How does Integrative Body Psychotherapy contribute to Quality of Life?

Mark Froesch-Baumann, May 2002

Introduction

Quality of life has been a subject of an increasing number of publications in the last decades. In an earlier study I described philosophic, historical, social, economic, medical and psychological attempts at quality of life, health and well-being and summarized them into a definition relevant to psychotherapy (Froesch, 2001). In this article, I am summarizing my results, extending them in some points and discussing the potential to enhance the quality of life at individual and social levels of both psychotherapy in general and Integrative Body Psychotherapy (IBP).

1. A Model for Quality of Life Relevant to Psychotherapy

The approach to quality of life, health and well-being of the humanities the social and natural sciences distinguishes between nine essential dimensions in the three areas of psychological well-being, body and environment. These nine dimensions affect considerably the quality of life of people on all their levels of being. In the following, the three areas and their dimensions are presented.

1.1. The Psyche: Psychological Well-Being

Research shows that psychological well-being depends on the interaction of various coherent dimensions (Ryff & Singer, 1996). The most important results show a damping role in coping with stress, the positive influence on the course of a disease and important immunological and endocrine effects (Fava & Sonino, 2000, p.188). So, for example, the maintenance of psychological well-being of breast cancer patients prolongs their survival time, while it is shortened by impaired well-being (Spiegel et al., 1989). Ryff and Singer (1996, p.15f.) have found similar contributions in the wide literature about good psychological functioning and have developed six dimensions of a *model of psychological well-being*. Besides specifically psychological aspects like perception, thinking, feeling and action, this model also includes social and spiritual aspects:

(1) Self-Acceptance. The most recurrent criterion of well being, the individual's sense of self-acceptance, performs a central contribution to mental health. This is defined by self-actualization (Maslow), optimal functioning (Rogers) and maturity (Allport).

(2) Positive Relations with Others emphasizes warm, trusting interpersonal relations, the ability to love, to feel empathy and affection and to experience deep friendship and intimacy.

(3) Autonomy means self-determination, independence, and the regulation of behavior from within. The fully functioning person (Rogers) is described as having an internal locus of evaluation. Individuation (Jung) is seen to involve a deliverance from convention, collective fears, beliefs and laws of the masses.

(4) Environmental Mastery is the ability to choose or create environments suitable to the psychic conditions and to participate considerably in a significant sphere of activity outside of oneself, to advance in the world and change it creatively through physical or mental activities.

(5) Purpose in Life. Mental health is defined to include beliefs that give one the feeling that there is purpose and meaning to life. One who functions positively has goals, intentions and a sense of direction, all of which contribute to the feeling of a meaningful life.

(6) Personal Growth requires not only achievement of prior characteristics, but also continuous development of one's potential, growth and expansion as a person. The need to actualize oneself and realize one's potential is central to perspectives on personal growth. Openness to experience is a key characteristic to continued growth and self-realization.

These criteria are conceptually distinct from prominent empirical indicators of well-being such as happiness or life satisfaction, most of which often lack theoretical foundation. However, there are notable parallels between the formulations of wellness from the literature and philosophical perspectives on the meaning of 'the good life'. Such contributions to human health are not bound to culture, although their expression and the relative accentuation can vary significantly. An empiric study of the operationalized model shows differences in good functioning according to age, sex, class and cultural differences (Ryff & Singer, 1996).

1.2. The Body: Physical Well-Being and Physical Health

(7) Physical Well-Being means exclusively the relation of the person to its body as a subjective phenomenon. It does not correspond with physical health and only moderately with objective health criteria. Central are the physical conditions which the affected person perceives, experiences and values in a positive way. However, one cannot strictly separate physical well-being from psychological well-being, which is always also to be understood as a psychophysical well-being. The structure of physical well-being can be described with seven factors: (1) satisfaction with the momentary body condition, (2) feelings of peace and leisure, (3) vitality and joy of life, (4) relaxing strain / pleasant tiredness, (5) pleasure and desire, (6) concentration and reactivity as well as (7) a well-groomed, fresh and pleasant body feeling (Frank, 1991).

Physical well-being is of big relevance to psychotherapy, because 'a fundamental therapeutic aim consists in reaching a positive dialogue with one's own body. Different examinations show very clearly that psychosomatically disturbed persons hardly succeed in body dialogue, because their perception of their physical functions and needs is insufficient or distorted, and they often give only little attention to their healthy body experience. These people need specific guidance to achieve appropriate body attention and a positive, pleasurable body experience. On the background of precise knowledge about the structure of physical well-being success is more likely to be' (Frank, 1991, p.91).

