Training Therapists and the Private Logic of Science

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Abstract

Presently, description and measurement of illness, and empirical validation of intervention strategies are of privileged importance in the mental health field. Endless measurements are being developed in service of delineating the healthy from the sick, and effective cures from quackery. Description however can always be betrayed by experience of the thing itself, and we mistake our successive approximations for truth at great peril. Private logic is key concept in Adlerian theory, as is the assertion that such logic is infinitely mutable. Dr. Moshe Feldenkrais, an innovator in the field of somatic education, used his insight into the scientific method to rigorously apply logic to the process of individual learning by means of increasing awareness of embodied experience. His inquiry coalesced into a method that now bears his name, and has proven to be a powerful agent for changing private logic. It has proved so definitively in the one case I can speak to authoritatively, mine. Based on this evidence, I set forth to probe existing literature for corroboration. I believe there is ample evidence to suggest that learning to attend to embodied experience should be integral to educational curriculum standards in the training of psychotherapists. Furthermore I believe that expanding the scope of practice of mental health professionals of all disciplines to include working knowledge of embodied practice is of the utmost importance in upholding the moral and ethical obligations of the field.
Table of Contents

Abstract ................................................................................................................................................. 2
Preface ......................................................................................................................................................... 4
One .............................................................................................................................................................. 7
   A Paradigm Shift ................................................................................................................................. 8
   Statement of Thesis ............................................................................................................................ 12
   Methods ............................................................................................................................................... 14
   An Ecological Inquiry .......................................................................................................................... 17
   Summary ............................................................................................................................................... 19
Two ........................................................................................................................................................... 21
   Neural Substrates ................................................................................................................................. 24
   Dualistic Barriers ................................................................................................................................. 28
   Summary ............................................................................................................................................... 32
Three ......................................................................................................................................................... 34
   Problems with Evidence ....................................................................................................................... 35
   Problems of Living ............................................................................................................................... 37
   A Culture of Science ............................................................................................................................. 39
   Summary ............................................................................................................................................... 42
Four ............................................................................................................................................................ 44
   Craft Based Practice .............................................................................................................................. 45
   Somatic Education ............................................................................................................................... 47
   Summary ............................................................................................................................................... 51
Author’s Note ............................................................................................................................................ 55
References ................................................................................................................................................ 59
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Preface

Wisdom, like other iterations of our native intelligence, empathy and compassion for instance, is emergent from primary processes we have identified as in common to our inherited biology. Unlike other mammals, we possess a complex ‘top-down’ system for measuring and constructing categories of knowledge, broadly referred to as intellect. However, like other mammals or perhaps all forms of sentient life with which we share common ancestry, we are sustained by the bottom-up consciousness that can by its nature only be felt (Shepherd 2010; Panskepp & Biven 2012; Siegel, 2010). Our sense of a ‘felt’ intelligence however, is more than an intellectual construct, and it has been demonstrated to influence us largely outside of our conscious attention (Vandekerckhove & Panskepp, 2009). Such raw sensory data can be accessed through structured practice, and its formative effects on our sense of self can be brought into conscious awareness through rigorous self-study.

The following research was inspired by my lack of a sufficiently comprehensive theory on which to establish clinical practice in the field of mental health. My own training and experience in other disciplines including fine arts, martial arts, contemplative practice, and somatic education, have highlighted the importance of attending to embodied experience as the grounds for cultivating empathy for my own suffering, and consequently, for the helping relationships I build with others as a clinician. Adlerian theory, with an emphasis on the inherent creativity of the individual and recognition of the indivisibility between the mental and the physical, provides valuable tools and insight on the human condition. Yet Adlerian therapy still attempts to function within the paradigm of cognitive science; a science that privileges intellect and reason over the felt-sense of being human (Shepherd, 2010).
The anticipated goal of this study is an attempt to reconcile the practice of mental health care, an experiential process that is premised on the encounter between two or more individuals, with a scientific paradigm that seems to minimize the subjective aspect of experience. There is clear scientific evidence that we must regard the experience of both parties, the therapist and the client, or clients, as being of equal importance (Carlson, Watts, & Maniaci, 2005). And yet, there appears to be continued emphasis on minimizing the subjectivity of the practitioner in even the most progressive educational contexts (Shaw, 2004). Acknowledging the subjective experience of the clinician raises serious questions about the validity of clinical evidence gathered from within a paradigm that still effectively minimizes the embodied, relational, nature of the mind. Furthermore it also may represent a challenge to the continued reliance on a pathology-based conception of mental health and illness.

The premise that one human’s experience can be objectively and impartially observed by another negates what every one of us has known experientially from birth. Namely, that we exist as a body in relationship with others. Although Descartes’ maxim, I think, therefore I am, is a logical approach to explaining existence, the propagation of mental health cannot occur without embracing the fact that I feel, therefore I am. In practice, the strategy of attending to internal cues elicited by the presentation of clients is well known to clinicians from a variety of theoretical orientations (Shaw, 2004). Only by attending to our own internally felt sense of self, are we able to engage compassionately with the suffering of others. In times of crisis we do not rely only on our factual knowledge about psychological theory, but equally on the experiential sense of what it is like to be someone (Miller, 2005).

Siegel (2010) has gone to great lengths to demonstrate that internal and external knowledge are necessary compliments for clinical work. Yet, if mental health professionals do
not understand the rigors and joy of self-inquiry how can we ask it of our clients? And how can we as a field ask of our practitioners what we are unable to teach them due to the constraint of our philosophical bias? Experiential learning in the context of both therapy and therapist training is paradoxical in that it is at once structured while at the same time relies entirely on the infinitely variable subjective sensations of the participants.

There is at this point sufficient evidence that the mind is an intrinsically embodied and extrinsically relational process to suggest experiential learning should be at the bedrock of training the professionals that we grant license to promote mental health in others (Siegel, 2010; Panskepp & Biven 2012). Using heuristic methodology, which according to Moustakas (1990) draws heavily from the lived experience of the researcher, my primary source has been my own educational experience — the ongoing process of increasing my sensitivity and organization in both motivation and action, as a mental health professional. The challenge of searching for supportive literature is complicated by my ongoing interest in interrogating the philosophical assumptions that dictate what evidence is, and which evidence is deemed to be worth attributing meaning to. Any lack of clarity resulting from tension between these two objectives is my own.

As a culture we have yet to reach the threshold for a paradigm shift that would fundamentally alter the distribution of powers from a structure of moral avoidance to one of moral richness (Shaw, 2004). Psychometric tools may prove relevant to further articulating the relevance of embodied practice in training of mental health professionals. That, however, will have to be the purview of future research. The question raised for me in this project, having constructed the following conception of the embodied and relational dynamics of the clinical encounter, is how to motivate people now, from within the current paradigm, when so many forces are allied against it?
Adlerian theory is premised on the inherent creativity of the individual — creativity expressed by the establishment of a *private logic*, a forming of the schema of apperception that is foundational to each individual’s life-style (Carlson et al., 2005). This logic develops during early childhood — a time of great perceptive ability and limited capacity to understand context. Private logic, hidden even (or perhaps especially) from the individual who creates it, in fact becomes the scaffolding that is context — the means by which individuals understand and navigate their social-embeddedness (Carlson et al., 2005). The education of mental health care professionals can be seen as an opportunity to refine the private logic of practitioners as they move through their training. In this paper I will ask questions of the private logic held by the field of mental health care and seek to expand the *a priori* assumption of cognitive science that the mind is the brain, and that isolated neurological activity generates the self.

Adlerian therapy is reliant on the notion that private logic can change, and that our creative capacity continues beyond childhood (Ansbacher & Ansbacher, 1956). It is the inherent creativity of the individual that allows our sense of self to mature even in adulthood and to recover from injuries sustained in the course of living. Adler observed the creative elasticity of the self before there was evidence of its biological basis. Remarkably, Adler’s intuition has been confirmed in recent decades by neuroscientists and concepts such as neuroplasticity are rapidly yielding new disciplines of study that support the statement made by the founder of neuropsychology, Donald Hebb, in 1949 “neurons that fire together wire together” (Fisher & Ogden 2011, p. 10).

In Adlerian conversations the notion that *anything can also be different* is an oft-repeated aphorism. Alfred Adler described feelings of inferiority as the force motivating the development
of personality (Adler & Mairet, 2011). He also sagely identified the profound and formative effect of what he termed organ-inferiority. According to Adler these feelings of inferiority based on the inevitable biological variation within species manifest as organ-jargon, specifically, what the individual “will express with the body when words are not used” (Carlson et al, 2005, p. 99).

Rather than pitting the body and mind in a battle for control, the concept of organ-jargon creates a context for understanding the physical components of our emotional experience, and equally a means of addressing how emotion influences our physical experience. However, such a concept is also in opposition to “centuries of dualistic thinking that has split asunder mind and body, spirit and matter, function and structure” (Hartley, 2004, p. 13). As a result of continued cultural bias that privileges thinking over feeling, and intellect over sensation, the field of mental health has failed to fully leverage the power of embodied experience in both forming, and transforming, private logic. Even more important to the purposes of this paper is to address how ignoring the subjective, embodied, experience of mental health professionals compromises our ability to train therapists and counselors. If, in fact, the practice of self-care and self-inquiry sustain successful delivery of mental health services, these must arguably be the keystone of our efforts to educate future mental health care providers.

A Paradigm Shift

To fully appreciate mental function as a product of both embodied experience, and the ecology of our physical and social environments, requires a paradigm shift that Shepherd (2010) describes through Joseph Campbell’s telling of the archetypical hero’s journey. Shepherd (2010) suggests the intellect, rooted in the neural activity of what he refers to as the cranial brain, must descend from the crown of the spine to its root in the pelvis, and be unified with the enteric brain that lies intertwined within the gut. He states this quest entails a departure from what is known
intellectually, and requires uniting the convictions of intellectual certainty with the passing uncertainty of sensation. Shepherd (2010) states that in this journey the hero “usually has to face a grasping tyrant in the form of a king, ogre, or monster who stifles the energies that feed and vitalize the universe” (p.14). In the present cultural climate this tyrant is undeniably the logic by which we regard the study of mental activity and physical action as mutually exclusive.

