

Palacký University Olomouc

Faculty of Arts

Department of Psychology

**The Process-oriented approach to working with body symptoms:
effects, benefits, and potential in psychosomatics**

**Procesově-orientovaný přístup při práci s tělesnými symptomy: efektivita,
přínosy a potenciál v psychosomatice**



Dissertation thesis

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Words of thanks

The presented dissertation thesis reflects over seven years of my studies of the Process-oriented approach to working with body symptoms, as well as three years of research my colleagues and I have dedicated to the field. Since high school, I have been fascinated by the mind-body connection and the ability for our bodies to feel, change, and heal. After completing my undergraduate studies, my attention was continually drawn to body-oriented psychotherapeutic approaches, leading me to become a student of diploma training in Process-oriented Psychology.

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I hereby proclaim that I have written this dissertation thesis named “The Process-oriented approach to working with body symptoms: effects, benefits and potential in psychosomatics” by myself, under the supervision of PhDr. Marek Kolařík, Ph.D., and using only cited literature. Studies 1 and 2 presented in this thesis were in the process of publishing during the writing of the thesis and are used with the consent of all co-authors (see Appendix 3).

Místopřísežně prohlašuji, že jsem dizertační práci na téma: „Procesově-orientovaný přístup při práci s tělesnými symptomy: efektivita, přínosy a potenciál v psychosomatice” vypracovala samostatně pod odborným dohledem PhDr. Marka Kolaříka, Ph.D. a uvedla jsem všechny použité podklady a literaturu. Studie 1 a 2 prezentované v této práci byly v procesu publikování v průběhu psaní disertace a jsou použity se souhlasem všech spoluautorů (viz Appendix 3).

In Olomouc on the 30th November 2020

Signature

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Introduction

Body symptoms are a part of our everyday lives. As human beings, we all experience them. Some might be easy to deal with, whereas others can be dangerous and life threatening. So why might we be interested in the deeper process behind these disturbances? Western medicine helps us to heal our bodies; we can get medicine, surgery, and all kinds of treatment that in many cases, we wouldn't survive without. Yet we might still ask, why is this happening to us now? How could body symptoms be connected to our current life?

The modern psychosomatic approach is, from a broad perspective, seen as an interdisciplinary concept with a basic attitude and view on the diagnosis and therapy of diseases, that includes equally physical, mental, and psychosocial factors (Tress, Kruse & Ott, 2008; Morschitzky & Sator, 2007). The holistic bio-psycho-socio-spiritual approach explains the multifactorial influence in the development of a disease and requires the same approach in its treatment (Morschitzky & Sator, 2007).

Process-oriented Psychology (also called Process Work) is a phenomenological approach developed in the 1970s by Arnold Mindell, who researched body symptoms and Jungian dream analysis (Diamond & Jones, 2004). According to the literature and existing limited amount of research, exploration of symptoms can give clients meaning. For instance, body symptoms can be perceived as a reaction to something or as a direction for change in life (Mindell, 2001; Morin, 2019; Weyermann, 2006). In Process-oriented Psychology, the main goal is to bring awareness to what is happening right now (Diamond & Jones, 2004). Thus, with body symptoms we are interested in discovering what the message is behind the symptom for each individual.

My personal as well as professional path, together with my curiosity, brought me to the question: How do we as psychologists and therapists support our clients in different areas in their lives, often including the experience of painful body symptoms? I remember when I first went to a Process Work seminar in 2013, taught by Ivan Verný in Prague, to learn about how to work with body symptoms. I was fascinated by the fact that this approach can bring more awareness and assist in navigating through our present life by unfolding and finding the meaning behind the body symptom we usually just suffer from and strive to get rid of. Verný said that from a Process-oriented Psychology perspective, the body

symptom, similar to a dream, is seen as an unread letter; it has a message for us (I. Verný, personal communication, January 19, 2013). I started to work on my own body symptoms, as well as my clients', and was fascinated by the potential of this approach. While I was writing this thesis in 2020, the whole world was affected by the COVID-19 pandemic - how synchronistic. The whole world was suffering from this widespread flu, that from a Process Work point of view is seen also as a dream that might have a message not only for individuals, but also for society and the world (Sedláková, 2020).

The presented thesis is divided into two parts: theoretical and empirical. In the theoretical section, I (1) describe the historical and theoretical background of the Process-oriented approach to working with body symptoms, (2) introduce mind-body relationship, a holistic approach, and psychosomatics, and (3) discuss the current research of Process-oriented approach to working with body symptoms. The empirical portion consists of three empirical studies. Study 1 presents the effects of the Process-oriented approach on symptoms severity, well-being, and client satisfaction. During the writing of this thesis, this study was submitted and accepted for publication in an impact journal called "International Body Psychotherapy Journal" (Sedláková, Dominik & Kolařík, 2020). Study 2 presents qualitative results of subjective participants' experience of working on body symptoms with Process-oriented Psychology. This study was submitted for publication while writing this thesis (Sedláková & Kolařík, 2020). Study 3, currently unpublished (Sedláková, Kolařík & Dominik, 2020), presents the identification of significant events and working alliance on the experimental session by using the Process-oriented approach to working with body symptoms.

Within this introduction, I would like to address the potential overlap and similarities in the theoretical part of this thesis and my previous diploma (Sedláková, 2013a), and rigorous thesis (Sedláková, 2013b). Both contain explanations of the mind-body relationship, the holistic approach, psychosomatics, and the rigorous thesis also contains the neurobiology of the mind-body connection. However, the presented thesis contends with an entirely new research topic. It should be noted that I use some portions of my diploma and rigorous thesis in the theoretical section, but I do so in accordance with the recommended guidelines and accepted practice at the Department of Psychology at Palacký University Olomouc.

Theoretical part: History and theory of Process-oriented Psychology, psychosomatics, discussion and critique of the current research of the Process-oriented approach to working with body symptoms

In this section, I will describe the historical and theoretical background of the Process-oriented approach to working with body symptoms, introduce mind-body relationship, a holistic approach, and psychosomatics, and will further discuss the current research of Process-oriented approach to working with body symptoms.

1 History and theory of Process-oriented Psychology

The first chapter is devoted to the history and theory of Process-oriented Psychology. Although Process-oriented Psychology covers a wide field of application, I will focus only on the area of body symptoms, illnesses and health. I will explain the main concepts that are used in this approach as well as their application. I will further describe new directions in Process-oriented Psychology in the area of body symptoms. The last part of this chapter is devoted to my personal experience from an internship at the Process Work Institute in Portland.

1.1 History of Process-oriented Psychology

Arnold Mindell, a graduate student in physics at the Massachusetts Institute of Technology, arrived in Zurich, Switzerland, in 1961, a few months after Carl Jung's death, to conduct research in theoretical physics at the Swiss Federal Polytechnical Institute. After complaining to his roommate that he was having bad dreams, he decided to begin therapy with one of Jung's most devoted students and a leading Jungian analyst at the time, Marie Louise von Franz. Mindell was fascinated with dreams and decided to change careers from physics to psychology and become an analyst. He began regular dream analysis and psychotherapy with Jung's nephew, Franz Riklin and Marie Louise von Franz and later trained as a Jungian analyst. After graduating, he continued as a private practitioner, and later became a training analyst at the Jung Institute (Diamond & Jones, 2004).

From the beginning, Mindell was fascinated by dreams and dreaming. When he first began therapy with Von Franz, however, his scientific mind made him skeptical that his dreams could be meaningful. Von Franz challenged him to disprove this proposition by using his background in physics to understand psychology. Inspired by this challenge, he wrote his thesis on Jung's theory of "synchronicity" - the theory of nonlocal connections. He explored how one's inner experience could be connected nonlocally to outer events through meaning (Diamond & Jones, 2004).

Although Mindell became a skillful dream analyst, he was not fully satisfied with interpreting or discussing the meaning of unconscious material. He was interested in exploring and experimenting with the living unconscious at the moment (Diamond & Jones, 2004). He wanted to put his hands on the unconscious, he wanted to find out what it looked

like, how it felt, how it appeared in three-dimensional reality. He wanted to develop a method of working with the unconscious in the here-and-now, in sensory based and tangible ways, and experiment with it more directly (Mindell, 2004).

1.1.1 Dreambody

While working as an analyst, Mindell's own physical health problems led him to study widely in the fields of health, disease, traditional and alternative medicine, and bodywork. He experimented with bodywork approaches and medical treatments. Although he found some physical relief, he was not satisfied with the fragmentation he felt in treating his physical problems with methods that were not compatible with his psychological approach. As a Jungian analyst, he was committed to Jung's teleological approach, the idea that dreams have a purpose or meaning. He thought that body symptoms, like dreams, must contain meaning and purpose for the individual (Diamond & Jones, 2004). Similarly, he could never accept the idea of pathology; as a Jungian analyst he had the idea that events were meaningful, so perhaps what was happening in his body was meaningful too, not simply pathological or wrong (Mindell & Mindell, 2002).

During the time Mindell was grappling with this theoretical problem as well as his own symptoms, he visited a client who had been hospitalized with stomach cancer. Mindell (2001) describes the story of how his experiment with the idea that symptoms could be meaningful led him to discover the **“dreambody”** concept:

A patient with whom I was working then was dying of stomach cancer. He was lying in the hospital bed, groaning and moaning in pain. Have you ever seen somebody who is dying? It is quite sad and terrifying. They flip quickly between trance states, ordinary consciousness, and extreme pain. Once, when he was able to speak, he told me that the tumor in his stomach was unbearably painful. I had an idea that we should focus on his proprioception, that is, his experience of the pain, so I told him that since he'd already been operated on unsuccessfully, we might try something new. He agreed and so I suggested that he try to make the pain even worse. He said he knew exactly how to do that and told me that the pain felt exactly like something in his stomach trying to break out. If he helped it break out, he said, the pain worsened. He lay on his back and started to increase the pressure in his stomach. He pushed his stomach out and kept pushing and pressing and exaggerating the pain until he felt as if he were going to explode. Suddenly, at the height of his pain, he shouted out, "Oh Amy, I just want to explode, I've never been really able to explode!" At that point he switched out of his body experience and began to talk to me. He told me he needed to explode and asked if I would help him to do so. "My problem," he

said, "is that I've never expressed myself sufficiently, and even when I do, it's never enough." This problem is an ordinary, psychological problem that appears in many cases, but with him it became somatization and was pressing him now, urgently expressing itself in the form of a tumor. That was the end of our physical work together. He lay back and felt much better. Though he had been given only a short time to live and had been on the verge of death, his condition improved, and he was discharged from the hospital. I went to see him afterwards very often, and every time he "exploded" with me. He'd make noises, cry, shout and scream, with absolutely no encouragement on my part. His problem was clear to him; his ever-present body experiences made him acutely aware of what it was he had to do. He lived for two or three years longer and then finally died having learned to express himself better. What it was that relieved him I don't know, but I do know that the work relieved his painful symptoms and helped him to develop. It was then, also, that I discovered the vital link between dreams and body symptoms. Shortly before he had entered the hospital, the patient dreamed that he had an incurable disease and that the medicine for it was like a bomb. When I asked him about the bomb, he made a very emotional sound and cried like a bomb dropping in the air, "It goes up in the air and spins around sshhhsss...pfftpff." At that moment I knew his cancer was the bomb in the dream. It was his lost expression trying to come out and finding no way out it came out in his body as cancer, and in his dream as the bomb. His everyday experience of the bomb was his cancer; his body was literally exploding with pent-up expression. In this way his pain became his own medicine, just like the dream stated, curing his one-sided lack of expression (Mindell, 2001, p. 2-4).

Mindell named the mirroring of physical experiences in dreams the dreambody. He described the dreambody as a dreamlike, unifying field that gives expression to body symptoms and dreams alike. He published his first book on this concept in 1982, entitled "Dreambody: The Body's Role in Revealing the Self" (Mindell, 1998). When Mindell presented his dreambody idea a few years later to the psychotherapeutic community in Zurich, he showed its connection to Jungian psychology and also modern Western science, such as Taoism, alchemy, shamanism, and indigenous cosmologies. After several years of focusing on body symptoms and dreams, and their connection to childhood dreams, Mindell extended his work to include any type of disturbance, for example conflicts, moods, complexes, and relationship problems. He started to use the phrase "the dream happening in the moment," to convey the idea that all experiential phenomena are manifestations of a dreaming reality and serve as a way of accessing non-ordinary consciousness. And so, the work became known as Process-oriented Psychology (also called Process Work) (Diamond & Jones, 2004).

1.2 Theoretical background of Process-oriented Psychology

As described in the previous chapter, Process-oriented Psychology has been expanded from dreambody work and working with dreams and childhood dreams into a much wider approach, including working with individuals, couples, families, organizations, conflict facilitation, groups, and global issues (Diamond & Jones, 2004). Moreover, Mindell and his colleagues and Process Work practitioners all around the world have continued developing this approach. Despite the fact that Process-oriented Psychology touches on many interesting topics, this chapter will focus mainly on the area of body symptoms.

1.2.1 Process

The main concept of the Process-oriented approach is “**process**”. We understand process as the flow of experience (or information) in oneself and in the environment. The Taoist masters taught that aligning oneself to nature (the Tao) as it changes is the key to a happy life. Resisting change or struggling against the Tao creates tensions and difficulties. Transformation occurs naturally once a person is able to trust nature and go along with what is happening. Process-oriented Psychology offers a conceptual and practical system of following process in present life, building on foundational Taoist ideas with concepts and techniques influenced by psychology, physics, and various spiritual traditions (Mindell & Mindell, 2002; Diamond & Jones, 2004).

Following the flow of process involves caring for the absurd and going against conventional beliefs and ways of seeing things. Mindell uses a Native American metaphor to describe this: that following a process is like riding the horse backwards. According to him, it requires a different way of seeing. "Following the unwanted, unintended message goes against collective belief, which says that if you follow the unknown, it will lead you off the edge of the world... But Process Work says that if we have the courage to follow unintentional signals... we do not fall off, but discover new worlds" (Mindell & Mindell, 2002, p. 11). Mindell further describes that following the flow of process involves going with what is happening in a given moment, rather than resisting it. According to him, this does not mean just letting things happen, or passively accepting difficulties. It means that when an obstacle arises, we face it in order to find out what changes are meant for us in that challenge. It is more a spiritual attitude that is interested in discovering how our innermost

being attunes itself to whatever arises in everyday life, and how this prevents us from being victimized by our experiences (Mindell & Mindell, 2002).

Following the flow of process involves noticing change as it occurs and uncovering the elusive or hidden dimensions of experience. In Process-oriented Psychology we distinguish the flow of process in terms of “**primary process**” and “**secondary process**” separated by an “**edge**” (Diamond & Jones, 2004).

Primary process

Primary process refers to experiences that are better known and closer to a person's sense of identity. It means noticing the signals of identity, which include the elements with which the client is identified (Diamond & Jones, 2004).

Secondary process

Secondary process refers to those experiences that are further from a person's sense of identity. These experiences can also be seen as marginalized elements. By “marginalization,” we mean that they are set aside from the focus of identity. Whether these elements are conscious or unconscious, we put them aside and do not follow them (Diamond & Jones, 2004).

Edge

Primary and secondary processes are separated by an edge. The edge is described as the limit of the known identity as well as a point of contact with unknown experiences or identities. An edge is often felt as nervousness, discomfort or excitement because it is an encounter with something new or unfamiliar (Diamond & Jones, 2004).

These three concepts offer a conceptual framework for tracking experience and organizing perceptual information. This is helpful for a therapist to distinguish which parts of a person's experience are closer to their everyday sense of themselves, and which parts are split off and hold potentially useful meaning and information for their known identity. In everyday life we constantly receive messages from the primary and secondary process. Primary and secondary information often conflict with or contradict each other. Processes are rarely completely known (primary) or unknown (secondary). Some processes appear only as remote and sudden dream images, while others are well known (primary) but

disliked or judged (secondary). A person may be aware of a secondary process but be unable to see its value (Diamond & Jones, 2004).

1.2.2 Levels of reality

According to Mindell, the process can be perceived in three levels of reality: “**consensus reality**”, “**dreamland**” and the “**sentient/essence**” level (Mindell, 2013).

Consensus reality

Consensus reality describes the realm of experience that is generally consented to or agreed upon as real. Consensus reality corresponds to majority views and statistical norms. It is a collective understanding about the nature of reality. Experiences on consensus reality level can be discussed and described objectively. According to Mindell, our most primary process is connected to the reality of the culture and world we are living in (Mindell, 2013).

Nonconsensus reality

Nonconsensus reality consists of subjective, dreamlike experiences that are not generally agreed upon as real, such as feelings, fantasies, dreams, projections, and other experiences that make up our inner world. These experiences are those that people do not normally permit themselves to feel, notice or talk about. They are often marginalized. They may be avoided, ignored, or not noticed. Sometimes experiences are marginalized because they are threatening. Sometimes this happens when experiences are too subtle or unusual for our ordinary awareness to perceive them (Diamond & Jones, 2004). Mindell calls this level of reality a “dreamland”. Later on, he added a “sentient (or essence)” level of reality, which he describes as a field of unity - the field from where all the experiences emerge. According to him, what Jung meant by the unconscious are the dreamland and essence levels of reality (Mindell, 2013).

1.2.3 Noticing and unfolding the process

Noticing a process requires the use of differentiated awareness. Borrowing from Carlos Castaneda, Mindell used the terms “**first attention**” and “**second attention**” to distinguish between different types of awareness and their relationship to consensus and nonconsensus realities. First attention is the awareness we use to perceive consensus reality - the world of objects, people, and events. Second attention perceives the

unintended experiences that are ignored by first attention. Mindell defines second attention as the ability to focus upon things we normally neglect - often irrational experiences, external and internal. The second attention is the key to the world of dreaming, unconscious and dreamlike experiences, accidents, and synchronicities (Mindell, 1993).

Unfolding a process involves noticing a secondary experience in the initial description of a problem, amplifying its expression until a new meaning or aspect of identity emerges, and then integrating the new experience into everyday life. This approach rests on concepts from communication theory, such as **“intended”** and **“unintended”** communication (Watzlawick, Bavelas & Jackson, 2011).

The primary process brings intended communication through language and intentional gestures. The secondary process conveys unintended communication nonverbally in body posture, gestures, movements, and in speech patterns and paralanguage (including volume, rhythm, and tone of voice) that hold implicit meaning. Ordinary conversation always contains both intended and unintended communication. Confusion and miscommunication in conversation are often the result of double messages, a mix of intended and unintended communication (Diamond & Jones, 2004; Watzlawick et al., 2011). In Process Work, we are interested in those double signals as they’re a “dream door” to nonconsensus reality - to the part of ourselves we haven’t been in touch with yet (or haven’t been in touch with enough). We use the term “dream door” to indicate that the way a secondary process appears to the everyday personality is like the sign on the door.

1.2.4 Signals and channels

Intended and unintended communication consists of numerous pieces of information called signals. Signals may be easily perceptible (steady signals that persist long enough for perception to occur) or hard to detect (signals that barely cross the threshold of perception, called “flickering signals”, “flirts”, or “pre-signals”) (Mindell, 2000). Process-oriented Psychology practice is based on an ability to detect flickering and nonflickering signals, to differentiate between consensus and nonconsensus reality signals, and to follow the dreaming signals that lead to the unknown. Dreaming signals are collectively referred to as **“sensory-grounded information”** (Diamond & Jones, 2004).

Sensory-grounded information is the language of the dreaming process. It communicates secondary information on its own terms and in its own way. A secondary process is normally described through the filter of the primary process's ideas and interpretations. For instance, a client might say that she feels depressed. This is not a description of the dreaming experience, but it is an interpretation. In order to find out about the dreaming experience on its own terms, sensory-grounded information must be unfolded. Unfolding means following the information in its nature while using a method of amplification (see next Chapter 1.2.5). In this example, we could do this by asking the client how she/he/they experiences the depression. The client might describe the sensory-grounded experience as heavy, low, etc. We can also see those signals in the client's body in the present moment, e.g., her eyes close slightly, her breathing becomes slow, and her shoulders go down (Diamond & Jones, 2004).

Sensory grounded information emerges in different ways, or “**channels**”. A channel is a sensory, motor, or relational mode of perceiving or communicating experience. These channels are divided into: **visual, auditory, movement, proprioceptive, relational, and world channel**. When we look at or see something, we are experiencing something through the visual channel. Hearing something or using sound to communicate engages the auditory channel. Experiencing something through movement occupies the movement (or kinesthetic) channel. Feeling something in the body happens in the proprioceptive channel. We also have experiences in the relationship channel, in interaction with others, or in the world channel, in which experience is centered in the environment (e.g., institutions, world events, the earth, nature) (Diamond & Jones, 2004).

1.2.5 Amplification and feedback

Amplifying sensory-grounded signals by following feedback allows a dreaming experience to emerge. When signals are addressed through a therapist's attention and encouragement, they increase their strength; that's what we mean by “**amplification**”, the signals actually self-amplify (Diamond & Jones, 2004).

Amplification of a disturbance increases awareness, helps its underlying process to emerge and enables the person to step into the flow of experience. The idea of amplifying the experience of the things that bother us is radical to the Western attitude, which usually

seeks to get rid of these disturbances. Alchemists used amplification centuries ago when they increased the fire under the pot of the “prima materia” in order to transform it into gold (Mindell, 1998).

Following sensory-grounded information is governed by “**feedback**”. The concept of feedback comes from the systemic approach, in which feedback is information that helps to adjust or maintain a system's output. It may be negative or positive. Although Process Work borrowed the terms positive and negative feedback from the systemic approach, it uses them somewhat differently. Positive feedback refers to the strengthening of a signal in response to the therapist’s intervention. Negative feedback refers to a lack of noticeable increase in the strength of a signal in response to an intervention. It does not mean that an intervention is wrong or right. Both provide information about a person's process, pointing to the next step in the process of accessing their dreaming experience (Diamond & Jones, 2004).

1.2.6 Integration

After amplifying an experience by following feedback, when the dreaming experience is accessed and embodied, the therapist helps the client to integrate this experience in their daily life. It should be noted that instead of pushing for change, the therapist can help the client relate to a process as an expression of fate, or the Tao. From this viewpoint, integration is about relating to the unknown instead of trying to tame it (Diamond & Jones, 2004). To clarify, its focus is on bringing awareness to the lesser-known parts of ourselves that we've accessed through amplification, and how this experience might be useful in the present as well as long-term.

1.2.7 Metaskills

Mindell’s wife, Amy Mindell, made a major contribution to the theory and practice of Process Work with her concept of “**metaskills**”. Metaskills are the feeling attitudes, values, and beliefs that deeply inform our way of working with others. Metaskills encompass beliefs about life and death, nature, learning, and growth, as well as the feeling with which skills are applied. They breathe life into interventions, making them effective, making our work come alive. Metaskills are grown rather than learned. They may develop naturally out of life experience, or they may develop as a result of conscious effort. Some of the

metaskills that are central to the practice of Process Work are: following nature, beginner's mind, deep democracy, metaposition, playfulness and curiosity, you today, me tomorrow etc. (Mindell, 2003)¹.

1.3 Working with body symptoms in Process-oriented Psychology

1.3.1 Body symptoms from a Process-oriented Psychology point of view

In medicine there are two basic approaches to working with body symptoms - allopathic and homeopathic. With the allopathic approach, the symptom is perceived as an enemy that should be combated, removed, eliminated, neutralized, etc. These standards of care aim at addressing people's biological need for relief from symptoms. It should be noted that modern traditional medicine mainly views the symptom only on the level of consensus reality. The symptom is seen as something that exists in itself, threatening a patient's health and sometimes even life, and thus should be eliminated. The other approach, so-called homeopathic, being unconventional in medicine, is often used to deal with psychosomatic symptoms. In this approach we don't fight against the symptom, but sometimes even amplify it to better understand its meaning. Like is cured by like (Hiller, 2013).

Process-oriented Psychology sees the body as an entity that is dreaming and expressing itself through the channel of physical experience (sensory-grounded experience of the body symptom). Therefore, body symptoms and illnesses are perceived as the expression of the dreambody. Process-oriented Psychology attempts to follow the process in a neutral, respectful and non-judgmental way, in order to discover the deeper meaning of disturbances such as body symptoms and illnesses (Mindell, 1998; Mindell, 2001).

In Process-oriented Psychology literature, it has been described many times that the symptom appears in order for the individual to notice that it is time to change something within their personality, or in other areas of their life. The symptom has a meaning, it carries a certain message for the client. And so, in Process-oriented Psychology, we view the symptom as the physical manifestation of a client's secondary process, related to the dreaming level. Having understood what to quit or, conversely, bring into life, and having made these changes, we can sometimes relieve or get rid of the symptom (especially if it is

¹ For a more detailed description of metaskills, see A. Mindell's book "Metaskills: The Spiritual Art of Therapy" (Mindell, 2003).

an acute symptom). However, symptoms are not always possible to overcome (Mindell, 1998; Mindell, 2001, Morin, 2014; Morin, 2019).

Long-term or chronic symptoms are perceived as life-long challenges connected to mythical and spiritual aspects of a person's life. While the message behind the chronic symptom needs to be lived, its challenge to the person's identity is often huge and it often takes a long time to embrace and live its message. Working on chronic symptoms over long periods of time is referred to as working on our **"life myth"**². It brings forth various aspects of our mythical pattern. Our awareness of chronic symptoms often diminishes over time; they have become parts of our primary identity, and we have learned to live with them and accept their existence as part of normal everyday life (Mindell, 1998; Morin, 2019). Mindell also explains that chronic disease is often a lifelong problem, a part of someone's individuation process. He does not believe that a person actually creates disease, but that their soul is expressing an important message to them through the disease. Body symptoms are messages of the body, or information manifesting itself through the body (Mindell, 1988).

Sometimes a person's process is connected with living through a disease and even with dying. Mindell has repeatedly described cases in his work with clients when symptoms have manifested the process of dying. It is important to treat with respect and reverence a life-threatening disease (Mindell, 1998). It is very important to note, however, that in Process-oriented Psychology, we proceed from the premise that the purpose of working with the symptom is not healing, but first of all bringing the awareness to what is happening in the here-and-now. By entering the experience consciously, we can reveal the deeper meaning of the symptom or illness (Mindell, 1998).

² Process-oriented Psychology uses Jung's concept of the life myth. Jung originally coined this term to describe a patterning for life-long personal development. He found that childhood dreams, which often stayed in a person's memory into adulthood, revealed an archetypal or mythic pattern for a person's life. Mindell extended Jung's work on life myth and childhood dreams by proposing that patterning for a person's life can also be seen in long-term and recurrent experiences, e. g. chronic symptoms, illnesses, addictions, relationship patterns, etc. (Diamond & Jones, 2004).

1.3.2 Unfolding the sensory-grounded experience of body symptoms

In previous chapters, I described the history and general theory of Process-oriented Psychology and Mindell's concept of the dreambody (see Chapters 1.1 and 1.2). In this chapter I will focus on what the Process-oriented approach to working with body symptoms looks like, as well as the steps we take when we work with clients and their body symptoms. These steps can also be used as a method of "**inner work**"³.

As previously stated, the dreambody's message manifests itself through body symptoms or illnesses. Illnesses can be both dangerous (and in some cases fatal), and at the same time a wise teacher - showing us which direction we might take in the present moment or, in the case of chronic symptoms, the long-term. Marginalized aspects of a client's wholeness will emerge as a disturbing signal (e.g., a body symptom) (Mindell, 1990).

From my experience working with clients, in most cases (including my own) the person suffering from a symptom identifies themselves within their primary process as a victim of the symptom, as someone who suffers from the symptom. This is very natural, and we all know what it's like to be in this role. The client complains of discomfort or pain in the body and identifies themselves as someone who is sick.

As a first step when working with any body symptom, we need to collect as much information as possible about the symptom related to the primary process, for example, what diagnosis doctors made when the disease began, etc. We also collect sensory-based information: how the client experiences the symptom, and in what channel they are receiving the signals: i.e., body sensations (pressing, burning, stabbing), visual images (burning, taking up more and more space), sounds (ringing in the head), or gestures and movements (Diamond & Jones, 2004).

³ Process oriented inner work builds on Jungian active imagination (Johnson, 1996) and what is known today as mindfulness meditation practice. It focuses on following the flow of one's own experiences by noticing the most obvious signals, as well as subtler dreamlike experiences, and the most subtle, almost ineffable feelings and tendencies occurring within and around us. It is a creative and dynamic mindfulness practice (Mindell, 1990).

In Process-oriented Psychology we are tracking both parts - the primary process of the client that feels like a victim of the body symptom, as well the secondary part, creator of the body symptom. We call this part the “symptom-maker” (Mindell, 1990; Mindell, 1998).

