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Body-Mind Approaches in Different Applied Areas -
Body Awareness and Relationship Competencies of Therapists in the Context of Therapeutic Efficacy

Theses of Doctoral (PhD) Dissertation

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Introduction

The application of methods based on body awareness techniques has inspired many researches around the world over the past decades, from the field of medicine to psychological and pedagogical studies. In this thesis, we review the application of body-mind methods in therapeutic relationships, assuming that it goes far beyond the mere practice of providing specific body awareness exercises for the patients. The other pillar of the dissertation is the relationship paradigm, which becomes more and more prevalent nowadays in various therapeutic methods. In all approaches, there is a common basic assumption in explaining the therapeutic processes and changes in therapies. They all emphasise the relationship dynamics between the therapist and the patient instead of those theoretical and practical considerations which focus merely on the patient as an individual. Intersubjective theories in psychoanalytic literature or the embodiment theory of the cognitive field, both represent this trend.

There is increasing insistence on empirical evidence from clinical trials to support therapeutic approaches. In the case of the most common psychotherapeutic methods – such as cognitive-behavioural, analytic-dynamic, person-centred therapy or psychodrama – demonstration of their effectiveness for a particular diagnostic category has already been carried out in a number of studies. In practice, however, therapists use often more different methods in a personal way to establish effectiveness; therapists work eclectically (Szőnyi, 2015). Long-established therapeutic methods are constantly changing; therefore, direct investigation of these practices is also important. Some professionals tend to accept the conclusions from qualitative-social science methods (‘practice-based evidence’) rather than applying the empirical-statistical methods that are the foundation of evidence-based psychotherapeutic research, as they believe these qualitative methods enable a deeper understanding of the therapeutic phenomena (Szőnyi, 2015).

The main question when examining the efficacy of psychotherapy is to identify which factors increase the effectiveness of therapeutic change. The relationship between the client and the therapist has been clearly identified as a specific or non-specific factor in different studies that explore the efficacy of various therapeutic methods (Rogers, 1981; Buda, 1993; Szőnyi, 2015). In research examining the characteristics and operation of therapists, the relationship competencies, that is the skills of therapists that help to develop and maintain a constructive working alliance with clients, have received close attention. Related factors – such as the emphatic ability of the therapist, the authenticity of the professionals, and the unconditional acceptance of the therapist to the client – are all believed to have an impact on the therapeutic change, the emphasis on them depends on the type of therapy (Pintér, 2015).

All the aforementioned factors must be covered in the training of a therapist. This raises the question as to whether during the training of a therapist, alongside personal experience of the applied method and the supervision by an experienced therapist, more emphasis should be given to the teaching of the therapeutic techniques or the promotion of therapist’s relational skills and competencies (Szőnyi, 2015). Researchers in the field of implicit relational knowing, for example, place greater emphasis on relationship competencies. Implicit relational knowing is a form of procedural knowledge

concerning how we do things with intimate others. Implicit relational knowing stores relational patterns from early mother-child interactions and is distinct from conscious, verbalizable knowledge and from dynamic unconscious (Lyons-Ruth, 1998). Implicit relational knowing influences adult attachments as well, including both patient and therapist in a therapeutic relationship (Simon M. et al., 2001; Pető, 2003).

In their study, Stern and co-workers (1998) analysed detailed records of therapists to explore the mechanisms of therapeutic change. One of their most important assertions was that, even in verbal or 'talking' therapy, the majority of therapeutic change is rooted in the implicit relational knowing of therapist and patient in an unconscious, procedural province, which is responsible for how we act or feel in a relational context. This approach attaches special importance to the procedural, affective, dynamic domain in the therapeutic context, beside the explicit, verbal domain.

This intersubjective movement in psychoanalysis, of which Stern is one of the most noteworthy representatives, has had a nourishing impact on other psychotherapeutic methods by putting the focus on the importance of the therapeutic relationship. Notwithstanding, according to clinical, developmental observations and attachment studies, the concept of intersubjectivity is not unified (Bokor, 2017), with different authors using the concept in a number of ways. In the approach of Stolorow and Atwood (1992, cited by Bokor, 2017), the notion suggests that psychological phenomena cannot be regarded as the result of isolated intrapsychic mechanisms; rather they are formulated in the interaction of subjects who mutually influence one another. Relationships, including the therapeutic relationship, are also formulated in the interaction of two subjects in an intersubjective field created by the interplay of the two subjective worlds. According to this approach, important characteristics of the therapist include their active participation in a joint activity, their authenticity, a continuous reflectivity of their own subjective world, their attunement to the patient's affective domain, and an attention focused on the 'here and now' (Stern et al., 1998, 2002; Fónagy, Target, 2005).

If the operation of the relationship between therapist and client is so significant to the therapeutic process – to therapeutic changes and the efficacy of the therapy – it may be useful to explore those methods that support the development of relationship competencies of professionals. There are various techniques in verbal and non-verbal self-awareness methods to consider. This dissertation focus on the application of those methods that are based on body awareness techniques in supporting the therapist-client relationship. These techniques, asides from developing the relationship competencies of therapists, may bring other benefits for practising professionals. First of all, they may improve the mental and physical wellbeing of the therapists, for example helping to cope with stress in work and in everyday life, or refilling the drained attentional and emotional capacities of the professionals. Moreover, these body awareness techniques may facilitate more conscious management of the professionals' physical and mental processes during their helping relationships, providing an important source of information in this complex therapeutic situation.

To support these assumptions, following the Theoretical Background a mixed method research is presented. The participants of the research were therapists who practise or practised different body awareness techniques.

