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Perceived Helpfulness and Unfolding Processes in Body-Oriented Therapy Practice

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Abstract

To examine the underlying processes of an innovative mind-body practice, Mindful Body Awareness, this exploratory study involved four case studies analyzed phenomenologically using the dialogal method. Mindful Body Awareness combines manual (touch-based) and verbal processing, and is focused on facilitation of client body awareness. Four individuals were recruited to receive weekly 1.25 hour sessions over four weeks. The Helpfulness Aspects of Therapy (HAT) form was administered immediately after each session to access participants' perceptions of the therapy experience. In addition, the Scale of Body Connection was used to examine pre- and post-body awareness and bodily dissociation. Analysis involved phenomenology and descriptive statistics. The overall perceived helpfulness of the intervention was evident in the four themes that emerged from the analysis. These themes were gaining interoceptive awareness, personal agency, therapist trust and conceptual framing, and transformation. The participants' responses were also used to investigate the therapy process across time. A pattern of increased interoceptive depth was apparent, as was a concomitant progression in embodied sense of self. Improvements in body awareness and bodily dissociation were evident for two of the four participants. These findings help to identify primary components of Mindful Body Awareness and suggest the role of these components in the embodiment process.

Embodiment and embodied cognition, which were originally philosophical and theoretical concepts, have received attention from mainstream psychological researchers in recent years. The attention paid to embodiment in human experience by phenomenological psychology appears increasingly to be becoming more practicable and thus embodiment is beginning to appear more often in treatment studies and in research in general.[1] The importance of further exploration of embodiment as grounded in human experience cannot be over-emphasized. Without continued emphasis on the description and interpretation of embodied experience as well as on demonstrations of its usefulness in clinical and research settings the practices' retention may be jeopardized. For the purposes of this study, embodiment is defined as the experience of conscious connection to the body (Csordas, 1994).

This paper focuses particularly on the intersection of embodiment with a new approach to body-oriented therapy called Mindful Body Awareness. This body-oriented therapy is distinguished from other contemporary treatment modalities in that it combines

[1] Even a cursory search of the literature leads to the identification of a proliferation of studies and articles that explore the territories of body and perception. Examples include Finlay and Langdridge (2006), Newman (1997) and Todres (2007).

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manual therapy with verbal processing to enhance body awareness. Mindful Body Awareness is theoretically grounded in the work of experiential therapy (Elliott, Greenburg, & Lietaer, 2004) and mindfulness (Kabat-Zinn, 1990) and is being developed in the realms of both research and education.[2]

Mindfulness is the practice of maintaining a compassionate, accompanying presence within the self while 'observing' internal processes (Kabat-Zinn, 1990). Mindful attention specific to bodily experience facilitates present-moment awareness of sensation and emotion, enhancing psychological processing. This enhancing is evident from the thirty years of research on Focusing (Gendlin, 1981), an experiential process that involves bringing attention into the body to help identify and attend to an overall sense of moment-by-moment awareness (the 'felt sense') (Hendricks, 2001). This awareness, which is born of a non-judgmental and compassionate attitude, is seen as a key element in the integration of aspects of ongoing awareness (Gendlin, 1996). Mindful Body Awareness also involves 'presencing,' which is defined as the conscious choice by both client and therapist to engage in mindful presence within the context of body-oriented therapy practice (Blackburn & Price, 2007).

It is not possible to approach the subject of embodiment without further description of two significant contributors. Maurice Merleau-Ponty and Eugene Gendlin are both phenomenologists who emphasize the subject differently. Due to space limitations this article simply provides a summary of their main contributions to the current project. Merleau-Ponty's seminal ideas on embodiment qua perception have been published in an edited volume of his papers, *The Primacy of Perception* (Merleau-Ponty, 1964), and notably in *The Phenomenology of Perception* (Merleau-Ponty, 1945/1962). His work in these volumes represents an attempt to save 'body' from the perils of relativism that would consider it as merely one more thing sensed among all the other possible objects sensed. This article is based on an acceptance of Merleau-Ponty's notion that perceiving is a kind of sensing from the inside, an orienting center, which itself is a further kind of perceiving and orienting of the self. Body conceptualized in this way is alive and responsive, not static or relative to other intentions, nor "capable of an univocal determination" (Merleau-Ponty, 1964, p. 67).

[2] Research specific to this approach is being conducted by Price, referenced later in this text. Blackburn's website (http://www.presencingsource.com) contains information pertaining to his conceptual writings and educational efforts.

Gendlin's work aims to further this phenomenological tradition. For Gendlin, embodiment, or body in the philosophical sense, is more than a 'center' for perceiving as described by Merleau-Ponty "but also of acting and speaking in situations" (Gendlin, 1992, p. 345). Gendlin speaks for what he terms 'bodily sentience', which overthrows the order of perception-first with its vestiges of a top-down order common to the early phenomenologists. Instead, Gendlin announces:

> Let us upset that ancient order altogether. If one begins with the body of perception, too much of interaction and intricacy has to be added on later. Perception is not the bottom. There is an implicit interactional bodily intricacy that is first – and still with us now. (p. 253)

Gendlin's implicit interactional bodily intricacy is a philosophical concept that breaks the perception-first model and also points to a new experiential order that can be sensed in the here-and-now. In his formulation, each word is used specifically and not at all in the usual way. Instead of taking each rich term separately it is possible, given space limitations here, to sense for the self the 'body' that is our experience of life now (in this moment). Experienced in this way, body is not first perception, tissue process, cognition, or feeling. Although body is these elements they do not work separately first and then act to create a conscious experience of life. Instead, present in the moment is an implicitly working felt or sensed body, whole and intricate. However, knowledge of Gendlin's philosophy, or of how his new terms function, is not necessary in order to obtain a sense of 'body'. If he or she were inclined do so, the reader could, on their own, take a moment to sense their living now.

