Depression And Body Psychotherapy

Laura Steckler & Courtenay Young

Abstract

Depression is a condition of both the body and the mind. Body-Psychotherapy uses somatic interventions such as working with posture, touch, and using body awareness – as well as traditional techniques – to help their clients become more in touch with themselves, and express the affect that is held within their bodies. This can lead to an improvement and lighten the load of the heart: the somatic focal point of depression.

Key Words: Body psychotherapy, Depression.

Depressão e Psicoterapia Corporal
Sumário

A depressão é uma condição do corpo e da mente. A psicoterapia corporal trabalha com as perspectivas tradicionais e com intervenções somáticas tais como o trabalho com a postura corporal, toque e utilização da consciência corporal para ajudar os clientes a entrarem mais em contacto consigo próprios, ajudando-os a expressar o afecto contido no seu corpo. Esta intervenção pode levar a uma melhoria e a um alívio da carga do coração – o ponto de focagem somático da depressão.

Palavras chave: Psicoterapia corporal, Depressão.

La dépression et la psychothérapie corporelle
Résumé

La dépression affecte à la fois le corps et l'esprit. La psychothérapie corporelle utilise des approches traditionnelles, mais aussi des interventions au niveau du corps, comme le travail sur sa position et avec le toucher ; elle utilise la conscience du corps pour aider les clients à être mieux en contact avec eux-mêmes et à exprimer les émotions retenues par leur corps. Ceci peut apporter une amélioration et alléger le poids qui affecte le cśur, point focal de la dépression dans le corps.

Mots-clés: Psychothérapie corporelle, Dépression.

Depression und Körperpsychotherapie
Zusammenfassung

Depression ist ein Zustand von Körper und Geist. Körperpsychotherapie benutzt somatisches Eingreifen. Zum Beispiel mit der Körperhaltung arbeiten, dem Berühren und das Körperbewusstsein so gebrauchen um ihren KlientInnen zu helfen, mehr mit sich im Kontakt zu sein und die im Körper gehaltene Betroffenheit auszudrücken. Das kann zu einer

Besserung führen und das Gewicht auf dem Herzen leichter machen: Der zentrale somatische Punkt in Depression.

Schlüsselwörter: Körperpsychotherapie, Depression.

Депрессия и телесная психотерапия
Резюме

Депрессия – это состояние тела и разума. Для того, чтобы помочь клиентам прийти в больший контакт с собой и выразить удерживаемый в теле аффект, в телесной терапии используются различные соматические интервенции, такие, как работа с позой, прикосновением, телесным осознаванием. Все это может привести к улучшению общего состояния клиентов и облегчению «лежащего на их сердце груза», основной темы и соматической основы депрессии.

Ключевые слова: телесная психотерапия, депрессия.

*

Introduction

Who among us has not been depressed? Depression is now so common as to be considered the 'common cold' of emotional disturbance. In fact, statistically 25% of us will at one point or another become depressed in our lives. The body is part and parcel of the very definition of depression. The vegetative symptoms of depression are somatic by nature, including fatigue, low energy, sleep and appetite disturbances. If the reader has experienced depression, s/he will be familiar with many of the effects that depression has on the body. One very common complaint of depressed clients is being 'locked in' (Rowe, 1983, 2006) often with a sense of a weight on, or pain in, the heart. Pain feels more intense and tears are often not far from the surface.

In this article, we will address the role of the body in mild to moderate depression and Body-Psychotherapy approaches to depression. Body-Psychotherapists specialize in the use of somatic methods, but this does not mean that they exclude other aspects of the person; indeed cognitive, interpersonal, psychodynamic, systemic, environmental and biological elements are often integrated into a 'somatic' or body-oriented psychotherapy. This article holds the perspective that somatic methods are only one part of a very wide psychotherapeutic process.

Traditional theories of depression

It is beyond the scope of this article to review the many of theories about the aetiology of depression, though the combination of heredity and environment is widely held to be significant and the psycho-social environment also has an significant impact (Billings et al, 1983; Holmes & Rahe, 1967). There is evidence of genetic factors in some aspects of depression (Rainer, 1984). Emotional and historical factors can include early loss (Bowlby, 1960, 1969 & 1973) and the development of negative 'schemas' in early life (Beck, 1967, 1979 & 1987). Other learning-based theories include Seligman's 'learned helplessness' (1975), then reformulated within the framework of attribution theory (Gilbert, 1984). In addition, we have the psychoanalytic theory of depression (Freud, 1917) where depression is created in early childhood, leads to repressed loss and anger unconsciously turned inward. Socio-

economic status and reduced social support systems are also thought to play a role (Johnson, 2006), and depression seems to be more prevalent in women (Silverstein, 2002).

