

Russian Academy of Sciences
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Quality of Life Research

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Rhythmic ***Movement***
Psychotherapy

Working Paper

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Introduction

*Remember where you came from,
where you're going, and why you created
the mess you got yourself into in the first place.*

Richard Bach "Illusions"

What is Quality of Life? Many definitions exist, some of them are presented below.

QOL may be defined as subjective well being. Recognizing the subjectivity of QOL is a key to understanding this construct. QOL reflects the difference, the gap, between the hopes and expectations of a person and their present experience. Human adaptation is such that life expectations are usually adjusted so as to lie within the realm of what the individual perceives to be possible. This enables people who have difficult life circumstances to maintain a reasonable QOL.

- Janssen Quality-of-life Studies

The best way of approaching quality of life measurement is to measure the extent to which people's "happiness requirements" are met - i.e. those requirements which are a necessary (although not sufficient) condition of anyone's happiness - those 'without which no member of the human race can be happy.'

- McCall, S.: 1975, 'Quality of Life', Social Indicators Research 2, pp 229-248

Quality of Life is tied to perception of 'meaning'. The quest for meaning is central to the human condition, and we are brought in touch with a sense of meaning when we reflect on that which we have created, loved, believed in or left as a legacy.

- Frankl VE. 'Man's search for meaning.' New York: Pocket Books, 1963.

In quality of life research one often distinguishes between the subjective and objective quality of life. Subjective quality of life is about feeling good and being satisfied with things in general. Objective quality of life is about fulfilling the societal and cultural demands for material wealth, social status and physical well being.

- Quality-of-Life Research Center, Denmark

The approach to the measurement of the quality of life derives from the position that there are a number of domains of living. Each domain contributes to one's overall assessment of the quality of life. The domains include family and friends, work, neighborhood (shelter), community, health, education, and spiritual.

- The University of Oklahoma School of Social Work

There are essentially two perspectives taken in quality of life research: *social indicators* research which considers the elites' valuation of what the people need, and *conventional quality of life* research which studies what people want, in order to improve their quality of life.

- Quality of Life, Ramkrishna Mukherjee, Sage Publications, 1989.

Thus, quality of life is, by definition, a subjective concept, dependent on cultural perspectives and values. Values, the attributes of our world that we believe are functionally important, morally good, or personally desirable, are derived from our individual perspectives.

Our age, ethnicity, gender, socioeconomic status, education, health, religion, occupation, etc shape our perspectives. These differences in personal experience lead us to different beliefs about what is important, good, or desirable. These beliefs, or values, determine not only what we believe makes good quality of life, but also what conditions represent a quality of life problem.

We all would like to have a high quality of life, live a happy, healthy and fulfilled life, yet few seem to be able to do just that. Why must we have so much suffering, failures and disappointments? We just want to be secure in a loving relationship and a satisfying job with a good income and enjoy ourselves.

Instead, our relationships turn sour all too soon, we have a job that we do not like or we do not have one at all, there is never enough money and generally there is not much joy to be found anywhere. As a result we feel resentment, hopelessness, depression, perhaps also anger and hatred. Where and why did it all go wrong?

We can be happy or at least accepting in adversity and unhappy when we seem to have everything. What decides how we will react and how we will feel inside? It is no secret to psychologists that we are programmed since earliest childhood by everything that went on around us, but especially by the way our parents talked to us and to each other, by the way they felt and reacted and by the interactions with our siblings. Observing and imitating our role models programmed us.

If we were lucky and grew up in a happy and loving family, we probably have an inner program that makes it easy for us to lead a happy life in a loving relationship. If, on the other hand, there was much worry, anger, resentment and other negativity in our childhood, chances are that we will have a hard time being happy and loving as adults. That probably applies to most of us, we are victims of negative programming, during childhood.

Our feelings, our beliefs, our physical body, and the longings of our hearts are truly an unbreakable, wonderful unit serving as one. What happens in one part of us effects the other parts, as well as our entire being? In fact, the body/mind connection can no longer be ignored by any of us, including those in the helping profession.

Over the years our bodies become walking autobiographies that reflect the major and minor stresses of our lives. In the vicious cycle of body/mind pathology our body's tight patterns contribute to our locked-in-mental processes. We cannot separate mental from physical, fact from fantasy, or past from present. Just as the body feels the mind's grief, so the mind is constricted by the body's stubborn memory of what the mind and nerves used to feel. The recognition of this fact takes many psychologists on a different journey with their clients, one, which integrates the body as well as the psyche in order to improve their overall quality of life.

Techniques which embrace this concept are being used more and more by psychologists and psychotherapists to assist their clients in releasing blocked emotions and processing childhood wounds, attitudes, belief systems, and soul yearnings locked in their bodies. More often than not, pain and physical illness can be linked to emotional stress, trauma, abuse, or major loss.

The brochure is presenting the original author's program of rhythmic movement psychotherapy that is the synthesis of body-oriented psychotherapy, dance-movement therapy and rhythmic gymnastics (aerobics) approaches. Rhythmic movement psychotherapy is founded on the principle that a vital connection exists between personality and the way in which one moves, and that changes in movement behavior affect the emotional, intellectual, and physical health of the individual. Rhythmic movement psychotherapy is a form of psychotherapy, which uses rhythmic movement as a medium of change. Through body action - the most basic form of communication - a dialogue emerges that tells of an individual's relationship to self, others, and the environment. By working with movement patterns, and by focusing on the interrelationship

between psychological and physiological processes, individuals are helped to reveal, release, and transform internalized feelings, conflicts, and desires.

Feelings are experienced in the body. We protect ourselves from pain by deadening our bodies, by tightening our muscles and by not breathing enough. Discomfort with the body is endemic in our culture. The basic view underlying the concept of rhythmic movement psychotherapy is that the expressive aspects of a personality, in its gestures, movements, and postures, are a function of the individual totality. Given this totality, it is therefore theoretically possible to provide effective therapeutic intervention at any level of these behavioral modes, due to the phenomenon of their interaction. Rhythmic movement psychotherapy can be a powerful tool for stress reduction, relaxation, anger management, and the prevention of physical and mental health problems. By utilizing the rhythmic movement, patients increase their understanding and expression of feelings, recognize options, develop coping skills, increase focus and concentration, increase self-esteem, recognize strengths, accept limitations, learn to relax and hence work towards maximum integration.

Rhythmic movement psychotherapy help you to know what you feel, understand why you feel it, express what you feel, and act on the basis of your true feelings, enhance feelings of well-being by bringing you in-touch with your body. Listening to the "messages" of your body promotes the confidence of knowing when you are doing the right thing for you. Also, it helps with a wide range of psychosomatic ailments by supporting a person in understanding and becoming comfortable with their emotional sources.

We regard the objectives mentioned above as the milestones in the achievement of a high overall quality of life of each person.

Quality of Life: Dimensions

*Every person,
all the events of your life
are there because you have
drawn them there.
What you choose
to do with them is
up to you.*

Richard Bach "Illusions"

The global interest and research into what is meant by the quality of life has increased significantly in the past 10-20 years, notably within medical science, health care and rehabilitation.

The term Quality of Life (QoL) has been widely used in a number of disciplines to express the idea of personal wellbeing in a framework, which goes beyond the simple economist equation of wellbeing with income. Quality of life is generally used as the overarching concept, which encompasses income (and therefore consumption) but also includes other factors, which contribute to wellbeing (Jacobs, <http://www.comp.lancs.ac.uk/sociology/esf/papers.htm>).

The literature on quality of life generally fails to distinguish between the quality of individual lives and the quality of the collective life of a society (or a place) as a whole.

The starting place for most QoL studies has been the subjective experience of wellbeing of the individual. However the attempt to measure this has involved an inexorable slide towards a non-individual perspective. People's subjective perceptions of their wellbeing are so clearly non-comparable, and affected by expectation and social comparison, that attention quickly turned to the identification of objective conditions which influence subjective experience: people's objective state of health, for example, rather than their feelings of wellness. But many of these objective conditions are not (or cannot be measured as) peculiar to the individual at all. The quality of air, the level of education or indeed the level of employment, all requires collective or aggregate measurement. So the quality of life gradually became, for many researchers, a description of the collectively experienced conditions of a society or place, with only an indirect and contingent relationship to the subjective experience of wellbeing of individuals.

In the hands of Greens, this process has been taken further. Concerned to argue that the social costs of economic growth have increased to the point where they now outweigh the benefits of higher income, green writers have included factors such as loss of natural habitats, global warming and increasing inequality to their concept of quality of life. Yet these factors are not elements of personal wellbeing at all. They are components of the quality or health or sustainability of society as a whole. Their value is not derived from the aggregate wellbeing of individuals, but independently, from a conception of what constitutes a good society.

There are thus two related but separate concepts: individual QoL and social QoL. This is particularly important in relation to environmental goods. Some environmental goods and costs directly affect individual QoL - air quality, for example, or traffic congestion. But many do not. Natural habitats do not make me better off personally, nor does reducing the risk of global warming to future generations. These contribute rather to the health or quality of society. The same is true of many social or shared goods, including cultural goods which many people do not use themselves, such as universities and public service broadcasting.

Of course social QoL contributes to individual QoL: (some) individuals feel better off when they live in a better society. But this is not the justification for pursuing social QoL. They are logically separate. Conversely, individual QoL should contribute to social QoL: a society would not be very good or healthy if its natural habitats were preserved and inequality eradicated but its people were all stressed at work and going through divorce. If people feel that social QoL contributes to their own personal QoL this indicates a self-identification with, or feeling of membership of, society. Politically this would appear to be an important prerequisite for defending social goods whose contribution is to social QoL.

The simplest definition of individual QoL is the *subjective feeling that one's life overall is going well*. Note that this differentiates QoL from 'happiness', which tends to connote too transitory and emotional a condition. 'Overall' is intended to define QoL as the overarching judgement of how all the different elements of one's life combine together.

There are three problems with this definition, however. The first is that it can only be measured subjectively, by asking people about their own QoL. This raises all the familiar problems of subjective measurement, its reliability and comparability. The second is that QoL in this definition relies heavily on the character and dispositions of the individual. A person may be rich, successful in their job, healthy and happily married and *still* not feel their life is going well, perhaps because they have unfulfilled personal goals or simply because they have a depressive personality. If we say such a person does not have a good QoL, as we will have to on this definition, the concept becomes more or less meaningless in terms of public policy and research.

The third problem is the converse of this. Subjective satisfaction with one's life is strongly related to one's expectations of it. Expectations in turn are related to social position: people compare themselves to others in their self-perceived social position. Low expectations achieved lead to higher subjective reporting of QoL than high achievement that fails to meet expectations. This leads to the apparent conclusion that one way to increase QoL is to reduce people's expectations. Yet this fails to account for the desirability of personal growth and development, of the accomplishment of challenging individual life goals.

These problems suggest a definition of QoL not in terms of overall subjective experience, but as *a set of conditions relating to an individual's life that would appear to indicate, from outside, that it is going well*. This definition accepts that it may not, in fact, capture the subjective perception of overall wellbeing, but makes a generalized claim that - if these conditions obtain - in most cases it will.

The crucial distinction between the two definitions is not between subjective and objective measurement. Many of the factors, which contribute to QoL on the second definition, require at least a partial element of subjective measurement. It is between QoL as an 'overall' judgement and QoL as a set of separate conditions or factors, which contribute to this judgement. Whereas the individual can only make the 'overall' judgement, the separate factors can be observed and presented by the social researcher. There is no need, in fact, to combine them into a single 'overall' measure of QoL. To do so requires procedures for commensuration and weighting which will inevitably involve disputable value judgements.

International research into the quality of life tends to divide life into a number of domains, which are then studied separately. These domains might be physical, psychological and social; physical and mental health; emotional and cognitive dimensions, for example, happiness and satisfaction with life; the ability to function bodily, sexually, socially and occupationally; objective status in terms of finances, working conditions, family conditions, etc. The subject answers a number of questions on how well he or she is doing in these various aspects of life. The responses are scored, weighted and combined in various ways, thus giving us a quality-of-life rating scale.

Researchers seldom stop to contemplate why certain life domains are included while others are not. Establishing what domains are and are not relevant (should sex life be included?

should political attitudes be measured?) presupposes an overall theory of what the quality of life is, what makes a good life and what life is all about. The lack of a theoretical framework is a decisive weakness in much of the empirical research on the quality of life. Many of the leading researchers within the field have pointed this out. If practical research is to move forwards, it will have to rest on a sound theory: nothing is as practical as a good theory.

Multiple factors act and interact in determining one's quality of life, as Wilson and Cleary (1995) and others have observed. Thus the idea of assessing quality of life along multiple "dimensions" implies a departure from a simple linear scale with excellent quality of life at one end and greatly diminished quality of life at the other.

Numerous taxonomies of life domains have been proposed by social, psychological, gerontological, and health sciences researchers based on studies of general populations of both well and ill people. A typical taxonomy is that of Flanagan (1978), which categorizes 15 dimension of life quality into five domains, as shown below:

Physical and material well-being

- Material well-being and financial security
- Health and personal safety

Relations with other people

- Relations with spouse
- Having and rearing children
- Relations with parents, siblings, or other relatives
- Relations with friends

Social, community, civic activities

- Helping and encouraging others
- Participating in local and governmental affairs

Personal development, fulfillment

- Intellectual development
- Understanding and planning
- Occupational role career
- Creativity and personal expression

Recreation

- Socializing with others
- Passive and observational recreational activities
- Participating in active recreation

UNDP (1997) has been publishing the annual Human Development Index (HDI) for countries around the world. It examines the health, education and wealth of each nation's citizens by measuring:

- life expectancy
- educational achievement - adult literacy plus combined primary, secondary and tertiary enrolment; and
- Standard of living - real GDP per capita based on PPP exchange rates.

Ontario Social Development Council (1997) proposes that Quality of Life is the product of the interplay among social, health, economic and environmental conditions, which affect human and social development. The purpose of the Quality of Life Index (QOLI) is to provide a tool for community development, which can be used to monitor key indicators that encompass the social, health, environmental and economic dimensions of the quality of life in the community. The QLI can be used to comment frequently on key issues that affect people and contribute to the public debate about how to improve the quality of life in the community. It is intended to monitor conditions, which affect the living and working conditions of people and focus community action on ways to improve health. Indicators for the QOLI include:

- Social: Children in care of Children's Aid Societies; social assistance beneficiaries; public housing waiting lists etc.
- Health: Low birth weight babies; elderly waiting for placement in long term care facilities; suicide rates etc.
- Economic: Number of people unemployed; number of people working; bankruptcies etc.
- Environmental: Hours of moderate/poor air quality; environmental spills; tones diverted from landfill to blue boxes etc.

How does QOL compare with 'Standards of Living'? Standards of Living is a measure of the quantity and quality of goods and services available to people. It measures such aspects as GDP Per Capita, life expectancy, Births/1000, Infant Mortality/1000, Doctors/1000, Cars/1000, TV/1000, Telephones/1000, Literacy levels, %GDP spent on Education, %GDP spent on Health, Cinema attendance, Newspaper circulation, Fertility Rate, Density, Population per dwelling, etc. Quality of Life is the product of the interplay among social, health, economic and environmental conditions, which affect human and social development.

The following categorization of Quality of Life concept is proposed by Jacobs (<http://www.comp.lancs.ac.uk/sociology/esf/papers.htm>):

- (1) Income and consumption
- (2) Health:
 - Physical
 - Mental (stress, depression, happiness)
- (3) Relationships:
 - Family
 - Friends
- (4) Satisfaction with:
 - Job
 - Leisure
- (5) Personal autonomy:
 - 'Free' time (in which activities can be 'chosen')
 - Life opportunities and choices
- (6) Security, of:
 - Person
 - Income, employment, housing etc
 - Lifeworld, including environment
- (7) Personal development: accomplishment, personal growth
- (8) Social goods contributing to individual wellbeing:
 - Environmental (air quality, townscape, etc)
 - Social (low crime, social order)
 - Public services (education, health, parks, etc)
- (9) Social goods contributing to a good society:
 - Environmental (natural habitats, risks)
 - Cultural (museums, art galleries, etc - if not used)
 - Ethical (equality, reduction in poverty, etc)
 - Government (democracy, etc)

Quality of Life Research Unit, University of Toronto (<http://www.gdrc.org/uem/qol-define.html>) definition of quality of life is: The degree to which a person enjoys the important possibilities of his/her life. Possibilities result from the opportunities and limitations each person has in his/her life and reflect the interaction of personal and environmental factors. Enjoyment has two components: the experience of satisfaction and the possession or achievement of some characteristic, as illustrated by the expression: "She enjoys good health."

Three major life domains are identified: Being, Belonging, and becoming. The conceptualization of Being, Belonging, and Becoming as the domains of quality of life were developed from the insights of various writers (<http://www.utoronto.ca/qol/concepts.htm>).

The Being domain includes the basic aspects of "who one is". Belonging includes the person's fit with his/her environments. Becoming refers to the purposeful activities carried out to achieve personal goals, hopes, and wishes.

Each life domain has three following sub-domains:

Being	Who one is
Physical Being	<ul style="list-style-type: none"> · physical health · personal hygiene · nutrition · exercise · grooming and clothing · general physical appearance
Psychological Being	<ul style="list-style-type: none"> · psychological health and adjustment · cognitions · feelings · self-esteem, self-concept and self-control
Spiritual Being	<ul style="list-style-type: none"> · personal values · personal standards of conduct · spiritual beliefs
Belonging	Connections with one's environments
Physical Belonging	<ul style="list-style-type: none"> · home · workplace/school · neighborhood · community
Social Belonging	<ul style="list-style-type: none"> · intimate others · family · friends · co-workers · neighborhood and community
Community Belonging	<ul style="list-style-type: none"> · adequate income · health and social services · employment · educational programs · recreational programs · community events and activities
Becoming	Achieving personal goals, hopes, and aspirations
Practical Becoming	<ul style="list-style-type: none"> · domestic activities · paid work · school or volunteer activities · seeing to health or social needs.
Leisure Becoming	<ul style="list-style-type: none"> · activities that promote relaxation and stress reduction
Growth Becoming	<ul style="list-style-type: none"> · activities that promote the maintenance or improvement of knowledge and skills · adapting to change.

A person's assessment of satisfaction with life involves two subjective considerations: how important a given domain is for that person, and how satisfied one is with that domain. One can be unsatisfied with a domain that one considers to be of relatively little importance, and thus maintain a satisfactory overall quality of life. Dissatisfaction with a domain of great importance to an individual, however, would clearly contribute to lower overall life quality.

Discussion of QoL generally assumes that the relationship between income and QoL is unproblematic. Higher incomes allow higher consumption levels, and people are assumed to buy goods and services because they contribute to their QoL. In fact the relationship between consumption and QoL is not quite so simple (<http://home2.inet.tele.dk/fclk/what.htm>). The quality of personal relationships is not affected by income. In some cases there are society-wide relationships with income, which do not apply to all individuals: this applies to physical health, job satisfaction, personal development. Many affluent people do not experience high quality in these aspects of their lives; many poorer people do. In the case of social goods, these are not bought individually but provided through collective regulation or public spending. Higher individual income may enable a person to move to an area with (say) better environmental or crime conditions but it may not. However, those who perceive their general financial situation as bad, have a lower quality of life.

The type of job we have has no direct bearing on our quality of life. The essential thing is that we are content with our work, and have good relations with our colleagues.

In relation to health, life quality is often perceived as being less impaired by an objective diagnosis than by self-experienced inconvenience brought about through an illness. This indicates that modern medical treatment is not always aimed at optimizing life quality.

Quality of life has almost no connections with differences in consumption of alcohol or tobacco, eating habits or physical exercise.

These mean that in relation to the measured quality of life, it is unimportant what we are objectively (i.e. our sex, height, education, occupation, etc.), our quality of life is, to a high degree, connected to how we feel about ourselves. These mean that we need a model that could be able to give important insights into questions such as how quality of life interacts with aspects of life like illness, lifestyle, personal relations and material well being.

Taking into consideration the presented ideas we might be well advised to raise the question: do such strategic deliberations also call for an understanding of the psychodynamics involved in the encounter between environmental considerations and everyday life? Could it be that psychology, with its preoccupation with individual wellbeing, could contribute to our knowledge of *quality of life*? We compared the quality of life domains proposed by various authors with the hierarchy of human needs proposed by Abraham Maslow, the leader of the humanistic school of psychology that emerged in the 1950s and 1960s, which he referred to as the "third force" beyond Freudian theory and behaviorism. Abraham Maslow's theory states that people are constantly motivated by needs (Maslow, 1943). A classic presentation of these ideas is embodied in the following "hierarchy of needs":

1. Physiological
2. Safety
3. Belonging
4. Self-Esteem
5. Self-Actualization
6. Self-Transcendence

The first need is physiological. This includes things such as food, water, and oxygen. This need is one of the strongest motivators. This need has two unique features: 1) it can be completely or overly satisfied, and 2) it is a reoccurring need.

The next step in the hierarchy is the need for safety. After our physiological needs have been met, we are now motivated by our desire and need for safety. Stability, dependency, physical security, and freedom from illness, anxiety, and danger are just a few things we seek. The need for law and order also falls under the heading of safety.

If these first two needs are not met, a person will develop basic anxiety. Failure to have these needs met will result in problems as adults. A person will become neurotic and feel unsafe because of irrational fears carried over from childhood.

The need for love and belongingness is next. The need for love, friendship, a mate, a family, and the need to belong to a club, nation, or neighborhood mark this level. Many people remain stuck at this stage by constantly trying to be loved and accepted. This often happens when a person is partially denied. Someone who has never had love and affection will go a long time without love. Eventually, the person will devalue love. On the other hand, a person who receives love and is then denied will become rooted in this stage. Only by receiving adequate love can a person continue to develop.

Esteem needs are next. Maslow defined two levels of esteem needs - self-esteem and reputation. Self-esteem is a person's own feelings of worth and confidence, whereas reputation is based on recognition and prestige that is reflective of other people's opinion. Most people desire to be confident in their own eyes rather than in other's.

The final stage is self-actualization. People who are self-actualized are aware of their full potential and are capable of achieving it. They do not allow society or culture to deny them their basic needs. Many people never reach this stage of development. They will meet their other needs, but fail to progress further. Maslow said this was because people do not embrace the Being-values or B-values. These are the highest level of needs and are called "metaneeds." Maslow identified 14 B-values: truth, goodness, beauty, wholeness, aliveness, uniqueness, perfection, completion, justice and order, simplicity, totality, effortlessness, humor, and autonomy. When denied these values, we become pathological. When we are denied humor, we become somber, denied truth we become paranoid, denied justice we become fearful.

Each need builds upon its more basic neighbors. So, needs for safety can be adequately met only after one has met one's physiological needs such as food and sleep. Likewise, the wish to belong in a relation, a family, an organization, a culture, or a society, necessarily requires that one has realized a level of safety. By adequately satisfying the demands of a level, we are more fully freed to pursue issues relating to higher levels of self-expression and communication. Self-esteem, the liking and acceptance of oneself by oneself, is a pivotal level in the enfoldment of human awareness. With it, we are enabled to weather the stormy seasons of daily life; without it, we are lost ships at sea. By believing in the basic goodness of ourselves, we can allow ourselves to grow and blossom. If we don't fundamentally accept our own spirit, then we shall have little cause to support activities that can help us. Once, the landmark of self-acceptance has been secured, a person can work to achieve interesting and meaningful goals. Such purposeful and consistent effort will, in time, be successful and result in self-actualization, the shaping of one's life to accord with one's highest values and goals.

We have spoken so far as if this hierarchy was a fixed order but actually it is not nearly as rigid as we may have implied. It is true that most of the people have seemed to have these basic needs in about the order that has been indicated. However, there have been a number of exceptions.

There are some people in whom, for instance, self-esteem seems to be more important than love. This most common reversal in the hierarchy is usually due to the development of the notion that the person who is most likely to be loved is a strong or powerful person, one who inspires respect or fear, and who is self confident or aggressive. Therefore such people who lack love and seek it, may try hard to put on a front of aggressive, confident behavior. But essentially they seek high self-esteem and its behavior expressions more as a means-to-an-end than for its own sake; they seek self-assertion for the sake of love rather than for self-esteem itself.

There are other, apparently innately creative people in whom the drive to creativeness seems to be more important than any other counter-determinant. Their creativeness might appear not as self-actualization released by basic satisfaction, but in spite of lack of basic satisfaction.

In certain people the level of aspiration may be permanently deadened or lowered. That is to say, the less pre-potent goals may simply be lost, and may disappear forever, so that the

person who has experienced life at a very low level, i. e., chronic unemployment, may continue to be satisfied for the rest of his life if only he can get enough food.

Another cause of reversal of the hierarchy is that when a need has been satisfied for a long time, this need may be underevaluated. People who have never experienced chronic hunger are apt to underestimate its effects and to look upon food as a rather unimportant thing. If they are dominated by a higher need, this higher need will seem to be the most important of all. It then becomes possible, and indeed does actually happen, that they may, for the sake of this higher need, put themselves into the position of being deprived in a more basic need. We may expect that after a long-time deprivation of the more basic need there will be a tendency to reevaluate both needs so that the more pre-potent need will actually become consciously prepotent for the individual who may have given it up very lightly. Thus, a man who has given up his job rather than lose his self-respect, and who then starves for six months or so, may be willing to take his job back even at the price of losing his a self-respect.

Perhaps more important than all these exceptions are the ones that involve ideals, high social standards, high values and the like. With such values people become martyrs; they give up everything for the sake of a particular ideal, or value. These people may be understood, at least in part, by reference to one basic concept (or hypothesis) which may be called 'increased frustration-tolerance through early gratification'. People who have been satisfied in their basic needs throughout their lives, particularly in their earlier years, seem to develop exceptional power to withstand present or future thwarting of these needs simply because they have strong, healthy character structure as a result of basic satisfaction. They are the 'strong' people who can easily weather disagreement or opposition, who can swim against the stream of public opinion and who can stand up for the truth at great personal cost. It is just the ones who have loved and been well loved, and who have had many deep friendships who can hold out against hatred, rejection or persecution.

Summarizing the ideas, presented above we assume that psychological aspects of quality of life are relevant for people in "first", "second" and "third world" countries, even when poverty with all its limiting consequences is a major problem. As we've already mentioned, there is no necessary connection between life satisfaction and the life expectancy at birth or the per capita income. Rather the individual's perception and assessment of her/his own life course and certain life events (like marriage, birth of a child, unemployment, disease or death of the partner) will influence it. As we know from life event research, initiated by Holmes and Rahe (1967) and Dohrenwend and Dohrenwend (1974), the same events can have different psychological meanings to a person. Besides *personal* interests and goals the psychological meaning depends on the *environmental* context in which an event occurs (Neugarten and Datan 1973). Therefore Goodhart and Zautra (1990) regard quality of life as a function of person-environment relations (drawing on Lewin's (1951) statement that behavior is a function of person and environment). From a life event perspective also Lazarus' transactional model of stress experience can be considered for viewing quality of life (Lazarus and Launier 1978, Lazarus 1990, Folkman 1984). According to Lazarus humans have to be seen as pro-active individuals who act on the basis of certain cognitive appraisals about the self (e.g. on the basis of self-perceptions, causal attributions, locus of control, coping abilities, values and goals) and about certain situational demands. Person-related psychological abilities as well as norms and standards provided by the social context of a person play a role in person-environment transactions. The judgments of a person about her own personality result from her interaction with others. This was also thematized in Rogers' (1951) work about the "self-concept" which refers to individual perceptions about one's own abilities and characteristics (<http://boleswa97.tripod.com/plattner.htm>).