The form of therapy discussed in this paper directly asks participants to access their implicit interactional bodily intricacy, their awareness of their living in this moment. Grounded in this conceptualization of body as whole and sentient (as a centering) it is possible to describe that sentient quality precisely as it is, rather than reconstruct it from the many parts it may suppose. This speaks to the heart of the phenomeno-logical tradition; it involves giving voice to a particular experience, ideally without the burden of pre-understandings. There is no need to presume any originative order, however handy, in order to accomplish the task of describing the nature of the changes experienced by participants through phenomenological methods.

Nonetheless, as the following definition expresses, it is common to speak 'as if' there were an order that pre-exists that already whole awareness. Body awareness can be defined as:

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> The perception of bodily states, processes and actions that is presumed to originate from sensory proprioceptive and interoceptive afferents and that an individual has the capacity to be aware of. Body awareness includes the perception of specific physical sensations (e.g., awareness of heart activity; proprioception of limb position) as well as complex syndromes (e.g., pain; sense of relaxation; 'somatic markers' of emotions).
>
> Body awareness is hypothesized as the product of an interactive and dynamic, emergent process that a) reflects complex afferent, efferent, forward and back-projecting neural activities, b) includes cognitive appraisal and unconscious gating, and c) is shaped by the person's attitudes, beliefs, experience and learning in a social and cultural context. (Mehling et al., 2009, p. 4)

Merleau-Ponty and Gendlin both broadened the understanding of perception and embodiment to include inner awareness, acting, and speaking. Hypothesized biologic structures that may underlie perception and/or awareness, such as those posited in Mehling et al.'s (2009) passage cited above, are not understood as being the foundation of experience. Instead, the experience of body awareness has its foundation as a whole sense that is then later derived into various explanatory schemes by the person him or herself or by theorists. Based on how human beings live experience, rather than explanation, is therefore first. This is a reversal of the common order (i.e., central nervous system input begets perception which begets awareness) and is key to retaining a phenomenological understanding of what occurs in the new approach to body therapy studied in this paper.

Body awareness is fundamental to embodiment processes and involves the experience of one's overall sense of the body (Gendlin, 1968; Todres, 2007) as well as information from the inner body. Interoception is the processing of sensory information from inside the body (Cameron, 2001). The inner body is theorized as the origin of emotional awareness and a sense of self (Craig, 2002; Damasio, 1999; De Preester, 2007). Embodiment is thus a multilevel experience that involves the interplay between bodies, theorized components of the body, and the world(s) in which the body lives (Krieger, 2005). Agency, or sense of conscious choice, is by necessity implicated in any conscious embodied interaction with the world (Krieger, 2005) and contributes to a more unified experience of bodily self (Tsakiris, Schutz-Bosbach, & Gallagher, 2007).

Many experiential psychotherapy approaches are based on the assumption that healthy functioning occurs when as many aspects of the self as possible are integrated in awareness (Greenberg, 1998). These approaches involve a focus on inner bodily experience to facilitate client interface with the immediately sensed, but implicit, sensory and emotional awareness. Research on experiential psychotherapy demonstrates that the experience of accessing inner body experience is often accompanied by a transformational shift (often referred to as the 'felt shift' in focusing literature), which involves bodily felt change and new understanding (Hendricks, 2001). Therapists licensed to use touch who focus the session on body awareness, typically body-oriented therapists whose work involves combining touch-based approaches with verbal approaches focused on sensory awareness, usually find that the therapy process is intimately related to enhancing embodiment.

Mindful Body Awareness is a relatively new and innovative approach to body-oriented therapy. It is therefore important to examine the experience of participants who receive Mindful Body Awareness in order to better understand the perceived benefits of the therapy as well as the unfolding of the therapeutic process (Elliott et al., 2004). Previous studies that have investigated this intervention approach have found an increase in association to the body, manifested as a reduction in psychological dissociation and improvements in psychological and physical health symptoms. These studies have included examinations of participants' post-intervention reflections on the overall intervention experience through qualitative analysis of written questionnaires. These findings highlight the perceived benefits of increased emotional awareness, a more secure sense of self, and increased mind-body connection for women in recovery from childhood sexual abuse (Price, 2005, 2006), women with comorbid PTSD and chronic pain (Price, McBride, Hyerle, & Kivlahan, 2007) and women in treatment for substance use disorder (Price, Wells, Donovan, & Rue, in press).

The current study was designed to gather immediate post-session data in order to more closely examine the lived experience of Mindful Body Awareness. The aims of the study were: 1) to explore participants' perception of the helpfulness of Mindful Body Awareness; 2) to explore the progression of the participants' experience across time; and 3) to describe pre-post change in body awareness and bodily dissociation. To faithfully convey the complexity of the participants' lived experience of this new approach, the researchers chose to employ both qualitative and quantitative measures. The qualitative methods embrace the realm of the

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awareness of body and treatment as they coincide in the research setting. In contrast, the quantitative measures examine specific periods of time prior to and after the treatment. This can then be studied for any evidence that may further illuminate the nature of the treatment itself.

