

Embodied Clinical Truths

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Abstract

Among clients and psychotherapists, the body is not only the repository of trauma, but it is also a vast storehouse of expert knowledge. As therapists, we gather relational patterns slowly and implicitly through experience via full immersion within a variety of clinical contexts. This essay begins with the neurobiology of embodied truths, including the importance of implicit learning in service of executive memory and prescriptive knowledge as guided by right-brain intuition. Next, I set forth seven assumptions about professional development I held at the beginning of my career as a clinical psychologist. One by one, each assumption is presented and then systematically rebutted in light of embodied clinical truths I have garnered over the past three decades.

Keywords: embodied knowledge, clinical intuition, wisdom

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Within the somatically-oriented healing community, it is well-known that the body “bears the burden” (Scaer, 2001) as well as “keeps the score” (van der Kolk, 2014), especially with respect to trauma. Unprocessed emotions and other residues of traumatic events accumulate deep within the brain/body’s electrical, chemical, and mechanical workings. In what seems like an increasingly stressful and stressed-out society, we clinicians regularly encounter people with dysregulated emotions and undigested trauma. Some are victims of tragedies; others have witnessed atrocities; still others were subject to subtler forms of relational trauma. Relational trauma (Schoore, 2001) emerges from the very earliest misattunements, whether consisting of emotional “misses”, or outright abuse or neglect. Beginning in infancy and lodged deep in the body in pre-symbolic form, the relative presence or absence of relational trauma shapes insecure or secure attachment style. What the mind cannot recall or translate into words, “the body remembers” (Rothschild, 2001). If statistics give us any clue, it appears that the incidence of insecure attachment has gone up considerably over the past 20 years, especially within the avoidant/dismissive category (Konrath, Chopik, Hsing, & O’Brien, 2014).



Figure 1. Earned Attachment, Caption: Although many of our clients begin psychotherapy with insecure attachments, if all goes well, they will finish with the status of an earned secure attachment.

Happily, trauma is not all that the body holds onto, because the body also remembers positive experiences as well as tracks the entirety of our professional accomplishments. As psychotherapists, the integrated body/mind/brain system collects relational patterns revealed over the course of each clinical encounter. Every practitioner enjoys a slow accumulation of embodied expertise that is gathered in context, without effort. The 10 year, 10,000 hour rule, as formulated by Obler and Fein (1988) and recently popularized by Malcolm Gladwell (2008), states that it takes approximately 10,000 hours or 10 years, whichever comes first, to gain full competency in any skilled enterprise. This rule applies to widely diverse areas – psychology, architecture, mathematical discovery, musical composition, cooking, dance, surfing, and virtually every area of the humanities, arts, and sciences.

When the integrated mind/body/brain system is repeatedly immersed in full context, then “executive memories” (Fuster, 2003) form. In contrast to the “what” or “why” of life, executive memories involve the pragmatics of “how”. In contrast to semantic knowledge, this is the stuff of “prescriptive knowledge” surrounding questions like “How do I respond to this dilemma?” “What should I do next?” (see Goldberg, 2005). As body workers and psychotherapists, through repeated practice in dealing with a host of problems, interventions, and outcomes, our bodies develop prescriptive knowledge. As this happens, we implicitly, unconsciously grasp levels of nuance and degrees of complexity in bodily-based processes impossible to achieve consciously through explicit learning. Whereas explicit memory takes effort, deliberation, and conscious attention, implicit learning is automatic, effortless, and nonconscious (Claxton, 1997). Explicit knowledge gets stored in various lobes of the neocortex related to initial contexts of learning, while implicit memories get stored in the frontal lobes (Goldberg, 2005), the seat of executive decision making.

Brain Lateralization and Embodiment of Work

When collecting knowledge of all kinds, the mind and body work hand-in-hand. The conscious brain/mind gathers explicit knowledge in tandem with the nonconscious brain/body gathering implicit knowledge. Cooperation between these two aspects of self parallels cooperation between the left and right sides of the brain. The left brain is in charge of the right side of the body, including the right visual field, while the right brain takes charge of the left side of the body. Simultaneously, the right brain is also in charge of integrating information from both sides of the body (McGilchrist, 2009). This additional integrative aspect means that the right brain functions in an open, holistic way, as opposed to the more narrow pursuits of the left side.

