How Can Hakomi, a Mindfulness-Based Somatic Psychotherapy, Contribute to the Treatment of Anorexia Nervosa?

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ABSTRACT

Hakomi Mindful Somatic Psychotherapy, also called the Hakomi Method of Experiential Psychotherapy, is generally referred to simply as Hakomi. Research shows current standard specialist treatments for anorexia nervosa are only moderately effective, therefore novel treatment approaches are needed. Currently there is little research specifically on the use of Hakomi in the treatment of anorexia nervosa. The aim of this hermeneutic literature review is to stimulate thinking regarding approaches to psychological treatments for adults with anorexia nervosa and to consider how Hakomi, a mindfulness-based somatic (mind-body) psychotherapy, might contribute to the treatment of anorexia nervosa. This review contemplates on literature found on three topics: current approaches to treatments for anorexia are not sufficient—what attitudes and limitations are involved; there may be links between anorexia and trauma; and anorexia nervosa might benefit from a therapeutic approach Hakomi can provide. Finally, this review considers how Hakomi encourages and cultivates approaching life in a holistic way which may enhance understanding of treatment and therapy options.

Hakomi psychotherapy offers an approach that can benefit the therapist and client by incorporating mindfulness and mind-body holism into a way of being and living as well as through a therapeutic treatment approach. Thus, Hakomi can contribute to any psychotherapy. The cooperative nature of studying the client's experience allows the therapist to come alongside the client, thus not threatening the client's sense of control, which is important to clients with anorexia nervosa. Such a focus on valuing the client's experience can be a paradigm shift for clinicians who are used to a more directive approach. Additionally, Hakomi helps the therapist to embody and utilise an accepting, mindfulness-based, mind-body approach that is missing—and needed—in most psychotherapies recommended for treating anorexia; it may also be helpful for treating developmental or relational trauma. Literature revealed that trauma is found to

be so prevalent in mental health populations, that trauma treatment is recommended for all mental health clients.

This research argues that Hakomi can potentially contribute valuably to the treatment and understanding of anorexia nervosa by offering a mindfulness-based embodied approach that incorporates parts work, which allows an integrated understanding of the patient's lived experience of their symptoms, and can speed recovery. Additionally, this research suggests that Hakomi provides a holistic approach that may fit with some indigenous holistic models of health and well-being, such as the New Zealand Maori. Ultimately, this research considers how Hakomi can contribute to the psychotherapeutic treatment of clients with anorexia nervosa and how clients experiencing anorexia nervosa may need to be treated.

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ATTESTATION of AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

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Chapter 1: Introduction

Why Research the Use of Hakomi in Treating Anorexia Nervosa?

Anorexia nervosa (AN or anorexia) is a restrictive eating disorder (ED) that leads to significantly low weight and holds substantial health risks. It has the highest mortality rate of all mental illness (Arcelus et al., 2011; Birmingham et al., 2005) reaching 10-20% (Wesselius et al., 2020). Relapse is common (Berends et al., 2018), with adult statistics showing 0-25% remission by the end of treatment (Murray, Loeb, et al., 2018). Additionally, the global Coronavirus pandemic has led to a rise in EDs and intensification of ED behaviours (Nagata & Murray, 2021). Analyses of current specialist AN psychological[1] treatment approaches show they are only moderately effective with little difference in effectiveness between the various approaches (Atwood & Friedman, 2020; Galmiche et al., 2019; Jansingh et al., 2020). Researchers, therefore, are calling for novel approaches for treating clients[2] with AN (Hay, 2020; Kotilahti et al., 2020; Murray, 2019, 2020; Nagata & Murray, 2021; Solmi et al., 2021).

Currently, there is little literature regarding the use of Hakomi specifically in treating anorexia. Ron Kurtz developed Hakomi in the 1970s as a mindfulness-based, somatic (body) psychotherapy that integrated eastern and western philosophies. It broadly positions itself in the theory and practice of multiple fields such as attachment theory, Buddhist psychology, neuroscience, object relations, self-psychology, Rogerian therapy, and body psychotherapy (Johanson & Weiss, 2015). With novel treatments for AN needed, it seemed worth considering the research question: how can Hakomi, a mindfulness-based somatic psychotherapy, contribute to the treatment of anorexia nervosa?

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[1] The term “psychological” has to do with the mental aspects like cognitive therapy; however, in research “psychological treatments” are often heterogeneous including psychodynamic psychotherapy and others.

[2] I use the term ‘client’ rather than ‘patient’ or other words because it is the word my environments used and I did not find a better, concise way.

How I Came to This Research Topic

I trained concurrently in the Masters of Psychotherapy programme at New Zealand's Auckland University of Technology (AUT)—which taught mainly relational psychodynamic psychotherapy—and in the New Zealand Hakomi Comprehensive Professional Training. During my AUT training, I undertook a placement at an ED clinic. While I had no particular interest in that area at that time, it soon had personal relevance once I recognised that I had previously experienced mild anorexia nervosa in my life. To get a sense of each health professional's role, I interviewed the ED clinicians—psychiatrist, clinical psychologist, dietician, medical officer, nurse, occupational therapist, and psychotherapist—and each stressed the significance of trauma in their clients' lives. Yet, none of the clinicians were trained in working with trauma. There was a general perception that working with clients experiencing anorexia tended to be challenging, and that working at an ED clinic brings up the clinician's own eating-related challenges. Indeed, it brought to light my own tendency toward orthorexia[3].

At my placement, all my clients were adults and I was advised to use the Specialist Supportive Clinical Management (SSCM) treatment approach, an evidence-based approach used to treat adults with EDs (Schmidt et al., 2015). The basic format of SSCM is two-fold: address ED behaviours during the first half of the session and discuss anything important to the client in the second half. The psychological approaches I saw being used at the clinic seemed to mainly focus on changing client thinking and behaviours through education, coping skills, and willpower; while using exposure therapy focussed on eating. There was some use of psychodynamic psychotherapy and dialectical behavioural therapy (DBT) for more extreme presentations. In a population known for its rejection of the body, I wondered how a Hakomi approach—with its principles of nonviolence, mindfulness, and mind-body

[3] Orthorexia is an unhealthy focus on eating in a healthy way.

inclusion—might offer a different treatment, and whether it would be effective. As an example of the different approaches, the goal of altering behaviour to eat more seems an obvious necessity when significant food restriction is life-threatening; however, that goal conflicts with the strategy the clients come to depend upon, known as their protection or “defence” (Lavie, 2015). Since a Hakomi approach nonviolently supports the client’s defences, I became curious how Hakomi might work in this environment.

Aim and Scope of This Research

The aim of this hermeneutic inquiry is to stimulate thinking regarding approaches to psychological treatments for adults with AN and to consider how Hakomi might contribute to the treatment of AN. My understanding of this topic grew by reflecting on literature that focused on three areas: current approaches to treatments for anorexia are not sufficient; there may be links between anorexia and trauma; and clients experiencing anorexia might benefit from an approach to therapy which Hakomi provides.

To keep within the limitations of a smaller literature review, this research was mostly limited to literature regarding psychological treatment approaches for adults with AN, which often extended to EDs in general. To keep the results more generally applicable, I did not distinguish between characteristics such as gender, race, the stage the client is in (duration or severity of AN), subtypes, co-morbidities, or between treatment locations or service models (hospital, inpatient, day programmes, out-patient, private, or public). I conceptualised my audience as psychotherapists—and other clinicians—providing psychotherapeutic support for clients experiencing AN. Additionally, this review did not address aspects of mind-body-spirit, which make up holism. Finally, the research only included resources in English.

Eating Disorder Descriptions and General Information

While this review attempted to locate literature specifically on anorexia, at times research referred more broadly to EDs, which refers to a broad category that includes three main diagnoses: AN, bulimia nervosa (BN), and binge eating disorder (BED)

(American Psychological Association, n.d.). Anorexia nervosa involves refusal of food to the point of starvation, and distorted body image. Bulimia nervosa involves cycles of eating excessive amounts of food (binging) then purging by vomiting or with laxatives. Binge eating disorder involves frequent out-of-control eating patterns without purging (American Psychological Association, n.d.).

While people with EDs may present with very different behaviours, they share many similarities. Anorexia nervosa and BN are most often paired in research (Mott & Lumsden, 2019) and share some personality characteristics; although people with AN show more constraint and control—versus the impulsivity of those with BN—and a lower awareness of sensory experiences (Pryor & Wiederman, 1996). All three EDs (AN, BN, BED) present with dichotomies of being both regulated and dysregulated, depleted and depleting, and fragile and resistant which "create a number of double binds for people diagnosed with eating disorders that become exacerbated under the conditions of managed mental healthcare" (Lester, 2019, p. 726). Additionally, they all result in an overvaluation of the self which is associated with shame and is mediated by severe self-criticism and negative social comparisons (Duarte et al., 2016). A 2014 systematic review and meta-analysis found common characteristics in people with EDs (AN, BN, BED), which included a tendency to be high in insecure attachment, an inability to recognise emotions, poor understanding of mental states, negative self-evaluation, and perceived social inferiority with a sensitivity to social dominance (Caglar-Nazali et al., 2014). "Eating disorders are, in their simplest form, a set of embodied, physical acts that function to negotiate what are perceived as overwhelming internal and external stresses and demands" (Cook-Cottone, 2016, p. 98).

Clients presenting with anorexia can be perceived as challenging for clinicians[4]. They often do not see their illness as impairing and, therefore, can be seen as

[4] "Clinician" is used in this review to refer to broader clinical roles, including psychotherapist, psychologist, mental health nurse, occupational therapist, etc.; "therapist" refers to the role of psychological therapist, and can be any clinician providing psychological therapy. Sometimes these terms are used interchangeably.

treatment resistant (Holmes et al., 2021; Treasure et al., 2010), with a need to feel in control (Stockford et al., 2019). Progress can be slow and difficult (Oyer et al., 2016). Furthermore, clients with AN tend to harbour disappointment that is directed towards themselves and others (Treasure et al., 2010) and are known for evoking strong countertransference (the emotional stimulation in the psychotherapist in relation to the client) (Lester, 2019).

Basic Description of Hakomi

Hakomi Mindful Somatic Psychotherapy, also called the Hakomi Method of Experiential Psychotherapy, is generally referred to simply as Hakomi. Hakomi is a psychodynamic depth psychotherapy which works beyond symptom alleviation to address the underlying cause of symptoms (Johanson, 2015a). As such, it acknowledges developmental influences on unconscious processes which then mould current experiences and behaviours. Hakomi has been referred to as a body psychotherapy or, more specifically, as a mindfulness-based or -centred, somatic, mind-body, and experiential psychotherapy. In his later life, Ron Kurtz called it "assisted self-study" (Kurtz et al., 2018; Morgan, 2013; Weiss et al., 2015) since it assists the client to gain a deeper understanding of themselves (Morgan, 2015a). Kurtz believed Hakomi could be a part of any method of psychotherapy (Kurtz et al., 2018).

A basis for all therapeutic work in Hakomi is through a certain type of therapeutic alliance called loving presence. Therapeutic alliance has been found to be a key beneficial component in most healing relational dynamics and requires a personal relationship of confidence and mutual regard between therapist and client (Ardito & Rabellino, 2011). Another central characteristic of Hakomi is its experiential attitude. While the client is in a state of mindfulness, the therapist offers experiments to reveal unconscious assumptions that are preventing emotionally nourishing experiences (Kurtz, 2015). "It provides an opportunity to complete, in a positive way, the old, painful experiences that led to those assumptions in the first place" (Kurtz, 2015, p. 21). Being body inclusive, Hakomi utilises awareness of the body as a source

of information for the therapist and the client. “Somatic” means “pertaining to the body” which can be subjective or objective. That felt sense the client experiences internally is subjective, which is not directly observable by others; whereas external aspects—such as posture, gestures, expressions—can be objectively observed by others (Daye, 2015b). The therapeutic process may involve the client’s body in mindful somatic awareness, such as observing sensations; or it might include various forms of mindful therapeutic touch.

In this hermeneutic inquiry, I attempt to convey a cursory sense of the Hakomi method to underpin my exploration. The authors of the Hakomi text (Weiss et al., 2015) wrote over 350 pages to describe this experiential psychotherapy. As Bageant (2012) forewarned, “although I keep citing Kurtz’s book, it is vital to know that Hakomi training is experiential in nature” (pp. 184-185). Being experiential, it needs to be experienced to be fully appreciated and understood.

Understanding Hakomi Through its History

When Ron Kurtz started developing Hakomi in the 1970s, he was at first influenced by academic psychotherapy approaches like behaviour modification and Rogerian therapy. Slowly, he included concepts from many areas including Gestalt, Bioenergetics, Pesso Boyden System Psychomotor, Feldenkrais, Neuro Linguistic Programming (NLP), systems theory, attachment theory, and Buddhist and Taoist sources (Kurtz et al., 2018; Weiss & Johanson, 2015b). His background included experimental psychology, mathematics, physics, electronics, and Eastern wisdom traditions (Weiss & Johanson, 2015b). Kurtz and several of his colleagues, including the renowned trauma therapist Pat Ogden (who went on to develop Sensorimotor Psychotherapy—a blend of bodywork and Hakomi), formed the Hakomi Institute in 1980 to teach the Hakomi method (Weiss & Johanson, 2015b). The word Hakomi was chosen after one of Kurtz’s colleagues had a dream in which Kurtz handed him a slip of paper with the words “Hakomi Therapy” written on it (Kurtz, 2018). After some research, they learned Hakomi resembled a Native American Hopi word meaning “How

do you stand in these many realms" or "Who are you?", which fits with a psychotherapy that helped uncover who you are (Weiss & Johanson, 2015b). The principles of Hakomi were identified as the basis of the approach.

Hakomi's Five Foundational Principles

Hakomi is based on a set of five key principles: mindfulness, mind-body holism, nonviolence, organicity, and unity. These theoretically underpin every aspect of the method including the therapist's presence, called "loving presence". Hakomi therapists, therefore, need to fully understand and embody the principles (Johanson, 1985). The Hakomi Institute website (Hakomi Institute, 2015b) clearly and concisely conveys the importance of these principles in the development of the therapist and Hakomi as a therapy:

> Each Hakomi principle translates into specific practices and ways of being that evoke clients' innate impulse toward healing. Although no one can embody these principles in every moment, the intention to do so is the core of Hakomi's work. A key aspect of Hakomi training is learning to embody the principles … as a deep and consistent part of who you are and how you work. Our goal is to foster high quality, caring therapists as dedicated to their own self-awareness as they are to understanding others. This requires a heartfelt, long-term commitment to your own personal and professional growth. (Hakomi Institute, 2015b, The Hakomi Principles, paras. 1-2)

Description of the Principles and How They Relate to Therapy

These principles work synergistically (Johanson, 2015b). *Mindfulness* reveals real change is not from effort but from awareness. Mindfulness is more than present moment awareness; it is *compassionate* awareness of the present moment, characterised as "receiving the present moment, pleasant or unpleasant, just as it is, without either clinging to it nor rejecting it" (Boorstein, 1997, p. 60, as cited in Perrin, 2015). Mindfulness brings awareness of *mind-body holism*, which maintains that the body and mind are inseparable and interact and influence each other. *Nonviolence* allows a willingness to abandon any agenda or intention, especially if it seems to conflict with what is emerging from the client; thus, it allows, supports, and does not interfere with organicity—the natural healing impulse of the client. Hakomi therapists trust that once they assist the client into noticing their current somatic experience

mindfully, then the principle of *organicity* steps in, and the client's own awareness will facilitate whatever change needs to happen. Hakomi therapists are aware of what is happening for the client because of the principle of *unity,* which acknowledges "our multiply determined selves and the larger context within which they relate" (Daye, 2015b, p. 5). This reflects Hakomi's understanding that all individuals have different "parts" or subpersonalities that, ideally, are acting in harmony with each other. Additionally, while people are different, they are not entirely separate from each other because organic, living systems inter-relate, revealing connections between minds and bodies, hearts and souls (Johanson, 2015b; Kurtz et al., 2018).

The Subtleties of Nonviolence

A description of how nonviolence became included as a principle helps in the understanding of how the word is used and its importance in supporting the "defences" in Hakomi. Ron Kurtz (2015) adopted nonviolence directly in reaction to overly directive therapy by supporting the defence instead of trying to overcome it. As a student during a Bioenergetics bodywork training, Ron Kurtz's client was lying flat and arched her back in defence. Rather than pushing her down as the protocol stipulated in order to force past the defence, Kurtz drew on his background in Buddhist nonviolence and instead put his hand to help lift her back and support what she was naturally doing. His action immediately provided relief since she was no longer having to do it herself (Lavie, 2015). This nonviolent attitude is part of the therapist's loving presence which changes the quality of relational dynamics.

The importance of taking action to stabilise the client, such as feeding or restraining movement for a client with AN, may seem to conflict with the idea of nonviolence; however, nonviolence does not mean passivity. Instead, it focusses on *how* something is done, rather than *what* is done (Ogden, 2021). Arun Gandhi (2017) saw nonviolence as including an attitude of respect, understanding, acceptance, appreciation, and compassion towards the other. In Nonviolent Communication (Rosenberg, 2015), nonviolence means clearly understanding how to use force

protectively and not punitively. Pat Ogden (2021), who adopted principles similar to Hakomi in her Sensorimotor psychotherapy, shared the subtleties of nonviolence:

> The dynamics of violence in therapy can be nuanced, revealed in a critical or judgemental attitude toward the client, in a subtle dismissal of their emotions, thoughts, desires, gestures, appearance… Nonviolence requires the cultivation of a non-judgemental attitude that accepts and welcomes all parts and responses of clients with compassion, especially those aspects the client themselves cannot accept. (p. 411)

Nonviolence is the act of just noticing and allowing, which comes about through mindfulness; the therapist is receptive, open, and curious, "*not acting* [emphasis added] on any impulse to change, judge, or prove a theory about what is being observed" (Perrin, 2015, p. 109).

Hakomi's Place in Body Psychotherapy

Hakomi fits within the framework of body psychotherapy, also known as somatic psychology or body-oriented psychotherapies (BOP). The same general principles of other psychotherapies apply to BOP since it is psychotherapy that includes the body (Röhricht, 2009). Body-oriented psychotherapies integrate body-oriented techniques, theories, and practices, in addition to—not in place of—cognitive verbal psychotherapy (Lazzaro-Smith, 2008). While the Hakomi community has its own leadership—the Hakomi Institute of Europe and the Hakomi Institute of the USA—it also has many Hakomi members participating in and contributing to the European Association for Body Psychotherapy and the United States Association for Body Psychotherapy (Johanson, 2015a). The Hakomi Institute has branched into Canada, Spain, Japan, Australia, New Zealand, Israel, and Colombia. A basic component of body psychotherapies is understanding the expressions of self through the body (Morgan, 2015a). Nick Totten (2003) defined Hakomi as a process-oriented therapy as opposed to an expressive therapy like Dance Movement Therapy. While I agree Hakomi is process-oriented, it can also incorporate expressive therapy since "developing movements…or creating art that corresponds with the new worldview can be

integrative. There are endless possibilities that can be collaboratively agreed upon and supported" (Weiss, 2015b, p. 235).

Preliminary Literature Review

My initial search of the terms anorexia and Hakomi, in scholarly databases, revealed many results that included Hakomi generally amongst other treatments, often other body-oriented therapies (Brytek-Matera & Czepczor, 2017; Dmochowski et al., 2013). From my own experience of other body-psychotherapeutic treatments, and from information I found (Bloch-Atefi et al., 2014; Rosendahl et al., 2021; Totton, 2003), Hakomi might have a similar feel of exploration, but the therapy process can look very different. I found one article describing Hakomi working with EDs, including anorexia, which was written by Hakomi therapist, Lee Moyer (1986). To find more literature, I expanded the scholarly database search to include eating disorders and body psychotherapy; however, most of the therapy descriptions did not resemble Hakomi. Then I found a reference that sounded exactly like a Hakomi approach—Pat Ogden's description of using Sensorimotor psychotherapy to work with a client with BN (Ogden, 2015). When I expanded my search further, I included books on Hakomi and found nothing specific on anorexia or eating disorders. This indicated a gap in the literature worth exploring further.

Significance of This Study

This literature review offers consideration of another approach to the psychotherapeutic treatment of adult clients experiencing AN—a Hakomi approach that could include mindfulness, mind-body holism, and loving presence. I hope this review contributes to an understanding of how Hakomi can support a psychotherapist when working with the challenges of anorexia presentations, and how it could offer the client a respectful, mind-body approach to treatment. Finally, this review considers how Hakomi's philosophical living systems approach might contribute to a broader, more holistic view of psychological treatments for AN.

How This Paper is Structured

Chapter 1 introduces the subject of my research and the aim of the dissertation. It defines and describes key elements of EDs and Hakomi relevant to the research question. It then reveals what I found in the initial literature review. Chapter 2 includes topics related to the methodology and methods used in this research. It describes hermeneutics and how I conducted this research. Chapters 3, 4, and 5 are the "data" chapters that reveal the literature found.

The first of the data chapters, Chapter 3, examines current approaches to AN treatment, considers the drive to find novel information, and explores clinical attitudes and their possible explanations. Chapter 4 starts by touching on the complexity of defining trauma before revealing research linking trauma with AN. It then investigates trauma treatments, reveals a call for universal trauma-informed care and considers why there is so much trauma, before delving into research that explores alternative psychotherapeutic therapies that share similarities with Hakomi. Finally, the last data chapter, Chapter 5, considers how Hakomi can contribute to the treatment of clients presenting with AN by linking descriptions of desired AN treatment qualities with qualities found in Hakomi. The chapter provides literature that reveals important aspects needed for treating AN, before presenting information on Hakomi that may contribute to treating AN, such as how Hakomi can contribute to the therapist and client, and to therapeutic presence. It considers Hakomi training and aspects of Hakomi, such as it working faster and being appropriate for those of Te Ao Maori. Lastly, it considers Hakomi's limitations and the current research environment. Finally, Chapter 6, summarises the research before discussing concepts that came up in the literature throughout this research process. The strengths and limitations of this study are explored; and implications for psychotherapists, especially those who work with clients experiencing AN as well. It finishes by suggesting future research directions then offers a conclusion.

Chapter 2 – Methodology and Method

In this chapter, I discuss hermeneutics as my methodological choice and the hermeneutic literature review as my research method to answer my research question. I consider how hermeneutics reflects Hakomi philosophy and describe my literature review process.

Considerations When Selecting the Methodology and Method

My own history influenced my choice of research and research approach. Romanyshyn (2020) suggested the researcher is drawn to the research through their own wounding; therefore, research is a re-searching of the soul. It was not until I learned how AN commonly presents itself through certain cognitions and beliefs that I realised I had experienced short periods of AN in my life. One aspect often found associated with AN is caregiver misattunement (Cook-Cottone, 2006; Pellegrini et al., 2021). I recognised that I experienced caregiver misattunement as a child. When I considered this, I recognised that part of my desire to search for more effective treatments for AN came from my experience of a sense of misattunement of the therapies and clinical attitudes at the ED clinic towards AN clients' presenting symptoms. Anorexia nervosa treatment is complex, so it is easy to understand that one can be left with the feeling that something in the treatment is amiss. However, my yearning for a sense of attunement at the clinic provided the impetus for me to explore more deeply what might create attunement in a therapeutic context for clients with AN. I later identified attunement in the literature as part of Hakomi's loving presence (Morgan, 2015a), and as something clients with AN identified as desirable in a therapist (Oyer et al., 2016).

The Methodology: Hermeneutic Research

When choosing a methodology for my research, I started by considering a heuristic research approach to explore and make sense of my own intensely emotional responses regarding my perception of AN treatments. I reasoned, however, that there was a greater need to explore other options for treating people with anorexia; and,

since I had trained in Hakomi, it seemed natural to explore its use in treating clients with AN. Since my initial literature review revealed only one research article on Hakomi specifically treating an ED, with mention of AN, there seemed to be a gap in the literature that I might fill by asking: how can Hakomi, a mindfulness-based somatic psychotherapy, contribute to the treatment of AN?

Due to an initially sparse result found in literature, I wanted to be open to modifying the search as needed to further my understanding of the topic, while I used my current knowledge of Hakomi and AN. The aim of qualitative research is to develop understanding; and the interpretivist paradigm encourages interpretation by the individual from their ideological perspective—to move beyond descriptions of the text to interpreting their significance (McLeod, 2015). Searching for absolute, scientific truths and other attempts to measure phenomena which are pursued by a quantitative positivist paradigm does not lend itself to accommodate changes that happen with the very human process of learning (Moreira & Pedrocosta, 2016). Similarly, I was not interested in emerging themes or explaining phenomena such as the qualitative methodology, phenomenology, might provide (Giddings & Grant, 2002).