The Quality of Life Group of the World Health Organization has conceptualized physical health and environment in addition to the psychological and social (WHOQOL Group, 1998, p.551; Gladis, 1999, p.322). The group defines quality of life as 'individuals' perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns.' The definition attaches great importance to a subjective evaluation of quality of life which must take place in their cultural, social and environmental context.

(8) Physical Health contains the facets pain and discomfort, sleep and rest, energy and fatigue, mobility, activities of daily living, dependence on medical substances and medical aids as well as work capacity.

1.3. The Environment

(9) The Environment contributes essentially to the quality of life. The WHOQOL Group names the following environmental aspects: Freedom, physical safety and security; home environment; financial resources; health and social care: accessibility and quality; opportunities for acquiring new information and skills; participation in and opportunities for recreation/leisure activity; physical environment (pollution/noise/traffic/climate); transport.

2. Quality of Life in Psychotherapeutic Mainstreams

Before I concentrate on the Integrative Body Psychotherapy, I will briefly show the main differences in the three psychotherapeutic mainstreams: Psychoanalysis resp. psychodynamic therapies, cognitive and behavioral therapy, humanistic psychotherapy (gestalt, client-centered

and body psychotherapy). The notion of quality of life was hardly explicitly described in all attempts up to now. That's why the present consideration is the result of a search in literature for statements about good life, happiness, satisfaction, health or well-being in the theoretical basis, images of man, personality theories, the understanding of health and disease and the objectives of therapy relevant to practice (cf. Froesch, 2001). This search has proved an abundance of qualities, skills and conditions which can be assigned to the nine quality of life areas. The divergence in the nature of quality of life between the different procedures are low: it appears in form of good feelings and perceptions as well as increased scope for action concerning oneself, one's body, others and the world, while the environment is hardly described. All schools share the goals self-actualization and self-realization, relational ability, autonomy and physical health. Differences appear from separate ideas about what causes quality of life:

- *Psychoanalysis* emphasizes consciousness, quest for the truth and me-strength, however neglects control of the environment and search for meaning (Mertens 2000; Köhler 1993; Mentzos 1984; Freud 1933);
- *Cognitive Behavioral Therapies* aim at cognitive, emotional, physical and behavioral functioning, however show little interest in search for meaning and growth. If some facets seem surprisingly humanistic, this is owed first of all to the contributions from Albert Ellis' rational emotive therapy (Beck 1991; Margraf 1996; Grawe 1998; Ellis 1991);
- *Humanistic Psychotherapies* stress awareness, genuineness and freedom of choice at the very moment in the here-and-now, social interdependence and orientation of meaning as well as holistic growth as the aim in life (Bugenthal 1964; Clarkson & Mackewn 1995; Perls 1982, 1996; Petzold 1982; Rogers 1991).

3. Quality of Life in the Integrative Body Psychotherapy

3.1. Integrative Body Psychotherapy IBP

The most essential difference of body-oriented methods to other psychotherapies is the explicit and straight inclusion of the body in the therapy. Basis are the discoveries of the Freud pupil Wilhelm Reich about connections and correspondences between posture or structure and mental experiencing as well as his conviction that every psychological appearance manifests itself physically in persons. Also Keleman (1992, 1994) has described the parallel development of physical and emotional differentiation in detail. Rothschild (2000) and van der Kolk (1994, 2000) could prove the memory for everyday and traumatic experiences at the body level. Therefore, there are many reasons to include mind, emotions *and* body in a successful psychotherapy.

In 1985, Jack Lee Rosenberg, the founder of the Integrative Body Psychotherapy, and his assistants presented the IBP approach for the first time in written form in the book 'Body, Self & Soul - Sustaining Integration' as an 'exciting new therapy, supporting human growth. A method concerned with the whole person, integrating body, mind, feelings and spirit! A method which causes deep and durable changes!' (Rosenberg, Rand & Asay, 1985/1993, p.12). At that time the separate elements of the method were not new. They come from psychoanalysis, object relations theory, self-psychology and development psychology, the client-centered approach, bioenergetics, gestalt, transpersonal psychotherapy, body therapy and movement therapy, medical models, acupuncture, yoga, meditation and dance as well as the work with death and dying. Rosenberg's merit was bringing together these various elements, on the basis of the humanistic image of man, to a model of personality and development coherent in itself.

