

ALTERNATIVE PSYCHOTHERAPIES AND THE BODYMIND PHENOMENA

John Hartung, PsyD

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I will relate “my story” about body-mind phenomena through several stories from my clients. I use “alternative” to describe certain therapies often left outside the mainstream.

I had taught (at the University of Colorado campus in Colorado Springs) and practiced traditional therapies for many years, but eventually grew discouraged by the prevailing view that an effect size of .80 was about the most benefit that psychotherapy could offer a client. In addition, as far as I could tell, what was being called evidence-based therapy applied to only about 15% of my real-life clients. In my search for alternative treatments that might offer my clients more hope for healing, I rediscovered body-mind realities.

Dissociation, trauma resolution, and physical healing

In 1992 I studied eye movement desensitization and reprocessing (EMDR). My third EMDR client was “Linda”, a very dissociative victim of serial sexual and physical abuse, with a long and troubled medical history as well. Linda worked collaboratively with all 11 of her “parts”, and frequently would report dramatic medical improvement after she had worked through a particular traumatic memory with EMDR. More than once her attending physician changed a diagnosis because Linda would no longer evidence the symptoms that had justified a surgical appointment only a week earlier. I also had to confront medical skepticism in this context: several times her physician became angry at being “tricked” by this “manipulative” client. What he never explained to me or to her was how his diagnostic instruments would give contradictory findings from one week to the next. He expressed no interest in how body-mind concepts could explain Linda’s medical changes, yet wrote a book about Linda’s “miraculous” changes – concepts he found more acceptable than the body-mind truths that Linda was living.

Later that year a therapist asked me to do an EMDR consult for a traumatized person, “Jeremy”, who was epileptic, legally blind, suicidal, and non-responsive to talking therapy. During an intense and extended treatment session Jeremy worked on a memory from age 8, when he recalled witnessing his father severely beating the client’s brother. During EMDR processing Jeremy discovered that “I lost my sight at that moment; I could no longer look at the world!” After that session he said the memory no longer felt troubling, reported no further suicidal thoughts, and returned to his original therapist. I was surprised to receive a call a week later; Jeremy had visited his ophthalmologist and was notified that after 30 years of stable measures, his eyesight was improving. While psychogenic blindness is familiar to every psychologist, I had not previously witnessed the relationship between physical and psychological in quite this way.

Similar reports followed from other EMDR clients who found that by resolving traumatic memories, they also noticed relief from chronic pain and other physical and medical symptoms. And in more than one case, the client would return for a surgical procedure, be told that the symptoms were no longer present, and have the procedure cancelled. It was rare, however, for a medically trained person to express curiosity about the type of psychotherapy I was conducting.

In 1996 I accompanied Francine Shapiro, the founder of EMDR, and an Argentine friend, psychiatrist Pablo Solvey, to Bogotá, Colombia. We worked at a center for children with cancer where we trained psychologists and supervised their treatment of the children's traumatic memories. One child had recently had her cancerous arm amputated, and was distressed by the resulting phantom limb pain. Pablo had been witnessing, in his own EMDR work, body-mind phenomena similar to those I noted above, and decided to try EMDR as the child focused on the phantom pain along with feelings of abandonment at having been separated from her family. Much to our surprise, after an hour of treatment the child said that her phantom pain was gone. At follow-up 2 years later, the pain had not returned (Shapiro & Forrest, 1997).

Sandra Wilson and Bob Tinker, Colorado Springs psychologists, began to formalize the treatment of phantom pain (Tinker, Wilson, & Becker, 1997). A recent report from one of their German colleagues describes how EMDR can produce complete abatement of phantom limb pain; in the case study described, the patient had undergone opiate medication and other pain interventions for three years, but his pain had persisted prior to being treated with EMDR (Schneider, Hofmann, Rost, & Shapiro, 2007).

Paraprofessional providers, Asian medicine, and body-mind issues

After the Bogota training, Shapiro asked us to continue the Spanish-language trainings, so Pablo and I, along with Michael Galvin – a former CPA president – soon were working throughout Latin America. We all had been finding EMDR to be a powerful trauma treatment, which meant that it was also helpful in reducing or eliminating physical and medical symptoms related to traumatic memories. There was a problem, however: for various reasons, EMDR can be taught only to professional therapists. In many Latin countries, however, professionals can be rare. The UN estimates that a million people in a rich country have access to some 700 mental health professionals; a million people in a poor country have access to about three. Clearly, it would be fruitless to expect professionals to reach more than a few of those seeking psychological help. We would need to search for treatments that we could teach to paraprofessionals.

