Naropa University

Alchemical Injury: Self-Transformation Through Dance/Movement Therapy and Internal Family Systems in Highly Embodied Adults with Chronic Injuries

Thesis submitted in partial satisfaction of the requirements of

Master of Arts in

Somatic Counseling Psychology: Dance/Movement Therapy and Body Psychotherapy

By

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The Thesis of Sabrina S. Santa Clara is approved and accepted in partial fulfillment of the requirements of a Masters of Arts in Somatic Counseling Psychology: Dance/Movement Therapy and Body Psychotherapy.

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ABSTRACT OF THESIS

Alchemical Injury: Self-Transformation Through Dance/Movement Therapy and Internal Family Systems in Highly Embodied Adults with Chronic Injuries

Sabrina S. Santa Clara

Master of Arts in Somatic Counseling Psychology:
Dance/Movement Therapy and Body Psychotherapy

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This thesis seeks to answer the question, can the combination of Internal Family Systems therapy and Dance/Movement Therapy help to transform an ego-based orientation to self towards a more transpersonal orientation to Self in highly embodied individuals with adult-onset chronic injuries. This thesis seeks to answer a second question; Is there a positive correlation between psychological functioning and the transformation of an ego-based orientation to self towards a more transpersonal orientation to Self? The author defines adult-onset chronic injury and makes the case that this population is neither acknowledged nor appropriately served by the medical/psychological community. Furthermore, the author makes a case that adult-onset chronic injury in highly embodied individuals is experienced differently than in those who are not highly embodied. The author provides a psycho-spiritual model for working with this population that aims to improve psychological functioning through the transformation from an ego-based orientation to self towards a more transpersonal orientation to Self.

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Chapter 1: Introduction

In the past two years I have had five unsuccessful knee surgeries. The process of repeated injuries, surgeries, and countless medical appointments has been arduous. Significant injuries produce a wide variety of symptomology such as inability to cope (Albinson & Petrie, 2003), depression (Seff, Grecas, & Ray, 1992), Posttraumatic Stress Syndrome and anxiety (Wang, Tsay, & Bond, 2005), need for external support (Hardy, Richman, & Rosenfeld, 1991), dependency issues (Rodanová, 1977), employment difficulties (Abbott, 1997), existential crisis (Zidén, Wenestam, & Hansson-Scherman, 2008), divorce (Jacobs, 1996), disrupted family relationships, financial hardship, erosion of self-esteem, and self-identity crisis (Ewan, Lowy, & Reid, 1991). In my case, I experienced each of these symptoms.

While chronic injuries are difficult for all people, they are particularly unsettling to highly embodied individuals (HEI). HEI are those whose self-identity is strongly based upon their physical sensations, expression, and capability. As a highly embodied individual, losing my ability to move freely led to an upheaval in my understanding of my self. There is little organized psychological support for someone in my position. Available grief groups are primarily limited to individuals and family members dealing with terminal illnesses. Support for chronic injuries is likewise limited to the most severe injuries such as Traumatic Brain Injury (TBI) and Spinal Cord Injury (SBI). In fact, the majority of research on chronic injuries is focused on TBIs (Lemma, 1997; Boehm, 1988; Nadell, 1991) and SCIs (Bohanski, 1983; Lohne, 2008; Matheis, E., Tulsky, & Matheis, R., 2006; Vargas, 1991).

Why This Thesis is Important

The dearth of research and support for those suffering from chronic injuries leaves this population greatly underserved. In order to begin the process of assisting this underserved

population, this thesis will work towards answering the research question: Can the combination of Dance/Movement Therapy (DMT) and Internal Family Systems (IFS) support Self-transformation in highly embodied individuals who have a chronic injury that was acquired in adulthood? Moreover, does the transformation from an ego-based orientation to self towards a more transpersonal orientation to Self correlate to improvement in psychological functioning? It is my hypothesis that using a combination of DMT and IFS therapy will be an effective treatment for HEI with adult onset chronic injury (AOCInj). Both DMT and IFS therapy (1) work towards integrating different aspects/parts of an individual into a cohesive whole, (2) are body-centered therapies, therefore, they are appropriate modalities for working with individuals who orient to the world through their physical sensations, and (3) include within their framework a concept of self that includes transpersonal qualities.

Key Terms

Key terms will be used throughout this paper; some of these terms will vary from common psychological uses. Key terms are laid out for the reader's ease.

Adult Onset Chronic Injury (AOCInj): An injury (or series of injuries) that significantly alters normal daily activities, has been in duration for at least 12 months, has required repeated medical intervention, is non-terminal, is expected to have a lifetime duration, and does not directly affect the cognitive ability of the individual. AOCInj excludes more severe forms of chronic injury such as spinal cord injury, traumatic brain injury, and injuries in the elderly.

*Dance/Movement Therapy (DMT): DMT is "*The psychotherapeutic use of movement to further the emotional, cognitive, physical, and social integration of the individual (American Dance Therapy Association, 2008, ¶ 2)."

Highly embodied individual (HEI). HEI, an original term coined by the author, are those people whose self-identity is strongly based upon their physical sensations, expression, and capability. They experience their bodies as intrinsic to their self and orient to the world via their physical sensations; they consciously process their experiences through their bodies. They use physical expression of internal states to self-resource.

Internal Family Systems (IFS): IFS is a psychotherapeutic approach that is founded in systems thinking and multiplicity of personality. The psyche is perceived of as having parts (subpersonalities) and a transpersonal Self. The goal of IFS therapy is to help the client become more Self-led rather than parts-led.

Self-transformation: Self-transformation is a process by which ego-based orientations to self (e.g. self-identity) are transformed to a fuller sense of Self that incorporates transpersonal components within it.

Thesis Organization

Chapters two and three provide a literature review of Dance/Movement Therapy and Internal Family Systems. Chapter four shows the intersection of DMT and IFS therapy as it relates to treatment with highly embodied adults with adult onset chronic injury. Chapter five defines the author's original theory about highly embodied individuals and adult onset chronic injury. Chapter five also proposes why and how DMT and IFS therapy can be used with HEI with AOCInj to transform ego-based orientations to self into transpersonal orientations to Self, and more importantly, why such transformation can improve psychological functioning.

Chapter six discusses a hypothetical experimental research design and discussion based upon a 26-week protocol of a combination DMT and IFS therapy with an experimental group and a control group. There are many psychological symptoms that may result from chronic

injury (e.g. depression, anxiety). This study, however, will be primarily focused on assessing the effectiveness of DMT and IFS therapy on Self-transformation. The assumption of this research is that the transformation of an ego-based sense of self to a transpersonal orientation to Self will result in decreases in chronic injury related psychological symptoms. While this study will not focus on treating psychological symptoms per se, an assessment tool will be used to ascertain the correlation between Self-transformation and changes in psychological symptomology. Included in chapter six are the implications for the field, limitations to the study, as well as its applicability to other populations. This thesis ends with concluding statements in chapter seven.

Chapter II: Literature Review – Self, Self-Transformation, and Internal Family Systems (IFS)

The following chapter will provide an outline of the IFS therapeutic model. IFS was chosen as a therapeutic model because of its strong focus on the transpersonal Self. Most people have an ego-based sense of self; they base their sense of self on what they think, believe, accomplish, are capable of, etc. Those with AOCInj typically experience a rupture in their orientation to their sense of self. Since the transpersonal Self is a centerpiece of IFS theory, related theories of self, the many varied definitions of self, and relevant research will be discussed. Transformation from an ego-based orientation to self to a transpersonal orientation to Self is often the outcome of IFS therapy, which makes this an appropriate model for HEI with AOCInj. Self-transformation will also be reviewed.

Internal Family Systems

IFS is a body-centered, psychotherapeutic model developed by Richard Schwartz that is strongly based on the development of relationship between individual parts (aspects) of a person and how those parts relate to the Self. Richard Schwartz, like Jung and Assagioli (1975), adheres to a multiplicity model (Schwartz, 2004) of personality, that is, each individual has a multitude of subpersonalities, otherwise known as parts. Parts of the individual are perceived of as, paradoxically, both separate from the Self and as critical elements of the Self. Parts can be compared to the drops of water in the ocean. All the drops of water make up the ocean; however, the magnificence of the ocean cannot be understood by focusing only on the drops of water (B. Cargill, personal communication, January 2, 2009). Incorporated within IFS are elements of a variety of psychotherapists and theoretical orientations including: Family Systems Theory, Humanism, Buddhism, Developmental Psychology, Trauma Theory, Gestalt therapy, and Jung's active imagination (Schwartz, 2001).

Self. Schwartz was greatly influenced by both Jung and Buddhist philosophy, which is evident in his adoption of the use of the capital S in Self. Schwartz, like Jung, has referred to the Self as equivalent to the Buddhist concept of no-self. The Self in IFS therapy is transpersonal; it includes a spiritual dimension that lends to "states of consciousness that extend beyond the usual limits of ego and personality" (Welch, 2000, pp. xix-xx). Within the IFS framework, eight of the main qualities of the Self are "curiosity, compassion, calmness, confidence, courage, clarity, creativity, and connectedness" (Schwartz, 2001, p. 13). Within the IFS model, ego-based orientations to self (e.g., self-concept) are viewed as parts, whereas Self is transpersonal in nature; no matter how regressed a person may be, the Self is ever present.

IFS is an empowering model in that it assumes that everyone has a Self, even those with personality disorders that traditional psychotherapy views as disorders of the self. Self, in the IFS orientation, can be compared to the moon that is ever present; even though the sun's light can prevent the moon's visibility, the sun cannot eradicate the moon's existence (B. Cargill, personal communication, January 2, 2009).

Parts. IFS therapy works towards integrating all aspects (parts) of the human being (Schwartz, 1987). Parts are "sub-personalities or aspects of…[the]…personality that interact internally in sequences and styles that are similar to the ways that people interact" (Schwartz, 2008, p. 6); they are the personality qualities attached to states of mind. IFS is not the first model to discuss parts. Virginia Satir combined the study of systems theory with intrapsychic subpersonalities (Schwartz, 1995), and John Rowan (1990) wrote an entire book on subpersonalities. In the IFS model there are three broad categories of parts: managers, exiles, and firefighters.

Exiled parts are often what Jung would call shadows (Conger, 1988) and what Nathaniel Brandon (1991) would call the disowned self. They are usually young aspects that were not (or are not) allowed full expression. Some examples of this are: a) a young man who grows up in a *machista* culture is demeaned when he shows sensitivity and emotions – the sensitive and emotional aspect of him must be exiled; and b) a child who was angry at her abusive father could not risk experiencing her own anger as this could threaten her survival. A part that holds unprocessed trauma is usually exiled. Young parts can be exiled via a singular experience or series of experiences, spoken or unspoken cultural mores, individual or collective trauma, and ancestral burdens (i.e., beliefs passed down from generation to generation).

Parts may also be exiled in adulthood. For example, a woman whose husband is no longer interested in sex shuts off her sexual feelings in order to keep the relationship stable; her sexuality goes underground and becomes exiled. Another example would be a war veteran who had to learn that being in a relaxed state could get a person killed; as a result, relaxed and playful states may become exiled. Exiled parts are often a byproduct of traumatic experience, which will be discussed further in this chapter.

There are other parts within the system that may either deny the exiles existence and/or create an internal war with those exiles in order to keep them under control. The parts are called protector parts, as they protect the exiles, usually via control, force, addiction, or dissociation. IFS terms for these protectors are managers and firefighters.

The primary role of managers is to internally prevent exiles from leaking out and taking over. Managers also try to control the external world (i.e., the individual's environment and relationships). Managers do this to protect against judgment, humiliation, abandonment, and rejection from the outside world. Managers are the parts responsible for making sure the person

looks good to the world. It is through the managers that a false (ego-based) self-identity is formed; they are the parts that create the stories and the narratives that people live by (Schwartz, 2001). The orientation to parts in the IFS model shares similarities with Freud's concept of the ego (Gay, 1989), Winnicott's concept of the false self (Rodman, 2003), and Kurtz' concept of character strategies (1990).