The IBP model serves the diagnostics, allows hypotheses to the etiology, pathogenesis and salutogenesis of disturbances and leads to individualized psychotherapeutic interventions containing educational, cognitive and behavioral-therapeutic steps besides the above-mentioned

body- and talk-oriented approach. IBP integrates new developments and results of research, thus extending its concepts and treatments, for example by trauma therapy (Levine, 1998) or pre- and perinatal trauma therapy (Emerson 2000, Janus 1997). IBP is applied in singles, couples and group settings. In addition to the classic self-contact and self-development oriented therapy there is also a structured, problem centered and solution oriented short time therapy. Practice shows that there are no real contraindications, however, there may be contraindications against certain interventions as for example body-opening techniques with heavily traumatized persons because of the danger of retraumatizing or with patients having a very impaired self-structure (danger of uncontrollable regression). In the case of such indications, other interventions are introduced into the treatment.

3.2 Quality of Life in the Framework of Integrative Body Psychotherapy

Even if at this point, the notion is for the first time described explicitly within the framework of the IBP model, quality of life can be found in the image of man, the therapy goals, the different levels of integration, the particularly effective techniques and the development-psychological basics of IBP. In the following I describe how the nine dimensions of the quality of life-model come into IBP.

(1) Self-Acceptance

One of the most important concepts of IBP is self-psychology and development of the sense of self. The self or sense of self is, in the sense of Kohut's self psychology (1977/1999), the core of the personality: the sense of identity, continuance and meaning (Rosenberg et al., 1985/1993, p.398). Winnicott's notion of 'real self' and Sterns concept of the sense of self are also important for the self-concept (Scharfetter, 1996, p.99ff; Stern, 1985/1992). If the individual loses self-contact, he is called fragmented. Defragmentation, as a therapeutic tool, means the recovery of the self-image on a cognitive, physical, emotional, social or spiritual level.

In harmony with the humanistic image of man, goals of IBP are on the one hand self-regulation, self actualization and maturity. On the other hand, the restitution of the relations ability at the levels on which it is disturbed or has even never existed is essential for the therapy process. In the relational model of IBP (systemic approach), quality of life develops from an intact relational network within a person (intraorganismic) or interpersonal (interorganismic) or as a combination. Subsystems of living systems communicate together and are in relation for the organism as a whole to be and remain viable (IBP-Institut, 2000). This requires a process of becoming conscious and (re-) finding a core sense of self (Stern, 1985/1992). This also means to know oneself: ‚IBP helps individuals experience their potential by heightening aliveness and authenticity and through mental-health skills to sustain well-being … The secret is to reawaken authenticity and aliveness in the body … This body, or somatic, awareness of self, is the most fundamental experience in life. At this level we are able to witness the messages of our inner voice and experience a deep internal feeling of stability, consistency, the wonder of being alive, and a nonverbal body experience of truth and authenticity. Somatic experience allows us to acquire a sense of self that can be sustained no matter what we are faced with in life. But when our sense of self is not grounded in our body, we do not know where to look for the missing experience. Without somatic awareness, to avoid the feeling of emptiness and instability, we are compelled to try to find a substitute for the experience of self through 'doing' behaviors' (Rosenberg & Kitaen-Morse, 1996, p.7/23).

In IBP, the modification of patterns of perception, thinking and action is essential for the encouragement of self-acceptance. Presence in the here-and-now, self-contact and flexible self-boundaries play a part as well as self-empathy, activation of resources or the ability to take a meta-position. Self-acceptance shows by a more positive basic mood also in emotionally incriminating life situations, more joy of life and a body feeling of identity and continuity. The result is a deep feeling of inner stability and consistency. The patient's consciousness of his life

history is meaningful as long as it is the cause for suffering and limitations in the present. When needed, reconciliation by understanding, handling and meaning of the events as well as coherence is strived for.

At an emotional level, self-acceptance shows by a more positive basic mood, more joy of life, uninhibited access to emotions and freer expression of the latter. At the mental-cognitive level, it shows by a more positive life attitude, changed patterns of thought and behavior, acceptance of the unchangeable, ability to take a meta-position ("witness"), raised frustration tolerance and affect control as well as increased motivation.