Once we get a sensory-based description of the symptom related to the secondary process, we amplify the signal in the channel where it manifests itself, by bringing the client's attention to it and supporting this direction while following the feedback. By unfolding this signal with sensory-grounded awareness we unravel, in a more tangible way, a new quality to which the client did not have access before (Mindell, 1998; Mindell, 2001).

Then, if possible, we add other channels to further unfold the secondary process. For example, if the symptom manifests as pressure, the client can imagine how the pressure might also look, sound, move, etc. The important point here is that as the client imagines their own symptom, they are in the role of the symptom-maker (not the role of one who only suffers from the body symptom). This is what belongs to the secondary process. The task is to explore the manifestations of the symptom-maker in as much detail as possible; to move like it, feel it inside, notice how it looks, how it sounds, and then to try it on oneself. And so through unfolding the original sensory-grounded quality of the symptom and adding other channels, the client can then experience a “dream figure”, an embodied experience of the originally disturbing and marginalized experience. By dream figure, we mean a mythological or historical figure that lives this unfolded quality naturally. Experiencing and expressing dream figures is a very creative part of the work (Mindell, 1990; Mindell, 1993; Mindell, 1998).

The last part of the work seeks to integrate the experience into the client's daily life (Diamond & Jones, 2004). At this point, we might ask the client how this dream figure or the unfolded experience might be useful in their everyday life, perhaps in relationships, in their relationship to themselves, at work, in society, or in the way they interact with the world. Of course, at any point in which we are working with our clients or on ourselves, we also work on edges (described in Chapter 1.2.1) whenever they emerge.

1.3.3 Rainbow Medicine

Mindell suggests a unifying medical paradigm “**Rainbow Medicine**” and shows how its concepts are found not only in classical and alternative medicine, but also in physics,

spiritual experience, and altered states of consciousness. According to him, Rainbow Medicine means a multidimensional approach in medicine (Mindell, 2004). This section further explores what he means by this concept.

Just like the rainbow has many colors, the body has various colors of reality. One color is the consensus reality, the tangible and physical aspects of the bio-medical reality to which we are all accustomed. In this reality, the body has a head, two arms, legs, a heart, etc. and is seen as an object located in time and space. However, like all material objects, the body contains other colors and frequencies. Another color is a dreamlike dimension that cannot be easily measured and located in time and space. This reality includes experiences of fantasies, subjective feelings, dreams, and dream figures. The third color is an essence level and includes perception of subtle tendencies and a lucid sense of the force of silence from which dreams arise. In the dreamland, we can't measure or locate the body's quantum wave patterns or subtle feelings. Nevertheless, most people can feel these subtle tendencies even before they manifest as recognizable patterns (Mindell, 2004).

Rainbow Medicine, according to Mindell, therefore includes the real time and real space of physical reality as well as dreamlike levels of the body's psychological reality. And so, Rainbow Medicine includes components of Western medicine such as anatomy, diagnosis, medication, surgery, etc., as well as alternative medical procedures involving subjective experience, dream patterns and all levels of consciousness. In contrast, he calls any medicine that involves only one level of reality as a "one-color medicine" (Mindell, 2004).

In Rainbow Medicine, we can see an overlap with the concept of the bio-psycho-social model of disease (that will be described further in Chapter 2.3), which is the conceptual basis of modern psychosomatics (Tress et al., 2008; Morschitzky & Sator, 2007) as well as the starting point for the World Health Organization's concept of health. However, Mindell's Rainbow Medicine goes far beyond the consensus reality level and introduces the new dreambody concept based on his studies of physics, analysis, Taoism and shamanism (Mindell, 2004).

1.3.4 Extreme states and coma work

In this chapter I will briefly introduce how Process-oriented Psychology works with extreme states of consciousness as well as comatose states, all of which may be perceived as body symptoms or health issues.

Extreme states

Process-oriented Psychology uses the term “extreme states” for serious psychiatric mental states such as psychosis, catatonia, depression, mania, etc., in order to express that these states are perceived as extreme in our society, rather than seeing them as solely an individual’s pathology. In the mid-1980s, Mindell worked with the staff and patients of a mental health agency in Dubendorf, Switzerland. The team included doctors, social workers, patients, interns, and politicians who were responsible for funding the agency. Mindell worked with patients at the agency as well as with the larger social issue of mental health in the city. He developed certain methods of working with these extreme states within the Process-oriented Psychology framework. For example, he called psychiatric clients “**city shadows**”. These patients, according to his observation, reflected the values and norms of a given culture or society that determine whether a state of mind is normal or abnormal. He saw extreme states as being valuable, or at least neutral - as alternative states of experience rather than as fixed, pathological conditions. Therefore, the concept of city shadows (the Process-oriented view on extreme states) is to look for value and meaning in these states of consciousness and see ways of making them more useful and less disturbing to individuals and society (Mindell, 1988).

Coma work

Coma work in Process-oriented Psychology includes theory and practice for psychotherapeutic work with patients in comatose, vegetative, and other highly withdrawn states of consciousness. Mindell and his wife developed this methodology based on observations that patients who appear non-communicative according to the usual neuropsychiatric diagnostic criteria can still experience the world around them and are capable of communicating by using subtle, often barely detectable nonverbal signals. In coma work, we focus on and amplify whatever residual ability the patient has to perceive

their world, we communicate with the patient about their condition, and thus make patients active decision-making participants in their own care (Mindell, 2009).

From a Process-oriented Psychology point of view, the comatose patient is capable of perceiving and relating to outer and inner experience. The therapist first tries to identify what communication channels are open to the patient (e.g., eye movement, breath changes, and facial expressions), and then use those channels to relate to the patient's experience. After that, the therapist attempts to interact through these often subtle and minimal signals and amplify them while watching the feedback as a guidance of the flow of the process. Although awakening the patient from the comatose state is not the goal of the Process-oriented Psychology, it has been known to happen as a consequence of these interventions. Additional goals are to help the patient communicate in whatever way is open to them, help the communication between the patient and their family, and facilitate the patient's participation in decisions regarding their care (Mindell, 2009; Morin & Reiss, 2010).

1.4 New directions in the Process-oriented approach to working with body symptoms

Process-oriented Psychology is still being developed by Mindell, his wife and colleagues, and other practitioners all around the world. In this chapter, we would like to introduce new directions in the Process-oriented approach to working with body symptoms. At the end of the chapter, I will describe my own experience with some of these new directions that I gained from my internship at the Process Work Institute in Portland.

1.4.1 Big Medicine

Pierre Morin recently introduced the concept of "**Big Medicine**" in his new book "Big Medicine: Transforming Your Relationship With Your Body, Health, And Community", representing many years of experience from his work as a physician and Process Work practitioner, as well as the experience of his colleagues. Big Medicine explores the current mainstream topography of health and illness from a Process-oriented perspective. Morin describes today's version of medicine as "small medicine" - an approach that has turned into the provision of healthcare that is dominated by technologies, process flow charts, and lists of best practices. According to him, this type of medicine is based on the idea that the

body is a machine and healthcare supplies are the mechanics which repair faults when the machine is broken. While “small medicine” is powerful and very often successful, it has lost its depth and soul as well as its human and social connection (Morin, 2019).

In his theory he describes a “small health,” as a term that stresses the reductionist and mechanistic features of mainstream Western and allopathic medicine. On the contrary, a “big health” endorses a more inclusive concept of health; it sees illness and disease as a path toward health. In Big Medicine, illness and disease is not only failed health but also a new cultural experience that has its own language and meaning. And thus, Big Medicine is a multi-layered, holistic approach to healing by using a Process-oriented approach (Morin, 2019).

Big Medicine is the application of big health. In addition, it uses theories and methods from Process-oriented Psychology to explore and facilitate a person’s and community’s experience of health and sickness. This approach highlights the dynamic, forward-moving qualities of life and looks at all manifestations of life with a value-neutral ethical lens (Morin, 2019).

As we can see in Morin’s Big Medicine as well as Mindell’s Rainbow Medicine, allopathic medicine plays a large role in their concepts (Mindell, 2004; Morin, 2019). They both try to expand Western’s medicine perspective by integrating the Process-oriented Psychology paradigm, to include the dreaming behind body symptoms or illnesses.

On top of that, Morin’s Big Medicine emphasizes the aspect of culture and community. In mainstream culture, health has a dominant standing. The majority perspective turns against illness, disease and death. Nobody wants to fall ill, suffer, or die. On the other hand, we have no choice, because ill health and death are part of life. And so, why not be curious and discover a new world beyond illness and disease? According to Morin, culture not only shapes our attitudes toward health, illness and death, but also contributes to the burden of illness and disease. This contributes to cultural structures of systemic oppression. In this way, politics and policies are directly linked to life expectancies and our individual likelihood of staying healthy (Morin, 2019).

From a Process-oriented Psychology perspective, Morin, as well as Mindell, perceive illness and disease as expressions of marginalized aspects of our identity (Mindell, 2004; Morin,

2019). According to Morin, Big Medicine, however, uses a cultural lens to better understand our experience of illness and the systemic structures which affect our bodies and minds. Life is a place in which health and illness coexist. They are both seen as an articulation of deeper processes which are present in the individual as well as in communal (cultural) experience (Morin, 2019).

Big Medicine sees disease and illness as a process, as an aspect of the nature of life. Thus, Big Medicine avoids identifying individuals and groups with their disease or illness diagnosis. People have a process, and they are not the condition they suffer from (Morin, 2019). From a Process-oriented point of view, we are interested in the nature of body symptoms and illnesses, and we are curious to find the messages behind them for us as individuals and, as Morin describes, as a community and culture.

1.4.2 2nd training and body symptoms

One of Mindell's recent theories is the concept of a "**2nd training**". According to Mindell, the "1st training" includes diversity awareness, group process skills, leadership concepts, and conflict methods such as cognitive training. The 2nd training then helps people to be more effective by increasing their awareness and ability to flow - that is to be creative and powerful during conflict. Even though he describes the theory of 2nd training in the field of leadership, he also includes working with body symptoms while using this new approach (Mindell, 2019).

When we look closer at this new direction, we see that Mindell goes deeper and focuses more on the essence level. He uses, as he does in all his theories, his knowledge of physics to explain this level of reality and suggests how to work with it. Mindell describes the essence level as the level of awareness where dreams appear. He also calls the intelligence of that level our "processmind". He prefers this term instead of the unconscious because of the remarkable, apparently nonlocal (or as Jung might describe, synchronistic) intelligence behind the processmind. According to Mindell, we can also call it God, great spirit or anything else. Mindell compares the essence level to the universe before the Big Bang. The universe is 13.8 billion years old and we know that there was a Big Bang, but we know very little about what made it happen. He explains that if we are in touch with our deepest selves, we are in touch with the pre-dreaming state, with the spontaneous

creativity of our universe. In other words, as our present universe came from a Big Bang, so our lives, thoughts, and dreams contain similar qualities (Mindell, 2019).

But how can one access the essence level? Mindell suggests that it is enough to just relax, let go, breathe as if in a pre-dream state, and let one's body move...until images arise describing those movements. He also uses the Zen Buddhist concept of "empty mind" as another way to perceive the essence level. The 2nd training is based on the subtle and flowing experience of the origins of consciousness, and recognizes how the essence level and flirts emerge as ideas and dreams in consciousness in everyday life (Mindell, 2019).

The process of moving through levels of consciousness appears as what Mindell calls "phases". Mindell describes four phases in organizational or group settings, but they are applicable with any kind of issue or body symptom in our life. Those phases are described below in the context of our topic - body symptoms:

Phase 1: relaxing with the symptom,

Phase 2: fighting it with medicine or alternative medicine,

Phase 3 becoming the thing bothering you (symptom-maker) and looking at yourself through its mind,

Phase 4: flowing through all this with detachment (Mindell, 2019).

The 2nd training is based on the individual being open to phase 4, and the way we can flow with all the other phases. It is about experiencing phase 4 and its ability to relax in phase 1, fight in phase 2, dream and role-switch in phase 3, and detach in phase 4. The essence level, the deeper, phase 4 state of mind, is important. When one can feel that level, one can flow better with all the other phases (Mindell, 2019).

As we can see in the description of Mindell's new work, this theory presents methods for complex work on body symptoms and includes more essence level work as one of the new directions of Mindell's Process-oriented Psychology. Mindell has been teaching this new direction over the last few years and applying it in different areas (group work, conflict facilitation, world issues, relationships, body symptoms, etc.).

1.4.3 Dreambody and Deep Bodywork

In this chapter, I would like to introduce another recent direction to working with body symptoms, described by Gary Reiss on his seminar “Dreambody and Deep Bodywork” in the summer of 2020 (G. Reiss, personal communication, July 18, July 25, August 1, August 8, 2020).

Reiss continues Mindell’s dreambody work and takes it a step further with “**Deep Bodywork**”. He appreciates all kinds of bodywork (Shiatsu, Hakomi, Craniosacral therapy, etc.) and highlights that Process-oriented Psychology works on what comes up for the client as well as on the relationship between therapist and the client. While most bodywork approaches are very structured, Process-oriented Psychology is about following feedback (see Chapter 1.2.5). In Deep Bodywork he suggests, in some cases, to use touch while working with the client as a supportive technique with the client’s consent and on safe areas on the body, even remotely (G. Reiss, personal communication, July 18, 2020). This approach brings more attention to the component of touch within the Process-oriented approach to working with body symptoms (while following the feedback of the client).

Just as other Process-oriented seminars which are focused on body symptoms, Reiss emphasizes the importance of a trauma-informed approach. We must be aware that the body remembers trauma and so, while working with someone on a body issue, we have to go slow, step by step, and watch the feedback of the client carefully. Similar to other teachers around the world on this topic, Reiss suggests that body workers, massage therapists, doctors, and so on should be more informed about the trauma approach, relationship channels with clients, and about the process behind body issues (G. Reiss, personal communication, July 18, 2020).

Reiss brings Mindell’s 2nd training approach into practice by describing Deep Bodywork as work on different components (like the phases in 2nd training, see in previous Chapter 1.4.2) which are part of the body symptom, illness or injury. He also includes coma-work as a part of Deep Bodywork. One interesting part of Reiss’s seminar is related to injuries. With injuries there is not only the hurt, but also the trauma around the hurt. He suggests various methods for working with injuries: returning to work on injuries which have been missed, working on the moment and atmosphere right before the injury happened and on the

position in which we were injured, picking up the process behind the injury itself, working on the essence level, working on the altered state around the accident or injury, as well as being aware of the world channel in terms of accidents and of the possible related trauma (G. Reiss, personal communication, August 1, 2020).

In line with other Process Work teachers and practitioners, Reiss stresses that Process-oriented Psychology is an integrative approach, and in terms of body symptoms and injuries, it is important to heal the body on all levels, with all kinds of medicine, and to work on the process behind a body issue. He likens Deep Bodywork to working on a night dream from a Process-oriented point of view, where all parts of the dream are represented by different figures with different qualities for the dreamer. According to Reiss as well as other Process Work practitioners, body symptoms, illnesses, diseases or injuries are complex processes, like a dream (G. Reiss, personal communication, July 25, 2020).

Last but not least, Deep Bodywork also includes looking into the childhood dream of the client and seeing if the message behind the body symptom or injury are reflected in some of the dream figures (G. Reiss, personal communication, August 1, 2020). I described before (see Chapter 1.1.1) that Mindell developed Process-oriented Psychology through his interest in identifying the similarities between the unfolding of body symptoms and night dreams of his clients (as well as his own). Process Work practitioners are still developing approaches to connecting different pieces of the process mirrored in different areas in our life as an expression of our life myth (described in Chapter 1.3.1). The connection between night dreams, childhood dreams (our first dream or memory from childhood) and the unfolding of body symptoms is very interesting, however it is also beyond the focus of this thesis. Regardless, this could be a rich area of study for future researchers on the topic of body symptoms and dreams.

1.4.4 My internship at the Process Work Institute

As a part of my doctoral studies at Palacký University in Olomouc, I went for an internship at the River's Way Clinic at the Process Work Institute in Portland, Oregon, USA. Under rigorous supervision while working at the clinic, I have had deep and enriching experiences, including the opportunity to attend many public seminars. In this chapter I would like to present what I experienced there as it relates to the topic of this thesis.

Dreambody Medicine Forums

Of the various experiences I had throughout my internship, the most inspiring experiences were in attending “**Dreambody Medicine Forums**”. Dreambody Medicine Forums happen almost every month at the Process Work Institute (typically in-person as well as simultaneously online, and only online since the beginning of the COVID-19 pandemic).

Dreambody medicine forums are inspired by the foundational Lava Rock seminars which Arnold and Amy Mindell and Max Schupbach taught in the 1990s. This clinic was held once or twice a year in Yachats on the Oregon coast, and focused on the Process-oriented approach to working with body symptoms. The goal was to nurture and support the self-healing potential of those affected by body symptoms, holistically considering collective, psychological, allopathic and alternative medical aspects in equal measure, with most attention given to the awareness and unfolding of the subjective experience of body symptoms. The current team of the Dreambody Medicine Forums - P. Morin, K. Wilde, J. Tomlin and Emetchi - were taught to work with symptoms in a holistic way by unraveling their meaning in a person’s life. Now they continue the traditions of the Lava Rock Clinic by organizing these Dreambody Medicine Forums, free of charge and open to everyone in person or online who is interested in this field.

Their vision has two goals: to help people with body symptoms by unfolding the deeper aspects of their symptoms’ process into the fabric of their lives, and to teach and train students and health professionals to work with body symptoms in a holistic way. At these forums, the team applies the Process-oriented approach to working with body symptoms and Mindell’s Rainbow Medicine. The most inspiring thing I discovered while attending these Forums was the community. Let’s take a look at what Dreambody Medicine Forums look like.

As mentioned before, the frequency is approximately once per month. The length of the event is usually between one and a half to two hours. Participants can attend in person as well as online (during the COVID-19 pandemic only online). The number of participants varies between fifteen and dozens of people. At the beginning, the facilitators introduce themselves briefly and introduce the structure and purpose of the forum. Then one of the facilitators works in front of the group with one of the participants on a body symptom.

The participant can choose any body symptom to unfold. During the work with the participant, facilitators describe the structure of the process. This is very important, as other participants can see and understand through a lived experience how Process-oriented Psychology is applied to the field of body symptoms. After the work is done, the facilitators open the space to the whole group. Anyone can share their experience of what they witnessed, and share their thoughts, feelings and ideas. Facilitators also offer some discussion questions, for example: How could the symptom and its unfolded message be connected with the culture and society the person comes from, and how could this be related to participants that come from different countries and cultures?

In having witnessed the Dreambody Medicine Forums, as well as having experienced them through working on some of my own body symptoms, I have been enriched not only by the individual part of the work, but by the fact that there were other people sitting in the circle, supporting the field as well as bringing their thoughts, ideas and insights. I wish these forums could be integrated into every hospital, psychosomatic clinic, and psychotherapeutic trainings, and as a part of the education for everyone who works in healthcare or a therapy field which includes a body component (psychotherapy, bodywork, physiotherapy, chiropractors, etc.).

I would like to share a personal experience of working on my own body symptom at one of the online forums. Interestingly, the work was done from my room in Portland while other people all around the world attended online via Zoom. This time I worked on a symptom of fear connected to the COVID-19 pandemic. The fear was not only a psychic symptom but also had an embodied component. For me, it was a very intense and strange feeling that was very unpleasant and went through my whole body very quickly from top to bottom. You might know this feeling - similar to when you feel like something really wrong has happened to you or your loved ones, or even that something might happen. However, everyone is different, so each of us will very probably have a different experience of fear. I had experienced different types of fear in my life, but this was one of the worst and I was interested in exploring it more deeply. On a consensus reality level, it was clear that the fear related to the pandemic, and especially worries about my parents who were at that time alone in my home country, the Czech Republic. When I followed the sensory-grounded experience of the symptom while having great support from one of the facilitators, I stood

up and followed the intense feeling in my body from the top to the bottom. My hands naturally started to copy the feeling in the movement and as I continued, there also came a sound and image of a huge waterfall together with it. I felt that I could let go of everything; I felt free and empowered. At that moment, there was no fear or worries about my parents or someone else's health, yet still I was aware about the pandemic happening in the world. While I kept doing this movement and sound, at some moment I felt that the waterfall was me. In other words, I felt it was not me who was doing this movement or sound, but that the movement and sound was coming through me. I was in touch with the essence level. After the work, as usual, the facilitators opened the space for the group. Many participants shared that it was refreshing for them, because they had also been experiencing a lot of fear and they felt relieved and empowered after witnessing my experience. And so, the body symptom wasn't only my individual symptom, but also a collective one. We might even say it was a global symptom as a part of the COVID-19 pandemic. The fact that these forums are happening in a group setting brings more awareness to the society we live in about how our body symptoms are connected to our culture, for instance, the situation we are facing right now as a society.

Aside from the Dreambody Medicine Forums, I have attended many public classes taught by teachers of Process-oriented Psychology from the USA, including the founders of the method, A. Mindell and his wife Amy. If I were to summarize what I have learned and developed here, the key points would include an increased awareness of cultural diversity, new possibilities for applying Process-oriented Psychology to body symptoms in a community setting, the diversity of experience of people coming from different cultures around the world, including their belief systems, diversity of power and rank issues, and so on. It helps me to see myself and the world more deeply as well as to appreciate the diversity of human beings and all the disturbances we experience in our lives, whether they be a body symptom, racial issue, relationship issue, or something else. I am very grateful for having the opportunity to do my internship in Portland, and thankful to the Department of Foreign Affairs as well as the Department of Psychology at Palacký University in Olomouc, the River's Way Clinic and Process Work Institute in Portland, the Institute of Process-oriented Psychology in Prague, my family and loved ones, teachers, supervisors, peers, colleagues and friends that supported me during my stay in the USA.

2 Mind-body relationship, holistic approach and psychosomatics

The second chapter is devoted to the mind-body relationship and its development over the last few centuries to the current holistic approach that is mainly applied in modern psychosomatics. Furthermore, I describe in more detail a bio-psycho-socio-spiritual model and its application in current psychosomatics. The next part is devoted to the neurobiology of the mind-body connection. At the end of the chapter, I briefly explain terminology of body symptoms that form the main area of interest of our research.

2.1 Mind-body relationship from a historical point of view to the present

The connection between body and mind has been viewed differently over time. Reflections on the domination of the mental or material substance and their relationship appear from the beginning of philosophy, but the explanation of the relationship between them has not always been clear (Sedláková, 2013a). The Eastern teachings of Indian and Chinese philosophy perceived man holistically. Martial arts, body positions and healing practices associated with the connection of body and mind have occupied an essential place. According to these teachings, our body is in our soul just as our soul is in our body (Hlavinka, 2008; Schermer, 2007).

The ancient Greek physician Hippocrates believed that feelings could control individual organs, for example, that the heart contracts in anger and gets wide in joy. The medicine of the ancient Greeks placed the same emphasis on mental and physical factors. In contrast, the medieval church preached a strict separation of the soul from the body (Morschitzky & Sator, 2007).

The representative of rationalism, R. Descartes, a proponent of “**dualism**”, who conceived of the mind (*res cogitans*) and the body (*res extensa*) as two separate entities, was absolutely crucial in the development of mind-body relationship in the 17th century. He claimed that soul and body are independent of each other, even if they are connected by God. At the same time, however, Descartes admitted that some information (but it should be noted that not the most important) is obtained by the soul from bodily perceptions. He considered the pineal gland in the brain to be the mediator of communication between body and soul. Unfortunately, the legacy of his dualism gained great popularity and influence in science, which can be seen in today’s medicine, psychology, research and

practice (Hlavinka 2008; Danzer, 2010). According to Schermer (2007), instead of “I think, therefore I am”, Descartes should have said “I am conscious, so I know I am”. The author draws a parallel with a computer that is able to think but does not realize itself. According to him, the unconscious is also able to think, although it does not realize that this is happening (Schermer, 2007).

Another philosophical approach was “**monism**”. Monism was based on the assumption that the body and the mind are not made up of two different substances, but only one, wherein one of them has a predominant nature. B. Spinoza spoke about the fact that this unified substance sometimes appears as spiritual and sometimes as material (PlhÁková, 2006). Further developments of this theory within psychology and psychiatry were “mechanistic materialism”, a view of reductionist psychiatry where mental manifestations are completely reducible to physical causes, and “metaphysical idealism”, which considers that any mental manifestation (including somatic illness) is caused by mental processes (Smith, 2007).

A later development of this approach was “**psychophysical parallelism**”, which is conceived as an offshoot of dualism. It understands the mind and the body as two different entities which interact with each other (Smith, 2007). This theory was developed by G. W. Leibnitz and further expanded in the second half of the 19th century by the founder of psychology, W. Wundt (PlhÁková, 2006).

The latest in development of the concept of the relationship between body and mind is the “**holistic**” approach. It views man in unity, in which the mind and body are not understood as two entities, but as one whole. The human being is understood as a unified system in which individual parts interact and together form a holistic substance (Kratochvil, 2002; Schlippe & Schweitzer, 2006). Thus, causal and linear models are replaced by circular ones (Smith, 2007). Holism is based on the assumption that the individual parts of an individual work together in the interest of the whole and are intertwined, so that a change in some part affects the whole being, just as a change in the whole affects its parts (Mackewn, 2004).

Therefore, the view of the relationship between soul and body has changed over time. I also notice a different approach between Western and Eastern thinking. In recent years I

have seen the increasing integration of some Eastern teachings into contemporary psychotherapy and medicine (e.g., Zen Buddhism, Taoism, Yoga, etc.) (Sedláková, 2013a). According to Schermer (2007), Eastern thinking supports a holistic approach; in practice, this means the inclusion of holistic approaches such as massage, dance, psychodrama, acupuncture, etc. in classical treatment.

2.2 Psychosomatics

As we learned in the previous chapter, the current conception of the relationship between mind and body represents the holistic approach (Tress et al., 2008; Danzer, 2010). Today, we find the holistic approach mainly used in psychosomatics (Sedláková, 2013a).

Building on previous historical information, we come to the threshold of the 20th century, to S. Freud and his students, who are mentioned in connection with the emergence of modern psychosomatics (and especially psychotherapy in general). The known conversion model (the process by which psychic contents are transformed into body symptoms) was intended to represent how psychological conflicts can manifest themselves in the form of body symptoms (Morschitzky & Sator, 2007; Tress et al., 2008). Perhaps the most important figures associated with the beginning of psychosomatic theory were F. Alexander and H. F. Dunbar, who laid a solid foundation for psychosomatics (Faleide, Lian & Faleide, 2010). However, Alexander's well-known "specificity theory" (seven psychosomatic diseases), in which certain diseases are the result of specific conflicts, has not been verified by research and is now considered outdated (Morschitzky & Sator, 2007). F. Alexander was the first psychosomatic theorist to outline a theory which considered both somatic and psychological factors in interaction (Faleide et al., 2010). The successors followed his theory and further developed it. In the Czech Republic, V. Chvála, L. Trapková, J. Poněšický, M. Kryl, J. Růžička and others represent modern psychosomatics. There are specialized psychosomatic clinics or departments in psychiatric clinics, where the psychotherapeutic process is specially set up and often body-oriented approaches are used (Sedláková, 2013a).

What does the definition of psychosomatics look like today? And what does it have to do with the holistic view of human beings? The word "psychosomatic" itself undoubtedly evokes in us the idea of the connection between "psyche" (soul) and "soma" (body). Let's

look closer at the definition of this term. For example, Morschitzky & Sator (2007) define the term psychosomatics in two ways:

- **As an interdisciplinary concept, basic attitude, and view of the diagnosis and therapy of illnesses, taking into equal account physical, mental, and psychosocial factors.**
- As a separate clinical field and field of research, where the core is the research and treatment of the interaction of body and soul in certain diseases, this field is practiced in special departments of hospitals and psychiatric clinics.

According to the topic of the thesis, psychosomatics is perceived, from a wider perspective, as an approach which uses the holistic model. Thus, I highlight the first from the above two mentioned definitions.

Danzer (2010, p. 9) writes at the beginning of his book that “psychosomatics is in,” sharing that not only experts (like doctors or psychologists) but also people from the public like this word and use it to bridge the gap of the classical medicine in order to formulate a holistic or integrated medical science (Danzer, 2010). There is also the interesting idea of looking at the psychosomatic concept as a dynamic model of human participation in one’s health, including the possibility of client involvement in improving their health, compared to the Western medical model, which is derived from mechanical-reductionist thinking and leaves the health care exclusively to physicians (Faleide et al., 2010).