Theoretical Background

The Concept of Body Awareness

There are many different types of body-mind methods based on body awareness. It is not easy to identify the common principles in these methods that might enable us to better understand the conceptualization of body awareness. In their qualitative research, Mehling and colleagues (2011) examined the common foundations of different therapeutic approaches based on body-awareness enhancing procedures (often referred to in the literature as 'mind-body approaches'). According to the definition established by the authors, body awareness in a narrow sense involves an attentional focus on, and awareness of, internal body sensations and, moreover, the observation of changes in physical processes. In this approach, body awareness is the subjective, phenomenological aspect of proprioception and interoception that enters conscious awareness; it is modifiable by mental processes including attention, interpretation, appraisal, beliefs, memories, conditioning, attitudes and affect (Mehling et al., 2011).

There exist additional, broader definitions of the concept as a construct of multiple dimensions. One of these broader definitions includes – besides noticing body sensations, emotional reactions and attentional responses to these sensations – active regulatory processes of attention, mind-body integration with emotional awareness, and self-regulation of emotions, sensations and behaviours (Mehling et al., 2009).

For a long time, the bodily sensations have been discussed only in the context of emotions in psychological research, and so the area has not received enough attention in academic psychology. In this writing, affects - adaptive somatic responses with communicative value – have been classified as body sensations if they can be identified as a form of subjective experience. Emotions are different, since they have cognitive and action components as well, which make the emotions easier to understand and manage. Many researchers argue that physical-physiological components do not always go hand in hand with the cognitive aspect of emotions, but also occur independently (Oatley and Jenkins, 2001). In the research, we also proceeded from the fact that these two phenomena may have separate pathways in the psychotherapeutic situation, and their relevance in the therapeutic process may be different.

Methods Based on Body Awareness

In this writing, we discuss the different techniques in two groups. According to the activity of the method there are passive and active body awareness techniques. In this paper, those methods are considered to be passive, which focus on body sensations in a motionless, passive state, such as, for example meditation, mindfulness, or relaxation techniques. In these methods, attention is gradually directed more towards the inside of the body. In all techniques, only one important element is the attention to body sensations, along with other important aspects.

In methods based on active body awareness techniques – for example Yoga, Tai chi chuan, dance and movement therapies –, the attention to body sensations is also only one element. However, in these methods, the practitioners move and observe their sensations in a variety of situations. In these cases, attention is directed at the same time

inward, to the body sensations experienced during the movement, and outward, connecting to the physical and social environment and the body sensations derived from these connections.

In the research, we have distinguished methods based on active and passive body awareness techniques, as we assumed that although they both work with body awareness, they have different effects in therapeutic circumstances, and allow their practitioners to acquire other abilities. In passive techniques, the stationary, immobile posture promotes to turn attention inwards to body sensations, and most of these methods instantly control these bodily feelings. In active methods, on the other hand, the movement of the body focuses attention both inward and outward, while perceiving important internal experiences takes place in a continuous interaction with the environment, so these experiences enable the development of different abilities.

Theories of Body and Mind Integration

A new generation of theories behind body awareness techniques are called embodiment theories in the literature. The new paradigm is about the unity of body and mind in its complexity. There is a kind of circularity between them: a continuous and mutual interacting effect. The embodied mind hypothesis claims that human thinking is inseparable from the body. According to the theory, thinking happens not only in the head – the mind is not just an entity in the head – rather thinking is embodied in an organism embedded in the whole physical and social environment (Varela, Rosch, Thompson, 1991). One of the main pillars of the approach is the metaphor theory of cognitive linguistics (Lakoff and Johnson, 1980), which states that the meaning of symbols cannot be understood based on abstract activity of the mind but rather on physical experiences (Simon, 2010).

A Meeting Point of the Cognitive and the Intersubjective Approaches

If cognition is ‘embodied’, that is, higher level mental activities are built on physical experiences, this operation mode may be decisive not only in childhood but also in adulthood and, moreover, not only in cognizing the physical world, but also in understanding the social environment. The embodied mind may be examined within its environment, whether the environment is the body itself (embodied cognition), the physical environment (situated cognition) or the social environment (embodied communication) (Tschacher, Bergomi, 2011). The therapeutic relationship in the intersubjective field and the therapist's relationship competencies meet in this new paradigm in the field of embodied communication.

The psychoanalytically based intersubjective approach and the embodiment theories of the cognitive sciences describe similar processes in the therapeutic relationship, albeit using different concepts. Embodied communication in therapy means that, beside semantic, linguistic communication, there is a physical and emotional level of communication between therapist and patient (Bucci, 2011). In all therapeutic processes, it is important to recognise that, in addition to the emotional experiences of the patient, the therapist should work with their own emotional and physical experiences in relation to the patient; some of these experiences are communicated back and forth in non-conscious level between patient and therapist (Bucci, 2011).

Change in Therapy

In theories related to the intersubjective approach, the above mentioned processes are described with phenomena such as emotion sharing, emotion mirroring, reflective function, or mentalization concepts that allow us to understand the mental and emotional states of others and ourselves. The previously discussed study by Stern and his colleagues about therapeutic change has brought such related concepts in the analytical tradition, as affect attunement, implicit relational knowing, the moment of meeting, or the authentic presence. According to the authors, this implicit relational knowing in adulthood can be overcome in moments of meetings in therapy, in the specific cases of affectively charged “now moments”, when the patient and the therapist experience intensively the present moment (Stern et al., 1998).

Although it is crucial for therapeutic change that both explicit and implicit content can appear in the process, much less attention has been paid to the latter until recently. Therefore, in the present study, we focused on those therapeutic factors causing changes, which are manifested at implicit levels in the continuous bodily communication of the therapist and the patient, and from time to time emerges in the dramatic and intense moments of meeting. We have reviewed the important role of body awareness experiences in these changes.