Hermeneutics seemed a natural choice for this research. I was naturally inclined towards hermeneutics with its emphasis on possible meanings and its thoughtful level of interpretation (Smythe, 2012). Smythe (2012) suggested that researchers are just naturally drawn towards some methodologies over others, and I naturally gravitated towards hermeneutics under the qualitative interpretivist paradigm. Hermeneutics reflects a psychotherapeutic perspective with its intersubjective exploration of what it means to be human (Martin & Thompson, 2003). Additionally, hermeneutics is useful when the data are already a synthesis of experience (Smythe, 2012), which means looking at the conclusions of others. As Giddings and Grant (2002) explained, “If the researcher moves from the stories and asks for the participant’s interpretation of that experience–explores what lies behind what is being said–the research has become more hermeneutic” (p. 17). Hermeneutics lies firmly

within the qualitative, interpretive research paradigm in which the researcher interprets the significance of the data in ways the participants themselves may not have been able to see (Giddings & Grant, 2002). This was my intention with this research—to consider and dwell on the literature to allow robust understandings to emerge.

The Method: Hermeneutic Literature Review

The method I chose for this dissertation is a hermeneutic literature review because it fits well with both the hermeneutic methodology and my desire to create meaning from my research sources (Smythe & Spence, 2012). When I started this research, I was interested in gaining understandings by synthesising a variety of sources that included treatments by therapies similar to Hakomi. Moreover, I wanted to include my thinking and reflections on the material, allowing room to explore the topic as it evolved, while intentionally including my own understandings gained from my knowledge of Hakomi and experience of working with clients with anorexia.

Furthermore, the hermeneutic literature review as a method lends itself towards a flexible, attuned approach towards research (Smythe & Spence, 2012). In contrast, a systematic review which involves deciding upon the research direction in advance, then identifying, synthesising, and assessing all available evidence to generate a robust, empirically derived answer to a focused research question (Mallett et al., 2012; Van der Knaap et al., 2008), would not allow room to change direction and tie in varied subjects that I anticipated my research would involve as I learned more about the topic. Nor would a thematic analysis that searches for patterns in a systematic way.

In a hermeneutic literature review, the researcher's subjectivity is part of the research tool. Texts and other resources become part of the research journey by provoking thinking in a cyclical process of searching, reading, thinking, talking, and writing–the hermeneutic circle (Kafle, 2011). Smythe and Spence (2012) argued that literature reviews should not be limited to an attempt to create the positivist-type objective truth through thematising, categorising, and critiquing to produce an

argument. Instead, they promote a hermeneutic paradigm to provoke thought in the researcher and ultimately the reader:

> The purpose of exploring literature in hermeneutic research is to provide content and provoke thinking. Literature, which can include anything that provokes thinking on the phenomenon of interest, becomes an essential dialogical partner from which scholarly thinking and new insights emerge. A hermeneutic literature review allows for researching in a more intuitive way, following what emerges as important. (Smythe & Spence, 2012, p. 12)

Hermeneutics and Hakomi Share Ontology

Hermeneutic worldviews fit well with Hakomi principles. Like Hakomi's flexibility in working within the principles which attunes the therapist to the client, "[t]he nature of a hermeneutic review is that there are few rules to follow; rather a way to be attuned" (Smythe & Spence, 2012, p. 23). Furthermore, the very human process of reflection, making connections and coming to understand is basic to psychotherapy. Schlelemacher saw hermeneutics as a psychological process coming from an intuitive connection between the interpreter and the writer (Palmer, 1969)—like the intuitive connection between therapist and client. Heidegger referred to the ability to be open to what is in the way and allow things to be just as they are as "releasement" (Orange, 2011); a fitting description of Hakomi processing. Additionally, Gadamer suggested that one needs to be full of undogmatic, humble, even playful curiosity to perform hermeneutic research (Orange, 2011). This stance matches the attitude Hakomi develops in the therapist (Daye, 2015a).

Both Hakomi and hermeneutics recognise that when seeking the whole, one makes sense of the parts and visa-versa. Hakomi was heavily influenced by systems theory ideas of interrelated, independent parts within a whole (Johanson, 2015b). When you look at the parts of a person—the roles a person adopts—they tell you about the whole (their experience in life); conversely, looking at the whole can help to understand the parts (Kurtz, 1990). The process of going from the parts to the whole and the whole to the parts is a never-ending hermeneutic circle where one never arrives at a permanent answer; one is always searching for the felt meaning (Boell &

Cecez-Kecmanovic, 2010). Similarly, the Hakomi therapist is on a continual journey of self-discovery, with themselves and their clients. To consider something fully requires acknowledging both the internal-subjective and external-objective aspects of both the individual and the collective (Wilber, 1995, as cited in Johanson, 2015b). While positivistic views are focussed on the exterior, observable aspects of both the individual and collective social structures, hermeneutics is focussed on the interior or hidden aspect of individuals and collectives (Johanson, 2015b).

Understanding the Development of Hermeneutics

The word hermeneutic means interpretation, with hermeneutics more broadly referring to the theory or practice of interpretation, especially of texts (Inwood, 1999). When the Protestant movement struggled with the unintelligibility of biblical texts, interest grew in hermeneutics as a way to clarify the obscure and find deeper meanings in the texts (Polkinghorne, 1983). In the 19th century, a German philosopher, Friedrich Schlelemacher, shifted hermeneutics from specific methods of interpreting texts towards an art of understanding which considered how people understand texts in general. He suggested that there is an intuitive connection between the interpreter and the text (Grondin, 1994). The reader and author are both human and, therefore, have some degree of shared understanding. Thus, the reader can draw on their own intuition. Wilhelm Dilthey added to this a process of attempting to recreate the author's historical situation to better understand the meaning the author intended. These were attempts to find the "true" meaning of the texts.

Twentieth century philosophers, such as Heidegger and Gadamer, challenged 19th century ideas of objective truth and argued the importance of context and subjective experience (Boell & Cecez-Kecmanovic, 2014). Heidegger moved the ontology towards an awareness of our preunderstanding which makes knowing possible. He described text interpretation as a process of circular engagement of the reader with the text. The reader's past helps them to understand texts, influencing what they are able to understand in that moment. As the reader learns and understands

more, they are then able to make more meaning of the texts. This circular engagement became known as the hermeneutic circle.

Gadamer developed Heidegger's ideas further. Gadamer (1989) was concerned with the philosophical aspect of understanding, and he claimed that scientific methods are unable to understand human sciences. He developed the concept of "prejudice", recognising that since both author and reader are intimately connected to their past, their history will be reflected in their understandings. "[Prejudice] also encourages the consideration of other possible prejudices and recognises the potential for understanding to change and expand" (Smythe & Spence, 2012, p. 13).

Exploring my Preunderstandings

In a hermeneutic process it is important to explore preunderstandings at the beginning of the research process for both the author and reader to be more aware of current understandings and reveal bias (Boell & Cecez-Kecmanovic, 2014). I am a middle-aged, white female of middle socioeconomic status living in New Zealand[5], with the known and unknown perspectives, privileges, and subjugations that come with that. I was raised in California, speaking only English. I have a background in early childhood education which I embraced while raising two children, having left the computer science world behind. I studied psychodynamic psychotherapy, therefore, I come to this research with an awareness that the unconscious develops from past experiences and affects one's current life. In addition, my study and teaching of early childhood education has reinforced the significance of early developmental years on later development. I became motivated to study psychotherapy after spending over 15 years studying Nonviolent Communication (Rosenberg, 2015) and using it as a counselling approach. My many years studying Nonviolent Communication grounded my understanding in the often-overlooked subtleties of violence. As with anyone, my

[5] Also called Aotearoa or Nīu Tīreni.

background may predispose me towards certain worldviews which could limit my ability to recognise the significance of other factors beyond my experiences and could add invalid assumptions that I do not recognise.

Additionally, I came to this research with some perspectives on trauma from trainings I attended. The longer Hakomi comprehensive training I completed included a section on working with trauma which addressed recognising and managing emotional overwhelm in the client if it comes up in a session. I complemented this with a trauma focussed training offered by a Hakomi teacher. In this training, trauma was divided into three categories: shock or acute—a single episode, non-relational, such as a natural disaster or assault; developmental/relational—involving the relational mind, generally ongoing trauma in a relationship; and complex—a combination of acute and relational. In this training I came to understand that the Hakomi comprehensive training works well with developmental (relational) trauma; however, the therapist needs to add resourcing techniques to stabilise the hijacking of experience that happens with more acute trauma.

While engaging in the research method, I became aware of a tendency to value the more positivist literature, which measures outcomes and data and attempts to provides a clear answer. For some time, I found I needed to remind myself of the hermeneutic process and my intention to provoke thinking until I came to accept the largely unstructured hermeneutic perspective and developed a more thorough understanding of the process. I recognised that by engaging in this open way of approaching the literature, it expanded my awareness from focusing on the more detailed aspects to broader concepts.

Considering Ethics

McLeod (2015) maintained that psychotherapy research has an ethics of care that requires careful consideration. While the researcher must ensure that no harm is done to any research participant, care also applies to the research community by ensuring one does not exploit or deceive. Additionally, care is shown in the writing of

the research by representing information accurately and citing references to give credit where it is due. Furthermore, McLeod (2015) purported it is important to maintain respect and consideration for the research process to maintain the integrity of the research field. I, therefore, was careful to abide by these suggestions.

Furthermore, it is important to consider various cultural perspectives and develop cultural awareness which allows one to understand others' realities and re-examine one's own. This process helps one to become aware of the impact of one's own values and biases on others (Chu et al., 2016). Cultural consideration is especially true in New Zealand which has a bi-cultural legal obligation to recognise the indigenous Māori culture and to honour and acknowledge their essential taonga (treasures). Much of the research I found did not indicate the culture or ethnicity of participants. Most research was from the United States, the United Kingdom (UK), or Australia; although some research from international journals indicated where the studies were conducted, which were mainly European countries. I found some references to Māori regarding EDs, and a more holistic approach to health, however this was limited. I would have liked to include more insights and understandings from various cultural perspectives but was limited by the scope of this research.

The Process of This Hermeneutic Literature Review: The Hermeneutic Circle

As a method, the hermeneutic literature review uses a circular approach which, over time, spirals into deeper and more comprehensive understanding of the subject (Boell & Cecez-Kecmanovic, 2010). Boell and Cecez-Kecmanovic (2010) suggested this can be broad or narrow: "Depending on the nature of an investigation, this encirclement can be wider, for broad overviews investigating general relationships, or narrower when a comprehensive survey of particular aspects is desired" (p. 133). My research started by looking at specific techniques and therapies which then led to looking more deeply at the Hakomi principles and broader definitions of trauma and treatments. As I learned more about the call for novel AN therapies and AN

connections to trauma, I saw my original sources anew and appreciated the wealth of knowledge contained within.

Throughout this hermeneutic process, I was drawn to various texts and topics, returning again and again to write and re-write as my understanding developed. Among these texts were the Hakomi textbook, *Hakomi Mindfulness-Centered Somatic Psychotherapy* (Weiss et al., 2015); Ron Kurtz's latest work (2018); Janet Treasure's books and articles, and others. My ideas slowly evolved from a focus on skills and techniques, like working with parts, to a broader philosophical approach found in loving presence to an understanding of Hakomi as one part of a bigger whole. In contrast, I started off reading many resources covering many sources, then returned to specific literature, writing, discussing with my supervisor, and searching for more information where there were gaps in my understanding.

Searching and Gathering Data

Initially, I systematically searched online databases and reference lists for results containing the words "Hakomi" and "anorexia", and "Hakomi" and "eating disorders". The databases included Google Scholar, PEP, PsycInfo, PsycNet, Cochrane Library, Emcare (nursing), and Medline. These searches revealed nothing directly linking Hakomi and anorexia beyond my initial source (Moyer, 1986). I then searched just using the term "Hakomi" and collected references that referred to aspects of Hakomi such as loving presence. I also found a few resources that mentioned Hakomi amongst others as a treatment for EDs. Overall, I collected 35 articles of some relevance to treating anorexia that included "Hakomi", but none revealing the use of Hakomi directly with anorexia or EDs. Only a few of these were included in my research because often I found more in-depth information in the Hakomi textbook (Weiss et al., 2015).

It became apparent that I needed to expand my scope, so I re-read Moyer's (1986) article which declared mind-body holism and mindfulness as two Hakomi principles she found most significant when working with clients with EDs. She also

listed two techniques as especially helpful: working with the child, and taking over critical internal voices used to elicit a reaction in the client to mindfully study (Weiss et al., 2015). This added to the intention I had to search for references regarding mind-body approaches, mindfulness, and parts work. I wondered about the differences between body psychotherapies and reasoned I could look for similarities in their treatment approaches. As Totton (2003) suggested, body psychotherapies are similar because they include the body, but can be quite varied in their approach to treatment. Overall, I found “mindfulness-based” and “embodiment” therapies more closely aligned to Hakomi principles than most others. The closest to Hakomi, by far, was Sensorimotor Psychotherapy developed by Pat Ogden; however, I found only one reference of Sensorimotor Psychotherapy working with an ED and that was with BN, not anorexia (Ogden, 2015). Ogden’s recount of her treatment approach towards a client with BN sounded exactly like a Hakomi therapy session working with “parts”. I recognised there were probably other approaches that could be considered but I needed to limit my review to key aspects. Additionally, my focus began to shift from treatment approaches towards broader themes such as characteristics of Hakomi that matched desired AN treatment approaches and, on another level, towards attitudes and perceptions I found in the research.

I expanded my searches to include the search terms: therapeutic presence, loving presence, trauma and anorexia, trauma and body psychotherapy, anorexia and treatment or intervention, eating disorder treatment or intervention, developmental trauma and anorexia, and relational trauma and anorexia as well as others. I added meta-analysis or review to the searches. As I found research, I further expanded my field by using the “cited by” option in the search engine and the reference section of these references to locate further research. Eventually, I reached a sense of “saturation”, as Boell and Cecez-Kecmanovic (2010) advised, where I noticed I no longer had the desire to search new sources but instead focussed more time on

writing, digesting, and re-reading. I continued within the hermeneutic circle; however, it was heavily weighted towards writing over researching.

Inclusion and Exclusion Criteria

This was a relatively small literature review, which limited the depth and breadth I could cover. I selected mostly reviews and more recent research which limits the scope of literature. As a priority, I looked for information that specifically addressed any form of anorexia. If the research referred to a more general presentation of EDs, then I describe it in my writing as such. Initially, the origin of a source was a secondary consideration. I read anything and everything that seemed relevant. After skim-reading and gathering around 200 references, I began to select the references to include in my writing. If some were similar, I would choose based on the credibility of the author or my familiarity with the respectability of the journal, if it was more recently published, or if it was cited more often—considering, of course, the year it was published.

The references I selected were those that told part of what I had noticed and wanted to convey. In my writing, I tended to write more extensively about a resource that seemed significant—perhaps it had been cited more frequently, was recently published, or reflected a point I was wanting to make. The literature sources were mostly from professional journals; however, I often found more relevant information in scholarly books in the field and, at times, I pulled information from websites. Often, I found I was looking to understanding the attitude and approach the author had towards anorexia or ED presentations in general, towards the client or towards the therapeutic process. Often my critique of the research was not as much about the research process being presented or the outcomes, but more about what the research revealed in the bigger picture such as clinical views and biases.

Tracking Data

To keep order, I needed a way to collate my findings. This evolved over time. To begin, I created folders that included the various topics: AN causes, AN clients, BOP, mindfulness, new therapies, trauma, trauma and AN, call for change, ED

information, Hakomi, therapy for clinician, therapeutic presence, client's views, and others. After colour-coding when I highlighted the documents for quick reference of relevant themes, I added the main topic to the title and filed the document to a correspondingly titled folder. I utilised the reference management tool, EndNote, ranking each article with the five-star rating method for later review.

Overall, I skimmed and collected over 200 relevant research articles and books. Around 50 references were trauma related and about 20 (besides references from Hakomi text books) referred to Hakomi in relation to my research. I realise that normally a hermeneutic literature review limits the amount of literature to a significantly smaller number in order to immerse in the reading and re-reading of the hermeneutic cycle; however, I found myself with extra time during the pandemic lockdowns. I still returned to certain references time and time again, and I found I also experienced the hermeneutic circle by returning to topics, rather than just certain references.

How the Data Were Analysed and Synthesised: The Hermeneutic Cycle

Smythe and Spence (2012) argued that the main reason for hermeneutic research is that it provides context and instigates thinking, from which new insights emerge. Part of my hermeneutic process involved discussions with my supervisors. Through these discussions, I was able to refine and make sense of a broad range of topics, and develop my understanding, and make sense of my prejudices. At times, I would meet weekly with my supervisor to discuss my latest findings and the sense I made of them. At times I felt quite excited, indignantly feeling the perspective of the client or incredulous at what I perceived as lack of awareness or lack of openness to new ideas.

As I read more and more positivist research in peer-reviewed literature, I noticed that I began to take on the values of the positivist paradigm. I wanted to search out all the evidence to come to a decisive, convincing conclusion on whether Hakomi is a useful treatment for anorexia. I noticed I had a desire to provide the answer and convince. Once I became aware of my focus, from re-reading articles on the

hermeneutic intention to stimulate thinking, my awareness expanded, and I was able to make a broader connection: Hakomi contributes to the whole but is only a part of it. I realised the need for a balance between both holistic and reductionistic approaches since each contributes in their own way, and if out of balance may lead to omissions.

Strengths and Limitations of the Hermeneutic Literature Review

In addition to what I described earlier, I would like to emphasise that people cannot consciously or unconsciously exclude their history (Gadamer & Lawrence, 1982); therefore, hermeneutics fits well with a psychotherapeutic point of view which recognises the influence of the past on our unconscious. Gadamerian hermeneutic philosophy maintains that research not only attempts to reconstruct the original meaning of the texts, but fresh insights are generated when the researcher deliberately includes the effect of their own prejudices and subjectivity (Boell & Cecez-Kecmanovic, 2014). A hermeneutic literature review acknowledges that insights may be found in unlikely places (Smythe & Spence, 2012) and allows for flexibility while researching.

A limitation to a hermeneutic literature review is its subjectivity. Because interpretation and understanding are inherent to the process, a different researcher would choose different research directions to take and place emphasis in different areas. Since this research is not empirical, the research process is not easily reproduceable or verifiable. Furthermore, the research breadth is limited because the researcher is limited by the number of resources they can consider in depth. The literature needs to be limited to be able to view and review the contents, building on what is learned. Additionally, a hermeneutic literature review does not provide for both a quantitative and qualitative exploration of the research. Empirical research provides quantitative results that can be compared and analysed and which can be useful.

Summary

This chapter followed my process of choosing the method and methodology, described hermeneutics, and explored my pre-understandings. It considered issues of ethics and described my literature review process, and finished by considering the

strengths and limitations of the hermeneutic literature review. The next three chapters delve into the literature review findings, beginning with the next chapter which looks at the need for novel treatment approaches and connections between trauma and anorexia.

Chapter 3 – Considering Perspectives

This chapter begins by revealing the call is out in research for novel psychotherapeutic approaches to anorexia treatment since current standard treatments have only moderate outcomes. In this chapter, I consider literature suggesting reasons clients with AN are difficult for including in randomised controlled trials (RCTs) and look at the literature regarding current standard specialist treatments being used for AN treatment. I then turn to literature that reveals suggested new treatments are not significantly different from existing treatment approaches and consider possible reasons for that. Next, I turn toward an editorial calling for experiments and consider its possible effect on clients before utilising it to contrast with a Hakomi approach. Further exploration of examples of clinical attitudes revealed in the literature are explored, considering what causes clinical blind spots, such as exhibiting certain character strategies, or their own mind-body split. I then contemplate literature revealing a living systems perspective and how its four quadrants help explain the need for mind-body integration.

The Call for Novel Approaches

To get a sense of recent research direction regarding treatments offered to sufferers of anorexia, I examined three consecutive yearly review articles (Murray, 2019, 2020; Nagata & Murray, 2021) that summarised the studies published in *Eating Disorders: The Journal of Treatment & Prevention*. In all three reviews, there is a focus on more of the same types of treatments with no mention of trauma and only one mention of what it refers to as a mind-body therapy–yoga–which it suggests may promote positive embodiment (Borden & Cook-Cottone, 2020; Nagata & Murray, 2021). Murray (2020) claimed an “urgent need for improved treatment options for those with eating disorders cannot be overstated” (p. 6). He then advised further research is needed for “optimisation” of existing treatments (Murray, 2019) and to “enhance”

current treatments (Murray, 2020); he called for research to define the “mechanisms” (causes) that are contributing to ongoing AN symptoms and treatment failures, and for research to find the “active mechanisms” that are working in current treatments in order to enhance them (Murray, 2019).

Attempting to find the “active mechanisms” to enhance the treatments that are currently working does not consider that perhaps they have been maximised and other areas need to be enhanced. Murray (2019) revealed research that suggests it was the “acceptance”, from Acceptance and Commitment Therapy (ACT), which was associated with overall slightly greater outcomes in EDs. Furthermore, studies published in the following year (Nagata & Murry, 2021) suggested DBT showed increased effectiveness for weight gain, again citing the importance of “acceptance” in both DBT and yoga research that year. It is worth noting here that acceptance is a main focus in the Hakomi method of therapy (Daye, 2015b) and yoga philosophy is part of one of the three foundations of Hakomi (Kurtz, 1985). When considering acceptance, the question arises regarding what is being accepted: acceptance of distressing affect, acceptance of self, acceptance of behaviours? In Murray (2019), with ACT they refer to allowing “aversive affective states” to be felt rather than employing strategies—such as not eating—to not feel them. Nagata and Murray (2021) referred to yoga improving self-acceptance, and DBT accepting the reality of one’s circumstances. In Hakomi, it is a way of acknowledging what is there, without trying to change it in that moment, which involves acceptance of emotional states, self, and situations.

Murray then sounded the alarm in a systematic review and meta-analysis of RCTs from 1980 to 2017 (Murray, Quintana, et al., 2018) which concluded "specialised treatments”[6] did not work better in achieving weight and psychological symptoms than the standard treatment to which they were compared. An immediate critique of the Murray, Quintana, et al. (2018) review was supplied by Lock et al. (2019) who pointed

[6] Out of 35 studies, the ‘specialised treatments’ were 21 psychosocial treatments (family, individual—CBT, and group treatments), 11 pharmacological, 2 medical, and 1 alternative–acupuncture.

out inconsistencies in the review where the “specialised treatments” were quite different from each other, with some being in the “specialised” group in one trial, and in the “comparator” group in another. All the “specialised treatments” chosen for RCT research did not show significant improvement.

Murray et al. (2019) responded to Lock et al.’s (2019) critique. They explained that the Murray, Quintana, et al. (2018) review was looking at treatment studies *in general* and not at the particular interventions since they were arguing that weight- and psychological-based outcomes should be measured separately in research and pointed out that intended follow up in research with AN often does not happen. They also suggested RCTs were not effective in AN research and referred to an editorial by Halmi (2008) that summarised the challenges of conducting randomized, double-blind, placebo-controlled treatment trials in anorexia, which then restricts the “evidence-based” treatment options.

Problems With Randomised Controlled Trials with Anorexia

Wanting to understand why there is little research on some treatment types, I looked at what literature presented in terms of problems when conducting research on the AN population. Conducting evidence-based research on the anorexia population is challenging because ethical problems are high in a population with low prevalence and high morbidity. Randomising the severely ill to a trial using an unproven treatment may be considered unethical (Beumont et al., 2004). Additionally, clients experiencing AN are ambivalent to engage in treatment and have high drop-out rates (Zeeck et al., 2018). However, Zeeck et al. (2018) revealed the treatments to which clients are ambivalent are those that focus on weight increase, eating behaviour changes, and addressing the client’s psychological problems.

Halmi (2008) provided an example of a typical RCT involving drug treatment in a hospital day programme where 45% of eligible adult clients refused the hospital day treatment; and, of those who agreed, 55% declined the drug treatment that would increase weight. After random assignment, 18% dropped out of the study, which Halmi

stated was an unusually low amount probably due to the short treatment period. Any results from the study would only apply to a minority of the AN population—those who agree to accept both drug and hospital day treatments. Because dropout rates for RCTs for adult psychological treatments are high—averaging around 40%—and because of the difficulty in recruitment, “it does not seem logical to recommend more multisite randomized, placebo-controlled trials for this population. The result would only be the study of a larger number of a biased sample” (Halmi, 2008, p. 1227).