In further discussion we regard Self-concept as the central focus in our approach to Quality-of-Life.

Quality of Life and Self-concept

*You're always free
to change your mind and
choose a different future, or
a different
past.*

Richard Bach "Illusions"

Self-concept may be defined as the totality of a complex, organized, and dynamic system of learned beliefs, attitudes and opinions that each person holds to be true about his or her personal existence. Self-concept is different from self-esteem (feelings of personal worth and level of satisfaction regarding one's self) or self-report (what a person is willing and able to disclose). It has been established by contemporary researches that the way an individual perceives himself goes to shape his behavior patterns.

A milestone in human reflection about the non-physical inner self came in 1644, when Rene Descartes wrote Principles of Philosophy. Descartes proposed that doubt was a principal tool of disciplined inquiry, yet he could not doubt that he doubted. He reasoned that if he doubted, he was thinking, and therefore he must exist. Thus existence depended upon perception.

A second milestone in the development of self-concept theory was the writing of Sigmund Freud (1900) who gave us new understanding of the importance of internal mental processes. While Freud and many of his followers hesitated to make self-concept a primary psychological unit in their theories, Freud's daughter Anna (1936) gave central importance to ego development and self-interpretation.

By far the most influential and eloquent voice in self-concept theory was that of Carl Rogers (1947) who introduced an entire system of helping built around the importance of the self. In Rogers' view, the self is the central ingredient in human personality and personal adjustment. Rogers described the self as a social product, developing out of interpersonal relationships and striving for consistency. He maintained that there is a basic human need for positive regard both from others and from oneself. He also believed that in every person there is a tendency towards self-actualization and development so long as this is permitted and encouraged by an inviting environment (Purkey and Schmidt, 1987).

Nevertheless, until now self-concept is also an illusive and often poorly defined construct. Reviews of literature have found at least 15 different "self" terms used by various authors (Strein, 1993). Terms such as "self-concept," "self-esteem," "self-worth," "self-acceptance," and so on are often used interchangeably and inconsistently, when they may relate to different ideas about how people view themselves.

Several authors have defined self-concept. William James (1890) holds it to be all that a person is tempted to call by the name me or mine. Murphy (1947) defines it as the individual as known to the individual. According to Symonds (1951), it is the way or manner in which the individual reacts to himself. He spells out four aspects of self: i. how a person perceives himself; ii. what he thinks of himself; iii. how he values himself; and iv. how he attempts through various actions to enhance or defend himself.

Sherif and Cantril (1947) use the term "ego" and define it as the constellation of attitudes of the type "what I think of myself, what I value, what is mine, and what I identify with." According to them, these attitudes, when activated, energize, direct and control the person's behavior.

Franken (1994) states that "there is a great deal of research which shows that the self-

concept is, perhaps, the basis for all motivated behavior. It is the self-concept that gives rise to possible selves, and it is possible selves that create the motivation for behavior".

Perhaps the most important distinction that differentiates various conceptualizations is whether self-concept is viewed as an overarching, global characteristic of the person, or as a set of self-evaluations specific to different domains of behavior. The global view, sometimes conceptualized as "self-esteem" or "general self-concept," is the older and probably the more common view (Strein, 1993).

In contrast to the traditional model of global self-concept, multifaceted models stress self-evaluations of specific competencies or attributes, for example, academic self-concept, physical self-concept, and so on. Although some theoretical models are hierarchical, with global self-concept at the apex, most of these models stress the distinctiveness of various self-concept facets. Consistent with research findings, most published self-concept measures now emphasize domain-specific self-concepts:

1. Physical dimension: Your physical dimension refers to your physical makeup. This would include such variables as height, weight, appearance, physical abilities, overall health, coordination, ease and quality of movement, ability to translate mental thought into physical action, nutrition, etc.

2. Intellectual Dimension: Your intellectual dimension refers to your mental abilities such as your abilities to problem solve, make decisions, critically evaluate information, understand the complexities of the surrounding world, to express yourself orally and in writing, to convince others of your position rationally, etc.

3. Emotional Dimension: Your emotional dimension refers to your feeling self. This would include your ability and willingness to experience emotions, your ability to express emotions, and your ability to respond to emotional expression in others. It would also include your ability to accept/display both positive and negative emotions.

4. Social Dimension: Your social dimension refers to how you see yourself in relation to other people. This would include such variables as your willingness to initiate new relationships, ability to carry on a conversation, level of comfort in dialogue, feelings of belongingness, ability to be assertive, etc.

The value of seeing ourselves in these four dimensions with their numerous "sub-dimensions" is that we can understand that all of us have strengths and weaknesses in each dimension and, as a result, to so intensely focus ourselves on one dimension is unfair and unkind to ourselves. For instance, society tends to measure us a lot by the physical dimension, but to focus on that exclusive of the rest ignores the majority of who we are.

There are two processes we must go through as we develop our self-concept. First, we must get an awareness of what our traits and behaviors are--our "self-image." We do this in two ways: self-appraisal and feedback from others. Second we must evaluate the desirability of those traits (our "self-esteem"), and we do this by applying criteria to our self-image.

Our self-appraisal is our own individual perception of our traits and behaviors. The feedback we get from others is a way we validate our self-appraisal. As we become aware of our traits, we evaluate them in terms of desirability.

In order to evaluate anything, including our traits and behaviors, we must compare those traits and behaviors to something. Through our fields of experience we have collected standards by which we measure ourselves. These standards come from all your experiences including family, friends, church, media, and your own thoughts. We use these to judge ourselves (and others too, but we are often much harsher on ourselves than on others.)

If your standards are internal standards, standards you have decided are right and reasonable for you, you can maintain a healthy sense of balance between setting goals for yourself for personal growth and feeling a sense of achievement. In other words, you have goals to reach, but they are attainable given your traits and abilities; they are not unrealistic.

The danger arises when we fall prey to external standards, standards that are thrust

upon us by societal forces: family, friends, media, etc. For instance, consider the unrealistic standards our entertainment industry sets for physical appearance for both males and females. Consider too why advertising, for example, has a vested interest in keeping those standards beyond what your present self is-it keeps us buying their products to try to meet those false standards. Another example is our tendency to measure ourselves in terms of material possessions or money. If we don't have the right type of car, house, clothing, hairstyle, and on and on, we aren't "with it." The way to be "with it" is to buy something that someone else says you ought to have, wear, use, etc. This is such a danger to our self-esteem because as one matures, the search for self-esteem can lead you into a more and more frantic attempt to meet these unrealistic standards.

In this frantic attempt, we easily fall prey to the "fallacy of oughts." The fallacy of oughts is the mistaken belief that we must satisfy everything we ought to be, ought to do, and ought to buy. These oughts are the products of our society, our peers, our colleagues and advertising. These are the standards we mistakenly feel we have to live up to. Once we get caught in the trap, we start masturbating, the act of abusing ourselves with attempting to meet this powerful and overwhelming world of oughts. We constantly strive to fulfill the external standard, ignoring our internal standards.

Thus these internal and external standards have an important dynamic. If we are under the influence of our internal standards, we use those standards to then evaluate the external ones, assimilating those that measure up, tossing aside those that don't. If we are under the influence the external standards, however, our internal ones often fall by the wayside as they get so overwhelmed and buried in the onslaught of external forces.

It is also becoming clear that self-concept has at least three major qualities of interest: (1) it is learned, (2) it is organized, and (3) it is dynamic. Each of these qualities, with corollaries, follows. As far as we know, no one is born with a self-concept. It gradually emerges in the early months of life and is shaped and reshaped through repeated perceived experiences, particularly with significant others. Most researchers agree that self-concept has a generally stable quality that is characterized by orderliness and harmony. Each person maintains countless perceptions regarding one's personal existence, and each perception is orchestrated with all the others. It is this generally stable and organized quality of self-concept that gives consistency to the personality. To understand the active nature of self-concept, it helps to imagine it as a gyrocompass: a continuously active system that dependably points to the "true north" of a person's perceived existence. This guidance system not only shapes the ways a person views oneself, others, and the world, but it also serves to direct action and enables each person to take a consistent "stance" in life. Rather than viewing self-concept as the cause of behavior, it is better understood as the gyrocompass of human personality, providing consistency in personality and direction for behavior.

Self-concept can also refer to the general idea we have of ourselves and self-esteem can refer to particular measures about components of self-concept. Some authors even use the two terms interchangeably. Self-esteem generally refers to how we feel about or how we value ourselves.

Self-esteem is a personal evaluation of one's worth as a person. It measures how much you respect yourself

- ◇ physically: (how happy you are with the way you look)
- ◇ intellectually (how well you feel you can accomplish your goals)
- ◇ emotionally (how much you feel loved)
- ◇ morally (how you think of yourself as a person)

How you see yourself affects every part of your life. High self-esteem makes for a happier life. It allows you to be your own person and not have others define you.

Self-esteem, self confidence and self-respect are all related. Self esteem is also defined as the judgments a person makes about himself or herself and is affected by self-confidence and

respect. Self-confidence believes in our ability to take action and meet our goals. Self respect is the degree, to which we believe we deserve to be happy, have rewarding relationships and stand up for our rights and values. All these factors affect whether or not we will have a healthy body image.

Franken (1994) suggests that self-concept is related to self-esteem in that "people who have good self-esteem have a clearly differentiated self-concept. When people know themselves they can maximize outcomes because they know what they can and cannot do".

James (1890) states that the intervening variable is personal expectations. His formula is:

$$\text{Self-esteem} = \text{Success} / \text{Pretensions.}$$

That is, increasing self-esteem results when success is improved relative to expectations. An interesting corollary to this equation is that expectations and self-esteem limit success:

$$\text{Success} = \text{Pretensions} * \text{Self-esteem.}$$

This equation states that success, especially the limits of one's success, can be improved by increasing expectations and/or self-esteem.

Bednar, Wells, and Peterson (1989) define self-esteem "as a subjective and realistic self-approval". They point out that "self-esteem reflects how the individual views and values the self at the most fundamental levels of psychological experiencing" and that different aspects of the self create a "profile of emotions associated with the various roles in which the person operates...and (that self-esteem) is an enduring and affective sense of personal value based on accurate self-perceptions." According to this definition, low self-esteem would be characterized by negative emotions associated with the various roles in which a person operates and by either low personal value or inaccurate self-perceptions.

In an examination of developmental considerations, Bednar, Wells, and Peterson (1989) suggest that feelings of competence and the self-esteem associated with them are enhanced in children when their parents provide an optimum mixture of acceptance, affection, rational limits and controls, and high expectations. In a similar way, teachers are likely to engender positive feelings when they provide such a combination of acceptance, limits, and meaningful and realistic expectations concerning behavior and effort (Lamborn et al., 1991). Similarly, teachers can provide contexts for such an optimum mixture of acceptance, limits, and meaningful effort in the course of project work as described by Katz and Chard (1989).

The matter of what constitute appropriate criteria of self-esteem cannot be settled empirically by research or even theory. These criteria are deeply imbedded within a culture, promoted and safeguarded by the culture's religious, moral, and philosophical institutions.

One's self-concept sets limits on one's behavioral possibilities in several ways. The first of these is that, by virtue of one's self-assigned-status, one may appraise oneself as ineligible for many forms of valued life participation. When one considers certain commonly encountered, global, self-assigned statuses such as "unlovable," "irrational," "inadequate," "incompetent," "worthless," or "inferior," one can easily see that, by virtue of their ascription, persons have declared themselves ineligible for various forms of participation in life. To believe oneself "unlovable," for example, is to appraise oneself as ineligible for the love of another person. To believe oneself "irrational" is to appraise oneself as ineligible to render logical, well-grounded judgments and decisions, a perceived ineligibility that is vast in its behavioral implications (Bergner et al., <http://www.sdp.org/sdp/selfconcept.html>).

A second limitation imposed by a person's self-concept is captured well in the expression: "I could never do that and still be me." Here, individuals are bound by self-concept in such a way that, being whom they take themselves to be the action in question is unthinkable as something they would or could do. In their minds, it would so violate who they are that, should they do it, they could no longer take themselves to be the same person, but would be forced to see themselves as a different (and usually distinctly lesser) person (Ossorio, 1976;

Rogers, 1959). In general, this constraint serves as a force for social good insofar as for most people antisocial acts such as child abuse or murder are "unthinkable" or "something I just could never do." However, at other times, this constraint proves debilitating in people's lives because crucially needed actions have become for them such unthinkables (e.g., leaving a destructive relationship, or defending their rights in an assertive and forceful manner).

A third and final type of limitation imposed by the self-concept is on what a person will take to be the case about the world. Essentially, persons will "read" the world in ways that are in keeping with their self-concepts. For them, this will be "just the way the world is." To have a self-concept is, in the end, not just to have a certain appraisal of oneself--it is to live in a certain world.

The present account of the self-concept ties together a wide variety of observed empirical phenomena and regards the self-concept a single causal/explanatory source lying at the heart of a wide array of factors crucial to the quality of persons' lives. Changes in it may therefore be expected to result in changes in these many factors and thus to have a profound impact on the overall quality of these lives.

In further discussion we regard the physical dimension including health as a central focus of self-concept in our approach to Quality-of-Life.

Quality of Life and Body/Mind Connection

*You are
never given a wish
without also being given the
power to make it true.
You may
have to work for it,
however.*

Richard Bach "Illusions"

More than fifty years ago the World Health Organization (WHO) defined health as the “complete state of physical, mental, and social well-being and not merely the absence of infirmity” (WHO 1948). In its definition the WHO acknowledged that an individual who is technically “cured” of disease may not necessarily be “well” and went on to indicate three dimensions of well-being. *Physical well being* assumes the ability to function normally in activities such as bathing, dressing, eating, and moving around. *Mental well being* implies that cognitive faculties are intact and that there is no burden of fear, anxiety, stress, depression, or other negative emotions. *Social well being* relates to one’s ability to participate in society, fulfilling roles as family member, friend, worker, or citizen or in other ways engaging in interactions with others.

The WHO declaration resonated with ongoing developments in the social sciences as theoreticians recognized the need for multiple indicators in assessing health and treatment outcomes. These efforts led to definitions of “health-related quality of life”. The determination of the health-related quality of life of an individual is implicitly made against a cultural background that includes a set of values, standards, customs, and traditions associated with a particular society.

The anthropology and ethnography literature is rich in references to the ways in which different cultures at different times and places have regarded the human body. Cultural beliefs regarding the body, health, and disease are often embedded in religious or spiritual traditions, which in turn may govern how diseases and disorders are regarded and treated.

In the medical model typical of Western society the body is partitioned into organs and systems, each with identifiable functions. The body is seen as functioning well unless disease disrupts it. Diseases in themselves are understood to be invariable across cultures. The medical model has traditionally dichotomized body and mind/soul/spirit—science and magic. Such a perspective sees the body as relatively objective and value-free, immune to nonsomatic influences.

That perspective began to change with the pioneering work of Hans Selye in the 1930s on the importance of stress in health and disease. Research in the intervening half century has confirmed the reciprocal connections of the nervous, endocrine, and immune systems, not only in relation to stress, but also in terms of the effects of emotions and cognitive processes on health status.

With the arrival of the "New Age" hundreds and thousands of people in the western world have been talking about "The Body Mind Connection". In all fairness, though, this is not new information for most of the world. In China, India, and Japan (to name just a few places) the body and the mind have been inseparable and complementary parts of human existence. Chinese Medicine and Ayurvedic (Indian) Medicine weave together the fabric of the mind and the body as one whole. From these perspectives it is impossible to fully evaluate disease of sickness without looking at all aspects of an individual's life, not only the physical, but the

emotional, and spiritual as well.

Many people are uncomfortable with ideas that suggest that their minds can make them sick or well. Not only does this seem "far out", it implies that if one is not well, it is his or her fault. Unfortunately, this is a much too common misinterpretation of the relationship between the mind and the body.

What makes this idea so difficult for most of us is that we've grown up in a society in which the most available and accepted form of medicine is one in which we relinquish our powers for healing. We go to the doctor with the expectation (and sometimes the plain and simple demand) that she or he makes us well, or at least are able to tell us what is wrong. I certainly do not blame myself for accepting these teachings, they're part of our culture: "The doctor knows best;" "If the suffering are 'psychosomatic,' i. e. not real;" "any type of medicine other than western, allopathic medicine is quackery and will only cause harm". From this understanding, illness is something that happens to us, something going wrong, and we need to go to a medical expert to make things "right" again. In the process, though, we give over our responsibility (and the power that goes with it) for our own health to another person, our chosen healer.

The difference today, as many both in and out of the medical community are coming to recognize, is that we are now learning that healing takes place on all levels, that the power of the mind and the strength of our emotions are equal partners with our physical bodies. Our bones represent our ancestry. They are solid; they are genetically influenced. Our muscle and soft tissues represent our life history; they are influenced by the work we do the stress we feel the habitual postures we hold. Our skin represents the present moment. Here we feel the winter breeze on our face, the hug of a loved one, the pain of physical abuse.

The body and the mind are very intimately connected. We have all heard this said, but perhaps we don't always grasp the meaning of that statement. It is hard to really understand that the body and all its physical manifestations are influenced by and actually reflect the state of the mind. So too, the mind is influenced and is affected by the body-self. We also tend to treat our bodies in a way that corresponds to our mind's state.

Feelings are both emotional and physical. In fact, before we are aware of experiencing emotional feelings, as small children, we only know physical feelings. Many emotional feelings are associated with physical manifestations, because that is how babies know their feelings! All feelings are originally body feelings. "Feeling good" is originally a reflection of body satisfaction, that is a feeling of being warm, safe, dry, satiated, etc. Fear is originally a body sensation, when the electrical energy of the body surges quickly from a stable baseline to an intense high. We are born with the capacity to discriminate such affect states, each of which reflects a different routing of electrical energy, from low to high or high to low, for example, with different grades of intensity. It is this combination of direction of electrical energy and intensity of change that led to the specific feeling. Of course, the baby does not know he or she is having a feeling of, say, disgust or shame or fear. The baby is responding to the physical change in energy. It is only later that the baby learns, from the mother or other caretaker, that the feeling he or she is having is called "happy," "angry," or "frightened." The body is the first knower of the experience.

Our language has captured this close association between body and mind. When we say "it's a pain in the neck," or "I got weak in the knees", we are referring to physical manifestations of emotional feelings. Fear often does indeed manifest as a weakening in the knees, and a neck pain often does reflect being overburdened, or otherwise overwhelmed. Something beautiful does soothe the vision ("a sight for sore eyes"), and disgust does manifest as nausea ("it made me sick to my stomach").

Many people live in their heads, in fact, most of us do! We have trouble recognizing that, for every feeling, we have a place in the body where we feel it! In fact, most people cannot tell you what they are feeling, let alone where they are feeling it! If you ask most people what

they are feeling, they will answer you with a thought. "How do you feel about that?" They will say, "I think she shouldn't do that", or "I'm used to it," or "I think it will work out better this way." Do you see how far away from feelings these answers lie?

For many people, this connection between mind and body is a mystery. After all, to those raised in a western culture, this holistic perspective is a very different look at our bodies. We probably grew up with our bodies treated in separate units, as has been the case in traditional western medicine for centuries. A separation of the mind and body is the mindset many of us still have in looking at our lives and our health.

Diseases thought to be caused, at least in part, by emotional factors are known as psychosomatic disorders. The term comes from the Greek psyche, meaning "spirit" or "soul," and soma, meaning "body" and refers to the effect of the mind on the body's health. Other terms used to describe psychosomatic disorders are psychophysiological disorders, psychogenic diseases, and organ neuroses (http://www.optonline.com/comptons/ceo/03889_A.html).

In psychosomatic disorders, repeated emotional stress can cause dysfunction or structural damage in the body's tissues, organs, and organ systems by chronically stimulating the involuntary nervous system and the glands of internal secretion. This process is in contrast to disorders caused by bacterial or viral infections. A headache, for example, can stem from a common cold or from muscle tension caused by stress. The headache of a cold disappears when the infection is gone, but headaches from continued emotional stress may be self-perpetuating. Tightened muscles in the neck, shoulders, and back increase the person's stress, which in turn increases tension in the muscles, which increases stress--setting up a vicious cycle. Chronic tension headaches often progress to chronic back pain, which can become disabling.

Franz Alexander and his colleagues at the Chicago Institute proposed the theory of psychosomatic disorders in the 1950s and 1960s for Psychoanalysis. They suggested that specific personality traits and specific conflict situations created particular psychosomatic disorders. For example, asthma was thought to result from a conflict between the need for dependency (wheezing was a symbolic cry for mother) and the fear of dependency. If the condition persisted over several years, it could result in damage to the respiratory system. Patients with peptic ulcers were thought to equate the need for love with the need for food, much like an infant. As a result, the stomach continuously secreted digestive enzymes that eventually damaged the stomach lining.

The body's reaction to stress can result in a variety of ailments: high blood pressure (hypertension), peptic ulcers, bronchial asthma, migraine headaches, ulcerative colitis, insomnia, skin diseases, and allergies. As in the case of all psychosomatic disorders, patients are usually unaware of the emotional conflicts underlying their conditions. This fact can make it difficult for a physician to diagnose the true cause of a psychosomatic disorder. A hypertensive patient, for example, may not know that he is repressing his anger and may believe instead that he is cooperative and mild-mannered.

Psychotherapeutic approaches then are used to help patients express emotions more constructively and to resolve long-term emotional conflicts. We propose the original method of body-oriented psychotherapy named Rhythmic Movement Psychotherapy. As well as many other body-centered therapies Rhythmic Movement Psychotherapy can

- Help you to know what you feel, understand why you feel it, express what you feel, and act on the basis of your true feelings.
- Enhance feelings of well being by bringing you in-touch with your body.
- Bring about greater clarity in making decisions and conducting relationships. Listening to the "messages" of your body promotes the confidence of knowing when you are doing the right thing for you.
- Promote feelings of "wholeness" by relating to the physical, mental, emotional and spiritual aspects of your being as equally significant and intimately related to each other

- Improve the quality of both personal and professional relationships by working directly with your style of relating.
- Reduce stress by helping to free chronic muscular constrictions using emotional and physical exercises and, where appropriate, massage.
- Help with shyness and timidity using the practical means of expression and role-play.
- Increase your energy by reducing the paralyzing effect of inner conflicts and by the oxygenating effect of breath-work.
- Reduce blocks to creativity by encouraging action and attention in the here-and-now as well as by looking at the deeper reasons for holding oneself back in one's work.
- Address sexual problems, lessening inhibition and confusion, by maintaining a commitment to frank discussion and by looking at the dynamics of sexual relationships.
- Help with eating disorders by emphasizing the embodiment of emotional phenomena as well as the emotional subtext of physical experience.
- Help with a wide range of psychosomatic ailments by supporting a person in understanding and becoming comfortable with their emotional sources (<http://www.bodymind.freeuk.com/>).

We accept that Rhythmic Movement Psychotherapy can improve person's quality of life through positive change of his/her self-concept.

What is Rhythmic Movement Psychotherapy?

*Learning
is finding out
what you already know.
Doing is demonstrating that
you know it.
Teaching is reminding others
that they know just as well as you.
You are all learners,
doers, teachers.*

Richard Bach "Illusions"

Rhythmic Movement Psychotherapy (RMP) is a body-based group therapy grounded in interpersonal, object-relations theory, and rhythmic movement analysis. Within a safe, therapeutic relationship RMP helps individuals express through movement and dance that which cannot be put into words.

RMP is founded on the principle that a vital connection exists between personality and the way in which one moves, and those changes in movement behavior affect the emotional, intellectual, and physical health of the individual.

People enter psychotherapy looking for a way to change. In rhythmic movement psychotherapy, as we talk about our life problems that bring us into therapy, we begin to recognize that our current condition is directly related to our inability to respond to new situations in our life. Our physical form and corresponding personality pattern is not physically and emotionally flexible enough to move with and integrate the excitation produced in some new situation. We are therefore unable to respond appropriately or in a fulfilling manner to our life's demands. While we must respect the creative solutions that we found to childhood conflicts and emotions around terror, abandonment, manipulation, and rejection, our stereotypical ways of being must be analyzed and understood as survival patterns.

Rhythmic Movement Psychotherapy is a technique for

- Understanding the personality in terms of the body;
- Improving all functions of the personality by mobilizing the energy bound by rhythmic movement;
- Increasing an individual's capacity to experience pleasure by resolving the characterological attitudes that have become structured in the body and that, therefore, interfere with its rhythmic and unitary movements.
- Enhancing confidence, personal growth, self-esteem and an individual sense of belonging.

Rhythmic Movement Psychotherapy uses the body as the media of change because:

- Feelings are experienced in the body.
- We protect ourselves from pain by deadening our bodies, by tightening our muscles and by not breathing enough.
- Discomfort with the body is endemic in our culture. It is an important factor in emotional distress.
- If we think too much about our problems and try to find solutions by purely intellectual means, there is a danger of ending up more and more "in our heads" and forgetting to experience life (<http://www.bodymind.freeuk.com/>).

Rhythmic movement therapy does not provide an alternative to the traditional talk-

therapy, but simply an aide. It helps the conscious mind to integrate preverbal ideas, emotions, and conflicts into its understanding of self. Patients are not always ready to reveal their best-kept secrets to even the best of psychiatrists, and sometimes they do not even know what exactly is affecting them. This is where the natural ability of every person to move comes in. Movement is something that all people are capable of (unless completely paralyzed), and in this way is not difficult to integrate into a therapy session. In rhythmic movement sessions, rhythmic movement is used in the loosest of terms to describe a series of movements performed by the patient. The trained rhythmic movement therapist is able to gain a more thorough understanding of the patient's mental state by closely examining the way in which the patient moves his or her body. The movements themselves will help the patient to express his or her emotions and uncover hidden memories or images by allowing preverbal thoughts to come to the surface.

The widespread emotional misery in our society has much to do with our diminished capacity for feelings, especially for tender, loving feelings. If at all, we seem to experience these only for a short period in our life when we fall in love and then yearn for them ever after.

The repression of our feelings has much to do with the male inspired cultural priority placed on the intellect in our society with a corresponding contempt for soft and tender feelings that are regarded as feminine. It is easier to gain power, to dominate and build an empire if one is not hindered by sentimental feelings. With their present bid for equal power, even many women cannot afford any more to be vulnerable and they steel themselves against feminine softness.

In addition, self-control is highly valued, especially in the Anglo-Saxon culture. We are not supposed to show anger or even displeasure but rather be outwardly polite while we may boil inside. Only in recent years has it become more acceptable to show tenderness in public, but even so, cuddling and touching, except in a ceremonial way, are still largely constricted to those who identify with the 'New Age Movement'. Conventional members of our society are as rigid and inhibited as ever.

We may say that our emotional dilemma arises from two sources. One is the suppression of our feelings enforced by the standards of our society and the other is the lack of role models for the development of tender feelings in our childhood.