The Research

The research is based on a study containing qualitative and quantitative elements. This study used a semi-structured interview method supplemented with questionnaires. The main objective of this research was to reveal the effects of practicing body awareness techniques, primarily in different verbal therapeutic methods. The central thesis of this study is that the body awareness experiences of the therapists have an important role not only in specially body-mind methods, in which body awareness techniques are among the therapeutic tools, but also in the mostly verbal methods as well, due to the theoretical considerations discussed above. Since even in these procedures, in addition to the explicit level of verbal interpretation, there are equally important events in the implicit domain of experiences. The effects of methods based on different body awareness techniques have been revealed to patients in numerous studies, but there is only a few research on the effects of these techniques practiced by the therapist on the therapeutic processes. That is why this study fills the gap, in which we attempted to divide this complex phenomenon into factors that may be important from the point of view of the body-mind approaches.

The basic assumption is that the use of methods based on body awareness techniques can have an impact on the therapist at several levels, and thus on the effectiveness of the therapeutic relationship. On the one hand, these methods can improve the mental and physical health of the professionals, thereby helping to achieve a physical and mental state in which they can perform their work more effectively. On the other hand, body awareness methods can support the enhancement of the therapist's attentional, empathic and coping capacities during the therapeutic relationship, and the development of their relationship competencies. The background to this is that by learning different techniques, professionals can acquire or develop such competencies

as focusing and maintaining attention, empathy, authenticity, acceptance, regulation of emotions and body sensations, or the ability of holding, and other relationship competencies. Based on these assumptions, the following hypotheses and questions were analysed in the research.

Hypotheses and Research Questions

Hypotheses of the Questionnaire Study

1. According to the first hypothesis, the effects of the active or passive nature of body awareness practice and the regularity of practice result in detectable differences in the level of body awareness. This effect may be even more intense with respect to the dimensions of body awareness that can be associated with attentional, emotional, and coping capacities.

2. In the second hypothesis, we assume that the active or passive nature and regularity of the body awareness practice of therapists affects the balance of stress and coping capacity as well as the various factors of stress and coping.

Questions of the Interview Research

1. Can the differences in body awareness have an impact on the therapist's relationship competencies, and hence on therapeutic efficacy? In this complex research question, we examine whether different patterns can be revealed in the reports of the therapists about successful and unsuccessful cases.

2. Our next exploratory question is whether the moments of meeting, the outstanding events of affect attunement and empathy, can be detected from therapeutic reports and, if so, what indicators can be used.

3. In the last question, we examine whether body sensations may be worthy of attention in therapeutic efficacy studies on an independent basis, not just as a factor of emotions.

Sample

The study involved 29 therapists using different verbal and nonverbal methods. The proportion of men in the examined sample was 14%, the mean age was 48 years (standard deviation (sd): 10). The youngest participant was 32, the oldest was 71 years old. Each of the therapists studied several therapeutic methods, and used more different ones at therapeutic meetings, and most of them practiced some kind of self-awareness technique during the study. Following the relevant items of the questionnaire survey and further exploratory questions of the interviews, the psychiatrists or psychologists (mostly clinical psychologists) were classified into groups of psychoanalysts (14 persons), cognitive (7 persons) and other nonverbal therapists (8 people) based on their most important method.

In addition, those who have learned or are currently practicing a body awareness technique involving some kind of active physical exercise, or some kind of passive techniques, have also came into two separate groups. When analysing the data, an additional independent variable came to the fore, which was generated from the number

of weekly exercises separated by the median: rarely or non-practicing (0-3 times / week) and frequently practicing group (4 or more times per week).

Methods

The questionnaire survey part of the research were interested in how the practice frequency of these active or passive methods influenced the results achieved by therapists in certain dimensions of a multidimensional construct of body awareness. In addition, how the practice of the therapists was related to their level of stress and coping capacity. In the other part of the research, we interviewed the professionals working with different therapeutic approaches. Then we prepared a psychological content analysis of these interviews, to reveal how body awareness experiences can affect the therapists' relationship competencies, attentional, empathic and coping capacities, and how it appears in their reports of successful and unsuccessful cases. We hope that from these results, new aspects and procedures can be proposed for research into the effectiveness of psychotherapy.

Tools

Two questionnaires were filled out by the participants to measure body awareness. One was the *Multidimensional Assesment of Interoceptive Awareness* (MAIA) developed by Mehling et al. (2012) based on a broader definition of body awareness. The Hungarian version was developed by Járai et al (2016) under the name of *Többdimenziós Interoceptív Tudatosság Skála* and was adapted to a Hungarian sample. The other body awareness measuring questionnaire used in the study was the *Body Awareness Questionnaire* (BAQ), which was developed by Shields et al (1989) based on a narrower definition of body awareness. This tool measures selective attention to physiological (non-symptom-related, non-pathological, and not emotional) body processes. The adaptation of the Hungarian version (BAQ-H) was performed by Köteles et al (2014).

To measure the various components of stress and coping capacity, and the balance of them, the *Rahe's Brief Stress and Coping Inventory* was applied (Rahe, Tolles, 2002). The original multidimensional questionnaire was translated by Rózsa et al (2005). In addition, the test battery used in the study included gender and age issues, the details about the therapist's own practice and application of different therapeutic methods, self-awareness (body awareness and other types) experiences, and sport activities.

The Process of Interview Research and Psychological Content Analysis

From the rich material of the text of the interviews, psychological content analysis refers to the two cases that the therapists reported to be significant in their therapeutic work. One of these cases was considered a successful event by the therapist, and the other was considered failed (or difficult). The analysis was based on the differences between the two reports. In each case, 3-3 questions were asked in the same structure and content: after telling the cases in details as much as possible, we asked the therapists to evoke any changes, or turning points in the therapy process with this patient. Furthermore, we asked them to remember any special moment when there was

a significant event between the therapist and the patient at the nonverbal level. These questions were about the possible occurrence of moments of meeting, but they also gave the opportunity to mention progressive, slow processes of therapeutic change.