Some of the biological theories implicate a hormonal imbalance: viz. post-natal depression[1] or menopausal depression. There are currently popular theories about depression being a neuro-chemical dysfunction; i.e., the 'serotonin theory' that has led to the influx of the hugely popular SSRI medications, and depression is also seen as an imbalance in the neuro-endocrine system where the hypothalamic-pituitary-adrenal cortical axis is thought to be overactive in depression (Chrousos, 1995).

In some cases, very stressful events can trigger a depression (viz: PTSD). Environmental factors that contribute to depression can include any major life stressor or major life change, with some form of additional loss seeming particularly likely to trigger an episode of depression.

Irrespective of the trigger or cause of the depression, most peoples' experiences of depression, their 'symptoms' of depression, tend to fall into four main groupings: Emotions or Feelings; Physical Symptoms; Thought Patterns; and Behavioural Symptoms (Young, 2009).

- **Emotions:** Feeling like crying a lot; feeling alone (even in company); feeling sad, depressed upset, hopeless, despairing, or just numb; feeling anxious, irritable or unreasonably angry; feeling lethargic; having no interest or enjoyment in things (even things that used to be enjoyable); a low self-esteem and feelings of worthlessness and/or guilt.
- **Physical Symptoms:** Loss of energy, lethargy, tiredness or fatigue; restlessness or agitation; changes in appetite (either poor or increased) and resulting weight loss or gain; difficulties in sleeping, either not falling asleep easily, not returning to sleep after mid-night waking, or early morning wakening; or a desire to sleep a great deal of the time; can have headaches, indigestion, stomach pains, and irregular periods.
- **Thoughts:** Difficulty in concentrating or a slowness in thinking; indecisiveness; loss of confidence in self; having an unusually negative or gloomy outlook; thinking that everything is hopeless (Abramson et al, 1989) or that the worst will happen; negative self-concept, self-reproach and self-blame, even self-hate; recurrent thoughts of death or suicide.
- **Behaviour:** Having difficulties in doing anything; neglecting everyday tasks, like regular meals and person hygiene; putting off doing things, even things that one normally enjoys; having short occasional bursts of energy, and then usually not completing things; cutting oneself off from friends, family, regular support, or social activities; difficulty in maintaining regular work hours.

To focus only on two of these factors – Thoughts and Behaviour –-seems incomplete, thus, in Body-Psychotherapy, the Emotions and the Physical Symptoms are also included to complete the picture, and to work with the whole person.

Depression as a body-mind phenomenon

We purport that depression is not a simple 'illness', it is a 'complex condition' and we believe it cannot be seen in any one particular way, nor can it be resolved by any 'one-way-works-for-all' method or medication. Depression is a 'state' that we can get into for a variety of reasons and one that we usually need a little help to get out of. Although there is great similarity

[1] There are also theories about post-natal depression being connected to a loss of attachment with the child. (McMahon et al, 2005)

amongst individuals in their experience of depression, each person is also unique and will have their own particular aetiology, triggers, significant factors, and individual journey out of depression: therefore an individualistic approach to the depressed person is particularly important. That 'special attention' can also be also very important for the depressed person: helping to lift them out of their depression.

The illness model of depression is currently very popular. This, in some ways, has served to de-stigmatise depression as a mental health condition, but it may in some ways also lead to a reinforcement of the body-mind split. It may also amplify the inherit helplessness in depression by assuming that the person must be 'treated' for an 'illness' rather than embarking on a process of self-healing that can sometimes be difficult and painful. It also assumes a 'one-size-fits-all' viewpoint that is antithetical to the uniqueness of the individual.

Depression is neither just a physical problem, nor just a mental/emotional problem: it is, of course, a combination of both. Body-Psychotherapy (in all its various forms) sees the person's mind and body as being indivisibly inter-related.