Firefighter parts are protectors that spring into action when managers are unable to keep the exiles exiled; firefighters put out the emotional fire with various soothing and escapist strategies. They may be highly reactionary and impulsive and can wreck havoc in a person's life. For example, when a woman is lonely and her normal managing strategies are not working or are not available (e.g., talking to friends, going to movies), firefighter parts may jump in to keep the loneliness at bay. Such firefighters may lead the woman to binge eat, compulsively shop, gamble, or use alcohol. Firefighters can be the source of addictions; addictions can run the gamut from drugs, alcohol, gambling, shopping, and television. Firefighters may also be the source of physical pain, illness, and dissociation. In their most extreme state, firefighters can be suicidal. Managers are polarized with firefighters because of the recklessness and mess they often cause in individuals' lives. In turn, firefighters are polarized with managers as managers can be very rigid, tight, and judgmental. These protectors have often assumed their roles in early childhood and are burdened just as exiles are burdened.

A *nonpathological model.* Like Podvoll's concept of a history of sanity (1985) and Kurtz' concept of character strategies (1990), parts are viewed as sane strategies to get unmet needs met within an unhealthy environment; they are not viewed as pathological aspects of the individual that must be eradicated. Every part is viewed as doing the best it knows how in order to help the internal system of the individual; however, these parts have limited resources for several possible

reasons. They are: (a) stuck at an age/time in which they took on their roles, (b) hold a particular belief system, (c) do not have access to the bigger picture, and/or (d) do not know or trust that the Self can effectively lead the system. The intention of IFS therapy, ultimately, is to unburden these protector parts from their extreme roles and to welcome the unburdened exile back into the internal system. The unburdening allows parts to transform so that they can work more collaboratively within the internal system, thereby allowing the Self to lead the internal system. According to Schwartz (2008), the goals in IFS therapy are fourfold:

1) To unburden parts from their extreme roles.
2) To assist parts in discovering their appropriate roles and to provide input to Self.
3) To differentiate and elevate the Self so that it can be an effective leader in the system.
4) To create a harmonious and balanced internal system.

Self-led therapist. Critical to the IFS methodology is the Self-led therapist. The Self-led therapist will be able to make contact with, attune with, and entrain with the client's Self more easily than would a parts-led therapist (Schwartz, 2004). A Self-led therapist makes it possible for the client's protectors (managers and firefighters) to allow the client's Self to emerge. This requires that IFS therapists have great familiarity with their own parts and how their clients' parts may activate their own parts. Moreover, IFS therapists must be able move their parts to a supportive position within their own internal family system when they have been triggered by a client's parts so that the therapist's Self is available to lead the therapeutic process. IFS therapists' efficacy is dependant upon their willingness to work on their own parts in their own IFS therapy and/or supervision. Furthermore, when it is appropriate to disclose, IFS therapists must be transparent when their own parts are triggered; they must admit they were operating

from a part and apologize to the client. This allows for authentic relationship, role modeling, and repair of the relationship due to interference from the therapist's parts.

Other Conceptualizations of Self and Parts

In order to understand the Self (note upper case S) from the IFS perspective, it is necessary to distinguish it from other concepts of self (note lower case s). An exhaustive review of theories of self is beyond the scope of this paper; critical concepts, however, are reviewed.

There are a plethora of books with the word 'self' or 'selves' in the title, such as Rosenberg's *Conceiving of the self* (1986), Ferrier and Briese's *Dance of the selves* (1992), Welch's *The energy body connection: The healing experience of self-embodiment* (2000), and Sidoli's *The unfolding self* (1989) to name a few. In the forward of Bernd Simon's *Identity in Modern Society*, John Turner (2004) stated, "The self is a human universal. It is an undisputed given of human experience and life" (p. x). However, what one defines as a self varies widely. The terminology of self and its related components (e.g. self-identity, core-self) is a fountain of ambiguities and contradictions (Robinson, 1982) and "has complex meanings and controversial implications" (St. Clair, 1986, p. iii). In fact, Harré (1998) argues, "for the most part, selves are fictions…certain features…are picked out…as if they had an existence of their own" (p. ix). In contrast, Schwartz would say that those features that appear to have their own existence are actually parts of the Self; The Self is a constant that exists before the story is created about who one is. Related theories of self that will be reviewed are: Jung's conceptualization of Self, object relations theory, self-identity, sense of self, self as a unity of consciousness, states of mind, and core self.

Jung's conceptualization of Self. Jung's orientation to Selfhood provides a strong base for Self in IFS theory. As noted earlier, IFS adopts Jung's use of Self with a capital S, "meaning the

world of the transpersonal, a world greater than the individual, more powerful than the ego. The Self is the totality of aliveness; it is wholeness, known and unknown, good and evil" (Whitehouse, 1979, p. 54).

Object relations theory. Objects relations theory would define parts as intrapsychic structures that are created in the process of becoming a self (St. Clair, 1986) via interpersonal experiences. Object relations theory would state that one cannot have a self without having parts; they are necessary to the process of the development of self. IFS differs in that it holds that an individual does not become a Self; an individual is born into Self. Self is always there – it does not have to be developed. Self is the *I am* that gets eclipsed by the burdened parts that split-off from the Self.

Self-identity. Markus & Nurius (1986) proposed that self-identity is a plethora of self-assessments that are relatively permanent and established by the time most individuals are well into adulthood. Self-assessments are made by individuals in a variety of domains such as vocation, occupation, hobbies, physical appearance, personality, skills, and abilities. Self-identity is relatively fixed, but does slowly change over time.

Change occurs more rapidly in periods of turbulence when an individuals' self-identity becomes inaccurate such as occurs with those suffering from AOCInj. IFS proposes that the components that make up self-identity are actually an amalgam of parts. Furthermore, it proposes that the method for healing self-identity crises is not to reestablish a more fitting self-identity, but rather to develop an awareness of Self. Self exists in each part underneath the burdens they carry.

Se*nse of self.* The sense of self is one of the theories of self that is ripe with ambiguity. Harré (1998) discusses two concepts that apply to the sense of self: one that refers to the personal attributes of the individual, the other that refers to the self "as the center of action and

experience" (p. 9). It is with this concept that Harré deems it more appropriate to refer to people as having senses of self, rather than a singular sense of self. Yet, he also attempts to prove the singularity of self. He makes the point that "people…are not internally complex. They have no parts" (p. 15). This paradox is very much in line with IFS theory in that parts are what may be recognized as senses of self and the Self is Harré's singularity of self.

Self as a unity of consciousness. This point of view that the mind (i.e. the self) is a unity of consciousness (Binet, 1896) is supported by a variety of theorists, even those who work with Dissociative Identity Disorder (DID). Robinson (1982) states that in his experience of working with people with DID, he has seen evidence that supports the idea of multiple personal identities and multiple self-identities, yet, he saw no evidence in any of his cases of multiple selves. Binet believed he disconfirmed the unity of self and confirmed, "the self is a dynamic composite of complex psychological states (Robinson, p. 907).

It is not surprising that ambiguities arise when theorists discuss a multiplicity of self versus a unity of self model. A similar paradox is named in the IFS model. Within the IFS model there is a clear recognition of a multiplicity of self/parts (Schwartz, 2004), that is, each person carries a variety of selves that are named within the IFS model as parts (a.k.a. subpersonalities) of the individual. By the same token, each individual has a unity, a Self, which exists before parts became burdened. The understanding that the Self operates in conjunction with the parts and inside the parts may be viewed like a hologram. Schwartz gives a helpful image that Self can be both a particle and a wave (B. Cargill, personal communication, March 10, 2009).

States of mind. Parts carry their own state of mind. According to Siegel (1999), psychological states are also known as states of mind. From a neurological point of view, a state of mind is a "clustering of a profile of activation within the brain's neural network" (Siegel,

p. 121). States of mind become established across time by the repeated connections of neurons that occur due to individual constitution and experience. They can be consciously modified over time by creating new experiences while in a particular state of mind.

This is highly relevant to survivors of trauma such as those with AOCInj as trauma often creates a traumatized state of mind. Trauma states are interpreted in IFS therapy as parts that carry the burden of the trauma; these parts interpret the present as if it were the past and often become dissociated from the Self. A state of mind then, is not the self, but a part of the self. In fact, it can be stated that all parts carry a state of mind, regardless of whether the state of mind is a result of trauma or not. The Self, on the other hand, resides in a state of mindfulness. One of the main premises of IFS is that people often move from state of mind (part) to state of mind without ever fully accessing the Self. This is because the Self is often hidden from view because parts are directing the system.

Core self. A more foundational orientation to self, according to Stern (1985), is the necessity of the development of a core self, that is "a preverbal sense of oneself as a cohesive, volitional, bounded entity" (Auerbach & Blatt, 1996). Stern believed that each human is born with an emerging self (Elson, 1989). The core self is an expansion of the emerging self. IFS would state that the core Self is not developed – it exists from conception; it is only the cognitive awareness of Self that can be developed as physical structure develops to permit such reflexive awareness. The irony is that parts usually take up most of the space in the system and the body; they have to move back in order to allow Self to become embodied. This allows the exiles to be healed by the Self presence of the client, which, in turn, allows the protectors to relax. Ultimately, it is the orientation to an ever-present Self, along with the paradox of a singular Self

in relationship to multiple self-identities that forms a fundamental root in the IFS therapeutic model.

Self-Transformation

The value of self-transformation is advocated in many schools of psychotherapy. Most recently, Wallin (2007) describes an attachment model of psychotherapy that supports self-transformation through the therapeutic relationship. Like most psychological models of self-transformation, Wallin's orientation to self-transformation operationalizes the self as something that is created within the context of relationship.

Spiritual models of Self-transformation, however, view Self-transformation as moving from an individualistic understanding of self towards an orientation to Self that includes transpersonal aspects. IFS is not simply a psychotherapy model, it is a psycho-spiritual model of Self-transformation. Moreover, as a body-centered therapy, IFS holds true to what Avstreih (2007) holds as a universal truth, namely, that "the body is a doorway to the richness of the inner being and a vehicle for integration, transformation, and healing' (p. 270).

Relevant Research

Reflexive self-awareness. Auerbach and Blatt (1996) have studied the relationship between reflexive self-awareness and psychopathology. Subjective and objective self-awareness can cause discrepant self-images; by adolescence, many individuals develop the capacity to integrate these divergent concepts of self. Working with the internal feelings of self and external feedback from others about self naturally produces a certain amount of psychological tension when feelings of self and external feedback are contradictory. However, it is this ability to work with both aspects of the self and to be reflexively self-aware that lends itself to psychological healing via the integrative functions of reflexive self-awareness.

Auerbach and Blatt discovered that a lack of reflexive self-awareness is strongly correlated with psychopathology. This is particularly germane to those with AOCInj as their subjective and objective self-awareness is in a state of flux; who they once believed themselves to be is no longer accurate. Likewise, they often receive external feedback that clearly informs them that they are no longer who they once were. For example, a woman who once attracted men with the sway of her hips no longer receives attraction signals from men with a crutch or an uneven gait. Reflective self-awareness is a critical skill needed to prevent and/or alleviate the psychopathology symptoms associated with AOCInj (see chapter 4). IFS is a therapeutic modality that is rooted in such awareness; however, reflective self-awareness in IFS therapy is approached in a mindful state.

Mindfulness. Mindfulness is an important component of IFS therapy because it is within mindful states that the Self can be accessed. Mindful awareness is a present moment experience; likewise, Self energy is experienced only within the present moment. Moreover, mindfulness awareness as taught by Jon Kabat-Zinn (1990) incorporates a mind/body approach that is strongly applicable to highly embodied individuals who orient to the world through their physical sensations. It is also applicable to those with chronic injuries because mindfulness awareness practices have been successful in reducing pain, anxiety and depression, as well as improving relaxation, body image, and self-confidence (Kabat-Zinn, 1993; Kabat-Zinn, Lipworth & Burney, 1985; Kabat-Zinn, et al., 1992) – all issues that are relevant to individuals with AOCInj.