Design

A multiple case study design was used. For the purposes of this study, a 'case' was defined as study participation by a single individual and the use of multiple cases thus allowed for examination of both individual responses and analysis across cases using mixed methods (Stake, 2005). Four individuals were recruited for study participation and four case studies were thus used for the study. This was a small unfunded project and recruitment therefore involved a convenience sample from the local university. Each participant received four weekly sessions of Mindful Body Awareness approach therapy, with each session lasting 75 minutes. The sessions were conducted by one of two massage therapists trained in the Mindful Body Awareness approach. Participation involved completion of a post-session written questionnaire, the Helpful Aspects of Therapy (HAT; Llewelyn, 1988) after each of the four sessions. In addition, baseline demographics and pre- and post-measures specific to body awareness and bodily dissociation were collected from the participants. All sessions were videotaped. The participants did not receive any monetary compensation for their involvement but did receive the Mindful Body Awareness sessions at no cost. The study procedures were reviewed and approved by the institutional review board for protection of human subjects in research at Seattle University.

The study was designed to be reflective of the participants' lifeworlds. Phenomenological methods are based on the conversion of participants' lifeworld expressions into psychological language that can be accessed by the wider scholarly and practice-based community. Dialogal phenomenology, the basic approach and method of analysis used in this study, retains the lifeworld aspect during all stages of analysis. In dialogal analysis, as in phenomenological research in general, priority is given to understanding the phenomenon as it presents itself. The eidetic is thus preserved through analysis of the data even as it is 'reduced' to language that is understandable to others. The goal of this type of research is not to make the data generalizable. Instead, validity emerges out of the team's interactive dialogue about the participants' responses, whether these emerge in the form of interview transcripts or, as was the case here, in the responses to the HAT questionnaires. In this study, we checked each other's assumptions (hidden or explicit) through extensive dialogue. This process may be seen as a 'bracketing' process, which is common to Husserlian phenomenological research (i.e., Denzin & Lincoln, 2005; Giorgi, 2009). The dialogal method does not 'set aside' or bracket assumptions; instead they are brought into the dialogue to assist the researchers in gaining a deeper understanding of the phenomenon under study and to serve as a 'check and balance' of interpretations.

With the exception of the lead author, none of the authors had experienced the treatment protocol. Instead of writing up our own personal descriptions of the treatment as is usually the case in the dialogal method, the initial study design involved several sessions where we discussed the protocol and reflected on the Mindful Body Awareness process. We agreed that some meaningful aspect of the experience of the treatment may have been lost if we waited too long following the session to interview the participants. Based on our dialogue we concluded that we needed a way to access participant experience soon after the sessions. We therefore selected the Helpful Aspects of Therapy (HAT; Llewelyn, 1988) questionnaire as a means of investigating the participants' experiences because the questionnaire asks participants to reflect upon their experiences immediately after the treatments. The HAT thus became our window into the lived experience of the treatment. When using the dialogal approach researchers typically first describe their own experience of the phenomenon under question and then proceed to develop the research interview questions based on this situation (Halling & Leifer, 1991). However, this was not possible for this research study as the team had not experienced the Mindful Body Awareness protocol. In keeping with the nature and spirit of the dialogal approach, this study aimed to engage with the phenomenon and use ongoing dialogue to give voice to the phenomenon. Consequently, the team engaged the phenomenon through the HATs and conversation around the experiences reported in them. As is frequently the case in dialogal research, there were many times when the phenomenon was mute to us, requiring us to enter into our own experience of the data together. This made for some very lively research team meetings.

We used mixed methods to triangulate qualitative and quantitative findings. Measures of body awareness and bodily dissociation have been examined in prior studies involving Mindful Body Awareness and are considered key underlying aspects of the therapy process. These measures were thus included to explore the relationship between pre- and post-response on these measures and the response to the HAT questionnaires. There is a wealth of commentary on mixed methods and their general usefulness (Creswell, Klassen, Plano Clark, & Smith,

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2011). A significant issue when conducting mixed methods research involves researchers overlooking, or simply being unaware of, the significant philosophical and epistemological differences that exist between research traditions. These differences necessarily call into question the compatibility of specific methods. Our team thoroughly discussed this issue at various points throughout the project. We concluded that our grounding in qualitative and phenomenological methodology did not hinder our work. Instead, this grounding served as the overarching theoretical and epistemological approach and gave voice to the experience. Our dialogal process therefore cohered and did not unduly influence the data with unresolved theoretical issues.

Recruitment Procedures and Data Collection

Four individuals were recruited for study participation through flyers posted at a university in north-western United States. Prospective participants were screened during the initial telephone contact using a standardized screening interview. Study inclusion required that participants be at least 18 years old and be able to attend sessions during weekday mornings. Study exclusions were current alcohol or drug addiction, current interpersonal violent relationship, current pregnancy, previous experience of receiving body therapy with an explicit focus on body awareness, or participant report of mental health diagnosis of schizophrenia, bipolar or dissociative identity disorder. Given the very small sample size, these exclusions were necessary in order to limit the heterogeneity of the sample and to exclude participants with mental health disorders that would be likely to inhibit therapeutic engagement. The first four individuals who were screened for study participation were eligible and chose to enroll in the study.