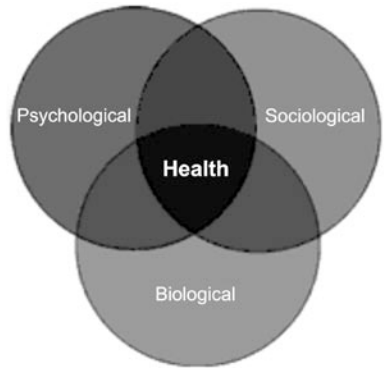
> *Experiences of physical symptoms and depression raise complex issues about the distinctions between mind and body. While depression is commonly viewed as a disturbance of emotion, its behavioural aspects, such as social withdrawal or changes in eating behaviours, are equally important. … Two areas of diagnostic and therapeutic concern are the confusion between depressive and somatic symptoms, in chronic disease, and in particular the neglected relationship between pain and depression.* (Dorwick et al, 2005)

Depression is also not purely a psychological condition. We know, for example, from a wide number of studies that (i) increased aerobic exercise or structured exercise is effective in alleviating mild to moderate depression and improves cognitive functioning (Kramer et al, 2006); (ii) that a combination of psychotherapy and medication is more effective than either one, or the other; and these have become the preferred sequence of mainstream treatment options. (NICE, 2004; SIGN, 2008)

However this article is about how depression is seen and worked with within the context of Body-Psychotherapy. As body-psychotherapists, we find that a wider-based and more eclectic approach is more fruitful than a one-size-fits-all model: thus we prefer an approach that also considers the person holistically. As a caring therapist, one does not wish to pathologize the depressed person, nor make them see themselves as 'sick' or 'ill'; nor make them a passive recipient of any particular therapy. Instead, we want to support the person to engage actively with their own healing process, to empower them to feel in charge of their own well-being, and to feel again the 'spark' and pleasure of life as they begin to emerge out of their depression.

Depression and the Body

There are many different schools and approaches within the field of Body-Psychotherapy such that it is difficult to generalise about them. We will attempt, however to describe a way of thinking and treatment approaches that we believe are consistent with many somatic approaches. The body-psychotherapy approach is consistent with the currently popular 'bio-psycho-social' model, often seen in health psychology contexts (Engel, 1977). This model acknowledges the complex interaction between the person's body, their mind and the environment. Any serious disruption to the essential 'balance' of the person's equilibrium can result in illness, depression or feelings of social alienation and all of these three main areas impact on the individual's health.



One well-known Body-Psychotherapist, Alexander Lowen (1972), wrote about depression and the body, taking the perspective that the depressed person has become out of touch with their body, and their feelings, and thus has developed an inability to respond emotionally. It is therefore necessary to re-establish a connection to their physical (somatic) self and for them to learn to recognize the physical manifestations of their emotions. He postulates that the disconnection with their body is synonymous with a disconnection with their feelings. Lowen postulates a number of cause-and-effect situations which actually foster depression and its resulting symptoms: one of these is the 'game' of "bringing up baby": rearing a 'socially acceptable' child by a process of deception and self-deception that become disastrous.

> *The game is played with the infant or child being at first entirely unaware of what is going on. Nevertheless, it is a game, like others, in which the child has to be outmanoeuvred if the desired result is to be obtained. The parent assumes, quite rightly, that the child will resist and that by the proper use of rewards and punishments his resistance can be overcome. The punishments are threats to withdraw love, disapproval, restrictions, castigations, and physical abuse.*
>
> *A parent who uses these tactics doesn't think he is playing a game. To him or her, the issues are real and serious indeed. The child who is allowed to have his own way will be a failure in life, a rebel and a misfit. And the parent who is afraid that this can happen feels he has a moral responsibility to prevent it. … By the same token he would regard the obedient child as a loving child and the rebellious one as hostile.* (Lowen, 1972, pp 161-162)

Lowen's theory is consistent with object relations and self-psychology theories that suggest that emotional disturbance is connected to a lack of mirroring and acceptance of a child's authentic self. The child then develops a 'false self' and inhibits his/her own organic impulses, thus dampening down her/his energy and authenticity. This numbing or deadening of the self is, we believe, a common theme in depressed clients.

In the family of origin, where the roots of depression often exist, life that could have been beautiful and exciting has become instead a sort of a battlefield, lacking in intimacy and joy, and ultimately feelings of being defeated. The child mourns for what it instinctively knows might have been.