(2) Positive Relations with Others

As mentioned above, IBP can essentially be viewed as a relationship model. The way of relations in the family of origin is of vital meaning for the development of self, the emergence of fears of inundation or abandonment or resources in the life history and the current relations ability of patients. Absolutely central is the concept of the boundary, understood as energetic restriction of the integrated self. 'The self-boundary is the sense (or the experience or the consciousness) of the self, that it is separated from the world, but, nevertheless, lives in a harmonious relationship with it' (Rosenberg et al.,1985/1993, p.395). It defines the self and allows a subjective body experience. At the boundary, contact and relation between I and You arise. These Boundaries are ideally flexible, can be defensive, rigid or stiff and show deficiencies or be absent completely. In therapy, they need to be appreciated by the therapist, he or she must not cross them at any rate without asking. The idea of the boundary integrates the central concepts of IBP presence, contact, relationship, integration, equality of relationship to the self and to others, liveliness as well as free flow and exchange of energy.

The development-psychological bases of IBP refer to other essential factors for good relations with others. For the healthy development of the core sense of self are needed (IBP-Institut, 2000): (1) bonding through loving and accepting attention by the primary caretaker (Bowlby, 1975; Brisch, 1999), (2) emotional attunement and extensive satisfaction of the primary needs by the caretaker (Stern, 1992) and (3) space as permission to follow its impulses towards autonomy and individuation (Mahler et al., 1976). Development can be damaged and disease caused by influences exceeding the coping mechanisms, above all the disregard of childish needs (misattunement) in the form of too much (inundation, boundary crossings) and too little (abandonment, deficit experiences) or the combination of both. The therapeutic relationship emphasizes compassion (somatic empathy), acceptance, congruence, professional calmness and boundaries. This relationship is of fundamental importance for the development of the ability for the encounter and relationship with oneself and others. Full insight and correcting experiences contribute essentially to the effectiveness of psychotherapy. In addition, the creation of an internal witness (meta-position) prevents the danger of dependence.

As a result, the following changes can be observed at the relational level in the therapy process: improved ability to relate to other people, readiness to take on social responsibility in family, occupation or politics and the feeling of being a relevant part of a social whole. Essential expressions of the improved relational skills are the ability to commit to intimate relationships and emotional closeness as well as to enjoy sexuality vividly and self-responsibly.

(3) Autonomy

As mentioned before, autonomy is another concept within the relational model of IBP which is also named relational autonomy model. Autonomy is an expression of emotional maturity and develops by the separation from the imprints of ones own life and learning history (primary scenario), the ability to self-contact and self-agency. This means recognizing ones own needs and asserting oneself adequately. Functioning relations distinguish themselves by an adequate balance (attunement) of sufficient bonding and enough breathing room for both partners. If a partner lacks the capability for autonomy, if he is a good agent for the other rather than for

himself, he will adapt himself excessively and give up his necessary breathing room, feeling restricted or inundated and unable to feel his affection any more. Consequently the role of the breathing room and the respiration in itself is essential for autonomy and the organism. 'Respiration is the fundamental function of your body. Without breathing all body systems fail. It is the first inner activity of your body serving self-preservation when you enter into this world' (Rosenberg, 1973/2001, p.36). Conscious deep breathing raises the metabolic process of exchanging oxygen and carbon dioxide and thereby the vitality. Breathing patterns are changed and pre- or unconscious material becomes accessible to the conscious treatment: 'Every reactive feeling of a person has an effect directly changing its respiration. Conversely one can affect his feelings by conscious changes of the respiration... many people... try to control their excitement by a limited respiration to be able to remain 'calm and composed'. They do this because one perceives his feelings much more consciously with full deep breathing' (Rosenberg et al., 1985/1993, p.130f). The contribution of safe and flexible self-boundaries is essential to the breathing room and thereby to autonomy, and this is – as shown earlier – where relationship with the other happens.

(4) Environmental Mastery

IBP-patients experience the mentioned interventions and concepts as helpful for their improvement of quality of life not only at intra- and interpersonal levels. Working with boundaries, steps out of fragmentation, experiential action, concepts of agency and character style (protection and resistance) as well as the consistent inclusion of the body help developing self-consciousness, autonomy and relational abilities as well as environmental mastery appropriate to the individual psychological condition. Many dysfunctional patterns having very destructive effects on relationships with others also hinder the choices and possibilities of creation in the material outer world as for example in profession. Through psycho-educative elements, self management and mental health tools, IBP supports problem-solving competence and activates existing resources serving the stabilization of the patients in the everyday accomplishment. This is expressed by a raise of frustration tolerance and affect control, the willingness to take on responsibility at work, in family and society as well as by increased feelings of self-efficacy and competence.