The attitude of the psychiatrist may reflect an example of attitudes held in the field and provides perspective regarding RCT research. Halmi (2008), a professor of psychiatry and, therefore, trained in the medical model, reveals a sense of resignation by suggesting that the prevention of chronic AN should focus on early diagnosis, which has better rates of recovery, and treating the underage population where the parents can enforce compliance. Halmi then turned to a hopeful new drug, asking: “How can we motivate seriously ill anorexia nervosa patients to voluntarily take this medication?” (p. 1228) and cites evidence that psychological treatment enhances drug compliance. This presents as an authoritarian attitude with a coercive approach and lack of consideration for the client’s desires. Hakomi therapist, Johanson (2015b), suggested therapists may be tempted to use subtle or overt force “for the client’s own good”, often because they are unaware of other options Without other ideas, Halmi concluded: “It is unlikely that predictably effective treatment for anorexia nervosa will be available until we decipher the reinforcing neurobiological mechanisms sustaining the disorder” (p. 1228).

Current Standard Specialist Treatments for Anorexia

There were three evidence-based psychological treatments for treating adults with anorexia that came up often in research for anorexia treatment: Specialist Supportive Clinical Management (SSCM), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), and Cognitive Behavioural Therapy (CBT). The current recommendations on the website of the New Zealand Ministry of Health (2021) refers

the reader to the treatment recommendations of the UK. The UK National Institute for Health and Care Excellence guidelines (NICE, 2020) recommend SSCM, MANTRA, and CBT; while the UK National Health Service (2021) website adds focal psychodynamic psychotherapy (FPT) to these three.

Recent research results (Atwood & Friedman, 2020; Galmiche et al., 2019; Jansingh et al., 2020) revealed the standard psychological treatment options—SSCM, MANTRA, CBT—for treating adult AN do not vary statistically from each other or from standard care. This supported results of earlier research by Byrne et al. (2017) where a RCT of MANTRA, CBT-e[7], and SSCM in outpatient treatment showed no differences between the three therapies in the primary outcomes of body mass index (BMI) and psychopathology. While all treatments showed clinically significant improvements, there were no differences between these treatments in achieving a healthy weight (mean=50%) or remission (mean=28.3%) at a 12-month follow-up[8]. The researchers concluded that while this adds evidence for these treatments, it highlights the need for improvement of treatments for anorexia.

One often-cited review (Zeeck et al., 2018) looked at all RCTs conducted in the previous 30 years and found the difference between the therapies used in research lacked observable differences when evaluating weight increase. The authors found they could not evaluate anything other than weight because there were no other outcome measurements between the trials that were consistent enough that they could compare. They suggested the similarities in outcomes may be explained because

> all specialised treatments address two important problem areas: They focus on weight and eating behaviour as well as psychological problems (e.g., pathology of the self, affect[9] regulation, dysfunctional cognitions, interpersonal difficulties). (Zeeck et al., 2018, p. 9)

[7] Enhanced CBT (CBT-e) is designed for EDs and attempts to address the maintaining factors (Atwood & Friedman, 2020).
[8] This research included 120 participants diagnosed with AN attending 25-40 sessions over 10-months; 60% completed the initial therapy with 52.5% at the 12-month follow up.
[9] Affect regulation refers to the attempt to alter one's emotional state.

Here, Zeeck et al. (2018) are suggesting these approaches have a similar focus: addressing behaviour and symptoms. Hakomi could offer a different approach: acceptance. “In fact, the new ‘acceptance therapies’ recognise what the Buddhists have known all along, namely, that resisting experience tends to exacerbate symptoms” (Daye, 2015a, p. 125). Daye (2015a) suggested that the medical model looks for “salves to heal the wounds” (p. 125) rather than acceptance of the experience. “Suffering is in the reaction, not inherent in the raw experience itself” (Fulton & Siegel, 2005; as cited in Daye, 2015a, p. 125).

Suggested Novel Therapy Approaches Seem Similar

While calling for novel approaches, the solutions offered reflect a similar focus as the current approaches. A recent review of RCTs for AN treatment (Solmi et al., 2021)—which includes Treasure as co-author—concluded, once again, there was no difference in treatment outcomes between current standard specialist treatments for AN (CBT, MANTRA, or psychodynamic-oriented therapies), and that novel treatments are needed. However, in the same year, Treasure et al. (2021) made treatment recommendations to a European project considering treatment programmes, which continue to send the treatment focus in the same direction. Under the heading, New Treatments, they offer that the current specialised treatment skills have been “manualised and digitised” to be delivered online with support. Treasure et al. then recommended adding social supports to address an AN client’s tendency towards isolation (Treasure & Schmidt, 2013), and suggested treatments that sound like more cognitive and behavioural approaches: “virtual reality to target food or body image fears and training approaches to improve food and social approach behaviours” (Treasure et al., 2021, p. 311). As new treatment approaches, Treasure et al. (2015) recommended a sequence of exposure therapy, cognitive approaches, drugs, brain stimulation, and inhibition training for the severe and enduring form of anorexia.

I was surprised to find another example of looking for something different within the same approach, then completely missing the role of mindfulness and the body in

treatment. Wesselius et al. (2020) provided extensive evidence connecting trauma and a severe and enduring form of anorexia (SE-AN), frequently citing Bessel Van der Kolk (2014)—a trauma specialist who wrote a book on the role of the body in trauma. Wesselius et al. acknowledged Van der Kolk's suggestion that trauma responses from the past may interfere with the effectiveness of CBT, so the solution they offer is Past Reality Integration (PRI), which combines the principles of CBT and psychodynamic treatments, because "the efficacy of [both] is scientifically substantiated" (p. 9). The difference they see in PRI is, the "[w]ork is being done on cognitions and behavior in the present, but with a link to its origins" (Wesselius et al., 2020, p. 10). They then cite, as if an afterthought, Van der Kolk's suggestion of the inclusion of "body-oriented methods such as yoga, mindfulness, theatre, and focusing…which have proven effective" (Wesselius et al., 2020, p. 9). It seems they are not wanting to stray far from evidence-based approaches, which keeps them looking in the same place. It is worth noting here that I have some experience with focusing and it seemed like a subset of a Hakomi approach. Röhricht (2009) depicted this pictorially amongst other body psychotherapies by placing focusing much smaller and to the side of Hakomi.

The Call for Experiments

Twenty international researchers co-signed an editorial—*Time to make a change: A call for more experimental research on key mechanisms in anorexia nervosa*—calling for researchers to collaborate on an experimental approach towards research objectives for AN (Glashouwer et al., 2020). Among the signatories was Janet Treasure who is familiar to me since she contributed to books I read that I found at the ED clinic (Schmidt et al., 2018; Treasure, 1997; Treasure et al., 2007). Treasure is a British psychiatrist who has spent over 30 years in the research and treatment of EDs and seemed to me to describe in her books a clear understanding of AN mechanisms—those aspects that keep it going.

The Glashouwer et al. (2020) editorial starts by suggesting that there are plenty of theories on the neurobiological, psychological, and sociocultural factors that maintain

AN; however, little experimental research has been undertaken testing the theories. Glashouwer et al. stated they wish to find a "clear determination of causality" (p. 361) through the "systematic manipulation of potential key factors" (p. 361). They sound desperate and determined with a clear idea on how they want to proceed:

> The need for theory firmly grounded in empirical evidence becomes strikingly clear when we consider that current treatments for patients with AN are limited in their effectiveness, and relapse after treatment is common… More knowledge about which causal mechanisms are involved in maintaining AN and which factors are crucial targets in the journey towards clinical improvement can help to develop more effective treatments for AN. (Glashouwer et al., 2020, p. 361)

They believe "novel" treatments to reduce symptoms will be clear once the connection between the trigger and symptom is known, and that knowledge requires a series of experiments where independent variables are isolated and manipulated. They provide guidance to researchers through directions describing the experimental process and offering research questions and steps such as: "Which key mechanism is the target of the study and which specific hypothesis is tested? [and] Which manipulation is used to target the mechanism, and is this manipulation strong enough?" (Glashouwer et al., 2020, p. 363). They suggest a hypothesis might wish to determine how something like a negative mood *exactly* affects a "specific core symptom" of AN, suggesting a researcher might induce a negative mood such as sadness through videos or music and study its effect against a control group where a neutral or happy induction was used. Once the causal mechanism is known, then its impact on AN symptoms can be investigated and, "Finally, this empirically based understanding of the mechanism in action can inspire novel ideas on how to tackle the mechanism in order to reduce symptoms" (Glashouwer et al., 2020, p. 362).

While this is not a treatment approach, it reveals an attitude of lack of consideration for the client since there does not seem to be any thought put towards the client's experience of this type of experiment. The experiment would probably be conducted at a treatment facility in a situation where the researcher will be neglecting to honour the client's needs in that moment to attend to their own needs around

conducting the experiment. It might be exposing the client to an experience that potentially could be subtly damaging—possibly even re-traumatising—since having their needs unmet could be a familiar experience and part of their aetiology. Furthermore, the experience could be the opposite of providing a much-needed attuned experience with another, which has been identified is needed by clients experiencing AN (Kotilahti et al., 2020; Lester, 2019; Oyer et al., 2016; Pellegrini et al., 2021). The client might perceive that they are not in control, because the researcher is *doing something to* them. Literature suggests that feeling out of control is detrimental to clients experiencing AN and is why they try so hard to maintain control (Pellegrini et al., 2021; Wesselius et al., 2020).

In contrast, the experimental attitude is a big part of Hakomi, but Hakomi has a holistic approach. Imagine the difference if the researcher, rather than being emotionally distant and objective, added loving presence—which includes the principles of mindfulness, nonviolent leading and following, trusting the process, and mind-body holism. The intention would change from the therapist following their own agenda, to joint cooperation that creates opportunities for the client to study their experience. A "[t]ailored flexible treatment solution, focused on therapeutic alliance[10] [is] urgently needed" (Kotilahti et al., 2020, p. 12999).

Clients experiencing anorexia have organised themselves to deny their needs. In Hakomi, gratification or, more precisely, how clients are unable to be gratified, is seen in terms of what the client has organised out of their experience; what might be missing experiences they have yet to integrate (Johanson, 2015b). What is disconnected so that they are not able to do or take in what is realistically possible (Lavie, 2015)? To be organically self-organising and self-correcting, all the parts must be incorporated and connected within the whole (Johanson, 2015b). The Hakomi therapist provides the missing experience to study how the client defends against it.

[10] The therapeutic alliance is the therapeutic relationship between a healthcare professional and the client, implying they are aligned in aspects of the therapy.

Thus begins the process of integration of the missing experience. While this interpretation is not the meaning the authors intended, it might help explain why relying only on reductionistic models provide limited help in understanding something complex such as anorexia. Reductionistic models are not really effective for understanding self-healing living systems—such as humans, mammals and other species—which are complex and unpredictable (Johanson, 2015b).

Clinical Attitudes

With an understanding of the subtleties of a nonviolent Hakomi approach, one can better recognise attitudes that do not respect the client's perspective. Two examples are revealed when Treasure et al. (2021) added "virtual reality to target food or body image fears and training approaches to improve food and social approach behaviours" (p. 311), and when Treasure et al. (2015) recognised typical AN symptoms—such as the need for control—as attempts at emotional regulation, however, then they labelled them habits to break:

> [F]eelings of control and adherence to rules and channelling negative emotions and lack of connection to others into food as a form of emotional regulation… These behaviours, repeated over time, become ingrained habits… Interventions to break these unhelpful habits might be of benefit in AN (p. 458).

Trainings, targets, interventions, breaking habits—these have the feel of those with authority *doing something to* the client or *trying to get the client to do* something which indicates an authoritarian perspective of the medical model. This contrasts to a Hakomi approach that allows room for the inherent wisdom of the client:

> [The medical model] viewed strategic adaptations to developmental wounding (in Hakomi called "character strategies") as signs of pathology—as unhealthy, neurotic disorders that required the diagnosis and intervention of an authoritative healer to remedy (Dychtwald, 1987). Hakomi takes a *gentler and more systemic view* [emphasis added]. We see character not as a pathological digression, but as a creative attempt to assert one's organicity—*to find personal empowerment in an untenable situation* [emphasis added]. (Eisman, 2015, p. 77)

While I can imagine this authoritarian model being used within a parent–child relationship where the parent is being coached to behave differently than they previously did—re-parenting; it still seems an unnecessary choice when options that

empower the client are available. In contrast, Hakomi has a different feel; the therapist holds the “maps”, but the client determines which path is necessary; the therapist guides with curiosity in an explorative way while the client is the expert on themselves (Murphy, 2015). In such a setting, the client can maintain their sense of control while experiencing an attuned relational dynamic. Griffiths et al. (2018) found the fear of losing control and the fear of change were the main barriers in clients with EDs to treatment uptake.

Furthermore, clinicians need to be aware of the common attitudes, patterns, and relational dynamics—transference and countertransference—that tend to get stimulated when working with clients with EDs:

> Collusion with the symbiotic wish, denial, overemphasis on doing and fixing, or being pulled into protocol-like psychotherapy in which we deal with an eating disorder and not a client, are all possible transferential traps for Body Psychotherapists working with eating-disordered clients. (Dmochowski et al., 2013, p. 729)

The above quote is from a book on body psychotherapy; however, this is relevant to any psychotherapy. The quote mentions transference, which refers to historical relational patterns that everyone has, and the countertransference that develops when they interact with others’ historical relational patterns; it is something psychodynamic psychotherapists are trained to notice. In Hakomi, they are called “systems” which “involve patterns of perceiving, feeling, behaving, and interacting that reinforce each other in circular ways” (Fisher, 2015, p. 243). The quote suggests the client with AN will stimulate a doing and fixing attitude in others which directs the focus away from themselves and the relational aspect while focusing on achieving the protocols of the therapy. If the other person also has a tendency towards doing, fixing, and achieving, they both could get stuck in a system which naturally reinforces and perpetuates the relational dynamics of the client and does not allow for change or healing.

In her book *Famished*, Rebecca Lester (2019) provides insights reached as a researcher at an American live-in ED facility, revealing how the interactions with clinicians are key to recovery for clients experiencing AN. One example exposes the

lack of deeper understanding or empathy found in a CBT approach. When a client relapsed, returning to the clinic, the client apologised to Rebecca, telling Rebecca she really wanted to get better, then wept. Rebecca sat with the client and held her hand. Later, a nurse expressed contempt for Rebecca validating what the nurse viewed as manipulative behaviour. The nurse, who comes from a CBT viewpoint, saw this as the client's attempt to get someone to feel sorry for her. "You can't validate that. That is exactly what she wants… [Rebecca wonders:] Does 'care' come to mean the explicit withholding of a response to suffering?" (Lester, 2019, p. 278).

What Keeps People From Recognising Something Different?

I wondered what might contribute to change towards attitudes regarding body-inclusive psychotherapy and wondered about biases. Eisman (2015) pointed out that the commonly used American Psychiatry Association's *Diagnostic and Statistical Manual* (DSM) does not have a term for what Hakomi characterised as Industrious/Overfocussed in which unrelenting doing and achieving are ways of adapting to developmental wounding. This character strategy shows up often with high achievers (Eisman, 2015). Additionally, "a client whose character style takes refuge in lots of thinking and theorizing may…continually return to the [safety of] familiar intellectual territory" rather than dwell in the body (Gale, 2015, p. 240). Could high achievers in roles that make decisions, who themselves have a mind-body split, contribute to the perpetuation of a mind-body split and the inability to see the usefulness of body-inclusive psychotherapies?

Considering another perspective, when people think they are smart or well-read or well-educated, they might think it if was worth knowing, they—or their peers—would know about it. Like the old Chinese saying, "Empty your cup", referring to a Zen master overfilling a student's teacup to illustrate the humility needed to learn (O'Brien, 2020). If one thinks they know, they have no room to learn. ‘'When they think that they know the answers, people are difficult to guide. When they know that they don't know, people find their own way' –Lao Tzu" (Johanson et al., 1991).

Living Systems Perspective

When Ron Kurtz was developing the Hakomi method, he was influenced heavily by systems theory which built upon the idea of interrelated, independent parts within a whole (Johanson, 2015b). Aspects of a holon—something that is simultaneously whole and a part, like a cell in your body—are inseparably intertwined. In systems theory[11], a living system has parts that are connected and communicating throughout the whole. In the 1970s, while other therapies, like Freudian, Jungian, behavioural, humanistic approaches were disputing their differences, rather than learning from each other, systems theory insightfully viewed the different theories as holistic. They all address the internal and external parts of the individual and the internal and external aspects of communities, family, culture, world, and environment (Johanson, 2015b).

Having examples might help to better understand this concept: Imagine four quadrants. Sigmond Freud, C.G. Jung, Jean Piaget, and Gautama Buddha fit in the Interior-Individual quadrant. B.F. Skinner with his behaviourism, John Watson, empiricism, and neurology fit in the Exterior-Individual quadrant. Wilhelm Dilthey, Max Weber, and Hans-Georg Gadamer with his hermeneutics fit in the Interior-Collective quadrant. Finally, Systems Theory, Karl Marx, and Auguste Comte with his sociology, fit in the Exterior-Collective quadrant (Johanson, 2015b). This is important for my topic because it reveals what is missing in some treatment approaches and introduces the idea that Hakomi can provide a means of communication between the parts—internal and external; mind and body. In western society, there is “such an overemphasis on objective materialism that the richness of subjective experience and the hermeneutics… were underplayed, resulting in an impoverished account of what it means to be human” (Weiss & Johanson, 2015a, p. 334).

[11] In this research, I refer to it as living systems.

Summary

In this chapter, I explored the call for novel approaches to anorexia, then provided literature describing the difficulties in RCTs with clients with AN. Literature revealed the current treatments are only moderately effective; however, researchers seemed to continue looking for something different from similar approaches. I considered how the call for experiments reveals an inconsiderate attitude towards the client and examined reductionistic and authoritarian attitudes found in literature. Throughout, I inserted literature from a Hakomi approach for comparison. Further, I contemplated why body psychotherapies are overlooked as a possible treatment by looking at Hakomi character theories and Systems Theory. The next chapter considers the association between anorexia and trauma, and investigates therapies with similar aspects to Hakomi.

Chapter 4 – Treatment Approaches

This chapter begins by considering the various approaches to defining trauma, before considering literature exploring relationships between trauma and anorexia which reveals that trauma researchers are also calling for novel approaches to trauma treatment as well as universal trauma-informed care. It then briefly considers literature that considers possible contributions to the ubiquitous presentation of trauma. The chapter then shifts to considering treatments similar to Hakomi, beginning with body psychotherapies. Literature reveals the early inclusion of the body in psychotherapy. While there is a lack of research in scholarly databases regarding body psychotherapy, there is a wealth of information in books by practitioners. This chapter then consider research regarding other approaches that reflect a Hakomi approach including embodiment, mindfulness, and parts work.

Trauma and Anorexia Nervosa

Considering the relationship between trauma and anorexia leads into the area of aetiology, which is an extensive and controversial topic. Brewerton et al. (2019) provided a broad description of the aetiology of EDs and their comorbidities: “[T]he development of EDs, PTSD and related comorbidities is the collective result of multiple predisposing, precipitating, and perpetuating factors, including genetics, epigenetics, temperament, dose and timing of trauma, disclosure experiences, and social supports” (p. 336).

Defining Trauma

Before considering connections between anorexia and trauma, it is worth considering trauma definitions. This revealed itself as a bit controversial when considering the American Psychiatry Association’s limited definition when compared to that of the psychosocial field which includes complex trauma (D'Andrea et al., 2012; Ford & Courtois, 2020b; Ford et al., 2013; Ford et al., 2015; Ford et al., 2018; Landy et al., 2015; Pai et al., 2017). Renowned trauma specialist, Bessel van der Kolk, failed in his attempt to get a developmental trauma disorder diagnosis added to the DSM-5

(Ford et al., 2018). Instead, the 5th edition of the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), joined many trauma symptoms together into the diagnosis of Post Traumatic Stress Disorder, known as PTSD (Ford et al., 2018). The DSM-5 no longer allowed for the patient's subjective experience in its description of traumatic events required for diagnosis as the previous DSM IV did (Ford & Courtois, 2020b; Landy et al., 2015; Pai et al., 2017). Some suggest getting rid of the criterion of exposure to trauma, while others suggest a label "poststressor stress disorder" for a non-trauma event and "nonstressor stress disorder" for no identified event (Pai et al., 2017). In contrast, the World Health Organization (WHO) recently added complex PTSD as a diagnosis in the International Classification of Diseases (ICD-11) (Ford & Courtois, 2020b). To meet the diagnosis of Complex PTSD in the ICD-11 (WHO, 2019), all the requirement for PTSD following exposure to a horrific event need to have been met; then, the additional complex symptoms are:

> 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. (https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559)

It is worth noting that these additional complex symptoms also describe presentations of anorexia: shame, withdrawal and social isolation, and emotion regulation difficulties (Oldershaw et al., 2015; Skårderud, 2007).

The description of traumatising events listed in these two diagnostic manuals leave out the subjective experience of the one who had the experience. The ICD-11 lists genocide campaigns, slavery, and torture, as well as prolonged domestic violence and repeated childhood sexual or physical abuse. The DSM 5 links trauma to events involving "actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013, p. 271). These seem to be extreme experiences. With these as a reference, events that might feel traumatic and life-or-death for a child, or

even someone older, would not be considered significant enough and would be dismissed. While the manuals focus on the event, Ford et al. (2015) suggested that while experiencing a traumatic event was originally thought to cause PTSD, research has shown that is not sufficiently the cause; instead, there are risk factors that increase the chances of PTSD and are, therefore, either the cause or highly related to the cause.

In contrast to the DSM 5 and ICD-11, the Psychodynamic Diagnostic Manual (PDM) (Lingiardi & McWilliams, 2017) provides a thorough account of various trauma presentations and offers broader definitions of the trauma event. The PDM describes trauma within various contexts (for example, trauma and adolescence, trauma and dissociation, trauma and feeding and EDs), and divides the overarching category of trauma-related disorders and stressor-related disorders into three sub-categories: adjustment disorders (AD)—reactions to psychological stress that occur within three months and last no more than six months; acute and PTSDs (develops from AD); and complex PTSD—a history of chronic neglect, trauma, and abuse. Neglect is significant because it creates insecure attachment which makes trauma more likely (Lingiardi & McWilliams, 2017). Complex PTSD is also called “developmental trauma” because it, “compromises an individual’s identity, self-worth, and personality; emotional regulation and self-regulation; and ability to relate to others and engage in intimacy” (Lingiardi & McWilliams, 2017, p. 190). Again, these factors also describe AN (Duncan et al., 2015).

In the PDM (Lingiardi & McWilliams, 2017), the type of trauma event is further described by five types: 1) impersonal/accidental/disaster/shock trauma; 2) interpersonal trauma, also called “betrayal trauma” which is, “committed by other humans as a means of gratifying their own needs by exploiting those of another” (Lingiardi & McWilliams, 2017, p. 184); 3) identity trauma—victimisation because of individual characteristics; 4) community trauma—based on group identity; and lastly, 5) ongoing, layered, and cumulative trauma—based on re-victimisation and re-

traumatisation. The PDM connects some EDs to complex (also called developmental) trauma:

> Some eating disorders may arise from the spectrum of developmental trauma, beginning with conflictual family dynamics and proceeding through disordered attachment to more overt emotional and physical neglect, and to overt emotional, physical, and sexual abuse. Such severity generally accounts for the comorbidity that often complicates diagnosis and treatment. (Lingiardi & McWilliams, 2017, p. 213)

Complex Post Traumatic Stress Disorder and Eating Disorders

Ford and Courtois (2020b) provided extensive research supporting their use of the term complex trauma (C-PTSD) in their edited book, *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models.* They distinguish between "clinical and professional practice guidelines" (such as the DSM) and "best practices and consensus guidelines", such as their use of C-PTSD. Their definition of C-PTSD refers to experiences that a) involve repetitive or prolonged exposure to, or experience of, multiple traumatic stressors; b) involve harm or abandonment by caregivers or significant adults resulting in a sense of betrayal; and c) occur at developmentally vulnerable times in the individual's life, especially in childhood where it can impact the child's biopsychosocial development. They state: "Beginning as early as in utero or infancy/toddlerhood, exposure to complex traumatic stressors in childhood (especially with no preventative or therapeutic intervention or other relief or support) can lead to neurobiopsychosocial problems all along the lifespan" (Ford & Courtois, 2020b, p. 15), which increases especially during vulnerable developmental periods such as adolescence (Ford & Courtois, 2020a). AN is known to develop during adolescence or during transitions such as leaving home for university, or after an event trauma.