Eligible participants were scheduled for four weekly appointments, all of which took place on the university campus. At the initial appointment, the consent form and baseline measures were administered by a research assistant prior to the Mindful Body Awareness session. At the subsequent appointments, the participants met with the research assistant immediately following completion of the session to fill out a written questionnaire. At the fourth appointment, baseline measures were also administered. With the exception of one participant was unable to attend the third session due to a family emergency, all sessions were attended as scheduled.

Participants' Background Characteristics

The participants were all women. In terms of racial/ethnic identity one of the participants was Indian, two of the participants were African American, and one of the participants was Hispanic. All had graduate degrees and were between the ages of 41 and 52. All were employed and had prior experience receiving massage but none had received prior body-oriented therapy. Two of the four participants reported a chronic health concern related to a physical injury. None of the participants was currently undergoing psychotherapy.

This pilot study clearly made use of a sample that does not represent local or national demographics. However, as qualitative methods in general and the dialogal method in particular do not purport to make general statements about the 'general population' we were not particularly concerned about matching population characteristics in the study. Our strategy for ensuring validation was based on the systematic rigour applied to the analysis, deep immersion in the participants' responses, constant checks and balances for researcher bias (accomplished through the research approach), and verification of findings through prolonged and persistent analysis (Creswell, 2007).

Intervention Procedures

The body-oriented therapy approach Mindful Body Awareness was used in the therapeutic sessions. Mindful Body Awareness includes the components of Mindful Awareness in Body-oriented Therapy (MABT; Price et al., 2007), a research protocol developed by the lead author and used in previous body-oriented therapy studies. This approach focuses on teaching interoception, the process of accessing and processing sensory input from inside the body (Cameron, 2001), using touch-based techniques. The therapeutic process is guided by what is brought into the session through the verbal and non-verbal interaction throughout the session between the client/participant and the therapist.

For this study, the therapists were provided with guidelines to follow during the four Mindful Body Awareness sessions. Each session began with the participant and therapist sitting down and engaging in 15 minutes of discussion regarding the participant's current emotional and physical well-being. In addition, in sessions 2 to 4, the body awareness homework experience was also discussed during this time. The next 45 minutes of each session focused on the therapeutic elements of Mindful Body Awareness. These elements included massage with body literacy to develop identification and articulation of sensory awareness, training in interoception and mindful presence to learn to bring awareness to the internal body and the use of non-judgmental observation of physical sensations, emotions, thoughts, and memories that might surface during this practice. The therapist used touch to facilitate participant attention

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to inner body awareness and to assess participant presence in the body. During this interaction, the therapist's firm but light holding touch served as an anchor for the facilitation of focused attention. The use of touch also communicated the therapist's presence and attention to an area in the client's body, thus enhancing the overall concentrated focus on the client's internal experience. In this regard, the therapist's touch functioned as an external support of the Mindful Body Awareness process. This support is particularly useful for individuals who tend to dissociate or who have difficulty attending to somatic and emotional experience.

Throughout each session, reflective listening was integral to all verbal interactions with the participant. In this way, the intervention was responsive to the participants' immediate concerns within the therapeutic session, which included factors such as culture, religion, race, and gender. For example, one participant explicitly spoke about gender, while another client spoke about culture and religion as critical aspects of her intervention experience. In each case, the participant and therapist dialogued about aspects of the participant's experience that were integral to the session and its progression. During the session the therapists acknowledged the participant's concerns, and the subsequent therapeutic direction of the session was based on further exploration of the participant's present moment bodily experience. This environment of respect and exploration is characteristic of Mindful Body Awareness, and is aimed at facilitating participant curiosity and engagement in the unfolding therapeutic process (Blackburn & Price, 2007). The close attention paid to the implicit and explicit dimensions of dialogue (aided by the body-sensing of participant and therapist) is one of the strengths of this approach and may increase the trust level between participant and therapist.

During the final 15 minutes of each session, the participant and the therapist were seated again. During this time the session was reviewed in order to facilitate cognitive integration of experiential experience. Additionally, body awareness homework for the interim week was also identified.

The participants were clothed throughout the sessions. All sessions were recorded by a remote video camera operated by a research assistant.

Interventionists

The research clinicians, one male and one female, were licensed to practice massage in the state of Washington. Both clinicians had over 20 years of experience in practice as well as extensive training in body-oriented approaches, including Mindful Body Awareness.

Measures

The primary research instrument was the Helpful Aspects of Therapy questionnaire (HAT; Llewelyn, 1988), a written questionnaire that was administered immediately after each Mindful Body Awareness session. The HAT consists of the following three primary questions/statements: (1) Of all the things that occurred in this session, which one(s) do you feel were the most helpful or important for you personally?; (2) Please describe what made this event most helpful or important; (3) Did anything happen during the session that might have been hindering?