The present paradigm rests on the untenable impulse to demonstrate that consciousness can be reduced to the movement of matter in the brain (Noë, 2009). This notion emerged in reaction against an interpretation of Descartes’ division between mind and matter. According to Hacking (2005) we have mistakenly clung to the notion of Cartesian duality as being between two distinct substances. In performing a closer reading of Descartes, he shows how Descartes was in fact making a distinction of category, of kind. In other words we have been asking the wrong questions. We ask the wrong questions of our clients, and of our therapists in training, because we mistakenly privilege reason over sensation. Asking why someone feels what they do is a fine practice, but the answer cannot do justice to the experience and implies the experience in, and of, itself is not enough. It is worth asking, and asking, and asking in the search for clarity, but it is a mistaken belief of the tyrant to think we will ever arrive at an answer with lasting conviction.

The private logic that guides mental health care under a medical model is a contextual division of kind between therapist or counselor, and client, which implies that one party is healthy and the other is sick. However, at its core the dichotomy between therapist and client is a false one. In fact, they are of the same kind which is to say, that both are human (Hacking, 2013). Of course when therapists are expected to serve as technicians that repair mental illness such dichotomy makes perfect sense. Therapists are healthy and clients are sick. And yet, even when
left as an implicit suggestion the designation of one party as sick and the other as well is a matter of great consequence to both clients and practitioners.

If left unexamined the construction of mental illness has the potential to undermine the humanity of both the client and the care provider (Amundson, Stewart, & Valentine, 1993). Discrimination between therapist and client is not at times unwarranted. In a therapeutic context two people are engaged in a consensual relationship with a specific purpose. Furthermore, there are ethical guidelines that define the scope and nature of this relationship. Without question such guidelines and definitions protect both participants, as well as facilitate the therapeutic work (Duncan, Miller, Wampold, & Hubble, 2010).

Amundson et al. (1993) suggest that rather than pathologizing the dysfunctional parts of the mind, we need to be asking how the self as a whole is experienced. This creates a space in which to engage the process of therapy from a vantage that uses curiosity to assuage the temptations of certainty — to invite investigation and exploration that is open-ended and sensual and to balance the pursuit of certainty with tolerance for the ineffability of mystery. And certainly not the faux balance that Shepard (2010) describes where the intellect is trained to listen to the body with the implicit agenda of learning how to better control it — still an expression of the tyrants agenda. Rather it seems we must seek a balance where the body, the root of our selves, has permission to listen to the world, to other selves, so that we can use this raw sensory data to inform our logic and reason.

We cannot reason our way into feeling (Panskepp & Biven 2012). We learn from feelings first and while our unconscious physiological reactions are unavoidable, they undeniably have profound influence over our conscious, intellectual activity (Panskepp & Biven 2012). Affect is primary, visceral, and the abstraction of reason is secondary (Damasio, 1999; Panskepp & Biven...
2012). Despite this we seem determined to define how the mind works, to impose top-down order on bottom-up sensation. Evidence from the newly established disciplines of interpersonal neurobiology (Siegel, 2010; Siegel 2012), affective neuroscience (Panskepp & Biven 2012), and the study of embodied cognition (Sucharov, 2002) further indicate the mind is as plastic as the neural substrates of our brains, is embodied and emergent from the felt experiences of the extended nervous system, and inextricably conditioned by the relational process of existing in both a social and physical environment.

Making these distinctions are of critical importance to our conception and promotion of what it is to have a healthy mind. Moreover they are critical to improving the strategies used in educating mental health professionals, stewards of minds that have strayed from health. Some experience of dysfunction must be present for a person to seek mental health services. But function is contextual, and so too must be our attempts to address and remedy dysfunction. Setting aside the question of what defines illness, we could ask how is it that we alleviate the suffering of our clients? In answering this question we are faced with a different set of challenges and we need a broader space in which to explore the nature and function of human consciousness than current academic standards permit (Trungpa & Gimian, 2005).

As the neuroscience suggests, conscious descriptive experience is one very small part of what it means to be human (Vandekerckhove & Panskepp, 2009). It follows that there is a phenomenal richness and wealth to be found in the bottom up sensation of what it means to feel human. We each inherit a phenomenally sensitive nervous system through which we received information from our environment and the other members of our species (Siegel, 2012). In fact, as a social species, we are especially attuned to one another (Siegel, 2012). And yet, these responses, the emotional affect and sensory impulses that are the raw data of experience, occur
mostly below the conscious awareness of our intellect (Vandekerckhove & Panskepp, 2009). Our work of facilitating self-inquiry is predicated on the notion that conscious awareness can be expanded and that we can continue learning to integrate more of the data we acquire from the whole self. As we do so we increase our internal organization and achieve greater sensitivity for taking compassionate action.

**Statement of Thesis**

If we as therapists have not engaged in the rigorous practice, inherent discomfort, scientific study, and joyful discovery of meanings that comprise self-inquiry — how can we ask it of our clients? Furthermore, how can the field of mental health and psychotherapy expect practitioners to engage with this challenging and complex process if the field does not support and validate, at an institutional level, the pursuit of such inquiry in their training? These questions regard not just what it means to be a therapist but encompass how we relate to the felt experience of being individuals, and the broader questions about what it means to be human. Additionally, as therapists we must be concerned with how it is that humans learn complex social emotions such as empathy. After all, therapists, counselors, and all other mental health professionals regardless of their theoretical orientation, are ultimately responsible for the ability to engage empathetically with their clients (Duncan et al., 2010).

In this paper I examine some of the embodied and relational aspects of the mind and ask questions regarding our current conception of mental illness that suggest errors in the scientific and cultural paradigm in which it has been studied. In consideration of an increasingly de-centered, and evidence-based conception of the mind (one which must be seen as extending beyond the function of an individual brain), and a concomitant imperative for revising the
standards of practice in mental health care, I will explore the discipline of somatic education as a valuable tool in the training of mental health professionals.

I will discuss the relevance of somatic education to the practice of psychotherapy, specifically related to the training of therapists’ ability to attend to their own experience of self in relation to their clients. At the most basic level, which we share with all other humans, each of us rely on an internally felt experience of autonomous existence as the primary and definitive measure of our reality. All too often the felt perception of being in the world misleads us, but this is no reason to negate the relevance of sensation. Meanwhile the past several centuries of inquiry, having arrived at modern cognitive science, seems to have tried to do just that (Varela, Thompson, & Rosch, 1991).

Is it important to make clear that the topic of this paper is not the nature or manifestation of the problems of living which we have relegated to the category of illness (Szasz, 2009). The purpose of this paper is to suggest that if mental health professionals step outside the paradigm of mental illness and instead consider how we regard human suffering, the role of the mental health professional changes significantly. For example, therapists would have more freedom, or even be encouraged, to acknowledge the roots of their work in traditional healing methods (Miller, 2005). The implications of such a revision are profound, and potentially in conflict with a greater reliance on psychopharmacology. Moreover, the implications of the increased prevalence of evidence based practices shake the foundation of the established research paradigm that some believe has been tainted indelibly by capital (Miller, 2005).

Our cultural history is littered with the effects of a mythology that negates the affective source of experience. Since the beginning of monotheism, and perhaps even as far back as the pantheism of the Greeks, we have been at odds with our animal heritage (Sewall, 1999).
Neuroscience is, at the very least, providing a clear indication that such heritage is inescapable and is a fundamental part of what it means to be human. Harried attempts to separate ourselves from the unpredictability of our inherited biology may in fact be at the root of many symptoms that underlie mental illness. The implications again impel us to deeply reconsider what it means to work in relationship with another human being who is suffering. We must understand the nature of our own suffering — you, me; reader and writer; researcher and clinician; patient or client; bureaucrat, regulator and even the members of behavior health boards. As humans we all experience suffering and our misguided attempts to negate this affects all of us.

Of course, suffering increases greatly with dysfunction, and the greater the dysfunction the more likely services of a mental health professional will be of value (Shaw, 2004). The nature of our work as mental health professionals is to assist others in learning to work with their own dysfunction. It behooves the mental health field, in consideration of our work, to examine how dysfunction is situated within a cultural ecosystem, one that negates the value of feeling and promotes the top-down process of intellect. Top-down functions are certainly instrumental to what makes our species unique, and yet our intellect is also only one part of what we are (Viamontes & Beitman, 2006). Therefore the question is not if, but how, this perspective on the subjective experience can be used to facilitate the training of mental health professionals.

**Methods**

This paper is a summary of research I have conducted to gain entry to the field of mental health. The quandary motivating this research is the general absence of literature that speaks to the embodied experience of the therapist (Shaw, 2004). This is no surprise and according to Gottlieb (personal communication, July, 2013) academic training in the mental health field is largely dis-embodied and *text-heavy*. While the field is slowly emerging from an unnecessarily
constrained model of the mind, there is still a cultural bias towards isolating the nature of the mind and the experience of having a body into distinctly separate fields of study (Shaw, 2004). In recent decades several somatic psychology programs have been created, which is encouraging. Unfortunately, the curriculum of these newer training programs remains largely outside the scope of more established training programs for mental health practitioners. Meanwhile, evidence continues to accumulate that our psychology is somatic and that the division between mental and physical activity is not only arbitrary but an obfuscation of what it is to be human (Varela et al., 1991).

My research is best described by what Moustakas (1990) termed heuristic methodology. He stated heuristic research is that in which “the self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge” (Moustakas, 1990, p. 9). Such an inquiry is predicated on the researcher using personal experience and reflection as the guide for an open-ended exploration of the chosen topic (Djuraskovic & Arthur, 2011). Accordingly, the researcher is not excluded from the study and in fact is “required to have direct experience of the phenomenon in question” (Djuraskovic & Arthur, 2011, p. 1572).

Concurrent to my graduate studies in mental health, I am participating in a professional training for a method of somatic education named after its founder, Moshe Feldenkrais. Feldenkrais’ (1981) contribution to the craft of human service is the assertion that the somatic experience of oneself from within can, and in his view must, be subjected to the same level of rigorous scrutiny as anything else we claim to study. Feldenkrais, like Adler, was ahead of his time intuiting the research now being done in fields such as affective neuroscience. The evidence clearly demonstrates the profound and formative effects of primary neurological processes, such
as affect (which includes sensation such as hot, cold, and hunger, as much as happiness and sorrow), on higher order process that include the abstraction on which we base our use of language, and the generation of meaning (Panskepp & Biven, 2012).