(5) Purpose in Life

For some patients, the search for the deeper meaning of life is the initial motivation for therapy. However, spiritual and existential individual questions appear regularly when patients experience more vividly and consciously their connection to their basic needs. Then conflicts appear often as dissonances between the individual needs and the current private or professional situation. IBP therapists offer support in creating meaningful personal contexts, leading to affirming contact to feelings as existential loneliness, acceptance of death and transience or in dealing with different periods of life. In body exercises, in contact to oneself, others and the outer world, transpersonal experiences - as for example being part of a bigger whole or well taken care of in life - are experienced by patients. An essential factor of psychotherapy also is being able to express non-influenceable feelings of rage, grief or powerlessness, to accept the unchangeable and to come to acceptance and peace with past and current events - often existential experiences. The conscious dealing with disease, growing old, dying, death, spiritual and religious questions can also lead to the transformation of values and life goals. All of them are essential topics in the search for the purpose in life.

(6) Personal Growth

In IBP the lifelong individual development is understood as a continuous process of integration. Sustaining integration must be seen on a continuum between lesser and optimal integration. As already shown, a fully integrated person is entirely in relation with the self, the other

and the environment. Moreover, he meets the requirements to retain and develop qualities like the following: autonomy and authenticity, the ability to handle challenges and stress, to live with a basic feeling of well-being, liveliness and meaningfulness, a differentiated capacity of perception and expression, ability to love, to enjoy sexuality and intimacy (emotional closeness), efficiency, creativity, acceptance of individual and social responsibility. This idealized image is hardly possible to hold permanently. Growth processes of this sort are rather to be seen as a constant being-on-the-way. Rosenberg's and Kitean-Morse's windsurfing story is the vivid picture for this lifelong process (1996, p.44): 'The secret of windsurfing is not how to stay up, but mastering the art of *getting back up* when you are down… In windsurfing as in good mental health, no one can stay up all the time… Working on them is constantly exhausting; learning how to get back up is much more exciting. With a little practice, you can learn to surf your own well-being and that of your relationship.'

(7) Physical Well-Being

Well-being on a somatic-energetic level is definitely important to IBP. In the energy model, physical well-being develops from a (largely) free flow of energy in the organism. One of the basic assumptions is that life means the existence of currents or flows of information and that experiences of life can inhibit or encourage the flow of energy: 'We may never forget that we are energy. The innermost self of people is energy as well as consciousness and appreciation of this energy' (Rosenberg et al., 1985/1993, p.26). In spite of different energy models all body-psychotherapeutic methods share the objective to support the energy flow in the human body by body-oriented treatment. 'This free energy flow connects psychological-emotional, mental and physical health and a free flowing of the sexual energy' (Langenbach, 1998, p.8). The IBP energy model is based on Reich's (1968) research and concept of life energy. At present it is affected more and more by neurobiological knowledge, assuming (in simplified words) the fact that energy is constantly moved through people in form of neuronal currents and hormones or peptides floating between specific receptors.

During the therapy session and over the course of a whole therapy, the therapist pays attention to the energetic condition of the patient and works toward increased liveliness, encouraging the experience of the blocked or bound energy, and toward bringing it back to flowing. This attempt corresponds with the psycho-neuro-immunologic peptid-receptor-flow through the body (Pert, 1999). Positive effects on quality of life are: improvement of the perception of body sensations and of body feeling, more available energy, strength and liveliness. These are as well the prerequisites for other quality of life aspects like self-acceptance, relationship ability and autonomy.

(8) Physical Health

Physical health is the expression of an undisturbed energy flow through the body, disease on the other hand is the consequence of a disturbed energy flow. Disturbances in the energy flow and somatic illnesses can appear on all levels of being. IBP takes this into account and treats the underlying causes besides the current problems, if necessary. So, for example, sexual disturbances cannot be explained medically in many cases. The understanding of residues of traumatic experiences or unresolved relationship conflicts and the new ways of dealing with them also lead to the reduction of somatic symptoms or diseases in a lot of such cases.

Prevention is another important issue serving quality of life: relationship abilities, activation of self-healing forces and development of the personality allow people to live in accordance with their possibilities. This is the most effective and most ecological form of prevention providing health at all levels. Self management and mental health tools like keeping a diary, body and breathing exercises, steps out of fragmentation, good parent messages, agency mantras, meditation, conscious nutrition and physical exercise are fundamental psycho-educative elements.