As we can see, the psychosomatic approach is very closely intertwined with the holistic conception of man and his continuum of health-illness. Thus, we can understand psychosomatics as a manifestation of holism in practice (Sedláková, 2013a).

2.3 Bio-psycho-socio-spiritual model

In 1977, the American physician and psychoanalyst G. Engel proposed a bio-psycho-social model of disease, which today is the conceptual basis of modern psychosomatics (Tress et al., 2008; Morschitzky & Sator, 2007) and also the essence of the concept of health of the World Health Organization. This holistic model explains the multifactored influence of the development of illness which requires the same approach in its treatment. A spiritual (or transcendent) component has been added to this model (Orel & Facová, 2009; Moore, 2010).

The individual components of the holistic approach exist and influence one other, or as Gestalt psychology would say “the whole is more than the sum of its parts.” They all participate in some kind of maintenance of balance (or stability of the system, homeostasis). A disturbance of some of these components can affect other components of the overall system and vice versa (Orel & Facová, 2009). In other words, in connection with the effort to bring a more personal and spiritual approach to today’s health care, Moore (2010, p. 16) states: “When a person becomes ill, his whole being is affected, but only a small part is paid attention.” Below I describe the individual parts of the bio-psycho-socio-spiritual model.

Bio (body component)

From a biochemical and biological point of view, the body consists of 70% of water, and the rest is hard and soft tissues (we have about 200 bones and 700 muscles) (Merkunová & Orel, 2008). In anatomy and physiology, the human organism is complexly hierarchically arranged and precisely regulated; three systems are responsible for ensuring this organism’s integrity - the nervous, immune and hormonal systems (Merkunová & Orel, 2008).

In contrast, modern physics presents a different view of the body. Today’s physicists see matter as a field of energy and intensity instead of an object in space. According to them, matter is solid, but at the same time formless energy. At the beginning of the 20th century, physics, as the most rational branch of modern science, perceived the world as a machine, activity of which can be predicted if we know its origin. However, accurate measurements of elementary particles later showed that the mechanical concepts of classical physics can’t be applied, because it cannot be proven that in a given experiment a certain electron passes through a certain hole without clearly disturbing the whole pattern of flowing electrons (Mindell, 2009). Heisenberg, who formulated the “uncertainty principle” in one direction defended matter as a whole (Mindell, 2009). This theory, as well as other theories in quantum physics, brought a completely new perspective on the perception of reality, as well as matter. Instead of describing the state of the system by precisely assigned physical quantities, quantum theories also assume states in which the measurement result is predictable only on the basis of probability (Mindell, 2009). The observer has a decisive influence on the result of quantum processes. It is also interesting for physicists to find that

the elementary particles of matter are not material particles, but aspects of the properties of the field. So instead of particles, there are relatively high field densities in certain areas of space and time, when these densities correspond to what classical physics calls matter. According to A. Einstein, it can be assumed that matter is formed by a space with an extremely intense field (Mindell, 2009).

Douglas (1973) offers another point of view on the body and describes the physical and social body. To Douglas (1973), the quality of the physical body is determined by the social body, because the perception of the physical body is through the social construct of reality. Smith (2007) further elaborates on this concept and points out that a person who “has a body” experiences themselves primarily as a mental entity, i.e. “I am when I think” and he often notices the body only when “it needs something” or when it is not working as it should. Fialová (2001) then integrates both ideas into one, and thus corporeality means “to have and to be.” We are the body, we experience emotions through the body, we live ourselves through the body. At the same time, our body is an instrument of movement and the essence of our entire existence (Sedláková, 2013a).

The body is a reflection of experience (whether conscious or unconscious), a means of communication, and plays a key role in non-verbal communication (Mackewn, 2004). Čížková (2005) states that verbal communication can be controlled to a certain extent, while non-verbal expressions can never be completely masked or suppressed. Similarly, Lowen (2009, p. 79) states that the body does not lie. If the body reflects our experience, then we can influence our experience back through the body (Plhánková, 2007). The body is a mirror of inner experience and reactions to the outside world. We get to know the inner and outer world mainly through the help of the senses: sight, hearing, touch, smell, and taste (Frýba, 1995). I consider the mutual influence of body and soul to be the alpha and omega of all body-oriented approaches using the potential of one’s own body.

Last, but not least, the body is also our source of energy. Lowen (2009) states that the term energy in biochemistry is used for research involving energy processes at the molecular and submolecular levels. Vital (life) energy is probably most encountered in Eastern teachings and in today’s relatively widespread traditional Chinese medicine, including traditional Chinese exercises such as Qigong, Tai-chi, etc. (Hlavinka, 2008; Wilhelm, 2003). Many psychotherapeutic directions are inspired by these teachings.

Kopřiva (1997) states that everything that happens to us has a response in the body and that with the body we also discover the world around us. Thus, the body is not only a mirror of our inner experience, but it also responds to stimuli and events which happen from the outside. Kopřiva (1997) describes the body as the center and the focus of our being, which speaks to the fact that bodily experiences give us the certainty that we live, breathe, feel, walk, have an appetite, we can move, and so on. According to many authors, it is very important that we develop bodily perception and understand the body's manifestations and symptoms (Sedláková, 2013a).

Psycho (psychic component)

The word is derived from the Greek word "psyche" (the soul) and in Greek mythology Psyche was a young beautiful goddess of mental beauty, Eros's mistress, and later the basis of life or the immortal soul, which is associated with the physical body only temporarily (Hartl & Hartlová, 2010). In the most general sense, the psyche is understood as a summary of subjective mental processes throughout life (Plháková, 2007). In contemporary psychology, there are also concepts such as mind, self, soul, and spirit, and, in Jung's conception, a being including a whole of conscious and unconscious mental processes (Hartl & Hartlová, 2010).

Mental processes may be more or less conscious. For these reasons, concepts such as consciousness and unconsciousness as developed by Freud are the fundamental concepts in analytical psychology (Plháková, 2007). Two fundamental dimensions of the human psyche are experiencing, as an internal, subjective action, and behavior as an external manifestation of mental processes (Nakonečný, 1997). Nakonečný (1997) states that the core function of the psyche is an adaptation of regulation.

Adaptation is a key concept in modern psychology. Life means constant adaptation, as a relationship which exists between the individual and the environment in which it is about satisfying needs. Regulation (as a complementary action to adaptation) means balancing the activity of the individual towards adaptation (Nakonečný, 1997). In other words, the regulatory function of the psyche helps a person to adapt to the environment, to change his surroundings systematically, and to change the system of his own existence (Nakonečný, 1997).

Similar to Plháková (2007), Nakonečný (2011) talks about the basic forms of the psyche. Both authors classify cognitive, emotional, and motivational processes among psychological processes (Plháková, 2007; Nakonečný, 2011). Psychology collectively refers to cognitive processes - this includes perception, learning, memory, thinking, speech, imagination. Emotional processes lead to the emergence of emotions (e.g., joy, sadness, anger, anger, or surprise). Motivational processes are forces that activate and direct our behavior (Plháková, 2007).

Socio (social component)

In its beginnings, psychology was focused on the individual and mental life, but gradually the concept of man as a social creature began to be applied to psychology (Křivohlavý, 2001). If we looked far into history and ancient times, we could encounter stories and descriptions of people's lives in smaller communities. Special attention is paid to the social aspect (and especially the social support) of a person today, especially in health psychology (Křivohlavý, 2001).

The social component of the holistic concept includes all theories of object relations from the neo-Freudians, with the most widespread theory of attachments today presented by J. Bowlby (2010). By the term "attachment", Bowlby (2010) means a strong and lasting social bond between two humans. After publishing the results of his research on dyadic relationships, Bowlby extended this concept to the wider population. Výrost & Slaměník (2001) talk about a number of social influences and circumstances which affect the overall functioning of man: individuals, but also various professional, age or other groups, as well as human society as a whole. It also includes, for example, the importance of socio-economic status. They also talk about the concept of life events, which have a social nature and force a person to change their established life regime and respond to them (for example: marriage, vacation, injury, illness, natural disaster, war conflicts, etc.) (Výrost & Slaměník, 2001).

In fact, nearly everything that happens in our lives is an interaction with other people; we learn through other people, we experience emotions through contact with others, we take care of others, we raise children, we work in teams, we are part of social networks on the Internet, etc. In practice, very often in the anamnesis of clients we encounter a disruption

in the social area (with emphasis on the closest relationships, and, unfortunately, the family background) (Sedláková, 2013a). Thus, working on the relationship channel is also an important part of psychotherapy, either through the therapist-client relationship, with clients working with each other, or when working with couples and the family system (Yalom, 2007; Schlippe & Schweitzer, 2006). In psychotherapy, therefore, we always consider the relational dimension, whether we work with an individual, group, or system.

Spiritual (spiritual/transcendental component)

This component was added in the holistic view of man later, probably as an effort to emphasize its existence, which currently is often neglected in the Western materialist-rational world. The culture, traditions and values of one's own family influence the formation of the spiritual component, and even if this is not included in one's education, I believe that everyone can find a personal path to it later in life (Sedláková, 2013a).

Schermer (2007) states that spirituality is the basis of all human experience, and it is also present in its denial. Říčan (2007) addresses the topic of spirituality in psychology. He describes there is much more interest in spirituality and religion in the past few years in the Czech Republic, as a post-communist country, where there was a "scientific atheism" till the 1980s.

In contemporary psychology, there is a significant influence of Eastern religions (such as Buddhism, Zen-Buddhism, Hinduism). Kratochvíl (2006) states that the question of spirituality in contemporary psychology more often arises in connection with a Buddhist meditative or religious view, or the view of Jung's and Frankl's psychotherapy. Spirituality represents the transcendence of everyday life, as it is formulated, for example, in popular essays by the American psychiatrist M. S. Peck. Similarly, Moore (2010) mentions that there is also the spiritual (or transcendent) component in addition to the body and mind component, and relationships. The spiritual component is much broader and can include the need for growth, self-transcendence, meaning and inclusion in the universe, as well as questions about the meaning, origin, and direction of man (Orel & Facová, 2009). Only then can one be seen as a bio-psycho-socio-spiritual unity (Orel & Facová, 2009). Let's not forget the Jungian concept of transcendental function, which consists of the connection of conscious and unconscious contents (Jung, 1997).

2.4 Neurobiology of the mind-body connection

In the last few years, there has been very progressive development in the field of neuroscience. The effort to reveal, describe in detail, and locate the functions of the human psyche in the brain goes hand in hand with the development of brain imaging techniques and new possibilities of research (Sedláková, 2013b). Research on neuronal plasticity shows that mental life can change body structure (Bauer & Kächele, 2005). These discoveries of modern science also essentially confirm not only holistic approaches, but especially the current psychosomatic concept of mind-body interconnection and show that human genes can be regulated during life, for example by emotional experiences (Bauer & Kächele, 2005). These and other findings are fascinating and open up a wide range of possibilities in the treatment and therapy of people with mental or somatic illness (Sedláková, 2013b).

One internationally recognized author interested in the neurobiology of the connection between mind and body is B. H. Lipton, who has been researching cell biology for many years. In his work, this representative of “new biology” brings the latest knowledge from his field and concludes that we are not victims of our genes, but masters of our own destiny (Lipton, 2011). How Lipton came to these conclusions? Let’s look at his observations which will help us understand the path of the author’s knowledge. From the beginning of the “age of genetics”, humans are programmed to accept the subordinate power to our genes. people are constantly afraid of an outbreak of a certain hereditary disease, we have accepted the idea that we are subject to our genes and therefore medicate a problem rather than looking more closely at it (Lipton, 2011). While I agree with Lipton that some diseases are caused exclusively by a single gene (e.g., Huntington’s disease), I believe that most other diseases, and especially mental ones, cannot be caused by a single gene (Sedláková, 2013b).

Nijhout (1990) in his paper “Metaphors and the role of genes and development”, says that when a gene is needed, a signal activates it from the outside, i.e., the environment has a fundamental influence on genetic control (in Lipton, 2001). Similarly, Bauer & Kächele (2005) describe that interpersonal relationships, traumas, and external situations affect body structures. Lipton (2011) also states that in his laboratory research that he saw the effect of environmental change on cells many times and concluded that the even more fundamental function in the control of a human cell is not the double helix of DNA stored

in the cell nucleus, but its membrane. Through the mechanisms of this membrane, the human body translates signals from the environment into behavior (Lipton, 2011). Thus, genes cannot pre-program the life of a cell or organism, because the survival of a cell depends on its ability to constantly dynamically adapt to a changing environment, in other words, the membrane function could be likened to a cell's brain because its interaction with the environment leads to a certain type of behavior (Lipton, 2011). The findings of Lipton, therefore, signify a very fundamental turn from causality and determinism to a systemic conception on a scientific level. Lipton further expands his findings and puts them into context with quantum physics (that matter and energy are the same, the universe is one invisible dynamic whole in which energy and matter are intertwined), which also provides biomedicine with a different perspective on understanding health and disease. (Lipton, 2011). Last but not least, it also deals with the great potential of the domination of the mind over the body, which is undoubtedly shown by research using the placebo effect in treatment (Lipton, 2011; Timuřák, 2005).

Bob & Vymětal (2005), performed research focused on the influence of trauma and stress and their mental processes on bodily functions (Bob & Vymětal, 2005). Their research takes a closer look at the defensive mental processes of dissociation and alexithymia. These aspects occur as a result of traumatic stress, as well as cumulative stress without a traumatic event, and which lead to a variety of endocrine, epileptiform, and immune pathological processes and are associated with alterations in gene expression (Bob & Vymětal, 2005). Neurobiological manifestations of stress consist of a disorder in the hypothalamic-pituitary-adrenal axis (HPA), or "stress system of the body" and are manifested by various symptoms, such as tachycardia (Bob & Vymětal, 2005). Disorders of the HPA axis are also related to dissociation, a disorder of the integrity of consciousness and internal separation of consciousness from a traumatic event, manifested by amnesia, depersonalization, derealization, or intrusive thoughts and feelings (Bob & Vymětal, 2005). In addition to these mental manifestations, however, dissociation also manifests itself at the biological level, for example, in forms ranging from various painful symptoms to dissociative seizures belonging to psychogenic non-epileptic seizures (Bob & Vymětal, 2005). The authors also come to a similar conclusion with alexithymia (loss of the ability to read their emotions), which can be the result of long-term stress even without traumatic

causes, and in which there is also the somatization of symptoms (Bob & Vymětal, 2005). Among other things, the authors discuss the possibilities of current psychotherapy and state that psychotherapy also affects the biological side of a person (which is to some extent changeable by psychological means) (Bob & Vymětal, 2005). The same opinion is encountered in K. Grawe's neuropsychotherapy (Grawe, 2007). All of the above authors claim, essentially the same as Lipton, that the possibility of influencing gene expression and bodily structures by mental and psychological means represents a breakthrough in understanding the human psychophysical being (Bob & Vymětal, 2005).

Let's look further at neurobiological studies which examine the connection between body and mind in terms of the influence of physical activities on human thinking and experience, the function of brain structures, and the level of neurotransmitters. In a study reported in the journal *Progress in Neurobiology*, Knöchel et al. (2012) found that exercise and regular physical activity have a number of positive effects on the biological and psychological processes in the human body, including a scientifically proven preventive and therapeutic effect on depressed mood, anxiety, and cognitive performance. The World Health Organization has also reported a clinically proven effect of regular exercise on mild to moderate depression, comparable to the effects of antidepressants (World Health Organization, September 15, 2020).

In another study, Buchheim et al. (2012) investigated recurrently depressed unmedicated outpatients (N=16) and control participants matched for sex, age, and education (N=17) before and after fifteen months of psychodynamic psychotherapy. Participants were scanned at two time points, during which presentations of attachment-related scenes with neutral descriptions alternated with descriptions containing personal core sentences previously extracted from an attachment interview. The outcome measure was the interaction of the signal difference between personal and neutral presentations with group and time, and its association with symptom improvement during therapy. Patients showed a higher activation in the left anterior hippocampus/amygdala, subgenual cingulate, and medial prefrontal cortex before treatment and a reduction in these areas after the fifteen months. This reduction was associated with improvement in depressiveness specifically, and with symptom improvement in the medial prefrontal cortex more generally (Buchheim et al., 2012). As we can see, this study demonstrates neurobiological changes in circuits

implicated in emotional reactivity and control after long-term psychodynamic psychotherapy and thus shows the connection between mind and body, and how psychotherapy can affect the body.

In another study, Greck et al. (2013) were interested in whether brain activity in the parahippocampal gyrus normalized after (inpatient) multimodal psychodynamic psychotherapy. By using fMRI, subjects were scanned while they shared the emotional states of presented facial stimuli expressing anger, disgust, joy, and a neutral expression; distorted stimuli with unrecognizable content served as control condition. Fifteen somatoform disorder patients were scanned twice, pre- and post-multimodal psychodynamic psychotherapy. In addition, fifteen age-matched healthy control subjects were investigated. The effects of psychotherapy on hemodynamic responses were analyzed implementing two approaches: (1) an a priori region of interest approach and (2) a voxelwise whole brain analysis. Both analyses revealed increased hemodynamic responses in the left and right parahippocampal gyrus (and other regions) after multimodal psychotherapy. The authors state that these results are in line with psychoanalytical concepts about somatoform disorder. They suggest the parahippocampal gyrus is crucially involved in the neurobiological mechanisms which underly the emotional deficits of somatoform disorder patients (Greck et al., 2013).

Zehentbauer (2012) describes various techniques and methods (such as dance, yoga, various exercises, meditations, etc.), which can be used to modernly mobilize the specific signaling molecules responsible for the production of morphine-like painkillers based on modern brain and neurotransmitter research (endorphins), or potassium-like anxiety-reducing substances. According to Zehentbauer (2012), this is the body's own endogenous drugs which it can specifically and consciously stimulate. The conclusions of the above-cited authors and research on modern neurobiology thus confirm the mind-body connection from a scientific point of view. The above-mentioned findings offer enormous potential for psychotherapeutic, psychosomatic, and other holistic treatment methods.

2.5 Body symptoms

Body symptoms and illnesses, as well as their diagnostics and treatment, are the main subjects of medicine. In European culture, Western medicine dominates. However, over

the last few decades, there has been an increase in diverse approaches practiced, such as Chinese medicine, Ayurvedic medicine, holistic approaches, and the previously mentioned psychosomatic approach. Each of these approaches has its own point of view on body symptoms and illnesses, their etiopathogenesis, and treatment.

In this chapter, I would like to introduce the body symptoms and illnesses which are the subject of our research, from a Western medicine point of view as this is the dominant approach in our Western European culture. We will define the following terms: symptom, illness, acute, and chronic.

Symptom

There are a large number of symptoms. Most of them can have several causes. A combination of symptoms is typical for a certain illness. The main symptoms of any illness occur frequently and are typically noticeable. Side effects are not in the foreground and their occurrence is not the rule. Subjective symptoms are the patient's complaints, while objective symptoms are obtained by physical examination. A typical accumulation of symptoms is called a syndrome (Vokurka & Hugo, 2015).

Illness

An illness is defined as a health disorder. It is usually detectable objectively, is perceived by a sick person, and becomes the subject of medical services. Over the course of time, we distinguish the initial period of pre-pathogenesis, early pathogenesis latent, or asymptomatic phase of the illness, advanced pathogenesis, and termination of the illness by cure, the transition to the chronic phase or death (Vokurka & Hugo, 2015).

Acute

Acute means rapid. An acute illness arises suddenly, and its symptoms are significant and serious, such as high fevers, severe pain, etc. Acute illnesses can completely heal or turn into a chronic form, and in the most severe cases lead to death (Vokurka & Hugo, 2015).

Chronic

Chronic means protracted, or permanent. Chronic illnesses are less severe than acute, but their symptoms are more or less permanent - sometimes remissions may be noticeable,

while at other times they worsen sharply. Their permanent effects can damage the body and its organs. Some illnesses have a chronic nature from the very beginning (Vokurka & Hugo, 2015).

As we can see, Western's medicine definitions reflect, as we described in the previous chapter (see Chapter 2.1) a mechanistic, objective description of any kind of body disorder or disturbance. Despite these criticisms, Western medicine has been intensively developing over the last few decades and we need it. It is the best that we have at present as a civilization. Often, those facing illnesses wouldn't survive without Western medicine's diagnostic methods and treatment.

With this in mind, if we look closer at the psychosomatic point of view, we can see an extension of Western medicine rather than something that contrasts with it. For example, Růžička (2010) states an interesting opinion and reflection on today's psychosomatic approach based on the background of four historical treatment systems (shamanism, healing, modern medicine, and psychotherapy): to be ill means not being able to live one's life freely among the possibilities that have been opened. Thus, illness does not concern only the body or soul, but our entire existence. At the end of his article, he talks about the controversial concept of illness as a purely biochemical (biophysical) reality. The author suggests that one of the basic treatment methods for holistic psychosomatic medicine should be psychotherapy, because it does not only deal with organs and their narrowly defined functions, but also examines a person's life and the possibilities of being in complexity (Růžička, 2010).

3 Research on the Process-oriented approach to working with body symptoms, its discussion and critique

The last chapter is devoted to existing research on the Process-oriented approach to working with body symptoms. I introduce several studies on the topic with one featuring a meta-analysis of the effectiveness of psychotherapy with psychosomatic diseases. At the end, I discuss the results of current studies and suggest next steps for future research.

3.1 Research on the Process-oriented approach to working with body symptoms

An exploration of the psychotherapeutic effect is essential to the development and application of functional methods in psychological practice (Timulák, 2005). Although Process Work is taught around the world and used by many practitioners, there has only been limited research related to the topic of body symptoms. The following studies were found in the EBSCO, ProQuest, and Medvik databases. Dissertation theses and Process Work diploma projects on the topic were found in the database on IAPOP's website (International Association of Process Oriented Psychology). A total of ten studies on this topic were found.

Weyermann (2006), in her dissertation research, examined the benefits of Process-oriented approach to working with body symptoms. Twenty female students aged 18-21 years participated in a one-off, experientially-oriented interview. Their socio-demographic characteristics were very similar: typically, they lived with their middle-class families outside of the city. The research consisted of a problem-centered interview allowing a subject-oriented combination of methods: a standardized questionnaire (SOC-L9) and partially standardized guided interview. Weyermann also invited study participants to make perspective drawings of their symptom at the beginning and at the end of the interview. The sketched drawings were considered in addition to the above-mentioned methods. There were three research question established in her study:

1. What are the characteristics of description of the subjective experience of body symptoms?

2. What are the features of sensory-grounded experiences and experiences of meaningfulness which are observed in the context of process-oriented symptom work?
3. Which effects of process-oriented symptom work can be established from the participants' sketched perspectives on their symptom (before and after the work)?

Through the course of the interviews, Weyermann found that participants' language in the experiential part of the guided interviews was tentative and searching, and vividly enriched with movement, gestures, and sounds. A closer examination shows that metaphors used to describe symptoms do not only have a communicative aspect, but also themselves interact with the new perceptions. The metaphors used by participants mostly had a direct connection to the essence of their symptom experience and to the descriptions in the "benefit finding" category (Weyermann, 2006).

Weyermann also found that participants largely attributed their symptoms to causal thinking. She believed this was due to the culturally dominant rational causal thinking about illnesses and symptoms. Participants described experiencing a broadening of their perspective through unfolding the symptom. The main themes were "changes in behavior", "familiarity", "wholeness", and "regaining control". From the unfolding of the symptom experience, nineteen participants described possibly useful applications they could use in their everyday life (Weyermann, 2006).

The third question brought findings about the changes of perspective of the participants' symptoms. Before working with the symptom, participants' sketches and descriptions came from a suffering or passive position, described as the "victim of the symptom" category, whereas patients' descriptions and sketches after the Process-oriented interview shifted to a positive and active attitude in the category of "activity and control" (Weyermann, 2006).

To Weyermann, these results indicate that Process-oriented Psychology can change the subjective experience of otherwise agonizing symptoms, promoting a resource-oriented strategy (Weyermann, 2006). Weyermann (2006) further relates this finding to the known correlation between a loss of control, a resigned victim attitude, and inadequate compliance with serious illnesses, such as cancer (Rudolf, 2000). Weyermann suggests that

the shift away from the “victim perspective” might have positive effects on compliance and the immune system in accordance with findings in psychoneuroimmunology (Kiecolt-Glaser, McGuire, Glaser, & Robles, 2002). These suggestions need more exploration and can indicate a direction for future research.

In another short study, Panáková (2003) describes the clinical experience of using the Process-oriented approach to working with body symptoms with her clients in three case studies (a 55-year-old male, a 40-year-old female, and a 34-year-old male). In each study, she describes how unfolding the body symptom brought more awareness into the clients’ current life and the issues they were dealing with. The author states that Process-oriented Psychology allows the client to change their perception of body symptoms - from non-conscious to conscious - and thus move from a passive attitude to an active one, in order to become the co-author of the therapy and of their life (Panáková, 2003).

Another study describes the case of a female patient in her forties with major depression and an eating disorder treated by Process-oriented Psychology (Fukao et al., 2007). In this case study, the authors describe that the patient identified herself with the “primary process” that she could not control her eating habits at first. The therapist worked with her symptoms as well as a nightmare she presented in which she was being chased by a monster, yet was never caught - her overeating, wrist cutting, and depressive symptoms were thought to be the expression of her “secondary process” for which she had the power of independent behavior. When she gradually became aware of this power by unfolding the quality of her symptoms as well as that of the dream, she became able to show her strength, overcome her trauma, and control her eating disorder (Fukao et al., 2007). According to the authors, Process-oriented Psychology seemed to be beneficial for this patient in the process of the recovery of her wholeness and in bringing solutions to her psychosomatic problems.

There exist several other diploma or dissertation theses on the topic of body symptoms and illnesses. These resources are either descriptive reports of subjective experiences from students of Process-oriented Psychology, which include the method they used and their body symptoms, or descriptive reports of a few case studies on this topic (Antonova, 2018; Ackermann, 1994; Camastral, 1995; Scott, 2014; Vassiliou, 2005). All of them share similar

findings of a broadening of their sense of identity and practical use of the unfolded experience of the body symptom in the everyday lives of participants.

In each of these theses, illness itself is looked at as a potentially meaningful experience, not only for the individual affected by it, but also for society (Ackermann, 1994). Seeing illness as an integral part of life, rather than as a disturbance which needs to be eradicated, reflects a shift in attitude towards unpredictable life events which focuses on awareness rather than control. The meaning of an illness experience can be discovered by bringing awareness to irrational and seemingly absurd fantasies connected to the illness experience and by unfolding the sensory-based experience of symptoms (Ackermann, 1994). Awareness of body states accompanying the illness and symptoms, as well as the memories and around crucial moments connected to the illness, seem to be clues to necessary life changes (Antonova, 2018; Ackermann, 1994; Camastral, 1995; Scott, 2014; Vassiliou, 2005).

In another dissertation thesis, Robinson (2009) takes a deep psychological view of Alzheimer's disease. She used a hermeneutic method of research to explore the condition's unique processes, symptoms, and inner experiences from a teleological perspective, which assumes that meaning and purpose may be contained within the condition's complex manifestations. She approached this through the thematic lenses of cultural influences, mythological underpinnings, symptomatic manifestations, states of consciousness, and clinical applications, as well as the primary theoretical foundations of Jungian psychology, archetypal psychology, Process-oriented Psychology, and transpersonal psychology, which are used to inform these thematic lenses and investigations. Her study suggests that people with Alzheimer's disease may function as a personal and collective shadow of Western cultural values, as it challenges the extraordinary value currently placed on youth, productivity, independence, rational thought, and personal identity. Investigations into Alzheimer's altered states of consciousness suggest that the condition may serve as a transitional experience from egoic to transpersonal realms of consciousness (Robinson, 2009).

Further Gusarova (2014) describes her over fifteen years of experience using Mindell's Process-oriented Psychology for consciousness recovery in neurosurgical patients who have survived severe brain injuries and are in different states of consciousness (the

vegetative state, the minimally conscious state, mutism, confusion, and post-traumatic Korsakoff syndrome) through working with “minimal signals” (micromovements, breathing, facial reactions, etc.), the feedback principle, psychosomatic resonance, and empathy. Gusarova (2014) states that the Process-oriented approach is the phenomenological interaction between an external observer and immediately felt subjective experience (one’s own or that of another person) that turns the observer into a participant and makes it possible to feel the experience to a greater extent. In contrast to other psychotherapeutic approaches interacting with the unconscious, Process-oriented Psychology is the only direction with developed tools for establishing contact with a person in deep altered states of consciousness. To Gusarova, this approach can be used to recover impaired consciousness in patients with brain lesions as well (Gusarova, 2014).