A comprehensive book on trauma entitled, *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models* (Ford & Courtois, 2020a) suggests the ED population share overlapping symptoms with complex PTSD and refer to EDs as comorbid issues of C-PTSD. They suggest: "Complex trauma

compromises attachment, security, self-integrity, and ultimately self-regulation" (Ford & Courtois, 2020a, p. 8). Attachment insecurity and poor self-concept was also found for those with EDs (Demidenko et al., 2010). Complex trauma develops from experiences that involve psychological and/or physical dominance, oppression, and intrusion, with a sense of inescapable injury—including emotional injury. Further symptoms include estrangement and withdrawal, severe mistrust, and dysregulated emotions and actions. Ford and Courtois (2020a) revealed depression, anxiety disorders, guilt, shame, anger, EDs, addiction, suicidality, psychosomatic and autoimmune illnesses, borderline personality disorders, and psychosis as reactions to complex stress and expressions of distress.

Research Linking Anorexia With Prenatal and Perinatal Trauma

Research has sought connections between EDs, especially AN, and prenatal and perinatal trauma for many years (Bakan et al., 1991; Cnattingius et al., 1999). Marzola et al., (2021) conducted a systematic review on the role of prenatal and perinatal factors in eating disorders which revealed individuals with AN were more likely to have had increased maternal age, multiparity, pregnancy complications, early birth, or small size for their gestational age. They state the data are suggestive of an association between early trauma and future AN but are not conclusive because they found methodological flaws in the research. Janet Treasure, along with Krug et al. (2013), conducted a systematic review of obstetric complications as risk factors for EDs and a meta-analysis of delivery method and prematurity. They determined that the findings were conflicting, and methodological limitations compromised ultimate conclusions. This conclusion was supported by Raevuori et al. (2014) who found the overall effect of prenatal and perinatal factors was small and operated in conjunction with other factors. Krug et al. (2013) confirmed, however, that mothers of clients with AN were more likely to have experienced high levels of anxiety during gestation. Two years later, St-Hilaire et al. (2015) followed mothers who experienced the same stressful environmental event and found those in their third trimester were more likely

to have a child develop disordered eating. St-Hilaire et al. proposed this suggests objective stress could be independent of any idiosyncrasies of the mother through genetic or environment pathways.

More recently, Larsen et al. (2021) conducted an extensive study in Denmark on the connection between future risk of EDs and prenatal and perinatal factors. They included data on all births from 1989-2010 and followed over one million individuals from age six for a 22-year period using data from national hospital registers that included birth statistics and ED diagnoses. They found risk for all EDs increased with increasing maternal and paternal ages. Additionally, risk for AN increased from premature delivery, with significant increased risk for those born under 33 weeks, slight risk for 33-36 weeks, and decreased risk for over 42 weeks. Other significant future risk factors for AN included genitourinary tract infection, low birth weights, multiple births, caesarean section, and congenital malformations of the mouth or digestive system. They also found most pregnancy complications were associated with increased depression and anxiety disorders in offspring. Larsen et al. (2021) concluded "pregnancy and early life are vulnerable developmental periods when exposures may influence offspring mental health, including eating disorder risk, later in life" (p. 870).

Evertz et al. (2021) provided extensive perspectives on the effect of pregnancy and birth on offspring and their parents in the 800-page edited book, *Handbook of Prenatal and Perinatal Psychology: Integrating Research and Practice*. They provide much broader concepts of traumatic events, including subtle stressors and trauma during prenatal and perinatal periods such as the doctor conducting an amniotomy or pushing the head of the birthing baby back into the mother to do an episiotomy so the mother will not tear (Emerson, 2021b). Within this book, Verny (2021) cited research that supports the findings that maternal stress during pregnancy produces lasting future undesirable change—including EDs—in offspring, with the cumulative effect being substantial, even when individual impactors seemed insignificant. It is interesting to consider how this understanding would affect how research is conducted since

individual factors might not reveal significant results, as Glashouwer et al. (2020) proposed with their research. To avoid future problems from prenatal and perinatal health disorders, attachment-guided birth culture is recommended which considers the experience of the foetus and infant during pregnancy and the birthing process (Hildebrandt, 2021). Additionally, even short psychotherapy is recommended for prospective parents since unresolved trauma from the parents' own births may be stimulated (von Kalckreuth, 2021).

Research Links Anorexia With Stress, Childhood Trauma and Childhood Maltreatment

Other studies recognised the role of early anxiety and trauma in future ED development. A systematic review and meta-analysis of childhood neglect in eating disorder populations found 53.3% of those with EDs had emotional neglect and 45.4% had physical neglect (Pignatelli et al., 2017). Treasure et al. (2015) found childhood anxiety preceded AN, as did shyness, social problems, and obsessive-compulsive personality traits. Additionally, those likely to develop EDs seem to be, "especially sensitive to the effects of stress/adversity and have high rates of premorbid anxiety disorders, personality traits, and … features that predispose them to PTSD and its symptoms" (Brewerton, 2019, p. 445). Larsen et al. (2021) provided a flow chart indicating early childhood trauma can set the stage for insecure attachment which predisposes people to EDs and future trauma. Moreover, clients with EDs who also had a trauma history manifested higher physical and psychological symptoms, with a more impaired clinical profile if they had both childhood and adult trauma exposure (Meneguzzo et al., 2021). Janet Treasure was one of the researchers who determined, "From conception onwards, individuals with EDs, on average, are more likely to have experienced greater adversity over their life course" (Chami et al., 2019, p. 1).

In an overview of trauma-informed care and practice for eating disorders, Brewerton (2019) lamented that, while substantial research provides evidence that people with EDs have very high rates of lifetime traumatic events and childhood

maltreatment, EDs are still not recognised as being associated with trauma. Monteleone et al. (2019) revealed childhood maltreatment as a risk factor for EDs by conducting a study where 94 people with AN completed questionnaires. They found all types of childhood maltreatment experiences connected with EDs, but more through emotional abuse than other types of childhood maltreatment. This was supported with additional studies (Monteleone, Cascino, et al., 2021; Monteleone, Tzischinsky, et al., 2021). Wesselius et al. (2020) provided extensive supporting research to argue that EDs are related to trauma. They advise the problems with current treatments for the more extreme and recurring type of anorexia (also called SE-AN) is that they cause a retraumatising effect from the coercion to eat and from others taking over control of client eating and other client behaviours.

In 2011, Reyes-Rodriquez et al. cited research that found the prevalence of PTSD along with an ED diagnosis ranged from 1-52% due to the broad classification of traumatic events: childhood sexual abuse, emotional abuse, accidents, and interpersonal loss and separation. They then conducted their own research by clinically assessing 753 women with AN and found that 39% reported one or more traumatic events in their lifetime, especially childhood sexual abuse, sexual abuse in adulthood, and death or illness of a family member or significant other. They presented a foetal programming hypothesis suggesting there is some vulnerability that may develop before birth that predisposes the child to develop PTSD and AN (Reyes-Rodríguez et al., 2011).

Trauma Treatments

Trauma research and anorexia research both recommend the same types of treatments, and both are searching for novel approaches (Hoge & Chard, 2018; Kotilahti et al., 2020). In their extensive book on trauma, Ford and Courtois (2020b) continue to recommend the evidence-supported individual trauma treatments—talk and exposure therapies (using CBT and psychodynamic psychotherapy)— while adding the body aspect with Eye Movement Desensitization and Reprocessing Therapy (EMDR).

Excitingly, they list as emerging psychotherapy models Sensorimotor psychotherapy, experiential approaches, and mindfulness approaches—all of which bode well for Hakomi. Ford and Courtois (2020b) also included complementary healing therapies such as yoga, acupuncture, energy psychology (tapping/acupoints), neurofeedback, and animal assisted interventions. Hoge and Chard (2018) declared funding in the last decade has disproportionately favoured trials of prolonged exposure therapy and cognitive processing therapy and they called for studies in areas that sound like something Hakomi might address:

> Novel pharmacological and psychotherapeutic approaches that target memory reconsolidation (sometimes referred to as "memory therapeutics") need to be moved toward the top of the priority list, including streamlined, body-centered, EMDR[12]-derived protocols and other approaches that incorporate imagery rescripting. (Hoge & Chard, 2018, p. 344)

The modalities Hoge and Chard offer as choices for body-centred memory processing are limited and specific. A big part of Hakomi is working in a mind-body, holistic way to process and integrate the felt sense that comes with memories (Gaskin & Cole, 2015).

Trauma researcher Pat Ogden (2020) suggested most approaches to trauma-related disorders focus mainly on the client's verbal narrative, emotional expression and meaning making; they lack the ability to address the "physiological and somatic alterations that perpetuate the symptoms of complex trauma" (p. 510). She suggested CBT can assist in addressing problem thoughts and beliefs and in addressing states of hyperarousal with relaxation skills, but it does not address somatic symptoms and fails to use physical interventions designed to recalibrate dysregulated physiology. When somatic symptoms are not addressed by explicit bodily attention, these physiological symptoms can "maintain and even exacerbate psychological symptoms despite otherwise adequate treatment" (Ogden, 2020, p. 510). For this reason, Ogden stressed a therapy with an awareness of body-based symptoms is necessary in trauma

[12] Eye Movement Desensitization and Reprocessing Therapy.

treatment. Could this be the answer that the editorial Glashouwer et al. (2020) are searching for when suggesting their reductionistic experimental approach?

The Call for Universal Trauma-Informed Care

The prevalence of trauma is high. The American Psychological Association's handbook of trauma psychology estimates 50-70% of the overall population and 60-100% of those struggling with mental health have a history of trauma (Classen & Clark, 2017). "[Trauma] is an inescapable, universal truth. It is everywhere" (Classen & Clark, 2017, p. 537). It is ubiquitous (Gerber & Gerber, 2019; Payne et al., 2015). Citing the common occurrence of trauma and the inability to be aware of the extent of trauma effects in a person, the call is out for all clinicians to become trauma informed (Brewerton, 2019; Classen & Clark, 2017; Racine et al., 2020), including dieticians (Dennett, 2021). This response needs to go beyond the use of questionnaires to check for trauma (Racine et al., 2020)."Trauma-informed care is not a specialized treatment; rather it is the foundation of basic competent care" (Classen & Clark, 2017, p. 537). Yet, still, when setting up trauma treatment centres, Dondanville et al. (2021) recommended focusing on evidence-based therapies: Cognitive Processing Therapy (CPT) and prolonged exposure. This is exactly what Van der Kolk (2014) suggested to *not* do for trauma; instead, he recommended body psychotherapy.

What is Contributing to the Trauma?

Over 20 years ago, Cnattingius et al. (1999) suggested research revealing perinatal factors were associated with risk factors for EDs that "may uncover the mechanism underlying the development of the disorder, even if only a fraction of cases of anorexia nervosa may be attributable to perinatal factors" (p.634). Emerson (2021a) estimated that the number of babies with birth trauma is so high that what was considered a traumatised length of new-born crying is now considered normal; he suggested that this is partly due to the increasing reliance on stress-inducing birth technology, the increase in cultural stress in developed countries, and unresolved parental and historical birth trauma. Evertz (2021) considered it through a broader

perspective by asking why humans have not reached an emotional maturity for "rational parental caring for the world and all its living beings?" (p. 785). He stated attachment and openness are mutually dependent so it would be easier for a child who has safely bonded to "create new knowledge and emancipatory ideas" (p. 785) than a child who was mostly fighting for its survival, emotionally and physically.

Trauma specialist Gabor Maté (2019) made a case that our culture sets us up to be attachment starved. Consider the 2020 pandemic and its effect on the collective trauma and the relational field between people with "the media storm that plays to our terror" (Taylor, 2020, p. 385). Ataria (2017) suggested that the traumatic origins of western civilisation are embedded in its community members and shape the structure of the culture. Additionally, Aposhyan (2004) suggested that the western culture is seriously disconnected from the body, nature, humanity, and spirit which is not inherent in every culture. In an interview about healing in 2000, a shaman from Burkina Faso was asked how her people dealt with chronic mental illness and, in essence, she replied:

> We don't have it. If there is a problem that emerges in childhood, we take care of it then. Whenever difficulties arise, we take care of them. Obviously, we have a different kind of dynamic in our culture. This fundamental sense of disconnection is no where more vivid than our disconnection with our own bodies. (Aposhyan, 2004, p. 52)

Much of the east has traditionally paid more attention to the "obvious correlations between social, mental, and physical conditions than is common in Western medicine" (Peseschkian, 2015, p. 892) and provided different ways of coping with conflict (Ataria, 2017). Jonathan Gustin (n.d.) suggested modern society offers no training practices that develop the ability to attune to one's "inner radio" in order to wake up, grow up, and show up, therefore it is left to chance.

Perhaps traumatised people do not make room for alternative perspectives, causing them to isolate those parts and not allow their integration. Yet, without integration—as Hakomi reveals—they are unable to take in what is available to them. If

people were less traumatised, would they be more likely to allow room for other wisdom? Instead, “[t]he human knowledge in thousands of years of wisdom traditions was spurned as premodern” (Johanson & Weiss, 2015, p. 334). Therefore, perhaps when considering prenatal and perinatal trauma, without negating their own perspective, others could learn from a Māori approach which seems to support the pregnant mother and delivery in a holistic way as more than just a medical procedure (Sharman, 2021).

Body Psychotherapy

Rediscovered

Pierre Janet is considered the first body psychotherapist, practicing psychotherapy before Sigmund Freud and for longer (Bühler & Heim, 2001). Freud was trained as a neurologist and was, initially, profoundly attentive to the body (Woodcock, 2022). However, when developing psychoanalysis, Freud chose not to focus on the body. Therefore, the developing psychodynamic psychotherapies left the body behind (Bühler & Heim, 2001). Some believe this was due to Freud wanting to distance himself from body psychotherapist Wilhelm Reich’s unconventional approaches and political slant (Young, 2006). Janet’s influence continued in body psychotherapy and has contributed to the body psychotherapies of today (Bühler & Heim, 2001).

Many of Janet’s concepts are being re-discovered, such as the importance of therapeutic presence, the importance of working with the body with traumatised patients, and the concepts of visceral consciousness and somatic resonance, which refer to being aware of and sensing the body and sensations in the body (Kurtz et al., 2018; Young, 2006). Young (2006) might be unintentionally providing the missing piece to the anorexia treatment puzzle in stating: “[P]sychotherapy, without reference to the body, is a somewhat lesser study, a specialization that (perhaps) misses out on something quite fundamental to human existence; a jigsaw with several quite significant sections missing” (p. 20).

Body Psychotherapies as a Treatment

Search results for body psychotherapies and anorexia or EDs mainly produced results that combined EDs amongst other categories of mental health disorders. The results that matched, however, were positive towards using body psychotherapies. For example, in a literature review, Frank Röhricht (2009) observed that BOP are especially relevant for disorders with body image aberration, to which he included AN, and also relevant for those with limited response to traditional talking therapies such as somatoform disorders, PTSD, AN and chronic schizophrenia. He suggested that with more research on the interface between neuroscience and psychotherapy, BOP could be one of the main psychotherapeutic modalities for these. Röhricht also cited a 2009 German study where each participant with AN received CBT, psychodynamic therapy, and BOP, with participants rating BOP as the most effective. Röhricht (2009) helpfully orients the various body psychotherapies, including Hakomi, into categories. Hakomi falls into the categories of “main mode of action” and “insight oriented” rather than the category “functionally oriented” for such things as relaxation and homeostasis. Another recommendation came from a psychiatrist practicing holistic integrative psychiatry: Wingate (2008) suggested EDs epitomise mind-body disorders and need many modalities of treatment including body-oriented and expressive therapies along with standard treatments for EDs.

Body Psychotherapy Research

Most scholarly database research search results for body psychotherapies referred to treatments that were more “functionally oriented”—for relaxation and homeostasis. A recent review and meta-analysis of RCTs on the effectiveness of body psychotherapy (Rosendahl et al., 2021) concluded it was significantly effective. Yet, when I looked into the review, there was only one research that sounded like body *psychotherapy*. The rest sounded like body-based interventions such as a brief body and movement intervention using boxing gloves, pillows, and other items to act out aggression for clients at an inpatient ED facility. This could have been similar to a

Hakomi experiment if it was studied mindfully for its wisdom—such as recognising entitlement to their needs in life and experiencing empowerment to get them met, which goes beyond catharsis (Johanson, 2015c; Monda & Eisman, 2015). A client does not need their eyes closed to mindfully study their experience. Additionally, since the treatment was manualised, the clinicians only had two days training for it from a certified dance therapist. The one research that sounded like body psychotherapy was shown effective for pain reduction. In another review Bloch-Atefi et al. (2014) focussed on body-centred, somatic, body-oriented, and mind-body therapy efficacy studies, which included many group-based treatments. They concluded BOP interventions are effective with different populations and settings. Again, while one sensorimotor group psychotherapy was the most like Hakomi, the rest only seemed similar because they included the body. Block-Atefi suggested more qualitative research is needed so body psychotherapies can be included among the main modalities. They suggested that RCTs may not best the best form of research for therapies so strongly dependent on the interpersonal relationship.

An extensive and comprehensive edited book on body psychotherapy, with 94 chapters and close to 1,000 pages, with a few Hakomi authors, has a chapter on EDs. In this chapter, Dmochowski et al. (2013) suggested addressing just behaviours perpetuate the mind-body split and that the common method used in CBT of keeping a food-log and talking about aspects of the disorder such as body image and cognitions can “be a trap in the intellectualization of the disorder” (p. 272). They cite references that the “relational self” acts as a bridge between the cognitive and somatic selves; therefore, addressing only one—the cognitive self—will not contribute to any sustainable improvement to the other. To assist recovery, they recommend helping the client develop bodily awareness—such as identifying satiety, dissociation cues and emotional needs, movement, self-regulation techniques that enhance relaxation, mindfulness, breathwork, and touch all within a “live and embodied therapeutic relationship” (Dmochowski et al., 2013, p. 727). Being able to recognise somatic

experience, link it to an affective state, and put that into words is important and needed for long-lasting change. They suggest that—unique to EDs—the body of the therapist and client become important components in the therapy with objectification, idealisation, devaluation, competition, fear, curiosity, or envy of either body coming into play. They suggest it is important that the therapist be able to relate well to their own body and body image.

Body Psychotherapy and Trauma

While little is found in scholarly journals, popular books on body psychotherapies often include trauma work, such as authors Bessel van der Kolk (2014; 1994), Peter Levine (1997), Pat Ogden (Ogden & Fisher, 2015), and Babette Rothschild (2000). These authors vary in their emphasis on acute trauma or relational trauma. Hakomi tends to have been developed for relational trauma and Ron Kurtz (2018) refers to Pat Ogden and Peter Levine for working with traumatic states where "an overwhelming state of fear takes over the body and mind" (p. 32). At the beginning of the book by Ogden, Minton, et al. (2006), both Bessel van der Kolk (renowned trauma specialist psychiatrist) and Daniel Siegel (child psychiatrist known for exploring interpersonal neurobiology) provide support for Ogden's therapy method—Sensorimotor psychotherapy. It seems that without research supporting their work, body psychotherapists resort to getting verification from those respected in their fields. As Beumont et al. (2004) noted in their clinical practice guidelines for AN in Australia and New Zealand, "'insufficient evidence' and 'no evidence' are not synonymous with 'evidence of ineffectiveness' and, in the absence of evidence, clinical consensus is legitimate" (p. 620).

Clients experiencing AN are renowned for their need for control and their resistance to treatment (Stockford et al., 2019). Trauma results from one's sense of control being compromised inducing a sense of powerlessness; if one felt in control, they would not have become traumatised (Rothschild, 2003). Hannon et al. (2017) supports previous research that AN provides identity and control for the AN client.

Certain principles of trauma treatment are becoming well-established, such as safety, choice, collaboration, empowerment, trustworthiness, and informed care (Classen & Clark, 2017). Out of Rothschild's 10[13] foundations for trauma safety, two stand out as especially tricky for those therapists treating clients with anorexia. Firstly, when considering the refusal to eat as a defence or coping strategy, it becomes awkward to implement the foundational suggestion: "Regard defences as resources. Never 'get rid of' coping strategies/defences; instead, create more choice" (Rothchild, 2003, p. 19). Rothschild suggested defence strategies are like old, *dependable friends* who get us through hard times which matches clients' descriptions of AN as their "best friend" or "the perfect solution" (Foye et al., 2019; Treasure et al., 2010). Trying to get rid of these defence strategies does not solve problems and can make them worse (Rothschild, 2003). Secondly, Rothschild (2003) offered: "Do not judge for noncompliance or for the failure of an intervention" (p. 21); when a medication fails, one looks for another. Thinking in terms of client "resistance" or "secondary gain" implies the client is impeding progress, either consciously or unconsciously (Rothschild, 2003) and affects the therapeutic alliance.

Embodiment

There is extensive literature on embodiment and anorexia and a few recent references are presented here. Fuchs (2021) suggested AN is an alienation of the self from the body. Embodiment, therefore, refers to a non-dualistic conception of the self which experiences the body, heart, mind, soul, and relationships as intertwined (Cook-Cottone, 2020). Cook-Cottone (2016) suggested an irony is present with EDs: the physicality and embodiment of ED symptoms means that while the client is trying to leave their body to avoid experiencing their true bodies, thoughts, and feelings, their

[13] The 10 foundations for trauma safety are: establish safety for the client outside and within therapy; develop therapeutic alliance; know how to stop hyperarousal when it gets out of control; identify and build client's internal and external resources; regard defences as resources; work to reduce pressure–do not use confrontation or provocative interventions; adapt therapy to the client not vice versa; have broad knowledge of theory–both the psychology and physiology of trauma and PTSD; do not judge for noncompliance; and, finally, put aside any technique to just talk with the client (Rothschild, 2003).

ED requires intense engagement with their bodies. When the client does not know what to do with intense emotions, AN helps turn down the intensity and numb them (Lester, 2019). Consequently, ED recovery requires clients to be able to be with and in their bodies in a healthy and effective way (Cook-Cottone, 2016). Moyer (1986) suggested Hakomi guides exploration of internal awareness, which is often a central issue with EDs.

Mindfulness

There are many references to the use of mindfulness in therapy. However, research on its use with EDs tends to be with BN rather than AN. In the edited book, *Eating Disorders and Mindfulness: Exploring Alternative Approaches to Treatment*, most of the research addresses BED. One empirical research study, however, suggested that while most research is on BED with mindfulness, they found no difference between the ED diagnosis (AN or BN) during a 10-week manualised group programme using mindfulness elements from DBT. The results found a significant reduction in avoidance of foods and the desire to be thin. In another study, mindful yoga was found to be helpful as well as mindful eating in the therapy session. One ED psychologist incorporating mindfulness shared it helps her feel more present and less reactive, with an expanded capacity to hold emotions that arise in session, and an ability to sit with rather than interpret therapeutic material. She revealed, “I feel a sense of optimism about the possibilities of each new moment. This is especially important in working with eating disorders, which can be prolonged or even fatal” (Boudette, 2013, p. 160). Additionally, she found it offered her new ways of self-care that extend beyond the therapy room.

Germer et al. (2013) suggested that mindfulness may be identified as a key element in the therapeutic relationship, treatment protocols, and to cultivate personal therapeutic qualities of well-being. It may even significantly bridge the gap between various psychological therapies as research reveals its usefulness and therapists start

integrating it into their practice for self-regulation, self-state awareness, and self-compassion.

Mindfulness tends to be applied more with client issues presenting in the neurotic range—meaning those who are aware of their own involvement in their issues and have a willingness to become introspective. Those with psychosis and personality disorders might need regular counselling in ordinary consciousness before they can look inside themselves (Johanson, 2006). For clients with anorexia, intrapsychic mindfulness, or even the invitation to physically relax, may trigger fears of losing control. In such instances, structure-building mindfulness is used instead of intrapsychic mindfulness (Günther, 2015; Johanson, 2006). This might look like asking the client to stamp their foot and notice the sensations. If the therapist can call the client's attention to what is occurring in the moment, it offers the client the awareness and self-control to interrupt automatic patterns and experience themselves in a new way (Siegel, 2007).

A question that often arises for psychotherapists once they understand the many benefits of mindfulness is: How do I integrate mindfulness into my daily practice of psychotherapy (Germer et al., 2013)? Hakomi uses mindfulness beyond the more traditional clinical application to cultivate an internal observer and includes uncovering the psychological structures of the person. Hakomi helps clients see "how they actually construct their realities by the ways in which they organize their experience" (Sparks, 2015, p. 59). Then the client becomes aware of what is automatic and habitual, and they can wake up from the trance of conditioning. Ron Kurtz revealed that in Hakomi the client only needs to be capable of 30 seconds of mindfulness (Kurtz et al., 2018).