Thomas Hanna is generally credited with coinining the term *somatic* to describe the experience of sensing oneself from within (Hartley, 2004). Hanna (1990) distinguishes between medically oriented therapeutic models, and the approach of somatic practitioners. He describes the difference as either acting on another body from an objective, third-person perspective, or interacting with the awareness of the first-person experience of change as sensed from within. This is a critical distinction that lies at the foundation of the practice of somatic education. While the practitioner, or educator, provides conditions and stimulus for learning, the process is predicated on supporting changes that emerge from within the pupil rather than imposing change from without. The nature and perspective of somatic work has profound implications for psychotherapy. The role taken by the somatic educator is however congruent with an Adlerian approach towards practitioner client relations, both perspectives being predicated on significant departure from an illness-based medical model.

The term heuristic, of course, also refers to a rule of thumb used in simplifying complex problems. Heuristics are useful for making quick judgments in reaching seemingly spontaneous decisions (Nevid, 2009, p. 251). A heuristic in this sense can be a boon to efficiency. Equally, it can contribute to the fundamental attribution error (FAE), which describes “the tendency to attribute another person’s behaviour to their dispositional qualities rather than situational factors” (Langdrige & Butt, 2004, p.359). This type of bias can be categorized with the actor-observer bias, among other common bias’ that influence how we interpret the causal factors affecting
peoples’ behavior. Consequently, the FAE is also highly pertinent to the work of therapists and the broader study of the mind.

Most importantly Langdridge and Butt (2004) examine the FAE through the lens of the phenomenological philosopher Maurice Merleau-Ponty who suggests that we are constitutionally unable to observe our world free of bias. Our understanding of the relationship between the parts and the whole is influential in regard to how we conduct ourselves as individual members of a society. Equally, as individual professionals within a field of practice, we must reckon with being empowered to diagnose and treat abnormality in mental function. The phenomenological perspective of Merleau-Ponty rests on the premise that behavior can be understood as the interaction between an individual and the environment, since one can never be separated from the other (Sucharov, 2002). Moreover, Merleau-Ponty’s work stresses “the embodied and intersubjective nature of our perception” (Langdridge & Butt, 2004, p.361). Such an interconnected worldview places phenomenology headlong in opposition with research methods that rest on the premise of a world comprised of discrete objects to be defined and measured independently from their environment (Langdridge & Butt, 2004; Shepherd, 2010).

**An Ecological Inquiry**

Self-inquiry is the process by which we make real the relationships between brain, body and environment (Fettes, 1999). The realization of constituent parts of the self into an indivisible whole is preliminary to the emergence of what Alfred Adler referred to as social interest. An individual’s mental health, in Adlerian theory, is correlated with their individual capacity for socially interested action (Carlson et al., 2005). A capacity for empathy that Adler saw as “an innate potentiality which has to be consciously developed” (Ansbacher & Ansbacher, 1956, p. 134). In Adlerian therapy, even the relationship is considered an intervention (Carlson et al.,
Therefore, the relationship must be built upon on the internal clarity of the practitioner (Duncan et al., 2010). The practitioner’s internal clarity is premised on their having the tools to adjust their own interfering beliefs and faulty private logic. If we cannot claim to fully understand even the healthy mind of practitioners, how can we foster their ability to engage empathetically with clients. After all, an empathetic relationship is what most reliably predicts the success or failure of the therapeutic intervention (Duncan et al., 2010).

The education of mental health professionals (whose work most often entails intervention where other systems, such as school and family have failed) is a logical site of intervention for addressing the cultural rift that divorces the mind from matter. As professional caregivers we are conditioned by the world in which we live, having been educated within the culture and formed by its assumptions. There are no students who will be a blank slate for the changes under consideration (Feldenkrais, 1985). However, expanding the scope of our training to include practices that embrace an embodied and ecological definition of mind will only increase our sensitivity to these critical issues.

As therapists, with our unique responsibility to protect the intimate disclosures of others, our own experience and integrity of self is of primary importance (Siegel, 2010). Taking into account current scientific theories that describe the mind as an embodied and relational process (Siegel, 2010), we must critically reevaluate the underlying private logic that dictates the education of mental health practitioners. Perhaps of greatest concern in this logic is the implicit suggestion that our subjective and embodied experience as practitioners is less relevant to need not be examined under the same rigorous and empirical methods as those with which we study the behavior of others in our clinical trials and laboratory observations (Varela, Thompson, & Rosch, 1991).
The fact that all people have this embodied experience in common has long been neglected in the study of the mind (Boadella, 1997). Pierre Janet, a psychotherapist of the generation before Freud wrote (nearly 125 years ago) to his contemporaries admonishing them for how much had already been forgotten about the value of addressing embodied experience in the treatment of mental health concerns (Boadella, 1997). Janet stated "it is not possible to advance in the study of the personality without having first understood the character of having a body" (quoted in Boadella, 1997, para 20). At the present moment, despite the establishment and practice of numerous and varied mental health disciplines, acknowledgment of (much less training in) how to work with our embodied experience is largely absent from graduate level curriculum for mental health practitioners.

**Summary**

I have examined Adlerian theory — what developed from Adler’s own empirical observations of the inherent creativity of the individuals he worked with — to propose that we can and must supplement our own inherent creativity with the application of scientific methods to the felt sense of self. I do not intend to make the case for a new, or separate, approach to mental health care or the training of therapists. Rather, I want to suggest that ethically, the somatic considerations of clinicians should not be excluded from the purview of practitioner training. The recent history of mental health care has seen practice driven largely by theory and conjecture (Duncan et al, 2010). Many theorists, Adler among them, accurately intuited what has now been empirically validated, and yet still it seems there is something we leave out — something that the perspective of extrospection inevitably misses: the internal sense of what it is to be a person, and to be in relationship with another.
From an Adlerian perspective the therapist and client must be seen as equals, both human, both informed by the same bottom-up sensory information that must be attended to and regulated from within. Adler was a staunch advocate for the notion of equality between practitioner and client and saw this as a fundamental expression of democratic principles (Ansbacher & Ansbacher, 1956). Engaging with the political science of determining where ultimate authority lies is tempting, however for the present purpose it is enough to consider how exactly to conceive of mental health care as a collaborative process between two interdependent selves. This requires a proper understanding of the nature of the selves between which the collaboration occurs.

Borrowing a metaphor from Sewall (1999), my objective has been to identify ways in which fundamental assumptions in the field of mental health continue to be conditioned by the mentality of the hunter, obsessively focused on reductively identifying objects in the environment, while ignoring the context that surrounds and informs the objective of the hunt. Sewall (1999) contrasts this with the perceptual imperative of a guide and provides a construct for "attending to contrast and anomalies in the landscape, to a disturbance in the patterns…looking for those distinctions that become apparent only from a relational perspective" (Sewall, 1999, p. 53).

The constituent parts of the mind can be studied, but the most elegant brain scan can do little more than indicate something that is being experienced. To work with the mind it must be properly defined, and in the pantheon of the sciences such a definition is only just beginning to emerge. It appears increasingly that the mind is an experiential process rather than a concrete and tangible machine (Siegel, 2012). Our methods for attending to clinically significant mental health issues rely on the assumptions of an obsolete paradigm; one that rests on the authority of
supposedly impartial clinicians who objectify the subjective experience of their clients (Lake, 2007).

Carlson et al. (2005) suggest that our individual system of making meaning is a predictor for future action. While everything can also be different due to the profound creativity of the individual, the same private logic that constrains us is also the inspiration for action that moves us toward the universal goal identified by Adler of overcoming inferiority (Ansbacher & Ansbacher, 1956). Carlson et al. (2005) describe how life-style functions to support the evolutionary imperative for survival, and thus we learn and make meaning from what we have experienced in order to meet the demands of what we encounter in the present.

In other words, to survive, both biologically and socially, we must construct and extrapolate meaning that can be applied to unforeseen and unanticipated circumstance. Our life-style affords us the opportunity to build on what we have learned, to develop habits, instead of learning anew the same lessons repeatedly. The efficiency afforded by habits of perception (aka: heuristics) is vital to our ability to complete the tasks of life (Carlson et al., 2005). Of course the constraint of predictive bias, of a solidified schema of apperception, is that we can become stuck in maladaptive patterns and thus unable to actively participate in the dynamic and ongoing process of making meaning and taking action in accordance with social interest.

Two

The self has many parts. Ultimately, per Alfred Adler, we can regard the self as an indivisible whole (Ansbacher & Ansbacher, 1956). However, in service of being able to use ourselves as we wish, we need to study how the self operates (Feldenkrais, 1981). The premise that predominates the study and practice of mental health, as evidenced by our conception and nosology of mental disorders, is that the mind, consciousness, and the self, are all a product of
the brain. While none of the authors cited below suggest we could have any of the aforementioned without a brain, Steinhart (2001) articulates the premise that “persons are realized by networks of subpersonal agencies themselves realized by cellular and molecular systems throughout the body” (p. 4). In light of this we must be willing to more closely consider what persons are, if in fact they are not reducible to the specific functions of individual brains.

Interpersonal neurobiologist Siegel (2012) states the mind is “an embodied and relational process that regulates the flow of energy and information” (p.3). If the mind is a bedrock from which the self emerges, and if this mind is inherently a relational process between individual and environment, then the attribution of solidity and permanence to an inherently dynamic and fluid process may in fact be the primary source of the mental distress experienced by the self (Trungpa & Gimian, 2005). Siegel’s (2012) model of the mind, grounded in both the objective study of neuronal function and the subjective study of experience through meditation, highlights the embodied and relational nature of the mind with specific implications for the work of mental health practitioners. His premise is that since we cannot be certain beyond rudimentary measurements of brain function, what is experienced in the mind of another, it is imperative that we develop an awareness of the nuance and variation of our own internal experience as clinicians (Siegel, 2010).

The experience of being human is richly layered with various levels of neural activity, sensorial experience from the body, and relational exchanges with both our physical and social environment (Siegel, 2012). Determining cause and effect in the realm of subjective sensory experience entails the study of a complex web of internal processes, the complexity of which is compounded exponentially by each individual’s interdependence within an environment.
that comprise our biology, and the psychological systems by which we generate and ascribe meaning to phenomena, is not a simple task.