Emotions, if not released in outward action, solidify by causing muscle contractions. The stronger the energetic charges of the emotion, the stronger the muscle contractions. Other parts of the body, on the other hand, may be more or less blocked off from the flow of emotional energies, and these parts will become weak and start wasting. By examining our body, we can get a reasonably good idea of the kind of emotional problems that have helped to shape it and, furthermore, of the corrective measures to be taken in order to improve ourselves.

Muscle armoring is a concept discovered by Wilhelm Reich (1949), an eminent psychiatrist and at one time the apparent heir to the position of Sigmund Freud. Reich found that the emotional disorders of his patients were to an amazing degree reflected in their body structures. In particular, patients with repressed feelings commonly had hard, rigid and permanently contracted muscles in certain areas of their body. Different kinds of negative emotions seemed to be associated with specific muscles.

Reich compared these rigid muscle structures to the armor of a medieval knight and called the process of their formation 'armoring'. While the steel armor of the knight had the purpose of protecting him against physical aggression, the muscle armor serves to protect us against emotional aggression.

At first glance it may sound somewhat far-fetched that contracted muscles should have anything to do with how we feel. But we can easily observe ourselves that we become tense when we are apprehensive, while our muscles relax when we are at ease. When we expect someone to cause us pain, such as sticking a needle into us or hitting us, we automatically tense our muscles and we may even hold our breath by contracting our diaphragm.

These are automatic body reflexes designed to diminish the expected feeling of pain. However, we may use the same mechanism if we want to diminish feelings for other reasons. As an infant we may have been afraid of being separated from our mother, of being left alone in a strange surrounding, so we tensed up and held our breath. Eventually we had to continue breathing but we did it rather shallow with contracted diaphragm and chest muscles.

With repeated fear responses these muscle contractions may gradually become permanent. The child may grow to develop a narrow chest with weak lung functions or if only the diaphragm remains contracted, a barrel chest may result. In both instances breathing remains permanently shallow and the child is susceptible to lung infections and asthma. The advantage of the armored chest or permanently contracted diaphragm is that we now do not feel our fear any more, it remains subconscious. However, we gradually may develop substitute outlets of our fear, such as being afraid of heights or of public speaking, and so forth.

Another example is the suppression of anger because we are told that it is not socially acceptable to show it openly. We may initially feel an angry emotion rushing upwards from the abdomen to the shoulder in order to hit out or to the throat to shout. When we suppress these impulses the emotional energy of the anger becomes stuck in the shoulder or in the throat and tenses the muscles tension there.

If this tension is not released by other means it may become permanent and if we continue our suppressive behavior pattern, these muscles become permanently severely contracted. In joints surrounded by contracted muscles we easily develop arthritis, while contracted throat muscles give us a weak voice and possibly stuttering and other speech and throat problems.

The muscle armoring becomes stronger and stronger with advancing age because we tend to repeat our set behavior pattern over and over again. This then forms our distinctive facial features, our body structures and our increasing rigidity. There are, of course, other factors that contribute to shaping our body and making it more inflexible, such as heredity, nutrition and occupational muscle use.

Another aspect of armoring is the generation of pain. The resistance of a contracted muscle to the flow of energy produces pain similar to the heat produced by the resistance of a thin wire to the flow of electricity. Short-term muscle contraction uses energy, therefore it causes no pain and can be used as a defense against expected emotional or physical pain.

However, if a muscle remains contracted with continued energy flow, pain is produced either directly or noticeable as tenderness only when the muscle is pressed. Finally, in a permanently contracted muscle that has become like a rope or sheet, the energy flow to the area is so diminished that there is no pain, even when pressed. Repeated deep muscle massage may eventually restore energy flow and temporary pain to the muscle. Some individuals can clairvoyantly perceive these energy flows.

Our emotions have a strong influence not only on our glands and inner organs but also on our external body structure. Certain emotions are traditionally linked with problems in certain organ functions. Anger, for example, damages the liver and conversely, irritability and quick temper are partly caused by liver problems. In a similar way, grief, negativity and anxiety are linked to the lungs; fear to the kidneys and intestines; excessive laughter or lack of joy to the heart; and worry to the spleen.

The same emotions and suppressed feelings that shape our body and are expressed in our 'body language' form also our character. Wilhelm Reich believed that without suppressed feelings we would not have a character, as we know it. We would all be open, free and loving in our relationships and dealings with each other.

Suppressed feelings, on the other hand, inhibit the free flow of feeling energies in our body and this causes us in our social interactions to react subconsciously to our suppressed feelings rather than to the immediate situation at hand. The various forms of inhibition of the free and natural flow and expression of feelings in different individuals are their 'character'.

We understand the child's development as moving through a series of thematic phases: existence, need, autonomy, will, love-sexuality, opinion, and solidarity-performance. Also the teenage period is understood as a significant period of personal development. It is part of our theory (based on actual observations) that the child in each of these thematic phases can go through a healthy development or get stuck in either hypo-responsive or hyper-responsive bodily-psychologically-socially patterns. The result of this psychological and social development is connected to the motoric development, and thus is mirrored in body and movement of the individual, so that defense patterns as well as resources are reflected in body, muscles-responses and movement. A special attention is also given to development and management of boundaries in interaction with others.

All distortions and denials of reality are compensated by special body attitudes. For example, the neurotic individual who is afraid of his feelings of fear covers them by an exaggerated expression of courage, which is manifested in a fixed postural attitude. His shoulders are squared off, his chest is inflated and his belly is sucked in. The patient is not aware that his attitude is a defense against fear until he finds that he cannot drop his shoulders, relax his chest or let his belly out. When the muscular tensions are released, the fear and its historical cause often rise to consciousness.

Every physical expression of the body has meaning; the quality of a handshake, the posture, the look in the eyes, the tone of the voice, the way of moving, etc. If these expressions are fixed and habitual, they tell a story of past experience. The interpretation of fixed, physical attitudes and the work upon chronic muscular tensions, which underlie them, add a new dimension of reality to the therapeutic experience.

Any limitation of mobility is both a result and a cause of emotional difficulties. It arises as a result of an unresolved historical conflict, but the persistence of the tension creates present-day emotional difficulties that clash with the demands of adult reality. Every physical constriction interferes with and prevents a unitary response to a situation.

Through special rhythmic movements, the client in rhythmic movement psychotherapy gains a deeper awareness of and contact with his body. From this awareness and contact, he begins to understand the relation between his present physical state and the experiences of his infancy and childhood, which created it. He learns that his denial of the body is a rejection of his need for love in order to avoid hurt and disappointment. He can interpret his rigidities as a defense against overwhelming rage. He can sense that his immobility stems from a deep-seated fear of aggression. Through the acceptance of his body and its feelings, the individual broadens his contact with all other aspects of reality.

Since the body is the base of all reality functions, any increase in a person's contact with his body will produce a significant improvement in his self image (body image), in his interpersonal relationships, in the quality of his thinking and feeling, and in his enjoyment of life.

When we think of the word movement, we usually associate it with traveling from one place to another as in "move out of the way." It is more than just a way to physically travel. It is a way of self-expression, a way of interpreting music, and an internal clock that can aid us in athletic prowess (<http://www.d230.org/sheehan/intrroto.htm>).

In order to move, we must all have rhythm. The way we walk, run, jog, dribble a basketball, swim or dance, each one of these tasks has its own unique rhythm. Without rhythm movement would be quite awkward. Learning to have an ear for rhythm or a feel for rhythm will help us become more efficient in movement in general.

Rhythm, like movement, is therapy in itself.

Rhythmic movement has existed in every human culture and is used in ritual, rites of passage and as a cathartic healing tool. In early civilizations dancing, religion, music and medicine were linked.

Rhythm is a patterned measure of time (<http://www.angelfire.com/me4/mindandmusic>).

We sense it in music as stressed and unstressed beats in a pattern that repeats itself over and over again. This pattern of stressed and unstressed beats is used to either enhance or thwart the way we perceive things. Rhythm is also the glue that holds our very lives together. All of our systems, from the smallest to the largest, work under the influence of rhythm. Rhythm plays an important role in the ability of our mind to organize billions of electrical impulses into clear, understandable mental pictures. When there is movement of any kind or size, microscopic or gigantic, rhythm controls that movement. When you change the rhythm of a movement you can also change the outcome of the movement. Rhythm then controls the way the message is sent along the neurological system, thereby controlling the way it is perceived. This means that rhythm can change our mental pictures or our perception of reality.

Each one of us is born with perfect rhythm. We have all been prenatally programmed by the ceaseless beat of our mother's heart and by her rhythmic stride. It is no wonder that by our first year of life, we are already teaching ourselves the elegant rhythms of walking and talking. We each possess an inborn grace and coordination that only need some encouragement and simple guidance to be rekindled.

Rhythm is life and our bodies are full of rhythm; not only our heartbeat and breath, but also each of our organs carries a certain rhythm. If we understand our own body rhythm we will become more efficient in movement. For example, Michael Jordan has incredible rhythm when it comes to the game of basketball. He is in tune to his body the entire game and is aware and in control of every movement his body makes. The rhythm of his game changes from fast to slow or vice versa. He can make these adjustments easily because he is in tune with his own body's unique rhythm.

We ourselves control body rhythm every time we walk down the hall. We all have a unique way to walk, run, skip, or jog. No two are quite the same, yet we can be together and be moving at the same time.

We can then take movement and adapt it to the rhythm of music. It is not our own rhythm, but an interpretation of the music we listen to or the concept we want to express. This is dance. Rhythmic movement can be a form of self-expression, and interpretation of music or a way to tell a story through movement.

Being in rhythm connects us all, and reawakens our inner resources for living. In RMP we study ways to share simple rhythm steps and develop them into complex layers of rhythm that enter our nervous system. Rhythm can increase our consciousness of personal and human dynamics. RMP builds the ability to understand and express rhythm through the body. It takes fears away, and teaches how to transfer emotions like anger and sadness into the creative energy of being in rhythm with your whole body. In RMP everybody is part of movement journeys through landscapes of rhythm.

In RMP we acknowledge that rhythm and movement are both healing tools for daily life. Getting in touch with a variety of rhythm elements has a carrying and healing effect on our whole being. Movement is the vehicle. Dance and movement can prevent many diseases. Through stepping, chanting and clapping we enhance our awareness and find ground and confidence. Over time we discover the meaning of certain rhythms and movements, and how they apply to our lives. During this training everyone develops a sense for flow and timing. The ability to listen opens up and everyone learns to stand firm with one's own rhythms.

Through rhythmic movement we get in deeper touch with our bodies. A brief but thorough stretching sequence helps to gain body awareness, flexibility and strength, a sense for alignment and energy flow. Dance archetypes and essences of different dances, such as Samba and Kathak energize the body, teach about flow and help to find movement meditations.

Trance is another important result of rhythmic movement. Trance, according to Webster's dictionary, is a state of profound abstraction or absorption. In trance the subject is abstracted from ordinary awareness and absorbed in the inner world with the feelings, images, and impressions that populate it.

Trance is not a loss of consciousness, it is a focus. Consciousness is always maintained, even in the deepest trance. Trance induction is an interaction between the therapist and client, which brings about a state that people, have already experienced or know about. In a state-related trance, it is easier to remember something when the subject is in the same state as at the time of the occurrence of the incident to be remembered. The trance feelings, images, and impressions become a powerful reality, and the more the subject is abstracted from ordinary awareness the more powerful that reality will be.

Rhythmic movement psychotherapy develops personal skills in weaving basic rhythmical energies with simple movements in dance, so they become healing tools for life, both for personal and therapeutic purposes.

Sources and Components of Rhythmic Movement Psychotherapy

*You
teach best
what you most need
to learn.*

Richard Bach "Illusions"

Rhythmic movement psychotherapy is based on body-oriented psychotherapy, dance-movement therapy and rhythmic gymnastics (aerobics) approaches.

Body-oriented psychotherapy (<http://www.eabp.org>).

Body-oriented psychotherapy has a long history, and a large body of literature and knowledge based upon a sound theoretical position. It involves a different and explicit theory of mind-body functioning, which takes into account the complexity of the intersections and interactions between the body and the mind. The common underlying assumption is that the body is the whole person and there is a functional unity between mind and body. The body does not merely mean the "soma" and that this is separate from the mind, the "psyche". Many other approaches in psychotherapy touch on this area. Body-oriented psychotherapy considers this fundamental.

There are many different and sometimes quite separate approaches within body-oriented psychotherapy, as indeed there are in the other branches of psychotherapy. There are also a wide variety of techniques used within body-oriented psychotherapy and some of these are techniques used on the body involving touch, movement and breathing.

Although each modality of within body-oriented psychotherapy may use a different specific strategy, there are some elements common to the field as a whole.

1. Observation of the body to determine physiological underpinnings of neurotic and psychotic character structures and emotional patterns.
2. Touching the body in specific ways designed to release bodily armoring, release neuromuscular tension, and promote less restricted movement.
3. Eliciting verbal responses and emotional catharsis as the body lets go of habitual tension patterns connected to memories and mental blockages.
4. Partnership between Body Psychotherapy practitioner and Body Psychotherapy client/patient in interpreting and evaluating the meaning of verbal, emotional and imaginative responses.

The origin of body-oriented psychotherapy - Wilhelm Reich. The father of "body-oriented psychotherapy" or sometimes referred to as "Body-Centered Psychotherapy" was Wilhelm Reich, an Austrian psychoanalyst and student of Sigmund Freud. In the 1930's he discovered the concept of "armoring". He came to realize that infants and children respond to emotional and physical trauma by muscular constriction.

This "armoring" was utilized to deal with pain and to protect themselves from fearful or traumatic experiences. During an actual traumatic event the part of the brain governing our instinctual response takes over and a tremendous amount of energy is mobilized to defend one's self by "flight or fight" or for shielding the onslaught of emotional or physical pain.

Although serving a useful purpose at the time, sadly this protective response also has a negative, downside. The same constrictive reaction stays with the child (or adult) and limits their ability to live their present lives to the full, with joy and spontaneity. Their feelings at the time become frozen by the trauma in a holding pattern. In fact, usually the trauma or fearful experience stays locked in the nervous system and is later triggered by any experience that is

remotely familiar or similar to the earlier trauma. Any reaction that is a major overreaction to an event in the present is most often a reaction to an unresolved event in the past.

These stored experiences then filter perceptions, distort relationships and can contribute to physical illnesses. Such unresolved experiences often leads to what we call post-traumatic stress symptoms, such as: anxiety, panic attacks, migraines, hypervigilance, disease, and various levels of disconnection from the body. Although talking about the event will help, trauma is principally a physiological response from the nervous system to danger so it is must be worked with and healed through the physiology - through the body.

In order to process these challenges in a positive setting, Reich applied very deep pressure to certain parts of the body and worked with the emotions, images, memories, and sounds that were released. Reich was able to break through the "armor" and reach the underlying, unconscious material stored in the muscles and surrounding tissue at the time of the trauma. Reich's work inspired many to explore and develop similar ways of helping people free their clients from protective armoring, along with their frozen, stored abuse and trauma, so life energy can flow freely through their whole being without fear and anxiety attached to it.

Reich created a whole range of techniques based on the psychosomatic hypothesis (also found in current relaxation and yoga techniques) that the mind moves the body, and the body moves the mind. Thus arm muscles may become chronically tense as a child clenches his fists to repress his impulse of punching his father. But then, later in psychotherapy, massaging these same tense muscles may help a patient to contact his repressed anger against his father. Much of Wilhelm Reich's early work on Character Analysis (first published in 1933) starts from the premise that people embody their neuroses, and this embodiment will provide much of the resistance to verbal analytical work and the neurosis will not clear until the physical embodiment has been dealt with.

Reich's main theories of the etiology of neuroses were in the sexually repressive attitudes in society. This caused him to go towards the very popular (then) Communist theories of restructuring society and caused him to set up the SexPol Clinics. These developments cemented the split with psychoanalysis, which is essentially conservative and did not wish to change the status quo in society in order to cure individual neuroses.

Bioenergetic Analysis by Alexander Lowen. Bioenergetic Analysis has developed out of psychoanalysis. Freud's student, Wilhelm Reich began to work directly with the body as a psychotherapeutic technique in the 1930's. In his "Vegetotherapy" he particularly worked to deepen and liberate breathing in order to improve and intensify emotional experience. Reich's students Alexander Lowen and John Pierrakos further developed and expanded this method into what today is called Bioenergetic Analysis (Lowen 1958, 1975).

The basis of the bioenergetic method is the tight interweave of mental-psychic and physical processes. The most important human life experiences find expression not only in mental-psychic functioning but also in the body: in posture, in reaction patterns and also in inhibitions of motility, breathing and expression. These embodied patterns represent a "character structure" which influences physical self-perception, self-esteem, self-image and basic patterns of interchange with the environment.

Alexander Lowen, the founder of Bioenergetics, believes that suppressing negative feelings and impulses actually armors and de-vitalizes the body, blocking the flow of energy which allows us to function in a life-affirming way. He believes that we suppress our feelings and impulses as a result of continual holding back of expression, and that this becomes a habitual mode and an unconscious body attitude. Lowen argues that depression can be healed through bodywork, because the relation between depression and depressed breathing is so great that any technique which activates breathing loosens the grip of the depressed mood. He says, "It does so by actually increasing the body's energy level and by restoring some flow of bodily excitation. Generally the increased breathing will lead sooner or later to some form of emotional release, either to crying or anger."

Broadly speaking, in its theory Bioenergetic Analysis corresponds to the psychoanalytic approach. The essential difference lies in the method of treatment. The bioenergetic therapist possesses in his/her use of body-related therapy, a "second language" with which to communicate with the patient.

While the patient in his physical actions displays the basic patterns in which he interacts with the world and with his relevant reference persons, the bioenergetic therapist can respond on the body level as well, giving support, confirming, encouraging, offering resistance or frustrating. In this way, a body-oriented dialogue comes into being which, in accordance with the patient's current ability or readiness, complements, accompanies and substitutes for verbal communication with the patient.

This "second language," experience shows, often speaks to the preverbal experience of the patient and thus revives early object relationships. In this way one succeeds more easily than in purely verbal therapy in reaching a sufficiently deep level of experience at which the basic structure of the acute problem or disorder becomes visible and can be treated.

Body-related work becomes efficient psychotherapeutically in two complementary ways.

1. Previously avoided movement, feelings and experiences are (re-)activated by body-related therapeutic interventions. This allows unconscious psychic material to come to light and to become accessible to mental-psychic elaboration and treatment. Body-related work is thus a means to access the unconscious material of the patient comparable to the interpretation of dreams in classical psychoanalysis. All the while the body makes its' appearance as a phenomenological reality, as a space for self-experience and as a bearer of expression and meaning in a symbolic enactment. The curative effect is based upon a newfound possibility for processing early experience, thus making possible their re-evaluation, completion and integration within the therapeutic process.

2. Although what was said above would seem sufficient to justify the use of body-oriented methods of psychotherapy, Reich and Lowen suggest yet another mode of operation; the mobilization of healing energy by energetic activation on an immediate body level. Essential techniques in this respect are the deepening of the breathing, releasing muscular tension by special breathing and expressive techniques and muscle release interventions. Techniques are also designed to enhance physical relaxation and motility in general, as well as encouragement and support of such unconscious physical processes as the free and deep expression of feelings. In doing so, intellectual mental processes are by-passed for the time being and only the physical changes of the aforementioned kind are attended to. Even more importantly, the newly gained access to deep emotional experience changes a number of physiological parameters along with the self-esteem of the person as well as many other intellectual mental processes. Connected to this process, the person's contact with his social environment also changes. In accordance with the underlying hypothesis, all these changes take place as a consequence of the energetic (that is physiological, muscular, etc.) occurrences.

Bioenergetic therapy as taught by Lowen and his collaborators combine these methods of body-oriented work with a consideration of the social system as it relates to a therapy process organized flexibly according to the development of the individual case. This combination of inner psychological-phenomenological, physical-energetical and social-systemic work is the real characteristic feature of bioenergetic analytic therapy. Lately, increasing importance is being attached to working with the therapeutic relationship in the sense of object relations theory. The enormous complexity involved in this undertaking makes far-reaching demands upon the therapist while on the other hand it also makes understandable why attempts at systemizing descriptions of this therapy method are scarce.

Bioenergetic analysis, as it has currently evolved, is a therapeutic approach that combines work with the body and the mind to help people resolve their emotional problems and to realize more of their potential for pleasure and joy in living. The bodywork of bioenergetics

includes both manipulative procedures and special exercises. The exercises are designed to help people get in touch with body tensions and to release them through physical movement. (Lowen and Lowen, 1977).

The Alexander Technique (<http://www.alexandertechnique.com/pt/homepage>). Australian F. Mathias Alexander, who felt that his own bad posture had caused his voice-loss problems, developed the Alexander Technique in the early 1900's. He began working on a system to teach simple, efficient movements that would help improve balance, posture, and coordination while relieving pain. The resulting technique became popular in the U.S. after the First World War, especially among artists, performers and intellectuals, and has been practiced successfully ever since.

The Alexander Technique is a system for teaching people how best to use their bodies in ordinary action to avoid or reduce unnecessary physical stress that is inevitably linked to pain and disability. The treatment is not a system of exercises; rather, it effects change through increasing patient awareness of poor body posture habits, to inhibit them, and to replace them with proper patterns of muscular movement. To anyone who immediately doubts that such change can be effected without exercise, it should be pointed out that slumping and other misuse of muscles throughout the body certainly can be called "changes," and do not require exercises either. The technique proceeds from the premise that most people have lost the "kinesthetic sense," i.e., the ability to determine via neuromuscular feedback whether their bodies are being properly used. In fact, such feedback has become so distorted that the sorriest postures, scoliosis or lordosis, for instance, feel more "right" than do correct ones.

The Alexander Technique awakens and re-educates the kinesthetic sense so that the patient no longer feels at ease in unhealthy postures and movements.

Unlike other bodywork disciplines, the Alexander Technique focuses on the relationship of head, neck and torso, which teachers call "primary control." Alexander Technique teachers believe that when these three are properly aligned, the head will lift upward and release the neck and spine, improving overall muscular function and allowing you to move your whole body in a harmonious way. Central to the technique are the four "Concepts of Good Use," which focus on freeing the muscles from unneeded tension:

- Allow your neck to release so your head can balance forward and up;
- Allow your torso to release into length and width;
- Allow your legs to release away from your pelvis;
- Allow your shoulders to release out to the sides.

This re-education process is accomplished with the aid of a rigorously trained therapist who is able to diagnose individual maladaptive body patterns and guide the patient to change through a combination of extraordinarily gentle touch and suggestion. The therapist repeatedly "arranges" the body into its best alignment, simultaneously employing verbal description to aid the patient in fixing the new alignment in the neuromuscular sense memory. Because so much cramped posture is the result of stress patterns, the therapist is particularly interested in locating muscles that have been shortened and tightened by chronic tension, and helping the patient to gradually release them.

The strength of the Alexander system is that it identifies, the decreases, neuromuscular tension that occurs below the level of conscious awareness, and confers a postural homeostasis involving an intricate and delicate interplay of muscle coordination and adjustment in the body. Dystonic misuse occurs when we do not know how to return to a balanced resting state after reacting to a given situation. The overcontraction and shortening of anatomical muscle may result in the muscle spindle failing to feed useful information back to the brain about just how much the muscles are contracting.

A healthy lengthening can be brought about, however, by learning voluntarily to release muscles as well as by inhibiting the actions that made them contract in the first place. That voluntary releasing of unnecessary muscle tension is a critical part of what is learned in the

Alexander Technique.

Feldenkrais Method (<http://www.sonic.net/~aumleya/fel.html>). The Feldenkrais Method is named after its originator, Dr. Moshe Feldenkrais, D.Sc. (1904-1984), a Russian born physicist, judo expert, mechanical engineer and educator.

The Feldenkrais Method is a form of somatic education that uses gentle movement and directed attention to improve movement and enhance human functioning. Through this Method, you can increase your ease and range of motion, improve your flexibility and coordination, and rediscover your innate capacity for graceful, efficient movement. These improvements will often generalize to enhance functioning in other aspects of your life.

The Feldenkrais Method is based on principles of physics, biomechanics and an empirical understanding of learning and human development. By expanding the self-image through movement sequences that bring attention to the parts of the self that are out of awareness, the Method enables you to include more of yourself in your functioning movements. Students become more aware of their habitual neuromuscular patterns and rigidities and expand options for new ways of moving. By increasing sensitivity the Feldenkrais Method assists you to live your life more fully, efficiently and comfortably.

The Feldenkrais Method is not a treatment or cure. Rather, it is a type of supportive therapy that can help in any situation where improved movement patterns (and awareness of those patterns) can help with recovery from illness or injury. Practitioners consider it useful for many types of chronic pain, including headache, temporomandibular joint disorder, other joint disorders, and neck, shoulder, and back pain. It is sometimes used as supportive therapy for people with neuromuscular disorders, such as multiple sclerosis, cerebral palsy and stroke. It's also helpful for improving balance, coordination, and mobility; many athletes, dancers, and other performers use the Feldenkrais Method as part of their overall conditioning.

The Feldenkrais Method has two components; you may use either or both of them, depending on your needs. One component, called Functional Integration, consists of hands-on sessions with a Feldenkrais practitioner, who uses touch to help you sense and improve your movement patterns. As you sit, stand, or lie comfortably, the practitioner may gently manipulate your muscles and joints. Unlike some forms of bodywork, Feldenkrais manipulations are all within the usual range of motion, without pain or "cracking" of joints.

The second component is a type of training called Awareness Through Movement, which focuses on slow, non-aerobic movement and specific motions from everyday life, such as sitting and standing. Practitioners consider the two components to be equivalent, complementary ways of achieving the same results. Loose, comfortable clothing is worn for both. Practitioners emphasize that the method does not involve traditional calisthenics.

The Feldenkrais Method aims to help you re-learn how to move your body, replacing old ways of movement with new, more efficient habits. It focuses on improving flexibility, coordination, and range of motion. Feldenkrais practitioners don't make any extravagant claims that the method will cure a specific ailment. They do say that it helps people become aware of how they move, and teaches them how to reduce stress on joints and muscles, and how to move more comfortably.

Arthur Janov's primal therapy (<http://www.primaltherapy.com/>). The work of Arthur Janov can be seen as a mixture of trauma-oriented psychoanalytic tradition and humanistic psychological ideas. After 17 years of practice, psychotherapist Janov started to create his own method. In 1970 he published his first book on his observations and the latest in 1990. The emphasis is on the experiencing and expression of previously blocked feelings and their integration into the total personality. The basic concept is Pain.

When the situation in childhood demands that the child does not feel, repression as a neurochemical survival mechanism comes in and creates tension, which creates all psychological and physiological symptoms. The prototypic traumatic situation is non-caring birth, and after that all care which does not provide for the child's basic needs. The repressed

pain creates a split between the three levels of consciousness. We do not know or feel what we want anymore.

After the real needs shut down symbolic needs are substituted for them, but they are only tension-releasing; that is abreactive. Janov claims that in primal therapy patients find their real needs and feelings after experiencing all the pain and agony, which has accumulated in the body as tension. Janov has made his esoteric claims about primal therapy as the only cure for neurosis so explicit that this has made him a sort of "persona non grata" in academic and psychotherapeutic circles.