The Scale of Body Connection (SBC; Price & Thompson, 2007) was administered pre- and post-intervention. The SBC is a 20-item self-report measure of body awareness (BA) and bodily dissociation (BD). Respondents are requested to respond to items based on a 5-point scale, ranging from 0 (not at all) to 5 (all of the time). BA and BD are distinct and uncorrelated dimensions of body connection with demonstrated reliability. The 12 'body awareness' items measure conscious attention to sensory cues indicating bodily state (for example tension, nervousness, peacefulness). The 8 'bodily dissociation' items measure separation from body, including emotional disconnection (for example difficulty attending to emotion). The SBC has previously been used in studies involving Mindful Body Awareness and has demonstrated positive pre-post change (Price, 2005; Price, Wells, Donovan, & Rue, in press). In this study, the SBC was administered prior to the first session (pre-intervention) and following the last session (post-intervention).

Analysis

The method of analysis was primarily phenomenological and made use of an adapted dialogal approach (Halling & Leifer, 1991) that was appropriate for the setting. The adapted dialogal approach involved research meetings where we met as a team and discussed and derived the themes, thus re-presenting the experience of the treatment. The dialogal approach is characterized by collaborative interpretation among researchers and is particularly beneficial for gathering the multi-dimensional perspectives of a team (Halling, Kunz, & Rowe, 1994).

Our team included clinical and research expertise in the fields of Mindful Body Awareness, experiential phenomenology, and Focusing. The research team also included the two research assistants who had witnessed the actual sessions while video recording.

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Their observations helped in checking our independent interpretations during the team dialogue. For instance, the research assistants were able to report the more subtle non-verbal cues present during the treatment sessions and this assisted the entire team in getting a deeper sense of the interaction and thus 'correcting' our analysis.

As a team we looked closely at the participants' experience, deriving broad themes based on their HAT responses and our dialogue about participants' experience. Each team member brought a specific perspective to the dialogue, including knowledge of the treatment protocol, observation of participation treatment experience, and dialogical method, and thus contributed to the rigor of the interpretive process. As is usual in dialogal research this team valued the multiple perspectives that the team members brought to the project as this multiplicity of perspectives contributes to the overall richness of the final analysis. In particular, our group managed the inherent potential power dynamics (e.g. between experienced researchers and research assistants) successfully due in part to valuing and accepting each other's unique perspectives.

The dialogal analysis involved many meetings, each lasting several hours over the course of nine months. Each meeting began with a revisiting of the individual HAT responses for each of the three questions. We systematically reviewed the responses for patterns or themes. We began by analyzing the HAT responses across the four sessions for each individual to examine themes that emerged in relation to perceived helpfulness of the therapeutic process. Individual themes across all four sessions were then combined. This was followed by the 'phenomenological reduction' of eidetic singularities or patterns into general themes expressing the helpfulness of the treatment. At this point, we came to a deeper understanding of the structure of the phenomenon of perceived helpfulness and realized that we also needed to include an analysis of the changing and unfolding process across the duration of the intervention. We then went back to the data to examine the unfolding process across time by analyzing each participant's HAT responses session by session. In addition, descriptive statistics were used to examine participant characteristics and scale responses. It should be noted that although the sessions were video-taped we chose not to include these in our analysis. However, the tapes may be used for research purposes at a later time. We chose not to use the tapes as we felt that viewing the tapes might take us away from the richness of the written responses by 'adding another variable'. We are aware that this decision may lead to some debate; our hope was that staying with a particular source of data (the HATs) and then engaging in a thorough analysis would better serve our aims and help us to meet the goals of the research project.

Results

Perceived Helpfulness

Four themes emerged from the analysis of overall perceived helpfulness across the four participants. These themes were labeled as follows: a) interoceptive awareness; b) sense of personal agency; c) relationship with therapist that facilitated trust and conceptual framing of the therapeutic process; and d) transformative experience. Table 1 (page 11) provides quotes that exemplify each of these themes.

These themes all indicate positive change based on increased awareness of inner body experience or 'interoception'. The helpfulness of attending to bodily sensation, in particular the new or 'relearned' ability to access and interact with body through interoception, was a primary theme. The participants used various words and phrases (e.g. feeling *"the tension gradually travel[ing]"*) to describe the experience and processes of engagement with deep sensory awareness. The perceived helpfulness of interoception tended to involve a concomitant increase in emotional awareness. One participant described this as gaining the appreciation that it was permissible to experience her body and connect her emotional state to her physicality. It was as if the women reestablished (or established for the first time) a powerful link between body and emotion. Although the nuances present in the written descriptions of what was helpful are hard to capture definitively we nonetheless came to sense a kind of liberation present in the participants' responses as they acknowledged and then used their body sensing. This was a new experience for each of the participants and attending to bodily sensing proved to be an important theme in its own right. However, this theme was also carried forward in the other themes we identified.

'Personal agency' increased as a result of learning interoceptive skills and using interoceptive practice in the weeks between sessions. Citing the helpfulness of the structure provided by homework assignments as an example, participants reflected that they could now begin to see themselves as more powerful agents in their own world, something that they had not uniformly experienced prior to the study. One participant's statement that she now has *"he ability to make myself feel relaxed and good on my own"*, conveys this theme. Others articulated that they found learning the process of Mindful Body Awareness to be concretely useful in their everyday lives. Learning these skills strengthened, even emboldened, the women's inner sense of being intentional and was positive for their own growth.