Michael and I found some of the “energy psychology” (EP) techniques, based on the meridian and chakra theories from traditional Asian medicine, to be especially powerful, safe, and relatively easy to use. We narrowed our preferences to thought field therapy (TFT) and emotional freedom technique (EFT), both based on acupuncture theory; the Tapas acupressure technique (TAT); and certain strategies that utilize the chakras sites,

such as Seemorg Matrix. EP could also be used along with EMDR. We eventually wrote about our experiences (Hartung & Galvin, 2003).

Several benefits immediately appeared. One was the utility of the techniques in training nonprofessionals, who could learn to treat themselves and others, effectively and safely, during a weekend course. This also allowed us to go to sites of natural disasters and civil violence, where professional assistance and time for follow-up were luxuries, and where language barriers made traditional talking therapies unfeasible.

Two other benefits appeared hand in hand. Because the Asian-based energy methods did not require much use of language, visualization, or other components of traditional therapy, we could reach persons who tended to somaticize their traumatic experiences. And in the process, it became apparent that the healing of a physical disorder would be accompanied by psychological relief (and vice versa).

Our earlier mind-body experiences in using EMDR (mentioned above) became more common as we added the Asian therapies to our repertoire. We re-discovered a path to healing for trauma victims that proceeded not by correcting unfriendly cognitions or negative emotions, but rather by directly targeting bodily symptoms. Many victims of trauma would not identify an event or a traumatic memory, would not allow that they harbored any negative belief, sometimes would even deny negative emotion – but they would readily complain about their peculiar physical aches, pains, and illnesses. Targeting these symptoms directly would often bring resolution – often followed by insight, memory recall, and an increased ability to report affect.

Psychologists do not practice medicine

EP allowed us to expand our work to expand to other medical concerns. Patients would report improvement in or correction of their allergies, asthma, fibromyalgia, chronic pain, and other medical conditions. As I extended my work into Asian countries, I found an ever higher percentage of people who expressed unresolved trauma through physical pain, illness, and other bodily sensations.

I once accompanied Sandi Radomski, an innovative allergy specialist, to Mexico City to treat allergy sufferers. Sandi practices EP methods with remarkably high success, such that she can name her approach “allergy elimination” without hyperbole (her website is allergyantidotes.com). Our sponsors from the Cuernavaca Gestalt Institute hypothesized that if treatment worked in the heart of the world’s most polluted city, it would be appropriate anywhere.

Under Sandi’s supervision we then treated the dozens of patients present, and in every case observable improvement was noted. Sandi’s approach involves using muscle testing from applied kinesiology to identify the *origins* of the allergic response, which included information about possible *traumatic events, relevant emotions, and related cognitions*. In other words, the treatment we conducted might be defined as both medical and

psychological practice. More and more scientists from the biochemical and quantum physics disciplines are, in fact, writing about the intimacy between the chemical, medical, psychological, and spiritual realms, and seem to be encouraging us to join forces for the benefit of clients. Their premise is that one cannot intervene in one area without affecting the others, giving special meaning to Candice Pert's coining of a new word, "bodymind." Authors in addition to Pert that guide the work I just mentioned include – to name a few – David Feinstein, James Oschman, Ken Pelletier, Beverly Rubin, and William Tiller.

Nonetheless, in these litigious times, treating a medical condition directly can bring a charge of practicing medicine without a license, so we experiment with ways to place the medical target within accepted psychological practice. At times we inquire about some related psychological condition. At other times we simply ask the person, "How do you *feel* about [the medical condition]?", and we then target and treat that feeling. If somatic change accompanies the psychological improvement, that is considered to be a side benefit. This allows the client to proceed with treatment, even while denying that the medical condition might be due to a traumatic event or negative thinking.