Another essential of the diagnostic as well as the therapeutic processes is the activation of early and more current personal, interpersonal and transpersonal resources.

(9) The Environment

The non-personal environmental conditions are hardly conceptualized as well within the framework of the IBP model as in the other described psychotherapy methods. However, they are important where they become stressors exceeding the coping potential of the individual. In most situations, therapy can increase the cognitive and emotional ability to cope with an incriminating environment, for example with professional pressure or lack of money. However, there are cases when it will be necessary to find alternatives to pathogenic situations, as for example strong environmental pollution or an extremely incriminating professional occupation.

4. Conclusions: IBP in the Context of Individual and Social Quality of Life

The article sketches an extensive model for the consideration of quality of life in the main areas of life body, psyche, social relations, spirituality and environment. Nine dimensions describe quality of life widely and have direct or indirect meaning for psychotherapeutic action: 'self-acceptance', 'positive relations with others', 'autonomy', 'environmental mastery', 'purpose in life', 'personal growth', 'physical well-being', 'physical health' and 'environment'. The strong representation of psychological variables corresponds with empiric results showing that intrinsic psychological intentions support the quality of life stronger than extrinsic materialistic goals (Kasser, 2000).

The search for quality of life in the literature of different psychotherapy schools turned out to be more difficult. The absence of elaborate conceptions surprised all the more as, besides applied psychology, psychotherapy could be considered as the specific discipline for the improvement of quality of life: Quality of life correlates to the highest extent with subjective psychological well-being. Environmental conditions have a far lower influence than one would expect. In good psychological health and with an adequate attitude, even life under difficult circumstances can be experienced worth living or be seen as an opportunity for restructuring and growth. In a state of mental misery, however, even the best material conditions cannot contribute essentially to well-being, provided that these are not the cause of the suffering. May be that with the growing interest of the psychologists and psychotherapists in salutogenesis their attention for research concerning quality of life will rise, too. As experts in the treatment of soul, mind and behavior, IBP as well as the standard psychotherapy procedures provide valid possibilities of intervention for the improvement and preservation of an extensive quality of life and well-being for both suffering and healthy people.

To sum up it can be said that IBP disposes of an extensive approach and a great variety of therapeutic strategies which fully meet all nine dimensions of quality of life within the possibilities offered to psychotherapy. Table 1 puts together the different aspects in an overview and points out (as has been proved in the work with clients): IBP is an integrative psychotherapy method in the best sense of the word.

Special thanks to my mother Rita Froesch for proof-reading of the translation.

Quotations from 'Body, Self and Soul - Sustaining Integration' (Rosenberg, Rand & Asay, 1985) and 'Total Orgasm' (Rosenberg, 1973) are translations from their German versions and may therefore deviate from the English originals.

Table 1: Elements of Quality of Life in the Integrative Body Psychotherapy

Area	*Causes for quality of life*	*Manifestation of quality of life*	*Consequences of q. of life*
(1) Self-Acceptance	• changed patterns of thinking: - positive approach to life - acceptance of the unchangeable - ability to meta-position, witness • changed patterns of perception: - presence in the Here-and-Now, self-contact - flexible self-boundaries - organized core sense of self - self-consciousness, self-knowledge - intact self-image - consistency, self empathy	• changed pattern of emotions: - more positive basic mood - more joy of life - freer access to emotions and their expression - relaxation - increase of motivation • changed patterns of body sensations: - body experience of identity & continuity - body sensation of authenticity and liveliness	- psychological, emotional, mental health - deep feeling of inner stability and consistency - self-confidence
(2) Positive Relations with Others	- ability for relationship and bonding - contact in relation to oneself and others - flexible self-boundaries - attunement of bonding and breathing room - dealing with closeness and distance - communication skills - presence, love, recognition - asserting ones needs - social responsibility (family, occupation)	- enjoying closeness and intimacy - free flow of sexual energy - liveliness in relationships - satisfaction of needs	- feeling of being a relevant part of a social whole
(3) Autonomy	- emotional separation from primary scenario - steps out of fragmentation - self-agency - feeling and knowing ones needs	- breathing room - equivalence of relationships to the self and others	- acceptance of existential loneliness - self-actualization
(4) Environmental Mastery	• changed patterns of behavior: - resource activation - mental-health skills - problem solving competence - frustration tolerance, affect control	- self-efficacy - ability	- success
(5) Purpose in Life	- affirmative dealing with existential feelings - spiritual and existential questions - acceptance of death and transience - putting periods of life in relation - creating meaningful contexts - express non-influenceable feelings of rage, sorrow or powerlessness	- acceptance of death and transitoriness - contact to 'inner voice' - acceptance of the unchangeable - coming to peace with the past - transformation of values & intentions	- feeling of being a part of a bigger whole - deep feeling for one's meaning of life - feeling of direction
(6) Personal Growth	- integration of body, mind, emotions, spirit - development toward the 'real self'	- increase of liveliness - relational autonomy	- self-realization - maturity - being whole and connected
(7) Physical Well-Being	- body awareness - conscious deep respiration and movement - improved sense for body feelings	- body experience of sense of self - free flow of energy, vitality, - positive body sensations - more energy, force & aliveness	- continuous well-being - deep experience of aliveness - joy of life
(8) Physical Health	- reduced somatic symptoms, diseases, suffering - acceptance of illness as part of life	- changed breathing, muscular, neurological, endocrine and immunological patterns	- physical health
(9) Environment	- cognitive, emotional, behavioral coping - responsibility, commitment for the environment	- take stressors as a challenge and opportunity for growth - ability to accept or leave unchangeable pathogenic environment	- satisfaction with the living environment