During evolution, brain lateralization, i.e., division of labor between right and left sides, extends as far back as millions of years to the onset of vertebrates. This means that brain lateralization preceded later mammalian capacities for social emotions and higher cognitive functioning. The most basic division of the two halves of the brain surrounds a primitive distinction – novelty versus habit. Among reptiles, mammals, and even birds, the right half of the brain takes charge of new situations, whereas the left half of the brain governs habitual activities (MacNeillage, Rogers & Vallortigara, 2009). Within human beings, we observe a progression of switches in brain dominance over development. No matter what one's culture or historical era, universally, the first two years of human life are devoted to right brain development (Schore, 2012). During this preverbal period, emotional, relational, and even cultural knowledge is gathered as a foundation for layering on later-developing cognitive skills. At approximately the start of the third year, dominance switches to the left brain in order to acquire language and conscious thought. Because Western culture so often privileges thinking over feeling, we can lose track of implications of this developmental picture – thought doesn't control emotion; it works the other way around. Emotion comes first, and sound emotion is necessary for sound thought.

From the standpoint of the body, the left brain is primarily in charge of voluntary movement. Through free will and activation of the striated muscles, we make and implement executive decisions. This means that when we consciously consider and decide to take an action or activity followed by moving our bodies accordingly, we operate in the domain of the left brain. By contrast, when we operate more out of internal silence and/or act more automatically or intuitively, we have shifted over into the domain of the right brain. Since effective psychotherapy is all about novelty and change, our interventions will be most effective if we approach our clients with open attention, again in the domain of the right brain. This stance allows us best to attend to the full context and complexity of the moment so that we may tap most deeply into our holistic font of embodied knowledge (Marks-Tarlow, 2012a; 2014a, b, c).

As an aspect of processing novelty, the right brain also perceives and responds to danger via the amygdala's warning system in combination with arousal of the sympathetic and parasympathetic branches of the autonomic nervous system (ANS). When we get excited, the sympathetic branch becomes activated. As we calm down, the parasympathetic branch kicks in. When chronically stressed, we may suffer from sympathetic hyperarousal or parasympathetic shutdown in the form of dissociation. Meanwhile, the enteric branch of the autonomic nervous system, which is evolutionarily the oldest of the three ANS branches, gets involved with digestion. We therapists become privy to "gut" feelings as part of embodied knowing precisely because of the right brain's oversight and stronger connection with the

smooth muscles of the organ systems. In conjunction with sensing our own arousal levels, various limbic structures like the insula and anterior cingulate help us sense what is happening in our own bodies (interoception) to assist us in gauging what is happening in the minds and bodies of others. When we feel pain in response to our clients' pain, we activate the very same internal circuitry as they do. What is more, the experience of social pain like exclusion or rejection activates the same neural circuitry as physical pain (Lieberman, 2013).

Whenever verbal and somatic psychotherapists attend to dysregulated emotions in our clients, it is the arousal dimension rather than the valence of emotion that is most problematic. To have negative emotions like anger or fear is normal and appropriate in context. Problems occur when the intensity of these emotions becomes too much to bear, leading people to live under chronic stress states of hyper- or hypoarousal. When we psychotherapists use our own mind/body/brains to regulate the nervous systems of those we serve, we intuitively attend to the arousal dimension of emotion, either by down-regulating, i.e., soothing, overly intense feelings or by up-regulating, stimulating, numb, suppressed or dissociated emotion. Because the right brain regulates emotion and arousal by drawing upon bodily functions automatically and subcortically (without conscious awareness), Allan Schore (2011; 2012) asserts the right brain is the receptacle of the unconscious mind, while the left brain is guardian of the conscious mind. This relational, body-based account of unconscious and conscious functions differs considerably from Freud's more disembodied, nonrelational formulation of the psyche.