Structural Integration (Rolfing) (<http://www.rolfguild.org/page2.htm>). The term "Rolfing" refers to a system of body education and physical manipulation developed by Dr. Ida P. Rolf. It is a method of structural integration that is the product of 50 years of study by Dr. Rolf.

Structural Integration is a process of re-education of the body through movement and touch. It systematically releases patterns of stress and impaired function. The primary focus of Structural Integration is facilitating the relationship between gravity and the human body.

Most bodies are in a state of imbalance. As we grow older, we often "shrink" in height and slowly lose flexibility. Our bones stay the same length and our muscles can still function, but the connective tissue is what changes the most.

Any imbalance in the body - no matter what the cause - is imprinted as change in the internal structure and has a long-range and cumulative effect. The body may attempt to return to its original state but without assistance it remains misaligned. For example, when someone sprains an ankle it is only natural to protect it by keeping as much weight as possible off the injured ankle and compensating with the other ankle by shifting as much weight as possible to the uninjured side of the body. The natural response to the injury changes the entire body's relationship to the gravitational field, and the neuromuscular system is re patterned as part of this process.

Structural Integration works by lengthening and opening the patterns in the connective tissue. As a result the thickened, toughened tissue becomes soft, rehydrated and more pliable, thus allowing movement and flexibility. Structural Integration changes the body's compensations because it organizes the imbalances in the tissue. The systematic approach to relating gravity through the myofascial layers aligns the body and improves posture. The body lengthens allowing muscles the space to work and joints the freedom to function.

While Structural Integration is primarily concerned with physical changes in the body, it affects the whole person. We are made up of emotions, attitudes, belief systems and behavior patterns as well as the physical being. All are related. Align the physical structure and it will open up the individual's potential. Clients often report positive changes, stating less stress, greater self-confidence and improved ability to handle life's changes. Such changes have been reported in all age groups.

Through guided movements of the client, the Rolfer slowly stretches and repositions the body's fascia, which is the supportive wrapping of the body. This restores normal length and elasticity to the network of deep connective fibers of the fascia and allows these changes in the "wrapping" to occur. Thus Rolfing is a system of soft tissue manipulation and movement education to realign and reorient the body.

Rubinfeld Synergy Method (<http://www.healing-journeys.com>). Ilana Rubinfeld created the Rubinfeld Synergy Method in the 1960s. Rubinfeld Synergy Method is an elegant system for integration of body, mind, emotions and spirit. Gentle touch and movement help a person access emotions and release blocking patterns. Rubinfeld Synergy Method involves the whole person. It works with the bodymind at physical, cognitive, intuitive, emotional and spiritual levels, providing a "synergistic" approach that is more powerful than any one of its individual components.

Even though Rubinfeld Synergy Method is so effective, it is exceptionally gentle, non-

Using gentle touch, movement, imagination, humor and verbal expression, the Rubenfeld Synergy Method opens gateways to conscious choices about our relationships - with ourselves, our family, our friends and being in the world.

Rubenfeld Synergy Method works on both the personal and transpersonal levels, depending upon the skills of the Synergist and the client's openness to exploration. Although the work is done in the present, dealing with the past is an important part of the process.

Ilana Rubenfeld summarizes the theoretical foundations of the method in these eighteen points:

- Each individual is unique.
- The body, mind, emotions and spirit are part of a dynamically interrelated system.
- Awareness is the first key to change.
- Change occurs in the present moment.
- The ultimate responsibility for change rests with the client.
- People have a natural capacity for self-healing and self-regulation.
- The body's life force and energy field can be sensed.
- Touch is a viable, accurate system of communication.
- The body is a metaphor.
- The body tells the truth.
- The body is the sanctuary of the soul.
- Pleasure needs to be supported to balance pain.
- Humor can heal and lighten.
- Reflecting clients' verbal expressions validates their experience.
- Confusion facilitates change.
- Altered states of consciousness can enhance healing.
- Integration is necessary for lasting results.
- Self-care is the first step to client care.
- Recognition of suffering and pain leads to their transformation.

The focus in a Rubenfeld Synergy session is on the present, yet resolving unfinished business with the past is part of the healing process. Using what you observe in your body as a metaphor for your experience of life, the Synergist can often help you become aware of beliefs and feelings that have been hidden from your conscious awareness. By focusing primarily on your body, you learn how to contact its vast source of innate intelligence and your own "inner wisdom."

Through the Synergist's use of active listening and gentle touch and movement, you become aware of your physical and emotional tensions and "holding patterns." Your breathing eases and your muscles begin to relax, allowing old memories to surface. You experience how old feelings and beliefs have been exerting strong, though often unconscious influence over how you feel and act in the present. You may experience these beliefs from a new perspective and decide to alter them. Becoming aware of choices you made at an earlier time, the reasons for those choices, and the impact they have had on your life makes it possible for you to make new choices about the ways you experience yourself, life, and the people around you. In your Rubenfeld Synergy sessions you may develop affirmations, movements, images, and breathing patterns that will help you integrate your new choices into your everyday life.

Hakomi Therapy. Hakomi Therapy is a system of body-centered psychotherapy, which is based on the principles of mindfulness, nonviolence, and the unity of mind and body. It was developed by Ron Kurtz and others at the Hakomi Institute in Boulder, Colorado.

The historical Buddha observed that life is suffering. As a body-oriented form of counseling, Hakomi is based on the observation that past hurts, both physical and emotional, are "somaticized," or incorporated into our bodies in the form of habitual muscular tensions and

energy restrictions. This physical armoring serves as an anchor for the unconscious core beliefs that govern our thoughts, feelings, and behaviors. Hakomi therapists use special techniques to access this unconscious information, and help client's process it toward improved self-understanding.

Hakomi helps people change "core material." Core material is composed of memories, images, beliefs, neural patterns, and deeply held emotional dispositions. This material shapes the styles, habits, and behaviors, perceptions and attitudes that define us individuals. Our responses to the major themes of life--safety, belonging, support, power, freedom, responsibility, appreciation, sexuality, spirituality, etc.--are all organized by our core material.

Some of this core material supports our being who we wish to be, while some of it--learned in response to difficult situations--continues to limit us. Hakomi allows the client to distinguish between the two, and to modify willingly any material that restricts his or her wholeness.

The heart of the Method is the precise study of the client's present felt experiences, as a way to discover personal organizing material. These experiences are either naturally occurring, or deliberately and gently evoked by having the client participate in carefully designed "experiments". This might be hearing a statement about a key theme, or having the client changes his or her physical position. It might be asking him or her to consider a certain possibility, or making a certain gesture. Through the "experiment", the client is invited to allow and carefully notice whatever responses happen inside of them, and ultimately to feel within their being the core factors that shape such responses. Once arrived at in this felt way, the core material can be studied, evaluated, and transformed.

Dance - movement therapy

(http://www.integmed.com/imsite/methods/dance_about.html)

(<http://www.interconnections.co.uk/Therapy/dance/dance.htm>)

Dance-movement therapy is the psychotherapeutic use of movement as a process which furthers the emotional, social, cognitive, and physical integration of the individual." It is founded on the principle that movement reflects an individual's patterns of thinking and feeling. Through acknowledging and supporting clients' movements dance therapists encourage development and integration of new adaptive movement patterns together with the emotional experience that accompany such changes. Dance-movement therapy is an effective treatment for people with developmental, medical, social, physical and psychological impairments. Dance-movement therapy is used with people of all ages, races, and ethnic backgrounds in individual, couples, family, and group therapy formats. Dance-movement therapy is practiced in mental health rehabilitation, medical, educational, forensic, nursing homes, day care, disease prevention and health promotion programs.

The main aims of dance-movement therapy are:

- Increasing self-awareness, self-esteem and personal autonomy.
- Experiencing links between thought, feelings and actions.
- Increasing and rehearsing adaptive coping behaviors.
- Expressing and managing overwhelming feelings or thoughts.
- Maximizing resources of communication.
- Contacting inner resources through contained creative play.
- Testing the impact of self on others.
- Helping a person manage feelings that interrupt learning.
- Enhancing social interaction skills.
- Testing inner with outer reality.
- Initiating physical, emotional and/or cognitive shifts.
- Developing a trusting relationship.

The use of dance as a therapeutic tool is founded in the idea that body and mind are completely integrated. While the relationship between the mind and body is constantly being

explored, theorized and discussed, the whole area certainly highlights the ingenuity of the creation and masterpiece in the human being.

The theory underlying dance therapy is that body movement reflects the inner state of the human, and that by moving the body within a guided therapeutic setting, a healing process begins. Emerging inner conflicts and issues from the unconscious to the consciousness of the person are addressed on all levels - physically, emotionally, mentally and spiritually. Seeking the full integration of mind and body, and bringing harmony between all the aforementioned levels of the human being is what dance therapy is all about.

The idea of using dance as a therapeutic modality was synchronistically developed by three different dancer/therapists in the 1940's and 1950's: Marion Chace in Washington, D.C., Trudi Schoop in Southern California, and Mary Woodhouse in Northern California. They came from different clinical orientations (Chace and Schoop were psychoanalytically oriented, Woodhouse was Jungian oriented), but all had in common the idea that movement was symbolic, non-verbal form of expression, as well as being developmental and a method of integrating mind, body and emotions.

Marion Chace is seen as the founder of dance therapy. She began her career as a dancer and choreographer, and studied in New York in the 1920s with Ted Shawn and Ruth St Denis at the Denishawn School of Dance. While she was primarily a performer, she launched into teaching and found that dance was meeting a far greater need than performance. She continued to teach within schools and hospitals, and learnt through trial and error the benefits of dance and expression for people who had certain needs. Her work within the hospitals was gaining reputation as professionals watched the positive effects of her work. In the 1940s she began giving lectures and demonstrations. In the 1960s she founded a training program for dance therapists at a music school based in New York. In 1966 she assisted in the establishment of the American Dance Therapy Association, and was the first president. Chace died in 1970.

Chace's theory was that dance was a form of communication which fulfilled a basic human need. She believed that every person had a desire to communicate, and sought to assist her clients in finding a way to communicate. Chace made unique contributions to the understanding of the therapeutic movement relationship, the use of ongoing verbal narration as a form of reflecting the group and individual process, the use of rhythmic movement as an organizing and clarifying force, and the use of dance as a cohesive group process.

Dance-movement therapy differs from other body oriented therapies in that it involves the active quality of motion and all that it implies developmentally, cognitively, emotionally and creatively, as well as seeing the body as a repository for emotions and energy.

Since the beginning of human culture people have been using movement and dance as an integral part of their lives. Movement ritual connects individuals to the world around them and provides an outlet for emotional expression. Dancing ritual allows for transcendental experience in which an individual can let go of themselves and release the tensions and feelings held holding inside. Communities realized the value of this release and used group movement ritual, often with the aid of a leader or shaman, to heal, unify, and strengthen individuals and groups.

Dancing goes back to primitive times, and magical powers have been attributed to it. When a witch doctor dances, it is to exorcise evil spirits from the sick person. During the Middle Ages people even danced to avoid the plague. The Tarantella of Italy is believed to have originated after a poisonous spider's bite caused tarantism, and the cure for it was a jumping dance. Around the end of the twelfth century, theologians began to fear the power of movement and dissolved the public practice of dance. It was not until the twentieth century with the beginnings of modern dance and modern psychology that dance was publicly recognized as a valuable healer. Today's dance therapy evolved from the age-old idea that dancing has the power to cure.

With the artistic and social breakthroughs of dancers like Isadora Duncan, Mary

Wigman, Bird Larson, and Ruth St. Denis, the interest and merits of spontaneous expressive movement received recognition in the time period around the turn of the twentieth century. At the same time, psychoanalytic thought was gaining momentum with the work of Freud, Jung, Adler, and Reich. Dancers became more interested in the unconscious as psychologists were becoming more aware that the body and the mind are inseparable.

These days, dance therapists are mental health professionals, who treat problems such as neurosis, psychosis, and even alcoholism with the dance. Dancing is a primal response to rhythm and music, so the dance therapist uses dancer's techniques to put the patient in touch with himself. A psychiatrist, of course, talks a patient through his problems, while a dance therapist uses the non-verbal, movement-oriented techniques.

In dance therapy, the patient is made aware of his feelings through sensation and movement. Emotional problems and conflicts become concrete this way, they say. By integrating body and mind, the goal of dance therapy is to build the self-esteem and self-identity of an emotionally ill person.

It is known that each one of our five senses sends messages to our brain through the nerves. And we react accordingly. In a nutshell, we jump for joy when we're happy about something, we slump when we are sad. That is body language. When the body doesn't react to the messages of the brain, we may blow an emotional fuse, and withdraw.

In Dance Therapy, patients are taught to act out hidden hurts. It is believed that acting out past hurts and frustrations can help the individual come to terms with his emotional problems and thus, learn to deal with them.

A Dance Therapy session consists of a small group, observed by a therapist. Sometimes, patients sit on the floor at the start, and as appropriate music plays, they keep time by striking beaters, in actuality bamboo reeds, against the floor. This is to help release hostility. Or daily routines are acted out, to the music. Finally the group begins to move around the room by walking, running, hopping, jumping, skipping, sliding, and leaping.

Then, patients learn how to re-establish contact with themselves by touching. First they touch their own hair, eyes, ears, lips, limbs, etc., then partners are selected and they are encouraged to touch each other's parts. Basically, these exercises lead to movements of varying tempo, dynamics and rhythm.

The purpose of all the various dance rituals and movements is to help patients participating gain new insights into themselves. And the session usually ends with a group hug, to create an atmosphere of love and acceptance.

Dance Therapy has been found very effective for people living out their lives in nursing homes. By providing opportunities for freedom of expression through movement, many of these old people regain more positive attitudes about themselves.

Although Dance Therapy is still a fairly new practice, it is known that it can provide an emotional release for pent-up, repressed feelings, and as a result, the patient may be sent on the road to improved mental health. And for the average person, putting on some music and dancing around in the kitchen, is not only great therapy, it's also fun!

Dance therapy has helped many groups, including psychiatric patients, children with learning disabilities, the elderly, deaf people, the mentally handicapped and people confined to assisted care facilities and nursing homes. It has been used successfully with blind and visually impaired persons.

It helps overcome physical limitations among the elderly and creates new opportunities for healthful exercise and rehabilitation. Dance therapy can improve the coordination of little-used muscles. For older people, dance therapy can help them depend less on others and increase their self-esteem. These benefits, in turn, reduce stress.

Because dance therapy can be individualized, it readily becomes an outlet for expressing anger, love, and fear. As an act of self-expression, it increases self-awareness and develops self-confidence. These are qualities that can be helpful in facing, treating, and coping

with disease, disability, and other health problems. Because dance requires interaction with others, it reduces feelings of isolation and promotes growth in social skills and relationships.

The physical motions of dance therapy are useful exercises, providing the same health benefits gained through exercise. Muscles are strengthened and mobility improved.

Roth (1997) believes that d/m therapy is something that everybody should practice themselves, in their day-to-day lives. Dancing is a form of exercise that is fueled by the soul. It wakes up a person's most essential nature, stretching intuition and imagination just as it is stretching the body. It expands your range of physical and emotional expression and introduces you to forgotten parts of your psyche. Roth (1997) encourages the idea that dancing should be like having a conversation with your body and spirit, helping them to reintegrate. It is all about regaining some knowledge of your self that you may have forgotten or pushed away. Roth (1997) recommends performing a series of movement's everyday that has rhythms in them, which feel completely natural to you. It is not so much a work out for your body, as it is for your spirit, and so you should feel completely comfortable in everything you do. This kind of movement requires an awareness of your emotions. Before you start dancing, Roth (1997) advises that you conduct a personal read on your present emotion. Then, depending on how you feel, pick music that will match, or complement, your mood. This will determine how you move on that particular day. If you are edgy and you put on calm, peaceful music, your body will begin to move in a slow, steady, and relaxing way. Eventually you will begin to adopt the emotion that goes along with these movements, and will yourself feel calm and peaceful. In this state of mind Roth (1997) feels that one is more able to examine what was making them feel edgy, or whatever other emotion, before. In this chapter, Roth (1997) has provided a practice that people who are not necessarily in need of a therapist could benefit from. Most people feel some sort of negative emotions in their life, and Roth (1997) has used the concept of dance/movement therapy to provide them with a new way of dealing with their problems, and, as she puts it, healing their spirit.

Stark (1987) explains that dance movement therapy helps its patients "to identify, experience, and express feelings and conflicts by working with muscular patterns and focusing on the interrelationship between psychological and physiological processes". In this way, Stark (1987) states, psychological information becomes available which may not have been accessible through strictly verbal therapies: "images, memories, and the personal meanings of life experiences are clarified through symbolic representations in movement".

According to Stark (1987), the theoretical basis and goals of dance/movement therapy begin with the acceptance that "every thought, action, memory, fantasy, or image involves some muscular tension". In order to be aware of your feelings, you must have some degree of body awareness. Balance, motor coordination, and the planning of movement involve both the perceptions of external objects or events and individual motor reaction. A kinesthetic sense is essential in developing emotional awareness and responses. Expressive behavior is the motor manifestation of emotions. If you perform an action that corresponds to a certain emotion, you begin to experience the visceral response. The more this action is repeated, the greater becomes the intensity of the emotional experience. The dance movement therapist works with the movement patterns associated with the emotion. The dance movement therapist then formulates therapeutic goals based upon the developmental level of the individual or group. The dance movement therapist strives to help the patient gain a greater understanding of the body and its actions, interpersonal relationships, and self-awareness. If a patient has repeatedly performed a certain movement, then repeating it once in a therapy session will produce a strong a emotion, whereas if the patient is not used to performing this action, the emotional response will be far less intense.

Dance-movement therapy encourages self-expression through the creative art of dance to improve self-confidence and well being. It uses movement, rhythm, and repetition to uncover deep feeling, and emotional issues, allowing them to be brought forward and treated. It

promotes an interaction between mind and body, and encourages the creative expression of tension, trauma, emotional problems, and stress. The physical exercise also improves flexibility, balance, self-confidence and physical fitness. The physical effort is both physically and psychologically invigorating. Making use of the natural joy, energy, and rhythm that are available to all people, dance fosters a consciousness of self.

Rhythmic gymnastics (<http://www.hickoksports.com/history/rhythmg.shtml>)

Rhythmic gymnastics' roots date back to the beginning of modern gymnastics. It borrowed many of its movements - plies, jetes, attitudes and arabesques - from classical ballet, but it evolved specifically from the Swedish system of free exercise developed by Peter Henry Ling in 1814. It also incorporated the German system of developing muscles using items like balls and clubs (apparatus in gymnastic-speak).

Ling's students were taught to use fluid body movements to express their feelings in what became known as "aesthetic gymnastics." Catherine E. Beecher, founder of the Western Female Institute in Ohio in 1837, developed Ling's idea further. In her program, "grace without dancing," young women exercised to music, moving from simple calisthenics to more strenuous exercises.

The foundations of rhythmic gymnastics cannot be attributed to any one person or movement, but to many great thinkers and outlets of creativity, and modern dance was one of its most important basis. In the early twentieth century, when modern dance was just in its infancy, there was no basic technique or school of such movement as there was for folk dancing, ballet, gymnastics, or any other movement art. Modern dance was completely new and abstract, yet an art which could be passed on. With such a void of knowledge to fill, many stepped up to the role of taming this new art form into a civilized, educational dance style. Such influences of the new art form included the contemporary ballets of the Russian dance schools and American and German Modern dance schools. The sources of these main streams had two major influences on the performers and teachers of the time: Francois Delsarte and Emile Jaques-Dalcroze. Each had a philosophy and method of movement that could be understood and molded to fit rightly into the training of students in the new art form.

In the latter half of the nineteenth century, Francois Delsarte (1811-1871) created a system of gymnastics (exercises which train the entire body in strength, coordination, and flexibility) to help actors develop natural poses and expressive gestures. His exercises emphasized grace and poise through proper carriage of the body. These exercises focused on strengthening the torso and adding flexibility to the joints to promote a graceful movement of the frame. His system of expressiveness and aesthetic beauty of the human body became popular in spas, as well as the theater schools, doing much to promote the idea of a more perfect and comfortable body as the Greek ideal. The Delsarte system of gymnastics was never meant to be a system of exercises; but the method, and the healthy philosophies, caught the attention of the dance world.

Meanwhile, Emile Jaques-Dalcroze devised eurythmics in 1911. Described as a system of muscular and musical instruction, the theatrical dance and European gymnastics institutes gradually picked up on his approach of teaching musical clarity through movement exercises. Dalcroze "first realized that musical rhythm depended absolutely on motor consciousness for its fullest expression." Natural movement exercises such as traveling steps or bouncing a ball are performed to the beat of a musical accompaniment in the efforts to create an outlet for expressing musical rhythm.

These two systems of body training were the basis of many modernists' movement ideals. Isadora Duncan, Mary Wigman and Genevieve Stebbins molded these systems into their own ideals of building stronger, more graceful human bodies. After them, many modernists continued their ideas and methods of training in dance.

Duncan, (1878-1927) an American famous for her free style of dancing, was greatly

influenced by Delsarte and Dalcroze. She incorporated their philosophies of health, grace, and musical expressiveness in her schools of dance. Athletic exercises in skipping, hopping, running and jumping were performed until they become inherently natural. Poses and expressions were stylized after the mood of the musical accompaniment. She even knew Dalcroze intimately, "Dalcroze is said to (have) come and watch the Duncan school classes all the time, taking notes etc." Duncan's style of grace and expressiveness further influenced the Russian Imperial Ballet Theater, as well as twentieth century artists such as Ella Ilbak, Maude Allen, Anna Ekston, and Ruth St. Denis.

Genevieve Stebbins, a student of Delsarte's "aesthetic calisthenics", was interested in developing strong and graceful students through her own expression exercises. Her school of Delsarte gymnastics (Genevieve Stebbins' School of Expression) in New York City did not go over as strongly as her latter schools in Germany did. Through the combination of expression exercises and Ling gymnastics, she founded a method of developing strong modern gymnasts and dancers. Her method was later combined by the European gymnastics institutes with the eurythmics training of Dalcroze. This new method of training folk dance competitors and theatrical acrobatic dancers was called Modern Gymnastics, later becoming rhythmic gymnastics.

Mary Wigman, (1886-1973) a German dance teacher, combined the "harmonic calisthenics" of Dalcroze with the movement system of Laban. She created a dance system that had a lyrical quality to it. Her technique was rooted in simplicity, natural rhythms, expression, and artistry. Her solo and group dances were dramatic and emotionally expressive, a new step in choreographic Modern dance works.

Without the educational methods of Dalcroze and Delsarte, rhythmic gymnastics may not have so quickly gained in popularity and strength as an art form of the twentieth century. Unlike the method of training offered by the gymnastics institutes (rigid, boring exercises), or the ballet training of classical schools (a dying art), the new approaches to movement were long in coming.

The Swedish school of rhythmic gymnastics appeared around 1900 and combined those various earlier forms of movement, and later looked to Finland for additional dance elements.

When Ernest Idla of Estonia created degrees of difficulty for each movement, rhythmic gymnastics took a major step on its way to becoming a true sport.

Rhythmic gymnastics arrived in North America in 1906, first appearing at a Finnish-Canadian athletic club in Toronto, but it wasn't very popular. Its profile did not increase until the 1960s, when teams from Evelyn Koop's Toronto Kalev-Estienne Club started giving performances and holding clinics across the country.

The sport was then known as "modern gymnastics" in Canada, and the Canadian Modern Gymnastics Federation was founded in 1969 as the national governing body. The first national championships were held the following year. The CMGF was renamed the Canadian Modern Rhythmic Gymnastics Federation in 1971 and the word "modern" was dropped from the group's name in 1981.

In the United States, the sport is governed by the USA Gymnastics, which also governs artistic gymnastics.

Ten European countries took part in the first world championships, held in 1973 in Budapest, Hungary. The United States didn't begin competing in the biennial world meet until 1973.

Individual rhythmic gymnastics was added to the Olympic program in 1984 and team competition was added at the 1996 Atlanta Games.

One more healing system that can be regarded as the source of Rhythmic Movement Psychotherapy method is **Rhythm Therapy** (http://www.viewzone.com/rhythm_therapy.html). Rhythm Therapy is a non-manipulative unified system of color coordinates, sound enunciation, physical movements and the utilization of music, with an emphasis on rhythmic foundations. It

is seems to stimulate growth of neural paths around damaged or dysfunctional portions of the brain, promoting harmonization of the left and right brain hemispheres. Rhythm Therapy has also been shown to enhance short-term memory, mind-body coordination, and to remedy impaired speech patterns.

Rhythm Therapy was discovered and developed by jazz drummer, Ronnie Gardiner, an American musician who has lived and performed in Scandinavia for over thirty years. Gardiner has performed with many of our century's greatest legends and he continues to perform while he balances his contribution to humanity through his development of this special therapy. He conceived the idea over twenty years ago as a result of a tragic loss and a personal crisis. The foundation, structure, and all the different sequences that comprise the evolved form of Rhythm Therapy were developed since then, in between his busy musical engagements.

In the fall of 1989, the chairman of the Stockholm Stroke Association approached Gardiner. An ardent music lover, the chairman asked Gardiner to initiate a training session with members of the association who desired some type of mental and physical stimulation. Rhythm Therapy was an immediate success. Participants sung praises of being able to speak better, of having a better memory and of acquiring an enhanced ability to concentrate while being less dependent upon the help of others. Other benefits from Rhythm Therapy were an enhanced social life, and, most of all, the feeling of power that stroke victims regained from the assertion of control over their lives. It seemed hard to believe that such benefits could come from such a simple form of therapy, but the results were obvious to everyone who participated.

A Rhythm Therapy session requires two hours, punctuated by one twenty-minute pause. It begins with a greeting, followed by deep breathing exercises and stretching movements, which are accompanied by classical music. Next there is a follow up and review of the previous session. Then the therapist gives a detailed instruction of the new rhythm sequence to be learned. The goal of Rhythm Therapy is to learn an entire score, consisting of many learned sequences of music and corresponding body movements. The entire score can last between three to four minutes in duration. The score begins with easy sequences, using 40-60 beats per minute, and gradually increases in both complexity and speed to about 80-120 beats per minute.

Rhythmic Therapy uses color coordinated symbols representing different parts of the body; red for the left side, and blue for the right side. The therapist, facing the patients, uses red and blue gloves to help the patient follow and mimic the sequences. Each sequence is numbered to denote the order in which it must be performed. It can be performed standing or sitting depending upon the condition of the patient. Each patient is instructed to pronounce the color symbol while simultaneously performing the corresponding movement in accordance with the rhythmic beat.

The main difference between traditional body-oriented psychotherapy (BOP) and rhythmic movement psychotherapy is due to the fact that the BOP is working with so called static body blocks by means of massage and static exercises. RMP is working with dynamic body blocks by means of rhythmic exercises.

The main difference between dance – movement therapy (DMT) and rhythmic movement psychotherapy is due to the fact that the DMT is using predominantly the spontaneous dance as a main method of healing. RMP is using highly structured movement exercises (“follow me” principle). The main idea of RMT is to TEACH a person the new movement patterns.