> *"Mourning…involves the repetition of the emotional situation the infant experienced during the depressive position. For under the stress of fear of loss of the loved mother, the infant struggles with the task of establishing and integrating his inner world, of building up securely the good objects within himself."* (Klein, 1952)

The accumulation of such defeats ends in depression and attendant low self-esteem and negative world-view. These are experienced emotionally, somatically, socially, behaviourally and often sexually. Effective treatment therefore needs to come both from analyzing and understanding some of the person's early dynamics, but it also needs to be geared towards restoring awareness, self-acceptance, empowerment and pleasure within the body – the antithesis of depression: a form of cognitive-somatic therapy perhaps. We, as body-psychotherapists, feel that the inclusion of a somatic component is essential in effective working with depression.

Energy, the body and depression

The effects of covering up the true self and carrying the burden of the false self are likely to have a significant biological/energetic consequence. This was highlighted in Wilhelm Reich's concept of 'character armour' (Reich, 1933, 1972) where emotional repression is embedded in chronic muscular tensions (hypertonic) and/or hypotonic collapse. Stanley Keleman (1985), another Body-Psychotherapist, goes further and sees people and their bodies as a complex of energetic structures (in both musculature and internal structures): rigid, dense, swollen, and collapsed; some of which (the 'dense' and 'collapsed') especially carry depression.

How can all these forces and stresses not also have an effect on the person's nervous system? It is clear that the autonomic nervous system (ANS) becomes imbalanced by both stress and possibly also by the suppression of affect, which is inherently a stressor. Whenever we get stressed, the 'sympathetic' half of the ANS is triggered and we generate stress hormones (primarily adrenaline, cortisol, GH, norepinephrine, and other cortico-steroids). These hormones are the mechanism by which we 'prime' our bodies (internal organs and musculature) for the basic animalistic survival "fight-or-flight" reflex. If we can discharge through intense physical activity, then our body regains its homeostasis, otherwise these hormones stay in the body. And this is why aerobic exercise is effective for depression as it 'burns off' the stress hormones, after which it is easier to relax. A combination of both aerobic exercise and relaxation also improves levels of serotonin and dopamine, and this is therefore a very simple and effective approach that can enhance the early stages of psychotherapy (Young, 2008).

Somatic Intervention

Affect is seen as part of the whole person. It is important to sense how we feel, to acknowledge and express feelings and to accept ourselves for having feelings. Williams et al (2007) suggest that responding with aversion or negation to feelings can trigger the fight-or-flight response that supports our premise that accepting emotion is an important therapeutic element of any therapy.

There is evidence that deeply experiencing affect, whilst recounting traumatic or highly distressing material, has a positive effect on the autonomic nervous system immune system and on depression (Goldman et al, 2005). Becoming aware of, and exposed to, emotion is increasingly seen as necessary for effective psychotherapy (Greenberg, 2008).

Body-psychotherapists tend to see emotions as being 'held' in the body, often below conscious awareness, and thus somatic interventions help to foster the person's awareness and the subsequent release of these.

A skilful emphasis on body awareness can facilitate this process. In the 'triune brain', the limbic system, especially the amygdala, has stronger neural connections to the right

hemisphere of the brain where we hold our proprioceptive 'sensing map' of our bodies. For these reasons, touch and body awareness seem to allow and promote a deeper experience and release of affect (Heller 2006). Keleman discusses other somatic interventions such as the need to restore pulsatory movement in the body:

> *The ability to turn pulsation into peristalsis, and peristalsis into pumping is at the base of healthy physical, emotional, mental, sexual, and interpersonal functioning. This ability gives the basic emotional language of feeling from which movement and expression grow. Distress creates contractions or weaknesses that distort pulsation. Somatic education brings people into deeper contact with the living foundations of existence, the pulsatory waves that generate excitement, feeling, thinking, and action.* (Keleman, 1985, p. 152-3)

He further discusses the need for the individual's needs to be considered in choosing particular interventions for the individual:

> *While there are many somatic techniques available in the market place, not all of them are appropriate for any given individual. Mechanical and cathartic movements, pumped-up breathing techniques, general excitory exercises, sensory awareness, reposturing and repatterning motor skills, dance movement, psychodrama, and grounding exercises must be viewed in terms of individual differences in structure. Relaxing muscles will not create emotional responsiveness in rigid structures. Breathing approaches will not help swollen unbound types. Reposturing the collapsed person will not develop his inner motility. Each structure must be approached uniquely. Emotional misery results for many people when they attempt to become someone else's somatic ideal.* (p.152)

Thus body-psychotherapists in general do well to have a variety of techniques available and to have sufficient experience to distinguish the differing needs of individual clients.