The issue of brain lateralization is a controversial one whose study has received lots of attention following the era when Sperry first conducted split brain research in search of a cure for epilepsy. When split-brain research became popularized in the 1980s, people made simplistic attributions of different activities to each hemisphere. For example, verbal activities like language were assigned to the left, while nonverbal activities like music were assigned to the right. In light of more nuanced research (see McGilchrist, 2009), virtually any activity can be processed by the right or the left brain. Most of us hear music with our right hemispheres, yet professional musicians differ by processing music with the left hemisphere. Similarly, while most language is processed by the left side, there are important exceptions to this rule of thumb, including processing our own names, curse words, other expletives, poetry, metaphor, and humor.

McGilchrist (2009) suggests it is most useful to conceptualize each side of the brain as carrying its own unique perspective on the world. The corpus collosum that connects the two halves, while designed to integrate opposite sides of the body, carries a different design when it comes to the conscious mind. Our subjectivities can only entertain one perspective or the other at a single point in time, not both at once. Whereas the left brain focuses on the detail and well-known patterns; the right brain focuses on the big picture and novel pursuits. During clinical work, I have emphasized the importance of shuttling back and forth between the two modes. This often amounts to right-left-right shifts in processing (Marks-Tarlow, 2014b), as when we begin with open focus (right), zoom in on a detail (left), only to open up again through free association (right). Meanwhile, over the course of time, as our various activities lose novelty, patterns get transferred from right-side to left-side processing. As we age and gain more experience, what started out new eventually becomes old. In the process, more and more implicit patterns get transferred from the right side of the brain over to the left side (Goldberg, 2005). As a result, many elderly people retain expertise in their fields of study and active hobbies, even though their aging brains may suffer from memory loss

or other cognitive decline. Happily, because the shift from right to left may never occur for complex social interactions, we clinicians, immersed in the uniqueness of each clinical encounter, enjoy the privilege of remaining perpetually grounded in the right brain's creative potential.

Clinical Intuition as the Source and Product of Embodied Truths

I present this brief account of the neurobiology of learning and memory to offer up the body as a storehouse of embodied truths. Embodied truths differ from the Aristotelian kind of truth that offers only two choices – true or false – with clean divisions between. Instead, the embodied variety are pragmatic truths that light our path in life, including heuristics for conducting our clinical practices with cunning and creativity. Pragmatic truths don't fall into neat categories. Instead, these are fuzzy truths with jagged edges that emerge from foggy circumstances. This kind of truth is not very useful for a game show competition, but does come in handy in scary or hairy, complex social circumstances. Embodied truths provide inner guidance; they are the stuff of wisdom. They assist us in groping through the chaos of life, despite feeling drenched in waters of uncertainty, mired in the mud of ambiguity, or torn into two by contradictory urges.

In short, embodied truths are the foundation for clinical intuition – a topic I feel quite passionate about (Marks-Tarlow, 2012a, 2014a, 2014b). Even for clinicians who concentrate in verbal psychotherapy like myself, through tapping into intuitive channels, we are all grounded in the body's learning. For this reason, I firmly believe that the interpersonal neurobiology of clinical intuition should occupy center field in every clinical training program, whether somatically oriented or not. In the thick of the moment, clinical intuition is what comes into play during the actual clinical encounter to fill the gap between theory and practice. I also maintain that access to these kinds of embodied, intuitive truths is a necessary, though not sufficient, condition to bring about deep change. What is more, the same kind of body-based knowledge is not only important in ourselves as clinicians, but is just as necessary in the people with whom we work. Embodied truths light up a 2-way street in psychotherapy as together, therapist and client search for the novelty and creativity inherent in deep, cellular change.