Because there has not been sufficient rigorous research done on this topic, I was also interested in the research in the fields of psychotherapy and psychosomatics in general. Řiháček, Pavlenko, & Franke (2017) performed a meta-analysis of forty-four studies on the topic of medically unexplained physical symptoms (hereby referred to as MUPS) in medical, as well as psychotherapeutic, practice. Their study sought to answer the question of whether and to what extent psychotherapeutic methods are effective in the treatment of these disorders. Physicians and psychotherapists often encounter patients presenting physical problems in their practice, for whom a positive somatic finding is either completely absent or does not sufficiently explain the presented symptoms. In practice, the somewhat imprecise term “psychosomatic disorders” is often used in this area, which assumes that psychological factors play a significant role in the development of these problems. Thus, MUPS are used for somatic illnesses, the etiology of which has not been satisfactorily explained. Estimates of the prevalence of these disorders depend on selected diagnostic criteria; e.g., for MUPS it is estimated at 40.2%, for various forms of somatoform disorder at 26.2% (Haller, Cramer, Lauche & Dobos, 2015). MUPS are also associated with the excessive use of medical care and sick leave (Aamland, Malterud, & Werner, 2012) and their treatment is often complicated (Sekot, 2013).

The results of Řiháček, Pavlenko, & Franke’s meta-analysis support the conclusion that psychotherapeutic methods are effective in the treatment of MUPS. Effect controlled reduction in somatic symptoms (which is considered the primary output of these studies,

in particular meta-analysis ranged between 0.12 and 1.17, with a median value of 0.35², which corresponds to small to medium size effect (Cohen, 1992). Positive change also occurs in other monitored areas, such as levels of depression or anxiety, quality of life and social functioning (Řiháček et al., 2017). Some studies suggest that psychotherapy may be a more effective treatment of these problems than pharmacotherapy (Nüesch, Häuser, Bernardy, Barth & Jüni, 2013; Perrot & Russell, 2014), or other forms of treatment (Chambers, Bagnall, Hempel & Forbes, 2006); direct comparisons, however, are lacking. As already mentioned, psychotherapy can be considered an effective treatment for MUPS. However, it should be noted that the effect achieved is not very high. It is necessary to further develop and modify various psychotherapeutic approaches so that they can help a larger number of patients (Řiháček et al., 2017).

3.2 Critique and discussion of the Process-oriented approach to working with body symptoms

A great amount of Process-oriented Psychology literature describes the theory and methodology of working with body symptoms. Generally, the theory states that unfolding the subjective experience of body symptoms can broaden the perception of who we are and support the potential for self-healing, as well as theorizing how this could support dealing with individual (Mindell, 2001; Mindell, 2004) and collective problems (Morin, 2014; Morin, 2019).

From the perspective of Process-oriented Psychology, body symptoms are seen as a secondary process (further away from what we identify with, which is considered the primary process). By unfolding this signal with sensory-grounded awareness we unravel, in a more tangible way, a new quality to which we did not have access before (Mindell, 1998). And thus, body symptoms are seen not only as a medical disturbance in the body, but also as an aspect of ourselves which we have been marginalizing or don't have enough access to. The literature describes many examples of Mindell's work with clients that describes the meaning of body symptoms for his clients (Mindell, 2001; Mindell, 2004). Mindell also emphasized the similarity between body symptoms and night dreams, sharing that unfolded quality of a body symptom is very often reflected in the quality of disturbing figures appearing in our night dreams (Mindell, 1998; Mindell, 2001).

Expanding beyond simply the individual level, Morin (2019) and his team of collaborators shifted the Process-oriented Psychology focus on the individual experience of body symptoms to the larger context of cultural and social issues. Morin (2014) explains that body symptoms may be linked to a larger cultural context. The language and concepts of “health” and “illness” are rooted in a normative context which assigns value and significance to certain experiences while marginalizing others. By using the qualifier “healthy”, we sustain abnormality and sickness in others (Morin, 2019). Morin argues that from this perspective, symptoms are marginalized - that is, they are something wrong and abnormal. As I described earlier (see Chapter 1.4.4), he and his collaborators organize a monthly Dreambody Medicine Forum, wherein one of the participants works on a body symptom with one of the therapists in front of the group. When the individual part of the work is done, the whole group reflects on and discusses what they have witnessed, as well as how the symptom and its unfolded quality might be connected with the social and cultural field. In his books, Morin (2014; 2019) considers what would happen if we lived in a culture which reacted to symptoms with interest and excitement, and helped explore the diversity it expresses.

In the previous chapter (see Chapter 3.1) I described some of the studies which have been performed on the Process-oriented approach to working with body symptoms. There exist only a few qualitative studies and case studies so far. Unfortunately, no quantitative study has yet been conducted on this topic. The biggest study so far has been the qualitative study from Weyermann (2006) with a twenty-participant sample size. In this study, she found that a Process-oriented approach can change the subjective experience of otherwise agonizing symptoms, promoting a resource-oriented strategy, which is represented by a change from the “victim attitude” to a position of “activity and control” (Weyermann, 2006). Similarly, Panáková (2003) in her article stated that Process-oriented Psychology allows the client to change their perception of body symptoms - from non-conscious to conscious - and thus move from a passive attitude to an active one, in order to become the co-author of the therapy and their life. Moreover, results from other studies share the finding of a broadened experience of personal identity and a practical use of the unfolded experience of the body symptom in the everyday lives of participants (Fukao et al., 2007; Antonova, 2018; Ackermann, 1994; Camastral, 1995; Scott, 2014; Vassiliou, 2005).

Morin (2014, 2019) describes that unfolding body symptoms and illnesses can shift perspective on these phenomena as meaningful not only for the individual affected by them but also for society - I found this point of view shared in other studies as well (Ackermann, 1994; Robinson, 2009). These authors see body symptoms and illnesses as an integral part of life and society rather than as disturbances that need to be eradicated. This reflects a shift in attitudes towards unpredictable life events. It focuses on awareness rather than control, and which claims that the meaning of an illness can be discovered by bringing awareness to the irrational and seemingly absurd fantasies connected to the illness experience and by unfolding the sensory based experience of symptoms (Ackermann, 1994; Morin, 2014; Morin, 2019; Robinson, 2009).

Similar results are found in the small number of qualitative studies that have been conducted on this topic. And yet, the existing qualitative research in this area is very narrow and needs to be expanded. It would be interesting to research the use of a particular method with specific symptoms, or to research the benefits of a particular method from a long-term perspective. The biggest criticism, however, is the fact that there has of yet been no quantitative research focused on the effects of the Process-oriented approach to working with body symptoms. Despite the fact that Process-oriented Psychology is in its nature a phenomenological psychotherapeutic approach, rigorous and evidence-based research is missing and needed to demonstrate the efficacy of this approach. This should be the next step for future researchers in this area, as well as including Process-oriented Psychology in studies which compare different psychotherapeutic approaches.

Because there exist no quantitative studies about Process-oriented Psychology, as well as a very limited number of qualitative studies, I and my colleagues decided to conduct our own research, creating what may be seen as a pilot study for the measurement of the effectiveness of the Process-oriented approach to working with body symptoms in order to supplement the currently written qualitative studies. The following part of this thesis will discuss our three research topics.

Empirical part: The Process-oriented approach to working with body symptoms: effects, subjective experience, identification of significant events, and working alliance

In the previous chapters, I explained the Process-oriented approach to working with body symptoms, the mind-body relationship, the holistic approach and psychosomatics, as well as several follow-up studies and discussions. In the following chapters, I will introduce three empirical studies my colleagues and I conducted in the last three years. It is important to note that these three studies were performed on the same research sample (that will be described only in the first study) and do not have a common general objective. They addressed three aspects of the Process-oriented approach to working with body symptoms and their results build up a complex view and hopefully fill some gaps currently debated within the realm of Process-oriented Psychology research.

4 Study 1: Effects of the Process-oriented approach to working with body symptoms on symptoms severity, well-being, and satisfaction

In 2020, our first study was submitted and accepted for publication in an impact journal called “International Body Psychotherapy Journal” (Sedláková et al., 2020). The research was motivated by the fact that there has been no research on the effects of the Process-oriented approach to working with body symptoms. The majority of the text in this chapter is taken from said publication with the consent of the co-authors (see Appendix 3). Our goal was to examine the effects of Process-oriented Psychology, when working with body symptoms, on clients’ well-being and satisfaction, and on symptoms severity, as well as to test four further described hypotheses.

4.1 Introduction

Most the psychotherapeutic approaches work with a client’s thought awareness, i.e., their inner conflicts, relationships, workplace problems, trauma, fears, discontentment, etc. and only a few of them include body awareness and body symptoms in the therapeutic work (Tress et al., 2008).

However, in accordance with the current holistic paradigm, the illness etiology is complex, including physical, mental and social factors (Morschitzky & Sator, 2007; Faleide et al., 2010), and a large amount of clinical and empirical literature is devoted to this issue (Bauer & Kächele, 2005; Bob & Vymětal, 2005; Grawe, 2007). There also exist medically unexplained physical symptoms (MUPS) which are being used for somatic illness, whose etiology has not been satisfactorily explained (Řiháček et al., 2017). Moreover, there are also several other illnesses generally considered to be caused mostly psychologically (Tress et al., 2008).

Bob & Vymětal (2005) state that the goal of psychotherapy should be to influence the health of mind and body through a psychotherapeutic effect on the biological function of clients. Research in this area seems to be indispensable. Exploration of the psychotherapeutic effect is essential to the development and application of functional methods in psychological practice (Timulák, 2005).

Process-oriented Psychology is a phenomenological approach developed in the 1970s by Arnold Mindell, who researched body symptoms and Jungian dream analysis (Diamond & Jones, 2004). It is used by hundreds of psychotherapists and facilitators around the world in the fields of psychotherapy, psychiatry, social work, conflict resolution, group work, coma care, organizational change, and community building (Diamond & Jones, 2005).

Exploration of symptoms can give clients a sense of meaning; for instance, symptoms can be perceived as a reaction to something, or a direction of change in life (Mindell, 2001; Morin, 2019; Weyermann, 2006). In Process-oriented Psychology, the main goal is to bring awareness into what is happening right now (Diamond & Jones, 2004). The attention of the therapist is divided between two processes: (1) noticing signals of identity, which are close to personal awareness and include elements with which the client is identified - "primary process", and (2) marginalized elements - "secondary process" (Diamond & Jones, 2004). By marginalized we mean that they are set aside from the focus of identity - sometimes they are unconscious, yet they can also be conscious, but we do not follow them. Signals of these two processes emerge in different ways - channels. Channels are divided into: visual, auditory, movement, proprioceptive, relational and world channel (Diamond & Jones, 2004). A marginalized aspect of a client's wholeness will emerge as a disturbing signal (e.g., a symptom) (Mindell, 1990). By unfolding this signal with sensory-grounded awareness we unravel, in a more tangible way, a new quality to which the client did not have access before (Mindell, 1998). Through unfolding this quality, the client can then experience a "dream figure", that is, an embodied experience of the originally marginalized quality (Mindell, 1990). The last part of the work includes integration of the experience into the client's daily life (Diamond & Jones, 2004).

Although Process-oriented Psychology is used by practitioners around the world, presenting cases and qualitative research results demonstrating the benefits of this method (Fukao et al., 2007; Mindell, 2001; Morin, 2019; Panáková, 2003; Weyermann, 2006), quantitative research is missing. However, there already exist several studies presenting other psychotherapeutic methods of working with a client's body symptoms bringing encouraging results (Akasheh & Sadoghi, 2010; Limburg et al., 2018; Lyonne et al., 2012; Rutledge, Redwine, Linke, & Mills, 2013).

Though Mindell and many other teachers around the world have found success in using Process-oriented Psychology with a focus on body symptoms, no quantitative research has been done on the topic, so we decided to conduct our own study. For this study, we propose four hypotheses:

H1: A significant interaction exists between Group and Measurement in all reported symptoms in the Global Severity Index (GSI) - Brief Symptom Inventory (BSI).

This hypothesis reflects the assumption that the experimental session will affect the level of reported symptoms.

H2: A significant interaction exists between Group and Measurement in the total score in the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM).

This hypothesis reflects the assumption that the experimental session will affect well-being, which can be used as an indicator of the positive impact of psychotherapy (Timuľák, 2005).

H3: A significant interaction exists between Group and Measurement in the Overall scale in the Outcome Rating Scale (ORS).

This hypothesis reflects the assumption that the experimental session will affect overall satisfaction, which can be seen as one of the indicators of the positive impact of psychotherapy (Timuľák, 2005).

H4: A significant interaction exists between Group and Measurement in symptom severity in the Individual Symptoms Scale (ŠIP).

The inspiration for this hypothesis originated from Weyermann's (2006) findings where participants reported subjective improvement of their symptom after the experimental session.

4.2 Methods

4.2.1 Participants

Sixty-seven clients (47 females and 20 males) participated in this study. Their age varied between 18 and 63 (mean = 38.4, SD = 11.3). The sample represented three types of clients: 31 participants were hospitalized in psychiatric clinics, 26 regularly attended a

psychological outpatient facility and 10 clients were individuals receiving common medical care and engaged in various self-supportive methods (such as yoga, meditation and physical exercises). Hospitalized and psychological outpatient facility clients represented a variety of mental illnesses: 46 were diagnosed with anxiety, stress-related and somatoform disorders and 11 with affective (mood) disorders.

Each participant chose one symptom to work on in the experimental session. In the experimental group, the following symptoms were treated: anxiety and nervousness (14), digestive diseases (4), back and joint pain (4), headache (3), body pain (3), respiratory diseases (3), eczema (1), sleep disorders (1), varices (1) and eye diseases (1). The control group was concerned with these symptoms: anxiety and nervousness (13), digestive diseases (5), back and joint pain (3), eczema (3), body pain (2), sleep disorders (2), respiratory diseases (2), headache (1), and eye diseases (1). Forty-nine participants described the chosen symptom as chronic and 19 as acute. Additionally, 9 participants mentioned that they suffer from other mental problems, 14 from somatic symptoms and 44 from both - somatic as well as mental problems. Twenty-one participants were regularly taking psychopharmaceuticals, 9 participants somatic medication, 19 both and 18 were not taking any regular medication.

4.2.2 Procedure and study design

In our study, we decided to use an additive design as an optimal way to do a research within a natural setting. In the additive design, a specific ingredient is added to an existing treatment (Borkovec, 1990). Therefore, there is reason to believe that the ingredient added to the treatment will augment the benefits derived from the treatment (Ahn & Wampold, 2001).

The participants were selected through a non-random sampling mediated by institutions (Miovský, 2006). Potential participants received information about the research via handouts distributed within the institution (at 2 wards in a psychiatric clinic, at 4 offices in two psychological outpatient facilities and in one place of group meditation) or during communication with their therapist. Of the total of seventy-one participants, sixty-seven were analyzed. Two participants didn't complete all the questionnaires and two did not meet the inclusion criteria.

The selection criteria for participation were as follows:

- People aged 18 - 65.
- Hospitalized in psychological outpatient facilities (with diagnosis of F3 or F4 categories in ICD-10) or using self-healing methods.
- Currently having a body symptom which they would like to explore (with the exception of oncological symptoms).

The exclusion criteria were stated as follows:

- Clients with diagnosis of F0, F1, F2 or F6 categories in ICD-10.
- Attending another individual psychotherapeutic session during involvement in our research.

Participants were randomly assigned to a control or experimental group using an alternating assignment during the recruitment process; i.e., we assigned odd participants to the control group and even participants to the experimental group. The control group consisted of thirty-two participants who continued with their treatment as usual. The experimental group included thirty-five participants who attended one experimental session to work on one of their symptoms in addition to their usual treatment. Participants from the control group, however, received a session following the study so that none were denied the potential benefits of the method. All participants' participation in the experimental session was used for data collection in the second and third study. Table 1 presents detailed demographic data broken down by groups.

| Demographics | Experimental group | Control group |
|--|--------------------|---------------|
| Mean age (SD) | 40.57 (10.47) | 36.03 (11.79) |
| Sex (frequencies) | | |
| Male | 13 | 7 |
| Female | 22 | 25 |
| Client type (frequencies) | | |
| non-clinical | 6 | 4 |
| clinical, inpatient | 16 | 15 |
| clinical, outpatient | 13 | 13 |
| Diagnosis (frequencies) | | |
| Anxiety, stress-related and somatoform disorders | 21 | 25 |
| Affective disorders | 8 | 3 |

Table 1: Demographics data by groups

To maximize comparability of the results, a standardized data collection procedure was followed. Questionnaires were administered to all participants individually, and they were provided with informed consent in face-to-face situations. The author of this thesis (myself, a female, at that time with almost five years of full-time therapeutic and diagnostic practice attending the second phase of the diploma training in Process-oriented Psychology) conducted experimental sessions (hereinafter referred to as a “session”) and administered data collection methods with each participant individually. Each session lasted 45 - 60 minutes. I will now introduce the specific general procedure of each participant group - experimental and control.

The procedure with the experimental group was as follows: after an individual decided to participate in the study, based on the information provided by me or another psychologist or an information flyer, we arranged a day and time of the meeting. Upon their arrival, I greeted the participant and introduced myself. Subsequently, I presented the informed consent form (see Appendix 4) and explained its content step by step. This was not only intended to address potential ethical problems, but also to explain the research procedure and rationale in a comprehensive way. The participant affirmed their consent by signing the document. Participants also completed a demographic questionnaire about their current level education and work, any current mental health issues (including their history), current or past somatic disorders, or medications (if known to the participant). Subsequently, participants undertook a session facilitated using Process-oriented Psychology methods and completed questionnaires (see Chapter 4.2.4) three times in total: immediately before, immediately after, and one week after the session.

The procedure in the control group was the same with the exception that participants only completed questionnaires twice, one week apart, with no session provided in the meantime.

The participants in the clinical group also provided consent for my consultation of their medical records which were archived at the institution where they were tested (or by me asking their psychologist to provide any necessary information from the patient’s medical records). In the medical records, I verified each patient’s medical history, length and circumstances of current hospitalization, and officially issued diagnoses.

The experimental session was held in three different places (two in the psychiatric clinic - both in the same building, and one in one of the outpatient facilities). In all of them, there were very similar conditions ensured: light, quiet, and spaciousness. However, in some cases, extraordinary events occurred during the session and data collection. For instance, in one session loud music playing outside of the building could be heard. In another, the voice of my colleague talking to someone in a neighboring room was audible. These extraordinary circumstances occurred only rarely and were noted, but they were not considered within the analyses.

4.2.3 Ethics of the clinical study

Because the study required testing clinical patients, potential ethical issues were considered, and steps were taken to minimize the risks. The study followed guidelines stated in the European Meta-Code of Ethics as well as in the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct. Each participant provided a detailed, verbal informed consent followed by signing a document (see Appendix 4), which contained the following general points:

- Information about the experiment: title, author, supervisor, grant support, and general objective.
- Summary of participant's task, including the general procedure and its length.
- Information about voluntary participation (specifically, the participant was informed that he or she can decline participation at any time without any adverse consequences).
- Potential health risks of the study (all participants were informed about a possibility of opening some topics that might require additional psychotherapy).
- Consent for acquisition and retainment of medical and personal data: name, gender, birth date, education, work, medication and - for the clinical group only - issued diagnoses and length of current disorder; this included consent for disclosure of medical documentation.
- A detailed explanation of data processing procedure.

All participants were legally able to provide informed consent. There were several aspects of the study that could potentially raise ethical issues. First, collecting participants' names presented a potential ethical issue. There was a reason for collecting participants' names

(only from participants from the outpatient facility); it allowed me to ask their psychologist to search their medical records. From a procedural point of view, it would be unreasonably difficult and technically inconvenient for the medical staff to issue anonymous labels to the patients and then to provide me excerpts from their records. The medical records of hospitalized patients in the Psychiatric Clinic in Kroměříž was accessible to me as a regular employee (psychologist in healthcare) at the clinic.

Second, the handling of medical records presented another potential ethical issue. I used the most ethically acceptable procedure when asking medical staff (psychologists from the outpatient facility) to provide excerpts from the patients' medical records. This was realized in outpatient facilities Cervoy and Psychological Center Kroměříž. No information was handed via e-mail or phone calls.

Third, data processing and retention presented yet another potential ethical issue. The processing steps were as follows:

- Task results and participants' names were saved locally immediately after the task was finished.
- My notes from the session were transcribed to an electronic form.
- The data from the patient's medical records were provided as described above.
- The task results, electronic notes, and information from the medical records (for the clinical group only) were merged based on participants' names.
- The data were anonymized with the exception of two backup offline media (USB drives) stored physically in a safe place. These backups were retained until January 1, 2019.
- All remaining data were processed and analyzed anonymously.

All participants were granted the opportunity to retroactively withdraw their informed consent (that would mean deletion of their data from all storage locations). However, this eventuality never occurred.

4.2.4 Experimental session

I was inspired by a previous qualitative study conducted by Weyermann (2006) and consulted it with skilled process-oriented therapist Ivan Verný. The session represented

both structured and creative work by using Process-oriented Psychology and lasted between 50 and 60 minutes.

Step 1: Primary identity. Participants were questioned about their everyday identity: Who were they during last days and who are they today? How do they live?

Step 2: Symptom description. Participants described the symptom they had chosen to work on, as well as their attitude toward the symptom and how they perceive it.

Step 3: Symptom drawing. In this step, participants simply drew themselves with the symptom and named it.

Step 4: Disturbing quality. Participants described the symptom and its manifestations more fully. A sensory grounded description was used (for instance warmth, tingling, pressure) and the most disturbing quality was identified.

Step 5: Amplification. Further on, the participants were supported to develop the quality in the way it emerged (through movement, proprioception, sound, imagination). At the end, the quality was given a form of a mythological or historical entity - a “dream figure” - that represents this quality naturally.

Step 6: Self drawing. Participants were drawing themselves with the identified embodied quality, named it and were questioned about their current attitude toward the symptom.

Step 7: Integration. Participants were asked a few questions to help to integrate the experience into their everyday life: e.g., Where and when have they already noticed this quality in their life? When and how could this quality be helpful in their life?

Step 8: Encouragement. Finally, participants were encouraged to return to the discovered quality or mythological figure, to try to experiment with it during the following week.

4.2.5 Test battery

Participants from the control group completed the following methods on the first questionnaire that was administered: Demographic questionnaire, Brief Symptom Inventory (BSI), Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM), Individual Symptoms Scale (ŠIP) and Outcome Rating Scale (ORS). On the second

questionnaire that was administered one week later, the test battery was identical, except for the missing demographic questionnaire.

Participants in the experimental group completed the following methods right before the session: Demographic questionnaire, BSI, CORE-OM, ŠIP and ORS. Immediately after the session, they completed the ŠIP for the second time. One week later, the questionnaire administration was the same as the second administration for the control group. All methods were administered in the Czech language.

Brief Symptom Inventory (BSI)

The Brief Symptom Inventory (BSI) is a shorter, multidimensional version of the Symptom-Checklist 90-R (SCL 90-R) questionnaire used to detect the presence of psychopathological symptoms (Derogatis, 2017; Derogatis & Melisaratos, 1983). The instrument consists of 53 items using a 5-point Likert scale covering nine subscales: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three general indexes: Global Severity Index (GSI), Positive Symptom Total (PST) and Positive Symptom Distress Index (PSDI) (Derogatis & Melisaratos, 1983). The psychometric properties of the Czech version of the method were investigated by Kabát et al. (2018). The nine-factor model was found to be valid as the method exhibited satisfying level of internal consistency (Cronbach's $\alpha=0.97$, McDonald coefficients $\omega_h=0.84$ and $\omega_t=0.97$) and its convergent validity was supported by moderate to high correlation with related SF-8 questionnaire. The Global Severity Index, representing BSI total score, showed excellent internal consistency (Kabát et al., 2018).

Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)

Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) is a 34-item self-report instrument developed for monitoring changes in clients during therapy within 4 domains: Well-being, Symptoms, Function and Risk (Evans et al., 2002). We administered the Czech version of this method, followed the four-factor model recommended for the similar Slovak version of CORE-OM (Bieščad, 2007) and analyzed the total score and factors of Well-being, Symptoms and Function accordingly (factor Risk is of little interest to us, as this study does not focus on risky behavior). After we finished the data collection, a study of psychometric properties of the Czech version of the CORE-OM was published (Juhová et

al., 2018), showing satisfying internal consistency (Cronbach's $\alpha=0.933$) and parallel validity demonstrated by moderate to high correlation with related methods (SCL-90 and RSES - The Rosenberg Self-Esteem Scale). Juhová (2015) also demonstrated test-retest reliability by $r=0.70$. However, a recent study (Juhová et al., 2018) showed little support for the four-factor model of CORE-OM. With regards to recommendations given by these authors, we will in this paper present the CORE-OM total score only.

Individual Symptoms Scale (ŠIP)

The Individual Symptoms Scale (ŠIP) is a Czech self-report instrument created by prof. S. Kratochvíl to evaluate the effect of psychotherapy (Timuřák, 2005). The instrument contains 10 empty boxes where the client writes symptoms and evaluates them on a prescribed 5-point scale. At the end of treatment, the client gets the completed form with initial symptoms and evaluates them again (Kratochvíl, 2006). The difference between the scoring before and after the therapy is an indicator of changes (Kratochvíl, 2006). The instrument is widely used in the Czech psychotherapeutic domain as well as in research (Turbová & Cagaš, 2005).

Outcome Rating Scale (ORS)

The Outcome Rating Scale (ORS) is an instrument to evaluate the effect of therapy, based on the concept of the OQ-45 questionnaire which is widely used (Miller, Duncan, Brown, Sparks, & Claud, 2003). The ORS includes four visual 10-centimeter-long analogue scales: Personal (personal satisfaction), In relationships (family, close relationships), In society (work, school, friends) and Overall (total satisfaction) (Zatloukal, Žákovský, Věžník, Řiháček, & Tkadlčíková, 2006). The client's task is to rate these scales by marking how satisfied they have felt in the given area over the last week. Preliminary analyses of psychometric properties of ORS show satisfying internal consistency (Cronbach's $\alpha=0.80$), lower test-retest reliability (test-retest $r=0.58$) and low to moderate correlation to related methods SCL-90 and RSES (Juhová, 2015).

4.2.6 Variables

The dependent variables were all reported symptoms (Global Severity Index GSI in Brief Symptom Inventory BSI), well-being (the total score in Clinical Outcomes in Routine Evaluation - Outcome Measure CORE-OM), satisfaction (the Overall scale in the Outcome

Rating Scale ORS), and symptom severity (the total score in Individual Symptoms Scale ŠIP). Within the main analysis, all those variables were related to one principle independent variable (the experimental session) and there were also several intervening variables: sex ratio, age, diagnostic group, education, and medication.

4.2.7 Data analysis

All available data were aggregated in an MS Excel spreadsheet. We used MS Excel version 1902 to detect and remove outliers (based on the Tukey's 1.5×IQR rule) and to analyze demographical data (i.e., client's age and clinical background). The rest of the data were analyzed in the Tibco Statistica 13.3 software using ANOVA for repeated measures followed by Tukey's post-hoc tests in case of significant results. Residual normality assumption for ANOVA was checked by using the Shapiro-Wilk test. In any cases of suspected abnormalities, the original data were transformed using a natural logarithm⁴ and the analysis was performed again. Log-transformation has traditionally been used to correct positively skewed data (Bland & Altman, 1996), even though its use bears significant limitations and might even fail in normalizing the data (Feng et al., 2014). If the log-transformation failed, this is noted by the respective results together with information whether corrected (i.e., log-transformed) or uncorrected data were used for the final analysis. We used parametric ANOVA for repeated measures, even if the ANOVA assumptions could not be fully satisfied, for two reasons: one is that from its principle, it is possible for the Shapiro-Wilk test to yield false positive results in larger samples, simply because statistical tests' sensitivity generally increases with increasing sample size; the second reason is that we are unaware of a non-parametric substitute for two-way repeated measures factorial ANOVA. Therefore, we proceeded with the parametric analyses even in cases of suspected violation of ANOVA assumption while transparently admitting that possibility. The data of this study were published in "Mendeley data" (Dominik, Sedláková & Kolařík, 2019).

⁴ In some cases, integer 1, 2 or 3 was added to all values to avoid calculating logarithm from values equal to or near 0.

Credibility Checks

Several steps were taken to ensure the credibility of the results: (1) the researcher's self-reflection in respect to the topic under study, (2) awareness of the first author's dual role (research therapist of the session and researcher in one person), and (3) using several methods for data collection to strengthen the study's validity.