In addition, we believe that some of the direct-contact body-psychotherapy techniques may be more fruitful in helping the person achieve deeper states of relaxation than relaxation exercises given to clients on CDs, such as with 'progressive relaxation' (Jacobson, 1938). Clients can only really relax to the extent that they are aware of their bodily tensions. The use of touch, inner awareness and 'deep listening' to the body can facilitate such deep relaxation, which can help with the anxiety and tensions that often accompany depression.

Touch can be particularly beneficial in work with depressed clients. Tiffany Field, a renowned US researcher in touch therapy, states that massage therapy has been shown to be especially effective for children, adolescents and adults in depression:

> *In all of the above studies, depression and anxiety levels decreased, and the stress hormones (norepinephrine, epinephrine, cortisol) were reduced. This could be explained by the shift in brain waves we have noted in our studies, with the EEG showing a shift from right frontal activity (typically seen in depressed people) to left frontal activity (typically seen in happy people) following a massage. These shifts were accompanied by an increase in positive mood. … These electro-physical changes (from a negative to a positive EEG pattern) and the related chemical changes (the stress hormones decreasing) may be what lies behind the decrease in depression that is noted following massage therapy. Additionally, the beneficial neurotransmitters serotonin and dopamine, both of which increase with antidepressants, also increased following massage therapy, which could further explain these findings.* (Field, 2003, p. 140)

The use of touch in body-psychotherapy is often quite different than its use in massage. It is more of a collaborative process within the therapy, rather than a therapeutic treatment

'done to' the client. It is vitally important that the person retains his or her own power and autonomy. The ethical use of touch means having very clear boundaries, with high respect for the client's wishes and their individual level of comfort with touch: and much has been written about the ethical use of touch in psychotherapy (Smith et al, 1998; Young, 2009; Zur, 2008), especially because there may have been suppression, manipulation, confusion, distortion, invasion or even abuse in the person's history, and, as we have mentioned, this can be a significant factor in their depression. So we must ensure that, in the use of touch, these elements never re-occur.

Some clients can only be touched on their hands or feet: some can only engage in self-touch. Whatever the body-psychotherapy method, we often find that touch can help people to clarify their own boundaries, to facilitate internal perception, to help to sense their feelings, and also to accept themselves more. One client recently reported, *"I can now feel my legs as they are meant to be!"* We are primarily working to help the person empower, appreciate and lighten (or even enlighten) themselves.

Depression and the Heart

Depressed patients often report a pain or a weight in their heart. The heart, in eastern energetic theory, has much to do with compassion for oneself and others. A depressive posture guards the wounded heart: the chest is often collapsed; the gaze turned downward; the feet are often ungrounded, turning inward, unable to support the person properly. When the therapist points this out to the person, they often will say that they are hiding, or that they are ashamed of themselves and they do not wish to be seen. This, of course, can hark back to the denial of the authentic self in childhood; but it may also reflect a loss of present-day self-esteem, as the person is not 'supposed' to be depressed, but to be 'successful' or 'perfect'.

Laura writes: *"One of my clients whom I will call 'Sarah' was suffering from chronic back pain. She had a markedly stooped posture. I had to be careful to not bring this aspect up too quickly in our relationship. Her self-esteem was very low, having had a highly critical mother and an abusive father. She needed to feel safe to receive any feedback. After some time, I was able to bring up this topic and show her how she sat: I mirrored her posture for her. We spent some time experimenting with the old and new posture; how she felt in her body how these different postures affected her pain, and what aspect of her personality was reflected in each. This was a major turning point in our therapy. Sarah was stunned to find that when she sat tall she had so much more energy that she initially became lightheaded. It took some time to acclimatize to this change. Even her vision improved. She then began to gently work towards new goals, to develop some compassion for herself, and to be able to tolerate her own reflection in glass. She told me about seeing a fabulous pair of shoes that she wanted to wear, but she thought that she couldn't – she wasn't the kind of person to wear such fantastic shoes. Her partner insisted that she buy them and she has now begun to experiment with wearing them, and other things that make her feel better. Her eyes have begun to shine; a spark has returned to her spirit; her fire is beginning to burn again."*