The main difference between aerobic exercises and rhythmic movement psychotherapy is due to the fact that aerobics is focusing only on physical component of human personality. RMP is using the body/mind connection in order to improve person’s mental health through bodywork.

Fundamentals of Psychosomatic Diagnosis

*If
you will
practice being fictional
for a while, you will understand
that fictional characters are
sometimes more real than
people with bodies
and heartbeats.*

Richard Bach "Illusions"

The main object of work in Rhythmic Movement Psychotherapy are behavioral patterns that are not physically and emotionally flexible enough to move with and integrate the excitation produced in some new situation. In our terms our character type determines such behavioral patterns. Character is what we do characteristically. That is, it is the typical ways in which we function emotionally, physically, intellectually, spiritually. Each of us has a characteristic way of walking, of talking, of responding to fatigue and sleeplessness, of becoming sexually aroused, of meeting new people, of using our eyes and voice, of understanding a problem. Character is what is characteristic of us. Character is what we are, what we do regularly.

A hallmark of free functioning is flexibility. No matter how similar to a past situation the present one is, the present moment is unique. You are not the person you were then - you cannot be - and the situations are therefore never identical, even if the other conditions appear to be identical. In contrast, habitual behavior is out of touch. To be responsive to unique situations is to respond differently than you have done before. This is free functioning, and it suggests that character restricts our responsiveness.

In another way of speaking, character is the organized totality of the tendencies and predispositions of an individual, grouped around and directed by a predominant tendency.

There are a number of existing systems of character types, beginning with Freud's original psychoanalytic description of oral, anal, and genital character. Alexander Lowen (1958), the creator of bioenergetic analysis, developed this into five character types - schizoid, oral, masochistic, psychopathic, and rigid. David Shapiro (1965) introduced four other useful types which are extensions of traditional diagnostic categories—paranoid, obsessive-compulsive, hysteric, and impulsive. Perhaps the most sophisticated system of character types is that of Stephen Johnson (1994) who integrates much of the material from these other systems. And of course, there are the personality disorders described in the DSM-IV (DSM, 1994).

All of these systems can be quite useful in understanding character and the structure of personality, but a person can also be a mixture of types. In other words, a person can be described using several numbers of types. This allows us to give a much more detailed and accurate description of the person's behavior and intrapsychic dynamics. All theories of character types are focused on describing a person's character, the problematic side of his personality. One might also use the theory from this book to describe the positive side of a client's personality, but here my intent is to describe and explain those aspects of a client's personality that may need to be changed in therapy.

I have developed a system of core problems corresponding with various character types. A core problem is a class of similar behaviors with the same underlying dynamics. It consists of an underlying core issue and the behavior that people typically use to express and/or

defend against this. There are three elements here: (1) The core issue refers to the deeper pain behind the person's behavior and feelings, for example feeling needy and deprived because of a lack of nurturing as a child. (2) The person's external behavior can be a pain-driven reaction, which is a direct expression of the core issue, for example, being dependent, or it can be a compensation or defense against the issue, for example, avoiding feeling or acting on any needs. (3) The core problem includes both the core issue and the behavior. Notice that any given core issues can have a number of different behaviors associated with it, each belonging to a different pattern. Conversely, a particular behavior can derive from a number of different core issues, therefore coming from different core problems. For example, if a person is judgmental toward others, this could derive from at least two different situations: (1) It could be a defense against closeness, caused by core issue in which the client is afraid of being harmed in an intimate relationship. (2) It could be a way of feeling superior to others as a way of compensating for an underlying feeling of inadequacy. The behavior by itself doesn't determine the core problem. In fact, neither the core issue nor the external behavior, by itself, can determine the core problem; both are required. I have placed together those core problems and schemas that are most related to each central capacity – dependency needs, aggression (either overcontrol or undercontrol) and sexual identity.

Temperament theory is the first system of character types that we examine.

The Four Temperaments (<http://www.op.org/domcentral/study/aumann/st/>).

According to the Encyclopædia Britannica, in psychology, temperament is the aspect of personality concerned with emotional dispositions and reactions and their speed and intensity; the term often is used to refer to the prevailing mood or mood pattern of a person.

The Greek physician Hippocrates, c.460-c.370 B.C., is referred to as the father of medicine. Although Hippocrates accepted the belief those disease results from an imbalance of the four bodily humors (blood, phlegm, yellow bile, and black bile), he maintained that the humors were glandular secretions and that outside forces influenced the disturbance. He taught that medicine should build the patient's strength through diet and hygiene, resorting to more drastic treatment only when necessary. Hippocrates postulated that an imbalance among the humors resulted in pain and disease, and that good health was achieved through a balance of the four humors.

The Greek physician Galen, AD 130-200, worked in the field of human anatomy where he identified numerous muscles for the first time and showed the importance of the spinal cord noting the resulting paralysis when the cord was cut at different levels. Galen was the first to consider the pulse a diagnostic aid. He showed that arteries carrying blood, not air, and added greatly to knowledge of the brain and nerves. His written treatises survived as the medical authority until the 16 century.

Galen introduced the aspect of four basic temperaments reflecting the humors: the sanguine, buoyant type; the phlegmatic, sluggish type; the choleric, quick-tempered type; and the melancholic dejected type. Galen also classified drugs in terms of their supposed effects on the four humors. He thus created a systematic guide or selecting drugs, which, unfortunately, was scientifically incorrect.

Pavlov, in the tradition of his time, made use of the Hippocratic theory that it is possible to recognize in humans four temperamental types; phlegmatic, choleric, sanguine, and melancholic. Pavlov argued that dogs with each of these types of temperament differed in behavior during his conditioning experiments because their nervous systems were constructed differently with respect to the properties to brain function he had defined. Two of the temperamental types-sanguine and phlegmatic-he considered to have strong nervous systems. In these cases the nervous system was also judged to be relatively balanced, in the sense that it did not show a tendency to veer either towards increased excitability (arousal) or towards increased inhibition (Claridge, 1985).

It can easily be concluded that temperament is used in different contexts and with

different meanings, hardly allowing any comparisons or general statements. One of the consequences of this state of affairs is that our knowledge on temperament does not cumulate despite the increasing research activity in this field. The increasing interest in research on temperament that can be observed in the last decade goes together with the growing variety of theories as well as methodological issues regarding temperament.

Strelau (1983) discusses five respects in which there is at least a popular difference between personality and temperament.

1. Temperament is biologically determined where personality is a product of the social environment.

2. Temperamental features may be identified from early childhood, whereas personality is shaped in later periods of development.

3. Individual differences in temperamental traits like anxiety, extraversion-introversion, and stimulus seeking are also observed in animals, whereas personality is the prerogative of humans.

4. Temperament stands for stylistic aspects. Personality for content aspect of behavior.

5. Unlike temperament, personality refers to the integrative function of human behavior.

There is a diversity of opinion among psychologists concerning the classification of temperament. For our purposes we may define temperament as the pattern of inclinations and reactions that proceed from the physiological constitution of the individual. It is a dynamic factor that determines to a great extent the manner in which an individual will react to stimuli of various kinds. Rooted as it is in the physiological structure, temperament is something innate and hereditary; it is the natural inclination of the somatic structure. It is, therefore, something permanent and admits of only secondary modification; it can never be totally destroyed.

The classification of the temperaments is based on the predominant characteristics of the physiological constitutions. It is by no means exclusive or definitive, nor does it signify that there are "pure" temperaments. As a matter of fact, individuals generally manifest a combination of several temperaments, but one or another will usually predominate. We shall use the emotions as the basis of our definition and classification of temperaments because the emotions are psychosomatic reactions of the individual and hence closely related to temperament. But we discuss the four temperaments according to the ancient classification of (1) sanguine, (2) melancholic, (3) choleric, and (4) phlegmatic.

Sanguine Temperament. A person of sanguine temperament reacts quickly and strongly to almost any stimulation or impression, but the reaction is usually of short duration. The stimulation or impression is quickly forgotten, and the remembrance of past experiences does not easily arouse a new response.

Sanguine persons usually have a serene view of life and are optimists. They are gifted with a great deal of common sense and a practical approach to life; they tend to idealize rather than criticize. Since they possess an affectionate nature, they make friends easily and sometimes love their friends with great ardor or even passion. Their intellects are alert, and they learn quickly, although often without much depth. Their memory dwells on pleasant and optimistic things, and their imagination is active and creative. Consequently, they readily excel in art, oratory, and the related fields, though they do not often attain the stature of the learned or the scholars. Sanguine persons could be superior types of individuals if they possessed as much depth as they do facility, and if they were as tenacious in their work as they are productive of new ideas and projects.

The principal defects of the sanguine temperament are superficiality, inconstancy, and sensuality. The first defect is due primarily to their immediate perception of ideas and situations, their retentive memory, and the creative activity of their imagination. While they appear to grasp in an instant even the most difficult problem or subject, they sometimes see it only superficially and incompletely. As a result, they run the risk of hasty judgments, of acting

with insufficient reason, and of formulating inaccurate or false conclusions. They are more interested in breadth of knowledge than depth.

Melancholic Temperament. The melancholic temperament is weak as regards reaction to stimulus, and it is difficult to arouse; however, after repeated impressions the reaction is strong and lasting, so that the melancholic temperament does not forget easily.

They have a sharp and profound intellect and, because of their natural bent to solitude and reflection, they generally consider matters thoroughly. They usually appreciate the fine arts but are more drawn to the speculative sciences.

When they love, it is with difficulty that they detach themselves from the object of their love. They suffer greatly if others treat them with coldness or ingratitude. The power of their will is greatly affected by their physical strength and health. If their physical powers are exhausted, their will is weak, but if they are in good health and spirits they are energetic workers. Normally they do not experience the vehement passions that may torment persons of a sanguine temperament. We may say in general that this temperament is opposed to the sanguine temperament as the choleric temperament is opposed to the phlegmatic temperament.

The unfavorable traits of the melancholic temperament are an exaggerated tendency to sadness and melancholy; an inclination to magnify difficulties and thus to lose confidence in self; excessive reserve and timidity, with a propensity to scrupulosity. Persons of melancholic temperament do not show their feelings, as do the sanguine; they suffer in silence because they find it difficult to reveal themselves. They tend to be pessimistic, and many enterprises are never begun because of their lack of confidence.

Those who are in charge of educating or training the melancholic temperament should keep in mind their strong tendency to concentrate excessively on themselves. Since they have good intellects and tend to reflection, they should be made to realize that there is no reason for them to be timid or irresolute.

Choleric Temperament. Persons of a choleric temperament are easily and strongly aroused, and the impression lasts for a long time.

The good qualities of the temperament can be summarized as follows: great energy and activity, sharp intellect, strong and resolute will, good powers of concentration, constancy, magnanimity, and liberality. Choleric persons are practical rather than theoretical; they are more inclined to work than to think. Inactivity is repugnant to them, and they are always looking forward to the next labor or to the formulation of some great project. Once they have set upon a plan of work, they immediately set their hand to the task. Hence this temperament produces many leaders. It is the temperament of government and administration.

These persons do not leave for tomorrow what they can do today, but sometimes they may try to do today what they should leave for tomorrow. If difficulties and obstacles arise, they immediately set about to overcome them and, although they often have strong movements of irascibility and impatience in the face of problems, once they have conquered these movements they acquire a tenderness and sweetness of disposition that are noteworthy.

They have greater patience than do the sanguine, but they may lack delicacy of feeling, are often insensitive to the feelings of others, and therefore lack tact in human relations. Their passions, when aroused, are so strong and impetuous that they smother the tenderer emotions and the spirit of sacrifice that spring spontaneously from more sympathetic hearts. Their fever for activity and their eagerness to execute their resolutions cause them to disregard others, to thrust all impediments aside, and to give the appearance of being egoists. In their treatment of others they sometimes display coldness and indifference, not to mention impatience with persons who are less talented.

Phlegmatic Temperament. The phlegmatic is rarely aroused emotionally and, if so, only weakly. The impressions received usually last for only a short time and leave no trace.

The good characteristics of phlegmatic persons are that they work slowly but assiduously; they are not easily irritated by insults, misfortunes, or sickness; they usually

remain tranquil, discreet, and sober; they have a great deal of common sense and mental balance. They do not possess the inflammable passions of the sanguine temperament, the deep passions of the melancholic temperament, or the ardent passions of the choleric temperament. In their speech they are orderly, clear, positive, and measured, rather than florid and picturesque. They are more suited to scientific work, which involves long and patient research and minute investigation than to original productions. They have good hearts, but they seem to be cold. They would sacrifice to the point of heroism if it was necessary, but they lack enthusiasm and spontaneity because they are reserved and somewhat indolent by nature. They are prudent, sensible, reflective, and work with a measured pace. They attain their goals without fanfare or violence because they usually avoid difficulties rather than attacking them. Physically phlegmatics are usually of robust build, slow in movements, and possessing an amiable face.

They are not interested in events that take place around them, but they tend to live by and for themselves, almost to the point of egoism. They are not suitable for government and administration. They are not usually drawn to corporal penances and mortification, and there is no fear that they will kill themselves by penance and self-abnegation. In extreme cases they become so lethargic and insensible that they become completely deaf to the invitation or command that would raise them out of their stupor.

The next system of character types under consideration is Kretschmer's typology.

Kretschmer's typology (<http://www.geocities.com/ptypes/temperaments.html>).

In 1925 Ernst Kretschmer (1925) published his book, *Physique and Character* in which he describes the "Cycloid" and "Schizoid" types. The temperaments, then, separate off into the two great constitutional groups, the cyclothymes and the schizothymes. Inside the two main groups there is a further dual division, according as the cyclothymic temperament is habitually more on the gay or sad side, and according as the schizothymic temperament tends towards the sensitive or the cold pole. An indefinite number of individual temperamental shades emerge from the psychaesthetic and diathetic proportions, i.e., from the manner in which in the same type of temperament, the polar opponents displace one another, overlay one another, or relieve one another in alternation.

This wealth of shades is further enlarged by variations in the psychic tempo. Hence, at any rate as far as cyclothymes are concerned, we have the empirical fact that the more gay are usually the more mobile, while those who belong to the moderate class with an inclination to depression, are usually more comfortable and slow. This we should expect from long clinical experience of the close connection between bright excitability and swift flights of ideas and psychomotor facility as manic symptoms and in melancholic symptomatology the connection of depression and inhibition of thought and will. And among healthy cyclothymic temperaments a certain mood-disposition usually goes with a certain psychic tempo, so that gayness and mobility are often bound up with the hypomanic type of temperament and a tendency to depression and slowness with the melancholic type.

But on the other hand such fixed relations between psychaesthesia and definite psychic rhythms are not to be recognized in the schizothyme, in that with the tender hyperaesthetics we often find astonishing tenacity in feeling and will, and, vice versa, capricious instability with people of pronouncedly cold indolence. So that in the schizothymic circle we often meet with all four combinations: sensitive as well as cold tenacity, and jerky sensitivity as well as capricious indolence.

The hyperaesthetic qualities manifest themselves empirically chiefly as tender sensibility, sensitivity to nature and art, tact and taste in personal style, sentimental affection for certain individuals, hypersensitivity and vulnerability with regard to the daily irritations of life, and finally, in the coarsened types, and particularly in post-psychotics and their equivalents, we find it in the shape of passion working in combination with 'complexes'. The anaesthetic qualities of schizothymes are manifested in the form of cutting, active coldness, or passive

insensitivity, as a canalization of interest into well-defined autistic directions, as indifference, or unshakable equilibrium. Their jerkiness is now rather indolent instability, and now caprice; their tenacity takes on the most varied shapes: steely energy, stubborn willfulness, pedantry, fanaticism, and logical systematism in thought and action.

The variations of the diathetic temperament are far fewer, if we leave out the strongly flavored dispositions (the querulous, the quarrelsome, the anxious, and the dry hypochondriacs). The hypomanic type besides the ordinary gay mood-disposition, also manifests as passionate jollity. It varies between the quickly flaring up fiery temperament, the energetic sweeping practical elan, being very variously occupied, and being equable, sunny, and bright.

Cyclothymic psychomotility is distinguished by the natural quality of reaction and bodily movement, which is now quick, now slow, but (apart from severe pathological inhibitions) always rounded and adequate to the stimulus. While among schizothymes we often meet with psychomotor peculiarities, and particularly in the lack of adequate immediacy between psychic stimulus and motor reaction, in the form of aristocratic, reserved, very restrained, or affectively lamed, or finally occasionally inhibited, stiff, or timid motility.

In their complex attitudes and reactions to environment the cyclothymics are in the main men with a tendency to throw themselves into the world about them, and the present, of open, sociable, spirited, kind-hearted, and 'naturally-immediate' natures, whether they seem at one time more jolly, or at another cautious, comfortable and melancholic. There emerges from them, among others, the everyday type of energetic practical man, and the sensual enjoyer of life. Among the more gifted members of the class, we find the broad expansive realists, and the good-natured, hearty humorists when we come to artistic style; the types of observant, describing, and fingering empiricist, and the man who wants to popularize science for the laity, when we come to scientific mode of thought; and in practical life the well-meaning, understanding conciliator, the energetic organizer on a large scale, and the tough, strong-minded whole-hogger.

The attitude towards life of the schizoid temperament, on the other hand, has a tendency to autism, to a life inside oneself, to the construction of a narrowly-defined individual zone, of an inner world of dreams and principles which is set up against things as they really are, of an acute opposition of 'I' and 'the world', a tendency to an indifferent or sensitive withdrawal from the mass of one's fellow-men, or a cold flitting about among them without regard to them and without *rapport* with them. Among them we find, in the first place, an enormous number of defective types, or sulky eccentrics, egoists, unstable idlers, and criminals; among the socially valuable types we find the sensitive enthusiast, the world-hostile idealist, the simultaneously tender and cold, formal aristocrat. In art and poetry we find them as stylistically pure formal artists and classicists, as romanticists flying the world, and sentimental idyllics, as tragic pathetics and so on to the extremes of expressionism and tendentious naturalism, and finally as witty ironists and sarcastics. In their scientific method of thought we find a preference for academic formalism or philisophical reflection, for mystical metaphysics, and exact schematism. And, lastly, of the types which are suitable for active life, the schizothymes seem to produce in particular the tenacious energetics, the inflexible devotees of principle and logic, the masterful natures, the heroic moralists, the pure idealists, the fanatics and despots, and the diplomatic, supple, cold calculators.

The next system of character types under our consideration is somatotypes proposed by W. Sheldon (1940).

Somatotypes.

In the 1940s, William Sheldon, an American psychologist proposed a theory about how there are certain body types ("somatotypes") that are associated with certain personality characteristics. Building on the previous work of Kretschmer, Sheldon's five year study analyzed 200 young men both morphologically and temperamentally, measuring in addition to

the primary components a number of apparently secondary temperamental characteristics. He discovered that there were three fundamental elements which, when combined together, made up all these physiques or somatotypes. With great effort and ingenuity he worked out ways to measure these three components and to express them numerically so that every human body could be described in terms of three numbers, and that two independent observers could arrive at very similar results in determining a person's body type. These basic elements he named endomorphy, mesomorphy and ectomorphy, for they seemed to derive from the three layers of the human embryo, the endoderm, the mesoderm and the ectoderm.

Endomorphy is centered on the abdomen, and the whole digestive system.

Mesomorphy is focused on the muscles and the circulatory system.

Ectomorphy is related to the brain and the nervous system.

Endomorphic Body Type: soft body, underdeveloped muscles, rounds shaped, over-developed digestive system. Associated personality traits (viscerotonia): love of food, tolerant, evenness of emotions, love of comfort, sociable, good humored, relaxed, need for affection. Viscerotonia has a relatively long, heavy digestive tube, with large liver, and with other subsidiary organs of digestion showing increased size of development. The life of a viscerotonic seems to be organized primarily to serve the gut.

Mesomorphic Body Type: hard, muscular body, overly mature appearance, rectangular shaped, thick skin, upright posture. Associated personality traits (somatotonia): adventurous, desire for power and dominance, courageous, indifference to what others think or want, assertive, bold, zest for physical activity, competitive, love of risk and chance. Somatotonia is so named because the complex traits to which it refers is associated with functional and anatomical predominance of the somatic structures-the moving apart of the body frame. Activity of the voluntary muscles appears to be prepotent. Such a person seems to live primarily for muscular expression.

Ectomorphic Body Type: thin, flat chest, delicate build, young appearance, tall, lightly muscled, stoop-shouldered, large brain. Associated personality traits (cerbrotonia): self-conscious, preference for privacy, introverted, inhibited, socially anxious, artistic, mentally intense emotionally restrained. The prepotent activity seems to be that of conscious attention, which involves an inhibition or "hushing" of other activities of the body.

Jung - Meyers/Briggs Typology.

(<http://www.ship.edu/~cgboeree/jung.html>)

Karl Jung saw universal "types" in human personality. These types are all present in all of us but there tends to be one predominant type or normal mode of organizing our experience. The types are both complementary and competitive. One can gain insight into oneself and others by understanding the structure that Jung described but one must not interpret it too narrowly or literally. The reality that underlies this simple intellectual model is far more complex and problematic than any description of it can suggest.

Jung's personality typology begins with the distinction between **introversion** and **extroversion**. Introverts are people who prefer their internal world of thoughts, feelings, fantasies, dreams, and so on, while extroverts prefer the external world of things and people and activities.

The words have become confused with ideas like shyness and sociability, partially because introverts tend to be shy and extroverts tend to be sociable. But Jung intended for them to refer more to whether you ("ego") more often faced toward the persona and outer reality, or toward the collective unconscious and its archetypes. In that sense, the introvert is somewhat more mature than the extrovert is. Our culture, of course, values the extrovert much more.

Whether we are introverts or extroverts, we need to deal with the world, inner and outer. And each of us has our preferred ways of dealing with it, ways we are comfortable with and good at. Jung suggests there are four basic ways, or **functions**:

The first is **sensing**. Sensing means what it says: getting information by means of the

senses. A sensing person is good at looking and listening and generally getting to know the world. Jung called this one of the **irrational** functions, meaning that it involved perception rather than judging of information.

The second is **thinking**. Thinking means evaluating information or ideas rationally, logically. Jung called this a **rational** function, meaning that it involves decision making or judging, rather than simple intake of information.

The third is **intuiting**. Intuiting is a kind of perception that works outside of the usual conscious processes. It is irrational or perceptual, like sensing, but comes from the complex integration of large amounts of information, rather than simple seeing or hearing. Jung said it was like seeing around corners.

The fourth is **feeling**. Feeling, like thinking, is a matter of evaluating information, this time by weighing one's overall, emotional response. Jung calls it rational, obviously not in the usual sense of the word.

We all have these functions. We just have them in different proportions, you might say. Each of us has a **superior** function, which we prefer and which is best developed in us, a **secondary** function, which we are aware of and use in support of our superior function, a **tertiary** function, which is only slightly less developed but not terribly conscious, and an **inferior** function, which is poorly developed and so unconscious that we might deny its existence in ourselves.

Katharine Briggs and her daughter Isabel Briggs Myers found Jung's types and functions so revealing of people's personalities that they decided to develop a paper-and-pencil test. It came to be called the **Myers-Briggs Type Indicator**, and is one of the most popular, and most studied, tests around.

The test has four scales. **Extroversion - Introversion** (E-I) is the most important. Test researchers have found that about 75 % of the population are extroverted.

The next one is **Sensing - Intuiting** (S-N), with about 75 % of the population sensing.

The next is **Thinking - Feeling** (T-F). Although these are distributed evenly through the population, researchers have found that two-thirds of men are thinkers, while two-thirds of women are feelers. This might seem like stereotyping, but keep in mind that feeling and thinking are both valued equally by Jungians, and that one-third of men are feelers and one-third of women are thinkers. Note, though, that society does value thinking and feeling differently, and that feeling men and thinking women often have difficulties dealing with people's stereotyped expectations.

The last is **Judging - Perceiving** (J-P), not one of Jung's original dimensions. Myers and Briggs included this one in order to help determine which of a person's functions is superior. Generally, judging people are more careful, perhaps inhibited, in their lives. Perceiving people tend to be more spontaneous, sometimes careless. If you are an extrovert and a "J," you are a thinker or feeler, whichever is stronger. Extroverted and "P" means you are a senser or intuiter. On the other hand, an introvert with a high "J" score will be a senser or intuiter, while an introvert with a high "P" score will be a thinker or feeler. J and P are equally distributed in the population.

Four letters, such as ENFJ identify each type.

ENFJ (Extroverted feeling with intuiting): These people are easy speakers. They tend to idealize their friends. They make good parents, but have a tendency to allow themselves to be used. They make good therapists, teachers, executives, and salespeople.

ENFP (Extroverted intuiting with feeling): These people love novelty and surprises. They are big on emotions and expression. They are susceptible to muscle tension and tend to be hyperalert. They tend to feel self-conscious. They are good at sales, advertising, politics, and acting.

ENTJ (Extroverted thinking with intuiting): In charge at home, they expect a lot from spouses and kids. They like organization and structure and tend to make good executives and

administrators.

ENTP (Extroverted intuiting with thinking): These are lively people, not humdrum or orderly. As mates, they are a little dangerous, especially economically. They are good at analysis and make good entrepreneurs. They do tend to play at oneupmanship.

ESFJ (Extroverted feeling with sensing): These people like harmony. They tend to have strong shoulds and should-nots. They may be dependent, first on parents and later on spouses. They wear their hearts on their sleeves and excel in service occupations involving personal contact.

ESFP (Extroverted sensing with feeling): Very generous and impulsive, they have a low tolerance for anxiety. They make good performers, they like public relations, and they love the phone. They should avoid scholarly pursuits, especially science.

ESTJ (Extroverted thinking with sensing): These are responsible mates and parents and are loyal to the workplace. They are realistic, down-to-earth, orderly, and love tradition. They often find themselves joining civic clubs!

ESTP (Extroverted sensing with thinking): These are action-oriented people, often sophisticated, sometimes ruthless -- our "James Bonds." As mates, they are exciting and charming, but they have trouble with commitment. They make good promoters, entrepreneurs, and con artists.

INFJ (Introverted intuiting with feeling): These are serious students and workers who really want to contribute. They are private and easily hurt. They make good spouses, but tend to be physically reserved. People often think they are psychic. They make good therapists, general practitioners, ministers, and so on.

INFP (Introverted feeling with intuiting): These people are idealistic, self-sacrificing, and somewhat cool or reserved. They are very family and home oriented, but don't relax well. You find them in psychology, architecture, and religion, but never in business. Both Jung and I admire this type.

INTJ (Introverted intuiting with thinking): These are the most independent of all types. They love logic and ideas and are drawn to scientific research. They can be rather single-minded, though.

INTP (Introverted thinking with intuiting): Faithful, preoccupied, and forgetful, these are the bookworms. They tend to be very precise in their use of language. They are good at logic and math and make good philosophers and theoretical scientists, but not writers or salespeople.

ISFJ (Introverted sensing with feeling): These people are service and work oriented. They may suffer from fatigue and tend to be attracted to troublemakers. They are good nurses, teachers, secretaries, general practitioners, librarians, middle managers, and housekeepers.