Parts Work

In the book, *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models*, under emerging experiential therapies, Fisher (2020) highlighted research that supports parts work as an effective method for treating C-PTSD since it helps clients to notice their emotional state and symptoms as

communication from their “parts”, which decreases overwhelm and is helpful to disentangle the client from the part—such as an anorexic part—and externalise it to create distance and perspective. Fisher described its usefulness:

> [T]he use of parts language is used to help anorexic clients to shift from identifying with their eating-disordered behavior to being in relationship to the symptoms held by “Ed” (i.e., their eating disordered part), increasing their ability to perceive the eating disorder as “other. (p. 537)

Fischer revealed this parts model is based on theoretical research findings from attachment, neuroscience, relational psychotherapy, and somatic treatments. However, she recognised no formal effectiveness research has been done. One pilot-study found: “this approach may alleviate severe symptomology and high-risk behavior” (Fisher, 2020, p. 548).

In the foreword to the Hakomi textbook (Weiss et al., 2015), Richard Schwartz—who developed Internal Family Systems (IFS) for working psychotherapeutically with internal parts of the self, which all people have—reveals how he met Ron Kurtz and the Hakomi community. Schwartz recognised that Hakomi was helping clients access what he called the “exiled part” of the client. Schwartz described these exiled parts as the young, vulnerable, hurt parts that he was also helping to heal and Schwartz saw Hakomi “was trying to get to in a different way… [T[hrough experiencing the loving presence of the therapist or other group members, the part’s beliefs would be released” (Weiss et al., 2015, p. xi).

In Schwartz and Sweezy (2020), Swartz tells two significant stories on how he developed IFS from family therapy when working with clients. First, he shares how he thought that by changing the external environment of the client—the family—that would be enough for the client to change; however, he came to realise change also needed to take place in the client’s internalised family—those internalised parts that were at odds with each other. Second, Schwartz shares how he tried to push past the defending part by demanding an ED client with bulimia, who had been cutting herself, join him in expelling and squelching the harming part; however, this backfired, and that part got

even stronger. Schwartz realised: “What if, the more we lectured, drugged, and tried to banish or control parts like this one, the harder they would fight to protect our clients? (Schwartz & Sweezy, 2020, p. 14).

In my experience, some clinicians adopted the term, “wise mind” from DBT and would use this in contrast with the “anorexic” part, responding to a client by saying something like: “That is the anorexia talking; what would your wise mind say?” This technique may work initially to externalise the ED behaviour and create separation from it for the client; however, considering Schwarz’s explanation, it may also stimulate the part that thinks it is protecting the client through the protective action of making the client restrict their eating. This understanding might explain the high drop-out rate for those therapists who do not understand this process and push to make the client eat without considering the needs of that protective part.

In Schwartz and Sweezy (2020), Schwartz also described the speed of progress when working with parts. He thought that working with the attachment needs of each part would mean slow change over time with lots of corrective experiences and role modelling with the therapist. Instead, Schwartz found clients were separating themselves from their more extreme states (parts) to find their inner Self-state, which could observe those other states and seemed to know what each one needed. The client was able take care of the parts instead of the therapist. For it to work, the therapist needed to be coming from their own Self—that respectful and non-pathologising part, which sounds similar to Hakomi’s loving presence.

Hakomi does not have labels for the roles of various parts the way IFS does; however, it also considers all people have various ego states or subpersonalities (Perrin, 2015) similar to descriptions used by psychiatrist and scientist, Daniel Siegel (Siegel, 2007). Just as Schwartz (2013) described in his parts-work, Hakomi does more than help the client become aware of and separate from the Self-states, it helps transform them (Reeds, 2015).

Summary

Literature revealed that defining trauma reveals some difference between diagnostic medicalised versions and consensus in the psychosocial field. Much literature in research, especially those found in books, supports prenatal and perinatal trauma as well as maternal stress found as predictors of future EDs in offspring with the cumulative effect of predictors being substantial when individual impactors seemed insignificant. Other research found maternal childhood anxiety and emotional maltreatment as predictors of later EDs. Literature on suggested trauma treatments show the approaches are similar to AN treatments— talk and exposure therapies (using CBT and psychodynamic psychotherapy); and, like AN, trauma practitioners are calling for novel psychological approaches to treatment. Research reveals trauma is ubiquitous; therefore, universal trauma-informed care is recommended for all those struggling with their mental health. Literature is then explored to consider what is contributing to the ubiquitous presentation of trauma.

The chapter then turned to consider the literature on treatments that share aspects of Hakomi, such as body psychotherapies, mindfulness, embodiment, and parts work. Body psychotherapies are not new; in fact, theories from 130 years ago are being rediscovered. However, there is little research on body psychotherapies. Still, there was support from practitioners in the field confirming body psychotherapies as useful in the treatment of EDs, especially when considering trauma treatments. To explore Hakomi's possible contribution, this chapter considered aspects that Hakomi uses such as embodiment, mindfulness, and parts work to consider their use in the treatment of clients experiencing anorexia. The next chapter considers aspects of Hakomi that can contribute to anorexia treatment.

Chapter 5 – How Hakomi Can Contribute

This chapter looks at what has been found to support recovery from AN, and considers Hakomi qualities that support these factors. Literature reveals the importance of relationships when it provides recommendations regarding therapy approaches and important recommendations for clinicians engaging with clients experiencing AN. Next, the chapter considers how Hakomi might support the therapist and contribute to the treatment of clients with anorexia. The literature in this chapter emphasises the importance of the therapeutic relationship in Hakomi, which is called loving presence, and considers how this is developed in the therapist. The chapter reveals literature that found Hakomi gets faster results by slowing down and working with the body. The need for mind-body integration and reveals how Hakomi approaches integration of experience are explored and Hakomi's potential to work with Māori is examined. Finally, Hakomi's limitations and its current research environment are considered.

Research Reveals Important Factors in Anorexia Nervosa Treatment

Interpersonal Relationships Are Important

There are various recommendations and guidelines for approaches to treating clients experiencing AN, but interpersonal relationships with the client seem to emerge as significant in most. The recommendations for the *Australian and New Zealand Clinical Practice Guidelines for the Treatment of Anorexia Nervosa* came from Beumont et al. (2004) who conducted a systematic review of research and extensive consultations with scientists, clinicians, carers, and consumer groups. Their recommendations included a multi-dimensional approach, with weight restoration being essential in treatment; however, they suggested a lenient rather than punitive approach since it was more acceptable to clients and less likely to affect clients' self-esteem. They saw psychological support, an empathic therapeutic relationship, CBT, and other psychotherapies as likely to be helpful, along with medication and dietary advice.

Oyer et al. (2016) conducted a small but representative study which interviewed clients and clinicians. Their findings that confirmed much of previous research. The

main characteristic with any therapy is the therapeutic relationship, especially when working with anorexia (Oyer et al., 2016). Oyer et al. reconfirmed the client's desire for individualised treatment which meant acknowledging each client's individual difference beyond their shared AN similarities. Additionally, they confirmed clients found having therapists overly focussed on the physical aspects instead of the underlying issues was unhelpful.

Relational Factors and Internal Work of Therapist

The therapists interviewed by Oyer et al. (2016) highlighted the importance for therapists to work on their own personal struggles that come up, while both therapists and clients thought unhelpful factors included a therapist's lack of attunement to the client's needs and a therapist's judgemental, invalidating attitude. Therapist factors that they stated contributed to a helpful alliance included empathy, genuineness, respect, and unconditional positive regard; while aspects that negatively impacted the alliance included over-structuring therapy sessions, excessive use of interpretations, and inappropriate silence (Oyer et al., 2016). There were two new findings in this research: 1) therapists disclosing their lack of expertise about specific topics and showing vulnerability helped build trust in the relationship; and 2) including others, such as family members, in the treatment, even though the clients were adults, was desired by clients with AN. Hakomi seems to fit many of these descriptions with its focus on the individual's unique presentation, mindful attunement, and necessary personal reflection of the therapist.

Suggestions for Treatment Approaches

Further recommendations came from Stockford et al. (2019) who conducted a systematic review and meta-synthesis on women's recovery from AN. They found AN is a means of asserting control and, therefore, concluded treatments should not be threatening to the client's sense of control or provoke a sense of powerlessness. Additionally, they found common themes in the clients' descriptions of recovery such as addressing a fragmented sense of self; a point where insight and commitment to

recovery happens; and reclaiming the self through meaningful relationships, rebuilding identity, and self-acceptance. Hakomi addresses these exceptionally well with its mindfulness approach. In conclusion, Stockford et al. (2019) suggested the need to incorporate psychological components of self-identity into recovery programs: "Acceptance by others and the experience of acceptance of the self are essential factors that facilitates recovery" (p. 344). Their advice to clinicians sounds very much like recommending a Hakomi approach:

> Clinicians need to be trained to understand the strategic functions of AN, to understand and meet the emotional needs of patients, and utilize reflective practice to explore personal attitudes towards patients, to facilitate the therapeutic process. (Stockford et al., 2019, p. 363)

To reiterate, they consider the therapeutic relationship is key and factors that are important to facilitate therapeutic relationship include: the clinician understanding the reasons for the client's behaviours, the ability of the clinician to recognise and meet the client's emotional needs, and the clinician being able to reflect on their own attitudes towards the client. Critiques of current focus on weight gain suggests treatment approaches should "not reinforce the source of the wounds associated with the development of eating disorders in the first place (e.g., the excessive preoccupation with feeding and external body characteristics)" (Kwee & Launeanu, 2019, p. 344) or emphasise compliance demands of others regarding the client's body.

Clinical Culture

In the book *Famished,* Lester (2019) considers how the clinical culture could contribute to the maintenance of EDs. Lester reflects on recent affect[14] theories and suggested: "These theories… give us some critical tools for thinking about how eating disorders are (re)produced in and through interpersonal relationships, social arrangements, and institutional contexts, which fertilize them as affective strategies" (p. 71). She suggested cultural geographers and cultural theorists help to understand

[14] Affect refers to the thoughts, feelings, sensations, and behaviours that are given an emotional term as a label (Lester, 2019).

“affective atmospheres” which refer to the ways cities—or a clinic—generate and are generated by particular affective characteristics. “They “have a ‘feel’ to them that infuses people and practices within them [which enable the generation of] certain kinds of realities within them” (Lester, 2019, p. 72). Lester suggested assisting clients by helping them find what helps them generate and maintain their own experiences of affect within different affect atmospheres “within and through everyday practices (such as structured mealtimes or therapy groups)” (p. 72).

An Integrated Approach

Additionally, Brewerton (2019) stressed the importance of treating all mental health conditions—ED, PTSD, and comorbidities—simultaneously rather than sequentially, since they are all interrelated. He further emphasised the need for these to be addressed ideally by the same clinician and facility where possible, which recognises the importance of the relational aspect of healing an ED. This integrated approach was further supported by Pellegrini et al. (2021) who suggested a multiple access model to psychotherapy that considers the complexity of ED in terms of dysregulation, body image distortion, and post-traumatic symptoms to help develop a sense of self.

Therapist’s Presence in Hakomi

The therapist’s presence in Hakomi is called loving presence. Some describe it as including “sacred love” (Kelly & Papps, 2021) and describe sacred love as feeling as though one is beholding something special or sacred in the moment (Kelly & Papps, 2021). Hearing the term “loving presence” in a Hakomi training can initially feel uncomfortable since it is unusual to use the word “love” in relation to psychotherapy (Kelly & Papps, 2021; Morgan, 2007). Loving presence is a state of consciousness where one is present in the moment and experiencing an embodied sense of well-being and positive affect (Murphy, 2015). Kurtz had an epiphany on how significantly his own state changed the course of a session and came to view this as the most important element of Hakomi (Kurtz et al., 2018). Embodying the Hakomi principles—

nonviolence, mindfulness, mind-body holism, organicity, unity—helps develop a state of loving presence in the therapist. “Loving presence is an attitude that will naturally emerge in us as we come to deeply understand these universal spiritual principles” (Kurtz et al., 2018, p. 16).

When the therapist is compassionate and attuned to the client, limbic resonance—a shared deep emotional state—is created between therapist and client that creates “the bubble” (Morgan, 2015a). It has been described by Allan Schore (2014) as right brain to right brain engagement. The bubble metaphor represents a felt connection of warmth, awareness, attention, and presence between the client and the therapist. Murphy (2015) described the intersubjective field fostered by the therapist as being open to the relational quality needed to respond to the attachment needs of the client. “Shared attention initiates attunement … [which] not only feels good in the moment, it likely alters the self-regulatory integrative fibers of the brain” (Siegel, 2007, pp. 290-291). If the attention and presence is overly stimulating for a client, the mindfully aware Hakomi therapist tracks this and responds (Johanson, 2015b).

Hakomi’s Therapeutic Presence Supports the Therapist

Hakomi’s loving presence helps develop the therapeutic relationship, which helps both the client and the therapist:

> The therapeutic relationship is the container in which all healing takes place in psychotherapy. It is crucial not only to the success of the therapy, but also to the overall positive experience of the client. This relationship works on many levels, both conscious and unconscious. It requires great attention on the part of the therapist and wholehearted effort to cultivate the attitudes that promote healing: loving presence, warmth, empathy, authenticity within intersubjectivity, openness, clarity, self-awareness, acceptance, discernment, and trust in the client’s unfolding process. *Such ongoing practice not only benefits clients but also deepens the therapist’s inner experience and wholeness* [emphasis added] (Murphy, 2015, p. 106).

Some experience loving presence—adding sacred love to unconditional positive regard—as a significantly different experience to unconditional positive regard (Johanson, 2015b; Morgan, 2007). Ron Kurtz did not distinguish between the two:

> Call it compassion or sympathetic joy. Call it unconditional positive regard. Call it love. Call it what you will. It remains the prime responsibility of the therapist. Open heartedness has a unique power to effect positive change. It is a sweet feeling too, and good for one's own mental health. (Kurtz et al., 2018, p. 152)

Clients presenting with anorexia are known for being challenging to work with (Lester, 2019) and holding a sense of loving presence provides the therapist with nourishment that avoids burn out (Kelly & Papps, 2021). Hakomi trains therapists to manage their own internal state and provides guidance for when they are stuck in a relational pattern, called a system (also called transference and countertransference) (Fisher, 2015). "[B]eing able to name [the system] in a nonjudgmental fashion, connect it to the client's presenting problem, and find a way to explore it with respect, curiosity, and warmth—is one of the hallmarks of a master psychotherapist "(Fisher, 2015, p. 243). Coming from a living systems perspective, Hakomi sees transference (a name for the client interpreting through their historical filters) as always present and representing the organisation of experience of the client's internal system (Johanson, 2015b).

Furthermore, AN behaviours that can seem manipulative, such as blaming others when disappointed or obscuring the truth such as hiding food and adding weight for weight checks, can be challenging for the therapist. The ability to actively cultivate a state of loving presence towards the client and shift animosity and disappointment can be a helpful tool. The principles of organicity and nonviolence help to re-establish the therapist's sense of trust towards the client's process. This requires the therapist to recognise change and growth is ultimately in the hands of the client. Trusting the client, however, can be hard to do and is a learned skill: "Many therapists who come to Hakomi training are overly stressed, holding too much responsibility for their clients' growth, and too little trust in their innate impulse to move toward wholeness" (Johanson, 2015b, p. 42). Practicing the skill of both leading and following helps the therapist become comfortable with not knowing (Gaskin & Cole, 2015).

Hakomi's Therapeutic Presence Supports the Client

A meta-analysis of various therapy approaches with clients with severe and enduring AN (SE-AN) suggested, "Tailored flexible treatment solutions, focused on therapeutic alliance … are urgently needed" (Kotilahti et al., 2020, p. 1299). It also suggested that treatment engagement with SE-AN might increase with less pressure to gain weight. Hakomi, as an assisted self-study, allows the client a sense of control, exploring their experience while not feeling alone or controlled. Defence behaviours are viewed as management behaviours since they manage and regulate what the client can experience (Gaynor, 2009). The therapist is there to assist the client in exploring the way the client manages their experience. In a 2018 review (Murray, 2019), research concluded that barriers for clients with AN to pursuing treatment included fear of change, fear of losing control, and low motivation to change. Acceptance produced better treatment outcomes, regardless of diagnosis or illness duration (Murray, 2019). Hakomi provides a means towards acceptance and does not push for change; the client has a sense of control and influences the therapy session. Hakomi principles, skills, and theory provide a level of awareness which tracks the client's internal experience and encourages working collaboratively. "These practices significantly reduce the possibilities of unacknowledged misunderstandings and harm from power-over directiveness" (Barstow, 2015, p. 140). A therapist's actions that may seem to be moral, ethical, and sensible to an observer can leave the client with AN unstrung and searching for safety (Grilo & Mitchell, 2011).

Compassionate, loving presence permits a client to go deeper into their experience so they discover early unmet needs in an experiential way (Lavie, 2011). Daniel Siegel (1998) provides evidence in his book that supports the use of a sense of connection and attuned communication in psychotherapy. If the client thinks the therapist has a judgement or has an agenda to use on the client, the client may automatically resist because they have the sense they need to be on guard with the

therapist. “We can’t keep one eye focused outward, figuratively or literally, and one eye inward. It’s like being asked to fall asleep standing up” (Johanson, 2015b, p. 50).

Hakomi teaches that one way to support the defence is through an experiment called “taking over”. The therapist supports what they see clients doing naturally for self-protection. For example, if a client is defensively wrapping their arms around themselves, they might use a blanket or someone else to “take over” that action, which offers to support that part of the client so they no longer have to maintain that protective strategy (Lavie, 2015). These “taking over” experiences can be profound:

> A carefully chosen experiment in taking over, implemented with sensitivity, respect, and full collaboration with the client, can be one of the single most powerful therapeutic experiences. It honors and supports the defense the client obviously thinks he needs while trusting it to the therapist to maintain, thus providing the safety for the client’s awareness to explore deeper levels of his organization. (Lavie, 2015, p. 185)

Hakomi Training Helps Develop the Therapist’s Presence

Hakomi teaches experientially how to get into and maintain therapeutic presence (Kelly & Papps, 2021). Since therapeutic presence in Hakomi is a special state of consciousness designed to support the process of self-healing in the client (Weiss, 2015a), Kurtz and the Hakomi Institute created countless exercises and practices that help the therapist identify and cultivate this state called loving presence (Murphy, 2015). Kurtz compared the therapist’s ability to go into a state of loving presence to a jazz musician or star athlete getting “in the zone” (Kurtz, 2006). To cultivate this state of mind, the therapist holds an intention of seeing something loveable in the client (Kurtz et al., 2018). This naturally comes about when attempting to understand the client’s inner world (Martin, 2015) and when holding a constant compassionate focus on the present moment experience of both the client and themselves (Kurtz et al., 2018). This means a large part of Hakomi trainings is cultivating mindfulness in the therapist and helping the therapist learn to cultivate mindfulness in the client (Morgan, 2015b).

Participants report a unique feel, style, and substance to Hakomi trainings that fosters professional and personal growth. “However it is not easy to articulate this uniqueness as it integrates art and science” (Weiss & Johanson, 2015a, p. 333). In my experience, Hakomi students and teachers talk about “the Hakomi bubble”. Here they are not referring to the therapeutic bubble, but that nourishing felt sense that happens in Hakomi gatherings. The Hakomi text describes this, too: “Practitioners who participate in Hakomi training report there is a unique feel, style, and substance to it that fosters both personal and professional growth in an accepting and creative crucible of learning” (Johanson & Weiss, 2015, p. 333). Kelly and Papps (2021) interviewed four Hakomi therapists to explore their understanding of therapeutic presence and identified the personhood of the therapist as being central to therapeutic presence and stated Hakomi training intentionally developed this. One Hakomi therapist stated: “Hakomi supports therapists to develop their personhood; supports and encourages and invites therapists to develop their personhood and that ongoing whole-of-life journey” (Kelly & Papps, 2021, p. 6). Marilyn Morgan (2007) conducted research on the experience of recent psychotherapy graduates, and one clinical psychologist thought her psychology training reduced her empathic functioning and well-being. After completing the Hakomi training, this clinical psychologist stated that loving presence felt very different to the unconditional positive regard she had been taught as a clinical psychologist.

Hakomi Training

Coming from a holistic approach, Hakomi teaches experientially; therefore, those used to prioritising the mind will notice the difference and may find it unusual. As Richard Schwartz related after meeting Ron Kurtz and the Hakomi community:

> I was blown away. At the time, I was an academic and as such, very intellectual and concerned about appearing professional. Sitting in on Hakomi conferences and training sessions, I found myself surrounded by lovely people of all stripes (psychotherapists, body workers, dance-movement therapists, and psychodramatists, as well as many nontherapists) who looked to me like they were constantly dancing, emoting, hugging, and “probing” each other. While my science-oriented sceptical parts were on guard, I couldn’t deny the power of the work and the way it both paralleled and complemented the path I was on. (Schwartz, 2015, pp. xi-xii)

While Schwartz makes it sound like it was all light-hearted, I can attest to the rollercoaster of emotions that emerge during the training. Fortunately, Hakomi provides a method to address these as they arise.

Ron Kurtz offered an invitation: “Come learn! Come find the joy of connecting with others and helping to heal the suffering that need not be!” (Gaynor, 2009, para. 58). He encouraged:

> Anyone who is capable of a few moments of calm will have no trouble pursuing self-study using this method. And just as exciting, assisting in that process is well within the reach of any good-hearted, intelligent person who takes the time to learn the method. (Kurtz et al., 2018, p. 4)

Slowing Down is Faster

Working therapeutically with clients experiencing AN is perceived as slow; yet some clients with AN are asking for therapists to not move too fast (Oyer et al., 2016). “Paradoxically, slowing down, trusting organic wisdom, not pushing for a particular result, supporting defenses as they arose, and encouraging curiosity (Johanson, 1988) and savoring (Kurtz, 1990a; Sundararajan, 2008) moved people along in their process further and faster” (Weiss & Johanson, 2015b, p. 339). As Ron Kurtz (2015) experimented in the therapy room, he noticed the therapeutic process began to focus more on following and supporting what wanted to happen and less on making it happen. As a result, the work became faster and easier. “When nonviolence, mindfulness, and compassion meet to create a healing space, a certain economy of therapy arises… Unnecessary confrontation and struggle yield, as defenses are respected for the organic wisdom they embody, and are supported as they arise" (Kurtz, 2015, p. 51). If the therapist does not create the healing environment, the process will take a long time (Kurtz et al., 2018).

Working with the Body

Working with the body opens the world beyond verbal-oriented consciousness (Weiss & Harrer, 2015). The body is considered the “royal road to the preverbal unconscious” (Günther, 2015, p. 281); therefore, body-psychotherapies, such as

Hakomi, provide opportunities not available in other modalities. The power of touch done therapeutically—nonsexually and appropriately initiated—is consider by some psychotherapists to be such a powerful tool in therapy—saving time, money, and energy—that it would unethical to not use it (Barstow, 2015). Touch is necessary to emotional well-being as well as physical health; however, it is not without its problems. Years of controversy surrounding the use of touch in psychotherapy caused it to be illegal in parts of the United States (Barstow, 2015). There are ethical guidelines for using touch in Hakomi. When touch is part of an experimental approach, to notice and perhaps study what happens internally from touch, it is done mindfully, deliberately, carefully, and consciously with a clear rationale for it. The therapist continually tracks for the client's response and checks in with the client on the impact of the touch (Barstow, 2015). Still, therapists need to be aware of clients that are fragile and do not have the ability to tolerate the degree of arousal that could arise from touch.

The Need for Mind-Body Integration Techniques

Many in the western culture have become accustomed to dissociation from the body (Morgan, 2015a). Neurobiologist, Antonio Damasio (2006), described it as "the abysmal" separation of body and mind. Ogden, Minton, et al. (2006) suggested all psychotherapists (cognitive, psychodynamic, psychoanalytic) are trained to listen to the client's language and affect, while tracking associations, psychic conflict, and defences; however, while they are trained to notice the client's body, actual engagement with the client's embodied experience is often outside their therapeutic interventions. In the book*, A Sensorimotor Approach to Trauma* (Ogden, Minton, et al., 2006), Daniel Siegel, and Bessel van der Kolk support Pat Ogden's suggestion that body-oriented interventions can increase the efficacy of clinical work by combining "bottom-up" (body) and "top down" (mind) interventions to develop a somatically integrated sense of self. Additionally, with their own body awareness, the therapist can reduce the risk of vicarious trauma since the therapist pays attention to what is happening in their own

body physically and emotionally and can then take actions to self-regulate (Rothschild, 2003).