For practitioners, after countless hours, months, and years of open immersion in clinical practice, if we are lucky, then our body-based capacities will reach full maturation to flower into wisdom. Although wisdom is not much discussed in our professional circles, it should be. A lit review by Meeks and Juste (2009) within a PubMed database using “wisdom” as the keyword revealed a seven-fold increase in articles on this topic between 1970 and 2008. Yet the total number of papers was shockingly low. Only 20 papers existed at the beginning of the time frame compared with 150 papers toward the end. Within professional circles, the topic of wisdom is neither a standard aspect of clinical training nor a regular part of professional dialogues. All too often the subject gets restricted to religious or spiritual discourse, with different religions viewing wisdom differently depending on their view of the mind/body interface. Some traditions elevate the mind while denigrating the body, which gets reduced to the “soulless” existence of “lowly” animals. From this perspective, in order to achieve wisdom and spiritual elevation, one must transcend the material level and rise “above” animal instincts. I admit, this is not the perspective I personally endorse.

Other spiritual traditions, especially the mystical ones without clear separation between god and humankind, erase clear distinctions between material and spiritual levels. They

posit an interconnectedness between everything that also extends to animals. From this perspective, the body often enjoys exalted status as temple of the soul. As a practitioner of yoga for the past 30 years, I am more comfortable with this stance. This is partly how I have come to respect my body as a vast repository of life truths extending beyond traumatic imprinting into embodied realms of intuition, play, and creativity. My two most recent books, *Clinical Intuition in Psychotherapy* and *Awakening Clinical Intuition*, emphasize this link between intuitive and bodily processes by focusing on limbic circuitry that humans share with other mammals. To analyze the underlying neural circuitry of clinical intuition, I place special focus on the SEEKING, CARE, and PLAY circuits shared by all social mammals (see Panksepp, 1998; 2012).



Figure 2. Spider Monkey Trust, Caption. Because the CARE circuit operates in all social mammals, mothers are motivated to care for their young.

Along with clinical and personal tales, my books contain animal tales. My aim is to honor the body's wisdom as shared by other animals. Not only do they sport the same basic emotions as we humans, such as anger, fear, and joy, but evidence also exists for complex social emotions, such as justice and morality, among four-legged canines who live in packs (Bekoff, 2004; Bekoff & Pierce, 2009).

The Wisdom Inherent in This Clinician's Experience

With this lengthy introduction in mind, the remainder of this essay reviews 30 years of practice as a clinical psychologist through the lens of embodied truths in order to highlight differences between disembodied presumptions and embodied truths. As a fledgling clinician

in the 1980s, I started out with a host of assumptions about what I should do and who I should be. Looking back with the benefit of 20-20 hindsight, the evidence of my life has contradicted each and every one.

Assumption 1: Certainty is better than doubt, and certain knowledge is best of all

Certainty definitely feels good, especially for beginning therapists. Most clinicians, whether oriented toward somatic or verbal psychotherapy, enter the field taking our job very seriously. This can lead to incessant worries surrounding desperate and traumatized people we encounter. We so urgently want to be of help. Particularly in life and death circumstances, the responsibilities we face feel overwhelming. We seek respite from the anxieties surrounding uncertainty and the self-doubts it so easily breeds. Certainty is one solution to our struggles. Beginning therapists often seek certainty in books, prescriptive formulas, or the elevated stance of supervisors, much like little children crave omnipotent, omniscient parents to quell feelings of danger and return to a sense of security.

Here is my first embodied truth: when it comes to clinical practice, certainty is not the answer. In fact, quite the opposite – the quest for certainty all too often constitutes part of the problem. Through my formal studies, I have learned that the universe is fundamentally nonlinear. This means that it is holistically interconnected, such that it is nearly impossible to pull apart all of its pieces cleanly. Clear concepts of truth and falsity may resonate with bodily experiences, yet emerge from language and concepts different cultures foster. Some people would hand over clear vision of what is true and what is false to God. I am not one of those.

From my perspective, a clean and clear division between what is true versus what is false is reserved mostly for technical calculations, like making tables or solving mathematical equations. From this viewpoint, the complex social universe in which our bodies and relationships reside is way too fraught with ambiguity, contradictions and paradoxes for certainty to be of dependable use. As clinicians, there is great danger in too much certainty. We can grow cocky, inflated or closed minded. The more certain we become as a regular stance, the more we narrow our scope of vision and close down our openness to other points of view or changing circumstances. Real life is damn messy, with dynamics that shift and turn fluidly like waves of water. If we become too certain, we also become rigid and impenetrable. Buddhism, which is more of a philosophy than a religion, is also a psychology which offers antidotes to various afflictions of the mind. What is the Buddhist antidote to doubt, one of the mind's worst afflictions? The prescription is not certainty. Instead, the prescription is to lower ourselves down so that we may connect with the earth. By placing our hands in the dirt, we become grounded, quite literally. This stance helps us to hold the uncertainty that is not only intrinsic to our very being but also to our clinical work with clients/patients who continually face crises and chaotic life transitions.