Self-esteem. There has also been a variety of research on the correlation between self-esteem and psychological issues (O'Brien, Bartoletti, & Leitzel, 2006). Seff, Grecas, and Ray (1992) found that both self-esteem and self-efficacy mediate the effects of depression and pain

management in injured individuals. Again, self-esteem, object relations, and other conceptualizations of self are not equivalent to the IFS concept of Self. The Self is fundamentally different in that it includes within it an orientation to self that is similar to the Hindu concept of *atman;* "the atman is a non-material realization of the real self as opposed to the material, experiential forms of self involving sensations, desires and thoughts" (DeVos, Marsella, & Hsu, 1985, p. 14). From this perspective then, it is not self-esteem that needs to be shored up in order to alleviate psychological issues, rather, it is an orientation to a Self that is larger than the ego functions of self-esteem.

IFS research. While IFS has been in development for the past 20 years and a clearly defined model for the last 15, there is no completed research available on this model. There are currently two studies being conducted on the efficacy of IFS therapy. Dr. Shelley Haddock at the University of Colorado in Fort Collins directs the first research project; Dr. Haddock is researching the efficacy of IFS therapy on clients with depression. The second project is under the administration of Nancy Sowell at Harvard University who is examining the effectiveness of IFS therapy in reducing pain in patients with rheumatoid arthritis. Since there has been no research completed on the effectiveness of IFS therapy, there has been no research on the relationship between Self and psychopathology. The IFS concept of Self and how IFS therapy works to create relationship between Self and parts is unique in the field of psychology. Practitioners of IFS know that the differentiation and elevation of Self into a leadership position within the psyche can enhance psychological functioning; this research project intends to quantitatively measure this correlation.

Self-transformation research. Likewise, there has been little, if any, research on Self-transformation as a healing tool for those with adult onset chronic injuries (AOCInj). Research

on self-transformation in the field of psychology is primarily limited to transformation of self-identity (Franchi, & Swart, 2003; Macrae, 2002), self-concept (Baker, 1987; Cohen & Ettin, 1999; Nack, 2001), and other ego-based orientations to self.

It is within the field of transpersonal psychology that transformation of an ego-based self to a transpersonal Self is acknowledged (Louchakova & Lucas, 2007; Wall, Peters, McDonald, & Warner, 2007; Scotton, Chinen, & Batista, 1996). New branches of psychology are emerging that incorporate a transpersonal self as a core component, such as Ken Wilber's (1986; 2000) integral psychology. There is currently no research on the transpersonal Self in psychology.

Summary

IFS is a therapeutic model that is designed to bring consciousness to the existence of Self and parts of self. Through the process of working with parts, the transpersonal Self naturally reveals itself. For adults with chronic injuries, ego-based orientations to self become ruptured. Using IFS as a method of transformation may move a person from an ego-based orientation to self towards a more transpersonal orientation to Self. The intended research project as outlined in this thesis is that DMT and IFS therapy can provide the healing that is ignored in those with chronic injuries. Moreover, because IFS therapy is a body-based approach to therapy, it is an appropriate intervention to be used with individuals who are highly embodied. Research on the healing capacity of IFS therapy in conjunction with transpersonal orientations to Self is nonexistent; however, related research indicates that IFS therapy as a Self-transformative modality could be highly beneficial to adults with chronic injuries who are highly embodied.

Chapter III: Dance/Movement Therapy (DMT)

The basic premise of DMT is "that body movement reflects inner emotional states and that changes in movement behavior can lead to changes in the psyche thus promoting health and growth" (Levy, 2005, p. 1). The following chapter will outline assumptions and healing principles of DMT that are particularly relevant to the highly embodied adult with chronic injuries. Of particular relevance are: (a) integration/wholism, (b) expanding and releasing patterns, (c) community, (d) therapeutic relationship, (e) symbolism, (f) authentic movement, and (g) the transpersonal Self. Several DMT pioneers will be discussed, along with modern applications of their principles. Furthermore, a review of DMT research as it applies to HEI with AOCInj will be provided.

Integration/Wholism

The American Dance Therapy Association (2008) website states that "based on the assumption that the mind and body are interrelated, dance/movement therapy is defined as the psychotherapeutic use of movement to further the emotional, cognitive, physical, and social integration of the individual" (¶ 2). DMT is, therefore, aimed at facilitating a clearer and more integrated self-definition (Payne, 1992). Like IFS, DMT is focused on giving voice to varying aspects of each person so that those aspects can function cohesively. The intention of some DMT subbranches, such as Authentic Movement, is to integrate parts of the individual while also gaining awareness of a transpersonal Self.

DMT was founded by several dancers who combined movement experiences with the methods of psychology from pioneers such as Freud, Reich, Lowen, Jung, Sullivan, and Klopfer (Levy, 2005). Like many theoretical orientations that came before it, DMT carries within its core principle a strong orientation to integration and wholeness. Note that the concept of integration is

not an eradication of parts into a fused single entity; Rather, integration occurs when the individual has an awareness of each aspect of themselves and develops relationships with those aspects so that all aspects are welcomed in the internal system.

Blanche Evan, a DMT pioneer, believed that each person had the possibility of wholeness (Levy, 2005), and that movement was a valid means for integrating the individual. "The major goal of Evan's work was to bridge the gap between the psyche and the soma, allowing that which became repressed or deadened to spring back to life through the resiliency of the body in the form of dance" (Levy, p. 35). Marian Chase, another DMT pioneer, looked towards a holistic approach and believed that dance heals the whole person.

Expanding and Releasing Patterns

Using movement as a method of psychotherapy produces images and emotions that bypass the functions of the mind that often censor experience. Words alone are labels for that which is already known, whereas expressive movement reveals the unconscious (i.e., the not yet known). Through movement, buried sensations, feelings, emotions, and images can be revealed. Expressive movement is a therapeutic process that can shift destructive patterns, habits, and belief systems (Halprin, 2000).

Censored experiences take the form of censored body movements. Take for example, a woman who has survived a rape. She may carry herself with a guarded stance: her muscle tone tight, her hips immobile, her head unwilling to create the soft tilt that often indicates flirtation or romantic interest, her overall stance unyielding, and her facial expressions unwilling to surrender into vulnerability. Her body has trapped her rage, fear, and other emotions associated with the rape. Her body carries the unspoken belief that to be soft and vulnerable is to invite pain. It is likely that she is not consciously aware of the holding patterns that her body has created.

Likewise, adults with chronic injuries develop movement restrictions: a) because their bodies are no longer safe places to inhabit, b) in order to protect their bodies from further injury, and c) as a result of trauma associated with the injury and repeated medical interventions. It is through movement that patterns loosen and new possibilities of movement arise. This results in new possibilities of physical and emotional sensation.

Chase used what her students, Chaiklin & Schmais (1979), referred to as body action in order to help client gain mobility of their physical structure. The client's body action reveals breathing and movement patterns that inhibit emotional expression. Body action can be changed so that the client may experience fuller movement and emotional expression, and a stronger relationship to the transpersonal Self and parts of self.

Limitations in movement and limiting beliefs coincide with the IFS orientation that parts of the individual get cut off from the larger Self. In working with physical restrictions from suppressed emotional material via DMT, the therapist is working with parts that restrict the free and spontaneous energy of the Self.

Trauma. Many survivors of trauma use unconscious movement patterns (including movement restrictions) in order to manage nervous system disregulations. The use of intentional movement can break through these managing repetitive movement patterns and allow the client a broader movement repertoire (including conscious stillness), which can help the client to sequence through trauma that has been trapped in the body (Ogden, Minton, & Pain, 2006).

Moreover, survivors of trauma often become trapped in a freeze response, in which the body's response ability to threat is curtailed. In the freeze response, the nervous system is hyperactive, though the outside form of the individual appears hypotonic. This freeze response is one of three responses to threats, the other two being fight or flight. Fight, flight and freeze

responses can all become chronic in the trauma survivor. Physical movement with sensate focus allows for the movement of chronic trauma reactions towards healing.

DMT can help people stay present in their bodies when "painful feelings or sensations related to past bodily trauma" (Mills & Daniluk, 2002, p. 80) resurface, thereby circumventing physical dissociation. The mover feels the emotions of the past in order to release them. Also, the discomfort of staying present with painful feelings and sensations is balanced in DMT by what this author describes as the healing element of joy. One only has to watch healthy children move to music to catch a glimpse of what is often lost by adulthood. The sheer pleasure of moving because it feels good is often pushed underground in the effort to meet societal standards of appropriate behavior. Joy is also often missing from survivors of trauma. Adults with chronic injuries, which often experience the trauma of repeated medical intervention, are also often unable to access joy. Reintroducing people to their natural internal desires to move, even with their physical limitations, can reestablish a sense of joy; joy is often a gateway to the transpersonal Self.

Community

Marian Chase: Marian Chase, who is considered the founder of what is now known as Dance/Movement Therapy, operated under the basic assumption that "dance is communication and…fulfills a basic need" (Chaiklin & Schmais, 1979, p. 16). "Dance therapy, in making use of the basic form of movement as a means of communication, offers the individual a means of relating himself to the environment or to people when he is cut off in the majority of areas by the patterns of his illness" (Chaiklin, 1975, p. 137).

While Chase wrote about her work, she did not clearly outline her theoretical perspectives. Chaiklin and Schmais (1979), Chase's students, outlined four components of

Chase's work: (a) body action, (b) symbolism, (c) therapeutic movement relationship, and (d) rhythmic activity or group movement relationship (in Levy, 2005). It is the later component that specifically addresses the healing functions of community.

Rhythmic activity creates a group rhythmic movement relationship. It is through the use of group rhythm that a group bond is formed. As the group moves in rhythm together, mirror neurons (see section on therapeutic movement relationship) of the individuals in the group activate together (Cozolino, 2002).

Synchrony, a fundamental concept in DMT that correlates to group movement relationship, has three elements that all broadly refer to more than one event occurring at the same time. The three aspects of synchrony as it relates to DMT are (a) rhythmic synchrony, (b) spatial synchrony, and (c) effort synchrony. When people move in time together, they are rhythmically synchronous. This does not mean that they are moving the same body parts or making the same actions, rather, they are moving to the same rhythm. Spatial synchrony builds on rhythmic synchrony in that people are moving together in time and are making the same shapes with the same body parts. Effort synchrony also builds on rhythmic synchrony as people move in time together and use the same effort quality even though parts of the body making the effort may be different. Effort qualities are: flow (free/bound), space (indirect/direct), weight (light/strong), and time (decelerating, accelerating).

In this definition of synchrony, rhythm is a critical component. Expression is facilitated by effort qualities. For example, participants would have a difficult time expressing anger if they only operated from a light effort quality. The DMT therapist might then give participants movement suggestions such as chop wood, thrash, etc. The sharing of these healing elements creates cohesion as "dance therapy encourages identification with a social group by structuring

the activity so that people move together in time and space" (Schmais, p. 19), thus creating a community. Halprin (2000) makes a point of stating, "community healing is very powerful" (p. 5). This is particularly relevant for those suffering from AOCI as they often feel out-of-sync with their partners, friends, coworkers, and society in general.

Ritual. "Movement ritual has allowed individuals since the beginning of civilization to bridge the gap between themselves and their universe. It affords a vehicle for their expression and transmission of fear, sadness, anger, and joy in the quest for survival and the meaning of life" (Bernstein, 1979, p. 3). Ritual is functional. "Humans are social animals, and rituals…[are]…an expression of this sociality, a way of renewing the bonds that…[hold]…a community together" (Ehrenreich, 2006, p. 10).