Similarly, attending to pleasant events and noting their effect on one's body can also help people with depression and can begin to restore their ability to feel pleasure again. The use of body-specific imagery appears to bring about somatic changes and we can take advantage of this by utilizing such positive imagery with clients. Building this into a regular practice can augment other bodily-oriented techniques. These techniques can include reminding them of pleasant events, intensely physical experiences, or any exhilarating or energising body practices, and emphasizing how they felt in their body at that time. Maria's "*favorite things*" song from *The*

Sound of Music captures these sorts of sensual experiences: *"Raindrops on roses and whiskers on kittens … and then I don't feel so bad."* It is likely that attending to these experiences with a somatic focus will have an impact on neurochemistry in a positive way. Attending to pleasant somatic sensation is widely used in mindfulness programmes, now recognized as effective in alleviating depression and preventing relapse (Kabat-Zinn et al, 2002)

Another Body-Psychotherapy technique, widely used, is 'somatic resonance' (Most, 1994). In the same way that a musical tuning fork can pick up the vibration from another, a therapist's body can 'tune into' a client's body. The therapist's own body awareness and the knowledge of their own body allows the therapist to feel the external influences coming from the client and to resonate with client's body energy. This can provide a kind of mirroring for the client that perhaps was missing from early life. The client's whole system can respond to being mirrored in this way.

Courtenay writes: *"One of my clients, a 60-year old woman paraplegic, was very depressed about her condition and her need for regular assistance, having formally been very independent. She was an amazing woman and – at my suggestion – had increased her exercise regime (upper body only, as she was paralysed from the waist down), which had brought some improvement in her mood. She was also planning to go and visit her daughter in Australia and was worried about the trip, not being able to cope with airplane toilets. But there was something deeper worrying her. She eventually disclosed that she was quite distressed because, every so often, her husband went off for what she suspected was a weekend sexual assignation (getting from someone else what she could no longer give him). She did not grudge him this, but, as the sessions progressed, she realized that – being a committed Christian – somehow she was condoning adultery. This was 'cutting her off'- one of the sources of her depression: from her minister, who had used to call regularly; her church friends, whom she was dependent on socially; and – it transpired – from her faith, her God. She was suffering from a depression of the spirit. Something of this communicated itself to me by somatic resonance.*

At this point, as her therapist, I stepped slightly outside of the normal counselling role; slightly outside of the normal GP surgery relationship; outside of the usual remit of the National Health Service; outside even of the traditional parameters of Body-Psychotherapy; but, not, as such, outside the normal role of the body psychotherapist. At this point, I tentatively suggested that nothing could really come between her and her God and maybe she should start praying again. Meeting her existential dilemma in this way, compassionately and empathically, seemed to do the trick. She suddenly became a lot more 'present' and burst into tears: my eyes were not dry either. Having seen her once more, a few weeks later, after her return from Australia in high spirits, she stated that she did not need further counselling."

Bringing It All Back Home

We have mentioned that in depression there is often a 'numbing out' – of affect, of sensation, of vitality. This may be connected to the avoidance of unpleasant, painful emotions, or the habitual disconnection from self, or to overwhelming life-stress aspects. The person may have developed this response either very early in life in response to overwhelming or punitive experiences that could not be contained except by suppression, or more recently being 'ground down' by events. Whatever the cause, therapy then becomes a process of recognition, re-connection, owning the causative factors, and re-entering the body in order to reclaim its power and vitality.

Laura writes: *"Another client, Bill, could not answer the question what are you feeling in your body right now. He struggled to make sense of his feelings as he had been repeatedly*

punished as a child for being anything but compliant and placid (see section on Lowen, above). *He allowed himself only certain feelings and always felt that his feelings had to make sense or he immediately invalidated them internally. After a period of working he was able to state one day 'my shoulders feel sad' after processing some childhood experiences that he had previously dismissed as irrelevant because he had little memory for them.*"

The practice of gently focusing, in a mindful manner, on the client's somatic sensations, without any judgment or expectation, and listening to the 'voice' of the body is a very potent tool for body-psychotherapists (Steckler, 2006; Gendlin, 1981 & 1996). Major shifts can occur from this sort of technique. The wonderful thing about this practice is that these shifts can occur for past experiences that are pre-verbal, as they are encoded in the body but not in the cortical thinking brain.