When coding the texts, in order to create the analytical units, the cases were divided into sentences, and the sentences in each cases were fixed on a worksheet of an excel table. Coding was done in this worksheet, and it was possible to summarize the results in the program, to produce tables and descriptive statistics. Based on a detailed Codebook, two independent coders have categorized the relevant parts of the sentences into four main themes: *Therapist's Body Sensations (TT), Therapist's Emotions (TÉ), Patient Body Signs (PTJ),* and *Relationship Signs (KTP).* Except for the *Patient Body Signs* category, we also distinguished positive and negative categories in the other three.

Results

In the course of statistical analysis we used the CogStat 1.8 and Statistica 13 software packages. Analysing the results of the questionnaires, due to the low number of the participants, is rather an addition to the interview research, and it is important mainly for the relations with the indicators created in the psychological content analysis and the examination of the validity.

Results of the Questionnaire Study

Hypothesis 1 – Body Awareness of the Therapists

The active or passive nature of the body awareness practice had less, but the regularity of exercise had a significant effect on the level of body awareness in the case of dimensions measured by different questionnaires. In both MAIA and BAQ-H, the more frequently practicing group showed significantly higher values compared to the rarely or non-practicing group. Furthermore, both questionnaires showed a tendency for the active group. We also examined separately MAIA subscales which were in relation with the attentional, emotional and coping capacities of the therapists. The mean of the more often practicing group was significantly higher on the *Attention Regulation Capacity* subscale and on the following 2 factors of the *Awareness of Mind-Body Integration* (MBI) dimension which measures a higher, more advanced level of body awareness: *Emotional Awareness* (EA) and *Self-Regulation* (SR). (Table 1)

Table 1: Means and standard deviations of the two groups in MAIA scale and its subscales N=29	*Rarely Practicing Group (0-3)*	*Often Practicing Group (4+)*
Total MAIA mean	**3.36**	**3.87**
standard deviation (sd)	**0.52**	**0.37**
3. *Attention Regulation Capacity* (ERC) mean	3.49	4.16
sd	0.77	0.43
4. *Emotional Awareness* (MBI-EA) mean	3.50	4.27
sd	0.85	0.50
4. *Self-Regulation* (MBI-SR) mean	3.11	4.00
sd	0.86	0.72

Hypothesis 2 – Stress and Coping of the Therapists

According to our second hypothesis, it can be assumed that the nature of the body awareness exercises (active or passive) of the therapists and the regularity of the practice affect the balance of stress and coping capacity. To test the hypothesis, we used the indicators of *Rahe's Brief Stress and Coping Inventory*, the sample was divided into four groups.

According to the results of the Kruskal-Wallis test, significant differences were found between the four groups in the *Global Stress and Coping Index* (GSCI) averages ($\chi 2(3, N=29)=12.22$, $p<0.01$). Active-passive nature of body awareness did not influence the values of GSCI (Mann-Whitney test: $U=99.50$, $p=0.83$), while the frequency of practice influenced it significantly ($U=27.00$, $p<0.001$). (Table 2)

Table 2: Means and standard deviations of GSCI in four groups **N=29**	**TP0-3** Passive, rarely practicing	**TP4+** Passive, often practicing	**TA0-3** Active, rarely practicing	**TA4+** Active, often practicing
GSCI mean	1.75	6.57	2	5.14
GSCI SD	3.86	2.06	1.69	2.42

Results of the Interview Research – Psychological Content Analysis of the Successful and Failed Cases

Descriptive statistics: By reviewing 56 reports, we received 28 successful and 28 failed (or difficult) cases. A total of 3835 sentences were encoded, of which 1886 in failed cases and 1949 in successful cases. The average length of a case in unsuccessful cases was 67.36 sentences (standard deviation: 28.89), and 69.61 sentences in successful cases (standard deviation: 28.98). 34.77% of the 3835 sentences contained the KTP code referring to the therapist-patient relationship (15.39% negative KTP, 19.38% positive KTP). 8.67% of the sentences received the TÉ code referring to the therapist's emotions (4.27% negative TÉ, 4.4% positive emotions), 12.45% the TT code of the therapist's body sensations (8.99% negative TT, 3.46% positive TT), and 6.69% the PTJ code about the patient's body signs.

Research Question 1 – Connections of Body Awareness, Relationship Competencies and Therapeutic Efficacy

In this complex research question, we examined several assumptions.

1.1 In successful and failed cases, the averages of the frequency in different indicators were compared with paired t-tests. In the negative and positive subcategories of the *Relationship Signs* (KTP), *Therapist's Emotions* (TÉ), and *Therapist's Body Sensations* (TT), we found significant differences in the relative frequencies of the successful and unsuccessful cases as we expected. Since a more positive therapist-patient relationship can be assumed in successful cases, more positive relationship signs

appear in the reports as well, so test subjects experienced and recalled more positive emotions and body sensations than negative. In failed cases, on the contrary, it is obvious that the number of negative relationship signs, emotions and body sensations will be significantly higher (Table 3).

N=28	KTP	KTP-	KTP+	TÉ	TÉ-	TÉ+	TT	TT-	TT+	PTJ
Successful mean	34,99%	**6,69%**	**28,30%**	9,32%	**2,44%**	**6,88%**	**8,11%**	**2,48%**	**5,63%**	8,48%
Successful SD	9,16%	6,24%	6,36%	6,23%	3,23%	4,47%	7,18%	3,12%	5,16%	5,56%
Failed mean	34,55%	**24,09%**	**10,46%**	8,02%	**6,09%**	**1,93%**	**16,79%**	**15,50%**	**1,29%**	4,89%
Failed SD	8,33%	7,50%	5,53%	5,18%	4,45%	2,05%	8,11%	7,78%	1,76%	4,86%

Table 3: The means and standard deviations of relative percentages of indexes in successful and failed cases

1.2 However, it is a more interesting significant result that the relative frequency of the *Therapist's Body Sensations* (TT) index, which includes positive and negative feelings as well, is also significantly higher in cases of failure, more than twice of the success rate, which is largely due to the high rate of negative bodily sensations. Only the TA4+ group (often practicing active body awareness technique) did not show this tendency. In this group, therapists mentioned almost the same amount of body sensations in successful (mean: 18.22%, SD: 6.63%) and in unsuccessful cases (mean: 19.36%, SD: 9.19%), in the successful cases, predominantly positive, in the unsuccessful, negative ones, like the other groups. While in the TP4+ group (often practicing passive body awareness technique), who also have a high level of body awareness, the TT of failed cases, mostly with negative bodily sensation, has more than quadrupled the TT score of successful cases, with predominantly positive feelings (failed TT mean: 17.73%, SD: 6.33%, successful TT mean: 4.39%, SD: 1.68%).