ISFP (Introverted feeling with sensing): They are shy and retiring, are not talkative, but like sensuous action. They like painting, drawing, sculpting, composing, dancing -- the arts generally -- and they like nature. They are not big on commitment.

ISTJ (Introverted sensing with thinking): These are dependable pillars of strength. They often try to reform their mates and other people. They make good bank examiners, auditors, accountants, tax examiners, supervisors in libraries and hospitals, business, home etc., and phys. ed. teachers, and boy or girl scouts!

ISTP (Introverted thinking with sensing): These people are action-oriented and fearless, and crave excitement. They are impulsive and dangerous to stop. They often like tools, instruments, and weapons, and often become technical experts. They are not interested in communications and are often incorrectly diagnosed as dyslexic or hyperactive. They tend to do badly in school.

The next theories we use for the purposes of diagnosis of character types are Freud's and Erikson theories of personality development (Freud, 1953; Erikson, 1959), and Horney's (1937) theory of basic anxiety. Also we use the description of Reich's and Lowen's character

types and descriptions of personality disorders given in DSM-IV (1994).

Freud's and Erikson's Stages of Development.

Sigmund Freud (1856-1939) is probably the most well known theorist when it comes to the development of personality. Freud's Stages of Psychosexual Development are, like other stage theories, completed in a predetermined sequence and can result in either successful completion or a healthy personality or can result in failure, leading to an unhealthy personality. This theory is probably the best known as well as the most controversial, as Freud believed that we develop through stages based upon a particular erogenous zone. During each stage, an unsuccessful completion means that a child becomes fixated on that particular erogenous zone and either over- or under-indulges once he or she becomes an adult.

In his "Three Essays on Sexuality" (1915), Freud outlined five stages of manifestations of the sexual drive: Oral, Anal, Phallic, Latency, and Genital. At each stage, different areas of the child's body become the focus of his pleasure and the dominant source of sexual arousal. Differences in satisfying the sexual urges at each stage will inevitably lead to differences in adult personalities. Conflicts between the sex drive and rules of society are present at every stage. A proper resolution of the conflicts will lead the child to progress past one stage and move on to the next. Failure to achieve a proper resolution, however, will make the child fixated in the present stage. The latter is believed to be the cause of many personality and behavioral disorders (<http://www.clas.ufl.edu/users/gthursby/fonda/freud.html>).

Freud specified various character types, which are expressive of the activities and conflicts of the various psychosexual stages of development and the defense mechanisms common to those stages.

Extending Freud's psychosexual stages of development, Erik Erikson divided the growth of the personality into eight psychosocial stages. An Eriksonian phase (<http://oldsci.eiu.edu/psychology/Spencer/>) is notable for its own developmental theme, for its relationship to the previous and subsequent phases, and for the role it plays in the total scheme of development. Development, he says, functions by the epigenetic principle. This principle says that we develop through a predetermined unfolding of our personalities in eight stages. Our success or lack of success, in all the previous stages in part determines our progress through each stage. Each stage involves certain developmental tasks that are psychosocial in nature. Although he follows Freudian tradition by calling them crises, they are more drawn out and less specific than that term implies. The various tasks are referred to by two terms. The infant's task, for example, is called "trust-mistrust." At first, it might seem obvious that the infant must learn trust and not mistrust. But Erikson made it clear that there it is a balance we must learn: certainly, we need to learn mostly trust; but we also need to learn a little mistrust, so as not to grow up to become gullible fools.

Karen Horney believed that much of personality results from interactions with society. She stated that the impacts of culture result in basic anxiety. Cultural influences include competition among individuals resulting in feelings of hostility and isolation, the subsequent intensified need for affection, and the overvaluation of love (1937). These influences effect both healthy and neurotic personality developments.

Like many other psychodynamic psychologists, Horney believed in the importance of childhood experiences. She also stated that, while childhood was the stage where most developmental problems arose, no single experience during childhood could be responsible for personality development. Personality is the result of the totality of childhood experiences.

People will develop neurotic trends because of basic anxiety. These trends are 1) moving toward people, 2) moving against people, and 3) moving away from people (1937). Moving toward people involves people being compliant in an effort to protect themselves from feelings of helplessness, which can often lead to codependency. People who move against others will often be aggressive to avoid the hostility of others. People believe that if they can humiliate others, it will keep them from being humiliated. Finally, moving away from others is

a way to abate feelings of isolation. By distancing themselves from others, people can avoid feeling alone. While these behaviors can be positive when used in moderation, it is when people choose only one behavior that neurosis begins.

Horney believes that social influences are more important than biological influences. She states that cultural interact results in both healthy and maladaptive personality development. She seems to rely on the idea of causality more than teleology. The way people relate to others is determined by their past interactions.

We also enter here the concept of defense mechanisms, which are unconscious protective maneuvers employed by the person to cope with anxiety, either neurotic or moral. They are a normal part of human experience and are not considered maladaptive or pathological unless used to such an extreme that they disrupt a person's life or distort reality.

The conception of character in body-oriented therapy was inspired by the work of Wilhelm Reich and continued by A. Lowen. Reich developed character analysis when it had become apparent that examining the mental life of those in psychoanalysis was not enough to effect significant changes in their lives. Reich concluded that the body needed analysis in the same way the psyche did. Although this was entirely in keeping with Freud's emphasis on psychosomatic unity, Reich and Lowen were much more interested in how the body is tied to the psychic life or mind than the other way around. Character analysis is a way of paying attention to the physical dimensions of the individual--the body: movement, breathing, musculature, speech, and posture--in the therapy.

For practical purposes we'll examine only three initial stages of personality development: oral, anal and phallic.

Oral Stage (Birth to 18 months). The oral stage begins at birth, when the oral cavity is the primary focus of libidinal energy. The child, of course, preoccupies himself with nursing, with the pleasure of sucking and accepting things into the mouth. The oral character that is frustrated at this stage, whose mother refused to nurse him on demand or who truncated nursing sessions early, is characterized by pessimism, envy, suspicion and sarcasm. The overindulged oral character, whose nursing urges were always and often excessively satisfied, is optimistic, gullible, and is full of admiration for others around him. The stage culminates in the primary conflict of weaning, which both deprives the child of the sensory pleasures of nursing and of the psychological pleasure of being cared for, mothered, and held.

Too much or too little gratification can result in an oral fixation or oral personality, which is evidenced by a preoccupation with oral activities. This type of personality may have a stronger tendency to smoke, drink alcohol, over eat, or bite his or her nails. Personality wise, these individuals may become overly dependent upon others, gullible, and perpetual followers. On the other hand, they may also fight these urges and develop pessimism and aggression toward others.

Area of Conflict - feeding. Love Crisis: Love vs Indifference. Here, the child is self-absorbed (narcissistic). Needs to recognize external world as necessary for fulfillment of needs. Primary activities are giving/receiving.

Major Defense Mechanisms:

1. Projection - "blame it" - attribute to others one's own unacceptable thoughts, feelings, impulses, etc. Actually, attempt to convert neurotic or moral anxiety into objective anxiety.

2. Denial - "Don't see it" - failing to perceive threatening objects in the external world. Main defense mechanism of alcoholics and drug addicts. Refusing to admit or face a threatening realities or situations by *denying* their seriousness.

3. Introjection - "Don't admit where you got it" - the acceptance of other's values and norms as one's own even if they are contrary to one's previous assumptions.

Breakdown - schizophrenia (indifference to its illogical extreme, "blunted emotional affect).

Trust versus Mistrust. Erikson's oral-sensory stage occurs during our first year of life. Similar to Freud's oral stage in that, "The infant 'lives through, and loves with, [the] mouth,' Erikson wrote (1959). This is the time of great vulnerability and when we are totally dependent on someone else. The mother or primary caregiver provides the child with every need. As children we learn to become dependent on someone else. Thus, we develop a sense of expectancy through a mixture of trust and mistrust. The child's sense of basic trust-as opposed to a sense of basic mistrust-becomes the critical theme in Erikson's first developmental phase. For the child a sense of trust requires a feeling of physical comfort and a minimum experience of fear or uncertainty. If these are assured him, he will extend his trust to new experiences. In contrast, a sense of mistrust arises from unsatisfactory physical and psychological experiences such as rejection from the mother, and leads to fearful apprehension of future situations. Once basic trust or mistrust has been acquired each can still be altered in later stages of life.

Three character types could be specified which are expressive of the activities and conflicts of the oral psychosexual stage and are resulted from the fixation on this stage: schizoid, narcissistic and paranoid character types. In accordance with Horney's theory all three character types are those moving away from people.

Schizoid character type (<http://www.geocities.com/ptypes/correspondence.html>). The DSM-IV (1994) Schizoid Personality Disorder as a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- neither desires nor enjoys close relationships, including being part of a family;
- almost always chooses solitary activities;
- has little, if any, interest in having sexual experiences with another person;
- takes pleasure in few, if any, activities;
- lacks close friends or confidants other than first-degree relatives;
- appears indifferent to the praise or criticism of others;
- shows emotional coldness, detachment, or flattened affectivity.

The Solitary personality type is a nonpathological representation of this category.

Oldham (1995) has defined the Solitary personality style:

1.Solitude. Individuals with the Solitary personality style have small need of companionship and are most comfortable alone.

2.Independence. They are self-contained and do not require interaction with others in order to enjoy their experiences or to get on in life.

3.Sangfroid. Solitary men and women are even-tempered, calm, dispassionate, unsentimental, and unflappable.

4.Stoicism. They display an apparent indifference to pain and pleasure.

5.Sexual composure. They are not driven by sexual needs. They enjoy sex but will not suffer in its absence.

6.Feet on the ground. They are unswayed by either praise or criticism and can confidently come to terms with their own behavior.

Alexander Lowen (1958) described the Schizoid Character as follows.

In the schizoid individual the main emotional trauma occurred around the time of birth. This may have been a distressing birth process or hostility from one or both parents towards the baby, commonly the baby was unwanted and it felt abandoned by the mother, either physically or emotionally.

The baby deals with this by withdrawing into itself, closing itself off from the world. This same technique is then used in later life whenever the individual feels threatened. The basic subconscious fear or anxiety is the feeling of being unwanted, having no right to exist, a psychological split between the desire to live in the physical world and a wish to withdraw into

the spirit world.

In communications with others this type tends to intellectualize and use impersonal language. The body structure is with elongated limbs and digits and weak joints, the body appears uncoordinated with right-left imbalances and often cold hands and feet. The energy structure is 'ungrounded' or 'airy-fairy' with frozen core energies. Schizoids tend to be rather spiritual and creative but in need of grounding and becoming an integrated whole.

Paranoid character type (<http://www.geocities.com/ptypes/correspondence.html>). The DSM-IV (1994) describes Paranoid Personality Disorder as a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her;
- is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates;
- is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her;
- reads hidden demeaning or threatening meanings into benign remarks or events;
- persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack;
- has recurrent suspicions, without justification, regarding fidelity or spouse or sexual partner.

The Vigilant personality type is a nonpathological representation of this category.

Oldham (1995) has defined the Vigilant personality style:

1. Autonomy. Vigilant-style individuals possess a resilient independence. They keep their own counsel, they require no outside reassurance or advice, they make decisions easily, and they can take care of themselves.

2. Caution. They are careful in their dealings with others, preferring to size up a person before entering into a relationship.

3. Perceptiveness. They are good listeners, with an ear for subtlety, tone, and multiple levels of communication.

4. Self-defense. Individuals with Vigilant style are feisty and do not hesitate to stand up for themselves, especially when they are under attack.

5. Alertness to criticism. They take criticism very seriously, without becoming intimidated.

6. Fidelity. They place a high premium on fidelity and loyalty. They work hard to earn it, and they never take it for granted.

Narcissistic character type (<http://www.geocities.com/ptypes/correspondence.html>). The DSM-IV (1994) describes Narcissistic Personality Disorder as a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements);
- is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love;
- believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions);

- requires excessive admiration;
- has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations;
- is interpersonally exploitive, i.e., takes advantage of others to achieve his or her own ends;
- lacks empathy: is unwilling to recognize or identify with the feelings and needs of others;
- is often envious of others or believes that others are envious of him or her;
- shows arrogant, haughty behaviors or attitudes.

The Self-confident personality type is a nonpathological representation of this category. Oldham (1995) has defined the Self-confident personality style:

1. Self-regard. Self-Confident individuals believe in themselves and in their abilities.

They have no doubt that they are unique and special and that there is a reason for their being on this planet.

2. The red carpet. They expect others to treat them well at all times.

3. Ambition. Self-Confident people are unabashedly open about their aspirations and possibilities.

4. Politics. They are able to take advantage of the strengths and abilities of other people in order to achieve their goals, and they are shrewd in their dealings with others.

5. Competition. They are able competitors, they love getting to the top, and they enjoy staying there.

6. Stature. They identify with people of high rank and status.

7. Dreams. Self-Confident individuals are able to visualize themselves as the hero, the star, the best in their role, or the most accomplished in their field.

8. Self-awareness. These individuals have a keen awareness of their thoughts and feelings and their overall inner state of being.

9. Poise. People with the Self-Confident personality style accept compliments, praise, and admiration gracefully and with self-possession.

Alexander Lowen (1958) described this character type as the oral structure.

The oral phase of our development is the period when we are totally dependent on the mother and normally breast-fed. The normal emotional development may be interrupted when the baby feels abandoned because the mother may have left or died or is when sick or for other reasons she could not fulfil the baby's need for physical and emotional nourishment.

The child is forced to become independent too early but that leaves it insecure with a tendency to cling and grab, it has a decreased natural aggressiveness with an increased inner need to be taken care of. There is a subconscious fear of being left alone, not getting enough or what one wants or needs. The individual feels deprived and empty and does not want to take responsibility. Resentment is common and a forced show of independence easily crumbles under stress.

The oral personality has experienced many disappointments and rejections and feels a strong need for warmth and support from a mothering partner. In later life s/he may become bitter because there was never enough to be satisfied, 'the world is unjust'.

The body is generally underdeveloped and may look immature with a weak, narrow chest and shallow breathing. The energies are mainly in the head with a good intelligence, while the body energies and emotional energies are rather subdued. The main task in personal development is to give up playing the victim and learn to trust that the universe will provide.

Anal Stage (18 months to three years). At one and one-half years, the child enters the anal stage. As the physical ability to control the sphincter matures (2-3 years of age), the child's attention shifts from the oral to the anal zone.

With the advent of toilet training comes the child's obsession with the erogenous zone of the anus and with the retention or expulsion of the feces. The child meets the conflict

between the parent's demands and the child's desires and physical capabilities in one of two ways: either he puts up a fight or he simply refuses to go. The child who wants to fight takes pleasure in excreting maliciously, perhaps just before or just after being placed on the toilet. If the parents are too lenient and the child manages to derive pleasure and success from this expulsion, it will result in the formation of an anal expulsive character. This character is generally messy, disorganized, reckless, careless, and defiant. Conversely, a child may opt to retain feces, thereby spiting his parents while enjoying the pleasurable pressure of the built-up feces on his intestine. If this tactic succeeds and the child is overindulged, he will develop into an anal retentive character. This character is neat, precise, orderly, careful, stingy, withholding, obstinate, meticulous, and passive-aggressive. The resolution of the anal stage, proper toilet training, permanently affects the individual propensities to possession and attitudes towards authority.

Thus the polarities between eroticism/sadism, expulsion/retention, anal function/fecal product are expressed in conflicts related to ambivalence, activity/passivity, mastery, separation, and individuation. Orderliness, parsimony and obstinacy are common traits of the anal character. Ambivalence, untidiness, defiance, and sadomasochistic tendencies represent conflicts from this period. Various aspects of obsessive-compulsive neurosis suggest anal fixation. The symbolic meanings of giving and withholding ascribed to the activity of defecation at this stage are condensed in the Freudian equation faeces=gift=money.

Area of Conflict - Toilet training. Love Crisis: Love vs Hate. Here aggression and love can be fused so that there are strong vacillations between love and hate. Primary activities are giving-withholding.

Defense mechanisms.

1. Intellectualization - "redefine it" - dealing with painful situation only on intellectual level. Intellectualization or isolation: hiding one's emotional responses or problems under a facade of big words and pretending one has no problem. Likewise, people may discuss war without vividly feeling the misery of many people dying. This is a repression of the painful parts. Freud believed that the compulsive hand-washer was trying to cleanse his hands of the guilt of masturbation but the feeling of guilt was separated from the hand washing.

2. Reaction formation - "reverse it" - concealing a motive by consciously experiencing the opposite. Love turns into hate or hate into love. Where there is intense friction between a child and a parent, it can be converted into exaggerated shows of affection, sometimes sickeningly sweet and overly polite. The feelings and actions resulting from a reaction formation are often excessive, for instance the loud, macho male may be concealing (from himself) sexual self-doubts or homosexual urges. Or, the person who is unconsciously attracted to the same sex may develop an intense hatred of gays.

3. Undoing - "take it back" - engaging in thoughts or acts to atone for immoral desires or acts. If you have done something bad, sometimes you can undo it or make up for it.

Breakdown - Obsessive-compulsive.

Autonomy versus Doubt and Shame by Erikson. As the infant gains trust in his mother, his environment, and his way of life, he starts to discover that his behavior is his own. During the second and third years of life, children begin to communicate more effectively, walk, climb, hold, and release objects. The muscular-anal stage, which parallels Freud's anal stage, involves the asserting of a sense of autonomy. Simultaneously, however, a child's physical, social, and psychological dependencies create a certain sense of doubt of his or her capacity and freedom to assert this autonomy and to exist independently. Ultimately, the key question becomes: To what extent wills society, in the form of parents, allow them to express what they are capable of doing? Toilet training is the major defining aspect of this stage. The child is taught to hold on and let go only at the right times and places. The parents either allows the child to continue this training at his or her own pace allowing independence or the parents may become frustrated displaying impatience with the child at his or her behavior. Thus the feeling of self-doubt and

sense of shame develops in the child (Erikson, 1959). All child-rearing patterns, Erikson points out, lead to some sense of doubt and shame. It is merely the particular behavior to which a positive or negative value is attached which varies from culture to culture or from family to family.

Two character types could be specified which are expressive of the activities and conflicts of the anal psychosexual stage and are resulted from the fixation on this stage: obsessive-compulsive and psychopathic character types. In accordance with Horney's theory all three character types are those moving against people.

Obsessive-Compulsive character type. The DSM-IV (1994) describes Obsessive-Compulsive Personality Disorder as a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following (<http://www.geocities.com/ptypes/correspondence.html>):

- is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost;
- shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met);
- is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity);
- is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification);
- is unable to discard worn-out or worthless objects even when they have no sentimental value;
- is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way or doing things ;
- adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes;
- shows rigidity and stubbornness.

The Conscientious personality type is a nonpathological representation of this category.

Obsessive-compulsive personality disorder describes a disorder of perfectionism and inflexibility. Symptoms may include distress associated with indecisiveness and difficulty in expressing tender feelings, feelings of depression, and anger about being controlled by others. Hypersensitive to criticism, these people may be excessively conscientious, moralistic, scrupulous, and judgmental.

Oldham (1995) has defined the Conscientious personality style:

1.Hard work. The Conscientious person is dedicated to work, works very hard, and is capable of intense, single-minded effort.

2.The right thing. To be Conscientious is to be a person of conscience. These are men and women of strong moral principles and values. Opinions and beliefs on any subject are rarely held lightly. Conscientious individuals want to do the right thing.

3.The right way. Everything must be done "right," and the Conscientious person has a clear understanding of what that means, from the correct way to balance the checkbook, to the best strategy to achieve the boss's objectives, to how to fit every single dirty dish into the dishwasher.

4.Perfectionism. The Conscientious person likes all tasks and projects to be complete to the final detail, without even minor flaws.

5.Perseverance. They stick to their convictions and opinions. Opposition only serves to strengthen their dogged determination.

6.Order and detail. Conscientious people like the appearance of orderliness and tidiness. They are good organizers, catalogers, and list makers. No detail is too small for Conscientious consideration.

7. Prudence. Thrifty, careful, and cautious in all areas of their lives, Conscientious individuals do not give in to reckless abandon or wild excess.

8. Accumulation. A "pack rat," the Conscientious person saves and collects things, reluctant to discard anything that has, formerly had, or someday may have value for him or her.

Alexander Lowen (1958) described this character type as the rigid structure.

The child felt its sexuality rejected, especially by the parent of the opposite sex. Sexuality at this age may mean innocently touching or playing with the sexual organs which is strictly forbidden by the parent, and a longing to be close to the parent of the opposite sex by being touched and cuddled remains unfulfilled. The child deals with this perceived rejection by developing a rigid muscle structure that makes it easier to suppress the feelings of wanting and longing.

As an adult the rigid individual will hold back, remain controlled, holding back the expression of feelings and not daring to surrender. Pride does not allow him or her to reach out to fulfil his or her needs, instead s/he prefers to manipulate to get what s/he wants.

While there is a high degree of outer control and success in the social and physical world, the rigid person tries to protect the inner vulnerability and is afraid of getting hurt. A strong ego is used to avoid letting go of inner feelings. A common complaint is that s/he does not experience strong feelings.

The energies remain on the periphery while the core is contracted. The body is well balanced and appears energetic and integrated. The individual needs to open up and share all feelings.

Antisocial character type (<http://www.geocities.com/ptypes/correspondence.html>). The DSM-IV (1994) describes Antisocial Personality Disorder as a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

- failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
- deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure;
- impulsivity or failure to plan ahead;
- irritability and aggressiveness, as indicated by repeated physical fights or assaults;
- reckless disregard for safety of self or others;.
- consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
- lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

The Adventurous personality type is a nonpathological representation of this category.

Oldham (1995) has defined the Adventurous personality style:

1. Nonconformity. Men and women who have the Adventurous personality style live by their own internal code of values. They are not strongly influenced by other people or by the norms of society.

2. Challenge. To live is to dare. Adventurers love the thrill of risk and routinely engage in high-risk activities.

3. Mutual independence. They do not worry too much about others, for they expect each human being to be responsible for him- or herself.

4. Persuasiveness. They are silver-tongued, gifted in the gentle art of winning friends and influencing people.

5. Wanderlust. They love to keep moving. They settle down only to have the urge to pick up and go, explore, move out, move on. They do not worry about finding work, and live well by their talents, skills, ingenuity, and wits.

6. Wild oats. In their childhood and adolescence, people with the Adventurous personality style were usually high-spirited hell-raisers and mischief makers.

7. True grit. They are courageous, physically bold, and tough. They will stand up to anyone who dares to take advantage of them.

8. No regrets. Adventurers live in the present. They do not feel guilty about the past or anxious about the future. Life is meant to be experienced now.

Alexander Lowen (1958) described this character type as the psychopathic personality.

The psychopathic structure emerges in early childhood due to a covertly seductive parent of the opposite sex. The child was antagonistic to the parent of the same sex and tried to get what it wanted by manipulating the parent of the opposite sex. This pattern is continued in adult life by trying to gain power, control and desire fulfillment by manipulating others.

Deep inner feelings of inferiority are covered by superficial feelings of superiority and contempt. This person believes: "I am right, you are wrong", s/he wants to win and does not take defeat easily. Inwardly the psychopath feels the need for others but fears appearing to be dependent or even look like a victim. Pleasure comes second to conquest and control. Needs are fulfilled by making others need him or her. The will is the predominant mental function.

The upper half of the body is commonly overdeveloped and the lower half underdeveloped. The chest is wide but the pelvis narrow and the legs weak. Correspondingly, the main energy flows are centered in and around the upper body and the front of the head. The life task is to learn true surrender and humility by admitting the inner longings and needs.

Phallic Stage (ages three to six). The phallic stage is the setting for the greatest, most crucial sexual conflict in Freud's model of development. In this stage, the child's erogenous zone is the genital region. As the child becomes more interested in his genitals, and in the genitals of others, conflict arises. The conflict, labeled the Oedipus complex (The Electra complex in women), involves the child's unconscious desire to possess the same-sexed parent and to eliminate the opposite-sexed one.

Fixation at the phallic stage develops a phallic character, which is reckless, resolute, self-assured, and narcissistic - excessively vain and proud. The failure to resolve the conflict can also cause a person to be afraid or incapable of close love.

Phallic Fixation: For men: Anxiety and guilty feelings about sex, fear of castration, and narcissistic personality. For women: It is implied that women never progress past this stage fully and will always maintain a sense of envy and inferiority, although Freud asserted no certainty regarding women's possible fixations resulting from this stage.

Defense Mechanism:

Repression - "Don't remember it" - active prevention of threatening thoughts from entering consciousness. Repression is referred to as the primary ego defense mechanism since the other ego defense mechanisms require it to have taken place before they may be expressed. Repression occurs when troublesome, anxiety laden, thoughts, experiences, or events in one's world are unconsciously relegated to one's unconscious mind. Repression must be distinguished from suppression and withdrawal. Suppression is more conscious and deals with unpleasant but not usually utterly despicable acts or thoughts.

Love Crisis: Love vs. Being Loved - here one is torn between the active (male) or passive (female) sexuality.

Breakdown - hysteria in women; homosexuality or perversions in men.

Initiative versus Guilt by Erikson (1959). From ages three to five the child enters the third stage of development known as the locomotor-genital stage. Having learned some measure of conscious control over himself and his environment, the individual can now rapidly move forward to new conquests in ever-widening social and spatial spheres. Corresponding to Freud's phallic stage, the child now has a strong desire to take the initiative in many activities including fantasies. As the child searches for and creates fantasies about the active person he wants to become, he consciously and unconsciously tests his powers, skills, and potential

capacities. He initiates behavior to go beyond himself; he intrudes into others' spheres and gets others involved in his own behavior. It is again the way in which the parents respond to this behavior that determines ultimately whether or not the child develops guilt. In the Oedipal relationship, for example, if the parents guide the situation with love and understanding, the child will learn what is acceptable behavior and is then able to channel the initiative toward realistic goals.

Two character types could be specified which are expressive of the activities and conflicts of the anal psychosexual stage and are resulted from the fixation on this stage: cyclothymic, histrionic and masochistic character types. In accordance with Horney's theory all three character types are those moving towards people.

Cyclothymic character type (<http://www.geocities.com/ptypes/correspondence.html>). DSM-IV (1994) describes this character type as a pervasive pattern of pronounced changes in mood, behavior, thinking, sleep, and energy levels, beginning by early adulthood and present in a variety of contexts, as indicated by seven (or more) of the following:

- has depressive periods: depressed mood or loss of interest or pleasure in all, or almost all, activities and pastimes alternating with hypomanic periods: elevated, expansive, or irritable mood;
- has a decreased need for sleep alternating with hypersomnia;
- has shaky self-esteem: naive grandiose overconfidence alternating with lack of self-confidence;
- has periods of sharpened and creative thinking alternating with periods of mental confusion and apathy;
- displays marked unevenness in the quantity and quality of productivity, often associated with unusual working hours;
- engages in uninhibited people-seeking (that may lead to hyper-sexuality) alternating with introverted self-absorption;
- becomes excessively involved in pleasurable activities with lack of concern for the high potential of painful consequences alternating with restriction of involvement in pleasurable activities and guilt over past activities;
- alternates between over-optimism or exaggeration of past achievement and a pessimistic attitude toward the future, or brooding about past events;
- is more talkative than usual, with inappropriate laughing, joking, and punning; and, then, less talkative, with tearfulness or crying;
- frequently shifts line of work, study, interest, or future plans;
- engages in occasional financial extravagance;
- makes frequent changes in residence or geographical location;
- has a tendency toward promiscuity, with repeated conjugal or romantic failure;
- may use alcohol or drugs to control moods or to augment excitement.