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It may seem strange that we have chosen to label this theme personal agency, especially given the range and quality of responses that led to the articulation of the theme. During the identification of this theme, we came to appreciate the experience of other phenomenological researchers who have commented on the transformation of eidetic information (Giorgi, 2003; Halling, Leifer, & Rowe, 2006). Stepping back from the eidetic to a certain extent allowed us to see the patterns while keeping the sense of the eidetic alive in us.

It also became clear that the 'therapist played an important role in facilitating trust' and conceptual understanding of the therapy process. This was seen as a key helpful component of Mindful Body Awareness. In this regard, participants indicated the central roles their therapist played in providing knowledge, structure, accompaniment, and emotional support. As one of the therapists in this study was male this may have added a layer of hesitation to trust building between participant and therapist. We found that the presence of a male therapist certainly shaped the trust building experience of at least one of the participants, who explicitly commented on this factor. However, in the same response she conditioned her caution with an appreciation for his skills and compassion. This theme was therefore also a process and not a quickly earned state of affairs. As a result of our dialogue, we also came to see that the conceptual understanding of the therapeutic process could also be related to the high level of education and professional accomplishment that characterized our participants.

The fourth theme was labeled 'transformative experience'. Each participant reported a moving experience involving spiritual connection and/or new insight that resulted from deep interoception. In one case, a participant expressed a reconnection to her spiritual and cultural heritage and experienced a profound and moving sense of floating into the light. Another participant stated that she had finally felt the connection of her newfound bodily awareness and the pieces of her life. These pieces, which had once been disconnected, came into some coherence and she felt that this would aid her in her life. Whether subtle or dramatic, transformation was experienced in relation to Mindful Body Awareness. As researchers, we are very aware that several dimensions co-exist with this theme including personal backstories that we were not privy to, unspoken reactions to the therapist, and the closeness of written responses to the session. However, these 'hidden' dimensions could be seen as both inhibiting and assisting the theme. Of course, we cannot definitively know the influence of that which was not spoken.

Perceived Hindering

Two participants indicated that there was something that hindered their experience during a Mindful Body Awareness therapy session. For one participant, during session one she felt hindered by the fact that she was receiving touch-based therapy from a male therapist. The other participant was bothered by an internal discontent specific to being concerned about pressing responsibilities and this made it difficult for her to be as present as she would have liked to be in session one. In session two, her discontent was specific to the feeling "*that peace and healing is 'transient or 'intangible*." No common theme emerged across the two participants, and each of these hindering aspects appeared to be resolved in later sessions.

Therapeutic Progression Across Time

The next step in the analysis was based on the following question: "Is there a clear pattern in the responses to what was helpful about Mindful Body Awareness across time that may point to underlying processes in the therapeutic trajectory?" In order to answer this question we examined the four participant responses chronologically to determine whether there was a pattern of change that emerged across time.

We found that for each week of the therapy, there was a pattern to the responses across participants that suggests a progression in interoceptive awareness and integration of experiential learning (see Table 2, page 12).

Interoceptive awareness and the benefits associated with that awareness appears to have increased each week. Integration was apparent in the cognitive/ theoretical processing of the interoceptive experience, and in the cognitive links and processing related to the relationship between bodily awareness and interactions with others/environment in daily life.

Specifically, the themes in session 1 reflect the primary components of the therapy process, including sensory and emotional awareness and the connection between these two forms of awareness, the development of the therapist/client relationship, and the application of embodiment in relation to daily life. Participants spoke of the importance of finding and feeling the connection to their inner life and external circumstances. As Table 2 shows, the participants' development of trust in the therapist and in their own processes (a new appreciation for some) was pivotal in developing a deeper connection with their body awareness.

Session 2 themes reflect increased body sensing awareness and cognitive framing of the session

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experience. As the women's body sensing deepened, we saw them begin to articulate its effects as a coherent (though eidetic) and still emerging understanding of the therapy process. In other words, the women reflexively put words to their experience of the process, framing its impact in ways that matched their own schema. However, the experience did not exactly fit existing ways of understanding themselves. One participant noted that in the second session she was able "*to relax into this. This, then, made it possible for me to think less with my head and more with my body*". Another participant experienced deep emotion and commented on her ability to stay present in the experience. A third example involves a participant's experience of interoception and the growing link between embodiment theory and practice that developed in the client-therapist interaction. The therapy process generally helped the women to find new ways to talk about their inner experience. It should not be surprising that none of the participants settled into a single formal understanding of the importance of the therapy for them. These themes instead captured something that is clearly ongoing and emerging.

The theme in session 3 reflects a therapeutic shift (symptom reduction, transcendent experience, and/or empowerment) that emerged from the continued development of deep interoception. This theme, expressed as discovery, was conveyed with startling poignancy. It seemed as if a brand new understanding had emerged, either as a result of the previous session or as a result of the body awareness practice done at home. One participant reflected that the shifts she experienced occurred "*in a consciousness raising manner.*" We see these shifts as relating to the participants' increasing awareness of their ability to connect to their bodies through interoception. We also take these reflections as an indication that the participants are agents in their own lives, which for them is also a matter of being more consciously embodied.

The theme in session 4 reflects increased integration of interoceptive experience in daily life through an expanded sense of self. In this last session, participants took stock of their entire experience and forged new territories for further exploration. One participant even experienced a spiritual event described as levitating, "*being carried into the air.*" This experience was not one of leaving the physical body but was instead a deep recognition of body. For the participants, increasing awareness expressed itself as a different or new relationship with their body and the importance of 'being in' their body.