However difficult or complex, mental health must be studied as emergent from within the whole system of the self. While cognitive science continues to privilege only measurable brain activity in the empirical sciences of the mind, it is increasingly clear this is only one aspect of mind (Noë, 2009). Even within the brain there are layers of neuronal consciousness, each correspond to a different type of memory through which we construct the narrative of a continuously existing self (Vandekerckhove & Panskepp, 2009). Additionally there is the proprioceptive sense of relating to gravity that informs our relationship with the physical spaces through which we move (Feldenkrais, 1985). And there is movement, which Wolpert (2011) contends is the reason we evolved such large brains in the first place.

Steinhart (2001) examines an assertion from the birth of neuroscience that the transfer of a brain from one body to another would transfer the person. He uses this line of reasoning as an example of discredited, but nonetheless unduly influential, reasoning that rigidly separates the study of the soma (body) and the psyche (mind). He states that the premise of this thought experiment also lies at the heart of the assumption that the brain is the locus of personhood. Challenging the notion that brains are persons, he illustrates how the individual organism consists of three additional systems that exhibit computational properties, a function that has historically be synonymous for the mind, which together by means of their interrelatedness are what in fact comprise the person.

Steinhart's (2001) article examines what is still a strictly biological investigation of personhood, yet one that is considerably more expansive than the conceptualization of most cognitive science in which functions of the brain are sufficient to explain the existence of a self.
He discusses the evidence that the concentration of neurons in the gut referred to as the *enteric nervous system* processes information in ways that mimic the cranial brain in all but name. In fact, he cites those who have historically discovered this 'second brain’ and notes with bemusement that it has been 'found' only to be ignored and forgotten by the medical establishment at least twice in the past century (Steinhart, 2001).

Steinhart’s (2001) description of the nervous system that is intertwined and distributed throughout the entire abdominal region, provides further evidence that study of the individual self must include the intra-personal dialogue between the enteric (located in the viscera, or ‘gut’) brain, and the more exhaustively (but perhaps no more understood) brain located in the skull as suggested by Shepard (2010). Similarly, in consideration of how this self exists entirely in relation to other selves and within a physical environment, to study, diagnose, or attempt to treat, the mental health of an individual in ignorance of these relational and embodied considerations appears increasingly at odds with the evidence.

**Neural Substrates**

Burkitt (2012) asserts that perception is dialogical, a process that occurs between entities, and examines the premise that how individuals perceive and relate to themselves and others, that is, how they construct and inhabit their sense of self, cannot be reduced to simple cognitive processes as suggested by a computational model of the mind. Such a radically relational perspective undermines the notion of a neutral observation or impartial action as perception is always “motivated by both shared ideologies and meanings within a culture and also by highly personal emotionally evaluative stances taken towards things, others and towards one’s own self” (Burkitt, 2012, p. 1). Burkitt’s qualm with a purely cognitive study of the self is that the experience of the body has been deemed of marginal significance. This, he states, is evidenced
by the tendency to study cognition as not only somehow separate from the body’s experience of being in the world, but also by a preoccupation with identifying the constituent parts of cognition. To do so renders the mind as functioning independent from the felt sense of affect and emotion as tangibly registered in the body (Burkitt, 2012). However, even the following cursory examination of the constituent parts of brain activity seems support the case for an embodied and relational model of the mind.

Viamontes and Beitman (2006) provide a comprehensive summary of advances in neuroscience that shed light on the processes targeted by psychotherapy. Their research has been oriented towards psychotherapeutic change and they comprehensively illustrate just what in the brain is being affected by therapy. Viamontes and Beitman (2006) make an important distinction between the default brain which is the collection of neural circuitry that “support individual and species survival at the most basic level,” and the more complex systems that “facilitate transcendence of the default brain by permitting the consideration of an expanded set of variables before the initiation of actions” (p. 225; p. 238). The distinction seems to be one that highlights the difference between the foundation of our mammalian brain which we share with other species and the aspects our neural function that make us unique as humans.

The default brain includes what is thought of as the subconscious mind, memory, emotions, and the systems that interpret reward and risk. The functions at this level are fairly simplistic in terms of the number of variables engaged in responding to stimulus, and as such the developing human gradually learns to subject these processes to increasing control and intentional scrutiny. Illness and injury can damage the more complex mechanism’s higher control and thus what is often seen in mental dysfunction is the reemergence of the default brain (Viamontes & Beitman, 2006).
Viamontes and Beitman (2006) present their own definition of the mind as “a self-referential synthesis of the functional capacities that emerge as the brain addresses internal and external milieus” (p. 226). By their account, historically the mind has been regarded in terms of what it does, with much less attention paid to the process of how it functions. For example, they cite how Freud organized his observations with the conception of the ego, id, and super ego, from which he then “developed techniques to access and influence these functional constructs” (Viamontes & Beitman, 2006 p. 226). Additionally they state that while behaviorists and cognitivists have since formulated different constructs than Freud, these have still been premised on a top-down approach of focusing on “higher order functions...without regard for the neural circuitry that generates the phenomena” (Viamontes & Beitman, 2006, p. 226). It is their contention that the most significant processes at play in therapeutic change emerge from the bottom-up processes of the mind. In short, Viamontes and Beitman, (2006) suggest that much of what has been developed as psychotherapeutic technique has been developed with very little understanding of what is actually going on in the brain at a neuronal level.

Viamontes and Beitman’s (2006) research into these sub-structural functions are indeed fascinating and relevant, but they still seem to suggest that the mind is fundamentally an internal representation of phenomena through the abstract formation of language. While the importance and relevance of language need not be discounted, there is by now sufficient evidence to suggest that a representational model of mental function does not tell the entire story (Varela et al, 1991). Viamontes and Beitman (2006) allude to as much suggesting that modes of access to the mind that rely predominantly on language, such as psychotherapy, may not be sufficient to change bottom-up neural function. Furthermore they suggest that “cognitive and emotional centers process information simultaneously [which] can lead to the production of a body state that
motivates approach or withdrawal, followed by cognitive assessment that dictates the opposite” indicating the need to re-conceptualize mental health as the ability sense and regulate discrepancies between the simultaneous top-down and bottom-up processes (Viamontes & Beitman, 2006 p. 245)

Carney, Cuddy, and Yap (2010) attempt to measure exactly this relationship. They designed an experiment to examine the subjective emotional responses of people who held physical postures associated with nonverbal displays of either high or low power. The results of their study suggest that the concept of embodiment must be understood as something which extends beyond emotional and cognitive states to encompass physiological expression and behavioral choices (Carney et al., 2010). Furthermore, their data seem to suggest that "by simply changing physical posture, an individual prepares his or her mental and physiological systems to endure difficult and stressful situations, and perhaps to actually improve confidence and performance" (Carney et al., 2010, p. 5). Such evidence indicates a causal loop whereby our behavior affects our mood, which in turn affects our body state, which then affects our behavior.

While the physiological behavior has an effect on cognition and affect, clearly the inverse is true as well. Oosterwijk, Rotteveel, Fischer, & Hess (2009) demonstrate that simply thinking about an emotional state can change on our physiology. Their study was inspired by research that had indicated “inferences can go beyond simulations in sensory-motor areas in the brain, initiating actual expression, overt behavior, and even introspective feelings” (Oosterwijk et al., 2009, p. 458). The prior studies they reference demonstrated that physiological changes can be effected by presenting one person with pictures of another person experiencing a strong emotion.

Oosterwijk et al. (2012) chose to measure the effect that simply thinking of an emotional state has on a person’s physical posture. Participants in their study were asked to generate word
lists related to either pride or disappointment, while measurements were made of changes in their height. The results confirmed that, “the activation of emotional knowledge about disappointment can lead to the spontaneous adaption of the posture associated with this emotion” (Oosterwijk et al., 2009, p. 463). Interestingly the results were less clear on the positive side as the increase in postural height was less significant when generating words associated with pride. As with most behavioral studies a limited sample and methodological constraints require caution in drawing conclusions. However, this study offers further evidence to supports the correlation between mental and embodied states.

**Dualistic Barriers**

Costall (2004) argues that our mechanistic, biomedical, cognitive-behavioral paradigm is premised on negating the whole as transcendent from the function of the individual parts, and rests on the faulty assumption of a dualism that excludes humans from the rest of the natural world. Costall (2004) states that cognitive revolution which profoundly shaped contemporary practice and research in clinical psychology relies on a theory that “reduces the phenomena of human mental life to differences in reaction time or to different patterns of erroneous judgments” which essentially rely on studying and measuring the mind outside daily life (Costall, 2004, p. 180).

Consequently, research that has emerged from the present paradigm, may from Costall’s (2004) perspective lack validity in light of two key methodological errors: relying on “highly contrived experiments…set up to test the arcane predictions from the latest theory” and “the reliance on using only observable behavior for evidence, in negation of the felt experience that such behavior is only an indication of” (p. 180). Costall (2004) describes a number of innovations in the field of psychology stemming from the cognitivist rejection of behaviorism all
of which still retain the “mechanistic notion of mind as an input-output device, where the path between input and output is traced as information flow, rather than...connections” (p.182).

Costall (2004) suggests that the study of human psychology is built on a faulty foundation in which the scientist is conceived of separate from what he studies and that we as a species are thought of as separate and distinct from all other species.

The working assumptions of physical science prevalent at the emergence of modern psychology— which psychology emulated in pursuit of the legitimacy being wrested by to the so-called hard sciences from the clutch of religion — have since been revised by the revelations of relativity and quantum theory rendering obsolete the notion that we can exclude ourselves from what we study (Costall, 2004, p. 184). And yet inexplicably, our study of the mind is still beholden to the faulty assumptions of Newtonian physics. Costall (2004) contrasts the assumptions of the cognitivists with the insights of Darwin. Darwin’s theory of evolution, quite radical even to this day, places humans in nature and “undermined the dualism of subject and object at the heart of both Cartesian mechanistic science and Cartesian mentalistic psychology” (Costall, 2004, p. 185).