The Artistic personality type is a nonpathological representation of this category.

The following ten traits and characteristics are typical of the Artistic personality type.

1. Mood swings. Those of the Artistic temperament tend to experience a greater range of emotion than those of any other type. They are very emotionally reactive.

2. Artistic inclinations.

3. Independent work.

4. Relationships secondary. Those of the Artistic temperament are quite likely to choose relationships which will further their work rather than relationships which are intrinsically rewarding, and their spouses may well find that marital relations take second place.

5. Great productivity. Persons of the Artistic type are highly disciplined, gifted with superior powers of concentration, and capable of producing great quantities of high quality work; they also enjoy frequent periods of recreation and inactivity.

6. Disinhibition. They are hedonistic and impulsive.

7. Keen perceptions. The Artistic temperament is especially attuned to color, line, texture, shading - touch, motion, seeing, and hearing in harmony. The senses of Artistic individuals seem more keenly tuned than those of others.

8. Kindness. Although those of the Artistic type may adopt an aggressive, tough exterior, they are remarkably gentle, kind, and generous.

9. Extroversion and introversion. The interpersonal conduct of those of the Artistic type alternates between the greatest extremes of sociability and social reticence.

10. Love of nature.

Histrionic character type (<http://www.geocities.com/ptypes/correspondence.html>). The DSM-IV (1994) describes Histrionic Personality Disorder as a pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- is uncomfortable in situations in which he or she is not the center of attention;
- interaction with others is often characterized by inappropriate sexually seductive or provocative behavior;
- displays rapidly shifting and shallow expression of emotions;
- consistently uses physical appearance to draw attention to self;
- has a style of speech that is excessively impressionistic and lacking in detail;
- shows self-dramatization, theatricality, and exaggerated expression of emotion;
- is suggestible, i.e., easily influenced by others or circumstances;
- considers relationships to be more intimate than they actually are.

The Dramatic personality type is a nonpathological representation of this category.

Oldham (1995) has defined the Dramatic personality style:

1. Feelings. Dramatic men and women live in an emotional world. They are sensation oriented, emotionally demonstrative, and physically affectionate. They react emotionally to events and can shift quickly from mood to mood.

2. Color. They experience life vividly and expansively. They have rich imaginations, they tell entertaining stories, and they are drawn to romance and melodrama.

3. Attention. Dramatic people like to be seen and noticed. They are often the center of attention, and they rise to the occasion when all eyes are on them.

4. Appearance. They pay a lot of attention to grooming, and they enjoy clothes, style, and fashion.

5. Sexual attraction. In appearance and behavior, Dramatic individuals enjoy their sexuality. They are seductive, engaging, charming tempters and temptresses.

6. Engagement. Easily putting their trust in others, they are able to become quickly involved in relationships.

7. The spirit is willing. People with Dramatic personality style eagerly respond to new ideas and suggestions from others.

Masochistic (Self-defeating) character type. The DSM-IV (1994) described Self-defeating Personality Disorder (<http://www.geocities.com/ptypes/correspondence.html>) as a pervasive pattern of self-defeating behavior, beginning by early adulthood and present in a variety of contexts. The person may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer, and prevent others from helping him or her, as indicated by at least five of the following:

- chooses people and situations that lead to disappointment, failure, or mistreatment even when better options are clearly available;
- rejects or renders ineffective the attempts of others to help him or her;

- following positive personal events (e.g., new achievement), responds with depression, guilt, or a behavior that produces pain (e.g., an accident);
- incites angry or rejecting responses from others and then feels hurt, defeated, or humiliated (e.g., makes fun of spouse in public, provoking an angry retort, then feels devastated);
- rejects opportunities for pleasure, or is reluctant to acknowledge enjoying himself or herself (despite having adequate social skills and the capacity for pleasure);
- fails to accomplish tasks crucial to his or her personal objectives despite demonstrated ability to do so, e.g., helps fellow students write papers , but is unable to write his or her own;
- is uninterested in or rejects people who consistently treat him or her well, e.g., is unattracted to caring sexual partners;
- engages in excessive self-sacrifice that is unsolicited by the intended recipients of the sacrifice;

The behaviors do not occur exclusively in response to, or in anticipation of, being physically, sexually, or psychologically abused. The behaviors do not occur only when the person is depressed.

The Self-sacrificing personality type is a nonpathological representation of this category.

Oldham (1995) has defined the Self-sacrificing personality style:

1. Generosity. Individuals with the Self-Sacrificing personality style will give you the shirts off their backs if you need them. They do not wait to be asked.

2. Service. Their "prime directive" is to be helpful to others. Out of deference to others, they are noncompetitive and unambitious, comfortable coming second, even last.

3. Consideration. Self-Sacrificing people are always considerate in their dealings with others. They are ethical, honest, and trustworthy.

4. Acceptance. They are nonjudgmental, tolerant of others' foibles, and never harshly reproving. They'll stick with you through thick and thin.

5. Humility. They are neither boastful nor proud, and they're uncomfortable being fussed over. Self-Sacrificing men and women do not like being the center of attention; they are uneasy in the limelight.

6. Endurance. They are long-suffering. They prefer to shoulder their own burdens in life. They have much patience and a high tolerance for discomfort.

7. Artlessness. Self-Sacrificing individuals are rather naive and innocent. They are unaware of the often deep impact they make on other people's lives, and they tend never to suspect deviousness or underhanded motives in the people to whom they give so much of themselves.

Alexander Lowen (1958) described this character type as the Masochistic Character.

The parents and especially the mother were domineering and gave love in a conditional way. The mother may have been self-sacrificing and the child was made to feel guilty whenever it was resisting and trying to assert itself. This made it feel trapped, defeated and humiliated. Therefore, the real feelings were held inside and creativity suppressed. Much anger, hate and resentment are hidden underneath a submissive and polite exterior.

The individual complains a lot and dwells on the negative side of things. By subconsciously provoking others s/he may be given an excuse to become angry, to let off steam, but generally the outward attitude is to please others.

The body may be heavily build with overdeveloped muscles and short neck and waist. Tensions are strongest in the neck, jaw, throat and pelvis. The energies and emotions are internalized. To become free, the masochist needs to express feelings and become more assertive and aggressive.

Summary of Major Problems of Character Types:

- A. Orals - have problems with dependency needs (boundaries, communication).
- B. Annals - have problems with aggression - either overcontrol or undercontrol.
- C. Phallics - have problems with sex and sexual identity (self-image).

The systematization of the existing classification of character types is given below.

Table. Systematization of the existing classifications of character types.

Author	Character types classification							
	I			II		III		
Hippocrates/Galen	melancholic			phlegmatic	choleric	Sanguine		
I.P. Pavlov	weak			strong, balanced	strong, non-balanced	strong, balanced		
E. Kretschmer	asthenic schizoid schizothymic			athletic epileptoid		Pyknic Histeroid Cyclothymic		
W. Sheldon	cerebrotonia ectomorphy			somatotonia mesomorphy		Viscerotonia Endomorphy		
S. Freud	oral			anal		Phallic		
K. Horney	“away from people”			“against people”		“toward people”		
Myers-Briggs	ISTJ	INTJ	ENTJ	ESTJ	ESFP	ENFJ	ENTP	INFJ
DSM-IV	schizoid	narcissistic	paranoid	obsessive - compulsive	antisocial	histrionic	cyclothymic	Masochistic
J. Oldham	solitary	self - confident	vigilant	conscientious	adventurous	dramatic	artistic	self – sacrificing
W. Reich A. Lowen	schizoid	oral	-	rigid	psychopathic	hysteric	-	Masochistic

Rhythmic Movement Psychotherapy: Correction of Self Image

*You are led
through your lifetime
by the inner learning creature,
the playful spiritual being
that is your real self.*

Richard Bach "Illusions"

Following the results of the previous diagnosis section the main objects of work in Rhythmic Movement Psychotherapy are for orals – core problems of boundaries and communication, for annals – core problems of aggression and overcontrol, for phallics – core problem of self-image. Also we work with three core problems common for all character types: grounding, blockage release and integration.

1. Boundaries

Personal boundaries are the physical and emotional borders around us. A concrete example of a physical boundary is our skin. It distinguishes between that which is inside you and that which is outside you. On a psychological level, a person with strong boundaries might be able to help out well in disasters- feeling concerned for others, but able to keep a clear sense of who they are. Someone with weak boundaries might have sex with inappropriate people, forgetting where they end and where others begin. Such a person may not feel "whole" when alone.

Our psychological boundaries develop early in life, based on how we are held and touched (or not held and touched). A person who is deprived of touch as an infant or young child, for example, may not have the sensory information s/he needs to distinguish between what is inside and what is outside her/himself. As a result, boundaries may be unclear or unformed. This could cause the person to have difficulty getting an accurate sense of his/her body shape and size. This person might also have difficulty eating, because they might have trouble sensing the physical boundaries of hunger and fullness or satiation. On the other extreme, a child who is sexually or physically abused may feel terrible pain and shame or loathing associated to his/her body. Such a person might use food or starvation to continue the physical punishments they grew familiar with in childhood.

Using the special movement exercises RMP helps person to establish their boundaries, to feel the exact body shape and thus to enter the communication process without fear to "be eaten" by others. Rhythmic movement psychotherapy help you to know what you feel, understand why you feel it, express what you feel, and act on the basis of your true feelings, enhance feelings of well-being by bringing you in-touch with your body.

2. Communication

The ability to make friends, socialize and engage in small talk is something most of us take or granted however some people are simply not capable of normal social interaction. The most noticeable characteristics of such people are usually the absence of friends and their tendency to have obsessional interests be it astronomy, cars or Star Trek. Perhaps they seem awkward and clumsy, they may avoid eye contact, perhaps they use complicated words yet misinterpret facial expressions and body language and while they seem unable to hold a two-way conversation or join in group activities they will talk monotonously at length about their particular obsessional interest or interests.

During RMP sessions a person understands his/her situational communication problems and learns effective communication patterns. Through body action as the most basic form of communication a dialogue emerges that tells of an individual's relationship to self, others, and

the environment. By working with movement patterns, and by focusing on the interrelationship between psychological and physiological processes, individuals are helped to reveal, release, and transform internalized feelings, conflicts, and desires.

3. Aggression (http://txtx.essortment.com/whatisaggress_rxeo.htm).

Psychologists have found that attempts to define aggression are fraught with difficulties. There does appear to be a consensus though that 1.) animal studies can shed a great deal of light regarding aggressive behavior in humans and 2.) some evidence exists for a continuum between mild through to severe aggression.

For instance, we can all demonstrate aggression under certain circumstances and sometimes it is even encouraged (, as is the case in competitive sports). On the other hand, psychopaths demonstrate high levels of this behavior without any apparent goal or reason.

At a basic level, aggression in humans may be physical (e.g. hitting out) or verbal, while in animals it may be manifest as a threat or as an attack. There are therefore various 'kinds' of aggressive behavior:

1. Self-defensive behavior - when aggression results from threats to the individual is accompanied by fear and is generally preceded by escape/avoidance attempts.
2. Social conflict - a variety of activities, all of which relate to interspecific competition for resources that are important for reproductive success.
3. Predatory attack - attack of an object which approximates to a natural prey species
4. Parental defense - similar to animal Maternal Aggression
5. Reproductive termination - refers to infanticide - killing of the young.

In conclusion, the difficulties of defining aggression lie in the fact that there are many different kinds of aggressive behavior. Which type of behavior that will be exhibited therefore depends on the environmental circumstances, the active neural circuits and the specific, 'triggering' stimuli and/or how useful the behavior is to the animal/human exhibiting the aggression. All of these factors should therefore be considered when attempting to explain aggressive behavior - it is NOT enough to simply say he/she is 'aggressive'.

RMP helps people to identify the usual sources and subjects of their aggressive behavior and helps to relax in critical situation of aggression. By utilizing the rhythmic movement, patients increase their understanding and expression of feelings, recognize options, develop coping skills, increase focus and concentration, recognize strengths, accept limitations, learn to relax and hence work towards effective anger management.

4. Overcontrol

With the behaviors we choose we attempt to control our lives. All behaviors are made up of three components: what we do, what we think, and what we feel. All behaviors are an attempt to satisfy powerful forces within ourselves. Regardless of our circumstances, all we do, think, and feel is always or best attempt at the time to satisfy the forces within us.

Sometimes this behavior may be ineffective or even destructive. For example, it could be psychosomatic illness, drug addiction, and other radical behaviors as individuals struggling to gain control of their lives in the best way they know how. Conversely, some people give up when feeling they have lost control. This ineffective behavior may persist even when other options later become available.

Control is not a need; it is a way we must function to fulfill our needs. Our behavior is our attempt to reduce the difference between what we want (our picture in our heads) and what we have (the way we see situations in the world). This behavior involves acting, thinking, feeling, or may involve our bodies. We often hang on to a picture in our heads even if it means in engaging ineffective behaviors. There are four separate components of what is called total behavior, doing (or active behaviors), thinking, feeling, and physiology. The more we are able to recognize all of the different components of our behavior the more we will be in control of our lives.

The main aim of RMP while working with the overcontrol core problem is to teach a person other productive behavioral stereotypes for fulfilling his/her needs. Listening to the "messages" of your body promotes the confidence of knowing when you are doing the right thing for you.

5. Self-image (see below)

6. Grounding

Alexander Lowen has established the concept and practice of Grounding, which occurs first of all on the physical level. Being grounded is to have a physically secure but flexible stance. Phenomenological this means to be connected to reality. The emphasis on grounding and on contact with reality leads in therapy to working on the social directness of nearly all emotional movements. Thus the social, familial, professional, political and ideological relatedness of the person also becomes the focus of attention in therapy.

The special RMP movement exercises help a person to increase the feeling of grounding.

7. Blockage release and Integration.

The psychological defenses one uses to handle pain and the stress of life - rationalizations, denials, and suppressions, are also anchored in the body. They appear in the body as unique muscular patterns that inhibit self-expression. These patterns can be identified and understood by a psychotherapist who knows how to look at the structure, movement and breathing patterns in a person's body. Rhythmic movement psychotherapists focus special attention on the muscular patterns in a person's body. They are interested in these patterns and their relationship to movement, breath, posture and emotional expression. Every physical expression of the body has meaning; the quality of a handshake, the posture, the look in the eyes, the tone of the voice, the way of moving, the amount of energy, etc. If these expressions are fixed and habitual, they tell a story of past experience.

The rhythmic movement psychotherapist studies these muscular patterns and introduces the client to physical expressions or exercises to help them experience in present time these patterns of constriction in their body. The therapist explores with the client what it would feel like to begin to release these patterns and recover some of the feelings they have repressed during childhood and continue to repress in their adult life. The rhythmic movement psychotherapist also helps their clients come to understand how and why their patterns of constriction developed; how these very defenses that are hindering their life today, allowed them to survive in an early environment that was not supportive of their being.

As these repressed emotions emerge, clients begin to realize that these patterns inhibit their capacity for spontaneity and creativity in self-expression. They begin to understand that as these defenses became chronic, so have the muscular patterns in their body. These somatic defenses affect their emotional well-being by decreasing energy level and restricting the capacity for genuine self-expression in relationships; they are not free enough in their body to feel joy, happiness, love, sadness, fear, sensuality and anger. As clients progress in psychotherapy, old, ineffective patterns which block connection, pleasure, spontaneity and joy slowly dissolve. Through the physical and emotional release of bodywork and the experience of a safe, healthy, supportive connection with a therapist, the client relates to his/her self and others in new, more satisfying ways. Through identifying patterns of blocked self-expression in the body, the psychotherapist develops a clearer understanding of the various personality types and their corresponding psychological problems. Understanding a person's specific patterns of blocked self-expression suggests the basic defensive structure of the individual, which developed as a result of their personal psychological history. In the context of theory of rhythmic movement psychotherapy, discovering patterns of blocked self-expression and their corresponding connection to personality type, allows the emergence of a potential framework for the course of therapy.

In this section we present the example of Rhythmic Movement Psychotherapy session

with the focus on self-image as a problem. The duration of the session is 2 hours and it starts with the introduction into the theory of the problem under consideration given by therapist. Each session is devoted to one selected core problem. The core problem could be proposed by the member of the group, but could be also selected by the therapist.

Theory.

Self-image is:

- ⇒ How you regard yourself.
- ⇒ The mental picture of how you believe you appear to others.
- ⇒ How you picture your physical self.
- ⇒ How you believe others see you physically.
- ⇒ Your idea (positive or negative, rational or irrational) of how you present yourself to others and how you are subsequently judged by them.
- ⇒ A personal assessment of your character, personality, skills, abilities, and other attributes.
- ⇒ A powerful internal mechanism influencing how you feel about yourself.
- ⇒ An accumulation of scripts you have been given (consciously or otherwise) and have learned well throughout your life.

Your self-image is developed by how you assess the following factors in your personhood:

- ⇒ Physical appearance.
- ⇒ Shape of your body.
- ⇒ Accomplishments in academics.
- ⇒ Achievement in athletics.
- ⇒ Social skills.
- ⇒ Value system.
- ⇒ Skills, abilities and competencies.
- ⇒ Relationship with family, relatives, siblings, peer group, and others.
- ⇒ Behavior in social and professional situations.
- ⇒ Background and environment from which you came.
- ⇒ Roles played in life at school, home, work and in the community.
- ⇒ Jobs and job titles held.
- ⇒ Goals, ambitions and aspirations for the future.

It is from your self-image that you:

- ⇒ Develop labels for yourself.
- ⇒ Develop scripts as to how you believe you should act to fit the image.
- ⇒ Develop expectations for how you are to act and react.
- ⇒ If you act and react according to the expectations, then you develop high self-concept.
- ⇒ If you act and react differently from the expectations, you see yourself in a negative light, resulting in a poor self-concept.
- ⇒ Develop self-talk by which you continuously reinforce your self-image.
- ⇒ Positive self-talk yields self-affirming behaviors.
- ⇒ Negative self-talk yields self-defeating behavior.
- ⇒ Set goals for yourself.

If self-image is too high or unrealistic, you set goals that are often unreachable or too perfectionistic. You continue to fall short of the mark. If self-image is too low and unrealistic, you set goals that are too easily reached, never attaining overall satisfaction. If self-image is realistic, you can set attainable goals leading to overall satisfaction.

Practically it is relatively easier to indicate and improve low self-image, than idealized (too high) self-image. The idealized self-image is supposed to be a means of avoiding

unhappiness. Since unhappiness automatically robs the child of security, self-confidence is diminished according to the unhappiness and ensuing lack of security. This unhappiness cannot be measured objectively. What one personality may be able to cope with quite well and does not experience as drastic unhappiness, another temperament and character feels as a dismal woe. At any rate, unhappiness and lack of belief in oneself are interconnected. Hence, the creation of the idealized self-image serves the purpose of obtaining the missing self-confidence, so that thereby pleasure supreme can be gained. This is the unconscious reasoning process.

The more you try to identify with your idealized self image, the harder is the disillusionment whenever life brings you into a position when this masquerade can no longer be maintained. Many a personal crisis is based on this factor and much less on the outer difficulties. But these difficulties then become an added menace, beyond their objective hardship. The existence of the difficulties is a proof to you that you are not your idealized self, and that robs you of the false self-confidence you tried to establish with the idealized self.

Sense of failure, frustration, and compulsion, as well as guilt and shame, are the most outstanding indications of your idealized self-being at work. These are the consciously felt emotions of all that lies hidden underneath.

In contrary to many other psychotherapies who are working with self-image through verbal intervention, we are improving (or balancing) the self-image through direct bodywork (rhythmic movement) with body image.

Body image, one part of self-image, is the way people see their bodies in their mind's eye. Body image is an individual's experience of his/her body. It is the mental picture a person has of his/her body as well as the individual's associated thoughts, feelings, judgments, sensations, awareness and behavior. Body image influences behavior, self-esteem, and our psyche. When we feel bad about our body, our satisfaction and mood plummet. If we are constantly trying to push, reshape or remake our bodies, our sense of self becomes unhealthy. We lose confidence in our abilities. It's not uncommon for people who think poorly of their bodies to have problems in other areas of their lives, including sexuality, careers and relationships.

Body image is (http://www.edereferral.com/body_image.htm)

- ⇒ How you see or picture yourself.
- ⇒ How you feel others perceive you.
- ⇒ What you believe about your physical appearance.
- ⇒ How you feel about your body.
- ⇒ How you feel in your body.

Body image affects how people view themselves because:

- ⇒ Physical appearance is the external presentation people make to others.
- ⇒ Physical appearance is the first quality by which people are judged.
- ⇒ Our society is very physical appearance oriented, e.g., where thin is in, muscles and flat stomachs are in, etc.
- ⇒ If you feel attractive, you will act accordingly; the reverse is true if you feel unattractive.
- ⇒ Your self-image is affected by the ways others react to your physical appearance.

Body image is not static - but ever changing; sensitive to changes in mood, environment, and physical experience. It is not based on fact. It is psychological in nature, and much more influenced by self-esteem than by actual physical attractiveness as judged by others. It is not inborn, but learned. This learning occurs in the family and among peers, but these only reinforce what is learned and expected culturally.

Body image is developed through interactions with people and the social world, changing across life span in response to changing feedback from the environment.

Body image is shaped by many factors including:

- * judgments or comments from others,
- * sexual and racial harassment,
- * stigmatization,
- * prevailing social values,
- * physical changes in the body during puberty, menopause, and pregnancy,
- * socialization,
- * how the individual feels about him or herself,
- * violence—verbal, physical or sexual abuse, and
- * actual conditions of the body—illness or disabilities.

People can develop many different body image, eating and weight problems. Because body image is neither a static nor a one-dimensional idea, it is helpful to situate the range of body image problems on a continuum. This enables us to see that body image issues vary in severity and effect but also to recognize they stem from common roots.

At one end of the continuum are healthy body and self-esteem, which represent the goal of body and self-acceptance. Dissatisfaction with body image follows, then weight preoccupation, yo-yo dieting, dieting induced overweight, and emotional and compulsive eating. Finally, on the opposite end of the continuum are eating disorders such as anorexia and bulimia. The following is an explanation of the continuum of body and food issues:

Healthy Body Image: When a person's mental picture of her body is accurate and her feelings, assessment and relationship towards her body are positive, confident and self-caring, she probably has a healthy body image. She probably also has a positive self-concept. Self-esteem is defined as the judgments a person makes and maintains about herself. It is a general attitude of approval or disapproval that indicates whether the person believes herself to be worthy and capable. While self-esteem is shaped by many factors, including how others respond to a person, healthy body image has become a key facet of positive self-esteem, especially for women. This is because we live in a culture that places so much emphasis on appearance and women's bodies.

Body Image Dissatisfaction: The most common body image problems are dissatisfaction and distortion. Dissatisfaction simply means not liking one's body or specific body parts. Distortion is the inability to accurately judge the size of one's body. Both body image problems are more common in girls and women. In a society that places so much emphasis on measuring up to rigid ideals, few women escape self-esteem problems related to these body image issues. Narrow ideals leave little room for difference, diversity, individuality or respect for natural changes in the body across life span, which directly relates to lowered self-esteem.

Emotional/Compulsive Eating: When an individual feels unable to stop herself from eating, she may be eating compulsively. Out-of-control eating happens when the person does not acknowledge what she is doing, by eating quickly, secretly or in a trance-like state. Often, people eat compulsively following periods of dieting or starvation. People may also eat compulsively to cope with emotional difficulties, hardship, or traumatic experiences.

It is important to note that 35-75% of women with serious eating and weight problems have experienced some form of abuse, such as sexual abuse, physical abuse and witnessing violence between parents. Some women with eating disorders develop problems with alcohol or drugs. Women may binge on alcohol or use alcohol and drugs to facilitate bingeing. Alternately, a woman may be dependent on the addictive substance and engage in "eating disordered" behavior.

Preferences for body shape have varied over time and between cultures. In a culture where a woman's value is determined by the attractiveness of her body, her identity becomes closely connected with how she looks. This causes the culture to view women's bodies as objects, which, in turn, cause women to see themselves as objects. Treating the body as an

object may affect an adult woman's physical health. It can also have an enormous long-term impact on emotional health. Preoccupation with physical appearance causes many to become afraid of their bodies and bodily functions, channel energy away from more important things in life into a self-perpetuating and losing battle, and leave them with more intensified feelings of hatred for their bodies and often themselves. Changing feelings and attitudes about the body is a longer term answer than changing the body, but one that is more likely to work. It is also a permanent solution. By examining underlying feelings about their bodies, exploring the cultural and individual roots of these feelings, and expanding notions of what is beautiful, women can learn to accept their bodies. Through this process, many women also find greater self-confidence, personal power and acceptance.

The main idea of Rhythmic Movement Psychotherapy when doing body image correction is to change the movement stereotypes. Having in mind the unbreakable connection between body and mind we can say that the change of movement stereotypes will change person's mental stereotypes and makes person more flexible.

The Rhythmic Movement Session consists of three parts: warming up, rhythmic movement and integrating.

Warming up (example only).

Each member of the group is presenting two short dances: "My real self" and "My idealized self".

Rhythmic Movement (examples only).

The most effective methods in creating new movement stereotypes are character dances: Latin dances (mamba, rumba, cha-cha-cha), rape, hip-hop, etc. We present the description of "Bad Boy Walkin' (Shame on You!) dance.

Bad Boy Walkin' (Shame on You!)

Choreographer: Vicki E. Rader, E-Mail: rader_vicki@bah.com

Web Page: <http://www.countrydance.net/cdn/VRader.html>

Type: 4 Wall Line Dance

Steps/Count: 32

Bpm: 120

Music: "Bad Bad Boy" by John Fogerty - 120 bpm, CD: Blue Moon Swamp

"Bring It Down to Jelly Roll" by John Fogerty - 116 bpm, CD: Blue Moon

Swamp

Description:

Heel-toe Struts And Finger Snaps

1-2 Step forward on right heel; drop toe to the floor, snap fingers of right hand

3-4 Step forward on left heel; drop toe to the floor, snap fingers of right hand

5-6 Step forward on right heel; drop toe to the floor, snap fingers of right hand

7-8 Step forward on left heel; drop toe to the floor, snap fingers of right hand

(Optional styling for Bad Bad Boy: Strut like you're ba-a-ad; bend knees with each step, snap fingers like you're cool)

Toe Sweep 1/2 Right, Toe Sweep 1/4 Left

9-10 Slide right toe forward, begin sweeping a 1/2 circle to the right (your body will follow, pivoting on the left foot)

11-12 Complete the 1/2 circle sliding right foot in next to left foot (shifting weight to right foot); hold the count

13-14 Slide left toe forward, begin sweeping a 1/4 circle to the left (your body will follow, pivoting on the right foot)

15-16 Complete the 1/4 circle sliding left foot in next to right foot (shifting weight to left foot); hold the count

- Right Grapevine, Monterey Turn
- 17-18 Step right on right foot; step left foot behind right
- 19-20 Step right on right foot; step left foot together with right
(shifting weight to left foot)
- 21-22 Touch right toe to right side; pivot 1/2 right on left foot stepping right foot next
to left
- 23-24 Touch left toe to left side; bring left foot together with right
(shifting weight onto left foot)
- Cross-Rock Steps
- 25-26 Step right foot across left foot and rock weight onto right foot;
rock back onto left foot
(Optional styling for Bad Bad Boy: Shake your right index finger forward
twice with the rock-step ("...shame on you!"))
- 27-28 Step right foot home; hold the count
- 29-30 Step left foot across right foot and rock weight onto left foot;
rock back onto right foot
(Optional styling for Bad Bad Boy: Shake your left index finger forward
twice with the rock-step ("...shame on you!"))
- 31-32 Step left foot home; hold the count
- Start Again!