In 1977, psychoanalyst, Susie Orbach, wrote *Fat is a Feminist Issue* and it has been in print ever since (Starkman, 2016). With over 30 years of working with body image and EDs, she speaks of the need to address the body in psychotherapy. Orbach (2006) argued, "psychoanalysis' mentalist stance can fail to sufficiently address the subjective experience of the body as a body and in doing so can miss crucial dimensions of the patient's experience" (p. 89). She proposed one's sense of one's body comes about in relation to others. Her suggestion for therapists sounds like a Hakomi approach:

> [T]he therapy relationship is a laboratory for seeing what we/the patient/does and how they can try to take something from the therapist. *The dosing has to be quite tiny*… Developing the emotional muscle for 'taking in good things' is crucial. (Starkman, 2016, p. 6)

This sounds very similar to a Hakomi approach helping the client explore taking in nourishment (Monda & Eisman, 2015) and is especially relevant to clients experiencing AN, since they are struggling with taking in nourishment.

Hakomi Provides for Integration of Experience

Ron Kurtz was influenced by Pierre Janet's concept that mental health problems stem from an upsetting incident overwhelming the mind at a time when a person is emotionally vulnerable and they have no emotional support to process it. Since the felt experience is not integrated, the person buries it in the unconscious. This unintegrated experience can create "an irritation of a sort and affects the person's mental states and behavior. Among the effects are the development of habits, beliefs, and unconscious behaviors that control feelings and memory, and keep the unintegrated material from reaching consciousness" (Kurtz et al., 2018, p. 142). I think of Treasure et al. (2015) referring to clients with AN as developing an unhelpful habit that needed to be broken.

Releasing contained emotions is tremendously satisfying since relaxing the habits of containment allows something new to emerge: expression and relief (Kurtz, 2015). Kurtz et al. (2018) described the conditions needed for integration—and therefore healing—as three phases: “First, we must create a relationship within which the painful work can be done. Second, we must bring the unintegrated event into consciousness. And third, we must support the process of integration” (p. 42). In integration, the client reconciles themself to what was and accommodates the new (Kurtz, 2015; Weiss, 2015b). For me, this sounds like acceptance. During integration, the therapist continues to be present and attentive, without interfering with the client’s inner work (Kurtz, 2015).

Working with Māori

Hakomi can offer respectful treatment for Māori clients experiencing anorexia. Public perception in New Zealand is that Māori are largely unaffected by EDs; this systemic bias may account for lack of service access for sufferers (Lacey, Clark, et al., 2020). Māori women show similar, even higher, rates of AN compared to the general population. A 2006 New Zealand survey revealed rates of anorexia are 0.7% for Māori and 0.6% for the whole population—of which Māori are 15% —with no isolated AN statistics for Māori men (Lacey, Cunningham, et al., 2020). As a treatment approach, the Hakomi principles and holistic approach allow it to “sit comfortably alongside” (Tait-Jamieson, 2016, p. 45) a Māori model of health, Te Whare Tapa Whā—the four walls of the house. This model acknowledges the equal influence of the four walls to well-being: physical health, spiritual health, family health, mental health (Ministry of Health, 2017). The mind-body holism might even be easier for someone from Te Ao Māori (the Māori world) to grasp than someone from western cultures, since a Māori approach to health incorporates a more holistic view between mind, body, and spirit (Mark & Lyons, 2010; Tait-Jamieson, 2016).

Hakomi Limitations

Hakomi has several pronounced limitations. Considering a systems perspective, Hakomi mainly focuses on the internal organisation of the individual which helps the client understand how their own internal system operates. This does not address the external aspects of the individual which need to be considered separately (Weiss et al., 2015). Additionally, it seems Hakomi works well for relational trauma and may not prepare the Hakomi student for working with acute trauma where the body is hijacked and reliving an overwhelming fear (Kurtz et al., 2018). Furthermore, Hakomi is not something that is quickly learned or conveyed. As such, it will not be well understood in a two-day training or from a manual. I imagine it is like learning a language: it provides access to a culture and a new way of thinking and being in the world; however, it requires regular involvement and immersion to fully embrace it.

A main concern regarding Hakomi practice is when the application of techniques is not appropriately practiced (Günther, 2015). The Hakomi method needs to be engaged cautiously with clients who are more clinically disturbed; therefore, the ability to continually assess and diagnose the client is essential (Günther, 2015). For more fragile clients, mindfully experiencing the present may be both difficult and unhelpful. This means, “the foundation of the explorative Hakomi method—the mindful exploration of present-moment experience—would not be possible to execute uncritically at the outset of therapy” (Günther, 2015, p. 284). The therapist, therefore, needs to recognise when clients are dealing with intense emotional experiences such as anxiety, and may not be able to mindfully observe their bodies. Furthermore, the familiar psychotherapeutic use of uncovering and working through, might not work for the more traumatised clients, especially if self-observation is not possible. Awareness of the process as it unfolds is as important as the knowledge about disorders and methods of treatment. To be aware, the therapist needs to continually track the client to notice whether they are reactive or reflexive (Günther, 2015). Being reactive shows up as identifying with a part and not being present to their experience (Perrin, 2015).

Additionally, clients experiencing AN are generally considered disconnected from their bodies, meaning they are not in contact with their internal world (Camozzi et al., 2017). With this being the case, certain somatic techniques might not work well initially. However, a Hakomi therapist (personal communication April 9, 2021) who worked extensively with clients with anorexia, suggested that a mind-body approach was especially needed by clients with AN. While it might not be appropriate initially, a mind-body psychotherapy provides the tools to slowly move the client towards experiencing and trusting their body's signals. This therapist suggested that an important part of knowing a technique is knowing when to use it.

Hakomi and Research

The Hakomi Institute website and the Hakomi textbook (Weiss et al., 2015) list many references to research regarding Hakomi and relevant to Hakomi; however, like body psychotherapy, Hakomi does not have a body of double-blind RCT trials (Johanson, 2013-2014). In 2009, a Hakomi therapist, Greg Johanson, provided a 54-page selected bibliography with over 1,000 references on mindfulness use in therapy (Hakomi Institute, 2015). Within this, the few research studies that referred to EDs referred primarily to bulimia; only three references were to anorexia. Two were case studies: one used mindfulness from DBT and one used mindfulness from ACT. The third reference was a workbook on reclaiming oneself from anorexia. As revealed earlier: "'[I]nsufficient evidence' and 'no evidence' are not synonymous with 'evidence of ineffectiveness' and, in the absence of evidence, clinical consensus is legitimate" (Beumont et al., 2004, p. 620). Luyten et al. (2012) suggested reliance on the medical model and manual-based interventions has led to a gap between research and clinical practice; therefore, greater collaboration between researchers and practitioners is needed. They suggest the focus needs to be on therapeutic principles instead of treatment packages. This fits with Hakomi philosophy. Since Hakomi views healing as integration and not through the medical approach of "fixing" what is wrong, there is no need to search for the "root cause"; in fact, this "violates the mind-body-spirit holism

upon which the Hakomi method rests" (Daye, 2015a, p. 125). Instead, therapies can be validated in practice (Fisher, 2020, p. 547). Johanson (2009) suggested psychology and psychotherapy need to use a systems theory approach that can "take us beyond inadequate cause-and-effect, linear, deterministic, reductionistic models, and analysis" (p. 185). This means adopting principles to accommodate dynamic living systems that have history and change over time, allowing for novelty to be created; it means welcoming the uncertainty of the universe (Johanson, 2009).

Summary

In this chapter, I have considered how Hakomi might contribute to treating clients experiencing AN by first considering factors found in literature as desirable in AN treatment, such as focusing on respectful relationships, the therapist doing their own work, slowing down, considering clinical culture, and providing an integrated approach. I then reflected on aspects of Hakomi that addressed factors found important in treating clients with AN. I explored one factor, Hakomi's therapeutic presence—called loving presence—in detail, and provided references in literature that revealed loving presence supports the therapist as well as the client. From there, I looked at how Hakomi training develops the therapist, and revealed the focus of trainings, and students' experiences of Hakomi training. I then turned to consider some characteristics of Hakomi that would address aspects of working with clients with AN such as being faster, such as slowing down with mindfulness and the advantage of working with the body. Next, I explored the need for mind-body integration and the Hakomi concept of integrating experience, before considering Hakomi's relevance when working with Māori. Finally, I considered literature that reflected on the limitations of Hakomi and explored Hakomi's current research environment.

The next chapter is the discussion and conclusion chapter in which I summarise and discusses the finding. The strengths and limitations of the study are explored, as well as implications for psychotherapists, especially those who work with clients experiencing AN.

Chapter 6 – Discussion

In this chapter, I briefly summarise the literature presented in Chapters 3, 4, and 5, and offer a discussion on my research results in relation to my research question. I will consider the broader implications of this research for psychotherapeutic practice and explore the strengths and limitations of this research before considering directions for future research. The intention of this research was to use a hermeneutic literature review as a method to explore my research question: how can Hakomi, a mindfulness-based somatic psychotherapy, contribute to the treatment of anorexia nervosa? The aim was to stimulate thinking regarding approaches to psychological treatments for adults experiencing AN, and to consider how Hakomi might contribute to the treatment of AN.

Research Summary

Initially, in literature from Chapter 3, I found research that showed that the current standard specialist treatments for anorexia are only moderately effective; therefore, novel treatment approaches are needed. However, it seemed researchers remained looking within the constraint of their view of acceptable treatments, which did not recognise the therapeutic significance of the body and the mind-body connection. Hakomi is a body psychotherapy that incorporates both process-oriented and expressive body psychotherapeutic modalities that work therapeutically with communications from the body. I explored evidence in literature of clinical attitudes that could be harming to clients with AN, and may keep researchers from recognising alternatives to treatment—such as body-psychotherapeutic approaches. Finally, I considered how a living systems approach could contribute to a holistic understanding of an individual which might assist with understanding what is missing in treatment approaches for AN.

The literature in Chapter 4 revealed that trauma is defined differently between the diagnostic medicalised view and consensus in the psychosocial field used by practitioners, which includes an understanding of developmental relational trauma into

the use of the term complex trauma. Research suggests anorexia is linked to various forms of trauma, including prenatal and perinatal trauma, and childhood stress and maltreatment. Literature connecting prenatal and perinatal trauma and future EDs was extensive but was determined to be associative but inconclusive in some systematic reviews because of the methodological errors found. In the research, connections to trauma were found when considering the cumulative effect of events. Some researchers suggest that much more subtle conditions can be traumatising events than those defined in diagnostic reference manuals.

Literature revealed trauma was found as being widely prevalent in mental health populations, such that trauma treatment is recommended for all mental health clients. I reviewed literature that considered what might be contributing to the ubiquitous presentation of trauma. Research linked trauma presentations, which often specifically named AN or EDs in general, as benefiting from psychotherapeutic therapies that include mind-body integration, mindfulness, and parts work, to which Hakomi can contribute. In scholarly databases, research for body psychotherapies in trauma treatment was inconclusive, partly because the definitions of trauma and the definitions of body psychotherapies are not concisely defined. However, treatments for trauma using the body are popular in books from trauma practitioners. Since I found little research on body psychotherapies in treating AN or EDs, and little of that research had treatments that sounded similar to Hakomi, I sourced research that more closely resembled Hakomi in the use of embodiment, mindfulness, and parts work.

Finally, Chapter 5 considered what recent literature had suggested for future directions for treatment for clients with AN, and considered aspects of Hakomi therapy that matched these treatment directions. The quality of interpersonal relationships was revealed as a significant aspect of recovery from AN. Therefore, it is important that therapists understand how AN supports the client; that they provide an attuned, therapeutic alliance; and that they work on their own personal struggles that come up in relation to clients. Furthermore, it is important to consider how the clinical culture

influences affect. Additionally, providing an integrated approach that addresses comorbidities and trauma simultaneously rather than sequentially, and from the same clinician or facility is ideal. Literature revealed it is important to ensure treatments are not threatening to the client's sense of control or provoke a sense of powerlessness and instead rebuild identity and self-acceptance. Hakomi can contribute an additional approach to AN treatment since it provides a method for meeting needed AN treatment approaches: attunement, allowing clients a sense of control, and providing a vehicle for acceptance. Hakomi provides a highly evolved method and training which offers support for the therapist and, therefore, the client. It provides this through development of Hakomi's therapeutic relationship—loving presence. Loving presence incorporates the Hakomi principles of nonviolence, mind-body holism, mindfulness, organicity, and unity, with the felt sense of sacred love.

This chapter further revealed ways Hakomi may contribute to AN treatment. It suggested Hakomi provides for potentially faster therapy by slowing down with mindfulness, including the body, and incorporating parts work. It discussed the need for mind-body integration and revealed how Hakomi approaches integration of experience. Consideration was also given to the appropriateness for working with Māori and how Hakomi fits with their holistic approach to health. Finally, Chapter 5 revealed the limitations found for Hakomi and considered Hakomi's research environment.

Reductionistic Versus Holistic Approaches

One way Hakomi can contribute is that it helps cultivate living holistically, without mind-body separation. When Zeeck et al. (2018) conducted an extensive review of all RCTs researching any treatment for AN over the previous 30 years, they recognised that all the treatments focused on weight, ED behaviour, and psychological problems. Considering this from a living systems perspective, it seems these are addressing the external and internal approaches, although the psychological approaches referred to in this research are heterogeneous. As I came to make sense of it, CBT addresses the external aspect of the individual: such as behaviours and the

conscious mind; psychodynamic psychotherapy addresses the internal: the emotions and historical drivers and the unconscious mind. They all—including SSCM and MANTRA—perhaps provide the much-needed experience for a client with AN: the therapeutic alliance. However, none of them address the body in a way that integrates the mind-body communication the way Hakomi does.

In systems theory, living systems need communication between the various parts. I reasoned that Hakomi provides a means for this communication which allows the process of integration between the mind and body so that what has been unintegrated can integrate. The separation of mind and body, proposed by René Descartes, is common in Western thinking, but no part of the human experience can be purely mental or purely physical (Greg Johanson, 2015b). When researchers are trying to understand the mechanisms of the current therapeutic processes in AN treatment that are working, they are still not getting closer to including what they are missing—the body—or bridging the gap which allows for mind-body integration.

In my experience, psychodynamic psychotherapy helps the person feel their affect—the felt emotional aspect of one's emotional history. If emotions are felt in the body, but psychodynamic psychotherapy does not address the body aspects of trauma, then it seems there are internal and external aspects of the body; and, therefore, internal and external aspects of the mind. That seems to hold true: when one goes into certain mind-states, some are more internally oriented—perhaps such as trance and some mindfulness states; and some more externally oriented—such as ordinary consciousness. Additionally, affects are felt internally in the body, such as a racing heart, and movement and physical postures held externally. There needs to be a means of communication between these, which is where Hakomi can contribute. I realise I am not presenting a new model; rather, am illuminating my understanding in relation to this context of working with clients with anorexia. I also realise this does not include the spiritual aspects of mind-body-spirit holism, which may offer another piece to the healing puzzle.

Are All Mental Health Conditions on a Trauma Scale?

Perhaps all mental health conditions—including anorexia—are trauma related to a greater or lesser degree. One hundred and fifty years ago early body psychotherapist, Pierre Janet, proposed that all mental health problems stem from lack of support during emotionally vulnerable times (Kurtz et al., 2018). All people have been vulnerable, powerless infants and children (Totton, 2005) which could explain trauma's ubiquitous presentation (Classen & Clark, 2017; Gerber & Gerber, 2019; Payne et al., 2015; Totton, 2005). Could all people have unintegrated experiences buried in their unconscious? Richard Swartz (2021) shared that he has many clients come to him for psychotherapy after some event has caused their lives to crash because their focus on one aspect of their lives is unsustainable: "Those can be wake-up call events if I can help them keep the striving, materialistic, competitive parts of them that had dominated their lives from regaining dominance so they can explore what else is inside them" (p. 1).

Furthermore, trauma therapists suggest trauma disconnects the mind and body (Rothschild, 2000; Siegel, 1998; Van der Kolk, 1994), as does anorexia (Cook-Cottone, 2020; Fuchs, 2021). If so many people are traumatised, as researchers are suggesting (Classen & Clark, 2017; Gerber & Gerber, 2019; Payne et al., 2015), then many people are disconnected and in a place of prioritising the mind over the body. The general population is so accustomed to being dissociated from the body, they do not even recognise when they are dissociated (Morgan, 2015a). This would make it hard for them to see past their current mind and body split to recognise the value of mind-body integration, and hard for them to endorse mind-body psychotherapy for therapists to offer for clients experiencing AN. This would explain the blind spot I found within literature.

Early life trauma is revealing itself as a component of anorexia both in prenatal and perinatal environments (Evertz et al., 2021; Larsen et al., 2021; Marzola et al., 2021; St-Hilaire et al., 2015), and with childhood stress and maltreatment (Evertz et al.,

2021; Larsen et al., 2021; Marzola et al., 2021; Monteleone et al., 2019; Monteleone, Cascino, et al., 2021; Monteleone, Tzischinsky, et al., 2021; Pignatelli et al., 2017; St-Hilaire et al., 2015; Wesselius et al., 2020). Anorexia nervosa research suggests that this trauma is early developmental trauma and often happens outside of conscious awareness. It is important to learn more about this complex trauma presentation and how it contributes to some individuals developing AN. Hakomi's emphasis on listening to the communications from the body could potentially contribute further understanding of the nature of this complex trauma and provide understanding on the aetiology of this puzzling and very dangerous disorder. Then Hakomi can contribute both as a treatment approach and to understanding AN.

How Hakomi Can Contribute

Hakomi's loving presence provides a baseline that keeps the therapist in the realm of the principles, which contribute to a respectful, not overly directive, psychotherapy. Additionally, Hakomi therapists are able to integrate their mind and body and, therefore, can role model and guide clients with AN to become more embodied. Current standard specialist treatments for AN—SSCM, CBT, MANTRA, even psychodynamic psychotherapy—are not body-based treatments that provide body-based interventions which address somatic symptoms. Thus, they may be missing a crucial part in addressing clients holistically (Ogden, 2020; Orbach, 2006). Research shows that embodiment is an important missing link in clients experiencing AN (Cook-Cottone, 2020; Fuchs, 2021). Some research for trauma suggests combining bottom-up (body-based) approaches with top-down (thinking) approaches (Ogden, Pain, et al., 2006). Psychoanalyst Susie Orbach (2006) advised of the need to address the body in psychoanalysis, stating mentalisation just does not work fully. I can attest to the description in the Hakomi text that the incredible and significant change felt when exploring the body needs to be experienced to be believed and understood (Bageant, 2012).

Moving Towards a Hakomi Approach?

Researchers seem to be moving closer to a Hakomi approach by suggesting it was the “acceptance” in the treatment approaches of ACT, DBT, and yoga that was helpful (Galmiche et al., 2019; Murray, 2019; Ngata & Murray, 2021). Acceptance is part of loving presence in Hakomi. While DBT utilises mindfulness as a tool for stress reduction and present moment awareness, stress reduction is only a beginning step in Hakomi, which uses mindfulness to explore how a client organises and limits their life based on the past. The insightful and holistic trauma book *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models* (Ford & Courtois, 2020b) was a relief to find. It suggests a variety of truly novel approaches to trauma treatment: Sensorimotor psychotherapy, experiential approaches, and mindfulness approaches–which all bode well for Hakomi.

Helping the Clinician Helps the Client

Because relational dynamics are so important to the recovery of anorexia (Lester, 2019), it would benefit the client if all clinicians who engaged with the client were able to model what the client has struggled to experience: mutually respectful and mutually nurturing embodied engagement with another. Hakomi can help the clinician working with clients with AN in many ways. It can be a part of any psychotherapy (Kurtz et al., 2018). Hakomi offers more than merely adding the body to psychotherapy; it develops the personhood of the therapist in specific ways that cultivates loving presence. The mindfulness aspect of Hakomi brings the therapist into the present moment with compassion and helps the therapist cultivate a sense of curiosity, even when this is hard to do; which helps the therapist to be present to each individual client, even if the presentation seems common and familiar. Cultivating curiosity in the client can help them shift their state from the sheer terror they might be experiencing. For example, when the clinician finds yet another instance of a client hiding food or adding weights for weight checks, the therapist can choose curiosity about the experience for the client, enabling the therapist to see the client, and not just the behaviours. Hakomi’s

loving presence could help address attitudes in the clinician that lead to subtle violence, such as acting on judgements and criticisms, rather than getting curious about them.

> Even a modest practice of mindfulness can produce a range of benefits, including …improved response flexibility and the capacity to understand someone else's mind (Siegel & Hartzell, 2003); improved self-regulation (the ability to modulate emotional reactions); greater self-awareness; and a capacity to develop distance from impulses, beliefs, or feelings as they arise (disidentification). (Perrin, 2015, p. 110)

Additionally, the cooperative nature of studying the client's experience allows the therapist to come alongside the client, thus not threatening the client's sense of control, which is important to clients with AN. Such a focus on valuing the client's experience can be quite a paradigm shift for clinicians who are used to a more directive approach. Typical transference when working with clients with AN may cause the therapist to collude with the client's desire for a symbiotic relationship, overemphasise doing and fixing, and use protocol-like psychotherapy to focus on the eating disorder and not the client (Dmochowski et al., 2013). My intention at the start of this research was to explore treatments for anorexia; however, as I learned more, I became more aware of the client and how the client needed to be treated. I came to notice how I, also, had been focussed on the treatment and not the client.

Implications for Psychotherapy

As I researched and reviewed, I became more and more appreciative of the mindfulness-based, mind-body approach Hakomi uses, and the possibilities and options it offers for treating clients experiencing anorexia. While there is no ideal treatment, best way, magic wand, or silver bullet to treat EDs (Marlock et al., 2015), Hakomi provides the psychotherapist with a means to embody and utilise an accepting, mindfulness-based, mind-body approach that is missing—and needed—in most psychotherapies treating anorexia. Hakomi offers avenues for many of the approaches identified as useful in treating clients experiencing anorexia and furnishes an approach to grow out of reductionist thinking to be able to treat the client holistically—mind and

body, and the communication between the two. Working with clients experiencing AN, with its potential for death, creates anxiety in the clinician which can naturally stimulate a reductionistic approach that focuses on maintaining life. Hakomi can help make useful meaning of this response in the service of better listening to the experience of the client. Hakomi teaches the therapist how to cultivate and maintain a state of loving presence—unconditional positive regard combined with sacred love— which is central to its method and possibly central to the therapy needed for clients experiencing anorexia.

It might be worth repeating what I mentioned earlier: When people think they are smart or well-read or well-educated, they might think it if was worth knowing, they—or their peers—would know about it. Like the old Chinese saying, “Empty your cup”, referring to a Zen master overfilling a student’s teacup to illustrate the humility needed to learn (O'Brien, 2020). If one thinks they know, their cup is full and they have no room to learn. This research is intended to stimulate thinking regarding psychotherapeutic approaches for the treatment of anorexia nervosa.

Limitations and Strengths of This Research

A hermeneutic approach includes my prejudices; therefore, my subjectivity has influenced this research. It seems this reflects a possible criticism of my research—my prejudice towards a Hakomi approach. Because of the gap in the literature on Hakomi in the treatment of AN, there is little evidence specifically for or against its use. Instead, I am left inferring from broader connections, using my knowledge of what I learn in the literature to understand and make the links. Additionally, since Hakomi is experiential, I was limited by the written format of this literature review as to what I could convey and how I could convey it. Because AN is a complicated presentation, there are many aspects of it to investigate. A variety of approaches may be needed as options for personalised treatment for clients experiencing AN. My focus in this research has been exclusively on Hakomi and has not considered how other approaches can and do

contribute. My generalisations have also not distinguished between various trauma presentations or various anorexia presentations.

This was a relatively small study, which limited the depth and breadth I could cover. The topics of anorexia and trauma are extensive; so, while I tried to gain a true representation of the literature, it was not all inclusive. Furthermore, there were many options left unexplored such as attachment research and neurobiological research which would have had great relevance to my research topic. Additionally, I neglected to acknowledge the many contributors that have brought our current understanding to where it is. Finally, I generally conceptualised my audience as psychotherapists familiar with working with clients with AN; however, I have tried to make the writing of this research understandable and useful in general.