Being able to accept all one's feelings and to allow the overt expression of these is often the seminal healing element in therapy for various conditions, including depression. There is good evidence that either writing or speaking about past traumatic events in an embodied, affect-laden manner leads to initial lowering of mood and heightened distress, but, after weeks (or sometimes months), the immune system appears to become stronger and the person's depression lightens (Pennebaker, 1995). As clinicians, it is important to be aware of this.

Conclusion

There are a wide variety of somatic interventions and perspectives used in Body-Psychotherapy, but these do not preclude the use of cognitive, interpersonal or psychodynamic elements. Our basic approach is to include the person's body into the therapy, whether this be through some form of touch, the use of self-help exercise, movement, body awareness, breath-work, relaxation techniques, touch techniques or psychotherapeutic massage, deep tissue and postural work, or even imagery. As the body changes, the psyche follows suit; and vice versa: they are interconnected – two indivisible aspects of the greater whole that makes a person. We believe that this 'holistic' approach is effective, and that this sort of approach also harnesses the person's own unique healing resources to combat prevalent and normally occurring conditions such as depression.

Authors

Laura Steckler is a Clinical Psychologist, Body-Psychotherapist, and Somatic Movement Therapist. Originally American, she now lives and works near Edinburgh, in Scotland for the national health service and in private practice. She specialises in chronic pain.
E-mail: laura.steckler@btinternet.com
Courtenay Young is an experienced and accredited Body-Psychotherapist, and he also works in the UK National Health Service (NHS) as well as privately, in and around Edinburgh, Scotland.
E-mail: courtenay@courtenay-young.com

References

ABRAMSON, L.Y., METALSKY, G.II., & ALLOY, L.B. (1989) Hopelessness depression: A theory-based subtype of depression. *Psychological Review, 96, 358-372.*
BECK, A.T. (1967) *Depression: Clinical, experimental and theoretical aspects.* New York: Harper.

BECK, A.T. (1979) Cognitive Therapy of Depression. New York: Guilford Press.
BECK, A.T. (1987) Cognitive models of depression. *J. of Cognitive Psychotherapy: An International Quarterly, 1, 5-37.*
BILLINGS, A.G., CRONKITE, R.C. & MOOS, R.H. (1983) Social-environmental factors in unipolar depression: Comparisons of depressed patients and nondepressed controls. *J. of Abnormal Psychology, 92, 119-133.*
BOWLBY, J. (1960) Grief and Mourning in Infancy and Early Childhood. *Psychoanalytic Study of The Child, 15, 9-52.*
BOWLBY, J. (1969) *Attachment and Loss, Vol. 1: Attachment.* London: The Hogarth Press.
BOWLBY, J. (1973) *Attachment and Loss, Vol. 2: Separation.* London: The Hogarth Press. Dorwick, C., Katona, C., Peveler, R., & Lloyd, H. (2005) Somatic symptoms and depression: diagnostic confusion and clinical neglect. *British Journal of General Practice, 55 (520), 829–830.*
CHROUSOS, G. (1995) The Hypothalamic–Pituitary–Adrenal Axis and Immune-Mediated Inflammation. *New England Journal of Medicine, Vol. 332, pp. 1351-1363.*
ENGEL G.L. (1977) The need for a new medical model. *Science, 196: pp. 129–136.*
FIELD, T. (2003) *Touch.* Harvard: MIT Press.
FRATTAROLI, J. (2006) Experimental Disclosure and Its Moderators: A Meta-Analysis. *Psychological Bulletin. 132(6): pp. 823-865*
FREUD, S. (1917) *"Mourning & Melancholia"* The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916): On the History of the Psycho-Analytic Movement, Papers on Metapsychology and Other Works, pp. 237-258.
GENDLIN, E.T. (1981) *Focusing.* New York: Bantam.
GENDLIN, E.T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method*. New York: Guilford Press.
GREENBERG, L. (2008). Emotion and cognition in psychotherapy: the transforming power of affect *Canadian Psychology*, 49(1):49-59.
GOLDMAN, R., GREENBERG, L., & POS, A. (2005). Depth of emotional experience and outcome. *Psychotherapy Research. 15*,248–260.
HOLMES, T.H. & RAHE, R.H. (1967) "The Social Readjustment Rating Scale." *Journal of Psychosomatic Results* **11** (2): 213-8
JACOBSON, E. (1938) *Progressive relaxation.* Chicago: University of Chicago Press.
JOHNSON, A. (2006) "Sources of Depression Among Low-Income Parents: A Mixed Methods Approach" Paper presented at the annual meeting of the American Sociological Association, Montreal Convention Center, Montreal, Quebec, Canada, Aug 10, 2006. Retrieved 29/12/2008 from www.allacademic.com/meta/p105293_index.html
KABAT ZINN, J. SIEGAL, Z., WILLIAMS, M, & TEASDALE, J. (2002) *Mindfulness-based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. New York: Guilford.
KELEMAN, S. (1985) *Emotional Anatomy.* Berkeley, CA: Center Press.
KLEIN, M. (1952) *"Some Theoretical Conclusions Regarding the Emotional Life of the Infant."* In *Envy and Gratitude and Other Works, 1946-1963.* New York: Delacorte.
LOWEN, A. (1972) *Depression and the Body: The biological basis of faith and reality.* New York: Penguin Compass.
McMAHON, C.A., BARNETT, B., KOWALENKO, N.M., TENNANT, C.C. (2005) Maternal attachment state of mind moderates the impact of postnatal depression on infant attachment. J*ournal of Child Psychology & Psychiatry, Vol. 47 No. 7, pp. 660 – 669.*
MOST, W.G. (1994) Somatic Resonance. Internet article retrieved 28/2/09 from http://www.ewtn.com/library/spirit/somatic.txt
NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE (NICE) (2004) *Depression: management of depression in primary and secondary care – NICE guidance CG 23.* NHS 60: Available from: http://www.nice.org.uk/CG023
PENNEBAKER, J. W. (1995). *Emotion, disclosure and health*. Washington, DC: Educational Publishing Foundation.