Pre-Post Body Awareness and Bodily Dissociation

Pre-post change in body awareness and bodily dissociation was examined through quantitative measures. Two participants had a large pre-post increase in body awareness as well as a large reduction in bodily dissociation. The other two participants showed little pre-post change on either dimension. The participants with improved scores had low baseline body awareness scores and high baseline bodily dissociation scores. In contrast, the participants with no substantial change had higher body awareness scores and lower bodily dissociation scores at baseline. These results suggest that the scale was a better indicator of change among the participants with less optimal body connection than for individuals with good body connection as all four individuals' qualitative responses indicated positive change in awareness and association to body.

Discussion

This is the first study to examine the session-by-session experience of participants receiving Mindful Body Awareness treatment. The study presented an opportunity to examine the immediate perceived helpful aspects of the approach, as well as an opportunity to investigate factors that might hinder the therapeutic experience. Finally, the study was also able to examine the progression of the therapy process across time. According to the findings, participants' perceptions of the helpfulness of Mindful Body Awareness are related to interoception, sense of personal agency, therapist-client communication and trust, and transformative experience. Participants in this study benefited from the process in both anticipated and unanticipated ways. For instance, although we anticipated that the treatment would result in some progression of body awareness we did not anticipate the spiritual and lifeworld changes the participants experienced. Similarly, we anticipated that the presence of a trusting, trusted, empathic and skilled practitioner would be a positive element in the process, but we did not anticipate the high importance the participants attached to the therapist. We wondered whether this aspect of the experience had something to do with the fact that these were highly educated women who were familiar with the routine of education even though this process was unlike any other form of education they had received. In regards to this point, we saw in the HATs various indications of which particular aspects of the therapist the various participants considered to be important. However, these indicators remained eidetic and were not shared across participants.

The hindering aspects of experience were minimal. Although some of these aspects may potentially have become larger issues, they were each discussed within the context of the session and appeared to be resolved. It is likely that the use of check-in time at the beginning of each session as well as Mindful

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Body Awareness's emphasis on reflective listening helped facilitate the discussions and led to the abatement of these hindering aspects.

The perceived helpfulness themes of gaining interoceptive awareness, the importance of trust in the participant-therapist relationship, and improved sense of personal agency are similar to themes that have emerged in previous studies of Mindful Awareness in Body-oriented Therapy. In previous studies, these themes have been identified post-intervention and have been used to describe the important experiences associated with receiving the intervention (Price, 2005, 2006; Price, et al., 2007; Price, Wells, Donovan, & Brooks, 2012a, b).

The results of this study contribute to the literature by providing a more detailed description of the session-by-session process. This detailed process description illuminates the role of interoception in the embodiment experience, the possibility for transformative experience evolving from deep interoception, and highlights the change that can happen in a very short period of time, particularly in healthy women. There appear to be incremental building blocks toward embodiment in the Mindful Body Awareness process for which interoception, and level of interoception, is fundamental. As we reviewed the HAT responses, we were particularly aware of the sense of potential integration between session experience and daily life. Attention to, and reflection on, this interaction seemed to be facilitated by the daily homework that the participants undertook between sessions. This was exciting data because we were able to see some of the steps that contribute to greater embodiment in the short four session process. We were particularly struck by the ways that Mindful Body Awareness practice facilitates the link between sensation and emotion, and how useful this was in the embodiment process. Our team saw how potent an increase in embodiment could be in positively affecting the participants' relation to and action in daily life. Several of our participants experienced shifts in their relationships to existing issues of daily life (for example, demands of partners, work, childcare, and commitment to health and spirituality for instance) that they characterised as significant.

This increased sense of embodiment was reflected in the overall pre-post improvements in body awareness and bodily dissociation. However, the degree of pre-post change on the SBC for the two participants with higher baseline scores in both body awareness and dissociation was not reflective of the qualitative level of positive change reported in these participants' HAT responses. In other words, the gains in therapy were not well reflected in the pre-post scale (SBC) responses for the participants who were already bodily aware. These results suggest that the scale was a better indicator of change for the participants with less optimal body connection. All four individuals' qualitative responses indicated positive change in awareness and association to body. This suggests a ceiling effect on the SBC when used with highly aware samples.

Based on the results of this study it would be possible to conclude that this therapy is best suited for high functioning and highly educated persons. However, previous studies have used a similar intervention process called Mindful Awareness in Body-oriented Therapy (MABT) and have demonstrated the feasibility, acceptability and preliminary efficacy of eight individual MABT sessions in the reduction of mental and physical health symptoms among women with a wide range of current functioning (employment) and educational backgrounds in substance use disorder treatment (Price, Wells, Donovan, & Rue, in press), and in recovery from sexual trauma (Price 2005, 2006; Price et al., 2007). Instead, the results of the current study, which indicate large gains in embodied self-awareness over the course of only four sessions, suggest that fewer sessions may be needed to achieve similarly therapeutic gains for high functioning, educated, healthy women. This finding is important, particularly given the emphasis on pathology in both intervention studies and in scale development. This is one of the first studies concerning the use of mind-body therapies to promote wellness among healthy individuals.