A strength of this study was how the hermeneutic literature review complemented my desired research process, allowing for integration and learning, and the flexibility to follow the various paths that seemed as if they could add to my understanding of this research. As I immersed myself in the literature, I could examine perspectives found in the text, recognising in the literature familiarities from the ED clinic and from my Hakomi experience, while exploring my understanding and experiences of the literature, as I broadened and deepened my understanding and knowledge of it all. Through the circular hermeneutic process, I read and re-read, contemplated, dialogued with my supervisors, wrote, searched and selected, read more before writing and starting the process again, with emphasis on various parts of the circle at different stages of the research process. When I revisited subject-matter, I found my understanding had broadened. Critically assessing texts came easily when I felt stirred emotionally by their approach or when I agreed or disagreed significantly with their perspective. I recognise I experienced many shifts in perspective over this research journey and even worked through the strong desire I had to want to convince, which still shows up residually in my writing.

I returned again and again to the hermeneutic concept that this research is meant to stimulate thinking and does not need to prove anything or need to provide an answer. As a reminder to myself, I periodically returned to the quote: “The purpose of exploring literature in hermeneutic research is to provide content and provoke thinking” (Smythe & Spence, 2012, p. 12). As my research progressed, I expanded into a more holistic approach in my literature review and began to let go of the need to come to solid conclusions regarding Hakomi’s contribution and the need to provide answers in a convincing way. This approach emerged as a broader, more holistic view of Hakomi and how Hakomi can fit in the treatment of anorexia as a piece to a much bigger and ever-changing puzzle.

Future Research

To expand on this research, gaining more understanding regarding Hakomi techniques and approaches that tend to work better with clients experiencing AN might be helpful. Lee Moyer (1986) mentioned working with child states and working with parts was useful and she stated she was going to write more about the techniques in the second part of her writing, which I searched for extensively but could not find. Research, therefore, could interview and draw on the experiences of Hakomi therapists who have worked specifically with clients experiencing AN. Over the course of my research, I had seven therapists who had worked with clients with AN share with me how Hakomi provided a needed alternative therapy approach for working with AN, and I had one client with AN share they found Hakomi a welcome relief and became a Hakomi therapist because of it.

Further research might explore the outcomes of competent certified Hakomi therapists who are experienced with AN compared to other treatments. Alternatively, research could follow clinical outcomes of therapists already working with clients with AN who complete a more extensive Hakomi training. The use of Hakomi online might reach a broader audience. While Hakomi can easily address the body somatically online, future research could consider the use of touch through telehealth with

assistants. In Ron Kurtz's last 20 years of working, he shifted to using others, such as assistants or clients who knew each other, to offer physical touch and other techniques that Hakomi utilises (Kurtz et al., 2018). Finally, it could be useful for psychotherapists, and more inclusive of a broader range of therapies, if measures and tests of clinical significance were adopted specifically for psychotherapy (Fay, 2017).

Conclusion

I have come to a clearer understanding that in the hermeneutic cycle it is important to continually re-read with an aim to understand more. The hermeneutic literature review process recognises there is constant, unending learning which leads to constant re-interpretation which ideally leads to more comprehensive understanding (Boell & Cecez-Kecmanovic, 2010). This review has stimulated my thinking regarding the treatment of adults with AN and how Hakomi might contribute. I hope it provides that same opportunity for the reader.

In this literature review I found that researchers continued to look for new treatment options for AN within the same approaches and neglected to recognise the importance of working therapeutically with communications from the body. Literature revealed anorexia seems to be connected to some form of unintegrated experience referred to as trauma—especially when recognising the subjective experience of the person experiencing it. Research showed links between future AN and prenatal and perinatal trauma, especially when cumulative, and between childhood stress and emotional maltreatment and future EDs. Furthermore, I found that Hakomi can contribute by offering a mindfulness-based embodied approach that incorporates parts work and therefore it may provide faster recovery. Additionally, Hakomi's holistic approach may fit for those of Te Ao Māori.

I found as I read and re-read, I became more aware of how important relationships are for recovery from anorexia and how Hakomi can contribute to a choice in attitude in the therapist towards clients experiencing AN. Hakomi can provide an approach to AN treatment that enables the therapist to embody an accepting,

attuned, mindful, mind-body approach; as well as the ability to cultivate that in their client. Anorexia is complex, so the more listening and attention brought to each client allows for that client's unique puzzle to slowly come together. Hakomi can offer a missing piece to a much larger wellness puzzle for the client experiencing anorexia.

Furthermore, in the discussion I shared that the literature led me to understand that Hakomi can contribute a holistic approach towards psychotherapeutic treatment of AN, and provide a means to move out of reductionistic thinking that is so prevalent. Additionally, I proffered the idea that all mental-health presentations, including anorexia, may be on a trauma scale which could benefit from a respectful mind-body approach. I revealed findings that Hakomi can encourage a trauma- and anorexia-friendly attitude in the clinician by developing the clinician's loving presence, which includes developing their own mind-body connection that can then provide role modelling for the client. I explored the recognition in research of what works for AN and trauma may be moving towards appreciating what Hakomi has been doing for many years but also cautioned Hakomi's lack of training for working with more acute trauma. Ultimately, I went from considering how Hakomi can contribute to the psychological treatment of clients with AN to considering how clients experiencing AN may need to be treated.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

American Psychological Association. (n.d.). *Eating disorders.* American Psychological Association. https://www.apa.org/topics/eating-disorders

Aposhyan, S. M. (2004). *Body-mind psychotherapy: Principles, techniques, and practical applications*. W. W. Norton & Company.

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: A meta-analysis of 36 studies. *JAMA Psychiatry, 68*(7), 724-731. https://doi.org/10.1001/archgenpsychiatry.2011.74

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology, 2*, 270. https://doi.org/10.3389/fpsyg.2011.00270

Ataria, Y. (2017). *The structural trauma of western culture: Toward the end of humanity*. Springer. https://link.springer.com/book/10.1007/978-3-319-53228-8

Atwood, M. E., & Friedman, A. (2020). A systematic review of enhanced cognitive behavioral therapy (CBT-E) for eating disorders. *International Journal of Eeating Disorders, 53*(3), 311-330. https://doi.org/10.1002/eat.23206

Bageant, R. (2012). The Hakomi method: Defining its place within the humanistic psychology tradition. *Journal of Humanistic Psychology, 52*(2), 178-189. https://doi.org/10.1177/0022167811423313

Bakan, R., Birmingham, C. L., & Goldner, E. M. (1991). Chronicity in anorexia nervosa: Pregnancy and birth complications as risk factors. *Internation Journal of Eating Disorders, 10*(6), 631-645.

Barstow, C. (2015). Ethics: Right use of power. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 139-148). W. W. Norton and Company.

Berends, T., Boonstra, N., & van Elburg, A. (2018). Relapse in anorexia nervosa: A systematic review and meta-analysis. *Current Opinion in Psychiatry, 31*(6), 445-455. https://doi.org/10.1097/yco.0000000000000453

Beumont, P., Beumont, R., Hay, P., Beumont, D., Birmingham, L., Derham, H., Jordan, A., Kohn, M., McDermott, B., & Marks, P. (2004). Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. *FOCUS*. https://doi.org/10.1111/j.1440-1614.2004.01449.x

Birmingham, C. L., Su, J., Hlynsky, J. A., Goldner, E. M., & Gao, M. (2005). The mortality rate from anorexia nervosa. *International Journal of Eating Disorders, 38*(2), 143-146. https://doi.org/10.1002/eat.20164

Bloch-Atefi, A., Smith, J., & Melbourne, J. S. (2014). The effectiveness of body-oriented psychotherapy: A review of the literature. *Psychotherapy and Counselling Federation of Australia*. http://pacja.org.au

Boell, S. K., & Cecez-Kecmanovic, D. (2010). Literature reviews and the hermeneutic circle. *Australian Academic and Research Libraries, 41*(2), 129-144. https://doi.org/10.1080/00048623.2010.10721450

Boell, S. K., & Cecez-Kecmanovic, D. (2014). A hermeneutic approach for conducting literature reviews and literature searches. *Communications of the Association for Information Systems, 34*(1), 257-286. https://doi.org/10.17705/1cais.03412

Borden, A., & Cook-Cottone, C. (2020). Yoga and eating disorder prevention and treatment: A comprehensive review and meta-analysis. *Eating Disorders, 28*(4), 400-437. https://doi.org/10.1080/10640266.2020.1798172

Boudette, R. (2013). Integrating mindfulness into the therpay hour. In DeSole, L. M. (Ed.), *Eating disorders and mindfulness: Exploring alternative approaches to treatment.* (pp. 151-161). Routledge.

Brewerton, T. D. (2019). An overview of trauma-informed care and practice for eating disorders. *Journal of Aggression, Maltreatment & Trauma, 28*(4), 445-462. https://doi.org/10.1080/10926771.2018.1532940

Brewerton, T. D., Alexander, J., & Schaefer, J. (2019). Trauma-informed care and practice for eating disorders: Personal and professional perspectives of lived experiences. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 24*(2), 329-338.

Brytek-Matera, A., & Czepczor, K. (2017). Models of eating disorders: A theoretical investigation of abnormal eating patterns and body image disturbance. *Archives of Psychiatry and Psychotherapy, 19*(1), 16-26. https://doi.org/10.12740/APP/68422

Bühler, K.-E., & Heim, G. (2001). General introduction to the psychotherapy of Pierre Janet. *American Journal of Psychotherapy, 55*(1), 74-91. https://doi.org/10.1176/appi.psychotherapy.2001.55.1.74

Byrne, S., Wade, T., Hay, P., Touyz, S., Fairburn, C. G., Treasure, J., Schmidt, U., McIntosh, V., Allen, K., Fursland, A., & Crosby, R. D. (2017). A randomised controlled trial of three psychological treatments for anorexia nervosa. *Psychological Medicine, 47*(16), 2823-2833. https://doi.org/10.1017/S0033291717001349

Caglar-Nazali, H. P., Corfield, F., Cardi, V., Ambwani, S., Leppanen, J., Olabintan, O., Deriziotis, S., Hadjimichalis, A., Scognamiglio, P., & Eshkevari, E. (2014). A systematic review and

meta-analysis of 'Systems for Social Processes' in eating disorders. *Neuroscience & Biobehavioral Reviews, 42*, 55-92. https://doi.org/10.1016/j.neubiorev.2013.12.002

Camozzi, G., Ghidoni, A., Tedeschi, M., Finotto, A., Zannini, A., Gibin, A., & Manicardi, E. (2017, March 9-11). *Metabolic emergency and evolution of anorexia* [Paper presentation]. National Congress of the Italian Society for the Study of Eating Disorders, Rome, Italy. https://doi.org/10.1007/s40519-017-0388-7

Chami, R., Monteleone, A. M., Treasure, J., & Monteleone, P. (2019). Stress hormones and eating disorders. *Molecular and Cellular Endocrinology, 497*, 110349. https://doi.org/10.1016/j.mce.2018.12.009

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology: Research and Practice, 47*(1), 18. https://doi.org/10.1037/pro0000055

Classen, C. C., & Clark, C. S. (2017). Trauma-informed care. In S. N. Gold (Ed.), *APA handbook of trauma psychology: Trauma practice* (pp. 515-541). American Psychological Association. https://doi.org/10.1037/0000020-025

Cnattingius, S., Hultman, C. M., Dahl, M., & Sparén, P. (1999). Very preterm birth, birth trauma, and the risk of anorexia nervosa among girls. *Archives of General Psychiatry, 56*(7), 634-638. https://doi.org/10.1001/archpsyc.56.7.634

Cook-Cottone, C. (2006). The attuned representation model for the primary prevention of eating disorders: An overview for school psychologists. *Psychology in the Schools, 43*(2), 223-230. https://doi.org/10.1002/pits.20139

Cook-Cottone, C. (2016). Embodied self-regulation and mindful self-care in the prevention of eating disorders. *Eating Disorders, 24*(1), 98-105. https://doi.org/10.1080/10640266.2015.1118954

Cook-Cottone, C. (2020). *Embodiment and the treatment of eating disorders: The body as a resource in recovery*. W. W. Norton & Company.

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *The American Journal of Orthopsychiatry, 82*(2), 187-200. https://doi.org/10.1111/j.1939-0025.2012.01154.x

Damasio, A. R. (2006). *Descartes' error*. Random House.

Daye, M. (2015a). The experimental attitude in Hakomi therapy: Curiosity in action. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 120-128). W. W. Norton and Company.

Daye, M. (2015b). Introduction. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 3-12). W. W. Norton and Company.

Demidenko, N., Tasca, G. A., Kennedy, N., & Bissada, H. (2010). The mediating role of self-concept in the relationship between attachment insecurity and identity differentiation among women with an eating disorder. *Journal of Social and Clinical Psychology, 29*(10), 1131-1152. https://doi.org/10.1521/jscp.2010.29.10.1131

Dennett, C. (2021). Trauma-informed nutrition care: Learn why and how negative past experiences can impact counseling dynamics and determine patient outcomes. *Today's Dietitian, 23*(6), 36-39.

Dmochowski, S., Ben-Shahar, A. R., & Carleton, J. A. (2013). Body psychotherapeutic treatments for eating disorders. In G. Marlock & H. Weiss (Eds.), *The handbook of body*

psychotherpay and somatic psychology (pp. 724-736). North Atlantic Books. http://www.jacquelineacarletonphd.com/text/pdfs/bptforeatingdisorders.pdf

Dondanville, K. A., Fina, B. A., Straud, C. L., Finley, E. P., Tyler, H., Jacoby, V., Blount, T. H., Moring, J. C., Pruiksma, K. E., Blankenship, A. E., Evans, W. R., & Zaturenskaya, M. (2021). Launching a competency-based training program in evidence-based treatments for PTSD: Supporting veteran-serving mental health providers in Texas. *Community Mental Health Journal, 57*(5), 910-919. https://doi.org/10.1007/s10597-020-00676-7

Duarte, C., Ferreira, C., & Pinto-Gouveia, J. (2016). At the core of eating disorders: Overvaluation, social rank, self-criticism and shame in anorexia, bulimia and binge eating disorder. *Comprehensive Psychiatry, 66*, 123-131. https://doi.org/https://doi.org/10.1016/j.comppsych.2016.01.003

Duncan, T. K., Sebar, B., & Lee, J. (2015). Reclamation of power and self: A meta-synthesis exploring the process of recovery from anorexia nervosa. *Advances in Eating Disorders, 3*(2), 177-190. https://doi.org/10.1080/21662630.2014.978804

Eisman, J. (2015). Hakomi character theory. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 76-90). W. W. Norton and Company.

Emerson, W. R. (2021a). Birth trauma: The psychological effects of obstetrical interventions. In K. Evertz, L. Janus, & R. Linder (Eds.), *Handbook of prenatal and perinatal psychology: Integrating research and practice* (pp. 559-575). Springer.

Emerson, W. R. (2021b). Stress, trauma, and shock: The failures and successes of cathartic regression therapy. In K. Evertz, L. Janus, & R. Linder (Eds.), *Handbook of prenatal and perinatal psychology: Integrating research and practice* (pp. 519-542). Springer.

Evertz, K. (2021). Prenatal psychology holds the key: Thoughts about the cultural meaning of prenatal psychology. In K. Evertz, L. Janus, & R. Linder (Eds.), *Handbook of prenatal and perinatal psychology: Integrating research and practice* (pp. 459-467). Springer.

Evertz, K., Janus, L., & Linder, R. (Eds.). (2021). *Handbook of prenatal and perinatal psychology: Integrating research and practice*. Springer.

Fay, J. (2017). 12 Step psychotherapy: A time-limited, cost-effective depth therapy. *Ata Journal*. https://openrepository.aut.ac.nz/handle/10292/12480

Fisher, J. (2020). Experiential approaches. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models* (pp. 533-549). The Guilford Press.

Fisher, R. (2015). Jumping out of the system. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 242-251). W. W. Norton and Company.

Ford, J. D., & Courtois, C. A. (2020a). Defining and understanding complex trauma and complex traumatic stress disorders. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models* (Vol. 2, pp. 3-34). The Guilford Press.

Ford, J. D., & Courtois, C. A. (Eds.). (2020b). *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models* (2nd ed.). The Guilford Press.

Ford, J. D., Grasso, D. J., Elhai, J. D., & Courtois, C. A. (2015). *Posttraumatic stress disorder: Scientific and professional dimensions*. Academic press.

Ford, J. D., Grasso, D., Greene, C., Levine, J., Spinazzola, J., & van der Kolk, B. (2013). Clinical significance of a proposed developmental trauma disorder diagnosis: Results of an

international survey of clinicians. *The Journal of Clinical Psychiatry, 74*(8), 841-849. https://doi.org/10.4088/JCP.12m08030

Ford, J. D., Spinazzola, J., van der Kolk, B., & Grasso, D. J. (2018). Toward an empirically based developmental trauma disorder diagnosis for children: Factor structure, item characteristics, reliability, and validity of the developmental trauma disorder semi-structured Interview. *The Journal of Clinical Psychiatry, 79*(5). https://doi.org/10.4088/JCP.17m11675

Foye, U., Hazlett, D. E., & Irving, P. (2019). The body is a battleground for unwanted and unexpressed emotions: Exploring eating disorders and the role of emotional intelligence. *Eating Disorders, 27*(3), 321-342. https://doi.org/10.1080/10640266.2018.1517520

Fuchs, T. (2021). The disappearing body: Anorexia as a conflict of embodiment. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, 1-9. https://doi.org/10.1007/s40519-021-01122-7

Gadamer, H. G. (1989). *Truth and method* (2nd ed.). Sheed and Ward.

Gadamer, H. G., & Lawrence, F. G. (1982). *Reason in the age of science*. MIT Press.

Gale, M. S. (2015). The flow of the process. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 237-241). W. W. Norton & Company.

Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000–2018 period: A systematic literature review. *The American Journal of Clinical Nutrition, 109*(5), 1402-1413. https://doi.org/10.1093/ajcn/nqy342

Gandhi, A. (2017). *The gift of anger: And other lessons from my grandfather Mahatma Gandhi*. Simon and Schuster.

Gaskin, C. L., & Cole, D. (2015). Following and leading. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 129-138). W. W. Norton and Company.

Gaynor, T. (2009, October 15). *Ron Kurtz in conversation with Therese Gaynor*. Irish Association of Humanistic and Integrative Psychotherapy. https://iahip.org/page-1075842

Gerber, M. R., & Gerber, E. B. (2019). An introduction to trauma and health. In M. R. Gerber (Ed.), *Trauma-informed healthcare approaches: A guide for primary care* (pp. 3-24). Springer.

Germer, C. K., Siegel, R. D., & Fulton, P. R. (2013). *Mindfulness and psychotherapy* (2nd ed.). The Guilford Press.

Giddings, L. S., & Grant, B. M. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 13*(1), 10-28. https://doi.org/10.5172/conu.13.1.10

Glashouwer, K. A., Brockmeyer, T., Cardi, V., Jansen, A., Murray, S. B., Blechert, J., Levinson, C. A., Schmidt, U., Tchanturia, K., & Wade, T. D. (2020). Time to make a change: A call for more experimental research on key mechanisms in anorexia nervosa. *European Eating Disorders Review, 28*(4), 361-367. https://doi.org/10.1002/erv.2754

Griffiths, S., Rossell, S. L., Mitchison, D., Murray, S. B., & Mond, J. M. (2018). Pathways into treatment for eating disorders: A quantitative examination of treatment barriers and treatment attitudes. *Eating Disorders, 26*(6), 556-574. https://doi.org/10.1080/10640266.2018.1518086

Grilo, C. M., & Mitchell, J. E. (2011). *The treatment of eating disorders: A clinical handbook*. Guilford Press.

Grondin, J. (1994). *Introduction to philosophical hermeneutics*. Yale University Press.

Günther, U. (2015). Strengths and limitations of the Hakomi method: Indications and contraindications for clients with significant clinical disorders. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 281-293). W. W. Norton and Company.

Gustin, J. (n.d.). *Soul circle - Introduction and meeting 1*. https://www.purposeguides.org/soul-circle

Hakomi Institute. (2015a). *Bibliography on mindfulness and psychotherapy*. https://hakomiinstitute.com/Resources/Biography-Mindfulness.pdf

Hakomi Institute. (2015b). *The Hakomi principles*. https://hakomiinstitute.com/about/hakomi-mindful-somatic-psychotherapy/the-hakomi-principles

Halmi, K. A. (2008). The perplexities of conducting randomized, double-blind, placebo-controlled treatment trials in anorexia nervosa patients. *American Journal of Psychiatry, 165*(10), 1227-1228. https://doi.org/10.1176/appi.ajp.2008.08060957

Hannon, J., Eunson, L., & Munro, C. (2017). The patient experience of illness, treatment, and change, during intensive community treatment for severe anorexia nervosa. *Eating Disorders, 25*(4), 279-296. https://doi.org/10.1080/10640266.2017.1318626

Hay, P. (2020). Current approach to eating disorders: A clinical update. *Internal Medicine Journal, 50*(1), 24-29. https://doi.org/10.1111/imj.14691

Hildebrandt, S. (2021). Attachment-guided birth culture as a means to avoid pre- and perinatal health disorders. In K. Evertz, Janus, L., & Linder, R. (Ed.), *Handbook of prenatal and perinatal psychology: Integrating research and practice* (pp. 193-206). Springer.

Hoge, C. W., & Chard, K. M. (2018). A window into the evolution of trauma-focused psychotherapies for posttraumatic stress disorder. *Journal of the American Medical Association, 319*(4), 343-345. https://doi.org/10.1001/jama.2017.21880

Holmes, S., Malson, H., & Semlyen, J. (2021). Regulating "untrustworthy patients": Constructions of "trust" and "distrust" in accounts of inpatient treatment for anorexia. *Feminism & Psychology, 31*(1), 41-61. https://doi.org/10.1177/0959353520967516

Inwood, M. (1999). *A Heidegger dictionary*. Wiley-Blackwell.

Jansingh, A., Danner, U. N., Hoek, H. W., & van Elburg, A. A. (2020). Developments in the psychological treatment of anorexia nervosa and their implications for daily practice. *Current Opinion in Psychiatry, 33*(6), 534-541. https://doi.org/10.1097/YCO.0000000000000642

Johanson, G. (1985). Editorial: When in doubt, go with the principles. *Hakomi Institute Professional Journal, Winter 1985*(2). https://hakomiinstitute.com/Forum/Issue2/EdDoubt.pdf

Johanson, G. (2006). A survey of the use of mindfulness in psychotherapy. *The Annals of the American Psychotherapy Association, 9*, 15-24. https://web.archive.org/web/20090508102915/http://www.gregjohanson.net/page.asp?ID=103

Johanson, G. (2009). Psychotherapy, science, and spirit: Nonlinear systems, Hakomi therapy, and the Tao. *Journal of Spirituality in Mental Health, 11*(3), 172-212. https://doi.org/10.1080/19349630903081093

Johanson, G. (2013-2014). Hakomi and the ambiguous nature of research. *Hakomi Forum,* (26), 11-26.

Johanson, G. (2015a). Hakomi in the context of research and science. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 347-359). W. W. Norton and Company.

Johanson, G. (2015b). Hakomi principles and a systems approach to psychotherapy. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 41-57). W. W. Norton and Company.

Johanson, G. (2015c). Working with a veteran and his family. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 319-331). W. W. Norton and Company.

Johanson, G., Johanson, G. J., & Kurtz, R. (1991). *Grace unfolding: Psychotherapy in the spirit of Tao-te Ching*. Harmony.

Johanson, G., & Weiss, H. (2015). Hakomi in context: The large picture in history and research. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 332-353). W. W. Norton and Company.

Kafle, N. P. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal, 5*(1), 181-200.

Kelly, S. W., & Papps, F. A. (2021). 'Really caring, really curious, and really there': A qualitative exploration of therapeutic presence from a Hakomi therapy perspective. *Body, Movement and Dance in Psychotherapy*, 1-16. https://doi.org/10.1080/17432979.2021.1939162

Kotilahti, E., West, M., Isomaa, R., Karhunen, L., Rocks, T., & Ruusunen, A. (2020). Treatment interventions for severe and enduring eating disorders: Systematic review. *International Journal of Eeating Disorders, 53*(8), 1280-1302. https://doi.org/10.1002/eat.23322

Kurtz, R. (1985). Foundations of Hakomi therapy. *Hakomi Forum, 2*, 3-7. http://hakomi.co.nz/assets/Foundations_of_Hakomi.pdf

Kurtz, R. (2006). Five recent essays. *Hakomi Institute Professional Journal, 16-17*, 1-8. https://hakomiinstitute.com/Forum/Issue16-17/1_Five_Recent_Essays.pdf

Kurtz, R. (2015). The essential method. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 19-30). W. W. Norton and Company.

Kurtz, R., Marvin, G., & Martin, D. (2018). *The Hakomi way: Consciousness & healing: The legacy of Ron Kurtz*. Stone's Throw Publications.