The implication of Darwin’s largely unrealized finding to the study of the mind is the notion that the environment and the organism cannot be studied independently of one another. Darwin’s insights take us beyond an environmentally deterministic approach in which the environment is an independent factor affecting the individual, challenging us to consider the inherent interdependence between the animal (us) and the environment (Costall, 2004). According to Costall (2004) Darwin’s insights were also primarily lost on the behaviorists who based their methodological focus on observable behavior, which, perhaps most significantly,
reinforces the logic that separates body from mind by making the body a passive mechanism collecting input for a disembodied mind (Costall, 2004).

Costall (2004) cites the research of James Gibson who conceived of the relationship between animal and environment in terms of affordances; Gibson defined affordances as the properties of environment that create the conditions for the animal to enact behavior. While there are limitations to this conception of affordances, Costall (2004) states it was a significant step in laying the ground for the notion of ‘mutuality’ between animal and environment. There is clearly value in making a distinction between the two, but “it is a distinction that presupposes their relation, just as riverbeds and rivers, and beaten-paths and walkers imply one another’s existence” (Costall, 2004, p. 191). The perspective of mutuality suggests the mind cannot be conceived of as existing separately from the environment of the body any more than the whole organism can be seen to exist separate from the physical and social environment in which is embedded. Therefore we should be concerned with the nature of the connection and not the artificially imposed separation.

Separating parts from the whole can be useful for study but the relevance of such study is questionable if it only functions to reify the separation it has created. Kono (2010) suggests a philosophy of self that sees the mind as “realized neither only in the brain nor only in the body, but in the whole system of brain-body-environment” (p. 329). As such he proposes that a systems theory approach provides the best model for understanding human behavior. He, like Costall (2004), claims that psychology needs to shed the mechanistic paradigm which has long been dominant to construct a new organic paradigm for the study of the mind (Kono, 2010). He states that the primary goal of psychology has historically been to compartmentalize human experience and as a result psychology has operated as a function of social control. Additionally,
he asserts that “the reason why psychology is still in the machine paradigm is a practical one: the linear causality that the mechanistic theory provides is considered to be useful for the control of human behavior” (Kono, 2010, p. 331).

It is not clear, or perhaps even relevant, to whom Kono ascribes these nefarious motives of social control, but it is clear that breaking an organism into smaller and smaller parts and trying to explain the whole by the function of the parts functions to minimize the agency of the whole. Kono (2010) advocates for a phenomenological approach to understanding the mind and points to a growing group of intellectuals and researchers that have begun to coalesce around the concept of the extended mind. Based in systems theory, the concept of extended mind posits the impossibility of delineating clear boundaries within the self as well as between self and other. Kono (2010) also makes reference to the work of James Gibson who, in his words, affirmed that “behavior is emergent and self-organized from organism-environment systems” (p. 336). This suggests a mind that exists entirely in a reciprocal exchange with the environment, and further challenges how we conceive of promoting change that occurs within the self.

Sucharov (2002) draws on the field of embodied cognition to generate an “understanding of experience as an emergent and distributed phenomenon of a dialogic communicative system” (p. 686). Sucharov (2002) writes from the perspective of a clinical psychoanalyst whose understanding of the therapeutic encounter has also been informed by quantum physics. Furthermore, his articulation of systems theory provides a bridge between the abstraction of epistemology and the realities of the clinical encounter. He conceives of the encounter between two minds as an empathetic dance and relates “the intrinsic ambiguity of this experience with respect not only to its meaning, but also to its location and ownership” which “dislodges
experience from the tidy compartment of intrapsychic space and spreads it throughout the relational field” (Sucharov, 2002, p. 687).

Sucharov (2002) conceives of the mind in a way that not only questions the boundaries between patient and therapist but also between the interior and exterior of the individual. He “calls into question the notion of an intrapsychic representational world, a notion that is contingent on the Cartesian dualities of internal/external and subjective/objective” and which “imprisons experience in a mythical intrapsychic space and creates an unnecessary barrier to mutual empathetic engagement” (Sucharov, 2002, p. 688). He acknowledges this is a subversive discourse that challenges theories even at the periphery of relational studies where many thinkers depend on a notion of the mind that relies on internal representation for its functionality. His critique rests on the premise that relational theorists rely unnecessarily on notions of internalization, inadvertently sustaining their reliance on the Cartesian duality of internal/external they seek to challenge (Sucharov, 2002).

Summary

Sucharov (2002) states that while many theories claim to transcend or contradict this split they often unwittingly reinforce it by subscribing to “an entrenched view of the mind as container of contents opposed to an external world” (p. 690). This perspective implies that the mind is an empty container at birth, and that development happens through a process of consumption, reinforcing the mind/body duality. Sucharov (2002) contends that to conceive of the mind in this way “excludes both body and other” from intrapersonal relevance, and this undermines the notion of experience as dialogical, in which understanding is embodied, and our embodiment is relational (p. 691). The radically embodied and relational perspective he proposes contradicts the assumptions of the psychoanalytic tradition. Sucharov (2002) demonstrates these
are unfortunately based on the premise of an isolated individual subject containing internalized, subjective experience. To fundamentally de-center both the client and the therapist leaves “no place for an objective, knowing analyst and a subjective analysand filled with representations” (Sucharov, 2002, p. 694).

A theory of embodied cognition abandons the premise of individuals as isolated entities and instead describes a “complex, open-ended, living system with properties of indeterminacy, non-reductive wholeness, decentralized emergence, and distributiveness of information throughout the system” (Sucharov, 2002, p. 695). Fundamental to such a theory is the recognition that communication is a continual process, without beginning or end. The relationship between individuals has to be seen as an infinite dialogue, and the development of self can likewise be considered a constant without fixed or predetermined boundaries (Sucharov, 2002). Sucharov (2002) summarizes research on the neurobiology of emotion and developmental theory to suggest that “brains are not isolated organs that store and transmit information…but are themselves players within a dialogic field and are wired at birth to participate in the kinds of co-regulated communicative process…confirmed by infant research” (p. 696).

From this evidence, it is not unreasonable to conclude that the self is both distributed throughout the various levels of the brain and extended nervous system, making it fundamentally embodied — as well as extended throughout the field of social and environmental relationships. Embodiment points to a central paradox of human existence, and again suggests the source of a great deal of our mental distress: that a sense of self is at once dependent on others and premised on the experience of having a separate, individuated, corporality. However, for Sucharov (2002) the potential discomfort of an individual’s isolated embodiment can be assuaged by successful integration within the network of relationships with others.
If brain, mind, body, and world, cannot in fact be clearly delineated, it is no wonder that the imposition of artificial boundaries between them creates confusion. If the self is best understood as a temporary but functional construct for organizing experience, perhaps to mistake it as something solid and permanent can be seen as a cause of suffering (Trungpa & Gimian, 2005). Sucharov (2002) concludes with the notion that our simultaneous experiences of separation and interconnectedness can either counter-balance one another, or be in opposition, and posits that tension between these two facets of being generate instability when both individuation, and connection, are not mutually supported by cultural and social conditions.

**Three**

We negate the felt sense of self and subjugate the richness of embodied experience to the tyranny of the known world, exclusively privileging only what can be measured and described by the intellect (Shepherd, 2010). If our conception of the mind is limited in this way then mental illness as we have defined it makes sense and requires only technicians that can effectively tinker with brain chemistry. However with a revised, more ecological model of the mind the critique of mental illness, presented in further on, made by Szasz (2009) takes on new relevance. And furthermore, if his *problems of living* cannot be reduced to an illness located within the brain or solved simply though language based interventions then the model of training of mental health practitioners maybe in need of revision.

If the mind, the self and the psyche, are variously learned, constructed accountings of experience then therapy (in the sense of the word that implies repair) is fundamentally educational in nature. An educational approach to creating therapeutic effect is at odds with the notion of illness where the solution (or medicine) originates externally. To change from within one must learn something new, something other than what is already known. Biological survival
has been predicated throughout our evolutionary history on reflexive adaptation to both the constraints of the environment and the internal demands of the organism (Feldenkrais, 2005). With the emergence of self-consciousness we stumbled upon the capacity for self-reflective awareness of our action. In other words, we became able to learn on purpose (Feldenkrais, 1972).

Perhaps we have become blind to the dichotomy between self and other as suggested by Sucharov (2002). The reductionist materialism that Lipton (2009) and Lake (2007) challenge in this section is nowhere more evident than in our denial of the relationship between our inner subjective lives and the objective stimulus we receive from our social environment. In his analysis of cell function Lipton (2009) makes clear that a cell’s genetic program functions only in response to stimulus from the environment. It seems then that as multi-celled organisms our functionality must not only expresses our inner nature but we must ultimately manifest as individuals in relation to one another. However, we choose to look anywhere but to our collective cultural assumptions in addressing the challenges faced by individual members of society.

Problems with Evidence

Lake (2007) asserts that assumptions we make about the cause of a disorder have significant influence over how we conceive of and measure the effectiveness of an intervention. Regardless of how we as mental health professionals define our clients’ suffering (either as inherent to the human condition, or as an illness that marks a deviation from health) the use of evidence as a basis of practice is an important mechanism for ensuring that mental health practice is grounded in fact. However, according to Lake (2007) the difficulty of pointing to any single cause of an individual’s suffering illustrates the inherent difficulty in empirically validating interventions.
According to Lake (2007) the limitation of *evidence-based practice* is the assumption of neutrality we bestow on the notion of evidence. Evidence produced by a study is inherently biased given that any study is indelibly formed by the paradigm from which it is conceived, executed, and evaluated (Lake, 2007). The perspective from which we research an intervention has to be seen as integral to the theory that describes both the origins of, and the treatment for, the disorder. For example, assumptions about what can and cannot be recorded profoundly affect what is or is not considered to be of clinical significance (Lake, 2007). This is especially relevant when trying to gather evidence for treating mental distress. 

Depending on how the mind is being defined, different factors will be considered worthy of measurement. Whether the mind is conceived of as a bio-mechanical process located solely within an individual’s brain, or seen as emergent from the interactions between the social and biologic forces at play in an individual’s experience, markedly different methods of study will be seen as relevant. In addition, markedly different interventions will be considered as appropriate. Needless to say, these considerations will suggest fundamentally different strategies for effecting change in individuals experiencing distress. If intellectual study, and language-based descriptions are privileged in the culture, invariably these will be more rigorously examined and more evidence of their successful application will be generated. 