4.3 Results

Before further analyses, the experimental and control groups were checked for differences in sex ratio, age, education, and subjectively reported symptoms severity on a scale from 1 to 10. No significant difference between the experimental and control group was found for sex ratio ($\chi^2(1) = 1.861$, $p = 0.173$), age ($t(65) = 1.669$, $p = 0.100$), education ($\chi^2(4) = 4.017$, $p = 0.404$), nor reported symptoms severity ($t(65) = 0.738$, $p = 0.463$).

Changes due to therapeutic work were analyzed separately for individual scores, which were identified to be of interest to the present research.

In the Brief Symptom Inventory (BSI), we were specifically interested in the Global Severity Index (GSI) and the Somatization subscale. In the case of the GSI, the model built on original pre-test/post-test data led to non-normal residual distribution ($W = 0.959$, $p = 0.031$ and $W = 0.927$, $p < 0.001$). Therefore, we modified the GSI scores by adding 1 and subsequently performing log-transformation, which helped to correct the pre-test residuals ($W = 0.985$, $p = 0.623$), but the post-test residuals remained non-normal ($W = 0.961$, $p = 0.039$). We decided to use the corrected data for the analysis. We found a significant main effect of Measurement ($F(1,63) = 33.881$, $p < 0.001$, $\eta_{\text{partial}}^2 = 0.350$), suggesting a difference in GSI scores between the first and second data collection regardless of group. We did not find a significant main effect of Group ($F(1,63) = 1.037$, $p = 0.312$, $\eta_{\text{partial}}^2 = 0.016$), which suggests that the experimental and control group did not overall differ in their ratings. Most crucially, however, we found a significant interaction between Measurement and Group ($F(1,63) = 6.238$, $p = 0.015$, $\eta_{\text{partial}}^2 = 0.090$). After inspecting the results of Tukey's post-hoc test, this is mostly due to a significant decrease in reported symptom incidence between the two measurements in the experimental group ($p < 0.001$), which, by contrast, was insignificant in the control group ($p = 0.118$). No difference was found between the groups in the pre-test ($p = 0.993$). For an overview of GSI analysis results, see Figure 1a.

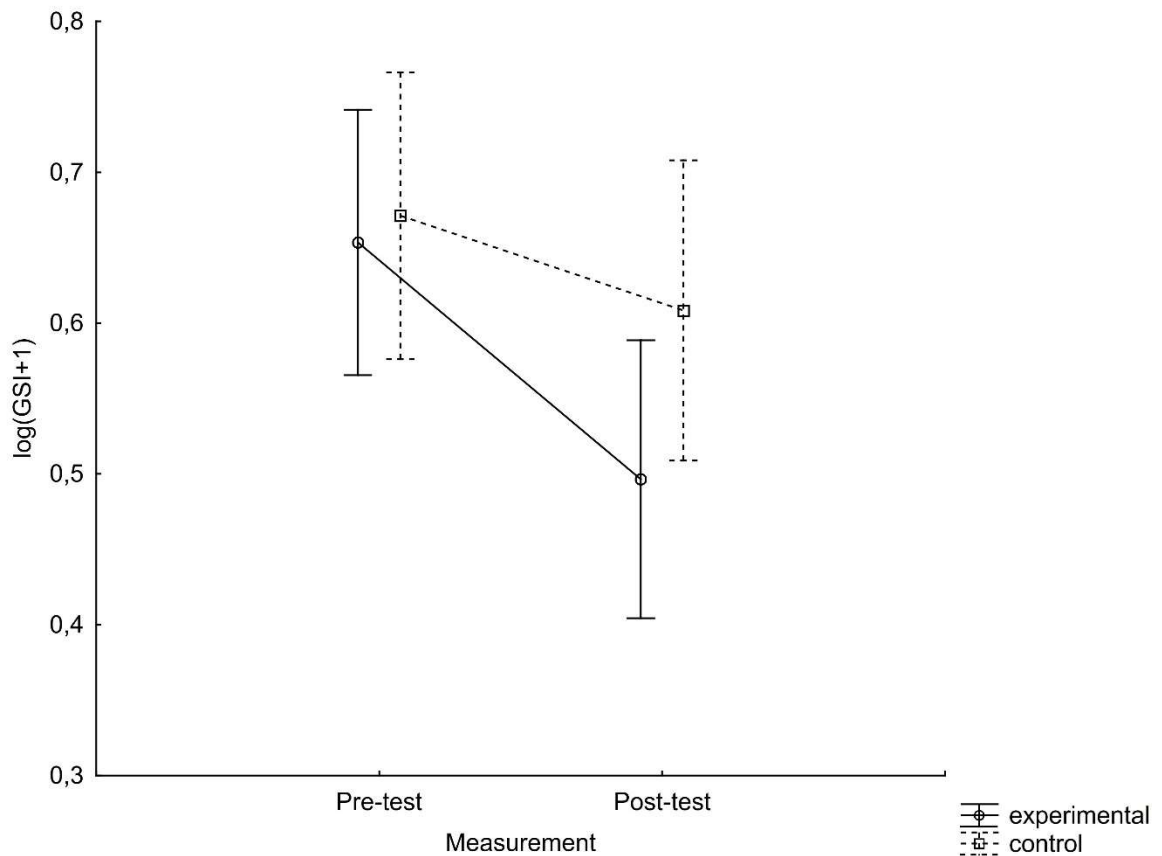


Figure 1a: Shift in the means of the GSI score between pre-test and post-test for the experimental and control group. The vertical lines denote 95% confidence intervals.

For the Somatization subscale in the BSI, the results are strikingly similar to the GSI scores. The residuals calculated from the model based on the original data were non-normally distributed ($W = 0.956$, $p = 0.024$ for the pre-test and $W = 0.945$, $p = 0.007$ for the post-test). Therefore, we log-transformed the Somatization scores by an increase of 2. Again, the pre-test residuals were successfully corrected ($W = 0.971$, $p = 0.137$) while post-test residuals remained non-normally distributed ($W = 0.957$, $p = 0.028$). We conducted the analysis on the corrected data. We found a significant effect of Measurement ($F(1,61) = 9.259$, $p = 0.003$, $\eta_{\text{partial}}^2 = 0.132$), while the main effect of Group remained insignificant ($F(1,61) = 0.070$, $p = 0.793$, $\eta_{\text{partial}}^2 = 0.001$). The interaction between Measurement and Group is significant ($F(1,61) = 4.288$, $p = 0.043$, $\eta_{\text{partial}}^2 = 0.066$). Tukey's post-hoc test clearly shows this to be due to a significant decrease in reported symptoms in the experimental group ($p = 0.002$), while the corresponding difference in the control group remains insignificant ($p = 0.911$). Furthermore, no significant difference was found between the

groups in pre-tests ($p = 0.907$). For an overview of the Somatization subscale analysis, see Figure 1b.

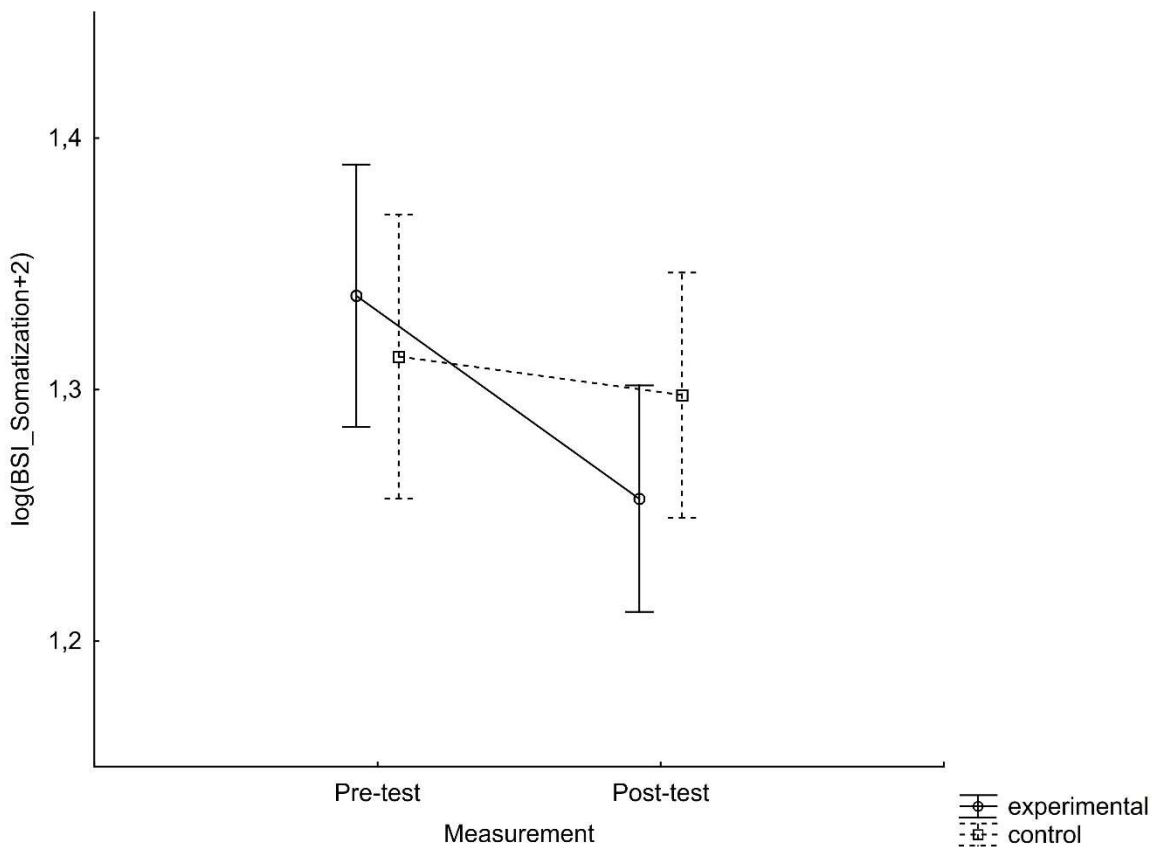


Figure 1b: Shift in the means of the BSI somatization score between pre-test and post-test for the experimental and control group. The vertical lines denote 95% confidence intervals.

An identical analysis was applied to the total score of the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM). The original data led to normally distributed residuals in the pre-test ($W = 0.975$, $p = 0.202$), but non-normal residual distribution in the post-test ($W = 0.956$, $p = 0.019$). Therefore, we log-transformed the CORE-OM data by an increase of 3, for which we achieved normal residual distribution for both pre-test ($W = 0.981$, $p = 0.387$) and post-test ($W = 0.967$, $p = 0.080$). We used the corrected data for the analysis. A significant main effect of Measurement was found ($F(1,64) = 14.121$, $p < 0.001$, $\eta_{\text{partial}}^2 = 0.181$), while the main effect of Group was insignificant ($F(1,64) = 1.979$, $p = 0.164$, $\eta_{\text{partial}}^2 = 0.030$). A significant interaction of Measurement and Group was found ($F(1,64) = 5.921$, $p = 0.018$, $\eta_{\text{partial}}^2 = 0.085$) and further supported by Tukey's post-hoc test showing significant improvement in the experimental group ($p < 0.001$), while this difference

remained insignificant in the control group ($p = 0.800$). The groups did not significantly differ in the pre-test scores ($p = 0.925$). For an overview of the CORE-OM analysis, see Figure 2.

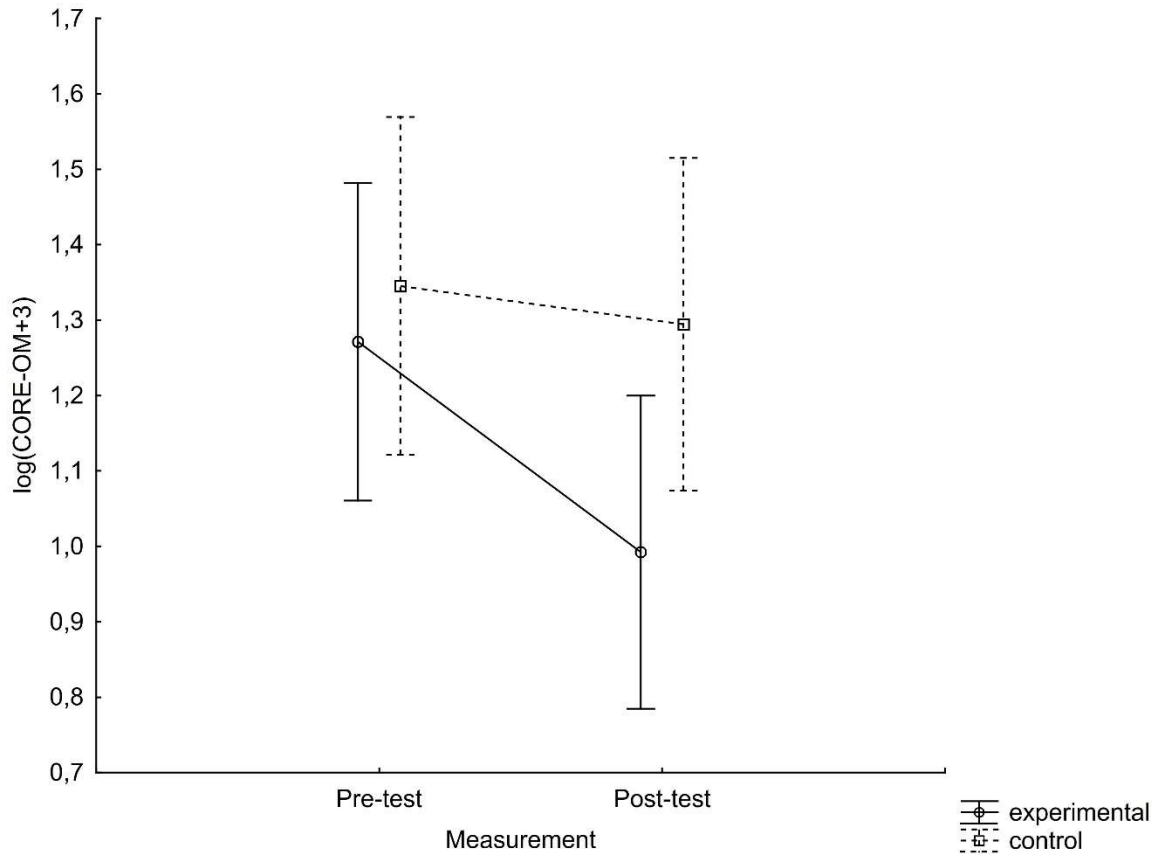


Figure 2: Shift in the means of the CORE-OM overall score between pre-test and post-test for the experimental and control group. The vertical lines denote 95% confidence intervals.

Unlike in the previous cases, the Individual Symptoms Scale (ŠIP) was analyzed in two ways, because in the experimental group it was administered immediately before, immediately after and one week after the session (unlike the control group, in which it was administered only twice - before the session and one week later). Therefore, while the first analysis follows the pre-test/post-test template presented so far, the second analysis adds a within-subject repeated-measures comparison of situations before, right after and one week after the experimental session. The first analysis was conducted on the uncorrected data since no deviation from normal distribution was found in either the pre-test ($W = 0.967$, $p = 0.087$) or the post-test residuals ($W = 0.978$, $p = 0.323$). The outcomes of the model show a significant main effect of Measurement ($F(1,61) = 54.556$, $p < 0.001$, $\eta_{\text{partial}}^2 = 0.472$), a

significant main effect of Group ($F(1,61) = 7.288, p = 0.009, \eta_{\text{partial}}^2 = 0.107$) and a significant interaction between Measurement and Group ($F(1,61) = 5.332, p = 0.024, \eta_{\text{partial}}^2 = 0.080$). Tukey's post-hoc test revealed a significant decrease in reported symptoms in both the experimental and the control group ($p < 0.001$ and $p = 0.006$ respectively). However, the improvement seems larger in the experimental group, because while no significant difference between the groups was found in the pre-test ($p = 0.795$), a significant difference was found in the post-test ($p = 0.003$). For the ŠIP results overview, see Figure 3a.

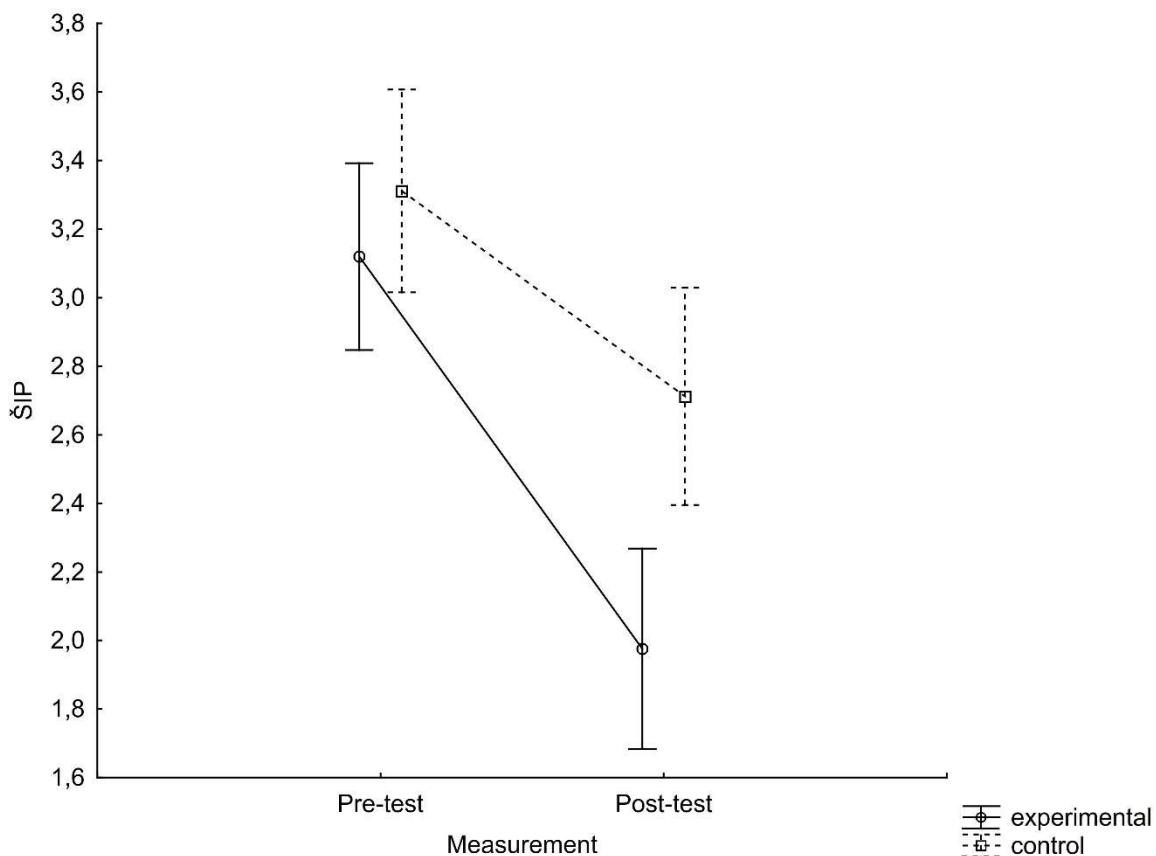


Figure 3a: Shift in the means of the ŠIP score between pre-test and post-test for the experimental and control group. The vertical lines denote 95% confidence intervals.

The additional analysis of the ŠIP data aimed to examine the within-subject differences of the ŠIP score before, right after and one week after the session in the experimental group. The residual normality assumption was satisfied for all three consecutive measurements ($W = 0.951, p = 0.139$; $W = 0.967, p = 0.404$ and $W = 0.938, p = 0.061$, respectively). The one-way repeated-measures ANOVA showed a significant main effect on Measurement ($F(2,64) = 77.236, p < 0.001, \eta_{\text{partial}}^2 = 0.707$). The main effect of Group could not be

assessed, because no control comparison was available for the assessment immediately following the session. Tukey's post-hoc test revealed that all examined differences were significant - there was a significant decrease of the reported problems right after the session compared to before the session ($p < 0.001$); a milder, but still significant increase in the reported problems one week after the session compared to right after the session ($p < 0.001$); and a significant decrease between the measurement before the session and one week later ($p < 0.001$). For an overview of the results, see Figure 3b.

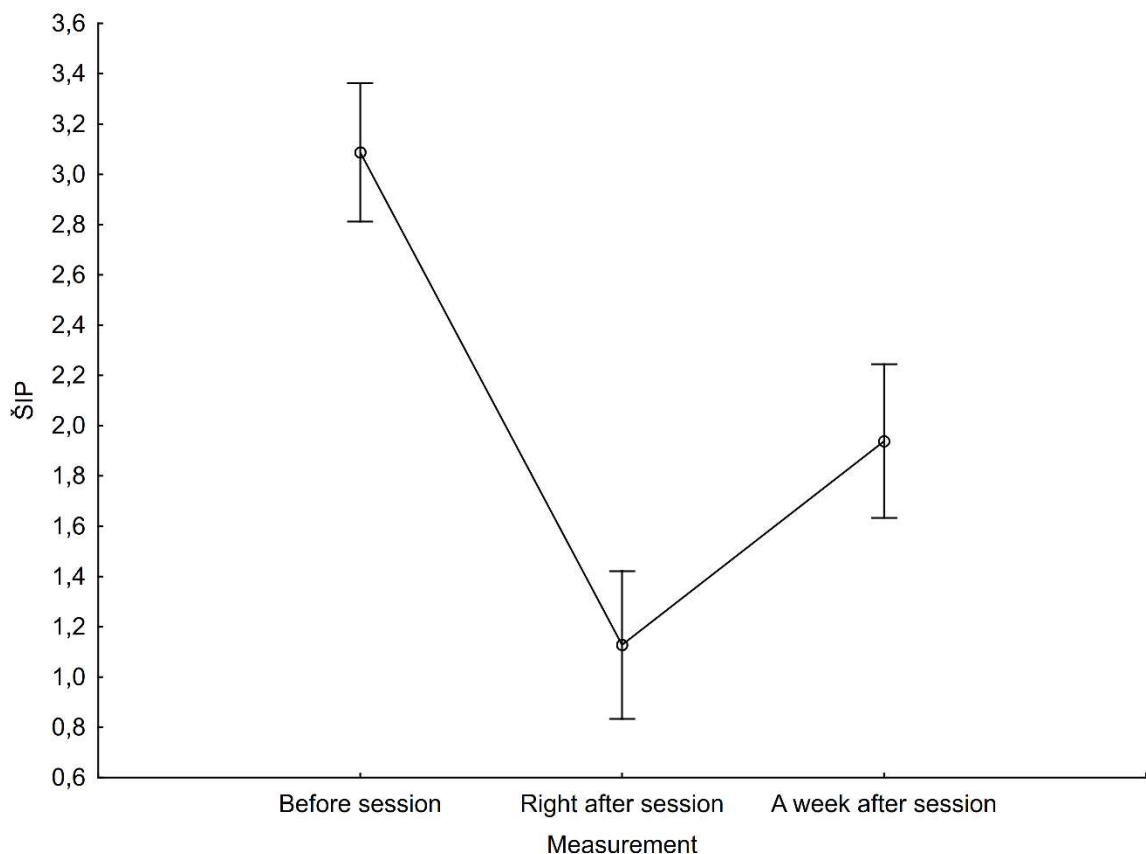


Figure 3b: Shift in the means of the ŠIP score between measurements before the session, right after the session and one week after the session. The vertical lines denote 95% confidence intervals.

The Outcome Rating Scale (ORS) contained four scales which were of interest to us (Personal, In relationships, In society and Overall). All four scales exhibited negatively skewed residual distribution (see Table 2).

| Scale | W _{pre-test} | p _{post-test} | W _{post-test} | W _{post-test} |
|------------------|-----------------------|------------------------|------------------------|------------------------|
| Personal | 0.952 | 0.012* | 0.932 | 0.001** |
| In relationships | 0.945 | 0.005** | 0.903 | < 0.001*** |
| In society | 0.948 | 0.007** | 0.936 | 0.002** |
| Overall | 0.942 | 0.004** | 0.934 | 0.002** |

Table 2: The Shapiro-Wilk test results for the ORS subscales. Note: * signifies $p < 0.05$, ** signifies $p < 0.01$, and *** signifies $p < 0.001$.

Logarithmic transformation did not help to correct the data, as it is used to correct positively, not negatively skewed distributions. Therefore, a parametric ANOVA was used, but caution is advised in the results' interpretation. For detailed results, see Table 3. In the case of all four ORS scales, the main effect of Measurement was significant in all scales. The main effect of Group was insignificant in all scales. The only significant interaction between Measurement and Group was found in the "In society" scale, which Tukey's post-hoc test clearly showed to be due to difference between the first and second measurement in the experimental group ($p < 0.001$), while other differences remained insignificant. Interactions between Measurement and Group in all other scales were insignificant. Even though these interactions were found to be insignificant, Tukey's post-hoc test revealed a significant difference between the first and second measurement in the experimental group ($p = 0.042$ for the Personal scale; $p = 0.002$ for the "In relationships" scale; and $p = 0.002$ for the Overall scale), while the corresponding difference was not found to be significant in the control group ($p = 0.955$ for the Personal scale; $p = 0.233$ for the "In relationships" scale; and $p = 0.695$ for the Overall scale). No significant difference was found between the groups in the pre-test ($p = 0.992$ for the Personal scale; $p = 0.710$ for the "In relationships" scale; $p = 0.744$ for the "In society" scale and $p = 0.990$ for the Overall scale).

| Scale | F(1,65) | p | η_{partial}^2 |
|------------------|---------|------------|---------------------------|
| Personal | | | |
| Measurement | 5.032 | 0.028* | 0.072 |
| Group | 0.092 | 0.763 | 0.001 |
| Interaction | 2.250 | 0.138 | 0.033 |
| In relationships | | | |
| Measurement | 16.216 | < 0.001*** | 0.200 |
| Group | 2.499 | 0.119 | 0.037 |
| Interaction | 1.593 | 0.211 | 0.024 |
| In society | | | |
| Measurement | 7.546 | 0.008** | 0.104 |
| Group | 0.009 | 0.926 | 0.001 |
| Interaction | 9.488 | 0.003** | 0.128 |
| Overall | | | |
| Measurement | 11.325 | 0.001** | 0.148 |
| Group | 0.949 | 0.334 | 0.014 |
| Interaction | 3.190 | 0.079 | 0.047 |

Table 3: ANOVA results for the ORS subscales. Note: * signifies $p < 0.05$, ** signifies $p < 0.01$, and *** signifies $p < 0.001$.

To summarize our findings in the context of the proposed hypotheses:

H1: A significant interaction exists between Group and Measurement in all reported symptoms in the Global Severity Index (GSI) - Brief Symptom Inventory (BSI).

Hypothesis was accepted, $F(1,63) = 6.238$, $p = 0.015$, $\eta_{\text{partial}}^2 = 0.090$. After inspecting the results of Tukey's post-hoc test, this is mostly due to a significant decrease in reported symptom incidence between the two measurements in the experimental group ($p < 0.001$), which, by contrast, was insignificant in the control group ($p = 0.118$). No difference was found between the groups in the pre-test ($p = 0.993$).

H2: A significant interaction exists between Group and Measurement in the total score in the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM).

Hypothesis was accepted, $F(1,64) = 5.921$, $p = 0.018$, $\eta_{\text{partial}}^2 = 0.085$. Specifically, Tukey's post-hoc test showed significant improvement in the experimental group ($p < 0.001$), while this difference remained insignificant in the control group ($p = 0.800$). The groups did not significantly differ in the pre-test scores ($p = 0.925$).

H3: A significant interaction exists between Group and Measurement in the Overall scale in the Outcome Rating Scale (ORS).

Hypotheses cannot be accepted, since the effect of the interaction was found to be insignificant ($F(1,65) = 3.190, p = 0.079$). However, a suggestive trend in its favor was found. Tukey's post-hoc test revealed a significant difference between the first and second measurement in the experimental group ($p = 0.002$) while the corresponding difference was not found to be significant in the control group ($p = 0.695$). No significant difference was found between the groups in the pre-test ($p = 0.990$).

H4: A significant interaction exists between Group and Measurement in symptom severity in the Individual Symptoms Scale (ŠIP).

Hypothesis was accepted, $F(1,61) = 5.332, p = 0.024, \eta_{\text{partial}}^2 = 0.080$. Further, Tukey's post-hoc test revealed a significant decrease in reported symptoms in both the experimental and the control group ($p < 0.001$ and $p = 0.006$ respectively). However, the improvement seems larger in the experimental group, because while no significant difference between the groups was found in the pre-test ($p = 0.795$), a significant difference was found in the post-test ($p = 0.003$).

4.4 Discussion

In our study, both the GSI and Somatization subscales in the BSI were found to be influenced by interaction between groups (experimental and control) and measurements (before and after the session for the experimental group or before and after the waiting period for the control group). Post hoc tests revealed this to be due to a decrease in symptoms severity in the experimental group, clearly suggesting that Process-oriented approach lowers the reported severity of experienced symptoms.

