presence (her contact and verbal and somatic process) as illustrated in the video parallels the subtle, fine attunement of positive infant-caretaker relationship. RSM's foreground method of whole body mind communication through sensory and verbal communication provided a unique feedback loop between synergist and client which is not available in the non-touch modalities of psychotherapy: a loop which made use of important principles both of trauma treatment and of attachment theory. Many therapists are sensitively attuned to clients. In this video, the RSM modality of touch allowed the client to neurologically activate her sensory attunement to the synergist's support and regulation in her state of physiologic activation. The therapeutic "holding environment" of RSM made contact with the client's core experience of activation. The synergist's use of humor (distraction) was done in the context of gently making contact with the client's somatic markers of the traumatic event before the client had verbalized this. The client's evolving energetic releases and verbalizations were supported by this same somatic and synchronistic contact. These understandings suggest a conceptual formulation of why and how RSM is effective.

This session subsumed the current neurobiological understandings of the mind- body-brain interrelationship and mutual dependency. The RSM process directly included right brain/left brain processing in its simultaneous use of touch and talk. The story of the body was "listened to" simultaneously with the story of the mind. Mental processes and somatic processes were "allowed" in the process of the session as organically as they evolved. With the synergist supporting a heightened somatic awareness, the client had the opportunity to evaluate stored mental components from a subjective state of bodily response. The body became a resource and a guide for the client to know her self and to make changes in the autobiographical narrative of her life.

This videoed session demonstrated that RSM is particularly supportive in guiding a client in the processing of a traumatic memory from childhood. The synergist used the client's dream content to heighten her somatic and emotional "here and now" awareness of the held dynamics of the trauma in a less intense way than a directly activated trauma response. Learning that Angel died in the dream was devastating and the dream allowed the client to observe a self who could feel this and describe the underlying family dynamic of the original trauma. The synergist was then able to name the client's early developmental pattern with her caregivers (family trance) and weave the cognitive incongruities of the dream into the trauma memory while simultaneously supporting the client's conscious somatic awareness of herself. The simultaneous heightened somatic awareness, supported by the synergist, allowed the client to experience her relaxed (integrated) somatic response to her subjective truth as a resource for herself. This helped the client to establish boundaries and an experience of self as separate from the trauma.

This session demonstrated the elegant weaving of new cognitive information and titrating of intense physiological responses with a new somatic experience of the self. It also provided the client with a "bottom up" (and inside out) heightened inner awareness of herself. Her shift in a sense of self in relation to her trauma occurred in the present state of an awareness of her body mind self. She was somatically and cognitively supported to complete unfinished business from the traumatic events and change her neurally patterned way of relating to her parents.

As mentioned in Neurobiology, an intervention with the present sense of self (core consciousness of self) is the only intervention available which effects or has the possibility of transforming a person's consistent (autobiographical) sense of his/her self over time. The client's enhanced awareness of her shifting somatic experience of herself while processing past emotional content with the cognitive interweaves of the synergist enabled her to shift her present sense of herself. She experienced this transformation of self; she shifted her perception of herself in relation to her past trauma and her perception of herself in the future. The client had access to an action (speaking her truth), somatic support to discharge the constricted energy associated with speaking and cognitive information that resonated with her body- brain.

The synergist was able to physically and emotionally support an integrated physiological state for the client. This allowed the incoherent (non logical) components of the dream narrative and trauma memory to be discarded and a coherent somatically based narrative to evolve. In this session the client not only metabolized some of the stored physiological components of her memory, she also developed a new self-awareness in relation to the memory and thereby had access to choice about her present and future behavior.

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