Lake (2007) states “western biomedicine continues to look exclusively to the basic sciences for explanatory models of illness causation” (p. 40). He states that the core theories of fields of science are used not only to explain the causes of illness but also to explain the effect of treatments. Lake (2007) argues that researchers “begin with epistemological and ontological assumptions that are metaphysical in nature, but which seek to end in empirically verifiable physical results” creating an unresolvable circular logic (Lake, 2007, p. 40). He concludes that
what we consider to be proof in the scientific sense is in fact only a system of evidence that evolves in relation to the discovery of new evidence. According to Lake (2007), this mutability of externally objective proof illustrates the need to place greater weight on the subjective experiences of patients as well as clinicians.

Problems of Living

The recently published 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 2013) seems to mark an increase in latitude given to clinicians for describing the dimensionality of their client’s symptoms in diagnostic assessments, required in most setting for the delivery of care. However, it is necessary to interrogate the context in which the diagnosis is being given in order to highlight implicit and explicit errors in conceiving of the self as an isolated phenomena, isolated even within an individual to the functioning of the cranial brain. The very notion of proposing a statistically derived diagnosis which by its nature cannot account for the situational factors of an individual, is problematic. The practice of psychotherapy, as it is most broadly conceived, relies precisely on assessing and treating the pathology of an individual as independent from their physical, social, and cultural environment.

Despite controversy surrounding its development and deployment, the DSM drives the mental health field’s conception of disorder and organizes research on both mental disorders, and best-practices in clinical intervention. While it is valuable to have a common language to describe the facets of individual distress, it is untenable that the standard nosology guiding clinical practice all but ignores the causal role of both social and embodied experience (Hacking, 2013). Clinical evidence certainly helps in describing broad patterns of distress and can be useful in developing effective interventions. Unfortunately, most research is conducted with
groups of people who are required to have already been diagnosed with an existing disorder to qualify for the study (Wachtel, 2010).

The mental health care system uses diagnosis from within a medical model of treatment to justify reimbursable services. Szasz (2009) critiques the nosology of mental illness considering both the explicit meaning of labeling someone as ill (especially in a realm as elusive and misunderstood as the mind) and the implicit assumptions this designation betrays regarding the delineation of what is normal. Szasz (2009) wrote before technological advances allowed neuroscientists more detailed examination of brain function. He notes there is (even at the time of his writing) increasing evidence of organic illnesses in the brain where physical damage to the organ contributes to a disturbance in mental function.

Szasz (2009) also insightfully states “the assumption is made that some neurological defect…will ultimately be found for all the disorders of thinking and behavior” (p. 113). While Szasz’s writing predates the theories of embodied cognition and the extended mind, he nonetheless anticipates the problem of locating the mind, and the source of mental distress, within an individual’s brain. He states that attributing disordered thinking and behavior solely to a physical defect of the brain denies that mental struggle is as an essential part of what it means to be human.

Szasz (2009) claims that to deny this essential struggle is an error that rests on the perceived duality between mental and physical symptoms when mental function is “inextricably tied to the social (including ethical) context…in much the same way as the notion of bodily symptom is tied to an anatomical and genetic context” (Szasz, 2009, p. 114). He does not argue against studying and treating diseases of the brain, however, he does propose that our categories of mental illness generally describe something that is of a different nature. Attaching the
designation of illness to a mental condition implies that the condition is some sort of *disease entity* that can be transmitted through purely physiological means, when “all the evidence is the other way and supports the view that what people now call mental illnesses are for the most part *communications expressing unacceptable ideas*” (Szasz, 2009, p. 116). Accordingly, Szasz suggests that what we have called mental illness should be removed from classification as illness and be regarded as the various ways we express the struggle with problems of *how* we should live.

**A Culture of Science**

Sue and Sue (2013) describe how the criteria used to diagnose the mental health of our clients are grounded in statistical analysis that “fails to take into account differences in time, community standards, and cultural values” (p.93). The dominance of an ideology is often so structurally embedded in a culture that it can be nearly impossible to identify. Sue and Sue (2013) use as an example the fact that descriptors of race have mostly functioned to illustrate a deviation from the norm thereby hiding the invisible bias that presupposed one race as the standard against with others are measured. Sue and Sue (2013) claim that whiteness has long functioned as the absence of race and illustrate that one of the primary functions of white racial identity has been to mask the insidious entitlement its very existence implies. They describe the development and expression of white racial identity as occurring in a way that is not only invisible, but often repulsive to consider for those who have inherited it, and state furthermore that we only come to know of its existence because, like oxygen “only when we are deprived of it does it suddenly become frighteningly apparent” (p.317).

It seems an apt parallel can be drawn between the influence of scientific values and those of whiteness as we have maintained a related understanding that ‘science’ implies the absence of
culture when it in fact epitomizes the basic traits of a cultural worldview: “As a result, people assume universality: that regardless of races, culture, ethnicity, or gender, everyone shares the nature of reality and truth” (Sue & Sue, 2013 p.123). Sue and Sue (2013) relate this invisible norming to the study of mental health. They state that as a field we have made assumptions about the universality of our theories and goals, often in ignorance of the very clients in whose service we claim to be working. Even the widely lauded pursuit of insight in therapy is not a value neutral goal, and “…definitions of mental health such as competence, autonomy, and resistance to stress are related to White middle-class notions of individual maturity” (p. 95).

Scientific study itself exists in a privileged bubble that is often thought to be somehow independent from culture. Much as we in the field of mental health privilege notions of individual autonomy as congruent with well-being, according to Sue and Sue (2013) we also assume that “when people fail in life, it is because of their own lack of ability, interest, maturity, or some inherent weakness of the ego” (p. 95). It certainly seems that although mental health research should still be concerned with the ontology of the individual psyche, it could pay far more attention to the cultural environment in which that psyche exists. Describing the notion of common factors in therapy, and the inevitable plurality of the therapeutic encounter, Sparks and Duncan (in Duncan et al., 2010) state “the largest source of variance is not easily generalized because these factors differ with each client” (p. 368). It follows that research is inevitably biased against describing individual experience as it is, by its nature, preoccupied with creating objective categories.

Watters (2011) explores in detail the problems caused by assuming that scientific values are universal. He states American mental health practitioners and researchers operate as if their theories of the mind place the field beyond “the influence of constantly shifting cultural trends
and beliefs” (Watters, 2011 p. 4). Watters (2011) critique of the DSM highlights the section on ‘Culture-Bound Syndromes.’ He claims that the existence of these four pages at the end of the volume perfectly illustrates the assumption that the previous 844 pages describe conditions that are not bound by culture (Watters, 2011). He states, rather, that the expression of human suffering with its difficult emotions and prompting of internal conflicts draws on a limited number of recognized and accepted symptoms that are defined within the culture.

As an example, Watters (2011) examines a recent epidemic of anorexia in Hong Kong through interviews with a physician in Hong Kong who specializes in researching the occurrence of eating disorders. This Dr. Lee makes clear, based on his own clinical records, that only after the high-profile case of a woman who starved herself to death was there an exponential increase in what had previously been a rare condition among his patients. Further, the presenting symptomatology of the patients who had struggled with disordered eating shifted dramatically to conform to the DSM criteria, a shift he attributed to the fact that the ensuing media coverage repeatedly quoted from the diagnostic criteria from the DSM and thus reified the previously unfamiliar condition of anorexia (Watters, 2011).

In conversation with Watters (2011) Dr. Lee suggests “the increasingly wide use of the Western diagnostic categories and the many assumptions that lay behind them had the potential of blinding local clinicians to the unique realities of patients in different cultures” (Watters, 2011, p. 23). Throughout his conversation with Dr. Lee about the rise of anorexia in Hong Kong, an investigation of PTSD treatment in Sri Lanka after the Tsunami in 2005, and the recent surge of mood-disorders in Japan, Watters’ (2011) consistent thesis is that these patients’ experiences “are examples of the unconscious mind attempting to speak in a language of emotional distress that will be understood in its time” (Watters, 2011 p. 32).
Lipton (2009) describes, from a different perspective, how we have been blinded by the subtle dominance of a scientific orthodoxy. He spent a quarter of a century teaching cell-biology to medical students, the bedrock of bio-medicine that is predicated on an examination of what is considered the basic building block of life: cells. Not only do the principles of cellular biology underlie the study and practice of physical medicine but they are equally influential for cognitive scientists (Lipton, 2009). Lipton’s revelation again came with the application of quantum principles that undermined the very premise of the teaching and research he had spent his life conducting. While the laws of Newtonian physics are useful in describing the general behavior of larger bodies of matter, the revelations of quantum physics illustrate that all matter is fundamentally energy (Lipton, 2009). As cells themselves are built of elements, which are built of atoms, which are fundamentally vibrations of pure energy occurring at a specific time in a specific place, Lipton (2009) saw that western medicine is operating on conceptually limited assumptions about the nature of reality, especially pertaining to the principles of cause an effect within biological processes.

**Summary**

Our private logic is based on empirical evidence. This logic operates as an ‘a priori’ theory, a construct that we use to predict and interpret experience with the intent of making sense. This logic is constructed, and learned by heart, from experience. As a consequence of living, our ability to relate directly to experience gradually becomes supplanted by the dogma of our established logic, and we find it more and more difficult to change or revise our guiding fictions on the basis of new evidence (Ansbacher & Ansbacher, 1956). In that way one could say we become impaired — we become stuck. Harboring constructs, fictions, private logic, theories on the nature of being, is not a crime. Nor is it a shameful act, and most importantly, neither is it
an illness. It is as necessary to the functioning of the self as the oxygen we breathe. When this (human experience) is regarded as something it is not (illness) we become mired in describing the symptoms, obsessed with eliminating problems that are paradoxically fundamental to our existence as self-aware creatures (Trungpa & Gimian, 2005).

The therapist draws forth certain sensation (per their specific competence) through language, creative expression, movement, to help clients attend again to the evidence of what the client finds in their subjective experience. With new evidence on the table the therapist can then help point the client towards the possibility of disrupting their a priori assumptions. Learning again to attend to experience as they initially did in the formulation of their private logic, we support clients in a process of verification. Given new evidence we invite them to accept or amend their lifestyle — a construct of fictions that remains, but now more open to revision in the face of new evidence. Perhaps in this light the role of the therapist can be understood to facilitate a return to learning from direct experience. Yet how can this skill be practiced if the therapist is not supported in the direct study of their own experience?