A similar effect was found in the CORE-OM and ŠIP. Nevertheless, contrary to our expectations, the control group reported a significant decrease in ŠIP, although to a lesser extent than the experimental group. This can be attributed to the attention the clients paid to their symptoms while answering the ŠIP scale, which might have led to relief due to a simple externalization of the reported symptoms. An alternative explanation may be that

the mere expectation of the upcoming treatment might have induced a drop in reported symptoms severity.

Additionally, we analyzed the ŠIP data with regards to reported symptom severity before, right after and one week after the session to examine the course of the change in more detail. The results visualized in Figure 3b show a large drop in reported symptom severity immediately after the session, followed by a slight but significant increase during the follow-up week period. It should be noted that this three-time-point analysis is limited, as we cannot conclusively attribute the effect to Process-oriented approach due to a relevant control group missing from our methodological arrangement. Further research in the temporal course of the effects of Process-oriented approach might be needed, especially with focus on longer-term effects (months or years).

The ORS contains four scales generally reflecting changes in the respondent's satisfaction attributable to the therapy. Post-hoc tests on all of these four scales showed a significant increase in subjective well-being in the experimental group, while in the control group it did not. However, a significant effect of the interaction between Measurement and Group was found only in the "In society" scale, so the results should be accepted with caution.

Analysis of all analyzed scales (GSI, BSI Somatization, CORE-OM, ŠIP and all ORS subscales) also revealed a significant main effect of Measurement suggesting that certain improvement may be found in the experimental group as well as the control group. Nevertheless, this is not surprising because all participants, including those in the control group, were subjected to "as usual" treatment, and so a certain amount of improvement is to be expected. A larger degree of improvement in the experimental group in most scales, however, still supports the idea of a greater effectiveness of Process-oriented approach to working with body symptoms.

The results of this study may supplement the theoretical literature and scarce empirical research of Process-oriented Psychology and similar methods. Generally, Process-oriented Psychology literature says that examining the subjective experience of symptoms can broaden perception of who we are and support our self-healing potential (Mindell, 2001; Mindell, 2004; Weyermann, 2006). Unfortunately, no such quantitative research of

Process-oriented Psychology has been done yet, so we do not have the opportunity to compare our results to previous studies.

4.4.1 Limits and Future Research Implications

In our study, symptoms were understood as disturbing body manifestations regardless of whether they were acute or chronic. For a future study, it would be interesting to focus on one specific group of symptoms.

The sample represents a population of individuals suffering from personal problems and body symptoms motivating them to seek treatment in some form. Selecting only some defined groups of clients in a future study would allow us to compare these groups and to obtain more specific findings.

The method we used for the study design - i.e., quantitative analysis of repeated measures - is listed by Timuľák (2005) as one of the recommended methods for studies of the effects of psychotherapy and is commonly used in similar psychotherapy research designs. Using self-report questionnaires limits the full range of variables possibly worth examining and so it is advisable that further research employ different methods for data collection.

In the data analysis, even though the log-corrected GSI and BSI Somatization scores exhibited normal distribution in the first measurement, the data tended to shift toward a positively skewed distribution in the second measurement. The same phenomenon can be observed in all of the ORS scales, even though in these cases the residual distribution was not normal even in the pre-test. This was clearly caused by the tendency of the participants in the experimental group to report an improvement, while control group participants reported only a small, mostly insignificant, improvement. Even though none of our analyses contradict each other, a different approach to statistical analyses might be utilized in the future research, although as stated earlier, we are aware of a used non-parametric substitute for two-way repeated measures factorial ANOVA.

Lambert, Hansen, & Finch (2001) found that two criteria predicted improvement in psychotherapy related to the number of sessions completed: severity of the input problems and early positive response to therapy (which means that the client improved rapidly during the first three sessions). A larger number of sessions in future research on this topic should be a promising step.

Given that our study is a first step on this topic, it was clear from the beginning that there would be only a small team of researchers available, and thus a dual role would be inevitable. We made sure that the primary data analysis was carried out by the second author who was not subjected to dual role and that the researcher with dual role was maximally flexible between the role of therapist and researcher. A promising step for a future study would be to separate the two roles between two independent researchers.

4.5 Conclusions

Starting in the twenty-first century, the interconnection between medicine and psychotherapy has become useful in many cases. It is likely that symptoms in general may have a strong social and financial impact at the global level and that developing effective therapies could be one of the most important directions for global health. The distribution of constantly developed new pharmaceuticals is a good example of tackling this challenge; the development of psychotherapeutic methods should not lag behind.

The presented study brings encouraging findings where Process-oriented approach to working with body symptoms seems to be effective in reducing the severity of subjectively reported body symptoms and increasing well-being and satisfaction in society. We hope that our findings can help therapists and their clients find a way to creative and helpful work with body symptoms, turning them into a meaningful and enriching experience.

5 Study 2: Where our body symptoms guide us: a qualitative research study using Process-oriented approach

In this chapter I will introduce a qualitative study on the Process-oriented approach to working with body symptoms. The idea for this research was inspired by my own practice and several studies suggesting that using Process-oriented approach to working with body symptoms is meaningful for clients. It has been suggested that the Process-oriented Psychology can change the client's attitude toward their body symptoms. The text of this chapter is mostly taken from an article that was submitted for publication in 2020 (Sedláková & Kolařík, 2020) with the consent of the co-author (see Appendix 3).

5.1 Introduction

Symptoms accompanying an illness, whether acute or chronic, are troubling and a medical resolution is necessary in many cases. The capabilities of modern medicine in the twenty first century are, for most of us, indispensable (Morin, 2019). Within the current holistic paradigm, which builds on psychosomatic principles and interconnections between mind and body, the illness etiology is complex, including physical, mental and social factors (Morschitzky & Sator, 2007; Faleide et al., 2010) and a large amount of clinical and empirical literature is devoted to this issue (Bauer & Kächele, 2005; Bob & Vymětal, 2005; Grawe, 2007). There also exist medically unexplained physical symptoms (MUPS) in somatic medicine, which are used for somatic illness, whose etiology has not yet been satisfactorily explained (Řiháček et al., 2017). Moreover, there are also several other illnesses with a known etiology, which are generally considered to be mostly psychological (Tress et al., 2008).

MUPS are also associated with excessive use of medical care and sick leave (Aamland et al., 2012) and their treatment is often complicated (Sekot, 2013). Bob & Vymětal (2005) have argued that the goal of psychotherapy should be to influence the health of the mind and body through a psychotherapeutic effect on the biological functions of clients (Bob & Vymětal, 2005). To support psychotherapists and clients in the use of body awareness and work with body symptoms, we need to know more about specific psychotherapeutic methods, as well as their applications and effects. Many clients who visit psychotherapists report body symptoms along with the problems in their life. However, clients often do not

expect to explore these problems with their psychotherapist because they believe that their body symptoms are only in the hands of medical doctors and are surprised to learn that there are ways to work on them through psychological methods. Due to the assumed mental involvement in the etiology of body symptoms, the following question arises: what specific psychotherapeutic method is helpful in the treatment of body symptoms and what is the subjective experience with the method?

Process-oriented Psychology is a phenomenological approach developed in the 1970s by Arnold Mindell, who investigated body symptoms and Jungian dream analysis (Diamond & Jones, 2004). Mindell and his colleagues have continued to develop this method into the present day. Process-oriented Psychology is currently used by hundreds of psychotherapists and facilitators around the world. It is used in the fields of psychotherapy, psychiatry, social work, conflict resolution, group work, coma care, organizational change and community building (Diamond & Jones, 2004).

Process-oriented Psychology promotes integrity and the appreciation of marginalized experiences (Diamond & Jones, 2004). These marginalized experiences include unwanted and unintentional phenomena in life, body symptoms being one of them. According to many practitioners and clinical literature, exploration of symptoms can give symptoms a meaning, for instance depicting them as a reaction to something or an indication of a change in life direction (Mindell, 2001; Morin, 2014; Weyermann, 2006).

In Process-oriented Psychology, the entire attention of the facilitator is divided between two processes: (1) noticing the signals of identity, which include the elements with which the client is identified - the "primary process", and (2) marginalized elements, which are often subconscious - the "secondary process" (Diamond & Jones, 2004). By marginalized we mean that they are separate from the main focus of the client's identity but are not quite unconscious. Signals can emerge in different ways called channels, and these are divided into the visual, auditory, movement, proprioceptive, relational and world channel (Diamond & Jones, 2004). The marginalized aspect of a client's wholeness will emerge first as a disturbing signal (e.g., a body symptom) (Mindell, 1990). By unfolding this signal with sensory-grounded awareness we unravel, in a more tangible way, a new quality to which the client did not have access before (Mindell, 1998). We can also call this new quality a "symptom-maker" (the part which creates the symptom) (Mindell, 1990). The symptom

experience is explored by examining its manifestation in the body, movement, imagination or voice according to the channel in which the signal emerges. By unfolding the original disturbing signal in its sensory grounded quality, we often discover a “dream figure” (Mindell, 1990). The dream figure is the fleshed out and embodied experience of the emerging (originally marginalized) quality. The last part of the work includes integration of the experience into the client’s daily life (Diamond & Jones, 2004). One of the goals of Process-oriented Psychology is to make it easier to facilitate the dynamic interaction between the known parts of our wholeness and the new, emerging (or we can also say marginalized) aspects of our wholeness (Mindell, 1998). The moment when both the known parts of our identity and the new emerging aspects meet is called the “edge”. The edge is the border of the identity which defines the distinction between who we are and who we are not (Diamond & Jones, 2004).

Research on psychotherapeutic methods is essential for the development and application of functional methods in psychological practice (Timulák, 2005). Although Process Work is taught around the world and used by many practitioners, there has been limited research performed related to body symptoms. Weyermann (2006) has examined the benefits of the Process-oriented approach to working with body symptoms among 20 women aged 18-21 using an interview and subject drawings. The results indicate that Process-oriented Psychology can change the subjective experience of otherwise agonizing symptoms and promote a resource-oriented strategy represented by a change from the “victim attitude” to a position of “activity and control” (Weyermann, 2006). Panáková (2003) describes her clinical experience in three case studies. The author states that Process-oriented approach allows the client to change their perception of their body symptoms - from unconscious to conscious - and thus move from a passive attitude to an active one in order to become the co-author of the therapy (Panáková, 2003). Fukao et al. (2007) present the benefits of Process-oriented approach in their case study of a female patient with depression and an eating disorder. They found that the patient was able to overcome her trauma, stop her wrist-cutting behavior, and control her eating disorder. The above-mentioned findings inspired us to conduct a deeper qualitative research study where the main aim would be to provide the subjective experience of participants when using this method. For this study, we proposed 3 research questions:

Q1: What is the individual's attitude toward the symptom over the course of time?

This question is based on the findings of Panáková (2003) and Weyermann (2006) where they found that individuals reported a change in perspective toward the symptom after the session. Each of these studies used a small sample size, so we decided to apply this question to a larger sample.

Q2: What is the individual's lived experience of the symptom over the course of time?

The inspiration for this question comes from Mindell's work (Mindell, 1990; Mindell, 1998; Mindell, 2001), my own practice, and the findings of Weyermann (2006). As with the first question, we have added the dimension of time as an important factor used in psychotherapy research (Timuľák, 2005).

Q3: What are the changes in the individual's symptom one week after the experimental session?

Psychotherapy is based on self-awareness, self-development, and changes (Kratochvíl, 2006). This question opens the possibility to get information about changes whether they were perceived by individuals positively or negatively or as unfulfilled changes (Elliott, 2012).

5.2 Methods

5.2.1 Participants

Viz Chapter 4.2.1

5.2.2 Procedure

The process of participant selection was the same (viz Chapter 4.2.2). All 67 participants attended the experimental session (hereinafter referred to as "session"). The first author (me) conducted the session and questionnaire administration one week apart while simultaneously collecting data individually from each participant.

The procedure was as follows. After an individual decided to participate in the research, based on the information provided (by me, another psychologist, or an information flyer), we arranged a meeting. Upon arrival, I greeted the participant and introduced myself. I presented the informed consent form (see Appendix 4) and explained its content and

purpose step by step. This was done to address potential ethical problems and explain the research procedure and rationale in a comprehensive way. Participants confirmed consent by signing the document. Participants were also asked to complete a demographic questionnaire about their education, work, current mental health issues (as well as their mental health history), current or past somatic disorders, medication (if known to the participant) and length of current hospitalization. Subsequently, participants underwent a session using Process-oriented Psychology that lasted 45 - 60 minutes. In addition, participants filled in several other questionnaires immediately after the session, with which we do not work in this study (HAT, SRS, WAI). One week after the session, they attended an individual structured interview and 29 of them also completed a Client Change Interview (CCI). The therapist's session protocol was conducted by a research therapist with all participants during the session. Several months (from 6 to 18) after the session, all participants received an online catamnestic questionnaire, which 41 of them completed. The methods were administered in the Czech language. The experimental session was held in three different places (two in the psychiatric clinic - one in the same building and the other in the one of the outpatient facilities). Similar session conditions such as light, quiet, and spaciousness were ensured across all sites. However, in some cases, extraordinary events occurred during the session and data collection. For example, occasionally loud music playing outside the building or the voice of my colleague talking to someone in a neighboring room could be heard. These extraordinary circumstances occurred rarely and were noted; they were not considered in the analyses.

5.2.3 Ethics of the clinical study

Viz Chapter 4.2.3

5.2.4 Experimental session

Viz Chapter 4.2.4

5.2.5 Qualitative methods of data collection

Individual structured interview

An interview is one of the most advantageous methods for obtaining qualitative data (Miovský, 2006). We used a structured form including 3 open and 3 combined open and

scaling questions. The interview began with the questions: “How have you integrated the experience from the session into your everyday life during the past week? Rate it on a scale of 0-10, from not successful to very successful.” The following question was: “What would you need to integrate better?” The next one was: “How do you perceive the symptom now, a week after the session? Rate it on a scale of 0-10, from not bothering you at all to bothering you a lot.” The fourth was: “What is your attitude toward the symptom now?” The fifth one was: “What sense of meaning did you get from the session? Rate it on a scale of 0-10, from no sense at all to very meaningful.” And the last question was: “Could you describe this meaningfulness verbally?”

Drawings

Drawings are widely used in research on the perception of physical symptoms, health and illness (Guillemin, 2004; Liamputtong & Fernandes, 2015; Piko & Bak, 2006; Rennerfelt, Zhang, Karlsson, & Styf, 2018). According to Guillemin (2004), a sensitive process of realization takes place through the act of drawing itself, including at one time the past and the present in which new meanings can emerge. Visualization also has a rich potential to make unconscious aspects of human experience visible and can tend to balance the participants’ varied abilities to express themselves verbally (Guillemin, 2004).

Therapist's session protocol

The protocol was constructed according to our research topic. The one-page document included each step of the session with space for the research therapist’s notes about the participant’s process and a record of the participant’s direct statements (i.e., the process structure, attitude to the symptom, the disturbing quality, the unfolded quality and dream figure, reflection on this experience in the context of the participant’s personal and professional life, relationships, social field and world).

Client Change Interview (CCI)

The Client Change Interview (CCI) is a 60 to 90-minute semi-structured interview developed for qualitative and quantitative evaluation of psychotherapeutic changes from the client’s perspective. It can be used both during and after psychotherapy (Elliott, 2012). The CCI includes the following areas: changes for the better or worse perceived by clients since the beginning of their psychotherapy; evaluation of these changes; extra- and intra-therapeutic

causes of changes perceived by clients; client-perceived resources and limitations on their part affecting the changes; and perceived helpful and hindering aspects of psychotherapy (Elliott, 2012). We used a translation of the revised version (Elliott & Rodgers, 2008) from the Centre for Psychotherapy Research (Ebertová et al., 2015).

Catamnestic questionnaire

The method was administrated online through Google Drive and consisted of 25 items. 6 of the questions were demographic and the remaining 19 (including 8 scaled questions) were focused on the symptom: "What is the attitude toward the symptom and how bothersome is the symptom now?", on the experience of the session: "How long has it been since the session?", on the meaningfulness of the experience, on the integration of this meaning in their life, what would be helpful to make the integration easier, if this experience has had an influence on their surroundings (relationships, work, society), if they noticed other changes since the session, and how they perceive the meaningfulness of the session over time.

5.2.6 Analysis

Based on the wide range of qualitative methods, the grounded theory approach has been chosen as the appropriate method for analysis (Strauss & Corbinová, 1999). The goal of the grounded theory method is to develop a general model or theory. The demographic data was analyzed using functions and frequency tables in MS Excel 2016. The rest of the data was analyzed using MS Word 2016 and Atlas.ti (version 7.5.4). After each interview, a preliminary data analysis was carried out thorough an analysis using all the collected data. The logic of theoretical sampling, which is an inherent part of the grounded theory methodology, was not followed here. In the analysis we followed the basic principles and procedures, which are common to all three influential versions of the method - Glaser's, Strauss' and Corbin's, as well as Charmaz's (Řiháček & Hytych, 2013). The drawings were evaluated in addition to other obtained data.

Credibility Checks

Several steps were taken to ensure the credibility of the results: (1) the researcher's self-reflection in respect to the topic under study, (2) repeated analysis of the data, which revealed more subtle meanings and allowed for more structured and detailed results, (3)

awareness of the dual role (therapist of the session and researcher in one person) for the first author, and (4) use of several methods for data collection to strengthen the study's validity.

5.3 Results

5.3.1 Attitude toward the symptom

Participants described their attitude in relation to their lived experience of the symptom over the course of time. The attitudes ranged from symptom rejection to symptom acceptance and a resource-oriented strategy (see Figure 4).

Prior to the session, participants expressed their attitude mostly as a wish to not have the symptom and its rejection: "I wish it was over," or "It bothers me, I don't want to have it anymore" and in an extreme case as something they hate, "I hate the pain; I have a negative relationship to it." They also expressed a number of emotions such as hopelessness, unhappiness, fear, anger, shame, inferiority and self-criticism or negative naming of the symptom itself. A strategy for dealing with the symptom was only rarely reported. They described this mostly as fighting or trying to ignore it. This attitude best describes the concept of "**rejection**".

The attitude turned strongly toward acceptance by the end of the session. Participants described this as acceptance, understanding and usefulness: "I know it is needed, it made me feel bad before" or "It is part of me." Their emotions also shifted toward joy, happiness, hope for the future, self-confidence, strength, and a reduction of previously disturbing emotions - less anger and fear. Above all, they described a strong commitment and hope to continue working on themselves, that the symptom is manageable, and that they have control over it. This attitude is included in the concept of "**acceptance**".

A week after the session, the participants continued naming their attitude toward the symptom as an effort to understand and manage: "The perception of the symptom has improved and I can get rid of it," or "I want to learn how to manage, how to live with it." They described the emotions partly as a reduction of the disturbing ones (similarly to those in the end of the session) and partly as returning to them, but with less intensity. Participants described their active attitude toward working with the symptom (e.g., trying to understand, noticing what happens in the situation, and an effort to manage it)

regardless of their emotions. This attitude best describes the concept of a “**resource-oriented strategy**”, which has been already used by Weyermann (2006). We decided to use the same name as it includes a focus on coping strategies by using the participants’ own resources and this fits with our results.

Finally, the attitude a few months after the session was described mostly as acceptance and an effort to understand: “I feel more acceptance for both the symptom and myself,” or “Sometimes the pressure comes back, but I understand it.” Very similar to the previous attitude, the focus here is on strategy. Participants described this mostly as managing the symptom better than before by using a different approach. They began to perceive it as a signal and information about themselves and that they are active in shaping their future life and health. This attitude best fits the concept of the “**persistence of the resource-oriented strategy**”.

5.3.2 The lived experience of the symptom

Since the attitude toward the symptom changed in the context of how participants experienced the symptom, we were able to identify certain phases of this change over the course of time (see Figure 4) and finally named this two-dimensional model as a “Symptom Transformation Trajectory”. In some cases, it changed in its own way, while in other cases, only parts of it were recognized.

(1) Limitations and suffering

When participants were questioned as to “What is the lived experience of the symptom?” before the session, they mostly answered that it is something which limits them, which makes their life uncomfortable and does not allow them to live like before: “It restricts me, it will not allow me to be what I was.” They stated a limitation in daily functioning, work and lifestyle: “It does not allow me to live a daily life, it even affects my working life.” They also described the symptom as something that has dominion over them, that turns on, comes and goes at any time, makes them weak, tired and something they suffer from: “It comes at any time, I have no control over it.” They also described losing control and low self-confidence: “It affects my self-confidence; I do not feel feminine”. The average symptom value was 7.5 (on a scale from 0 (no bother at all) to 10 (it bothers me a lot)).

(2) Broadened experience and control

At the end of the session, participants described the unfolded sensory grounded experience of the symptom as a new experience or knowledge about themselves: “I thought I should be calm, but now I see something else,” or “I have not felt that feeling in my life before or “It’s exactly what I was looking for.” They also described momentary feelings of relief and freedom: “I felt relieved” and reduction of the intensity of the symptom: “It has dissolved a bit”. Finally, they also very strongly described their feelings of control and confidence: “Now I have control over it,” or “I can do something about it, probably when I take care of my boundaries (at work), so my back will not hurt so much.”

(3) Change in perspective and subjective reduction of the intensity of the symptom

A week after the session, participants largely described the symptom as something which informs them: “It’s more motivational, it’s not a signal to escape, but a signal to express (emotions)” or “Escaping does not solve anything it’s like a ticking time bomb,” or “It allows me to rest, to indulge it, if I didn’t work so hard, it wouldn’t have to be so intense”. This change in perspective continued from the previous phase. Most participants also described lower intensity of the symptom: “It’s not so strong, I calm down,” or “It’s not as bad, I am breathing and talking better.” The average symptom value had decreased to 4.4 on a scale from 0 (no bother at all) to 10 (it bothers me a lot).

(4) Continuing with the change in perspective and reducing the intensity of the symptom

Several months later (ranging from 6 to 18 months) after the session, participants described their symptom experience mostly as a signal which informs them: “If it appears, I usually take it as a warning that I should be more attentive to the way I am in the situation I am in, that I am not with myself enough.” They also described lower intensity of the symptom: “The symptom appears only moderately and with lower frequency,” or that it is up-to-date and returns, but is not fundamentally limited, “It is still up to date, but it does not limit me.” They also described how they can cope better and with more relaxation as they change their perspective and approach toward it: “The anxiety has almost disappeared, tension sometimes occurs, but I can handle it better because of another approach to it.” The average symptom value several months after the session was 4.5 on a scale from 0 (no bother at all) to 10 (it bothers me a lot).

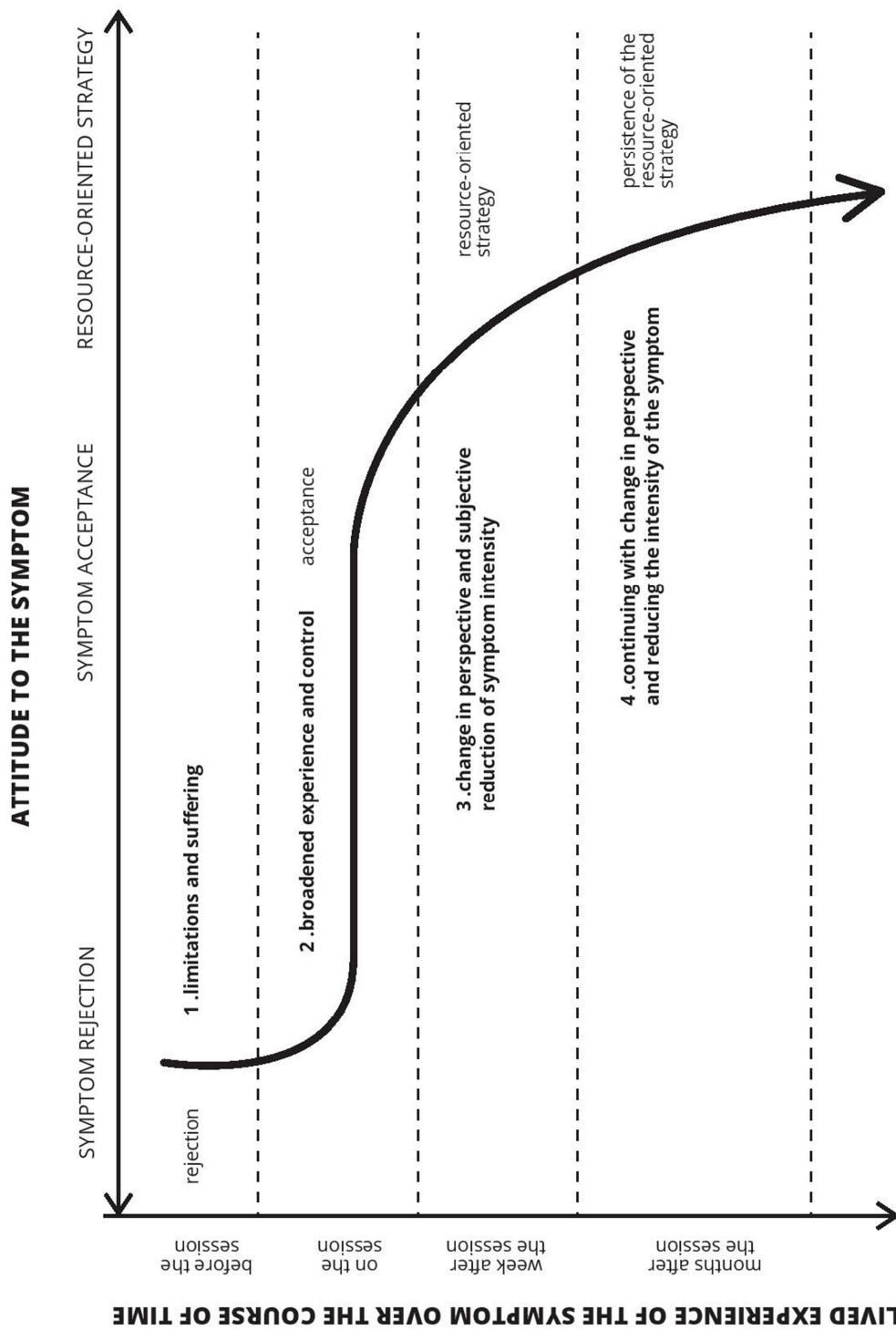


Figure 4: The Symptom Transformation Trajectory is a model describing participant’s lived experience by using two aspects: the attitude to the symptom (in a dimension from symptom rejection to symptom acceptance and a resource-oriented strategy) and the lived experience of the symptom over the course of time.

5.3.3 Variability in participants' experiences

Each participant's lived experience can be described by a specific variant of the "Symptom Transformation Trajectory" model using two aspects: the attitude toward the symptom (in a dimension from symptom "rejection" to symptom "acceptance" and "resource-oriented strategy") and the lived experience of the symptom over the course of time. It should be noted that each participant described her/his/their individual and unique experience with the symptom and the model captures the most frequent trajectory. We identified four other variants.

The first variant, represented in eight participants, corresponded with the model from phase (2) "broadened experience and control" and symptom "acceptance". In the first phase, before the session, participants described the symptom as something which tells them something and they do not know yet what and/or whether they are getting used to it and/or as a mixed attitude (e.g., it tells them something and it bothers them at the same time).

The second variant, presented in four participants, corresponded to the general model until the phase (2) "broadened experience and control" and symptom "acceptance". In the next phase, they described returning to symptom rejection, disturbing emotions and suffering from the symptom a week after the session and for several months after as well.

The third variant, present in three participants, corresponded to the general model until the phase (3) "change in perspective and subjective reduction of the intensity of the symptom" and "resource-oriented strategy". In the next phase, they described returning to non-control over the symptom, non-functioning and disturbing emotions several months after the session; but at the same time expressed their wish to manage the symptom and seek professional support (psychotherapy).

The fourth variant, presented with two participants, corresponded to the general model until the phase (2) "broadened experience and control" and symptom "acceptance". In the next phase, they returned to a rejection of the symptom a week after the session. Several months later, however, they followed the model with phase (3) with "a change in perspective and subjective alleviating of the symptom" and "a resource-oriented strategy".

5.4.4 Drawings

All 67 participants were asked to draw at two points during the session (D1 and D2) about their lived experience of the symptom: point D1 was before unfolding the sensory grounded experience of the symptom and point D2 took place afterwards. The changes between point D1 and D2 were noted with reference to the following criteria:

1. Changes in proportional relations between the depicted self and the symptom. When comparing the drawings made at the times D1 and D2, one can see that the self was depicted as larger in relation to the symptom at time D2 (at the end of the session) or the symptom was not depicted at time D2 at all. See Figures 5 and 6 below.