Assumption 2: Creativity is frivolous, while psychopathology occupies the center of any serious clinical practice

While I was in graduate school in clinical psychology, I chose a dissertation on depression. There was a huge prospective study already underway, and I wanted to be practical about finishing on time. While I kept to my timetable, there was a major problem with this course of action: I had very little interest in depression. After graduating and earning my California psychologist license, I suffered an early career crisis. Where was my passion? One day, I did a self-guided, deep meditation. Upon finishing, I knew that creativity was how I wanted to

focus my energies. Yet, no sooner did I discover what truly unified my heart, body, mind, and soul, then I became filled with self-doubt and shame. No one else I knew was focusing on creativity. Under the harsh lens of intense self-scrutiny, the subject seemed trivial. I felt self-indulgent. Or, perhaps I was merely a *Puella Aeterna* (eternal child). Why didn't I have more interest in areas like trauma or the severely disabled like the rest of my cohort?

Fortunately, I suffered through these self-doubts without letting them stop me. Something drove me on relentlessly. I studied theories of creativity and couldn't read enough about creative people. The more I have followed my passion, the more I have very slowly embodied the significance of what I was doing. I developed the courage intellectually to attend to nonlinear science and use my creativity to marry its concepts with clinical practice. I next turned to clinical intuition as nonlinear science in action, only to realize how much clinical intuition represents the art of psychotherapy, whereby each person, dyad, and clinical moment inspires a unique and creative response. Finally, I have discovered that everyday creativity isn't just the territory of talented therapists. Quite the opposite. As I mentioned earlier, to help patients ground themselves in their own intuitive foundations is to open up their full expression and bring alive their creativity, however ordinary the context may be. Along with fulfilling relationships, what more could anyone want?

Assumption 3: If I don't specialize and declare a narrow niche of expertise, I won't be taken seriously as a clinician

My graduate school at UCLA was completely research-oriented. When I entered the program, it was assumed that every incoming student would choose academia for a future career. For some unknown reason, everyone in my year rebelliously rejected this agenda. Not one of the ten or twelve of us wound up as a researcher solely in academia. Yet, no one was properly trained in the mechanics of private or community service. As I watched others hang out their shingles, most everyone else declared a specialty. Some people worked with anxiety conditions, others with eating disorders, and still others with sexual dysfunction or anger management.

As everyone else found their niches, I was busy doing the opposite. My net was getting broader and wider; some force in me resisted narrowing my focus. I continually read and trained outside my field. Meanwhile, my patient population was getting more, rather than less, diverse. Over the years, I have been blessed by such an interesting variety of folks who have crossed my threshold: FBI agents; artists, call girls, lawyers, doctors, composers, teachers, police detectives. I adore working with people from different ethnicities and cultural backgrounds, with patients who are African American, Japanese, Chinese, Indian, Iranian, Orthodox Jewish, and Cambodian. I have treated people who are gay, bisexual, and polyamorous. Over the last 30 years, I have also worked with just about every category of psychopathology there is, while treating people from every social class. I've even had several years of a healing correspondence with a man in prison for life under the charge of murder.

As I look back over my incredibly broad base of clientele, I realize that it is the breadth and diversity of my practice that has led to my current day expertise, not a course of specialization as I had presumed. An old trope translates PhD for Piled High and Deep out of generalizing (if not stereotyping) academics as concentrating more and more on less and less. But a complexity model of mental and physical health emphasizes the importance of moving in the opposite direction – toward variability, adaptability, and flexibility.