We conclude by returning to the general philosophical considerations addressed earlier. This study explored Merleau-Ponty and Gendlin's conversation about the nature of body. Based on the results of this study we suggest that this new approach to body therapy, with its focus on felt-sense and the articulation of this sense, does in fact facilitate the deepening of the relationship to the self as whole and sentient. The fractious framing of body as parts, heralded by Merleau-Ponty and Gendlin as deadening to our basic nature, is confounded by our results. The participants' responses show that body is whole, although distinctions arise as we attend to and follow its living presence. The distinctions of feeling, sensation, or cognition do not perturb our relationships to ourselves. Instead, through the use of the Mindful Body Awareness treatment modality these sensations quicken the experience of integration and change.

It is clear to us that the combination of learning and experiencing deep interoception, client-therapist discussion to facilitate framing of the experience, and the integration of Mindful Body Awareness in daily life (facilitated by body awareness homework) were integral to the perceived benefits of Mindful Body Awareness. These aspects of the therapeutic process

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were also integral to the change processes reported by participants. These change processes were expressed in the themes of interoceptive awareness, personal agency, therapist trust and conceptual framing, and transformation.

This was a very small study, based on only four case studies, and the findings are thus not generalizable. However, the findings do provide a picture of how the aspects of Mindful Body Awareness may facilitate an increased sense of self based on the integration of interoceptive awareness with awareness of self in the world. In western society, the internal is often avoided and the skills for attending to interoceptive information are not developed. The use of touch to develop interoception is unique and the findings of this study point to Mindful Body Awareness as a powerful approach to teach interoceptive skills and integrate experience in the facilitation of embodiment and therapeutic change.

Future analysis based on this study is planned, involving audio-taped post-intervention interviews with participants and investigation of therapists' responses to the HAT. This further research aims to further inform research and clinical practice using the Mindful Body Awareness approach.

Table 1: Perceived Helpfulness of Mindful Body Awareness

Themes	Quote examples
Interoceptive Awareness	*The tension gradually traveled down my neck, to my shoulder blades, past my lower back, into my buttocks, down the back of my thighs and calves, and then out through my toes. This was the first time I actually was aware of tension as a moving force that could be systematically guided towards exiting the body.*
Sense of Personal Agency	*That I have the ability to make myself feel relaxed and good on my own. I have the tools I need to work on my breathing.*
Relationship with Therapist Facilitated Trust and Conceptual Framing of the Therapeutic Process	*I had to hug her [the therapist] at the end of the session. I felt comfortable because she asked me to speak my mind, even when I asked her to move away. I felt I could ask for what 'I' wanted, rather than be aware of what she might want from me.* *It was most helpful for the therapist to explain the idea of the 1st versus 3rd person perspective of being 'in' one's body. This is something I will have to concentrate on because of the way I have learned to relate to my physical self.*
Transformative Experience	*Unbelievable, when {the therapist} had her hand on my heart and shoulder and I was breathing and becoming aware of my heart/heartbeat, I felt the most incredible sensation of levitation- rising into light. I felt happy and almost like I was going to heaven- no exaggeration."*

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Table 2: Therapeutic Process Pattern Across Time

Themes by Session	Quote examples
Session 1	
Experience sensation/ emotion link	*Finding a place to feel okay about 'feeling' and connecting emotion to physicality ... being able to rightfully associate feelings directly with the body. I had no idea I was repressing my body so much in the respiratory system and in my stomach, especially because of deep feelings.*
Importance of therapist – client interaction	*My body responded well and trustingly to {therapist's} gentle manipulation of my vertebrae and muscles. He was skillful and served as a good guide in encouraging me to be aware and responsive, both physically and verbally.*
Reflect on body experience in daily life	*It was good for me to understand how the aspects of the physical work being done relates to the normal activities I have and do in day- to- day life.*
Session 2	
Increased "feeling"	*... it was easier this time to relax into this. This, then, made it possible for me to think less with my head and to feel more with my body... both from without and from within.*
Link between theory and experience of embodiment	*I feel like my tears come rushing out and flow freely. I feel like I can stay with this feeling of grief and healing.* *I felt how my ankle and my head are almost attached by an invisible, intangible string. I could use my head to loosen the tension on/around my ankle. [The therapist's] holding specific points on my ankle and asking me to visualize my feelings. I could feel myself resting.*
Session 3	
Interoceptive experience is linked to experience of symptom reduction and sense of personal agency	*Identifying specific locations where I feel stress or tensions and focusing on how to use my breath and thoughts to enter those places and relieve my tension or stress.* *The realization that I have learned several things about my breathing in the previous session that I am actually using daily. The discovery that I can actually visualize my insides/ through my breathing. I discovered through the therapy that there is a tunnel in my chest- and explored the possibility of thinking about other parts of my body in a consciousness raising manner.*
Session 4	
Deepened interoception is accompanied by a more expansive sense of self	*I could 'feel' more acutely the sensations that are able to be felt. I was able to feel again (like the last time) that feeling of lightness, of levitating, being carried into the air and into a light of some sort. It was calm and beautiful. The tears I felt welling up-in gratitude toward a connection with my spiritual side.* *I become more aware of how to feel different parts of my body ... I liked gaining a new awareness of what it means to 'remember.' As a dancer my best moments are when I am in my body. I am realizing I can and should always be in my body.*

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