Kwee, J. L., & Launeanu, M. (2019). Practical strategies for promotoing embodiment in eating disorder prevention and treatment. In H. L. McBride & J. L. Kwee (Eds.), *Embodiment and eating disorders: Theory, research, prevention, and treatment* (pp. 342-357). Routledge.

Lacey, C., Clark, M., Manuel, J., Pitama, S., Cunningham, R., Keelan, K., Rijnberg, V., Cleland, L., & Jordan, J. (2020). Is there systemic bias for Māori with eating disorders? A need for greater awareness in the healthcare system. *New Zealand Medical Journal (Online), 133*(1514), 71.

Lacey, C., Cunningham, R., Rijnberg, V., Manuel, J., Clark, M. T. R., Keelan, K., Pitama, S., Huria, T., Lawson, R., & Jordan, J. (2020). Eating disorders in New Zealand: Implications for

Māori and health service delivery. *International Journal of Eating Disorders, 53*(12), 1974-1982. https://doi.org/10.1002/eat.23372

Landy, M. S. H., Wagner, A. C., Brown-Bowers, A., & Monson, C. M. (2015). Examining the evidence for complex posttraumatic stress disorder as a clinical diagnosis. *Journal of Aggression, Maltreatment & Trauma, 24*(3), 215-236. https://doi.org/10.1080/10926771.2015.1002649

Larsen, J. T., Bulik, C. M., Thornton, L. M., Koch, S. V., & Petersen, L. (2021). Prenatal and perinatal factors and risk of eating disorders. *Psychological Medicine, 51*(5), 870-880. https://doi.org/10.1017/S0033291719003945

Lavie, S. (2011). In search of a lost self: Reclaiming our missing experience. *Psychotherapy Networker Magazine*, *35*(5), 61-65.

Lavie, S. (2015). Experiments in mindfulness. In G. J. H. Weiss, & L. Monda (Ed.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 178-193). W. W. Norton & Company.

Lazzaro-Smith, M. (2008). Body psychotherapy for treating eating disorders. *The USA Body Psychotherpay Journal, 7*(2), 33-42.

Lester, R. J. (2019). *Famished: Eating disorders and failed care in America*. University of California Press.

Levine, P. A. (1997). *Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences*. North Atlantic Books.

Lingiardi, V., & McWilliams, N. (2017). *Psychodynamic diagnostic manual: PDM-2*. Guilford Publications.

Lock, J., Kraemer, H. C., Jo, B., & Couturier, J. (2019). When meta-analyses get it wrong: Response to treatment outcomes for anorexia nervosa: A systematic review and meta-

analysis of randomized controlled trials. *Psychological Medicine, 49*(4), 697-698. https://doi.org/10.1017/S003329171800329X

Luyten, P., Blatt, S. J., & Mayes, L. C. (2012). Process and outcome in psychoanalytic psychotherapy research: The need for a (relatively) new paradigm. In R. A. Levy, J. S. Ablon, & H. Kächele (Eds.), *Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence* (pp. 345–359). Humana Press - Springer. https://doi.org/10.1007/978-1-60761-792-1_21

Mallett, R., Hagen-Zanker, J., Slater, R., & Duvendack, M. (2012). The benefits and challenges of using systematic reviews in international development research. *Journal of Development Effectiveness, 4*(3), 445-455. https://doi.org/10.1080/19439342.2012.711342

Mark, G. T., & Lyons, A. C. (2010, Jun). Maori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science and Medicine, 70*(11), 1756-1764. https://doi.org/10.1016/j.socscimed.2010.02.001

Marlock, G., Weiss, H., Young, C., & Soth, M. (2015). *The handbook of body psychotherapy and somatic psychology*. North Atlantic Books.

Martin, D. (2015). The skills of tracking and contact. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 152-160). W. W. Norton and Company.

Martin, J., & Thompson, J. (2003). Psychotherapy as the interpretation of being: Hermeneutic perspectives on psychotherapy. *Journal of Constructiviest Psychology, 16*(1), 1-16. https://doi.org/10.1080/10720530390117830

Marzola, E., Cavallo, F., Panero, M., Porliod, A., Amodeo, L., & Abbate-Daga, G. (2021). The role of prenatal and perinatal factors in eating disorders: A systematic review. *Archives of Women's Mental Health, 24*(2), 185-204. https://doi.org/10.1007/s00737-020-01057-5

Maté, G. (2019). *Hold on to your kids: Why parents need to matter more than peers*. Ebury Publishing.

McLeod, J. (2015). *Doing research in counselling and psychotherapy* (3rd ed.). Sage.

Meneguzzo, P., Cazzola, C., Castegnaro, R., Buscaglia, F., Bucci, E., Pillan, A., Garolla, A., Bonello, E., & Todisco, P. (2021). Associations between trauma, early maladaptive schemas, personality traits, and clinical severity in eating disorder patients: A clinical presentation and mediation analysis. *Frontiers in Psychology, 12*, 1-11. https://doi.org/10.3389/fpsyg.2021.661924

Ministry of Health. (2017). *Māori health models – Te Whare Tapa Whā*. https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

Ministry of Health. (2021). *Eating disorders*. https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/eating-disorders

Monda, L., & Eisman, J. (2015). Hakomi character-informed interventions. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 252-271). W. W. Norton and Company.

Monteleone, A. M., Cascino, G., Pellegrino, F., Ruzzi, V., Patriciello, G., Marone, L., De Felice, G., Monteleone, P., & Maj, M. (2019). The association between childhood maltreatment and eating disorder psychopathology: A mixed-model investigation. *European Psychiatry, 61*, 111-118. https://doi.org/10.1016/j.eurpsy.2019.08.002

Monteleone, A. M., Cascino, G., Ruzzi, V., Pellegrino, F., Patriciello, G., Barone, E., Carfagno, M., Monteleone, P., & Maj, M. (2021). Emotional traumatic experiences significantly contribute to identify a maltreated ecophenotype sub-group in eating disorders: Experimental evidence. *European Eating Disorders Review: The Journal of the Eating Disorders Association, 29*(2), 269-280. https://doi.org/10.1002/erv.2818

Monteleone, A. M., Tzischinsky, O., Cascino, G., Alon, S., Pellegrino, F., Ruzzi, V., & Latzer, Y. (2021). The connection between childhood maltreatment and eating disorder psychopathology: A network analysis study in people with bulimia nervosa and with binge eating disorder. *Eating and Weight Disorders-Studies on Anorexia Bulimia and Obesity*. https://doi.org/10.1007/s40519-021-01169-6

Moreira, A., & Pedrocosta, A. (2016). Introduction: Qualitative analysis: Quantifying quality and qualifying quantity. *Qualitative Report, 21*(13), 1-5. https://doi.org/10.46743/2160-3715/2016.2606

Morgan, M. (2007). *The alchemy of love: Recent graduates' lived experiences of psychotherapy training: A hermeneutic study* [Master's thesis, Auckland University of Technology]. Tuwhera. https://openrepository.aut.ac.nz/handle/10292/10

Morgan, M. (2013). Attachment and Hakomi. *Hakomi Forum, 26*, 49.

Morgan, M. (2015a). The central role of the body in Hakomi psychotherapy. In H. J. Weiss, G. Johanson & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 33-40). W. W. Norton & Company.

Morgan, M. (2015b). Child states and therapeutic regression. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 203-216). W. W. Norton and Company.

Mott, L. A., & Lumsden, B. D. (2019). *Understanding eating disorders: Anorexia nervosa, bulimia nervosa and obesity*. Taylor & Francis.

Moyer, L. (1986). The context for Hakomi in the treatment of eating disorders. *The Hakomi Forum, 4*, 33-41. https://www.hakomiinstitute.com/Forum/Issue4/ContextEating.pdf

Murphy, J. (2015). The therapeutic relationship in Hakomi therapy. In H. J. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 93-107). W. W. Norton & Company.

Murray, S. B. (2019). Updates in the treatment of eating disorders in 2018: A year in review in Eating Disorders: The Journal of Treatment & Prevention. *Eating Disorders: The Journal of Treatment & Prevention, 27*(1), 6-17. https://doi.org/doi.org/10.1080/10640266.2019.1567155

Murray, S. B. (2020). Updates in the treatment of eating disorders in 2019: A year in review in Eating Disorders: The Journal of Treatment & Prevention. *Eating Disorders: The Journal of Treatment & Prevention, 28*(1), 21-31. https://doi.org/10.1080/10640266.2020.1723373

Murray, S. B., Loeb, K. L., & Le Grange, D. (2018). Treatment outcome reporting in anorexia nervosa: time for a paradigm shift? *Journal of Eating Disorders, 6*(1), 1-3. https://doi.org/10.1186/s40337-018-0195-1

Murray, S. B., Quintana, D. S., Loeb, K. L., Griffiths, S., Crosby, R. D., & Le Grange, D. (2019). Meta-analysis misunderstood: A cautionary tale in interpreting meta-analytic findings. *49*(4), 699-700. https://doi.org/10.1017/S0033291718003501

Murray, S. B., Quintana, D. S., Loeb, K. L., Griffiths, S., & Le Grange, D. (2018). Treatment outcomes for anorexia nervosa: A systematic review and meta-analysis of randomized

controlled trials. *Psychological Medicine, 49*(4), 535-544. https://doi.org/10.1017/s0033291718002088

Nagata, J. M., & Murray, S. B. (2021). Updates in the treatment of eating disorders in 2020: A year in review in Eating Disorders: The Journal of Treatment & Prevention. *Eating Disorders: The Journal of Treatment & Prevention, 29*(2), 123-133. https://doi.org/10.1080/10640266.2021.1909795

National Health Service. (2021). *Treatment - anorexia*. https://www.nhs.uk/mental-health/conditions/anorexia/treatment/

National Institute for Health and Care Excellence. (2020). *Eating disorders: Recognition and treatment*. https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#treating-anorexia-nervosa

O'Brien, B. (2020, August 26). *The saying "empty your cup"*. https://www.learnreligions.com/empty-your-cup-3976934

Ogden, P. (2015). I can see clearly now the rain has gone. In J. Petrucelli (Ed.), *Body-states: Interpersonal and relational perspectives on the treatment of eating disorders* (pp. 92-103). Routledge.

Ogden, P. (2020). Sensorimotor psychotherapy. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disordersin adults: Scientific foundations and therapeutic models* (2nd ed.). The Guilford Press.

Ogden, P. (2021). *The pocket guide to sensorimotor psychotherapy: In context.* W. W. Norton.

Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. W. W. Norton & Company.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. W. W. Norton & Company.

Ogden, P., Pain, C., & Fisher, J. (2006). A sensorimotor approach to the treatment of trauma and dissociation. *Psychiatric Clinics of North America, 29*(1), 263-279. https://doi.org/https://doi.org/10.1016/j.psc.2005.10.012

Oldershaw, A., Lavender, T., Sallis, H., Stahl, D., & Schmidt, U. (2015). Emotion generation and regulation in anorexia nervosa: A systematic review and meta-analysis of self-report data. *Clinical Psychology Review, 39*, 83-95. https://doi.org/10.1016/j.cpr.2015.04.005

Orange, D. M. (2011). *The suffering stranger: Hermeneutics for everyday clinical practice*. Routledge.

Orbach, S. (2006). How can we have a body?: Desires and corporeality. *Studies in Gender and Sexuality, 7*(1), 89-111. https://doi.org/10.2513/s15240657sgs0701_9

Oyer, L., O'Halloran, M. S., & Christoe-Frazier, L. (2016). Understanding the working alliance with clients diagnosed with anorexia nervosa. *Eating Disorders, 24*(2), 121-137. https://doi.org/10.1080/10640266.2015.1034050

Pai, A., Suris, A. M., & North, C. S. (2017). Posttraumatic stress disorder in the DSM-5: Controversy, change, and conceptual considerations. *Behavioral Sciences, 7*(1), 7. https://doi.org/10.3390/bs7010007

Palmer, R. E. (1969). *Hermeneutics: Interpretation theory in Schleiemacher, Dithey, Heidegger, and Gadamer*. Northwestern University Press.

Payne, P., Levine, P. A., & Crane-Godreau, M. A. (2015). Somatic experiencing: Using interoception and proprioception as core elements of trauma therapy. *Frontiers in Psychology, 6*, 93. https://doi.org/10.3389/fpsyg.2015.00093

Pellegrini, R. A., Finzi, S., Veglia, F., & Di Fini, G. (2021). Narrative and bodily identity in eating disorders: Toward an integrated theoretical-clinical approach. *Frontiers in Psychology, 12*. https://doi.org/10.3389/fpsyg.2021.785004

Perrin, J. (2015). Mindfulness as a psychotherapeutic tool. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 108-119). W. W. Norton and Company.

Peseschkian, N. (2015). The positive management of the body. In G. Marlock, H. Weiss, C. Young, & M. Soth (Eds.), *The handbook of body psychotherapy and somatic psychology* (pp. 847-898). North Atlantic Books.

Pignatelli, A. M., Wampers, M., Loriedo, C., Biondi, M., & Vanderlinden, J. (2017). Childhood neglect in eating disorders: A systematic review and meta-analysis. *Journal of Trauma & Dissociation, 18*(1), 100-115. https://doi.org/10.1080/15299732.2016.1198951

Polkinghorne, D. (1983). *Methodology for the human sciences: Systems of inquiry*. State University of New York Press.

Pryor, T., & Wiederman, M. W. (1996). Measurement of nonclinical personality characteristics of women with anorexia nervosa or bulimia nervosa. *Journal of Personality Assessment, 67*(2), 414-421. https://doi.org/10.1207/s15327752jpa6702_14

Racine, N., Killam, T., & Madigan, S. (2020). Trauma-informed care as a universal precaution: Beyond the adverse childhood experiences questionnaire. *JAMA Pediatrics, 174*(1), 5-6. https://doi.org/10.1001/jamapediatrics.2019.3866

Raevuori, A., Linna, M. S., & Keski-Rahkonen, A. (2014). Prenatal and perinatal factors in eating disorders: A descriptive review. *International Journal of Eating Disorders, 47*(7), 676-685. https://doi.org/10.1002/eat.22323

Reeds, M. M. (2015). Working through core beliefs. In H. J. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 217-226). W. W. Norton and Company.

Reyes-Rodríguez, M. L., Ann Von Holle, T., Thornton, L. M., Klump, K. L., Brandt, H., Crawford, S., Fichter, M. M., Halmi, K. A., Huber, T., & Johnson, C. (2011). Post traumatic stress disorder in anorexia nervosa. *Psychosomatic Medicine, 73*(6), 491-497. https://doi.org/10.1097/PSY.0b013e31822232bb

Röhricht, F. (2009). Body oriented psychotherapy. The state of the art in empirical research and evidence-based practice: A clinical perspective. *Body, Movement and Dance in Psychotherapy, 4*(2), 135-156. https://doi.org/10.1080/17432970902857263

Romanyshyn, R. D. (2020). *The wounded researcher: Research with soul in mind*. Routledge.

Rosenberg, M. B. (2015). *Nonviolent communication: A language of life: Life-changing tools for healthy relationships*. PuddleDancer Press.

Rosendahl, S., Sattel, H., & Lahmann, C. (2021). Effectiveness of body psychotherapy: A systematic review and meta-analysis. *Frontiers in Psychiatry, 12*(1486), 1-15. https://doi.org/10.3389/fpsyt.2021.709798

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma & trauma treatment*. W. W. Norton & Company.

Rothschild, B. (2003). *The body remembers casebook: Unifying methods and models in the treatment of trauma and PTSD*. W. W. Norton & Company.

Schmidt, U., Magill, N., Renwick, B., Keyes, A., Kenyon, M., DeJong, H., Lose, A., Broadbent, H., Treasure, J., Landau, S., Loomes, R., Yasin, H., Boughton, N., Whitehead, L., Watson, C., Ghelani, S., Bonin, E. M., Beecham, J., Serpell, L., Richards, L., & Johnson-Sabine, E. (2015). The Maudsley outpatient study of treatments for anorexia nervosa and related

conditions (MOSAIC): Comparison of the Maudsley model of anorexia nervosa treatment for adults (MANTRA) with specialist supportive clinical management (SSCM) in outpatients with broadly defined anorexia nervosa: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 83*(4), 796-807. https://doi.org/10.1037/ccp0000019

Schmidt, U., Startup, H., & Treasure, J. (2018). *A cognitive interpersonal therapy workbook for treating anorexia nervosa: The Maudsley model*. Routledge.

Schore, A. N. (2014). The right brain is dominant in psychotherapy. *Psychotherapy, 51*(3), 388-397. https://doi.org/10.1037/a0037083

Schwartz, R. C. (2013). Moving from acceptance toward transformation with Internal Family Systems therapy (IFS). *Journal of Clinical Psychology, 69*(8), 805-816. https://doi.org/10.1002/jclp.22016

Schwartz, R. C. (2021). *No bad parts: Healing trauma and restoring wholeness with the Internal Family Systems model*. Sounds True.

Schwartz, R. C., & Sweezy, M. (2020). *Internal Family Systems therapy* (2nd ed.). The Guilford Press.

Schwartz, R. C. (2015). Foreward. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 120-128). W. W. Norton and Company.

Sharman, A. (2021, December 10). Embracing Māori birth traditions is changing the future for Northland families. *The Spinoff*. https://thespinoff.co.nz/partner/10-12-2021/embracing-maori-birth-traditions-is-changing-the-future-for-northland-families

Siegel, D. J. (1998). The developing mind: Towards a neurobiology of interpersonal experience. *Signal, 6*(3-4), 1-11. https://perspectives.waimh.org/wp-content/uploads/sites/9/2019/07/Scan_6-28-2019_15-28-54_18.pdf

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. W. W. Norton and Company.

Skårderud, F. (2007). Shame and pride in anorexia nervosa: A qualitative descriptive study. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association, 15*(2), 81-97. https://doi.org/10.1002/erv.774

Smythe, E., & Spence, D. (2012). Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods, 11*(1), 12-25. https://doi.org/10.1177/160940691201100102

Smythe, L. (2012). Discerning which qualitative approach fits best. *New Zealand College of Midwives Journal,* 46, 5-12.

Solmi, M., Wade, T. D., Byrne, S., Del Giovane, C., Fairburn, C. G., Ostinelli, E. G., De Crescenzo, F., Johnson, C., Schmidt, U., Treasure, J., Favaro, A., Zipfel, S., & Cipriani, A. (2021). Comparative efficacy and acceptability of psychological interventions for the treatment of adult outpatients with anorexia nervosa: A systematic review and network meta-analysis. *The Lancet Psychiatry, 8*(3), 215-224. https://doi.org/10.1016/S2215-0366(20)30566-6

Sparks, T. F. (2015). Assusted self-study: Unfolding the organization of experience. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 58-65). W. W. Norton and Company.

St-Hilaire, A., Steiger, H., Liu, A., Laplante, D. P., Thaler, L., Magill, T., & King, S. (2015). A prospective study of effects of prenatal maternal stress on later eating-disorder manifestations in affected offspring: Preliminary indications based on the project ice storm cohort. *Interational Journal of Eating Disorders, 48*(5), 512-516. https://doi.org/10.1002/eat.22391

Starkman, H. (2016). Interview with Susie Orbach, Ph. D., CSW. *Clinical Social Work Journal, 44*(1), 4-7. https://doi.org/DOI 10.1007/s10615-015-0558-x

Stockford, C., Stenfert Kroese, B., Beesley, A., & Leung, N. (2019). Women's recovery from anorexia nervosa: A systematic review and meta-synthesis of qualitative research. *Eating Disorders, 27*(4), 343-368. https://doi.org/10.1080/10640266.2018.1512301

Tait-Jamieson, S. (2016). Using Hakomi to mediate cultural differences. *Hakomi Forum, 28-29*, 43-48. https://hakomiinstitute.com/Forum/Issue28/2016_Hakomi_Forum_Tait-Jamieson.pdf

Taylor, M. (2020). Collective trauma and the relational field. *The Humanistic Psychologist, 48*(4), 382. https://doi.org/10.1037/hum0000215

Totton, N. (2003). *Body psychotherapy: An introduction*. Open University Press McGraw-Hill Education.

Totton, N. (2005). *New dimensions in body psychotherapy*. Open University Press.

Treasure, J. (1997). *Anorexia nervosa: A survival guide for families, friends and sufferers*. Psychology Press.

Treasure, J., Cardi, V., Leppanen, J., & Turton, R. (2015). New treatment approaches for severe and enduring eating disorders. *Physiology & Behavior,* 152(Pt B), 456-465. https://doi.org/10.1016/j.physbeh.2015.06.007

Treasure, J., Oyeleye, O., Bonin, E. M., Zipfel, S., & Fernandez-Aranda, F. (2021). Optimising care pathways for adult anorexia nervosa. What is the evidence to guide the provision of high-quality, cost-effective services? *European Eating Disorders Review, 29*(3), 306-315. https://doi.org/10.1002/erv.2821

Treasure, J., & Schmidt, U. (2013). The cognitive-interpersonal maintenance model of anorexia nervosa revisited: A summary of the evidence for cognitive, socio-emotional and interpersonal predisposing and perpetuating factors. *Journal of Eating Disorders, 1*(1), 1-10. https://doi.org/10.1186/2050-2974-1-13

Treasure, J., Schmidt, U., & Macdonald, P. (2010). *The clinician's guide to collaborative caring in eating disorders: The new Maudsley method*. Routledge.

Treasure, J., Smith, G., & Crane, A. (2007). *Skills-based learning for caring for a loved one with an eating disorder: The new Maudsley Method*. Routledge.

Van der Knaap, L. M., Leeuw, F. L., Bogaerts, S., & Nijssen, L. T. (2008). Combining Campbell standards and the realist evaluation approach: The best of two worlds? *American Journal of Evaluation, 29*(1), 48-57. https://doi.org/10.1177/1098214007313024

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin Books Limited.

Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1*(5), 253-265.

Verny, T. R. (2021). The pre-and perinatal origins of childhood and adult diseases and personality disorders. In K. Evertz, L. Janus, & R. Linder (Eds.), *Handbook of prenatal and perinatal psychology: Integrating research and practice* (pp. 47-62). Springer.

von Kalckreuth, B. (2021). Psychoanalytic parent-infant-psychotherapy: Transition to parenthood. In K. Evertz, L. Janus, & R. Linder (Eds.), *Handbook of prenatal and perinatal psychology: Integrating research and practice* (pp. 577-584). Springer.

Weiss, H. (2015a). Characteristics of Hakomi. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 13-18). W. W. Norton and Company.

Weiss, H. (2015b). Transformation. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 227-236). W. W. Norton & Company.

Weiss, H., & Harrer, A. (2015). The body and the truth. In G. Marlock, H. Weiss, C. Young, & M. Soth (Eds.), *The handbook of body psychotherapy and somatic psychology* (pp. 265-287). North Atlantic Books.

Weiss, H., & Johanson, G. (2015a). Appendix 3: Hakomi in context: The large picture in history and research. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered psychotherapy: A comprehensive guide to theory and practice* (pp. 332-359). W. W. Norton and Company.

Weiss, H., & Johanson, G. (2015b). Hakomi's history. In H. Weiss, G. Johanson, & L. Monda (Eds.), *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice* (pp. 339-347). W. W. Norton & Company.

Weiss, H., Johanson, G., & Monda, L. (Eds.). (2015). *Hakomi mindfulness-centered somatic psychotherapy: A comprehensive guide to theory and practice*. W. W. Norton & Company.

Wesselius, H., Bosch, I., van Hastenberg, L., Simons, J., Kuiper, C., & van der Helm, P. (2020). A new perspective on extreme recurring anorexia and its treatment: A preliminary study. *Journal of Prenatal & Perinatal Psychology & Health, 34*(5), 369-393.

Wingate, B. (2008). Holistic integrative psychiatry and the treatment of eating disorders. In M. Maine, W. N. Davis, & J. Shure (Eds.), *Effective clinical practice in the treatment of eating disorders: The heart of the matter* (pp. 63-77). Routledge.

Woodcock, J. (2022). *Families and individuals living with trauma*. Springer.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Young, C. (2006). One hundred and fifty years on: The history, significance and scope of body psychotherapy today. *Body, Movement and Dance in Psychotherapy, 1*(1), 17-28. https://doi.org/10.1080/17432970500468299

Zeeck, A., Herpertz-Dahlmann, B., Friederich, H.-C., Brockmeyer, T., Resmark, G., Hagenah, U., Ehrlich, S., Cuntz, U., Zipfel, S., & Hartmann, A. (2018). Psychotherapeutic treatment for anorexia nervosa: A systematic review and network meta-analysis. *Frontiers in Psychiatry, 9*, 158. https://doi.org/10.3389/fpsyt.2018.00158