Assumption 4: Unless I affiliate with a single orientation and school of clinical thought, I am a dilettante, or even worse, a charlatan

The question of orientation has been a difficult one for me from the start. At UCLA, I was trained in cognitive, behavioral therapy. Never terribly comfortable with the idea that thought is more central than emotion, I went outside the gilded walls of the university to receive additional clinical training. I first gravitated toward Gestalt therapy, following the advice of a charismatic supervisor whose experiential approach felt so fresh and alive. While I loved Gestalt therapy in practice, I wasn't wholly satisfied in theory. During the 1980s the Gestalt community lacked a depth theory of the psyche. So I added psychodynamic to the stew by studying self-psychology and felt internal pressure to join an analytic institute. But I wasn't comfortable with the social politics of the various local institutes, which seemed petty, arbitrary and authoritarian. I desperately wanted to belong to a community of like-minded folks, yet something inside me prevented me from joining any group. Whatever this was kept pushing me on. Professionally, I found myself in a very lonely place for quite a number of years. The more I did my own thing, the more I felt like an outsider in my own field.

But once again, the embodied truths I have slowly gathered not only have challenged my preconceptions but eventually also settled my uneasiness about my own course and professional choices. Over time, my strength has come from my willingness to follow my heart, even at the expense of my internal, often naïve name calling. Looking back, each training I received was what I needed just when I needed it. My current grounding in interpersonal neurobiology has finally given me a community large enough to emphasize universal truths about psychotherapy that transcend any particular orientation or school of thought. Meanwhile, recent research affirms my embodied sensibilities by highlighting the quality of the therapeutic bond, regardless of orientation. Within the field of psychotherapy, trends come and go, much like fashion. They are neither right nor wrong; what is popular today is often passé tomorrow. As part of these trends, orientations and schools of psychotherapy seem to proliferate like rabbits. Each new school brings an important, often new, nugget to the therapeutic community. But no single one has a corner on the whole truth.

Assumption 5: The best way to gain expertise as a clinician is to study and emulate the practices of great clinicians

In clinical trainings, I vividly recall watching films of the various greats. I remember the Gloria tapes showing Carl Rogers, Fritz Perls, and Albert Ellis all doing psychotherapy with the same patient. On film, I have seen the work of Milton Erickson and Virginia Satir. I have read transcripts of countless other master therapists. Most recently, I have watched the videos of Pat Ogden doing sensorimotor therapy. I have marveled at the work of each of these individuals, each of whom is clearly a genius. At the very same time, especially at the beginning of my clinical career, the main impact of watching other clinicians in action was that I got terribly uncomfortable and confused. How did this person know to say that in that particular moment? That would never occur to me. What is wrong with me? So many of the responses I witnessed seem so connected to the various personalities, each so different from mine. Which comes first, personality or technique? How valuable is technique apart from personality? The more I watched others work, the more anxious and self-denigrating I became.

After all of my formal trainings, I went through a period of professional isolation. Looking back, I think I was trying to deal with my confusion by drawing a circle around

myself and my own practice. I needed to find myself from the inside out. Eventually, this brought me in an embodied way to my own style of doing clinical work, as well as to the importance of clinical intuition, whereby each clinician is encouraged to tap into his or her unique set of strengths and weaknesses as based on idiosyncratic genetics and social histories. To find my own style of psychotherapy from within my own practice was to capitalize on the constellation of strengths and weaknesses unique to me. Only by practicing in isolation could I seek and eventually find my authentic voice. Only in isolation did I find the safety to express myself authentically and transparently, with a non-defensive attitude. Looking back, the impulse to push away all other practitioners for a while allowed me to develop and learn to operate from an embodied foundation. Only from this solid perch, many years later in my career, have I grown better able to watch the work of others in a constructive fashion.