Parenthetically, I find it intriguing to wonder how psychological approaches based on vibrational healing might be employed in the treatment of the ever increasing challenges to the human organism from toxins, chemical production, pollution, and pharmaceutical contamination of drinking water. To take one example: every year US industry seeks to introduce 1,700 new compounds, 90% of which are approved by the EPA without restriction. We cannot stop this proliferation, so might an option not be to teach people to balance their energies so they can live with what surrounds them? This is precisely the assumption that Sandi Radomski follows in her splendid allergy elimination work. And why cannot psychologists at least collaborate in this option?

The therapeutic relationship in body-mind treatment

The electromagnetic and other energy processes involved in the energy psychology techniques also revealed to me some of the subtle interpersonal communications that appear to occur between people. I had known about "energy healers" for many years, but was unaware of how widely were endorsed the phenomena that appear to underlie energy healing. At many venues in Asia and Latin America in particular, my colleagues would smile when I expressed continuing surprise at what to them were normal, everyday matters, such as reading auras. Once, before a trip to Asia, I took a hard bike fall and injured my upper spine, as evidenced on an x-ray. A week later, in Indonesia, an energy practitioner watched my profile and asked me about the "red energy leakage" – at the exact same site on the x-ray. A week after that, I was photographed with a Kirlian camera while conducting EP in India; the photo showed an intact aura except for red flares coming from the same site.

Back in Colorado, I became acquainted with the work of John Zimmerman, MD, who as a physician-scientist at the University of Colorado School of Medicine had studied the magnetic nature of healing energy (Zimmerman, 1972). Seeking a solution to the problem

of non-union fractures (broken bones that do not heal), he noticed that cell resonance in healing bones was different from that in the cells of bones that fail to heal. He built a device that generated electromagnetic waves at the resonance of a healing bone. The device would be placed over the non-union fracture to send the healing resonance. In a manner that may sound similar to the tuning forks experiments in high school physics, the vibrational resonance in the cells at the site of the fracture would begin to entrain with, or “vibrate in ‘sync’ with” the resonance from the device, eventually healing the fracture.

Zimmerman subsequently utilized a Super-conducting Quantum Interference Device (SQUID) to demonstrate that persons who practice healing touch could produce powerful chemical and biological effects in subjects. Even though the magnetic field signals from the healing touch practitioners’ hand were at a weak intensity, they could effect therapeutic changes in subjects over whom the hands were held.

The teams I worked with were curious to test out the hypothesis of interpersonal intentionality, to test how a person or group might have a measurable impact on another person. We knew that heart coherence was positively correlated with measures of emotional, mental, and physical health, so we chose coherence as an outcome measure of our experiments (McCraty, Atkinson, Tomasino, & Bradley, 2001). Heart coherence, to oversimplify, is a measure of the sympathetic-parasympathetic balance in heart rate variability. We also were able to purchase simple biofeedback software from the Heartmath Institute (heartmath.com and heartmath.org).

In an early pilot study noticeable changes occurred in a subject when a group of psychologists that I was training focused on the subject and practiced different exercises from EP. The subject was a trauma victim who had already done individual work on his anxiety and anger. We had a measurable coherence baseline for him after his individual work was completed. He was then instructed to sit quietly, eyes closed, and simply to notice his experience. We observed changes in his coherence scores as we followed an ABAB model for intervention, which is to say that the rest of the group – visually separated from the subject – would practice an EP technique while holding “positive intentions for the highest good of the subject”, then suspend the EP exercise, then repeat this routine. When the group was doing EP and sending positive intentions, the subject’s coherence scores on the biofeedback measure increased dramatically; and when the group suspended their EP work, the subject’s scores fell to baseline.

These experiments allowed us to define the notion of a healing therapeutic relationship along the lines of vibrational medicine (Gerber, 2001), which naturally lead us to try out new clinical practices. Once I was in Sri Lanka working with tsunami survivors, on the edge of the Indian Ocean, a place of aching beauty and – because of the evidence of trauma all around us – aching sadness. I was training a group of nonprofessionals in energy psychology practices and, as was my custom, invited one of the participants to be treated in front of the group so I could demonstrate what they would soon be practicing. A woman reported that her right foot and lower leg had become numb after she realized

she had lost so many family members to the tsunami. She had sought medical attention without benefit so far; her physician next planned to conduct exploratory surgery.