RAINER, J.D. (1984) Genetic factors in depression and suicide. *American Journal of Psychotherapy, Vol. 38, 3, pp. 329-341.*

RAND, M.L. (2002) What is somatic attunement? *Annuals of American Psychotherapy Association, Nov. 2002. Retrieved 28/02/09 from http://www.highbeam.com/doc/1G1-95844670.html*

REICH, W. (1933, 1972) *Character Analysis. (3rd ed.)* New York: Farrar, Straus & Giroux.

ROWE, D. (1983, 2006) *Depression: The way out of your prison. (3rd ed.)* London & New York: Routledge.

SCOTTISH INTERCOLLEGIATE GUIDELINES NETWORK (SIGN) (2008) Non-pharmacological management of mild to moderate depression: A national clinical guideline. *NHS Draft Guideline, August 2008.*

SELIGMAN, M.E.P. (1975) *Helplessness: On Depression, Development, and Death.* San Francisco: W.H. Freeman

SILVERSTEIN, B. (2002) Gender Differences in the Prevalence of Somatic Versus Pure Depression: A Replication. *American Journal of Psychiatry, 159, 1051-1052.*

SMITH, E.W.L; CLANCE, P.R & IMES, S. (1998) *Touch in Psychotherapy: Theory, Research & Practice.* New York: Guilford Press.

STECKLER, L. (2006) Somatic soulmates. *Body, Movement & Dance in Psychotherapy Journal, Vol. 1, No. 1, pp. 29-42.*

WILLIAMS, M, TEASDALE, J.,SEGAL, Z. & KABAT ZINN, J. (2007) *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness.* New York: Guilford.

YOUNG, C. (2008) Re-Balancing the Autonomic Nervous System: A necessary prerequisite to effective counselling and psychotherapy. *International Journal of Psychotherapy, Vol. 12, No. 2, pp. 24-35.*

YOUNG, C. (2009) About the Ethics of Professional Touch. Internet article: retrieved 22/2/09 from http://www.courtenay-young.co.uk/courtenay/articles/The_Ethics_of_Touch_v.3.2.pdf

YOUNG, C. (2009) *"Help Yourself Towards Mental Health."* London: Karnac

ZUR, O. (2008) Ethical and Legal Aspects of Touch in Psychotherapy. Internet article: retrieved 22/02/09 from http://www.zurinstitute.com/ethicsoftouch.html