Assumption 6: Play is the opposite of hard work

I come from a high achieving family. My sister went to Harvard and is currently a tenured professor of developmental psychology who runs a culture lab that is named after her. My brother founded the world's largest nongovernmental peace-keeping organization, Search for Common Ground. My siblings are 15 and 12 years older than I am, respectively, and I felt the need to compete with them both from the start. Needless to say, especially in my early years, I was destined to lose the competition. This filled me with self-doubt and left me very insecure and neurotic in high school, but at the same time got me into prestigious places—Stanford undergraduate, followed by UCLA for advanced degrees. When I entered graduate school, I felt lots of pressure to work hard, but at the same time I no longer wanted to be neurotic. So, instead of joining my fellow students in study groups and running the risk of “catching” their anxieties, I often hauled my books down to the beach in order to study alone. I also practiced yoga and started to rock climb. Additionally, I countered my heady existence and intellectual confusions by learning how to dance. Upon finishing graduate school, when I entered private practice, from the very start I decided to limit my clinical practice to three long days – Tuesdays, Wednesdays, and Thursdays. I desperately wanted to retain balance in life and used the other days for other activities, including making art, indulging my body in yoga and exercise, and writing papers and books.

I started out feeling sheepish and rather guilty about my playful way of approaching clinical work. But looking back, again with the benefit of 20-20 hindsight, I now feel extremely grateful for the path my embodied wisdom has guided me toward. My balance of head, heart, and body activities has helped me stay fresh and passionate about my work, without a trace of burnout 30 years later. My preconception placed work and play on opposite sides of a continuum, yet my embodied experience has merged the two. I do my greatest clinical work out of a playful spirit. When playing, my clinical work doesn't feel hard at all, even though there are plenty of really difficult moments. Meanwhile, the more I study about play, both developmentally and evolutionarily, the more I realize that play is often where the greatest action and movement is in psychotherapy (Marks-Tarlow, 2012b, 2014c, 2014d, 2015). Trauma resolution tends to bring us back to safety, while play is the source of greatest growth. Certainly, this is true developmentally. All children stretch cognitively, emotionally, and behaviorally the most by exercising their imaginations.



Figure 3. Glee, Caption: Through imaginative play, children develop intrinsic motivation to follow their passions.

Through my intellectual work on a play model of long term psychotherapy I have come full circle on this issue. I now believe that formal games, like hide-and-seek, exist at implicit levels of psychotherapy as bids for engagement and disengagement, safety and trust. The more we participate in playful ways with clients, the stronger therapeutic bonds tend to grow.

Assumption 7: Psychotherapy is its own world that should remain cordoned off and separated from various other practices and pursuits

As mentioned, throughout my adult life I have been deeply absorbed in a wide variety of very different activities. Some involve the body; others involve the mind. Some involve solitary pursuits; others involve social interaction. I have practiced yoga for more than 30 years. I regularly draw and have illustrated most of my own books. I was a serious rock climber for years before having children. I take ballet and jazz classes several days a week. I started out doing many of these things in order to retain my own sanity. Maybe this is why I believed early on that each of these activities should remain quite discrete from my professional life as a psychotherapist.

As time has gone on, my embodied experience has once again flown in the face of this preconception. The more integrated everything is in my life, the more I realize that there are no separate chambers. Especially as I focus on authenticity and transparency within my relational style of psychotherapy, I can't help but to bring all of myself everywhere. I see this as the foundation for integrity. Meanwhile, my whole self is informed by the whole of what I do. Consider yoga. Whereas 20 years ago, I remained mum about this pursuit, now I talk about it whenever I can to

patients. I like to send people to yoga who are open to it. When patients have an active practice, it tends to speed up the change process. Meanwhile, I can move freely between emotional issues in the room and physical manifestations embodied on the mat.

A similar thing holds true for art. I used to follow this interest privately and apart from my professional life, but now I feel free to share art with fellow practitioners. I believe that each of the arts cross fertilizes psychotherapy in a different way. I have co-conceived with Pamela McCrory, PhD, curated, and co-edited “Mirrors of the Mind: The Psychotherapist as Artist” (Marks-Tarlow, 2013; Marks-Tarlow & McCrory, 2014). This juried visual art exhibition in Los Angeles, which includes poetry and other performance aspects, has touched a national nerve. Psychotherapists all over the country are interested in the arts, partly because of the embodied truths the arts offer to psychotherapists.