Literatur

Beck, A.T. (1991). Kognitive Therapie. In J. K. Zeig (Hrsg.), *Psychotherapie: Entwicklungslinien und Geschichte* (S. 257-278). Tübingen: Dgvt. (Original erschienen 1987: The evolution of psychotherapy)

Bowlby, J. (1975). *Bindung, eine Analyse der Mutter-Kind-Beziehung*. München: Kindler.

Brisch, K.H. (1999). *Bindungsstörungen. Von der Bindungstheorie zur Therapie. Stuttgart: Klett-Cotta.*

Bugental, J. F. (1964). The Third Force in Psychology. *Journal of Humanistic Psychology*, 1, 19-26.

Clarkson, P. & Mackewn, J. (1995). *Frederick S. Perls und die Gestalttherapie.* Köln: EHP. (Original erschienen 1993: Fritz Perls)

Ellis, Albert (1991). Die Entwicklung der Rational-Emotiven Therapie und der Kognitiven Verhaltenstherapie. In J. K. Zeig (Hrsg.), *Psychotherapie: Entwicklungslinien und Geschichte* (S. 195-233). Tübingen: Dgvt. (Original erschienen 1987: The evolution of psychotherapy)

Emerson, W. (2000). *Behandlung von Geburtstraumata bei Säuglingen und Kindern.Gesammelte Vorträge*. Heidelberg: ISPPM.

Fava, G. A. & Sonino, N. (2000). Psychosomatic Medicine: Emerging Trends and Perspectives. *Psychotherapy and Psychosomatics, 69,* 184-197.

Frank, R. (1991). Körperliches Wohlbefinden. In A. Abele & P. Becker (Hrsg.), *Wohlbefinden: Theorie, Empirie, Diagnostik* (S. 71-96). Weinheim: Juventa.

Freud, S. (1933). Neue Folge der Vorlesungen zur Einführung in die Psychoanalyse. In *Gesammelte Werke, Bd. 15,* (S. 447-608). Frankfurt a. M.: S. Fischer. (Original erschienen 1932)

Froesch, M. (2001). *Lebensqualität und Psychotherapie.* Studienarbeit am Psychologischen Institut, Klinische Psychologie I, Universität Zürich.

Gladis, M. M., Gosch, E. A., Dishuk, N. M. & Crits-Christoph, P. (1999). Quality of Life: Expanding the Scope of Clinical Significance. *Journal of Consulting and Clinical Psychology, 1999, 67* (3), 320-331.

Grawe, K. (1998). *Psychologische Therapie*. Göttingen: Hogrefe.

IBP-Institut (2000). Gesundheitsverständnis und Krankheitsverständnis. *Charta-Kolloquium 1, 25. März 2000.*

Janus, L. & Haibach, S. (Hrsg.) (1997). *Seelisches Erleben vor und während der Geburt.* Neu-Isenburg: LinguaMed.

Kasser, T. (2000). Two versions of the American dream: Which goals and values make for a high quality of life? In E. Diener E. & D. R. Rahtz (Eds.), *Advances in Quality of Life Theory and Research* (pp. 3-12). Dordrecht: Kluwer Academic Publishers.

Keleman, S. (1992). *Verkörperte Gefühle.* München: Kösel.