Žít ve vězení mysli



Figure 5: Drawing at the beginning of the session (D1) - Symptom - Anxiety: Life in the prison of the mind (text on the top) and thoughts of death (text in center of page).

Umím lázet věci na sebe

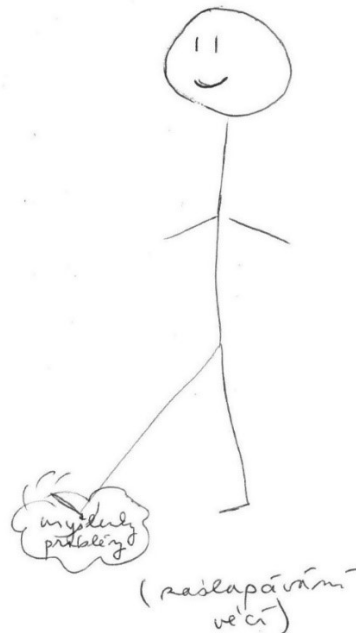


Figure 6: Drawing at the end of the session (D2): Dream figure - A solid, loud figure - The art of leaving things behind (text on the top), thought problems (text on bottom left), trampling things (text on bottom right).

2. Changes in the location of the depicted self and the symptom. In the drawings where the position of the depicted self and the symptom were almost comparable, changes in their relative position were shown. These changes appeared as a new arrangement of the self and the symptom. While at time D1 symptoms were drawn covering the self or interfered with the self, at time D2 they were portrayed as separate, next to or further away from the self. See Figures 7 and 8.

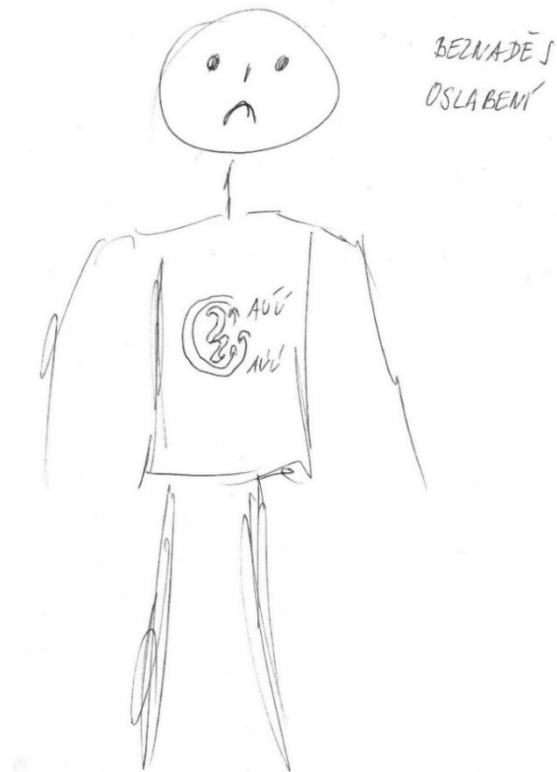


Figure 7: Drawing at the beginning of the session (D1): Symptom - Stomachache - Hopelessness, weakening (text in top right), ouch ouch (text in center).



Figure 8: Drawing at the end of the session (D2): Dream figure - King Arthur - I'm in first place (text in the middle), hooray (text at the top right)

3. Changes in the character of the symbolic elements. Such changes are seen in the participants' drawing at time D2 where there are clearly less tears, frowning faces, clouds, lightning and arrows. Unlike these suffering symbols, a smile, sun, energy and often arms upward evoking power and success were drawn at time D2. See Figures 9 and 10 below.

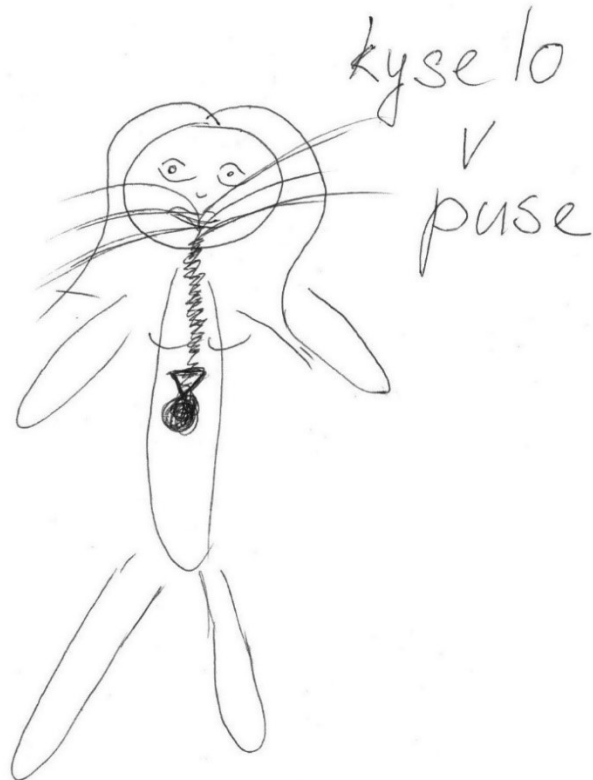


Figure 9: Drawing at the beginning of the session (D1): Symptom - Gastroesophageal reflux disease - Sour taste in the mouth (text at top right).



Figure 8: Drawing at the end of the session (D2): Dream figure - Swallow - "It doesn't matter", swallow (text on top).

5.3.5 Unfolding of the sensory grounded experience of the symptom

During the session using the Process-oriented approach, we first asked all 67 participants to describe their everyday identity. By unfolding the sensory grounded experience of the symptom, the new quality of their identity could emerge. Fifty-two of the participants described this new quality as a feeling of power, intensity, control, brightness, self-confidence and strength. They also used terms such as sharpness, decisiveness, resilience, self-expression and the need for a demarcation of their boundaries. As an umbrella topic, we could use the concept of **power**, although we would like to hold the more individual and unique experience named by participants, which is more accurate. Nine of the participants described the quality as a calm experience, a relaxation and a slowing down. This includes the concept of **relaxation**. Two described their experience as a reconciliation and self-acceptance, three others as freedom and one as safety.

Although edges were not the focus of our research, this aspect was widely represented in the data. Edges were described explicitly from the statements of the participants as they do not want to be selfish, unpleasant, thoughtless, they do not want to be rude or hurtful, that they can't say "no" or follow their needs. In the step of integration, they were asked how much of the emerging quality would be useful for them and they chose the optimal amount.

Many participants described that they **recognized the quality in the past** (with themselves or with someone else they know), but that they do not live it in their current lives. Or, as they also described, they live it, but at a much lower intensity than they would like to, or only in some areas of their lives. For some participants the quality was something completely new. This unfolded quality (secondary process) was therefore something that was rather separate from their everyday life up until this point (primary process).

Most of the participants described how this unfolded quality (aspect of themselves) would be **helpful everywhere** - in close relationships (with partners, children, parents, further family members, friends, etc.), at work (with colleagues, bosses, customers, etc.) and in society (on the street, in stores, at the doctor, etc.). They also reported only some of the above areas. This selectivity will most likely be related to the fact that some of them already live this quality in some areas of their life (e.g., with friends), while not in another one (e.g.,

at work). Only a very small number reported that they could use the quality only for themselves. As is apparent here, the unfolded quality of these symptoms is very closely connected with relationships.

In the integration step, participants were also asked if this quality could be beneficial for other people and fifty-eight of them answered that it could be. They described how it could be helpful for people with similar problems or a similar personality. They also described that by integration of the quality they would be more readable to others and that their communication could improve. They also reported that it could be beneficial for their families, at work, and in society if they would take care and be comfortable with themselves (and so others would feel more comfortable with them). Some of the participants also described that the new quality could bring about respect from others, could be helpful for conflict resolution, but also that not everyone might like their new behavior; it could be difficult for their larger community.

5.3.6 Other changes supported by the Process-oriented approach

In order to explore more about the changes a week after the session, we used data from 29 participants (from the CCI). All of them named the session as one of the causing factors of these changes. Other factors were also mentioned: support from others, walks, long-term self-development, hospitalization and the hospital environment, illness and a moment of stopping in everyday life, and external life events.

Participants described **changes in perspective** - their experience (almost as self-confidence and composure), thinking (the symptom is not only perceived as something disturbing, but as a signal which could be helpful) and their relationship to their body (in terms of greater body contact, awareness of body signals, and ability to work with the body). They also mentioned a new perspective of themselves (self-acceptance) and their life (a greater understanding of living contexts).

Another area of change mentioned by participants was an increase in ability to actively work not only with the symptom but also with themselves and their life troubles, allowing them to more regularly get into contact with their power. They also described that they are active in managing life situations and take an active role in shaping their future. We identified this area as a **resource-oriented strategy**.

Change in behavior in relationships was described mostly as the ability to communicate their opinions (what they want, feel or need). They also described that they are more aware in relationships, both of themselves and others (they understand others better, are more tolerant and at the same time are aware of their own needs).

Participants also mentioned **unfulfilled changes** and mostly described how they wanted to use the unfolded quality in their everyday life more than they did during the week following the session. This was because they did not have that many opportunities or it was difficult to get in touch with the quality. Some of them wanted to change their long-term issues or behavior of other people, which they viewed as unrealistic. From a Process-oriented perspective, these statements indicate edges, which could be further worked on in subsequent therapeutic sessions.

Changes for the worse. Participants were also questioned if they noticed changes for the worse. Some of them described the deterioration of their body condition in connection with difficult life situations (moving, work overload) and said the change occurred regardless of the session. Some participants mentioned worsening of symptoms and their subsequent improvement as they worked with themselves. Some also mentioned a tendency to return to the original mode of being. One of the participants named fears that following one's needs can bring about relationship difficulties. These topics and edges could be also further worked on subsequent therapeutic sessions.

5.3.6 Unfolded quality of the symptom and relationships

Of all 67 participants, most described that the unfolded **quality would be helpful everywhere** - in close relationships (with partners, children, parents, extended family members, friends, etc.), at work (with colleagues, bosses, customers, etc.) and in society (on the street, in stores, at the doctor, etc.). They also reported only some of the above areas. This selectivity is most likely due to the fact that some of them already live the quality in some areas of their life (e.g., with friends), while not in another one (e.g., at work). Only a very small part reported that they could use the quality only for themselves. As is apparent here, the unfolded quality is very closely connected with relationships.

Another noted change was a **change in behavior in relationships** after the session. This was described mostly as the ability for participants to communicate their opinions (what they

want, feel or need). They also described that they felt more aware in relationships, both of themselves and others (they understand others better, are more tolerant and at the same time are aware of their own needs).

5.4 Discussion

The findings of this study may supplement theoretical literature and the scarce empirical research on the Process-oriented approach to working with body symptoms (Fukao et al., 2007, Mindell, 2001; Morin, 2019; Panáková, 2003, Weyermann, 2006). In our study, we arrived at several findings suggesting that the Process-oriented approach to working with body symptoms is beneficial.

The resulting model called the “Symptom Transformation Trajectory” represents two individual aspects: the attitude toward the symptom (in the dimension from symptom rejection to symptom acceptance and the resource-oriented strategy) and the lived experience of the symptom over the course of time. In this model, the participant’s attitude toward the symptom changes from “rejection” to “acceptance” at the end of the session and continues with a “resource-oriented strategy” a week after the session. At the same time, the symptom’s lived experience changes from “limitations and suffering”, to “broadening experience and control” after the session, to a “change in perspective and a subjective reduction of symptom intensity” a week after the session. These changes persisted for several months after the session. Furthermore, integrated access combining verbal and graphic methods (drawings) opens up new ways to do research on the essential diversity and complexity of human experience. Changes in the drawings (D1 and D2) in our study are highly visible and support the findings of the lived experience of the symptom before and after the session. It should be noted that every participant described her/his/their individual and unique experience with the symptom, so our model and its variations should be not taken as an all-encompassing theory, but rather as an effort to capture participants’ momentary experience when using Process-oriented approach.

In reviewing a previous study of Weyermann (2006) using Process-oriented approach to working with body symptoms of 20 female adolescents, we found very similar results, namely that Process-oriented approach can change the subjective experience of otherwise agonizing symptoms and promote a resource-oriented strategy. Moreover, we discovered

that these changes persist several months later and lead to a reduction of the symptom's intensity such that participants feel better able to handle their daily life.

In fifty-nine participants we identified that the symptom experience was connected with their relationships. This became particularly clear in the integration step of the session, when the participants described that the unfolded quality could be helpful in their relationships, either with their close family and friends or in extra-familial relationships (at work, in society, with authorities - with clerks, doctors). They mostly reported that they could use it in communication (e.g., to express their opinions, needs, to explore themselves, to be honest), conflicts and that it could help them understand others more. The changes in behavior in relationships appeared widely a week after the session and for most of the participants also few months after the session. These findings may support the current holistic paradigm, which builds on the psychosomatic principles and interconnections between mind and body, where the illness etiology is complex, including physical, mental and social factors and also requires the same holistic approach in the treatment (Morschitzky & Sator, 2007; Faleide et al., 2010).

5.4.1 Study Limitations and Future Research Implications

The focus on the self-reported and research therapist's methods of data collection limit the full range of information possibly worth examining. Exploring the characteristics of the participants' relatives and medical professionals would allow us to obtain much richer data illustrating different perspectives. As it is our first step in the topic in this country, we only used one session to obtain general results. We suggest focusing in future research on the impact of long-term psychotherapy on clients. In our study, symptoms were understood as disturbing body manifestations regardless of whether they were acute or chronic. Furthermore, we did not differentiate between whether the symptom was medically unexplained or not. For future research, it would be interesting to focus on one specific group of symptoms. Given that our study is the first step in the quantitative research of Process-oriented Psychology it was apparent from the beginning that there will be only a small team of researchers available. The dual role - the researcher and the therapist - was thus inevitable. A promising step for future study would be to divide the two roles between two independent researchers.

5.5 Conclusions

In this study we identified several changes in the symptom experience of participants by using Process-oriented approach. Participants' lived experience changed from "limitations and suffering" to "broadening experience and control" and "changes in perspective and subjective reduction of symptom intensity". Furthermore, the attitude toward the symptom change from "rejection" to "acceptance" and "a resource-oriented strategy". We also identified that these changes persisted for several months after the session.

The current study suggests that Process-oriented Psychology seems to be beneficial and meaningful for working with body symptoms as a part of psychotherapy. We hope that our findings will encourage psychotherapists to introduce clients' body symptoms into their psychotherapeutic sessions in order to find a creative and helpful way of working with body symptoms, thus turning them into an enriching experience. One of the possible ways of doing this is to use Process-oriented Psychology.

6 Study 3: The Process-oriented approach to working with body symptoms: identification of significant events and working alliance

In this chapter, we will introduce a currently unpublished study of significant events occurring within therapeutic sessions using the Process-oriented approach to working with body symptoms (Sedláková et al., 2020). The idea of this study was inspired by several qualitative studies in different psychotherapeutic approaches which suggested possible relationships between client-identified significant moments and the overall therapeutic change (Timulák, 2007). Moreover, we are interested in working alliance as one of the predictors of psychotherapy outcomes (Horvath, Del Re, Flückiger & Symonds, 2011).

6.1 Introduction

Examination of client experiences is central to advancing theoretical understandings of mediational processes in therapy (i.e., how therapeutic processes get translated into post-session change) (Elliott, 2008). This has implications for predicting outcome. Furthermore, understanding the potential range and forms of client experience is an important component of therapeutic skill and can be assumed to lead to more effective interventions. Specifically, knowledge about key overlooked aspects of client in-session experience can be used to help therapists work more effectively with their clients (Elliott, 2008). Diverse terminology has been used in this area, including “significant episodes,” “helpful and hindering events,” or “important events.” What is shared across these terms is a focus on time-delimited episodes of the therapeutic process of a particular importance (either positive or negative) for the participant (Elliott, 2008). In our study, we use “significant events” as an umbrella term, since it covers events with both a positive and negative impact.

The study is based on one of the approaches to research of significant events within the psychotherapeutic process. This approach is based on the assumption that there are events in the therapeutic process that are more important in terms of therapeutic change than others (Timulák, 2007). These events can be identified in various ways, for example from the perspective of the therapist, from the perspective of the client, or using a coding tool based on a certain theory. In this study, we will deal only with significant moments that the client identifies themselves. On one hand, we are aware of the limits of using only the client’s

perspective (e.g., clients may not recognize some key moments and others may be overestimated). On the other hand, we assume that the moments that the clients identify as key have the potential to capture the clients' experience of the therapy, their perception of the therapeutic process and their view of therapeutic change (Cummings, Hallberg & Slemon, 1994).

There is a significant amount of research regarding significant events in therapy (Timulák, 2007). Based on a meta-analysis of seven qualitative methods, there are nine general categories of important events (described from the clients' point of view): (1) self-awareness/insight/understanding themselves, (2) behavior change/problem solving, (3) empowerment, (4) relief, (5) exploration of feelings/emotional experience, (6) the feeling that the therapist understands the client, (7) client engagement, (8) assurance/support /safety, and (9) personal contact (Timulák 2007).

Process-oriented Psychology is a phenomenological approach developed in the 1970s by Arnold Mindell, who researched body symptoms and Jungian dream analysis (Diamond & Jones, 2004). It is used around the world by hundreds of psychotherapists and facilitators in the fields of psychotherapy, psychiatry, social work, conflict resolution, group work, coma care, organizational change, and community building (Diamond & Jones, 2004).

Exploration of symptoms can give clients a sense of meaning; for instance, they can be perceived as a reaction to something or a direction of change in life (Mindell, 2001; Morin, 2019; Weyermann, 2006). In Process-oriented Psychology, the main goal is to bring awareness to what is happening right now (Diamond & Jones, 2004). The attention of the therapist is divided between two processes: (1) noticing signals of identity, which are close to personal awareness and include elements with which the client is identified (the primary process), and (2) marginalized elements (the secondary process) (Diamond & Jones, 2004). By marginalized we mean that they are set aside from the focus of identity - sometimes they are unconscious, but they can also be conscious, yet we do not follow them. Signals of these two processes emerge in different ways - channels. Channels are divided into: visual, auditory, movement, proprioceptive, relational and world channel (Diamond & Jones, 2004). The marginalized aspect of a client's wholeness will emerge as a disturbing signal (such as a symptom) (Mindell, 1990). By unfolding this signal with sensory-grounded awareness we unravel, in a more tangible way, a new quality to which the client did not

have access before (Mindell, 1998). Through unfolding this quality, the client can then experience a “dream figure”, that is, an embodied experience of the originally marginalized quality (Mindell, 1990). The last part of the work includes integration of the experience into the client’s everyday life (Diamond & Jones, 2004).

Although Process-oriented Psychology is used by practitioners around the world, with a few qualitative studies presenting cases and benefits of this method (Fukao et al., 2007; Mindell, 2001; Morin, 2019; Panáková, 2003; Weyermann, 2006), more rigorous research is still missing and so we decided to conduct another study.

Significant moments in research studies are usually captured using a short questionnaire, such as the Helpful Aspects of Therapy questionnaire (Llewelyn, 1988), administered right after each session, or through a semi-structured interview, such as the Client Change Interview (Elliott & Rodgers, 2008), performed retrospectively at the end of the entire therapeutic session. While the first method allows for data collection immediately after a session, the second method provides the ability to capture the meaning of individual events from a distance and in a broader context. Both methods have their advantages and limitations. In our study, we combine both methods, and we also add the Working Alliance Inventory and Session Rating Scale to capture the therapeutic alliance.

The above-mentioned findings inspired us to conduct a qualitative research study where the main aim was to identify important events, helpful and hindering aspects, as well as the participant’s evaluation of the Process-oriented approach to working with body symptoms. For this study, we proposed 3 of the following research questions:

Q1: What are the important events that occurred in the session?

This question is based on the assumption that there are moments or events in the therapeutic process that are more important in terms of therapeutic change than others (Timuľák, 2007; 2010). We assume that the moments that clients identify as key have the potential to capture the clients’ experience of the therapy, their perception of the therapeutic process, and their view of therapeutic change (Cummings et al., 1994).

Q2: What do participants find helpful and hindering in the session?

Identifying helpful, as well as hindering, moments in the experimental session brings us more information about the therapeutic process. The knowledge gleaned about these aspects of client in-session experience can help therapists to work more effectively with their clients in the future (Elliott, 2008).

Q3: How do participants perceive the working alliance?

In this question, we are interested in identifying the working alliance in the experimental session as a prediction of psychotherapy outcome (Horvath et al., 2011). The concept of working alliance captures goals, tasks, and emotional bond (Horvath & Greenberg, 1989).

6.2 Methods

6.2.1 Participants

See Chapter 4.2.1.

6.2.2 Procedure

See Chapter 5.2.2.

6.2.3 Ethics of the clinical study

See Chapter 4.2.3.

6.2.4 Experimental session

See Chapter 4.2.4.

6.2.5 Qualitative methods of data collection

The data was collected using a combination of questionnaires and qualitative methods.

Client Change Interview (CCI)

The Client Change Interview (CCI) is a 60 to 90-minute semi-structured interview developed for qualitative and quantitative evaluation of psychotherapeutic change from the perspective of clients. It can be used both during and after psychotherapy (Elliott, 2012). The CCI includes the following areas: changes for the better or worse perceived by clients since the beginning of their psychotherapy; evaluation of these changes; extra- and intra-

therapeutic causes of changes perceived by clients; client-perceived resources and limitations on their part affecting the changes; and perceived helpful and hindering aspects of the psychotherapy (Elliott, 2012). We used a translation of the revised version (Elliott & Rodgers, 2008) from the Centre for Psychotherapy Research (Ebertová et al., 2015).

Helpful Aspects of Therapy (HAT)

Helpful Aspects of Therapy (Llewelyn, 1988) is a questionnaire in which the client, immediately after the session, describes events that were perceived as helpful during the session or, on the contrary, hindering. The questionnaire contains a total of five questions that ask the client (1) to describe the content of the event, (2) to express what was important to them and what they took away from it, (3) to evaluate on a numerical scale the degree of its help or disruption, (4) to capture when this event roughly occurred during the session, and (5) how long it lasted. The client could also describe several events related to one session.

Session Rating Scale (SRS)

The Session Rating Scale is an ultra-brief visual analogue alliance measure with three interactive scales: (1) relational bond between the therapist and client, (2) agreement on the goals of therapy, and (3) agreement on the tasks of therapy, and one scale reflecting the Overall session (Duncan et al., 2003). The client's task is to mark a point on each visual scale after the session. The SRS was developed following many studies which found that a positive alliance is one of the best predictors of the outcomes of psychotherapy (Orlinsky, Rønnestad, & Willutzki, 2004). A Czech version exists and is in use, but has not yet been validated (Zatloukal et al., 2006).

Working Alliance Inventory (WAI-SR)

This inventory is a widely used 12-item measure of alliance in therapy utilizing the 5-point Likert scale covering three dimensions: Goal, Task, and Bond (Hatcher & Gillaspay, 2006). The WAI, as well as the SRS, examines the connection between a positive alliance and the outcome of psychotherapy (Orlinsky et al., 2004). The Czech version has been validated and its internal consistency was determined to be at a satisfying level (Cronbach's $\alpha=0.83-0.88$), allowing the instrument to be widely used, especially by researchers (Kořicová, 2016).

6.2.6 Analysis

In this study, the grounded theory approach was chosen as the appropriate method of analysis of the qualitative data (see Chapter 5.2.6). Further, as the SRS and WAI questionnaires are not normed, it allowed us to report descriptive statistics only.

Credibility Checks

Several steps were taken to ensure the credibility of the results: (1) the researcher's self-reflection in respect to the topic under study, (2) repeated analysis of the data, which revealed more subtle meanings and allowed for more structured and detailed results, (3) awareness of the dual role (therapist of the session and researcher in one person) for the first author, and (4) use of several methods for data collection to strengthen the study's validity.

6.3 Results

6.3.1 Significant events

To answer this question, we used data from all 67 participants (from HAT). We identified 70 important events in total. All participants mentioned at least one important event (some of them mentioned two), that occurred in the session. After data analysis we identified the nine following categories:

(1) Self-awareness/better understanding of self

This category includes events where participants described getting in touch with new parts of themselves - parts that they haven't been in touch with or haven't been in touch with for a long time, or parts they wish to be living more. They also described moments of better understanding themselves: who they are, what they need, what their boundaries are, who they are on the individual level as well as in relationships, in work, and to others.

(2) Therapist's interest/safe atmosphere

This category contains events described by participants as a therapist's interest, understanding, and support during the session. It also includes a safe and relaxed atmosphere during the session.

(3) Behavior change/problem-solving strategies

This category includes events that were connected with behavior change, e.g., realizing a need to change something in their behavior and/or a feeling of change through the live experience in the session. This category also includes events that brought participants concrete ideas about how they can continue to work on themselves in their life, as well as how can they use these ideas to solve problems - personal, in relationship, at the workplace, and/or with others (in society).

(4) Getting in touch with feelings/life experiences

This category includes getting in touch with feelings and emotions, as well as being aware of them, and gaining a new understanding of those feelings. Some also mentioned memories and life experiences that popped up and were important for them in understanding some of their inner parts, who they are, why, and where they come from.

(5) Contact with inner power

This category includes events where participants felt/got in touch with their power. Some participants described having experienced this power in the past and having lost access to it somewhat recently. Some mentioned that it is something they have been looking for in their life for a long time.

(6) Specific approach

This category contains events that were described as detailed work or focus on body symptoms. Going step by step from the description of the body symptom through working on it while using body awareness and sensory grounded experience. Participants shared that it helped them to focus and be more present as well as realize how they actually perceive the body symptom.

(7) Change in thinking

This category includes events that were described as a change in participants' thinking in how they perceive their life, the symptom, and different situations in the world; this also includes the ability to look at their life from a different point of view and see it in its

complexity. Participants also mentioned a change in thinking about the symptom as not only negative but something that has meaning and can be a guide for their life.

(8) Mind-body connection

Participants described events where they discovered a connection between the body and symptoms and their everyday life, and gained insights about this connection. They also mentioned the awareness of a connection between the body symptom and its quality, and how this reflects who they are, how they identify and who they want to become (e.g., being more direct, following themselves and their needs).

(9) Body experience/dream figure

This category includes events where participants described the importance of having a body experience in the session. These were represented by several types of events: sensory grounded experiences, experiences of the new quality through unfolding of the body symptom, action taken to work on the body symptom such as becoming a dream figure or showing a gesture that represents the symptom-maker with the therapist.

6.3.2 Helpful and hindering aspects

To identify the helpful as well as hindering aspects in the session, we used data from 29 participants (from the CCI).

In terms of helpful aspects, we identified 68 in total. All participants mentioned at least one helpful aspect (some of them mentioned two or three) that occurred in the session. After data analysis we identified the five following categories:

(1) Bodywork

This category includes participants naming a mind-body connection, active work with the symptom and the body, as well as getting in touch with themselves through body awareness - getting know who they are, what they need, and what their boundaries are.

(2) Process-oriented approach

Participants identified the Process-oriented approach itself as helpful. They described that it was something new for them, bringing a new view on body symptoms that it is optimistic,

has different values, and includes less work through thinking and more by following the body.

(3) Tool for everyday life

This category contains aspects of having a practical tool they can use in their everyday life, or in different situations, to work with the symptom. Participants usually described this tool as a dream figure, gesture, or specific body position they discovered in the session and to which they can return when they need it.

(4) Safe environment and therapist's approach

This category includes aspects of safety and the therapist's supportive, positive, and focused approach in the session.

(5) Participants' trust and willingness to try something new

Lastly, participants also mentioned some aspects of themselves that were helpful in the whole therapeutic process. They named trust, hope, and a willingness to try something new.

In terms of hindering aspects, we identified 18 in total. Some participants did not mention any, whereas others mentioned one or two. After data analysis we identified the five following categories:

(1) Lack of exact guidelines

Two participants described a lack of exact guidelines and clear answers about why they have the symptom and how they can decrease it or get rid of it.

(2) Questionnaires

The questionnaires were described as something that brought participants back to their more rational mind and also took a lot of time to fill out.

(3) Showing the symptom-maker on the therapist

Two participants mentioned a fear that they might hurt the therapist while showing the symptom-maker on her.

(4) Participants' high expectations and memories

Some participants described having a high expectation of themselves, as well as of the method. Another mentioned their fear in the beginning to try a new method. One also mentioned uncovering an unpleasant memory from their past.

(5) Only one session

Two participants described the time limitation as something which hindered them. They would have liked to have more sessions to explore and go deeper.