Even though movement in DMT is largely improvisational, structure (one component of ritual) is an important element that characterized the work of Marian Chase. DMTs founder began her groups with a warm-up, followed by theme development, and closing with a circle. The circle is a form that creates a sense of unity and community. Warm-ups prepare the body for movement and the psyche for connection. Themes are developed as the therapist perceives and responds to group needs. The closing circle acts as a universal symbol of totality (Jung, 1964) and wraps up the session with a sense of the individual being connected to something greater. The structure in DMT is ritualized and, by such ritualization, creates a communal sense within the participants.

Therapeutic Relationship

Therapeutic movement relationship. A relationship develops between therapist and client via the movement they create together. This mutuality within the movement is what is known as the therapeutic movement relationship; therapeutic movement relationship is one of the four

components of Marion Chase's work as designated by her students, Chaiklin & Schmais (Levy, 2005). Empathic movement reflection, also known as mirroring, is a key element of the therapeutic movement relationship. Mirroring, or moving in a similar manner to another person, activates mirror neurons. Mirror neurons are also activated even when one person in a pair is not moving (Cozolino, 2002). When an individual creates an action, such as scratching her head, the same brain pattern that is activated in the individual by such action is also activated in the observer – even though the observer is not physically scratching her head, her brain pattern is acting as if she is. This is why, via the process of mirror neuron activation, small movement adjustments by the dance movement therapist can facilitate the expansion of the client's movement repertoire. Expansion in movement repertoire permits the client greater access to parts that would normally inhibit movement action; this leads to a stronger relationship to parts and more Self energy.

Therapeutic holding environment. Zoë Avstreih, a psychoanalytically trained dance therapist, studied with Schmais and White in the Chace technique (Levy, 2005). Avstreih is also a practitioner, therapist and trainer of Authentic Movement. Avstreih recognizes the importance of Winnicott's (1957) concept of the holding environment within the therapeutic container. The holding environment has been defined as a "psychical and physical space within which the infant is protected without knowing he is protected" (Donald, n.d.).

This author holds the position that Winnicott's holding environment correlates to the Self's orientation to the universal environment. The use of Authentic Movement with an orientation to the holding environment with individuals whose self is ego-based helps to transform ego-based orientations to self towards a more transpersonal Self .

Symbolism

DMT shares with Jung a focus on symbolism as a tool that bridges the unconscious and the conscious. Symbolism can take a variety of forms such as imagery, fantasy, movement action, verbalization, and vocalization. Chase believed that symbolism was healing within its own right; interpretation by the therapist was unnecessary for symbolism to be meaningful for the client (Levy, 2005).

Jung believed that it is vital for the individual to contact and understand the symbolic information from the unconscious. Jung believed that people carried complexes, or "collections of psychological material that function most efficiently when they are together, and they usually group together because they all relate to a single archetype. Take, for instance, the mother archetype" (Butler, n.d., ¶4). Once personal material is stripped from the complexes, their archetypical core provides a means for individuation and the experience of Selfhood.

Jung utilized dreams and artistic process as direct avenues into understanding what was 'meant to be' for the person. For this purpose, Jung had used dance either as direct expression or through the 'dancing out of one's dreams'" (Bernstein, 1979, p. 5).

Authentic Movement

Mary Starks Whitehouse founded Authentic Movement, a particular form of DMT. "Authentic Movement can have powerful effects as a form of therapy, a spiritual practice, and a way to access creative resources" (Smith, 2007, p. 194). Jung was a strong influence in Whitehouse's belief that "polarity was present in all aspects of life and emotions" (Levy, 2005, p. 53). Polarity has a direct relationship to the IFS theory of parts; parts that are in extreme roles invariably have parts that are polarized with them on the other end of the spectrum. For example, a person may have a part that feels vulnerable, weak and incapable (usually an exile); that part

may be polarized with another part that overcompensates and appears to be confident, aggressive and strong (usually a manager).

Whitehouse was also influenced by Jung's method of active imagination, in which one uses free associations "to allow in all levels of conscious and unconscious experience" (Levy, p. 54). Carl Jung's development of the techniques of active imagination afforded the patient a vehicle for expressing unconscious material and paved the way for Dance/Movement Therapy. While Jung incorporated movement into active imagination, Whitehouse used movement as her primary tool. Whitehouse worked to integrate, via movement action, disowned body parts and psychological parts that limited physical and emotional expression.

Authentic Movement requires both a mover and a witness. The mover enters a mindful state, usually with eyes closed, and finds internal movement impulses. As a client moves through these impulses, different parts of the individual (including archetypal parts) emerge and are given permission for full somatic expression. Somatic expression might also include wordless vocalizations (Chodorow, 1991) and can sometimes appear to tap into a preverbal stage (Smith, 2007). "Authentic Movement is a practice deeply rooted in a trust for the body" (Avstreih, 2007, p. 271); although Whitehouse worked through the body, she also worked towards consciously integrating parts through dialogue and metaphor.

The witness is a critical component of Authentic Movement. The therapist is an external witness who bears witness to the client's improvisational movement process. As clients develop their ability to move through impulses while being witnessed, they eventually develop an internal witness, which can be correlated to Schwartz' concept of the Self. This process is both psychological and spiritual. Halifax (1999) expressed the spirituality of witnessing when she said, "we become the gods themselves" (p. 178).

The Transpersonal Self

Authentic Movement assists in developing a relationship to the transpersonal Self. Whitehouse believed in the interconnectedness of the psychic and the physical realms of experience. She said, "physical movement is an analogy to the psychic movement that leads to the center" (Frantz, 1999, p. 20). This movement to the center has the power to transform self-identity to be based in something more solid than skills, abilities, and personality traits; it fosters an embodied Self. Personal upheaval can lead to periods in which "the center cannot hold" (Yeats, 1996, p. 158). Those with AOCInj often find themselves with an inability to hold her or his center; this uncentering can be the catalyst that requires the search for a more solid center. At times like these, it is the center that needs to be reestablished in order to re-embody the Self.

Trudi Schoop, another DMT pioneer, spoke of the transpersonal UR experience. Ur is a German word that can be loosely translated to mean energy. Schoop and Mitchell (1979) define UR as:

> The vital force which keeps the whole universal complex on the move. From the microcosm of the atom to the magnitude of the great whirling bodies of matter in our heavens and beyond, there exists the ceaseless life-force of the UR energy. (p. 36 as quoted in Levy, 2005, p. 62)

Schoop believed that humans inherently possess the whole human range of feelings, thoughts and expression; however, in order to meet societal norms, unwelcomed aspects must be pushed underground (Levy). This is very similar to Schwartz' understanding that unwelcomed parts become polarized with other parts. The result is an internalized, conflicted state with opposing drives at the center of the conflict. Schoop believed that expressive movement could welcome back to consciousness the unconscious and unwelcomed aspects of

the individual. In doing so, the Ur/life-force energy of the individual could flow unimpeded and allow the individual to access the transpersonal UR experience.

DMT in Research

There has been a plethora of theoretical writings on DMT in the last 50 years. For example, Lowell (2007) sates, "people with physical differences, such as Parkinson's disease, scoliosis, or birth anomalies, often discover acceptance, compassion, healing and fresh life energy in the physical contact with others which may occur in a session" (p. 304). Research literature on the use of DMT with injured populations, however, is somewhat limited. DMT research has been conducted with a broad range of psychological issues such as survivors of childhood sexual abuse (Mills & Daniluk, 2002; Ziva, 1997), the elderly (Stockley, 1992), autistic children (Warnick, 1996), eating disorders (Krantz, 1999), psychotic children (Gunning, & Holmes, 1973), torture survivors (Gray, 2001), schizophrenia (Koch & Bräuninger, 2006; Lavender, 1977), depression (Koch, Morlinghaus, & Fuchs, 2007; Jeong, Hong, Lee, Park, Kim, & Suh, 2005), and those with psychosomatic disorders (Thulin, 1997).

If there is limited published DMT related research, there is even less DMT research related to chronic injury. Several studies related to illness, however, do bear relevance to the chronically injured as both the chronically ill and the chronically injured share psychological symptomology such as depression, isolation, dependency, and existential issues.

Horwitz, Kowalski, Theorell, and Anderberg's 2006 study showed DMT to reduced pain levels in sufferers of fibromyalgia. Likewise, Bojner-Horwitz, Theorell, and Anderberg (2003) showed that DMT reduced stress hormones in those with fibromyalgia. Since those with chronic injuries are often subject to chronic pain as well as to the stress associated with the injury and

medical interventions for the injury, DMT may be effective in reducing stress hormones and reducing pain levels in those with AOCInj.

Penny Lewis, a dance movement therapist, Gestalt therapist, and Jungian analyst (Lowman, 2004), who recently lost her battle with cancer, focused her later work with fellow cancer survivors (Lewis, 2003). Several studies on the use of DMT with cancer survivors have been published that have relevance to the chronically injured. Mannheim and Weis (2005) conducted a three-year study on the effects of DMT on cancer patients; DMT was shown to help cancer patients cope emotionally and physically. Results showed significant reduction of anxiety and depression, as well as improvements in self-esteem and quality of life. Moreover, the quality of patients' movements progressed towards healthy movement. A 2000 study (Dibbell-Hope) of Authentic Movement with 33 women with breast cancer found improvements in mood, distress, body image, and self-esteem. DMT, particularly Authentic Movement, has also been shown to be helpful with cancer patients in Hong Kong (Ho, 2005). These patients showed increased energy, reduced fatigue, and improvements in mood, body-image, and self-esteem. Patients also reported an increased sense of hope, ease, strength and social support, in addition to decreased negative mood and worry about the future. All outcomes from these three studies would be useful for the chronically injured adult.

While there are no DMT studies of individuals with chronic injuries, these studies do indicate that DMT is likely to be physically, emotionally, and psychologically helpful for adults with chronic injuries. They also indicate that DMT would likely be helpful in improving ego-based orientations to self, such as self-esteem and body-image. What is missing from the DMT research, however, is the study of Self-transformation as defined in this paper.

Summary

Dance/Movement Therapy is a well-established therapeutic modality that is highly suited to work with the chronically injured. While no studies have been conducted on the use of DMT as a Self-transformative intervention, the nature of DMT, and Authentic Movement in particular, would work well towards the therapeutic goal of Self-transformation. Moreover, it is an applicable therapy to those who orient to the world via their physical sensations and experiences such as highly embodied individuals. Working with the chronically injured certainly has its challenges due to client mobility issues. Such challenges, however, are not insurmountable, for as Halprin (2000) states, “any body, no matter how old or young, in whatever physical condition, has the capacity to move, even if it is just your little finger or a movement carried as an image in your mind’s eye” (p. 23).

Chapter IV: Integrating IFS with DMT

The following chapter will discuss the theoretical frameworks that DMT and IFS share in common. Frameworks that are relevant to the population of this thesis are: integration into wholeness, transpersonal orientation, and community focus. These frameworks are particularly relevant to the healing of HEI with AOCInj.

Integration into wholeness.

Bringing unconscious material to consciousness. Since Freud's time, the focus of many models of psychotherapy has been to bring unconscious material to consciousness. With DMT and IFS therapy, unconscious material is explored via beliefs, thoughts, emotions, images, and bodily sensations/impulses. As Moshe Feldenkrais said, "if you don't know what you're doing, you can't do what you want" (Staunch, 1985). Bringing awareness of experience to HEI with AOCInj is extremely valuable as these people are often isolated in their experiences. They are often so occupied with attempting to manage their life post-injury (doctors visits, being dependant, ruptures to work and social support system) that the larger issues, such as loss and existential issues, remain in the unconscious and, therefore, remain unprocessed.

Like Jung, Both IFS and DMT carry a theoretical value of bringing to consciousness previously unconscious material. Jung believed that the establishment of a working relationship between the conscious and the unconscious created wholeness (Geist, 1997). This is particularly relevant to HEI with AOCInj as their sense of wholeness is often ruptured. Within group DMT sessions, the empathic response that occurs in the mirroring process can link one participant's experience to another or to several others. One person may be, literally, moving through an existential crisis while those witnessing and mirroring begin to move through and become conscious of their own existential issues.