As this evidence continues to mount from a wide array of research perspectives and institutions, it seems we are returning to some of the knowledge that Janet (Boadella, 1997) had bemoaned our having already forgotten by the time of psychotherapy's birth. It is understandable for institutions charged with mandating scope of practice to be deliberate in the modification of such standards. None the less, the evidence presented so far in this paper has significant implications for the nosology of mental illness and prompts me to suggest a reexamination of how we train practitioners.

As a therapist we are no less human, and no less enmeshed in the tug of war between believing what we have learned in the past and learning from what we experience in the present.
For example, even in the short span of my learning to practice therapy I have already been confronted by numerous instances in which my assumptions, often hidden even from myself, about what it means to be a therapist interfere with my ability to assess and meet the needs of my clients. With one client in particular, who seemed content to speak only of the latest television show catching his interest, I found myself bemoaning to my supervisor the client’s unwillingness to engage in what I had to that point considered therapy. I was wisely counseled to consider how for this particular client consistent and supportive social contact could easily be conceived of as therapeutic.

Four

The essential ritual of Adlerian therapy is analysis of the life-style towards increased self-knowledge. The underlying mythology is that individuals nurtured in this way will increasingly be willing to act in consideration of the greater good of the species and the planet (Carlson et al., 2005). Social interest is not mandated from the top down, it is not a rigidly adhered to set of cultural values and norms invisibly woven into the fabric of doing business and capitalized on by the savvy few. Indeed, it is a guiding principle in which each individual voice is valued and respected, and no one voice feels compelled to drown others out.

Instruction in how to sense oneself on this road to social interest is the very thing that seems most often neglected in the education of therapists, if not dismissed outright (Shaw, 2004). While the meeting between a clinician and client is fraught with complexity, Siegel (2010) seems to seek relief from intractable political and philosophical quandaries. Yet he cannot deny that “...no matter what others, or we, try to say about it, if we don’t care for ourselves, we’ll become limited in how we can care for others. It is that simple and it is that important — for you, for others, and for our planet” (Siegel, 2010, p. 3). In short, to thrive in relationship, regardless of
how one *conceives* of the self, one must investigate the *experience* of one’s own self. The premise of, and the imperative for, suggesting mental health professionals receive training in somatic education is the notion that therapists’ own internal clarity is of the utmost importance in generating a successful therapeutic alliance. Mental health professionals are responsible for learning how to listen empathetically to individuals as they navigate the often challenging path of striving to overcome inferiority (Carlson et al., 2005). If the therapeutic alliance with the client is the variable, then the clinician’s relationship with, and perceptions of his or her own internal subjective experience, is the constant against which clinician growth can be measured.

**Craft Based Practice**

As practitioners of a craft, clinicians at any stage of development must continue to increase their own perceptual acuity internally, developing effectiveness through the practice of sensory observation from within. Young and Heller (2000) suggest in fact that therapy, as a craft, is a set of specialized skills and fundamentally different from a scientific discipline. They argue that as a craft, understanding and effectively practicing the skills of therapy is not predicated on objective study but rather continual improvement over time through experiential learning. Importantly, they also carefully demonstrate that science is not a monolithic, nor a mono-motivated pursuit, but one that is beholden to often overlooked political and cultural influences. Their definition of science, which includes the three sub-types of *experimental*, *theoretical*, and *clinical*, describes a "complex institutionalized set of strategies with ideological and economical intentions and methods of approaching knowledge" (Young & Heller, 2000, p. 116). Furthermore, they note the disturbing zealousness within the scientific orthodoxy that "debases and debunks alternative versions of reality, which may be based more on intuitive knowledge or subjective experience" (Young & Heller, 2000, p. 116).
For Young and Heller (2000) the field of psychotherapy has been unduly influenced by attempts to be perceived as scientific in pursuit of cultural legitimacy. It is their contention that the aims and purpose of psychotherapy are hindered by the conception of therapy as a science, an argument premised on the distinction they make between craft and science. In making their argument they examine arguments from the opposite perspective suggesting that psychotherapy should be the exclusive purview of psychologists and psychiatrists, professionals whose qualifications are from a more established academic discipline (Young & Heller, 2000). According to Young and Heller (2000), this position is premised on devaluing the more experiential nature of psychotherapists’ training, which is regarded as less scientific and therefore seen as potentially dangerous. While they cite the pressure of competing voices from within the field, they indicate that external pressure from the culture at large is even more significant in fueling tension between cognitive science and psychotherapy.

Ultimately, the distinction made by Young and Heller (2000) rests on the position that culturally we have unduly privileged science such that it is seen as the only legitimate means of ascertaining knowledge. Their argument seems not to negate the knowledge that is produced by the culture of science. In fact, Young and Heller (2000) make clear mental health care can and should be informed by scientific study of the mind. However, in making the distinction between craft and science they seek to remove therapy from the arena of continuously changing theories and endow the field of mental health care with a legitimacy that does not hinge on the changing tides of scientific opinion. Furthermore, their definition of psychotherapy as a craft allows them to embrace the messy and complex nature of therapeutic work. Most importantly, in designating therapists as craftspeople they conclude that "we cannot go with others where we have not gone
ourselves, or where we are not prepared to go ourselves...we cannot practice these skills effectively and be unmoved" (Young & Heller, 2000, p. 129).

Frank (2013), a self-described defender of science, who is nonetheless critical of the ways science is appropriated by culture, might locate Young and Heller’s (2000) argument as highlighting the difference between science and scientism. Yet, as Young and Heller (2000) and Shaw (2004) suggest, the present confusion within the sciences in evidence of a shifting paradigm — from one predicated on linear cause and effect to the recognition of "open systems; non-linear relationships; randomness, probabilities and chaos theory; fluctuating sub-systems; dissipative structures and feedback loops" all of which can describe with far more relevance the working of biological and social systems (Young & Heller, 2000, p. 128).

**Somatic Education**

Somatic education uses both language and touch to help students cultivate internal awareness while exploring simple, functional, movements from everyday life (Feldenkrais, 1981). The student is given opportunity to actively engage the internally felt sensation of self, which in turn can shed new light on the relationship between self and other. This discipline shares a fundamental philosophical tenant with Adlerian psychology. For Adler “the unitary self, with its striving for a unique goal in a uniquely perceived world,” was the key to understanding human behavior (Ansbacher & Ansbacher, 1956, p. 204). He stated, furthermore, that “under these conditions, all psychological and bodily processes and characteristics become tools for the self” (Ansbacher & Ansbacher, 1956, p. 204). It has long been known by Adlerian professionals as well as many of the thinkers that influenced Adler’s theories, that we hold and express within our physicality many of the emotional patterns that underlie and sustain maladaptive patterns of thought and action (Boadella, 1997).
Instead looking for pathology in the individual somatic education stimulates the innate self-regulating capacity of our nervous system, the sensitivity of which has been the engine of our biological evolution. Hanna (1990) differentiates between two types of learning, ontogenetic and phylogenetic. He states that "the myriad sensory-motor programs that have evolved through the mammalian, vertebrate lineage back to the earliest life forms" comprise our phylogenetic knowledge (Hanna, 1990, p. 8). This knowledge of the species is expressed by the reflexive and automatic functioning that undergird our basic survival mechanisms. Concomitant with collected wisdom of the phylum is our individual ontogenetic knowledge of the “sensory-motor programs that have been learned from birth...elaborated during childhood out of the ocean of reflexes beneath them” (Hanna, 1990, p. 8).

Within somatic education these two sources of knowing, inherited and learned, are understood to form the basis of the individual self-image. The somatic educator works at this interface to help students clarify their self-image, and improve its functionality. Feldenkrais (1972; 1981; 1985; 2005), a pioneer in the field, states that his students are most often not in need of corrective techniques, rather an increase in self-awareness in order to be "freed from unconscious restraints" (Hanna, 1990, p. 4). For Feldenkrais, this increase in self-awareness is facilitated by developing attentional awareness through clarifying the use and organization of the skeleton in generating movement (Hanna, 1990). While the professional expertise of somatic educators is often sought by individuals hoping to address physiological complaints, as might be expected given the evidence laid out on the previous pages, the relief provided by somatic learning has a positive and strong psychological component.

According to Feldenkrais (1972) there are four categories of experience in the world: thinking, feeling, sensing, and moving. He suggests that because these four categories of
experience are in fact not distinct but formulate a complex system of the self, to enact change in one realm is to invite change to the entire system. As physicist, engineer, and martial artist, he was drawn to both the practicality and tangibility of using movement to affect change in awareness of the entire self. Feldenkrais' method, aptly taught today under the moniker the Feldenkrais Method, comprises two distinct modalities. Awareness Through Movement lessons are taught in a group setting using verbal instruction to guide the students' exploration, while Functional Integration lessons are conducted one-on-one with the practitioner using a hands on approach to more directly facilitate individual learning.

Reese (n.d.) states that Feldenkrais was not only innovative in his instruction of movement but that his theories of learning were also ahead of his time and anticipated the recent science that has begun to examine the distributed and embodied nature of consciousness. While existing movement education ascribed to a top-down theory of motor control, by "strictly following position indications for good form or posture," Feldenkrais believed that "in actual practice, conscious self-direction alone does not elicit functional learning" (Reese, n.d., para. 2). Rather than prescribing a movement instruction based on adherence to an ideal form, Feldenkrais understood that "functional learning emerges through pursuing exploratory variations constrained and facilitated by functional demands and the environment" (Reese, n.d., para. 2). In essence, Feldenkrais was an early theorist in the field of systems theory who understood that the individual does not function independent of context.

The function of our actions, the actions through which our self-image is constructed, is then understood to be endemic to the purpose that they serve. Hanna (1990) proposes that our ontogenetic movement patterns, and therefore our foundational construction of a self-image, are formed by three distinct phylogenetic reflexes: the trauma reflex, the startle reflex, and the
Landau response. The first is a protective response to avoid the repetition of injury, the second is a response to the stress of eminent threat, and the third is the response elicited to prepare us for action (Hanna, 1990). Each of these reflexes become habituated in the individual, and when excessively stimulated function to constrain the range of emotional and cognitive responses as well as movement.