Difficult or painful moments but still good or perhaps helpful were the third aspect. We identified 28 moments in total. Some participants did not mention any whereas others mentioned one or two. We identified five following categories:

(1) Self-awareness

The category contains moments where participants realized something about themselves, such as their belief system, what they need, or what they need to change in their life. Also realizing who they were in the past, who they are now, and what the next step is in their life. Some also mentioned uncertainty of the application of this work to their everyday life.

(2) Working with something they were afraid of

This category includes moments of fear of working on something (the body symptom) that is painful or scary. This fear was mentioned at the beginning of the session, yet participants also shared that it was surprisingly helpful and relieving to put attention on it.

(3) Participants' feelings and memories

The category contains moments where participants felt emotional while they got in touch with something important for them. Two participants mentioned uncovering memories from the past that made them uncomfortable, while at the same time realizing that they needed to work on those topics.

(4) Active work

Some participants mentioned that the active part of the session was challenging for them as it was something new. Some shared that it was energy-intensive, but at the same time

helpful for them to show the symptom-maker as they saw the meaning from it by the end. Some participants also mentioned surprise through getting in contact with their power.

(5) Following without knowing

This category includes moments where participants didn't know the answers in advance or what the result of the therapeutic work would be. It was challenging for some because they have a strong preference for knowing everything in advance.

6.3.3 Working alliance

Last but not least, we were interested in participants' subjective ratings of the session expressed through the Session Rating Scale (SRS) and Working Alliance Inventory (WAI). These methods are not normed, allowing us to report descriptive statistics only. We report the results in Table 4.

| Scale | Max | Mean (SD) | Median (1 st quartile; 3 rd quartile) |
|--------------|-----|---------------|---|
| SRS Relation | 10 | 9,690 (0,568) | 9,90 (9,70;10,00) |
| SRS Goals | 10 | 9,624 (0,666) | 9,90 (9,60;10,00) |
| SRS Task | 10 | 9,666 (0,640) | 9,90 (9,70;10,00) |
| SRS Overall | 10 | 9,651 (0,835) | 9,90 (9,80;10,00) |
| WAI Goal | 5 | 4,321 (0,633) | 4,50 (4,00;4,75) |
| WAI Task | 5 | 4,284 (0,745) | 4,50 (4,00;4,75) |
| WAI Bond | 5 | 4,340 (0,604) | 4,50 (4,00;5,00) |
| WAI Overall | 5 | 4,313 (0,605) | 4,42 (4,00;4,75) |

Table 4: Descriptive statistics of SRS and WAI scales. The Max column states the maximum rating a participant could provide in a specific scale. "SRS Relation" refers to the scale "Relational bond between the therapist and client", "SRS Goals" refers to the scale "Agreement on the goals of therapy" and "SRS Task" refers to the scale "Agreement on the tasks of therapy". The other labels used in the table correspond to the names of the scales.

6.3.4 Research reflection and participants' comments

Although this data is beyond the scope of the research questions of this study, we decided to analyze this data to get the overall results of the research and to investigate possible future research directions. Participants mostly viewed the whole research experience as

something interesting and new. They also mentioned that it was surprisingly effective, positive, beneficial, deep, practical, and useful. It allowed them to get to know themselves better and also have a tool that they could use to come back to the experience from the session. They expressed a wish to include this approach in their usual treatment and that they would also recommend it to other people. Two participants also mentioned concerns about trying a new approach at the beginning.

The following comments in response to the entire experiment were stated: satisfaction and good research design; thanks and acknowledgment; a wish to publish more about this topic and inform people about it; and a belief that the method could be helpful for many people (even in one-session form).

Regarding the feedback for recommendations for improvement, the following was mentioned: to describe the method in more detail at the beginning of the research process; to ask more consensus reality-based questions about the symptom in the session, as well as the life circumstances of participants; to have more time (for more sessions) to work more deeply; and to offer suggestions for how to continue with this learning process.

6.4 Discussion

The findings of this study on the topic of working with body symptoms using Process-oriented approach reveal significant events as well as a working alliance, both often researched in psychotherapy. The significant events research paradigm represents a specific approach to studying client-identified important moments (helpful or hindering) in the therapy process (Elliott, 1985; Timulák, 2010). The main idea for this type of research is that identified helpful events are often the moments of the most fruitful therapeutic work, and thus, we can learn about the therapeutic process from them (Timulák, 2007). Complementarily, hindering events can enrich our understanding of the potential pitfalls of therapy. Therefore, qualitative significant event studies allow for a detailed description of processes leading to a significant impact that can be particularly informative for clinical practice.

We believe that these findings may supplement the theoretical literature and scarce empirical research on this topic (Fukao et al., 2007, Mindell, 2001; Morin, 2019; Panáková, 2003, Weyermann, 2006). In this study, we arrived at several findings suggesting that the

Process-oriented approach to working with body symptoms as a psychotherapeutic method is beneficial and might also be used in psychosomatics.

We identified nine categories of important events that occurred in the session: (1) self-awareness / better understanding of self, (2) therapist's interest / safe atmosphere, (3) behavior change / problem-solving strategies, (4) getting in touch with feelings / life experiences, (5) contact with inner power, (6) specific approach, (7) change in thinking, (8) mind-body connection, and (9) body experiences / dream figures. In comparison to the nine general categories of important events from the clients' point of view, described by Timuřák (2007): (1) self-awareness / insight / self-understanding, (2) behavior change / problem solving, (3) empowerment, (4) relief, (5) exploring feelings / emotional experiences, (6) feeling that the therapist understands the client, (7) client engagement, (8) assurance / support / safety, and (9) personal contact, we can summarize that the categories we identified in our study are very similar. There are three different categories specifically connected to the body in our study: specific approach, mind-body connection, and body experiences / dream figures, that clearly represent the specific approach to working with body symptoms in our study.

Furthermore, we identified 5 categories in the area of helpful aspects: (1) bodywork, (2) Process-oriented approach, (3) tool for everyday life, (4) safe environment and therapist's approach, and (5) participant's trust and willingness to try something new. Those categories mostly overlap with the important events categorized above. It should be noted that the important events were identified by participants at the end of the session, whereas the helpful aspects (as well as the hindering aspects and difficult but still helpful moments) were collected one week after the session. This overlap clearly shows that the important events as well as helpful aspects capture the significant events of the method and are more or less sustainable for at least one week after the session.

In terms of hindering aspects, we identified the following five categories: (1) lack of exact guidelines, (2) questionnaires, (3) showing the symptom-maker on the therapist, (4) participants' high expectations and memories, (5) only one session. These aspects might be seen as an inspiration for future research and for the method itself.

Last but not least, we identified the following five categories as difficult but still helpful moments for participants: (1) self-awareness, (2) working with something they were afraid of, (3) participants' feelings and memories, (4) active work, (5) following without knowing.

Finally, in order to assess the quality of participants' subjective experience of the Process-oriented session itself, we administered two scales - the Session Rating Scale (SRS) and Working Alliance Inventory (WAI). As can be clearly seen in Table 4, all ratings in the SRS and WAI scales reach close to the maximum possible rating, suggesting that the participants viewed the sessions positively.

It should be noted that throughout psychotherapeutic research and literature, two aspects are presented as important for the psychotherapeutic effect: motivation and the therapeutic relationship (i.e., the rapport). Based on existing research, Lambert, Harmon, Slade, Whipple, & Hawkins (2005) assume that 40% of the effect in psychotherapy can be attributed to the client's personality and 30% to the therapeutic alliance.

Motivation is considered one of the most important predictors of the psychotherapeutic effect (Orlinsky, Grawe, & Parks, 1994). Although we have not dealt with this aspect, participant motivation could play an important role in our research. Since participation in our study was voluntary, it can be assumed that the participants were more or less motivated to try out a new psychotherapeutic method. Nevertheless, more specific data focused on participant motivation would be needed in future research.

The quality of the therapeutic relationship (alliance) and psychotherapist's personality are reported as more important factors of the effects of psychotherapy than specific psychotherapeutic methods or approaches (Joyce, Wolfaardt, Sribney, & Aylwin, 2006; Horvath, 2006; Norcross & Lambert, 2011). There is no way to separate the psychotherapist's personality and rapport from the psychotherapeutic process. Process Work, despite being a unique approach, also recognizes the importance of the "metaskills", which the therapist uses to relate to the client's process and the client (Mindell, 2003; Diamond & Jones, 2004). Metaskills represent the therapist's feeling attitudes with which the therapist intervenes. In the context of what was said at the beginning of this paragraph, Process-oriented Psychology sees metaskills as central to the therapist's way of working. As all the ratings in the SRS and WAI scales in our research were close to the maximum

possible rating, we suggest that the participants positively perceived not only the therapeutic relationship and the session in general, but also other aspects of the therapeutic process, such as its goal or task.

6.4.1 Study Limitations and Future Research Implications

The focus on self-reported data collection limited the full range of information possibly worth examining. Exploring the personality of the research therapist would allow us to obtain much richer data illustrating wider perspectives. In future research, we suggest focusing on the impact of long-term psychotherapy on clients. In our study, symptoms were understood as disturbing body manifestations regardless of whether acute or chronic. Furthermore, we did not differentiate between whether the symptom was medically unexplained or not. For future research, it would be interesting to focus on one specific group of symptoms. Given that our study is one of the first steps in the research of Process-oriented Psychology, it was apparent from the beginning that there would be only a small team of researchers available. The dual role of researcher and therapist was thus inevitable. A promising step for a future study would be to divide these two roles between two independent researchers.

6.5 Conclusions

In this study we explored significant events occurring within the Process-oriented approach to working with body symptoms and the working alliance rate. We identified nine categories of important events that occurred in the session: (1) self-awareness / better understanding of self, (2) therapist's interest / safe atmosphere, (3) behavior change / problem-solving strategies, (4) getting in touch with feelings / life experiences, (5) contact with inner power, (6) specific approach, (7) change in thinking, (8) mind-body connection, and (9) body experiences / dream figures. We also identified five categories in the area of helpful aspects: (1) bodywork, (2) Process-oriented approach, (3) tool for everyday life, (4) safe environment and therapist's approach, and (5) participant's trust and willingness to try something new. In terms of hindering aspects, we identified the following five categories: (1) lack of exact guidelines, (2) questionnaires, (3) showing the symptom-maker on the therapist, (4) participants' high expectations and memories, and (5) only one session. Last but not least, we identified the following five categories as difficult but still

helpful moments for participants: (1) self-awareness, (2) working with something they were afraid of, (3) participants' feelings and memories, (4) active work, and (5) following without knowing. The ratings in the working alliance scales reached close to the maximum possible rating, suggesting participants' overall satisfaction with the session.

The presented study suggests that Process-oriented approach to working with body symptoms even as a one-session therapy brings benefits and is perceived by participants as something new that brings self-awareness, the sense of a mind-body connection, problem-solving strategies, changes in thinking, etc. It seems to be beneficial to work with body symptoms as a part of psychotherapy and we assume it might be also useful in psychosomatics. Further research on this topic is needed.

7 Summary of key conclusions of studies 1, 2 and 3

The present thesis consisted of three studies regarding the Process-oriented approach to working with body symptoms.

Study 1 examined the effects of the Process-oriented approach to working with body symptoms on clients' symptoms severity, well-being and satisfaction. Quantitative repeated measures were obtained from 67 participants randomized into experimental and control groups. The effect of Process-oriented approach was assessed using a two-way ANOVA for repeated measures supplemented by Tukey's post-hoc test and descriptive statistics on subjective session rating scales. Compared to the control group, the experimental group clients displayed a subjective alleviation of reported symptoms, a significantly larger improvement in subjective well-being and higher satisfaction (personal, in relationships, in society and overall) after the session. The SRS and WAI ratings suggested clients' overall contentment with the session. The results suggest that the Process-oriented approach to working with body symptoms seems to be effective in reducing the severity of subjectively reported symptoms and increasing well-being and satisfaction in society.

Study 2 explored the subjective experience of participants who experienced the Process-oriented approach to working with body symptoms. The sample consisted of 67 adults. A grounded theory method was used as a methodological framework. The lived experience of the symptom changed from "limitations and suffering." to a "broadening experience and feeling of control," and a "changing of perspective and subjective reduction of symptom intensity." The attitude toward the symptom changed from "rejection" to "acceptance" and a "resource-oriented strategy". These changes also continued for several months after the session. The findings suggest that Process-oriented Psychology seems to be beneficial and meaningful for working with clients' body symptoms as a part of psychotherapy and in psychosomatics.

Study 3 explored significant events occurring within the Process-oriented approach to working with body symptoms and the working alliance rate from the participants' point of view. The sample consisted of 67 adults. A grounded theory method and descriptive statistics were used as a methodological framework. We identified overarching categories of important events, helpful aspects, hindering aspects, and difficult but still helpful

moments for participants. Participant ratings in the working alliance scales reached close to the maximum possible rating, suggesting participants' overall satisfaction with the session. These findings suggest that working with body symptoms from a Process-oriented approach brings benefits and is perceived by participants as something new, that brings self-awareness, the sense of a mind-body connection, behavior change, change in thinking, etc. We assume that working with body symptoms from a Process-oriented framework is beneficial and might be also used in psychosomatics.

Summary

Process-oriented Psychology (also called Process Work) is a phenomenological approach developed in the 1970s by Arnold Mindell, who originally studied physics and later researched body symptoms and Jungian dream analysis (Diamond & Jones, 2004). As a Jungian analyst, he was committed to Jung's teleological approach: the idea that dreams had a purpose and meaning. He thought that body symptoms, like dreams, must contain meaning and purpose for the individual (Diamond & Jones, 2004). While working on himself and with clients, he discovered a mirroring of physical experience in dreams and started to use the term "dreambody" (Mindell, 1998). According to Mindell, the dreambody is a dreamlike, unifying field which gives expression to body symptoms and dreams (Mindell, 1998). After several years of focusing on body symptoms and dreams, he extended his work to include any type of disturbance, including conflicts, moods, complexes, and relationship problems (Diamond & Jones, 2004). Mindell and his colleagues have been developing the method ever since. Process-oriented Psychology is currently used by hundreds of psychotherapists and facilitators around the world in the fields of psychotherapy, psychiatry, coma work, social work, conflict resolution, group work, organizational change, and community building (Diamond & Jones, 2005).

The connection between body and mind has changed over time. Theological speculation about mind-body unity is reflected in Western medicine which has separated the body from the mind since the time of Descartes in the 17th century (Mindell, 1998; Morschitzky & Sator, 2007). The thinking about the mind-body dichotomy was already shifting to a holistic approach in 1977 with Engel's bio-psycho-social model of disease, which was later extended by a spiritual component, and is today the conceptual basis of modern psychosomatics (Tress et al., 2008; Morschitzky & Sator, 2007), and also the starting point for the concept of health for the World Health Organization. The holistic bio-psycho-socio-spiritual approach explains the multifactored influence of the development of illness which requires the same approach in its treatment (Morschitzky & Sator, 2007). Modern psychosomatics in its wider perspective is seen as an interdisciplinary concept, basic attitude, and view on the diagnosis and therapy of illnesses, which equally include physical, mental, and psychosocial factors (Tress et al., 2008; Morschitzky & Sator, 2007). The

Process-oriented approach to working with body symptoms can be seen as one of the methods used in a holistic approach and psychosomatics.

According to the literature within the field of Process-oriented approach to working with body symptoms, the exploration of symptoms can give the symptoms meaning; for instance, they can be perceived as a reaction to something or a direction for change in the client's life (Mindell, 2001; Morin, 2019). In Process-oriented Psychology, the main goal is to bring awareness to what is happening right now (Diamond & Jones, 2004). And so, when working with body symptoms, we are interested in what the message is behind the symptom for the individual. Morin also adds a collective level to this interest by describing how health and illness are part of the society we live in, and how the meaning of body symptoms can be seen as a part of the society as well (Morin, 2019).

An exploration of the psychotherapeutic effect is essential to the development and application of functional methods in psychological practice (Timulák, 2005). Although Process-oriented Psychology is taught around the world and used by many practitioners, there has only been limited research performed related to the topic of body symptoms. According to some of the authors of existing studies, we found out that:

- Process-oriented approach can change the subjective experience of otherwise agonizing symptoms, promoting a resource-oriented strategy (Weyermann, 2006).
- Process-oriented approach allows the clients to change their perception of their body symptoms from non-conscious to conscious, thus moving from a passive attitude to an active one, in order to become the co-author of their therapy and their own life (Panáková, 2003).
- Process-oriented approach seems to be beneficial for the clients in the process of recovery and brings solution to psychosomatic problems (Fukao et al., 2007).
- Process-oriented approach brings a broader experience of one's identity and a practical use of the unfolded experience of the body symptom into one's everyday life. Illness itself is seen as a potentially meaningful experience, not only for the individual affected by it (Antonova, 2018; Ackermann, 1994; Camastral, 1995; Scott, 2014; Vassiliou, 2005), but also for society (Ackermann, 1994).
- Process-oriented approach suggests that people with Alzheimer's disease may function as a personal and collective shadow to Western cultural values, because it

challenges the extraordinary value currently placed on youth, productivity, independence, rational thought, and personal identities (Robinson, 2009).

- Process-oriented approach can be used to recover from impaired consciousness in people with brain lesions (Gusarova, 2014).

Because quantitative research is missing from the field and there exist only a limited number of qualitative studies on the topic, we decided to create our own study. We cover the quantitative, which focuses on the effectiveness of the method, as well as the qualitative, where we explore the subjective experience of participants with the method, identify significant moments of the experimental session, and reflect on the working alliance between client and therapist. All three studies were a part of one research project, yet each of them focused on a specific goal and brought different findings.

Study 1 examined the effects of the Process-oriented approach to working with body symptoms on clients' symptoms severity, well-being and satisfaction. We used an additive design. Quantitative repeated measures were obtained from 67 participants randomized into experimental and control groups. Thirty-five participants from the experimental group underwent an experimental session using Process-oriented approach and were administered questionnaires immediately before, immediately after and one week after the session. Thirty-two participants in the control group were administered questionnaires twice, one week apart, while no session was provided in the meantime. We used the following methods for data collection: the Brief Symptom Inventory (BSI), Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM), Individual Symptoms Scale (ŠIP) and Outcome Rating Scale (ORS). The effect of Process-oriented approach was assessed using a two-way ANOVA for repeated measures supplemented by Tukey's post-hoc test and descriptive statistics on subjective session rating scales. Compared to the control group, the experimental group clients displayed a subjective alleviation of reported symptoms, a significantly larger improvement in subjective well-being and higher satisfaction (personal, in relationships, in society and overall) after the session. The results suggest that the Process-oriented approach to working with body symptoms seems to be effective in reducing the severity of subjectively reported symptoms and increasing well-being and satisfaction in society.

Study 2 explored the subjective experience of participants after a session using the Process-oriented approach to working with body symptoms. The sample consisted of 67 adults. An individual structured interview, drawings and a therapist's session protocol review were conducted with all participants. Moreover, with 29 of the participants, a Client Change Interview (CCI) was conducted and 41 of the participants completed a catamnestic questionnaire. A grounded theory method was used as a methodological framework. The lived experience of the symptom changed from “limitations and suffering,” to a “broadening experience and control”, and a “changing of perspective and subjective reduction of symptom intensity”. Furthermore, the attitude toward the symptom changed from “rejection” to “acceptance” and a “resource-oriented strategy”. These changes also continued for several months after the session. These results suggest that Process-oriented Psychology seems to be beneficial and meaningful for working with body symptoms of clients as a part of psychotherapy.

Study 3 explored significant events that occurred within a session using the Process-oriented approach to working with body symptoms and the working alliance rate from the participants’ point of view. The sample consisted of 67 adults. We used the following methods for data collection: the Client Change Interview (CCI), Helpful Aspects of Therapy (HAT), Session Rating Scale (SRS), and Working Alliance Inventory (WAI-SR). A grounded theory method and descriptive statistics were used as a methodological framework. We identified overarching categories of important events, helpful aspects, hindering aspects, and difficult but still helpful moments for participants. The participants’ ratings in the working alliance scales reached close to the maximum possible rating, suggesting participants’ overall satisfaction with the session. These findings suggest that working with body symptoms from a Process-oriented Psychology framework brings benefits and is perceived by participants as something new that brings self-awareness, the sense of a mind-body connection, behavior change, change in thinking, etc. We assume that working with body symptoms from a Process-oriented Psychology framework is beneficial and might be also used in psychosomatics.

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Appendices

Appendix 1: Abstract of the thesis (EN)

Title: The Process-oriented approach to working with body symptoms: effects, benefits and potential in psychosomatics

Author: PhDr. Mgr. Barbora Sedláková

Supervisor: PhDr. Marek Kolařík, Ph.D.

Number of pages and characters: 142 pages, 285 255 characters

Number of appendices: 9

Number of references: 135

Abstract:

The presented thesis is divided into two parts: a theoretical introduction and empirical research. The theoretical portion explains the theoretical and methodological background of Process-oriented approach to working with body symptoms, the bio-psycho-socio-spiritual model in holistic medicine, and the concept of modern psychosomatics. The empirical portion consists of three studies. Study 1 examines the effects of the Process-oriented approach to working with body symptoms on clients' symptoms severity, well-being and satisfaction (personal, in relationships, in society, and overall). The results show that the Process-oriented approach to working with body symptoms seems to be effective in reducing the severity of subjectively reported symptoms and increasing well-being and satisfaction. Study 2 explores the subjective experience of participants in response to the Process-oriented approach to working with body symptoms. It describes their lived experience of the symptom over the course of time - changing from limitations and suffering to an experience of broadening of identity and control, as well as a changing of perspective and bringing of a subjective reduction of symptom intensity. Study 3 explores significant events and working alliance rate from the participants' point of view. The findings suggest that working with body symptoms in the Process-oriented approach is reported by participants to bring self-awareness, a sense of mind-body connection, a progression in self-development, a change in thinking, etc. According to the results of our studies we assume that the Process-oriented approach to working with body symptoms is effective, beneficial and has significant potential as a psychotherapeutic method in modern psychosomatics. Further research on this topic is needed.

Keywords: Process-oriented Psychology, Process Work, body symptoms, psychosomatics, psychotherapy

Appendix 2: Abstrakt disertační práce (CZ)

Název: Procesově-orientovaný přístup při práci s tělesnými symptomy: efektivita, přínosy a potenciál v psychosomatice

Autor: PhDr. Mgr. Barbora Sedláková

Školitel: PhDr. Marek Kolařík, Ph.D.

Počet stran a znaků: 142 stran, 285 255 znaků

Počet příloh: 9

Počet titulů a použité literatury: 135

Abstrakt:

Prezentovaná disertační práce je rozdělena na dvě části: teoretický úvod a empirickou část. V první části je vysvětlen Procesově-orientovaný přístup při práci s tělesnými symptomy, bio-psycho-sociálně spirituální model v holistické medicíně a koncept moderní psychosomatiky. Empirická část se skládá ze tří studií. První studie zkoumá efektivitu Procesově-orientovaného přístupu při práci s tělesnými symptomy v oblasti závažnosti reportovaných symptomů, well-being a spokojenosti (osobní, ve vztazích, ve společnosti a celkové) participantů. Výsledky ukazují, že Procesově-orientovaný přístup při práci s tělesnými symptomy je efektivní v oblasti redukce závažnosti symptomů, zvýšení well-being a spokojenosti ve společnosti. Druhá studie přináší subjektivní zkušenosti participantů s Procesově-orientovaným přístupem zaměřeným na práci s tělesnými symptomy. Studie zachycuje prožívání a vnímání symptomu v průběhu času - proměnu z limitace a utrpení do rozšířené identity a kontroly a dále změnu perspektivy a subjektivně vnímané snížení intenzity symptomu. Třetí studie se zabývá významnými událostmi a pracovní aliancí z pohledů participantů. Procesově-orientovaný přístup přináší sebeuvědomění, pocit propojení mysli a těla, pokrok v seberozvoji, změnu v uvažování atd. Dle výsledků výše uvedených studií předpokládáme, že Procesově-orientovaný přístup při práci s tělesnými symptomy je efektivní, přináší benefity a má výrazný potenciál jako psychoterapeutická metoda v oblasti moderní psychosomatiky. Další výzkum na dané téma je potřebný.

Klíčová slova: Procesově-orientovaná Psychologie, Procesová Práce, tělesné symptomy, psychosomatika, psychoterapie

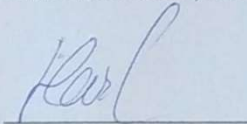
Appendix 3: Co-authors' declaration

Appendix 3: Co-authors' declaration

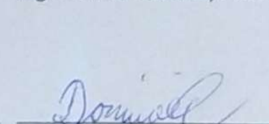
I agree with the use of the following papers as a part of the doctoral thesis of PhDr. Mgr. Barbora Sedláková titled "*Process-oriented psychology working with body symptoms: effects, benefits and potential in psychosomatics*":

- Sedláková, B., Dominik, T., & Kolařík, M. (2019). Process-oriented Psychology Working with Body Symptoms: Effects on Symptoms Severity, Well-Being and Satisfaction. [Manuscript submitted for publication]. Department of Psychology, Faculty of Arts, Palacký University.
- Sedláková, B., & Kolařík, M. (2020). Where our Body Symptoms Guide Us: A Qualitative Research Study using Process-oriented Psychology. [Manuscript submitted for publication]. Department of Psychology, Faculty of Arts, Palacký University.
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PhDr. Marek Kolařík, Ph.D.



Mgr. Tomáš Dominik, Ph.D.



Appendix 4: Informed consent in Study 1, 2 and 3

Note: This informed consent was provided in the Czech language. The informed consent was used for all participants.

Informed consent with participation in a research

I, _____, the undersigned, agree to participate in the research study "The Process-oriented approach to working with body symptoms: subjective experience and possible use in psychosomatics" - PhDr. Marek Kolařík, PhD., & PhDr. Mgr. Barbora Sedláková, realized between 1. 3. 2017 and 31. 12. 2018 with the financial support of the Internal Grant Agency of Palacký University in Olomouc.

I declare that I was clearly and intelligibly acquainted with the purpose and procedure of this research project. I also confirm that I am aware of all my rights: to a confidential and secure environment; respect of my current state; the ability to suspend or terminate participation in the research project orally at any time; and to anonymous data processing in accordance with the Privacy Policy 101/2000 Sb. I was also informed of the purpose, scope, and use of information from my medical records provided to the experimental therapist.

Date _____ Signature _____

If you are interested in the research results, write your e-mail _____

We sincerely thank you for your participation!

PhDr. Mgr. Barbora Sedláková

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Palacký University Olomouc

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Appendix 5: Experimental session instruction (Therapist's session protocol) used in Study 1, 2 and 3

Note: This protocol was provided in Czech language.

Participant code: _____ Date: _____

Step 1: Primary identity. Who have you been the last several days and who are you today? How do you live?

Step 2: Symptom description. Could you describe the symptom you have chosen for this research? How do you perceive it? What is your attitude toward the symptom?

Step 3: Symptom drawing. Draw yourself and the symptom and name it. _____

Step 4: Disturbing quality. Describe the symptom and its manifestations more specifically. What is its sensory grounded experience (for instance warmth, tingling, pressure) and what is its most disturbing quality?

Step 5: Amplification. Participants were supported to develop the quality in whatever way it emerged (through movement, proprioception, sound, or imagination). At the end, the quality was given the form of a mythological or historical entity - "a dream figure" - that represents this quality naturally.

Step 6: Self drawing. Draw yourself with the identified embodied quality and name it. What is the current attitude toward the symptom right now?

Step 7: Integration. Participants were asked a few questions to help to integrate the experience into their everyday life: e.g. Where and when they have already noticed this quality in their life, and when and how this quality could be helpful in their everyday life?

Step 8: Encouragement. Finally, participants were encouraged to return to the discovered quality or mythological figure, to try to experiment with it during the following week.

* notes about edges _____

Appendix 6: Demographic questionnaire

Note: This demographic questionnaire was provided in Czech language.

For reasons of copyright protection, the test battery is not included in the electronic version of this dissertation thesis.

Appendix 7: Test battery in Study 1

Note: All methods were administrated in the Czech language.

For reasons of copyright protection, the test battery is not included in the electronic version of this dissertation thesis.

Appendix 8: Test battery in Study 2

Note: All methods were administrated in the Czech language.

For reasons of copyright protection, the test battery is not included in the electronic version of this dissertation thesis.

The Client Change Interview (CCI) was used in Study 2 and 3 and is listed only in this Appendix.

Appendix 9: Test battery in Study 3

Note: All methods were administrated in the Czech language.

For reasons of copyright protection, the test battery is not included in the electronic version of this dissertation thesis.