Authentic Movement as a form of DMT greatly assists the process of consciousness as movers learn to become aware of their internal movement impulses that had previously been unconscious. Lewis (2007) states, "Authentic Movement…elicits unconscious material more directly than verbal therapy" (p. 79). Lewis also notes that Schubert (1975) reviewed several experimental studies that "support the hypothesis that dance/movement therapy deals more closely to primary process, right brain, unconscious…material than do verbal therapies" (p. 74). Authentic Movement is founded in Jung's model of active imagination and "provides a fully felt, fully experienced therapeutic process towards individuation and integration through total image embodiment and creative enactment" (Lewis, p. 79). Such movement therapies are indicated in HEI because their orientation to the world is through their bodies. When their bodies become unfamiliar territory, their orientation to the world becomes ruptured.

The process of working with parts in IFS therapy is related to the creative process of Jung's active imagination. Rather than focusing solely on movement impulses, IFS therapy seeks to find the parts, in or out of the body, that might lead to unconscious material. Impulses may arise from a word, a thought, a sensation, or an unconscious movement tag that indicates that there may be unprocessed emotions, memories, and/or beliefs. Accessing the body and the sensations therein can lead to exiled parts.

In using DMT and IFS therapy to allow for unconscious material to arise, the therapist is actively working with the client's states of mind. Each individual has numerous states of mind. For exmple, the state of mind an individual is in while in the presence of her mother is usually very different than the state of mind she is in when she is doing artwork. As mentioned previously in this paper, unprocessed trauma exhibits as a traumatized state of mind. Bringing

awareness to such states of mind is the beginning process of softening those states of mind so that they are not so extreme from one state to another.

Developing relationship between Self and parts. HEI are typically more integrated than non-HEI because their bodies and sensations are integrated into a sense of self. However, with the onset of chronic injury, new aspects/parts of the individual become fragmented. Grief, loss, isolation, shame, sexuality, dependency, trauma, financial worries, fear, awareness of the body as a finite being – these aspects often split-off from the main orientation to self because they are too intense and/or new for the person to organize around. Within the IFS framework, protectors hold the exiles at bay as they fear that the burdens the exiles hold would overwhelm the system. Developing a relationship between these split-off parts and Self is critical to recovery in HEI with AOCInj.

It is not surprising that integration is a fundamental goal in both DMT and IFS since both therapeutic models have connections to Jungian psychology. One of the primary goals of Jungian psychotherapy is to help clients to move towards psychological wholeness (Geist, 1998). As mentioned previously, Jung developed what he called active imagination to help clients make contact with unconscious material. It is within the unconscious material that clients find their shadows; shadows are parts that have been disowned. DMT, and Authentic Movement in particular, invites clients to "reclaim split-off aspects of being" (Avstreih, 2007, p. 272).

Expanding and releasing patterns. Every part/shadow/aspect has its own unique way of physically being in the world. For example, disempowered parts may have little muscle tone, while aggressive parts may have extreme muscle tone. Some parts may live in the belly (e.g. sadness), while other parts may be sensated more readily in the chest (e.g. anxiety and grief). Within the framework of DMT, sensations are connected to awareness. Awareness of sensations

in physical parts of the body often leads to the awareness of the psychological parts that inform them. These psychological parts carry burdens that need to be released (unburdened) in order to allow Self energy to charge the system again. DMT works towards integrating the entire physical and psychological body. Lewis (2007) discussed such integration when she wrote, "…repressed or unintegrated aspects of the individual's psychology may be allowed greater tolerance and acceptance through an embodied, enacted actual experiencing of their personification…a dialogue can be created producing a continuum of behavioral experiences rather than a polarized either/or pattern" (p. 75).

In order to heal the body-mind, individuals must learn how to reinhabit their bodies. It is the transformative power of Self energy that can reintegrate the body-mind split. In fact, embodiment is a requirement for Self energy. Those with AOCInj have difficulty integrating the uncomfortable aspects of their experiences. These uncomfortable experiences create holding patterns in the body that help the individual's system to organize itself. While these holding patterns may be effective in keeping the person functional in the short-run, they have negative, long-term consequences. It can be compared to jerry rigging a nonfunctional mechanical device; piece-meal, impromptu interventions will get the device functioning for the moment, but the device will eventually lose its integrity. Both DMT and IFS therapy are effective tools that can be used to release contracted patterns (due to pain, trauma, fear, etc.) and expand healthy patterns of movement, both on the physical and psychological planes.

Transpersonal Orientation

The premise of this thesis is that the combination of DMT and IFS therapy with HEI with AOCInj can help to transform an ego-based orientation to self (e.g. self-identity, core-self, sense of self, self-esteem) towards a more transpersonal orientation to Self; A transpersonal orientation

to Self can only occur when the individual is in an embodied state and in present time awareness. Furthermore, it is presumed that when parts develop relationship to the transpersonal Self and are able to relinquish their burdens, psychological functioning will improve.

IFS is a model that works directly towards the establishment of a relationship between the transpersonal Self and parts. While this component of IFS is rooted in Jung's work, it is significantly different in that Jung related the Self to the ego; Jung continued to use Freud's concepts of Id, Ego, and Superego, albeit he operationalized those terms somewhat differently. IFS theory, on the other hand, eliminates the constructs of Id, Ego, and Superego. Instead, IFS looks at the development of relationship between the transpersonal Self and parts, as well as the development of healthy relating among parts. Self, in IFS theory, is a nontransitory state; it is not body, or mind, or any other conceptualization. It is the is-ness of being that currently inhabits the body. The self in Authentic Movement also carries this orientation. Avstreih (2007) states that the essential self is the uncontaminated core of one's being "which is ever present and unchanging" (p. 273). She further states that in "touching this source, [and] being moved by the divine within, we begin to know the imperishable self" (p. 273). She further clarifies:

> in a state of open receptivity, both the mover and witness are pulled inward, activating the unconscious and the Self, the image of the divine that resides within…both are pulled towards the center, creating the space to be moved by contact with the Essential being…we touch…the unbroken wholeness of our being. One begins to realize that this body and this mind, which one identifies as 'me,' is animated by something which is essentially me and quite beyond me. (p. 272)

While there has been a plethora of research on ego-based orientations to self (Auerbach & Blat, 1996; DeVos, Marsella, & Hsu, 1985; O'Brien, Bartoletti, & Leitzel, 2006; Seff, Grecas,

& Ray, 1992), there has been little research on transpersonal orientations to Self. While both DMT and IFS speak to the transpersonal nature of Self, there have been no clinical studies that measure whether or not these models actually help clients to broaden ego-based orientations to self to incorporate a transpersonal orientation to Self. Moreover, there is no research on how psychological functioning is affected when clients switch from an ego-based orientation to self to a transpersonal orientation to Self.

Mindfulness. To enter into the sacred state of Self requires mindfulness. Mindfulness is a here-and-now orientation using an embodied, reflexive self-awareness. IFS is a therapeutic modality that begins with mindful awareness. That is, the IFS therapist connects with the client from a state of mindfulness, or Self energy; The Self energy of the therapist attracts the Self energy of the client. Somatic awareness and verbal interventions, along with the witness function of the therapist's and client's Self, provide greater space for more of the client's Self energy to emerge and to be fully embodied. Authentic Movement also uses somatic interventions to help the client enter into mindfulness. "Whenever a patient/client talks about a past, present or future experience in a manner which is disconnected from affective contact, the therapist may suggest that the individual bring the experience into the present through an embodied exploration" (Lewis, 2007, p. 75).

Community Focus

This project recognizes the isolation associated with AOCInj, therefore, creating community in those with AOCInj is a critical intervention in order to integrate the individual into the larger whole of society. Those suffering from AOCInj often lose their communities as they once knew it. People emotionally distance themselves because they cannot understand the pain and suffering of the injured individual and such injuries bring up their own physical and

emotional vulnerability. Lovers, who often become caretakers, emotionally distance because caretaking is usually an exhausting job and it is difficult to hold the energetic qualities of both caretaker and lover. Those with AOCInj distance themselves from their community out of depression, guilt and shame for their neediness, as a response to insensitive attempts at support, loss of self-identity, not knowing where they belong, and inability to participate in community events due to physical incapacity.

Group relationship. Human beings are social animals. Community is a critical component of well-being and healing; group therapy is one form of community. Dibbell-Hope (2007) refers to Shavin (1984) and Speigel (1979) when she states, "group therapy…provides an effective, efficient, and economical system of peer support, offers information, hope, and understanding from other patients facing similar issues, and often leads to increased responsiveness to medical treatment" (p. 338). Group therapy in the form of DMT is an appropriate intervention for HEI with AOCInj because: (a) they experience a loss of and need for community, (b) they orient to the world through their physical sensations, (c) their current crisis is rooted in their physicality, and (d) groups are cost effective. The latter is an important consideration for individuals who are already financially taxed by medical related expenses.

The use of active imagination in Authentic Movement helps to touch into transpersonal components. "Active imagination is a highly creative process entailing the active calling forth by the client of inner unconscious images, symbols, and mythic themes. From a transpersonal perspective, it is capable of reaching the depths of the soul and the collective world of the psyche" (Lewis, 2007, p. 75). Tapping into the collective world of the psyche is a form of community in which sufferers of AOCInj can relinquish their sense of aloneness. Furthermore, within the structure of Authentic Movement, nonjudgmental feedback is often provided in a

format introduced by Adler that begins with "I am the one who…" (Smith, 2007, p. 195). This "ritualized statement, which stands for 'I am the one among many who…' emphasizes both the individuality of the speakers, and…the speakers' awareness of their participation as members of a community" (Smith, p. 196).

"To have your 'true self' acknowledged (Miller, 1981) in a family or family-like group is an important condition for healthy development and healing. In Authentic Movement groups, aspects of persons that have not been 'seen'…often emerge to be witnessed and validated. The self comes to be experienced as more complete and more rested, incorporating previously split-off, unseen aspects" (Smith, 2007, p. 197). This is incredibly important for HEI with AOCInj as acquaintances, coworkers, and loved-ones often cannot comprehend the depth of loss experienced. The chronically injured often feel unseen in their pain and despair.

Ritual. Ritual is a fundamental aspect of human life. Each person has a plethora of unconscious rituals, such as putting the cap back on the toothpaste before brushing, that are often referred to as habits. These unconscious rituals create a rhythm and a structure to life.

Conscious ritual practice in DMT also provides rhythm and structure. However, the conscious ritual in DMT can lead participants into the world of the transpersonal. Lewis (2007) states, "group synchronistic repetitive body action of ancient rhythms has been successfully utilized in psychotherapies which address the transpersonal" (p. 74).

Therapeutic Relationship: Community is also created in the one-to-one therapeutic relationship. The IFS, Self-led therapist creates a relationship with clients that leads to the unfolding of Self-leadership in clients. It is from Self that the witness function originates. Avestreih (2007) states:

> The integrity of witnessing demands a willingness to become conscious of one's subjective experience. As the witness brings inner experience into consciousness and owns it she frees the mover from projection. Now, the mover has the opportunity to find herself, free from the expectations, labels and unconscious needs of the other. (p. 272)

When clients are able to access the transpersonal Self, they have greater ability to connect with others and see their connection to other living beings.

Summary

Chronic injuries are difficult for any population. However, chronic injury in adulthood, when self-identity is firmly established, results in a rupture to self-identity that provides a rich opportunity for Self-transformation. DMT and IFS therapy carry many common values that work towards the awareness of Self as transpersonal. Because self-identity in HEI prior to injury is highly based on their physicality, these two body-based approaches to psychological healing and spiritual transformation are well-suited to this population. Clinical research on IFS and DMT as they apply to Self-transformation and the potential benefits therein is highly indicated for this population.