1.3 In the case of *Therapist's Emotions* (TÉ) indexes, negative and positive emotions were mentioned with similar frequency in all groups, both in successful and unsuccessful cases, which coincided with our expectation that the perception of well-detectable, medium-strength emotions show relative independence from body awareness skills.

1.4 According to our preliminary assumptions, we have expected higher values of *Relationship Signs* (KTP) indexes for therapists practicing active body awareness techniques than for passive groups in both successful and failed cases. It was based on the fact that in the passive techniques the practitioners focus only on themselves and their body, as opposed to the active techniques, in which practitioners must pay attention to the groupmates or the adversary as well. This attention to partners in active methods can develop relationship competencies of the practitioners, and can influence the relationship indicators in the research.

Factorial ANOVA for the *Relationship Signs* indicator of successful cases (KTPS) showed a significant major effect of active-passive body awareness ($F(1.24) = 8.92$, $p < 0.01$). KTPS of active groups was higher than of passive groups (KTPS: TP0-3 mean: 27.74%, SD: 2.85%; TP4+ mean: 33.36%, SD: 4.55%; TA0-3 mean: 39.71, SD: 10.7%, mean TA4+: 41.03, SD: 9.32%). The regularity of the exercise had no significant effect and the interaction between the two factors was not significant. No significant effects were found in the index of failed cases (KTPF). We also examined the relationship indicators in a negative, positive breakdown, we got similar effects in the successful and unsuccessful cases, that is, the advantage of the active group appeared only in successful cases.

1.5 We analysed the correlations of various indicators in successful and unsuccessful cases, according to the frequency of practicing body awareness techniques (two groups: 0-3 and 4+), for the purpose of drawing conclusions from the patterns about the functioning of authenticity, one of the most important relationship competencies. Authenticity in the definition of Rogers means that the therapists have access to their own emotions, can be aware of them, and can express those at the right time, namely, the therapist's emotions and behaviours are congruent with each other. This definition has been complemented with body sensations by us, which must also be congruent with the therapist's behaviour.

Different significant effects and tendencies prevailed in the successful and failed cases in this context (Table 4). In the successful cases it was found, that TT and KTP ($r = 0.717$) as well as the TÉ and KTP ($r = 0.608$) indicators correlated significantly and closely in the often practicing group, that is, the more body sensations or emotions were mentioned by the therapist, the more relationship signs were reported in connection with the case. In the case of the *Therapist's Body Sensations*, we also got significant correlations in a negative-positive division, that is, negative body sensations correlated with the negative relationship indicator (TT-S and KTP-S), and positive body sensations correlated with the congruent positive relationship indicator (TT+S and KTP+S). In the case of the positive and negative indicators of the *Therapist's Emotions*, only tendencies came out, but they indicated a similar direction. In the rarely or never practicing group, only TÉ-S and KTP-S showed significant correlation, namely, the more negative emotions mentioned by the therapist, the more negative relationship signs could be encoded.

In the unsuccessful cases, a very different picture emerged. In the often practicing group (4+), TTF and KTPF represented a strong negative correlation ($r=-0.701$), that is, the more body sensations were mentioned by the therapist, the less relationship signs was detected. In the rarely or non-practicing group, two correlations were significant: between TPF and KTPF ($r=-0.546$), and between TT-F and KTP-F ($r=0.694$). In this group instead of the body sensations, the emotions of the therapist were negatively correlated with the indicator of the relationship, that is, the more emotions reported in the failed case, the lesser relationship signs were measured. In the case of negative body sensations, there was a significant positive correlation with the negative relationship signs, i.e. the more frequent mention of negative body sensations resulted in more negative relationship signs (Table 4).

Correlations of Pearson			Frequency of practicing: 0-3		Frequency of practicing: 4+	
			r(13)=	p=	r(11)=	p=
Successful cases						
1	TTS	KTPS	0.269	0.332	**0.717**	**0.006**
2	TÉS	KTPS	0.233	0.403	**0.608**	**0.028**
3	TT-S	KTP-S	0.338	0.218	**0.716**	**0.006**
4	TÉ-S	KTP-S	**0.594**	**0.02**	0.511	0.074
5	TT+S	KTP+S	0.037	0.895	**0.667**	**0.013**
6	TÉ+S	KTP+S	0.131	0.642	0.484	0.094
Failed cases						
7	TTF	KTPF	0.253	0.363	**-0.701**	**0.008**
8	TÉF	KTPF	**-0.546**	**0.035**	-0.283	0.349
9	TT-F	KTP-F	**0.694**	**0.004**	-0.294	0.33
10	TÉ-F	KTP-F	-0.041	0.886	-0.076	0.805
11	TT+F	KTP+F	0.392	0.149	-0.089	0.772
12	TÉ+F	KTP+F	0.006	0.983	0.343	0.251

Table 4: Correlations of Therapist's Body Sensations (TT), Therapist's Emotions (TÉ) and Relationship Signs (KTP) in successful and failed cases in two groups. "S" means successful, "F" means failed at the end of the indexes which can be positive (+) or negative (-) as well.