In contrast to therapeutic approaches that have emerged from a medical perspective, where change is enacted from the outside in, somatic education seeks to initiate change from the inside out. Though it is often done, to describe the somatic perspective as body oriented is misleading as it relies on a conception of the self where the division between mental, physical, and social activity, are seen as fundamentally distinct. In guiding students towards identifying more closely with physical sensation, practitioners endeavor to support the student in learning how to attend to the often unrecognized physicality of their emotional and intellectual experience. Simultaneously they draw attention to how, by so doing, the student can uncover new potential for self-regulation as they make movement within their physical and social ecosystem.

The notion that individual parts of a system can be affected in ignorance of the whole, though firmly entrenched in institutional policy and standards of care, is slowly beginning to shift in the face of new evidence. Mamtani and Cimino (2002) suggest the medical model is evolving as so-called ‘complementary and alternative medicine’ has become increasingly recognized and requested by patients, and subsequently studied and validated by clinical trials. This shift is important and indicates movement in the mainstream of health care towards an increasingly integrated model. Mamtani and Cimino (2002) indicate this shift has been most notable in the treatment of psychiatric disorders. Their optimism aside, such shifts are
constrained by the continued reliance on an illness model in which health is measured by the absence of symptoms affecting the parts and not the expression of a dynamic range of function in the whole.

For Adler, a division of the self into parts such as physical and mental or conscious and unconscious was by its nature misleading. He wrote “if we believe that the foundation, the ultimate basis of everything has been found in character traits, drives, or reflexes, the self is likely to be overlooked” (Ansbacher & Ansbacher, 1956, p.175). If the individual is indivisible then to change one part, for example a cognitive distortion, without identifying a resulting change in the distortion of the musculature, the impact of the intervention is less likely to take hold, and could have unrecognized consequences for the well-being of the whole person. A somatic approach, like Adlerian psychotherapy, is educational in nature and lessons are designed to equip the student with tools to learn about their own experience from the inside out.

**Summary**

The general question I have faced in reviewing this research is *what does it mean to be a therapist*, a professional charged with nurturing the minds of others; and by extension, how does one become this kind of practitioner? As a graduate student I have been learning the history and theory of mental health care, as well as the practical considerations involved in providing care such as assessment and treatment planning. The completion of a clinical practicum, under extensive supervision through both the school and an onsite supervisor, has been a valuable experiential component of the curriculum.

However, the focus has been by and large outside myself and focused on understanding the experience of others. Meanwhile I have been concurrently participating in a four-year professional training in the Feldenkrais Method. This training takes place in brief, intensive,
modules of two and four weeks that meet three times per year. The study, which includes discussion and intellectual examination of the method’s history, development, and current evidence-base, is predicated on the experiential practice of the method. This education is one that occurs solely within my own experience of being myself, and that nonetheless moves me to increase the sensitivity with which I use myself in relating to others.

Attempting to reconcile these two methods of study, and the resulting implications each has for clinical practice, has been fundamental to my development as a mental health professional. As such, my primary goal in writing this paper has been to research a philosophical, and empirically grounded platform from which to embark on clinical practice. Given that somatic education has been such a rich addition to my training as a mental health professional, I find myself wondering why is it not a standard part of the educational curriculum in the field? It is difficult for me to imagine that I am the only one for whom it holds benefit. This notion lead me to a preliminary examination of the cultural forces that exclude training in the perception of embodied sensation from curriculum in the education of mental health professionals despite overwhelming evidence that embodied and relational perspectives on human consciousness are fundamental to our work as caregivers.

As of this writing there is a relative paucity of research on the use of somatic education related to mental health care. A meta-analysis of research done on the Feldenkrais Method of somatic education found only one study, a single case-study, that looked at its effectiveness in providing mental health care (Buchanan, 2012). However, as Joly (2000) notes, somatic education is perhaps verifiable by different methods than those that dominate scientific inquiry. The premise that individual human beings are not reducible to their constituent parts contradicts
fundamentally the premise of empirical observations that attempt to delineate one thing from another.

I did find considerable evidence that the premise of research in the cognitive sciences rests on a priori assumptions regarding the nature and function of the human mind. This is of significant concern to the practice of mental health care and the ethical obligations of service providers to be responsible for, “the application of...mental health research, principles and procedures to maintain and enhance the mental health, development, personal and interpersonal effectiveness, and adjustment to work and life of individuals and families” (Herlihy & Corey, 2006, p. 87). Are we compromising our inherent and inherited capacity for empathy by negating the felt-self in the education of mental health professionals?

The implications of an embodied and ecological model of the mind, as well as research on the common factors for therapeutic effectiveness (Duncan et al., 2010), suggest that greater attention should be paid to the subjective experience of clinicians in training graduate students. It also suggests both a pedagogical critique, and a critique of the standards of care in the field of mental health. Our training and regulatory institutions have not kept pace with the exhaustive and accumulating evidence that consciousness is not simply a byproduct of neuronal activity, nor does its emergence and sophistication in humans occur in isolation from relationships within social and physical environments.

The felt experience of the therapist is largely ignored (Shaw, 2004). The clinician, who is by designation the healthy party in the therapeutic relationship, is no doubt in possession of a useful and valued perspective from which to consider the well-being of the client. And yet, there is doubt in my mind, given how little attention is paid to educating the embodied experience of the therapist, that we are being properly equipped to do so. Increasing one’s felt sense of self
through a physical practice such as somatic education will likely be shown in future research to increase situational awareness and empathetic fitness, both essential for the emergence of empathy. Perhaps then the licensing boards of mental health disciplines will consider requiring trainees to engage in the study of embodied practice.
Author’s Note

My grandfather was a research and teaching physician. In carefully controlled clinical settings he examined the body’s ability to regulate and manage its digestive system. He also committed himself to improving the methodology for training other doctors in the culturally dominant mode of assessing and addressing empirically verifiable links between cause and effect in biological illness. His daughter, my mother, was also deeply concerned with health. She was committed to promoting the ability to heal one’s self, and her explorations led her to the more ambiguous field of complementary and alternative medicine. She combined main-stream physical therapy with homeopathy, energy healing, mindfulness practice, and indigenous perspectives on health and well-being. Both were healers; neither could see eye to eye, nor did they but rarely give the other an inch.

I enter the field of mental health as a third generation healer. My moral, ethical, and aspirational considerations are colored by the unresolved tension in my personal lineage. It is a tension that speaks to a larger ongoing cultural debate between empirically-grounded materialists who pursue and refine strict clinical standards for evidence based practice, and those who embrace the relevance of direct experience. Though personal and institutional authority are often at odds in this debate (and often appear to be inextricably incongruent) I am interested in how we may be able to make use of one in order to foster the other, and I am optimistic about the potential for evolution in our community standards of care. I enter into this conversation with curiosity about how the choices we make in the education of our practitioners, and even our most basic conceptions of illness, affect the choices for healing that we make available to our clients.

The process of becoming a therapist is daunting. It involves developing a contextual understanding of what it is to practice therapy (learning and assimilating the history of the field)
while attempting to discriminate between theories that rely on precedent versus those that are supported by current science. It involves integrating one’s moral sense into the ethics of the field, and constantly questioning the science upon which the standards of care rest. Most importantly, and most often negated, it involves the therapist in learning to attend to, and bring to bear their whole self in the cultivation of a therapeutic alliance.

I feel excitement as I enter the field, buoyed by the remarkable surge of new research in a variety of disciplines where orthodox methods of inquiry are finally being turned towards examining the complexity of subjective experience. With a background in contemplative and embodied practice I am not surprised to hear scientists reporting on the results of studies with language that points to the unity of all things, and calling into question entrenched assumptions about the relationship between subjective experience and objective observation. In more ways than one I am profoundly grateful for the work of these tireless researchers.

These same scientists, perhaps unwittingly, give evidence couched in a contemporary language of power to describe and otherwise articulate what I have learned through the investigation of my own subjective experience. Namely that this thing I know as myself is largely a fiction, something that I have created over time through the compounding of various streams of input and the subsequent feedback loops generated by a marvelously adaptable nervous system I share with my fellows. In other words, I found myself to have constructed something remarkably congruent with the life-style described by Adler, guided by my fictive goal, and a unique private logic.

While I am an advocate for placing the genesis of knowledge and authority in the awareness of the individual it is not my intention to endorse the hubris of so-called rugged individualism on which this country was founded. The dominance of what I would describe as an
imperialistic individualism has spawned a society that is motivated by avarice and gluttony, and which threatens to consume in just a few generations all of the world’s resources in a vain search to increase personal comfort. The alternative to this destructive trend does not entail negating the validity of subjective experience. I believe that until an individual comes to know the basic honor and dignity of their existence they are compromised in their realization of socially interested action wherein one’s pursuit of individual knowledge is ultimately in service of the wellbeing of all (Ansbacher & Ansbacher, 1956).

As mental health professionals, licensed or otherwise, we hold immense power as arbiters of the soundness of others’ minds. The notion of social interest empowers us as practitioners to advocate for the health of the species as much as for the mental health of the individual. Plurality implies options and the field of mental health has been given the mantle of discriminating between normal and abnormal by means of evaluating behavior and assessing states of being. The very notion of describing ‘normalcy’ implies the prescription of a limit to what is considered functional and what is judged to be diseased. Driven by a biomedical model of individual pathology our field too often fails in examining the context and the social environment of the individual. Thus we neglect to nurture the culture for the sake of trying to cure the individual.

Mental health professionals need adequate training which must include a view of the mind as an ecological and embodied process. Only then can we lay claim to competence in addressing the concerns of the self within which mental function cannot be separated from the physiological or from the environment. It is not just brain science, it is people science. Specifically it is self-study. The challenge I face as a nascent clinician, in between studying movements of the body and inquiry into the composition and patterning of mental function, is that I have lacked a comprehensive theory to proceed in building my practice. It was the purpose
of my academic scholarship into both realms, mental and material, to create the underlying structure for such a road map, and perhaps to leave a relevant record for those who follow with similarly unconstrained interest in integrative practice to consider. I believe firmly that it is possible to reconcile the mental self — which seems to be at once everywhere and nowhere within the field of experience — with the tangible and material facets of embodied experience, and that in so doing we can make great strides in the cessation of suffering.
References