Chapter V: Using IFS and DMT with HEI with AOCInj

> Each of us lives in a body that has taken millions of years to evolve and which will continue to evolve as we pass from one generation to the next. Each of us has a unique body; there is not another one like it anywhere in the universe. And this body is intricately designed to survive. It has wisdom, wonder, and magic in it to perform the great dance of life. Our personal and cultural abandonment of our bodies can create illness, and a void in understanding how to regain our health. When we become ill, we may feel that our body, which we have taken for granted, has suddenly betrayed us. At this time, it is crucial to return to our bodies, to return home and reawaken our senses, so that the natural healer within can renew its strength and power. (Halprin, 2000, p. 21)

In the following chapter, the author proposes two new classifications: highly embodied individuals (HEI) and adult-onset chronic injury (AOCInj). These concepts were discussed earlier in this thesis; however, this chapter will provide in-depth definitions of these two concepts. A case will be made for the use of DMT and IFS therapy with this population along with practical applications in using IFS therapy and DMT with HEI with AOCInj.

Original Theory

Highly embodied individuals defined. While some research has been conducted on various aspects of embodiment, there is very little written about HEI. HEI, an original term coined by the author, are those people whose self-identity is strongly based upon their physical sensations, expression, and capability. HEI experience their bodies as intrinsic to their self and orient to the world via their physical sensations; they consciously process their experiences through their bodies. They use physical expression of internal states to self-resource. Both DMT and IFS are models that actively work with sensation as a form of knowledge and as a tool for

psychospiritual integration. In addition, the body-based focus of IFS and DMT is supported by neuroscience, studies in mindfulness, and various explorations in transpersonal experiences (Clark, 1999).

Csordas (1994) notes that human beings are corporal. There is no sensation, no thought, and no reasoning that is not mediated through the body; the body is the source of all knowledge. For HEI, the body is a critical source of knowledge and intrinsic to self-knowing. Unembodied people, on the other hand, tend to view the mind as the self, while the body is often perceived of as an object separate from self (Csordas). The body becomes that which obeys the mind's bidding, performs tasks, and subjugates itself to the master self. Highly-embodied individuals, however, orient to their bodies as an integrated component of the self. When these individuals are faced with a chronic injury, their body-self perception often switches to a body-as-betrayer orientation, which often results in what may be compared to as a crisis in faith. Using body-based psychotherapeutic modalities can be useful with this population to relinquish the body as betrayer orientation.

Susan Aposhyan (2004), creator of an approach to psychotherapy she calls Body-Mind Psychotherapy, defines embodiment as "the moment to moment process by which human beings allow awareness to enhance the flow of thoughts, feelings, sensations, and energies through…[their]…bodily selves" (p. 52). Aposhyan differentiates between the conditioned self and essence. The conditioned self is an ego-based orientation to self that is based upon experiences, whereas essence is perceived of as core self. This is somewhat similar to Schwartz' concept of Self; however, Aposhyan holds that core self can be developed. Schwartz, on the other hand, holds that Self always is; it can be revealed, but not developed.

Dr. Christine Caldwell, a body-centered psychotherapist and creator of The Moving Cycle, also sees her work as helping clients to move toward fuller embodiment that leads to the "recovery of the capacity to engage with the authentic self" (personal communication, February 23, 2009) and a reintegration of fragmented parts of the self. According to Caldwell (1996), reinhabiting the body leads to greater self-regulation because it is through the body that the authentic self is experienced. Furthermore, embodied people have access to "a gutsy, full-bodied, vibrant celebration of life, an actual experience of pleasure in the events of life, [and] a rejoicing in being here that makes us all poets and dancers, lovers and painters, humanitarians of the highest order" (p. 9). This means, then, that well-being and psychological recovery are not simply the absence of symptoms, but a reentrance into the full joy of being a Self-embodied human.

Gabrielle Roth, a highly embodied individual working to help others become more embodied, believes that a full self is an embodied self. In other words, those who are not living in an embodied state are cut-off from the fullness of who they are; they are limited, cordoned off, and contained. Their essence/soul/spirit/Self is shrouded by the dissociation of the body. To be in an embodied state, Roth (1989) advises people to erase the past and stay out of the future, because embodiment, by its very nature, is a present moment experience. Both IFS therapy and DMT work towards greater client embodiment and thereby, stronger connection to the transpersonal Self because the transpersonal Self is only experienced in an embodied state.

Neuroscience supports embodiment. The thinking mind (i.e. cortex) in humans is not fully developed until well into adulthood. This means, according to Cozolino (2002), that the majority of learning occurs before there is cortical development needed for conscious memory and awareness. At this stage, learning occurs primarily via bodily sensations. Infants are highly

embodied people by their very nature; for them, embodiment is a natural state of being. IFS and DMT work towards helping clients get back into their bodies. This is particularly meaningful for those with AOCInj because the body often becomes a conflicted place in which to reside.

Adult-onset chronic injury defined. Reid-Cunningham, Snyder-Grant, Stein, Tyson, and Halen (1999) defined adult-onset chronic illness (AOCI) as a non-congenital illness that has occurred in adulthood when the individual has already established a sense of identity. The author has modified the acronym AOCI to AOCInj to indicate adult-onset chronic injury. While there is some crossover between those who suffer from chronic illness and those who suffer from chronic injury, the trauma associated with chronic injury can be markedly different. Those with chronic injuries often have trauma from the initial injury as well as trauma from repeated medical procedures. The author further defines AOCInj as a chronic injury that has been in duration for at least 12 months, has required repeated medical intervention, is non-terminal, is expected to have a lifetime duration, significantly alters normal daily activities. AOCInj excludes chronic injuries in the elderly as well as more severe forms of chronic injury such as TBI and SCI.

Adult-onset chronic injury exclusions. People suffering from TBI, SCI, and the chronic injuries associated with age may have similar psychological symptomology; however, they are deemed to be significantly different for various reasons. Those with TBI may not have the cognitive capacity to fully understand what has happened to them nor to work within the IFS framework (Oh, Seo, Lee & Song, 2006). Appropriate therapeutic interventions for those on the mid to far end of the TBI spectrum are more behavioral and skills based rather than process based (Dahlberg, et al., 2007; Robertson, 2008). Those with TBI may have emotion control, expression, and perception deficits (Bornhofen & McDonald, 2008; Presecki, & Mimica, 2007; Tiechner, Golden, & Giannaris, 1999) that are not seen with other chronic injuries. Furthermore,

levels of dependency in TBI sufferers typically far outweigh those of the chronically injured who have not lost brain related functions (Johnston, Shawaryn, Malec, Kreutzer, & Hammond, 2006).

People with SCI are also excluded from the AOCInj definition because their experiences and symptomology are deemed to be more profound. This is particularly true for people who have sustained injuries in the cervical region of the spinal cord, which usually results in paralysis from the neck down (paraplegia). It is even truer for those with injuries above the fifth cervical vertebrae who often need medical intervention for basic life support functions.

Chronic injury in the elderly is also excluded due to differences in existential experience and timing of injury. For non-elderly adults, a chronic injury can be the first recognition that their bodies will eventually fail them. For the elderly adult, a chronic injury can mean impending death. This makes the existential issues face by the younger group as more shocking, and in the elderly as more immediate and profound. In contrast, the trauma associated with chronic injury in the non-elderly is, in some ways, more intense because it is an off-time event. Because DMT and IFS therapy help develop awareness of the transpersonal Self, they address existential issues that occur with AOCInj.

Childhood chronic injury is also excluded as children who suffer from chronic injuries (regardless of the source of injury) usually develop a self-identity as an injured, ill, or less than capable person. Trauma and pain in childhood are imbedded differently than in adulthood because it is in childhood that self-identity first becomes established. Furthermore, “children and adolescents with chronic illness have higher rates of psychosocial dysfunction” (Gortmaker, 1993, p. 330); the author posits that this is true for children with chronic injuries as well.

How AOCInj affects HEI. Most adults who were healthy prior to first injury have an established self-identity that does not include concepts of physical deficiency/incapability, social

ineptitude, and dependency. On the contrary, the self-identity of HEI typically contains within it concepts of capability and appreciation of their bodies' capabilities. Chronic injury in HEI creates a rupture to their self-identity. Such a rupture offers HEI the opportunity to transform an ego-based self-identity towards a more transpersonal orientation to Self.

Chronic injury creates a profound loss in HEI. One can no longer do the things one was once capable of; one may not be able to ski, jump, garden, bend, pull, twist, wrestle, pick up children, pick noses, have sex in certain positions, etcetera. The sense of powerlessness that comes with having no control over one's own physical reality (Halprin, 2000) can be infuriating, frustrating, depressing, and devastating. There are other losses that often occur as well, such as the loss of dreams, relationships, and financial stability.

Rabbi David Wolpe (1999) discusses the richness of loss in his book, *Making Loss Matter*. He states, "in times of grief we need to deal with the unreasonable, and only traditions that speak directly to the human soul will guide us through" (p. 6). For this reason, he believes that a spiritual based psychology is needed for those suffering loss. A "spiritual psychology bases itself on the idea that there is something outside ourselves without which we cannot understand ourselves" (p. 7). The transpersonal focus in DMT and IFS is a spiritual orientation to psychology that makes these methods highly indicated in HEI with AOCInj.

Wolpe (1999) speaks to the transformation of self-identity when he states, "we must lose ourselves to find out who we are, parts of ourselves must fade in order to make way for new ways of being" (p. 92). New ways of being can cultivate a relationship to a spiritual self that is "connected to something greater than ourselves" (p. 95). He notes that in order to find one's true self, one has to give up the parts that are not true self. This is what occurs when self-identity is ruptured through chronic injury; ego-based orientations to self are unwillingly forced into

retirement. One can either fill the space that is opened due to such retirement of parts with new ego-based aspects to create a new self-identity, or one can open to a spiritual, transpersonal Self that is connected to something greater.

Social rupture in the chronically injured. Social rupture is a common experience of the chronically injured. Friends and family of the chronically injured often are not able to reach out appropriately to the injured person; they often do not understand the impact the injury has to the injured person's daily life, nor the losses that are associated with chronic injury. Chronic conditions tend to make others uncomfortable because it is a reminder that they are also vulnerable. Friends and family who are uncomfortable with their own vulnerability will often attempt to fix the injured person; since they usually cannot fix the injury, they will typically attempt to soften or eradicate the injured person's uncomfortable feelings of grief, depression, anger, and hopelessness. Additionally, Westerners are not acculturated to the acceptance and welcoming of grief; Westerners will typically do anything they can to avoid feeling grief (Fulton, 2003). There is also the added complication that the primary support person (e.g. spouse) usually becomes the primary caretaker. The burden of caretaking can be arduous and can limit the availability of emotional support (Burlo, Bruno, & Roma, 2006; Tsigaroppoulos, Mazaris, Chatzidarellis, Skolarikos, Varkarakis, & Deliveliotis, 2009). It is not surprising that friends and family tend to emotionally retreat from the injured loved-one.

It is not just friends and family that distance themselves from the chronically injured person. Those with AOCInj often find themselves unable to relate to others who are not in similar situations; this is particularly true if they have experienced the insensitivity that healthy people often show towards the chronically injured. The world of those who suffer from AOCInj has been turned upside down. They grieve a multitude of losses, and "when people are grieving,

other people become almost unreal. The pain is so overwhelming that to recognize the reality of others is too great an emotional burden" (Wolpe, 1999, p. 88).

This social rupture occurs when those with AOCInj need community the greatest. Wolpe states, "the journey is made bearable, even wonderful, by community" (p. 39). Ongoing group DMT sessions can reestablish a sense of community that is often ruptured in the chronically injured. Being with others with similar long-term disabilities within a healing group can ease isolation and bring hope and camaraderie back into the clients' lives.

Those with AOCInj need social support for their emotional well-being; social support also has a direct correlation to physical recovery. Halprin (2000) discuses Dr. David Spiegel's mind/body connection to illness research at Stanford University in the 1980s:

> He [Spiegel] wanted to disprove the theory that there was a connection between psychotherapy and health, and was amazed instead to find a definite and convincing correlation. His study showed that cancer patients who joined a support group as a adjunct to their medical treatment doubled their survival time" (p. 16).