Integrating (example only).

Creating a new self-image using Magic dance techniques. Magic dance is the dance imitation of major human archetypes. Magic dance is based on a specific sequence of movements that allow a profound contact with the inner self. The combinations of movements have a precise correspondence inside each human being: the body is used as an instrument of inner knowledge and expression is carried out through all the senses, involving the whole of the human being.

Jung (1969) discovered that humans have a "preconscious psychic disposition that enables a (man) to react in a human manner." These potentials for creation are actualized when they enter consciousness as images. There is a very important distinction between the "unconscious, pre-existent disposition" and the "archetypal image." The archetype may emerge into consciousness in myriad of variations. To put it another way, there are a very few basic archetypes or patterns which exist at the unconscious level, but there are an infinite variety of specific images which point back to these few patterns. Since these *potentials for significance* are not under conscious control, we may tend to fear them and deny their existence through repression.

In his earlier work, Jung tried to link the archetypes to heredity and regarded them as instinctual. We are born with these patterns which structure our imagination and make it distinctly human. Archetypes are thus very closely linked to our bodies. In his later work, Jung was convinced that the archetypes are *psychoid*, that is, "they shape matter (nature) as well as mind (psyche)". In other words, archetypes are elemental forces, which play a vital role in the creation of the world and of the human mind itself. The Archetypes are as follows.

The Shadow. The most basic potential for patterning is the Shadow Archetype. This is the potential of experiencing the unconscious side of our unique personalities. As we move deeper into the dark side of our personality personal, identity begins to dissolve into "latent dispositions" common to all men. We experience the chaos, which indicates that we are drawing close to the material structure of psychic life. This "Other Side" may be manifested in a wealth of images. The image of "wilderness" is fundamental. Remember that Hanzel and Gretel were led "into the woods" and were trapped. Knights discover dragons, ogres, and thieves in the woods. The image may be that of the mob and its underworld, an urban

equivalent in which "Pretty Boy" Floyd is a hero. There is always "the concrete jungle." Dragons sail the sea, "the watery wilderness."

The Shadow is the easiest of the archetypes for most persons to experience. The Shadow is the personification of that part of human, psychic possibility that we deny in ourselves and project onto others. The goal of personality integration is to integrate the rejected, inferior side of our life into our total experience and to take responsibility for it.

The Anima Or Animus. The second most prevalent potential patterning is that of the Soul (Anima is the male name for soul; Animus is the female name for soul). Here we meet our inner opposite. Males meet their Anima; females their Animus. The Anima may appear as an exotic dancing girl or a weathered old hag--the form generally reflects either the condition or the needs of our soul presently. The Animus may appear as an exotic, sensual, young man or as an old grouch. Remember the Great Oz who ran the Emerald City? Consider Super Man and Lois Lane. Clark Kent is the inferior, shadow side of Super Man, but he is also closer to ordinary people. Lois Lane has no interest in Clark. She is infatuated with Super Man, her Animus; the masculine completion of her personality. Wonder Woman offers us an example of the Anima in action.

The Syzygy (Divine Couple). If one comes to terms with the Shadow and the Soul, one will encounter the enchanted castle with its King and Queen. This is a pattern of wholeness and integration. The opposites of the outer and the inner life are now joined in marriage. Great power arises from this integration. Christ and the Church, God and Israel are syzygy images. The believer who aspires to be the "bride of Christ" is modeling his or her experience in response to the syzygy archetype.

The Child. The Child Archetype is a pattern related to the hope and promise for new beginnings. It promises that Paradise can be regained. Child images like the New Year's Babe obviously derive from this archetype. So do the golden ring and the golden ball and most flower and circle related images. The birth of the Christ Child, who unites Heaven and Earth, Man and God, is a powerful archetypal event. Were the life of Jesus not interpreted by this archetype, it would lose most of its meaning.

The Self. The ultimate pattern is the *Self*. For Jung this is the God image. Human self and divine self are incapable of distinction. All is Spirit. Images of Spirit abound. Wind and breathe being two very common ones. The Spirit descends as a Dove upon Jesus in the wilderness. The voice declares to him his true nature: "You are my Son, my Beloved." This is an archetypal drama of the Self. Galahad achieving the Grail and ascending with it to Heaven is likewise an archetypal drama of Self. Lancelot's failure to achieve the Grail speaks of his failure to achieve the final discovery of Self.

Magic dance is emerging inner conflicts and issues from the unconscious to the consciousness of the person. Seeking the full integration of mind and body, and bringing harmony between all the aforementioned levels of the human being is what magic dance is all about.

Conclusion

What really matters in the process of Rhythmic Movement Psychotherapy is the relationship among the three basic levels of our earthly experience - the mind, the emotional body, and the physical body. The mind may access the spiritual truths of the utmost importance to all life, but it is only through the body that such truths are made relevant in the world around us. In this sense, we are all channels of light and love. It is only through the emotional body that emotion will flow to motivate us to do so - provided it is sufficiently free of insecurities (as to basic needs) to do so. Thus the bridge, between idealization (of the highest principles, qualities, healing, inventions, etc) and actualization, relies on effective "inner-personal communications." Cooperation between Universe and man and between man and man cannot be clearly honest and thereby effective, if man is not honest and cooperating within his own Being. With such self-honesty comes clarity of mind: purpose and meaning concerning our past experience, and how it relates to both the present and to future goals, is much more apparent.

Rhythmic Movement Psychotherapy helps people to improve their Quality of Life through understanding the personality in terms of the body; improving all functions of the personality by mobilizing the energy bound by rhythmic movement; increasing an individual's capacity to experience pleasure by resolving the characterological attitudes that have become structured in the body and that, therefore, interfere with its rhythmic and unitary movements and enhancing confidence, personal growth, self-esteem and an individual sense of belonging.

Bibliography

- [1] Baumeister, R. (1995). Self and identity: An introduction. In A. Tesser (Ed.), *Advanced social psychology*. New York: McGraw-Hill.
- [2] Bednar, R.L., Wells, M.G., and Peterson, S.R. (1989). *Self-Esteem: Paradoxes and Innovations in Clinical Theory and Practice*. Washington, DC: American Psychological Association.
- [3] Bergner, R. (1998). Characteristics of an optimal clinical case formulation. *American Journal of Psychotherapy*, 52, 287-300.
- [4] Bernhardt, P., Bentzen, M., and Joel I. (1997). *Waking The Body Ego. Bodydynamic Analysis: Lisbeth Marcher's Somatic Developmental Psychology. Part I: Core Concepts and Principles*. Bodydynamic Institute.
- [5] Boadella, D. (1991). *Organism and organisation: The Place of Somatic Psychotherapy in Society. Energy and Character*, vol. 22.
- [6] Freeman, R. (1988). *BodyLove: Learning to Like Our Looks and Ourselves*. Ph.D., Harper and Row.
- [7] Cannon, W. B. (1932). *Wisdom of the body*. New York: Norton.
- [8] Claire, T. (1995). *Rubinfeld Synergy Method: Touch Therapy Meets Talk Therapy*. In *Bodywork*. New York: William Morrow and Company, Inc.
- [9] Claridge, G. (1985). *Origins of mental illness*. Oxford, England: Blackwell.
- [10] *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (1994). 4th ed. American Psychiatric Association, Washington: Author.
- [11] Dohrenwend, B.S. and Dohrenwend, B.P. (Eds.) (1974). *Stressful life events: Their nature and effects*. New York: Wiley.
- [12] Dolan, B., Evans, C., and Norton, K. (1995). Multiple axis II diagnoses of personality disorder. *British Journal of Psychiatry*, 166: 107-112.
- [13] Eastwood, M.R. and Trevalyn, M.H. (1972). Relationship between physical and psychiatric disorder. *Psychological Medicine*, 2: 363-372.

- [14] Ekman, P. and Friesen, W.V. (1968). Nonverbal behavior in psychotherapy research. In J. Shlien, (Ed.), *Research in Psychotherapy: Vol. 3*. Washington, DC: American Psychological Association.
- [15] Engel, G. and Schmale, A. (1967). Psychoanalytic theory of somatic disorders. *Journal of American Psychoanalytic Association*, 15: 344-365.
- [16] Erikson, E.H. (1959), *Identity and the life cycle*. New York: International University Press
- [17] Eysenck, H.J. and Eysenck, S.B.G. (1976). *Psychoticism as a dimension of personality*. London: Hodder and Stoughton.
- [18] Eysenck, H.J. (1990). Biological dimensions of personality. In Pervin LA (Ed). *Handbook of personality: theory and research*. New York: Guilford Press.
- [19] Feldenkrais, M. (1990). *Awareness through Movement*, Arkana.
- [20] Flanagan, J.C. (1978) *A research approach to improving our quality of life*. *Am Psychol.*, 33: 138-147.
- [21] Folkins, C. H., and Sime, W. E. (1981). Physical fitness training and mental health. *American Psychologist*, 36: 373-389.
- [22] Folkman, S. (1984), *Personal Control and Stress and Coping Processes: A Theoretical Analysis*. *Journal of Personality and Social Psychology*, 46, 4, 839-452.
- [23] Franken, R. (1994). *Human motivation (3rd ed.)*. Pacific Grove, CA: Brooks/Cole Publishing Co.
- [24] Freud, A. (1966). *The ego and the mechanism of defense*. The writings of Anna Freud (Vol. 2, rev. ed.). New York: International Universities Press. (Originally published, 1936).
- [25] Freud, S. (1900). *The interpretation of dreams*. In the complete psychological works of Sigmund Freud. London: The Hogarth Press, 1962.
- [26] Freud, S. (1953). *Three essays on sexuality*. In J. Strachey (Trans.), *The standard edition of the complete psychological works of Sigmund Freud (Vol. 7)*. London: Hogarth Press. (Original work published in 1905).
- [27] Freud, S. (1931). *Libidinal Types*. *Collected Papers, Vol. 5, 1959*. New York: Basic Books.
- [28] Fromm, E. (1956). *The art of loving*. New York: Harper and Row.
- [29] Fromm, E. (1968), *The Revolution of Hope*. New York, Haper and Row.
- [30] Goodhart, D.E. and Zautra, A. (1990), *Assessing Quality of Life in the Community: An Ecological Approach*. In W. A. O'Connor and B. Lubin (Eds.), *Ecological Approaches to Clinical and Community Psychology*. Malabar, Florida, Robert E. Krieger Publishing Company.
- [31] Gorham, Linda J. (1995). *Dance therapy and self-psychology*. *Clinical Social Work Journal*, 23, 361-373.
- [32] Gruber, J. J. (1986). *Physical activity and self-esteem development in children: A meta-analysis*. In G. A. Stull, and H. M. Eckert (Eds.), *Effects of physical activity on children*. Champaign, IL: Human Kinetics.
- [33] Guimon J. (1997). *The Body in Psychotherapy*. Basel: Karger.
- [34] Hamachek, D. E. (1978). *Encounters with the self (2nd ed.)*. New York: Holt Rinehart and Winston.
- [35] Harter, S. (1983). *Developmental Perspectives on the Self-System*. In E. M. Hetherington (Ed.). *Socialization, Personality, and Social Development*. Vol. 4 of P. Mussen (Ed.). *Handbook of Child Psychology*. Fourth Edition. New York: J. Wiley.
- [36] Hartley, L. (1995) *Wisdom of the Body Moving: An Introduction to Body-Mind Centering*, North Atlantic Books.
- [37] Heath, C. (1986): *Body movement and speech in medical interaction*. Cambridge, England and Paris: Cambridge University Press and Editions de la Maison des Sciences de l'Homme.

- [38] Holmes, T.H. and Rahe, R.H. (1967), The social readjustment rating scale. *Journal of Psychosomatic Research*, 11, 213-318.
- [39] Horney, K. (1937). *The neurotic personality of our time*. New York: Norton.
- [40] Hughes, J. R. (1984). Psychological effects of habitual aerobic exercise: A critical review. *Preventive Medicine*, 13, 66-78.
- [41] Human Development Report, UNDP, 1997
- [42] Hutchinson M. G. (1985). *Transforming Body Image: Learning to Love the Body You Have*, PhD, The Crossing Press.
- [43] Jacobs T.J. (1994). Nonverbal Communications. *Journal of the American Psychoanalytic Association*, 42:3:741 - 762.
- [44] James, W. (1890). *Principles of psychology*. New York: Henry Holt.
- [45] Jung, Karl G. (1969). *Man and his symbols*. New York: Doubleday.
- [46] Jung, Karl G. (1923). *Psychological types*. Princeton, NJ: The Bollingen Series, Vol. 6.
- [47] Katz, L.G. and Chard, S.C. (1989). *Engaging Children's Minds: The Project Approach*. Norwood, NJ: Ablex. ED 326302.
- [48] Keirse, D. and Bates, M. (1978). *Please Understand Me: Character and Temperament Types*. 3rd ed. Del Mar: Prometheus Nemesis.
- [49] Kihlstrom, J. and Klein, S. (1994). The self as a knowledge structure. In R. Wyer and T. Srull (Eds.), *Handbook of social cognition* (2nd ed.). Hillsdale, NJ: Erlbaum.
- [50] Kirsch, N. (1982). Attempted suicide and restrictions in the ability to negotiate personal characteristics. In K. Davis and T. Mitchell (Eds.), *Advances in Descriptive Psychology* (Volume 2). Greenwich, CT: JAI Press.
- [51] Kobasa, S. (1979) Stressful life events, personality and health. *An Inquiry into hardiness. Journal of Personality and Social Psychology*, 37: 1-11.
- [52] Koestner, R., Zuroff, D. and Powers, T. (1991). Family origins of adolescent self-criticism and its continuity into adulthood. *Journal of Abnormal Psychology*, 100, 191-197.
- [53] Krasnushkin, E.K.(1942) About some relationships between mental and somatic diseases. *Neurology and Psychiatry*, 1: 20-23.
- [54] Kretschmer, E. (1925). *Physique and Character: an investigation of the nature of constitution and of the theory of temperament*. trans. W. J. H. Sprott. New York: Harcourt Brace.
- [55] Lader, M. (1975). *The psychophysiology of mental illness*. London and Boston: Routledge and Keyan Paul.
- [56] Lamborn, S., Mounts, N.S., Steinberg, L., and Dornbusch, S. (1991). Patterns of Competence and Adjustment among Adolescents from Authoritative, Authoritarian, Indulgent and Neglectful Families. *Child Development*, 62(5): 1049-1065. EJ 436489.
- [57] Lazarus, R.S. and Launier, R. (1978). Stress-related transactions between person and environment. In L.A. Pervin and M. Lewis (Eds.), *Perspectives in interactional psychology*. New York, Plenum.
- [58] Lazarus, R.S. (1990). *Emotion and Adaptation*. New York, Oxford: Oxford University Press.
- [59] Lecky, P. (1945). *Self-consistency: A theory of personality*. New York: Island Press.
- [60] Lewin, K. (1951), *Field theory in social science*. New York, Harper and Row.
- [61] Livesley, W.J. (1987). A systematic approach to the delineation of personality disorders. *American Journal of Psychiatry*, 144: 772-777.
- [62] Livesley, W.J. (1986). Trait and behavioral prototypes of personality disorder. *American Journal of Psychiatry*, 143: 728-732.
- [63] Lowen, A. and Lowen, L. (1977). *The vibrant way to health: A manual of exercises*. New York: Harper and Row.
- [64] Lowen, A. (1958). *The language of the body*. New York: Macmillan.
- [65] Lowen, A. (1967). *The betrayal of the body*. New York: Macmillan.

- [66] Lowen, A. (1970). *Pleasure: A creative approach to life*. New York: Penguin.
- [67] Lowen, A. (1975). *Bioenergetics*. New York: Penguin.
- [68] Lowen, A. (1980). *Fear of life*. New York: Macmillan.
- [69] Lowen, A. (1984). *Narcissism: Denial of the true self*. New York: Macmillan.
- [70] Lowen, A. (1988). *Love, sex, and your heart*. New York: Macmillan.
- [71] Lowen, A. (1990). *The spirituality of the body*. New York: Macmillan.
- [72] Marcher, L. and Ollars, L. (1991). *Bodynamic Analytic Developmental Re-birth Therapy*. *Energy and Character*, 22:2.
- [73] Markus, H.R., and Kitayama, S. (1991). *Culture and the Self: Implications for Cognition, Emotions, and Motivation*. *Psychological Review*, 8(2): 224-253.
- [74] Marsh, H. (1992). *The content specificity of relations between academic self-concept and achievement: An extension of the Marsh/Shavelson model*. ERIC NO: ED349315.
- [75] Marshall, K. (1993). *A bulimic life pattern*. In R. Bergner (Ed.), *Studies in psychopathology: The Descriptive Psychology Approach*. Ann Arbor, MI: Descriptive Psychology Press.
- [76] Maslow A. H. A. (1943). *Theory of Human Motivation* *Psychological Review*, 50, 370-396.
- [77] Mcauley, E., Mihalko, S. L., and Bane, S. M. (1997). *Exercise and self-esteem in middle-aged adults: Multidimensional relationships and physical-fitness and self-efficacy influences*. *Journal of Behavioral Medicine*, 20: 67-83.
- [78] McDonald, D. G., and Hodgdon, J. A. (1991). *Psychological effects of aerobic fitness training*. New York: Springer.
- [79] Mead, G.H. (1934), *Mind, Self and Society*. Chicago: University of Chicago Press.
- [80] Mechner, V. (1998). *Healing Journeys: The Power of Rubenfeld Synergy*, Chappaqua, NY: OmniQuest Press.
- [81] Mechner, V. (1998). *The Rubenfeld Synergy Method*. In Lynette Bassman (ed.), *The Whole Mind: The Definitive Guide to Complementary Treatments for Mind, Mood, and Emotion*. Novato, CA: New World Library.
- [82] Miller, N.E. (1976). *Learning, stress and psychosomatic symptoms*. *Acta Neurobiologiae Experimentalis*, 36: 141-156.
- [83] Murphy, G. (1947). *A Biosocial Approach to Personality: Origins and Structure*. Harper and Row Publishers.
- [84] Murray, H. A., et al. (1938). *Explorations in Personality*. New York: Oxford University Press.
- [85] Neugarten, B.L. and Datan, N. (1973). *Sociological perspectives on the life cycle*. In P.B. Baltes and K.W. Schaie (Eds.), *Life-span developmental psychology: Personality and socialization*. New York: Academic Press.
- [86] Norman, W.T. (1963). *Toward an adequate taxonomy of personality attributes:replicated factor structure*. *Journal of Abnormal and Social Psychology*, 66: 574-583.
- [87] North, T. C., McCullagh, P., and Tran, Z. V. (1990). *Effect of exercise on depression*. *Exercise and Sport Sciences Reviews*, 18: 379-415.
- [88] Oldham, John M., and Lois B. Morris (1995). *The New Personality Self-Portrait: Why You Think, Work, Love, and Act the Way You Do*. Rev. ed. New York: Bantam
- [89] Oleson, M. (1990). *Subjectively perceived quality of life*. *Image*, 22:187-190.
- [90] Ossorio, P. (1978). *What Actually Happens*. Columbia, SC: University of South Carolina Press.
- [91] Ossorio, P.G. (1981). *An outline of Descriptive Psychology for personality theory and clinical application*. In K. Davis (Ed.), *Advances in Descriptive Psychology*, Vol. 1. Greenwich, CT: JAI Press.
- [92] Ossorio, P.G. (1985). *An overview of Descriptive Psychology*. In K. Gergen and K.

- Davis (Eds.), *Social construction of the person*. New York: Springer Verlach.
- [93] Patterson, C. H. (1961). The self in recent Rogerian theory. *Journal of Individual Psychology*, 17: 5-11.
- [94] Pessa A. (1997). *PBSP - Pessa Boyden System Psychomotor*. In Caldwell C. (ed.): *Getting in Touch*. Wheaton: Quest Books.
- [95] Plant, J. (1937). *Personality and the cultural pattern*. New York: Commonwealth Fund
- [96] Purkey, W. (1988). An overview of self-concept theory for counselors. ERIC Clearinghouse on Counseling and Personnel Services, Ann Arbor, Mich. (An ERIC/CAPS Digest: ED304630)
- [97] Raimy, V. (1975). *Misconceptions of the self*. San Francisco: Jossey-Bass.
- [98] Raimy, V. C. (1948). Self-reference in counseling interviews. *Journal of Consulting Psychology*, 12: 153-163.
- [99] Raskin, N., and Rogers, C. (1995). Person-centered therapy. In R. Corsini and D. Wedding, (Eds.), *Current psychotherapies* (5th ed.). Itasca, IL: Peacock.
- [100] Reich, Wilhelm (1949). *Character Analysis*, 3rd ed. New York: Farrar, Straus, and Giroux.
- [101] Reich, Wilhelm 1932/1972: *De ungas sexuella kamp, (The Sexual Struggle of the Youth)* René Coeckelberghs Partisanförlag, Göteborg.
- [102] Reich, Wilhelm 1934/1973: *Hvad er klassebevidsthed? (What is Class Consciousness?)* Rhodos, København .
- [103] Reock, J. (1999). Rubenfeld Synergy Method. In Carolyn Chambers (ed), *Encyclopedia of Complementary Health Practices*. New York: Springer Publishing Co.
- [104] Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21: 95-103.
- [105] Rogers, C. R. (1947). Some observations on the organization of personality. *American Psychologist*, 2: 358-368.
- [106] Rogers, C.R. (1951). *Client-centered Therapy*. Boston: Houghton Mifflin.
- [107] Romney, D.M.(1993) *Attributional style and self-esteem*. Abstracts of the III European Congress of Psychology, Tampere.
- [108] Rosenberg J.L. and Rand M. (1985). *Asay D.: Body, Self and Soul*. Atlanta: Humanics.
- [109] Rosenberg, M. (1965). *Society and the adolescent self image*. Princeton, N.J.: Princeton University Press References.
- [110] Ross, B. (1988). *Human Motivation and Emotion*. New York: John Wiley and Sons.
- [111] Roth, G. (1997). *The practice. Sweat Your Prayers: Movement a Spiritual Practice.*, New York, NY: Penguin Putnam Inc.
- [112] Rubenfeld, I. (2000). *The Listening Hand, Self-Healing Through the Rubenfeld Synergy Method of Talk and Touch*. Bantam Books. Foreward by Joan Borysenko, Ph.D.
- [113] Rubenfeld, I. (1997). *Healing the Emotional/Spiritual Body*. In Christine Caldwell (ed.), *Getting in Touch: The Guide to New Body-Centered Therapies*. Wheaton, IL: Quest Books.
- [114] Ryle, G. (1973). *The concept of mind*. London: Penguin.
- [115] Seifert, K.L. and Hoffnung, R.J. (1994). *Child and Adolescent Development*. Boston: Houghton Mifflin.
- [116] Selye, H. (1974), *Stress without distress*. Philadelphia, New York: J.B. Lippincott.
- [117] Shapiro, D. (1965). *Neurotic styles*. New York: Basic Books.
- [118] Sheldon, W. (1940). *Varieties of Human Physique*. Harper and Row: New York
- [119] Sherif B. and Cantril J. (1947). *The Psychology of Ego-involvements*. New York.
- [120] Smith, E. (1985). *The Body in Psychotherapy*. MacFarland and Co.: London
- [121] Snygg, D. and Combs, A. (1949). *Individual behavior*. New York: Harper.
- [122] Stark, A. (1987, November). American Dance Therapy Association, a kinesthetic approach. *Dance Magazine*, 61: 56-57.

- [123] Stattman J. et al., *Unitive Body-Psychotherapy Collected Papers*, Vol 1 (1989) and 2, (1991), Afra Verlag.
- [124] Steimer-Krause, E., Krause, R., and Wagner, G. (1998). Interaction regulations used by schizophrenic and psychosomatic patients. In P. Ekman and E.L. Rosenberg (Eds.), *What the face reveals*. Oxford, England: Oxford University Press.
- [125] Sterba, R.F. (1976). Clinical and therapeutic aspects of character resistance. In Bergman M.S. and Hartman F.R. (ed.). *The Evolution of Psychoanalytic Technique*. New York: Basic Books Inc.
- [126] Strein, W. (1993). Advances in research on academic self-concept: Implications for school psychology. *School Psychology Review*, 22: 273- 284.
- [127] Strelau, J. (1983). *Temperament, Personality, Activity*. Academic Press: New York.
- [128] Swann, W. (1992). Seeking "truth," finding despair: Some unhappy consequences of a negative self-concept. *Current Directions in Psychological Science*, 1: 15-18.
- [129] Symonds, P.M. (1951). *The Ego and the Self*. New York.
- [130] Taylor Sh.E. and Brown J.D. (1994). Illusions and well being revisited: separating fact from fiction. *Psychological Bulletin*, 116: 21-27.
- [131] *The Alexander Technique: How to Use Your Body Without Stress*. Wilfred Barlow, M.D. Healing Arts Press, 1991.
- [132] Tice, D.M.(1991) Esteem protection or enhancement? Self-handicapping motives and attributions differ by trait self-esteem. *Journal of Personal and Social Psychology*, 60: 711-725.
- [133] Torrance, E.P. (1954). Some practical uses of knowledge of the self concept in counselling and guidance. *Educational and Psychological Measurement*, 14: 120-127.
- [134] Tyrer, P., Casey, P. and Ferguson, B. (1991). Personality disorder in perspective. *British Journal of Psychiatry*, 159: 463-471.
- [135] Valentino, C. (1989). *Body Image, Body Love*. American Health, June 1989.
- [136] Ware, JE. (1995). The status of health assessment 1994. *An Rev Pub Health*, 16:327-354.
- [137] Weiner, M. F. and P. C. Mohl (1995). Theories of personality and psychopathology: other psychodynamic schools. *Comprehensive textbook of psychiatry/VI*. Eds., Harold I. Kaplan, Benjamin J. Saddock. - 6th ed. New York: Williams and Wilkins.
- [138] Wilson, I.B. and Cleary, P.D. (1995). Linking clinical variables with health-related quality of life. *JAMA*, 59-65.
- [139] World Health Organization (1948). *Constitution of the World Health Organization: Chronicle of the World Health Organization 1*. Geneva: WHO.
- [140] Wylie, R. (1968). The present status of self theory. In E. Borgatta and D. Lambert (Eds.), *Handbook of personality theory and research*. Chicago: Rand McNally.

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