Research Question 2 - Moments of Meeting

The moments of meeting, the outstanding events of affective and empathic attunement, appeared in most of the successful therapeutic reports (85.7 percent), compared to the low prevalence rates of the failed cases (21.4 percent). Wilcoxon test was performed due to the damage of the normality, which presented a strong significant difference ($T=10.5$, $p<0.001$) in the occurrence of the moments of meeting in successful and unsuccessful cases. However, there was no significant difference in the number of moments of meeting mentioned in cases of success or failure in the two groups divided along the regularity of practice.

Research Question 3 – Body Sensations as an Independent Factor

The last research question – that body sensations can be considered not only as a factor of emotions, but also they are independently worthwhile in therapeutic efficacy analyses –, has been supported in several aspects based on the results presented so far. On the one hand, from the fact that in the case reports the therapists mentioned them more often than emotions, especially in failed cases. In reports of unsuccessful cases, the prevalence rate of mentioning body sensations was 16.8%, while the rate of emotions were only 8%, and this difference was significant ($t(27)=-4.78$, $p<0.001$). On the other hand, the interactions of emotions and body sensations with the relationship indicators showed remarkable differences. Namely, most of the cases, the body sensations were more closely related to the relationship signs, that is, quality of the relationships were more predictable from the body sensations than the emotions. This trend was even stronger in successful cases and at a higher level of body awareness.

Validation of the Therapist's Body Sensations (TT)

For validation, we correlated the values of the BAQ-H, MAIA scale with the successful TT (TTS), the unsuccessful TT (TTF) and the average TT index of the two. The BAQ-H values were significantly correlated with the average TT ($r=0.38$, $p=0.045$), while were not with the TTS and TTF, though there was a positive direction in the non-significant correlations (TTF and BAQ-H: $r=0,34$, $p=0.08$; TTS and BAQ-H: $r=0.27$, $p=0.16$). The values of the MAIA scale were significantly correlated with the expected positive direction with both the average TT and the TTF (average TT and MAIA: $r=0.48$, $p=0.01$; TTF and MAIA: $r=0.42$, $p=0.027$). MAIA and TTS were also positively correlated, although the correlation did not reach significancy ($r=0.34$, $p=0.073$).

To find out what the components of the TT index exactly measure, we further divided the device. In the successful and unsuccessful TT indicators (TTS, TTF) we distinguished positive and negative contents (TT+S, TT-S, TT+F, TT-F) and looked at their correlations with the values of MAIA and BAQ-H. Here we found interesting results. While the positive TT score for the successful cases (TT+S) showed a significant good correlation with the MAIA scale ($r=0.499$, $p=0.007$), the successful negative TT (TT-S) showed no correlation ($r=0.14$, $p=0.479$). The same pattern was found in relation to the value of BAQ-H (TT+S and BAQ-H: $r=0.457$, $p=0.015$; TT-S and BAQ-H: $r=-0.23$, $p=0.238$). The correlations between the MAIA and BAQ-H values and the positive and negative TT indicators of the failed cases was the reverse.

Conclusions

In this writing, we have tried to explore the main factors of change in psychotherapy which can increase the effectiveness. Different studies had identified one of them as especially important, namely the relationship between the client and the therapist. This factor was equally emphasized in various therapeutic approaches. The psychoanalytically based intersubjective approach and the embodiment theories of the cognitive sciences described similar processes in the therapeutic relationship with slightly different concepts. As professionals from both fields state, beside semantic, linguistic communication, there is a physical and emotional level of communication between therapist and patient. If the body and mind cannot be separated, then thinking and states of mind are strongly determined both consciously and unconsciously by physical factors. Consequently, therapists are responsible for their own physical and mental condition, which enables concentration, acceptance, attunement, authentic communication and other relationship competencies that support the functioning of the therapeutic relationship. Methods based on body awareness techniques can provide support in these fields, as they have the ability to promote the effectiveness of the work of professionals on several levels.

Beside the interview research, the results of the complementary questionnaire survey albeit in many respects point in the same direction, only allow for a cautious interpretation due to the low number of elements in each group. In general, it can be stated that on different scales of body awareness and coping, higher values are usually achieved by groups of therapists who practice body awareness techniques on a regular basis compared to rarely or non-practicing groups. Remarkable results have also emerged along the distinction between active-passive body awareness techniques, but they are still waiting to be confirmed by further studies with a larger number of elements.

In relation to the measurement of body awareness, the initial assumption was that both the frequency and the active-passive nature of the body awareness practice will affect the values measured in different dimensions of body awareness. Therefore, in addition to the sum totals of the scales, we also looked at the results of the different groups on important subscales. The two scales of body awareness (MAIA, BAQ-H) presented similar patterns with respect to the distinction between active-passive nature of body awareness and the frequency of practice. The active or passive nature of the body awareness technique did not seem to affect significantly the values achieved on the scales, that is, the level of body awareness. In the results achieved in the MAIA questionnaire there was only a tendency of higher values for the active body awareness group. Nevertheless, the regularity of practice the given technique has proved to be significant in every case. Therapists practicing some kind of body awareness technique 4 times or more a week had significantly higher body awareness values than those who practice only 0-3 times a week.

In our research, MAIA's multidimensional scale was better suited to measuring the body awareness of the therapists than BAQ-H, which only measures an ability to perceive in this field. The MAIA also includes dimensions that relate to more advanced forms of body awareness, and better covers the various aspects of body awareness required in therapeutic circumstances. For example, the three factors of the MAIA

Awareness of Mind-Body Integration (MBI) dimension which measure the access to higher, more advanced levels of body awareness well separated more frequently practicing therapists from rarely or never practicing ones.

In hypothesis 2 of the questionnaire study, we investigated the assumption that the active or passive nature and the frequency of practice affects the balance of stress and coping capacity. The active-passive nature of the body awareness technique is not, however, the frequency of practice here also had a significant influence on the balance of stress and coping capacity as well as on some stress and coping components. For those who practice passive body awareness techniques more regularly had the highest *Global Stress and Coping Index*, probably because these techniques specifically target coping with stress. It is also important to emphasize body awareness techniques as effective ways of coping, since other techniques of cognitive strategies are highly prevalent in coping literature and in the studies included therein.