Why further research is needed. Most of the written material on chronic conditions is related to chronic illness (Lynn, 1987; Reid-Cunningham et al., 1999). There is very little research on chronic injury, other than the most severe cases such as TBI and SCI (Frank et al., 1987; Good et al., 2006; Mazurek, & Mintz, 2006). There are probable correlations between chronic injuries and more severe chronic injuries such as TBI and SCI. For example, Hanson, Buckelew, Hewett, and O'Neil (1993) found that cognitive restructuring was positively correlated with acceptance of disability. There is certainly some correlation in psychological symptomology such as depression, dependency issues, and self-esteem. However, there are few,

if any, research projects that have studied Self-transformation in individuals with chronic illness or chronic injury.

Though there may be some crossover between those with AOCInj and those with TBI and SCI, research on TBI and SCI speaks to the male experience because 80% of those who survive such injuries in the United States are male, and men "are four times more likely than women to suffer spinal cord injuries (Good et al., 2006, p. 165). What research has been conducted on chronic injury is limited primarily to athletic injuries (Smith, Smoll, & Ptacek, 1990; Wasley & Lox, 1998), again, primarily with male athletes.

There is also no research on highly embodied individuals nor their orientation to self/Self. Because HEI experience their bodies as a part of their self, orient to the world via their physical sensations, and consciously process their experiences through their bodies, bodily trauma can be quite devastating for this population.

Practical Application

In both IFS and DMT models, the capacity of the therapist to be familiar with their own internal state is critical. IFS requires that the therapist be Self-led and continually working on integrating parts and Self. Likewise, DMT, and Authentic Movement in particular, focus on the therapist being able to maintain a witness function. For this reason, those using IFS or DMT with this population should be adequately trained. Furthermore, because the population has physical limitations, DMT and IFS therapists participating in the study must become familiar with anatomy and have familiarity with each client's injury. Medical clearance is indicated and working with a physical therapist or other appropriate medical personnel is recommended.

Individual IFS therapy would best be provided early in the injury process when clients may still be in the acute injury stage. IFS therapy may, however, be integrated at any stage of the

injury process. Because the issues with this population are ongoing, a 26-week IFS program is recommended.

Weekly group DMT sessions can be integrated when the client has received medical clearance to participate. It should be noted that DMT can readily be modified to accommodate individual limitations. Weekly sessions are recommended for a 16-week period. It is recommended that the first eight weeks of DMT be focused on more traditional forms of DMT, such as Chacian DMT, in which participants are active and working together as a group. This creates group cohesion and safety within the group. This structure also works towards specifically creating the community that those with AOCInj often lack. The following eight weeks of DMT could be deepened to working within the Authentic Movement framework. It is this author's premise that Self-transformation is mostly likely to occur with the combination of Authentic Movement and IFS as both of these modalities strongly emphasis witness function/Self, being in the present moment, oscillation between internal and external experience, and integration of parts. Due to the lack of professionals trained in both DMT and IFS, Group DMT and individual IFS sessions would likely be provided by different therapists who coordinate their work together.

Summary

HEI with AOCInj is a specific population that is greatly underresearched and underserved. This chapter provided definitions of HEI and AOCInj and made arguments for the use of DMT and IFS with this population. Applications for using the combined approached was outlined.

Chapter VI: Hypothetical Research Design

The following chapter will outline a proposed research design using a combination of Internal Family Systems (IFS) therapy and Dance/Movement Therapy (DMT) with highly embodied individuals (HEI) who have an adult onset chronic injury (AOCInj). The research is intended to test whether or not the combination of DMT and IFS can transform ego-based orientations to self towards a more transpersonal orientation to Self. Furthermore, pre- and post-tests provided will show whether or not there is a correlation between Self-transformation and psychological functioning.

Research Question

The overall research question for this study is: Can the combination of Dance/Movement Therapy and Internal Family Systems therapy assist in the transformation from an ego-based orientation to self towards a transpersonal orientation to Self in highly embodied individuals who have a chronic injury that was acquired in adulthood?

Hypothesis

The primary hypothesis of this study is: participation in a combined program that includes group DMT and individual IFS sessions with HEI with AOCInj will transform ego-based orientations to self towards a transpersonal orientation to Self. The secondary hypothesis of this study is: transformation from an ego-based orientation to self towards a transpersonal orientation to Self will positively correlate to improvement in psychological functioning.

Definition of Terms as Yet Unspecified

Improvement. Statistically significant positive change in levels of psychological functioning.

Psychological functioning. Psychological functioning will specifically address common areas of difficulty for those with AOCInj, such as depression, anxiety, existential crises, and Posttraumatic Stress Syndrome.

Model

The theoretical basis of this research project is based upon the premise that DMT and IFS are effective models for transforming ego-based orientations to self to transpersonal orientations to Self and that such transformation will positively correlate to psychological functioning.

Methods

Sample. Inclusion criteria for this study are: (a) highly embodied individual, (b) adult onset chronic injury, (c) no history of chronic illness or injury in childhood, (d) between the ages of 21 and 55, (e) no history of hospitalization for psychiatric illness, (f) no Axis II diagnosis, (g) not more than five years since onset of original injury, and (h) do not already have a transpersonal orientation to Self.

It is the hope of the author to have a minimum of 50 participants. The participants will be from the San Francisco Bay Area. The San Francisco Bay Area was selected due to the density of population and the presumed high level of embodied people within the geographical region.

Setting and therapists. Therapists providing DMT will possess ADTR certification through the American Dance Therapy Association. Therapists providing IFS therapy will have completed a Level 1 IFS training and have a minimum of five years experience working with the model. All individual and groups sessions will be held at the funder's site, San Francisco General Hospital.

Procedure. Flyers offering the free study will be posted at various sites where HEI or AOCInj sufferers may convene. Examples are California Institute of Integral Studies, John F.

Kennedy University, dance studios, yoga studios, physical therapy offices, and osteopathic surgery offices. Those who make contact will be interviewed by phone to screen for study eligibility based on inclusion criteria. Those who meet the inclusion criteria will be invited for an on-site, face-to-face interview, questionnaire, and assessment. The verbal portion of the interview will be semi-structured; participants will answer questions about their experiences with AOCInj, including the effects on their feelings about their bodies and themselves. Since there is little research available on this population, this exploratory qualitative work is intended to gather data for further research at a later date.

At the end of their interview, participants will be asked to complete a packet of paper-and-pencil questionnaires (without interviewer present to prevent interviewer bias) in order to measure pre-treatment quantitative levels of psychological functioning, as measured by psychological distress (SCL-90R), Posttraumatic Stress Syndrome (PDS), and mood states (POMS). To test respondents' tendency to present themselves in a positive light, the Marlowe-Crowne Social Desirability Scale will also be provided. Participants will also be asked to complete the Orientation to Self Scale to ascertain the level of ego-based versus transpersonal orientation to Self. This portion of the assessment should take approximately 60 minutes. These same questionnaires will be given to participants at the end of the study to assess changes in psychological functioning post-treatment. An additional semi-structured, qualitative interview will also be provided post-treatment.

Each participant will be told that there will be several treatment groups throughout the year and that they will be notified a month prior to when their treatment group begins. Half of the selected respondents will be randomly assigned to the first treatment group, the second half will be assigned to the control group. The control group will be provided bibliotherapy in the

form of a pamphlet on AOCInj. Following treatment completion of the experimental group, the experimental group will be given post-tests. Because six months will have passed from the original assessment interview, participants in the control group will be interviewed again using the same pretreatment interview, questionnaire, and assessments. Quantitative data from the five assessment forms will be analyzed to determine efficacy of the combined DMT/IFS treatment.

At this point, the control group will be offered the same treatment as the original experimental group. Data from the control group's participation in DMT and IFS therapy can also be gathered for further research and to later assess inter-test reliability.

Qualitative Measures

Telephone screening interview. The researcher will make telephone contact with all prospective participants who responded to the flyer. If the subject meets the inclusion criteria, an intake interview will be scheduled. It is expected that the phone interview will take approximately 15 minutes.

Pre-treatment questionnaire and intake interview. Each prospective subject will complete a pretreatment questionnaire (see Appendix A) that will include name, age, income, race, gender, contact information, type of injury, dates of medical intervention, past experience in physical activities, and embodied experiences. This information will be used to prepare a profile of injury and demographic information that might affect the individual's response to treatment. A 45-minute individual interview will be given in which the researcher will ask participants a series of questions (see Appendix B) about their experience with chronic injury and how such experiences have affected their feelings about themselves, their bodies, and their relationships to others.

Prior to treatment, participants will provide medical clearance from their primary physician. Costs for such visits will be covered by the study. If participants do not have a

physician, they may select one of their choice and the costs incurred will be covered by the study.

Post-treatment interview. The researcher will conduct an additional 45-minute interview with each subject at the end of the 26-week treatment period (see Appendix C). Questions in this interview will be focused on the participants' experience of each treatment model (IFS, Chacian DMT, Authentic Movement), their experience of the treatment, and how their participation affected their feelings about their body, their selves, and their relationship to others.

Quantitative Measures

Orientation to Self Scale. This Likert scale, self-report questionnaire will be designed to assess the subject's sense of self as being more ego-based or more transpersonal based. A prototype for such a scale can be found in Appendix D. A statistician and specialist would be consulted to create a valid and reliable scale.

Posttraumatic Stress Diagnostic Scale (PDS). (Pearson Education, 2008). This self-report questionnaire has 49 items that measure all DSM-IV categories for Posttraumatic Stress Syndrome. It takes less than 15 minutes to complete and has high reliability and validity.

Profile of Mood States (POMS). (McNair, Lorr, & Doppleman, 1971). This self-report questionnaire measures transient and fluctuating affective states. It has been used with non-psychiatric participants to measure six mood states (tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia, and confusion-bewilderment). It has 65 items and takes less than 15 minutes to complete. Validity and reliability are high.

Symptom Checklist 90-Revised (SCL-90R). (Derogatis, 1979). This inventory of distress has 90 items and takes less than 15 minutes to complete. It measures nine symptoms (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility,

phobic anxiety, paranoid ideation, and psychoticism) and three global indices of distress (overall psychological distress, intensity of symptoms, and number of self-reported symptoms). SCL-90R has satisfactory reliability.

Marlowe-Crowne Social Desirability Scale (M-C). (Crowne & Marlowe, 1964). This questionnaire measures respondents' tendencies to present themselves in a more favorable light than is actually experienced. This test has good reliability and takes less than 15 minutes to complete (see Appendix E).

Treatment Protocol

Treatment will begin with six weekly individual IFS sessions to help participants enter a mindful state and to work with parts that may have fear about movement-based therapy due to their injury. The following ten weeks will consist of weekly Chacian DMT sessions in conjunction with weekly individual IFS sessions. The last ten weeks will consist of weekly Authentic Movement DMT sessions and five biweekly IFS sessions.

IFS. In the initial six weeks of IFS sessions, the IFS therapist will focus on helping the client to enter into states of mindfulness while separating out parts from the Self. Particular attention will be paid to parts that have been burdened as a result of the chronic injury; there will be a focus on the body and its sensations. Trust will be developed with protector parts in order to get their permission to work with exiled parts that hold trauma from the injury and medical interventions. Helping the Self to be in a leadership position will be an additional focus. In the following ten weeks, the IFS therapist will begin to work with trauma associated with the chronic injury (concurrent with Chacian DMT). Traumatized parts may be unburdened as the Self energy increases and the Self assumes a stronger leadership role within the internal family system. During the last ten weeks of five biweekly sessions, the IFS therapist will focus on helping the

client to Self-resource so that they may be able to work with their parts outside the therapy setting. This will occur concurrently with weekly Authentic Movement sessions.