Final Thoughts

In the paragraphs above, I have set forth 7 assumptions of professional self-creation only to revisit each in light of the embodied truths of my actual clinical experience. Like the uroboros, the snake that swallows its own tale/tail (see Marks-Tarlow, 2008; Marks-Tarlow, Robertson & Combs, 2002), I have returned to the beginning of my career with the end in sight.



Figure 4. Uroboros

I love the symbol of the uroboros, especially as a student of nonlinear dynamics, with particular focus on chaos theory, complexity theory, and fractal geometry (see Marks-Tarlow, 2008; 2011). Throughout recorded history, the serpent has remained a symbol of chaos (see Hayles, 1990). The serpent that swallows its own tail is a symbol of chaos contained. Every known culture spins a creation myth that spells out the relationship between chaos and order (see Von Franz, 1972).



Figure 5. Chinese Dragon, Caption: In Chinese culture, chaos and order work hand and hand and the dragon is guardian of the pearl of wisdom.



Figure 6. Dragon and Hero, Caption: In Western culture, chaos must be vanquished in order for order and civilization to proceed.

In Western culture, perhaps our most popular creation myth is science in general, with physics of particular relevance to the relationship between chaos and order (Marks-Tarlow, 2003). Whether implicitly held or explicitly formulated, each person also spins out and carries our very own self-creation myth.

Perhaps an inborn, genetically programmed fear of snakes relates to a fear of chaos in our lives as well. The snake has always been a bipolar symbol of opposites, e.g., chaos and order, because the snake's venom provides both toxin and cure. This dual aspect accounts for the two intertwined snakes forming the healer's staff, or Caduceus, ancient symbol for Western medicine.

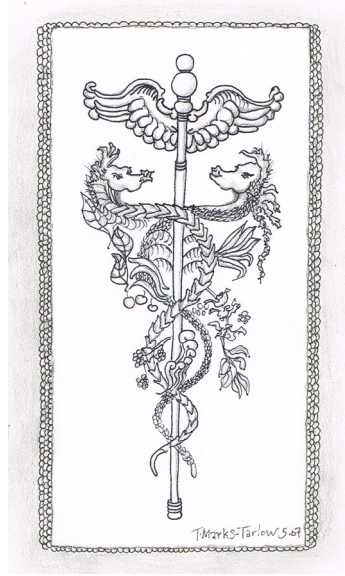


Figure 7. Caduceus

Jungian psychologist Eric Neumann (1954/1993) depicts the uroboros as the symbol of self-creation. In this essay, I assert that embodied truths as garnered from endless feedback loops of life experience form an important aspect of self-creation. We must all sort through the chaos of life to find inner order and the wisdom that is ours alone. By swallowing our own tails/tales, we take in and spit out life by first experiencing and then reviewing in light of further experience.

When it comes to clinical practice, truths are embodied in the lives of practitioners. I end with this advice: Follow your heart. Seek connection with your own inner vision and guidance. At the same time, be sure to stay open to input and feedback from others. This combination allows an internally grounded foundation alongside an externally open and flexible orientation. If you remain dedicated to truths as they present themselves in embodied form, I truly believe you stand the best chance of allowing your clinical intuition eventually to flower into wisdom. It takes courage to sink into your own experience and find your own embodied truths. The process can lead to great chaos and uncertainty at times. It is helpful to keep in mind the words of William Cowper, "Knowledge is proud that it knows so much; wisdom is humble that it knows no more."

BIOGRAPHY

Terry Marks-Tarlow, PhD, teaches developmental neurobiology at the Reiss Davis Child Study Center. She is a Research Associate at the Institute for Fractal Research in Kassel Germany and on the faculty of the Insight Center in Los Angeles. Her most recent books, *Clinical Intuition in Psychotherapy* (2012, Norton) and *Awakening Clinical Intuition* (2014, Norton) concern the importance of play, imagination, and creativity in psychotherapy. Dr. Marks-Tarlow embodies the balance of life between play, imagination and creativity through dance, art, and yoga. In 2010 she also wrote the libretto for the opera, "Cracked Orlando," with music composed by Jonathan Dawe.

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