The discussion of the interview research begins with the results of the validation tests, in which we examined how the *Therapist's Body Sensation*s (TT) indicator and its various components, correlated with the different body awareness constructs of the questionnaires. We can conclude from the correlation coefficients of the MAIA and BAQ-H scores and the average TT indicator that we could create a good body awareness indicator with the category of *Therapist's Body Sensations* in terms of validity.

If we continued to divide the TT indicator to positive and negative body sensations in unsuccessful and successful cases, we found that mentioning of congruent positive or negative body sensations with the success or failure of a given case was more strongly related to the body awareness scores of MAIA and BAQ-H. There are several possible explanations for interpreting these results beyond the fact that body awareness is a multidimensional construct. The results may also indicate that, in case of successful cases, the positive body sensations are congruent, they are more frequent in the given situation, easier to be aware of them and recalled them, so mentioning them is more closely related to the values of the questionnaire constructions of body awareness. In unsuccessful cases, negative body sensations are more frequent, and so on, so they are more likely to correlate with the construction of the questionnaires.

However, there were components in the TT index that presented less strong interactions with the questionnaire scales of body awareness. These weaker correlations may also have resulted from the fact that in the TT index we used, there were latent contents in the text referring for example to vitality affects, which can rarely reach the level of awareness in common people. These rarely conscious body sensations are not measured by questionnaires focusing on body awareness, but can be clearly detected from textual reports. These considerations led to the interview research, since it would not have been possible to explain this complex phenomenon to be investigated by the questionnaire tools alone.

In the first comprehensive question of the interview research, we sought to find out whether the differences in body awareness (according to the frequency or the active-passive nature of the practice) could affect the therapist's relationship competencies and thus the therapeutic efficacy. Our assumption was that the therapists' different reports

of successful and unsuccessful cases could show different patterns for this. Expanding the question in each subsection provided an opportunity to discuss the following results.

In unsuccessful cases, we expected a smaller difference between the four groups in the TT and TÉ indicators, because of the evolutionary significance of negative body sensations and emotions which can be easily detected even without a specific body awareness skill. In successful cases, we assumed greater differences in the *Therapist's Body Sensations* (TT) index, since in this condition the subtler bodily processes and vitality affects also play a role, and their level of awareness is likely to depend on the level of body awareness skill. We also expected that there would not be a big difference between the four groups in successful cases in *Therapist's Emotions* (TÉ), as in the sense of the strength of the body sensations, these are moderate, easy-to-detect feelings with cognitive evaluations, which are less dependent on body awareness skills.

The results of *Therapist's Emotions* (TÉ) indicators confirmed our assumptions. We could not detect any significant differences between the four groups, either in successful or unsuccessful cases, because in this category there were moderate feelings which were less dependent on body awareness skills.

According to our assumptions, the *Therapist's Body Sensations* (TT) indicator in the unsuccessful cases, due to the high rate of negative body sensations, was significantly more frequently measured, than in the successful ones, based on all groups. However, if we examined separately the four groups, this statement was true only for three. The fourth group, therapists who practice active body awareness techniques more frequently (TA4 +), had a high rate of TT in successful cases as well. This is related to the observation mentioned above that the awareness of negative body sensations in the average population is usually more frequent, because it has an evolutionary value, compared to the positive sensations for which (active) body awareness skill is required. We have emphasised the need for active body awareness, since in the TP4+ group, who also have a high level of body awareness, the TT of the failed cases (mostly with negative body sensations) was more than three times higher than the TT score of the successful cases (predominantly with positive feelings).

This result can be explained with the difference between active and passive methods, since these techniques basically sensitize practitioners in different ways. The vast majority of passive techniques are focused on relieving stress, eliminating negative bodily feelings, for example with the relaxation of muscle tension, so more attention is paid to the perception of negative body sensations. In contrast, positive body sensations and the more subtle feelings have a much greater role in active techniques, stemming from movements, and from the connections with other people and the physical environment. However, it is important to emphasize that it does not mean that only those therapists with a high level of active body awareness can experience these positive bodily feelings coming from the attunement with the patient, but it rather means that these therapists are more aware of these sensations and later are able to recall them more easily in reports.

In the *Relationship Signs* indicator (KTP), the difference between the active-passive groups proved to be significant only in successful cases, and in some of the KTP indicators besides the active-passive dimension, the regularity of the practice also

affected the values. In unsuccessful cases, therefore, the groups were more similar with each other, suggesting that each therapist has a patient, a therapeutic situation that makes it difficult to operate relationship competencies.

After discussing the indicators separately, we examined some correlations between the TT, TÉ and the KTP indicators, dividing the sample into two groups according to the frequency of practice. We did this to draw conclusions about the authenticity relationship competency.

Depending on the degree of body awareness, the correlations between the awareness of body sensations or emotions, and the relationship signs presented a different picture in the two groups separated by the frequency of practice. The results suggest that in successful cases the often practicing group of therapists rather use their body sensations to form the relationship, but emotions also play a role. In this group the more body sensations or emotions were mentioned by the therapist, the more relationship signs could be measured. In addition, the negative body sensations correlated with the negative relationship indicator and the positive ones with the positive indicator, and there were similar tendencies between the emotions and relationship signs, only to a lesser extent. In the rarely practicing group, only the negative emotions had such a strong correlation with the relationship. From our results, we can conclude that in successful cases, authenticity is a strong characteristic of the regularly practicing therapists, both in terms of body sensations and emotions, and the congruent relationship signs with them, and it is a characteristic of the rarely practicing group as well in the case of negative emotions and relationship signs.