Chacian DMT. There are several reasons for a ten-week protocol of Chacian DMT. Chacian DMT sessions are particularly useful in creating a sense of community and safety via synchrony, rhythm, ritual, and therapeutic movement relationship. Authentic Movement requires a level of safety that is enhanced by the safety developed in Chacian DMT sessions. Mindfulness and self-observation skills needed for Authentic Movement may be undeveloped in the participants. Chacian work may increase the mindfulness capacity of the group, allowing for more safety in the Authentic Movement sessions that follow. Chacian DMT sessions will begin after six weekly IFS sessions have been completed. Themes addressed in these sessions will be isolation, disappointment, dependency, being seen, body as betrayer/body as Self, fear of further injury, recognizing limitations and possibilities, recognizing internal impulses, existential issues, and transitioning to Authentic Movement format. Because participants may have limited mobility, the dance movement therapist must be skilled in adaptive DMT.

Authentic Movement. The last ten weeks of DMT sessions will be provided in the Authentic Movement format as Authentic Movement is a form that is highly focused on the Self as transpersonal. While the format of Authentic Movement is very different than Chacian DMT, Authentic Movement and Chacian DMT are both very ritualized in their structure. Themes for the Authentic Movement sessions will not be predesignated, but will be allowed to arise from the participants' movement/impulse material.

Research Analysis

Pre-test and post-test quantitative assessment scores will be compared for statistical differences. Changes in orientation to Self will be analyzed to measure for correlation with

psychological functioning in order to determine if there is a relationship between the two. Results will be measured against race/ethnicity, age, income, and gender to see if any of these variables affect outcome. The qualitative data will not be assessed at this time. Exploratory, qualitative data may be used in future research projects.

Expected Research Outcomes, Limitations, and Suggestions for Further Study

It is expected that, following the 26-week program, those who have received treatment will have moved from an ego-based orientation to self towards a transpersonal orientation to Self. It is also expected that those in the control group will not make such a transition. It is also expected that the switch to a transpersonal orientation to Self will positively correlate with improvements in psychological functioning. The reader should be reminded that correlation is not causation. Therefore, should there be a positive correlation between the transition towards a transpersonal Self and psychological functioning, further research would be indicated to explore whether or not the change to a transpersonal orientation to Self actually causes improvements in psychological functioning.

One downside to this study is that it is not longitudinal. While long-term results could be tested, they could not be compared to the control group because the control group will be receiving treatment following treatment of the experimental group. This research project could be designed as a longitudinal study, though it would require that the control group receive unequal treatment. The research designer believes that such a choice would be unethical; therefore, longitudinal focus was sacrificed in order to maintain ethical treatment standards.

The quasi-experimental aspect of this study means that another limit to this study is that it is designed to work solely with HEI. Another study could be created with participants who have

AOCInj who are not highly embodied. Further research using a group of HEI and non-HEI is indicated.

Another research design might include therapists who were trained in both IFS and DMT as they could provide more cohesion within the treatment plan. The downside to this type of study as that there are a limited number of professionals who are trained in both modalities and they are scattered across the country; this would likely require that the study be conducted in a variety of locations, rather than focused on a singular geographic region.

Likewise, the study is designed to assess the combination of DMT and IFS therapy as instigators of transformation from an ego-based orientation to self towards a more transpersonal orientation to Self. Combining these two models means that it will be unclear if one model is more effective in this goal than the other model. Further research using either DMT or IFS therapy with HEI with AOCInj could yield interesting results.

Because the quantitative portion of this study relies solely on self-report measures, this research project is subject to trait error. The M-C scale will be administered in order to account for such error; however, further studies that include external examiners would make the study more reliable.

Summary

This research begins the first study of three constructs: highly embodied individuals, those with adult onset chronic injury, and the process of transformation from an ego-based orientation to self towards a transpersonal orientation to Self. It is also one of the few studies designed to work within the IFS framework. It is the first proposed research project that uses a combination of DMT and IFS therapy. Furthermore, it is the first research project designed to study the use of DMT with AOCInj, HEI, and Self-transformation. This proposed study is designed to discover

whether IFS and DMT can assist Self-transformation in HEI with AOCInj and, if so, whether or not a transpersonal orientation to Self will positively correlate to improvements in psychological functioning.

Additional data will be retrieved in order to further assess whether or not results are influenced by gender, age, race/ethnicity, and income. It is the hopes of the author that this will be the first in a series of studies that focus on HEI and AOCInj as both these populations are underresearched and underserved.

Chapter VII: Conclusion

This thesis was inspired by the author's personal experience of: (a) being a highly embodied individual, (b) developing a chronic injury, (c) suffering an increase in psychological symptomology and a decrease in psychological functioning, (d) facing the lack of understanding and support in personal, medical, and psychotherapeutic communities, (e) feeling the experience of ruptured self, and (f) experiencing the eventual deepening into a more transpersonal orientation to Self. The author's journey has been long and arduous, like hacking a new path in an overgrown forest. It is the author's hope that the methods used in her own recovery and Self-transformation make the path a little clearer for those in similar crises.

This thesis makes the argument that a combination of Dance/Movement Therapy and Internal Family Systems therapy can be an effective tool for transforming an ego-based orientation to self towards a transpersonal orientation to Self in highly embodied individuals with adult-onset chronic injury for three reasons: Both DMT and IFS therapy (1) work towards integrating different aspects/parts of an individual into a cohesive whole, (2) are body-centered therapies, therefore, appropriate modalities for working with individuals who orient to the world through their physical sensations, and (3) include within their framework a concept of Self that includes transpersonal qualities.

Both these modalities have some of their roots in the work of the first transpersonal psychotherapist, Carl Jung; it is, therefore, not surprising that they share much in common. Both modalities have a transpersonal orientation that focuses on the healing aspects of bringing unconscious material to consciousness, developing a relationship between Self and parts, expanding and releasing patterns, creating mindful/witness awareness, developing community in both group relationship and therapeutic relationship, and incorporating ritual into healing.

This thesis makes the further argument that transformation from an ego-based orientation to self towards a transpersonal orientation to Self will positively correlate to improved psychological functioning. There is little direct research available on many of the concepts and modalities discussed in this thesis including: Internal Family Systems, highly embodied individuals, adult-onset chronic injury, and psychological functioning as it relates to a transpersonal orientation to Self. There is, however, sufficient related research to indicate that using a combination of DMT and IFS therapy in HEI with AOCInj would be effective in transforming ego-based orientations to self towards a more transpersonal orientation to Self, and that such transformation would result in improved psychological functioning.

Adult-onset chronic injury is not acknowledged within medical or psychological communities as a classification that carries common issues and shared symptomology. This population is, therefore, greatly underserved. Likewise, highly embodied individuals are not recognized as a class of people that carry a specific orientation to the world and to their bodies that makes AOCInj particularly life shattering. This thesis, and the research proposed therein, makes the first attempt to understand and rectify this situation.

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APPENDIX A: PRETREATMENT QUESTIONNAIRE

Name:_____ **Date:** _____

Address:_____ **Occupation:** _____

City/State/Zip:_____ **Home Phone:** _____

Email: _____ **Work Phone:** _____

Gender: ☐ Male ☐ Female ☐ Trans/IS **Date of Birth:**_____ **Cell Phone**: _____

Gross Income: _____ **Household Income:** _____ **Number in household:** _____

Race/Ethnicity (please circle all that apply): We understand that in racial and ethnic categories can be confusing and incomplete. Please feel free use the line underneath for any clarification you would like to provide.

African-American/Black Asian Hispanic/Latino Middle Eastern Native American

Pacific Islander Western White Other _____

_____

Type of Injury: _____ **Date first injured:** _____

Medical Interventions (include approximate dates): _____

_____

_____

_____

Past physical experience (include types of activities such as dance, athletics, tai chi, etc): _____

_____

_____

_____

Medications currently taking (aspirin, nutritional supplements, prescription drugs, etc.), include frequency and quantity:

_____

_____

_____ _____

Client Signature Date

APPENDIX B: INTAKE INTERVIEW

Name:_____ Date: _____

Tell me about your experience with this chronic injury:

Do you feel differently about yourself now than you did prior to the injury? If so, how?

Do you feel differently about your body now than you did prior to the injury? If so, how?

Has your relationship with others changed since you've had the injury? If so, how? Probe for spouse/partner/significant other, family members, friends, coworkers.

Do you spend more time alone now than you did prior to the injury?

Do you spend your time differently now than you did prior to the injury?

Has the injury limited your capabilities? If so, how?

Have you had any positive changes in your life due to the injury? If so, what?

APPENDIX C: POST-TREATMENT INTERVIEW

Name:_____ Date: _____

Can you tell me about your experience with the individual therapy sessions? What was helpful? What was not helpful? Do you feel that it has changed you? If so, how?

Can you tell me about your experience with the first segment of the movement therapy sessions? What was helpful? What was not helpful? Do you feel that it has changed you? If so, how?

Can you tell me about your experience with the second segment of the movement therapy sessions when Authentic Movement was being used? What was helpful? What was not helpful? Do you feel that it has changed you? If so, how?

Do you feel differently about yourself now than when you began this program? If so, how?

Has your relationship with others changed since you began this program? If so, how? Probe for spouse/partner/significant other, family members, friends, coworkers.

Do you spend your time differently now than you did prior to beginning the program?

How do you feel about the limitations in your capability? Has that changed since beginning the program?

Have you had any positive changes in your life that you attribute to your attendance in this program? Any negative?

Overall, how do you feel about yourself?

Appendix D: Orientation to Self Scale

1. I share a connection with all other human beings.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

2. I experience myself as part of something larger than myself.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

3. I am able to observe my feelings without being overwhelmed by them.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

4. I value myself because of what I can do and what I have accomplished.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

5. I understand my purpose in life.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

6. I view my body and mind as separate.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

7. I have value because I am part of something greater than myself.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

8. I share a connection with people I am close to, but not with strangers.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

9. I live my life in the present moment

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

10. I often ignore or disconnect from my own feelings.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

11. Wisdom comes primarily from the experiences I have had.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

12. I have value because I am part of something greater than myself.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

13. My feelings often overwhelm me.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

14. Wisdom comes from someplace deeper than experience.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

15. I often think about the future or the past.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Appendix E: Sample of the MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is *True* or *False* as it pertains to you personally.

1. Before voting I thoroughly investigate the qualifications of all the candidates.
2. I never hesitate to go out of my way to help someone in trouble.
3. It is sometimes hard for me to go on with my work, if I am not encouraged.
4. I have never intensely disliked anyone.
5. On occasion I have had doubts about my ability to succeed in life.
6. I sometimes feel resentful when I don't get my way.
7. I am always careful about my manner of dress.
8. My table manners at home are as good as when I eat out in a restaurant.
9. If I could get into a movie without paying and be sure I was not seen, I would probably do it.
10. On a few occasions, I have given up doing something because I thought too little of my ability.
11. I like to gossip at times.
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.
13. No matter who I'm talking to, I'm always a good listener.
14. I can remember "playing sick" to get out of something.
15. There have been occasions when I took advantage of someone.
16. I'm always willing to admit it when I make a mistake.
17. I always try to practice what I preach.
18. I don't find it particularly difficult to get along with loud-mouthed, obnoxious people.
19. I sometimes try to get even rather than forgive and forget.
20. When I don't know something I don't at all mind admitting it.
21. I am always courteous, even to people who are disagreeable.
22. At times I have really insisted on having things my own way.
23. There have been occasions when I felt like smashing things.
24. I would never think of letting someone else be punished for my wrongdoings.
25. I never resent being asked to return a favor.
26. I have never been irked when people expressed ideas very different from my own.
27. I never make a long trip without checking the safety of my car.
28. There have been times when I was quite jealous of the good fortune of others.
29. I have almost never felt the urge to tell someone off.
30. I am sometimes irritated by people who ask favors of me.
31. I have never felt that I was punished without cause.
32. I sometimes think when people have a misfortune they only got what they deserved.
33. I have never deliberately said something that hurt someone's feelings.