Keleman, S. (1994). *Forme dein Selbst. Wie wir Erfahrungen verkörpern und umgestalten.* München: Kösel. (Original erschienen 1987: Embodying Experience. Forming a Personal Life)

Kohut, H. (1999). *Die Heilung des Selbst* (7. Aufl.). Frankfurt a. M.: Suhrkamp. (Original erschienen 1977: The Restoration of the Self)

Langenbach. M.-L. (1998). *Tiefenpsychologische Körperpsychotherapie. Subjektive Veränderungen im psychischen und körperlichen Erleben von Teilnehmerinnen und Teilnehmern während und nach einer dreijährigen Therapiegruppe. Eine empirische Untersuchung.* Unveröff. Lizentiatsarbeit, Universität Hamburg.

Levine, P. A. (1998). *Trauma-Heilung. Das Erwachen des Tigers.* Essen: Synthesis. (Original erschienen 1997: Waking the Tiger. Healing Trauma)

Margraf, J & Lieb, R. (1996). Verhaltenstherapie. In H. J. Freyberger & R.-D. Stieglitz (Hrsg.), *Kompendium der Psychiatrie und Psychotherapie* (10. Aufl.) (S. 324-330). Basel: Karger.

Mertens, W. (2000). *Psychoanalyse. Geschichte und Methoden* (2. Aufl.). München: Beck.

Perls, F. S. (1982). *Grundlagen der Gestalt-Therapie. Einführung und Sitzungsprotokolle* (5. Aufl.). Mainz: Pfeiffer. (Original erschienen 1973: The Gestalt Approach & Eye Witness to Therapy)

Perls, F. S. (1996). *Gestalt-Therapie in Aktion* (8. Aufl.). Stuttgart: Klett-Cotta (Original erschienen 1969: Gestalt Therapy Verbatim)

Petzold, H. (1982). Vorwort von Hilarion Petzold. In F. S. Perls, *Grundlagen der Gestalt-Therapie. Einführung und Sitzungsprotokolle* (5. Aufl.). Mainz: Pfeiffer. (Original erschienen 1973: The Gestalt Approach & Eye Witness to Therapy)

Reich, W. (1968). *Character Analysis.* New York: Noonday Press.

Rogers, C. R. (1991). *Eine Theorie der Persönlichkeit und der zwischenmenschlichen Beziehungen. Entwicklet im Rahmen des klientenzentrierten Ansatzes* (3. Aufl.). Köln: GwG. (Original erschienen 1959: A Theory of Therapy, Personality and Interpersonal Relationships, as developed in the Client-Centered Framework. In S. Koch (Ed.): Psychology, A Study of a Science (Study I, Vol.3))

Rosenberg, J. L. & Kitaen-Morse, B. (1996). *The Intimate Couple: Reaching New Levels of Sexual Excitement Through Body Awakening and Relationship Renewal.* Atlanta: Turner.

Rosenberg, J. L. & Rand, M. L. & Asay D., (1993). *Körper, Selbst und Seele: ein Weg zur Integration* (2. Aufl.). Fulda: Transform. (Original erschienen 1985: Body, Self and Soul - Sustaining integration)

Rosenberg, J. L. (2001). *Orgasmus. Bewegen und erregen. Ein Bioenergetik-Übungsbuch* (Lizenenzausgabe). Berlin: Ulrich Leutner. (Original erschienen 1973: Total Orgasm)

Rothschild, B. (2000). *The Body Remembers. The Psychophysiology of Trauma and Trauma Treatment.* New York: Norton.

Ryff, C. D. & Singer, B. (1996). Psychological well-being: Meaning, Measurement, and Implications for Psychotherapy Research. *Psychotherapy and Psychosomatics, 65,* 14-23.

Spiegel, D., Bloom, J. R., Kraemer, H. C. & Gottheil, E. (1989). Effects pf Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer. *The Lancet*, 2, 888-891.

Stern, D. (1992). *Die Lebenserfahrung des Säuglings.* Stuttgart: Klett-Cotta. (Original erschienen 1985: The Interpersonal World of the Infant)

van der Kolk, B. A. (1994). The body keeps the score. *Harvard Review of Psychiatry*, 1, 253-265.

van der Kolk, B.A., Mc Farlan, A. & Weisaeth, L. (2000). *Traumatic Stress. Grundlagen und Behandlungsansätze zu posttraumatischem Stress.* Paderborn: Junfermann.