However, in the failed cases, very different patterns have emerged between the different indicators. For those who practiced on a regular basis, we got a strong negative correlation between body sensations and relationship signs. This means, that the more body sensations were mentioned by the therapist, the less relationship signs were detected. The same was the case in the rarely practicing group with emotions, i.e. the more emotions the therapist mentioned, the fewer relationship signs could be encoded. This may be explained by the fact that in such cases, the immediate communication of the therapist's strong, negative body sensations and emotions to the patient, which would be necessary for authenticity, cannot be feasible, because it is likely to be harmful to the patient and the therapeutic process. Instead of authenticity, there was likely to be an effort in both groups to cope with these negative feelings in some form, whether to have fewer relationship signs, or to improve the relationship.

As a result of the above findings, in the cases of unsuccessful, difficult therapeutic situations, therapists should rather seek to cope with these negative body sensations in some way. Although, authenticity would also be an important factor of efficiency in these difficult cases, it is still not possible completely because of the danger of interrupting the therapy. Body awareness techniques can help resolve this paradox. If the therapists are able to use these negative body sensations as information, and to regulate, overcome, and transform them in some way during the therapy, these sensations or emotions can be communicated authentically to the patient, and the therapeutic efficacy can be enhanced.

We focused on detecting the moments of meeting in our next research question, since we believed through them the effective application of body awareness could be presented as a relationship competence and coping method. The moments of meeting, the outstanding events of affective and empathic attunement, appeared in most of the successful therapeutic reports, compared to the low frequency in the unsuccessful ones, so we concluded that their presence could be a predictor of the prosperous outcome of the therapy. Although the frequency of practicing body awareness techniques in this research has not influenced the prevalence rate of mentioning the moments of meeting, it may be worth examining in the future whether there are variations in the differentiation of the phenomenon in reports according to the degree and nature of various body awareness practices.

Stern's work about the present moment (2010) draws attention to the potential dangers of present-moments, the treatment of which depends on the therapist's coping capacity as well. Stern states if such an intensive moment does not create a moment of meeting between the therapist and the patient, it may have negative therapeutic consequences. This may be because the therapist misses the moment, or experiences it, but he will be too strained and hides behind technical maneuvers, or even enters the moment, but can not find the authentic, spontaneous, adequate response in the situation. In most cases, this will not have serious consequences, and then comes the next moment in which he can try again. However, there is a risk that the therapeutic process may be compromised or even disrupted if the patient feels the therapist does not understand him.

Here, the therapist's relationship competencies come into play, and the skills acquired in body awareness techniques can be important elements in them. On the one hand, the own experiences in body awareness can help in the first case, since the therapist will be able to recognize these moments more effectively by detecting changes in his or her own body sensations. In the second case, if there is tension in the therapist, there are some body awareness techniques for coping with stress, especially in passive methods that can be applied even during the therapeutic process (eg. different breathing or relaxation techniques, or mindfulness). Of course, different cognitive coping strategies can also be successfully applied in this case. In the third case, the experiences gained in active body awareness techniques can significantly increase the ability of the therapist to respond authentically, spontaneously and adequately.

The third question of the interview research was whether body sensations could be worthy of attention in therapeutic efficacy studies independently not only as a factor in emotions. One of the relevant results of this interview research was that therapists mentioned their body sensations twice as often as emotions in the reports of failed cases. If this was only due to our research topic and the efforts of therapists to provide more content on such feelings in a research on awareness of body sensations, we would have received a similar pattern in successful cases. However, this did not happen in successful cases. As discussed above, in the failed cases, the strong presence of negative body sensations and their easier perception and recall may have been responsible for the results, as opposed to the emotions belonging to the middle area of feelings that may be less significant in evolution. The other relevant result were revealed in the theme of a relationship competence, namely authenticity, according to which the correlations of

emotions and body sensations with the indicator of relationship signs also presented remarkable differences.

Other statements in the theoretical background also provide additional supporting arguments for our last research question. Body sensations regardless of categorical emotions, can be investigated and need to be examined, since these feelings are present throughout the whole therapeutic process, even if they are not always conscious. The well-defined emotions emerge from these sensations much less frequently, and in them the primary body sensations are often significantly transformed by cognitive evaluation processes. Due to their primacy, body sensations can have a great impact on the various mental processes and behaviours even unnoticed, so if therapists occasionally monitor them in the therapeutic process, they can more effectively interact in shaping the relationship and therapy. In addition, body sensations are worthy of attention, because they are also important in the functioning of more relationship competencies, they also serve as a basis for authenticity, empathy and acceptance, and they can also be significant in the field of coping with the use of body awareness techniques. However, further studies are required to justify or reject the above assumptions. Nevertheless, it is already clear from these results that studies on awareness of body sensations can enrich the research in different psychological fields with many interesting insights.

The thesis has raised many theoretical and practical considerations, and even more questions that may affect future research directions and the training of therapists. If the effect of the relationship factors in the various therapeutic approaches is so decisive, then it is possible to consider various methods, therapeutic techniques as tools that help the patient to practice the "being in a relationship". In this case, more emphasis should be placed on the development of relationship competencies, including on body-awareness techniques, which can effectively support the process of therapy at several levels. It may be a cause for concern that the training is still characterized by theoretical and diagnostic overweight, although several decades ago Rogers emphasised (1981) that this is more against the ability of empathy, forcing the therapist into a professional role.

In order to develop effective training, further studies would be needed in the field of body awareness based techniques, which would specifically reveal the necessary aspects for therapists in these complex methods. Different techniques may be the most effective for different professionals, for different purposes. All body awareness techniques may be suitable for increasing attentional capacity. Empathic capacity seems to be easier to develop in active methods, especially in motion and dance therapies, and in practice of tai chi chuan. And in terms of coping capacities, the passive body awareness techniques, in which stress coping is targeted, can provide different skills, in comparison with an active method which offers multiple ways of linking to the physical and social environment. The richness and effectiveness of these methods have many unexplored opportunities that may deserve special attention in psychological research in the future.

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