I worked with her for about an hour, trying everything I had just taught them – TFT, EFT, TAT, heart breathing – but she reported only minimal change, and I began to grow frustrated that the usual effects of the EP treatments were not occurring. I reminded the participants that the techniques were powerful but not panaceas, and that sometimes we must face our limitations. Not willing to quit just yet, and recalling the group energy experiments I had been conducting, I decided to enlist the help of this group. I would not guarantee results (I never do), but said they might be able to make some healing contribution that I was not able to do. The patient and the other participants then consented for the patient to sit in the midst of the rest of the participants, who would send good intentions to her, and would hold different EP postures designed to direct positive energy. The patient would simply sit quietly, eyes closed, and experience whatever there was to experience.

From time to time I would ask them to take a break, and then invited the patient to walk around to self-assess her numbness, as she had done when working with me alone. Within a short time she reported having feeling in her foot and leg, and after about 30 minutes of group treatment she was walking freely, with confidence, she said, because she could now get information about where her foot was touching the ground.

I checked with my Sri Lankan sponsor, Karu Gamage, several months later; Karu said her surgery appointment had been cancelled because her physicians could no longer find the symptoms necessary to defend further medical intervention.

When these things occur – either under relatively controlled conditions or through unsystematic clinical experiences – my students invariably connect what they experience to the concept of therapeutic relationship, and they talk about the ways in which the therapist’s energy state affects the client. They also note that while the therapist’s intention (or attitude) has some impact, utilizing a specific *technique* (such as an EP pose or exercise) can enhance the impact of treatment.

“Psychological” training for physicians

I have trained medical practitioners in several countries. Typically they are physicians, employed in an ER or in general medical practice. They have concluded that many of their patients’ complaints have no organic or medical cause, and that medication produces modest benefit and toxic side effects. They have little time for relationship-based, language dependent, or other traditional therapies, and what they are looking for is training in psychological first aid. Energy psychology techniques have proven to be a good fit for them. In some cases they are already familiar with Asian approaches to medicine, so I remind them that they are already practicing psychology in the broader body-mind sense, and we then discuss how to conceptualize emotions and beliefs as alternative body-mind signatures of distress.

It is refreshing to work with these individuals because so frequently I encounter a dismissive skepticism, even anger, from other professionals. I am not alone in this. I recall a story about Bessel van der Kolk, one of the world's most articulate trauma researchers. Van der Kolk had found that EMDR was far superior to medication (Prozac) in reducing trauma symptoms, and set out to share the good news. However, when he first reported his results to an audience of physicians, the response was one of disinterest: "We prescribe medication, not psychotherapy", was the general attitude. Fortunately he was eventually able to publish the study (van der Kolk et al, 2007), though one might wonder how widely such information impacts practice.

Body-mind considerations in human performance

Colorado Springs is the site of the US Olympic Training Center and a world figure skating arena. My colleague, Chandra Nagireddy, and I have been working with athletes from these centers for some time, utilizing both EMDR and the various energy therapies as a part of training routines. Much of what we do follows the principles of energy medicine outlined by Woods Hole biologist James Oschman in his book titled *Energy medicine in therapeutics and human performance* (2003).

Chandra has been using approaches to identifying micro-traumas at the level of muscles – and perhaps tissue and cells. Often the emotional, mental, and somatic factors that interfere with an athlete's talent cannot be found on a conscious level – which is to say, through use of language or imagery – but can be detected with techniques of somatic experiencing, applied kinesiology, energy medicine, and variations of EMDR. These serve as a kind of "search engine" even as they promote healing of the underlying causes of compromised performance. Additionally, the client can utilize specific techniques from energy medicine and energy psychology when triggers occur during a competition (which can consist of smells, sounds, and muscle tension that cannot easily be replicated in a clinician's office).

Among our favored approaches are EMDR, EP, Peter Levine's somatic experiencing, energy medicine, and David Grand's brainspotting – all powerful body-mind tools.

While the model requires much more fine tuning, we are optimistic that this particular application of body-mind principles can be of help to athletes and other performers who seek to realize more of their potential. Some of the individuals who have worked with the model have subsequently set national records in their respective fields. They consistently report that they had not varied their training routines, and so they attribute their improvement in performance to their following the body-mind procedures just described.

About the author: John Hartung is a psychologist who resides in Colorado Springs. His PsyD is from the University of Denver. He is on the faculties of the University of the Rockies' School of Professional Psychology, the Center for Creative Leadership, and the Bodymind Integration Institute of Singapore.

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