

UNIVERSITY OF VICTORIA

*PROJECT*

**A Somatic Empathy Social Work Practice Conceptual Model for  
Disordered Eating, Trauma and Interlocking Systems  
of Oppression**

By

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## **Introduction**

The aim of this project was to explore the relationship between disordered eating (DE) and interlocking systems of oppression and experiences of trauma as they correspond to our understanding of interpersonal neurobiology, as these links had not been explored before in social work literature. This project offered me the opportunity to highlight the multifaceted complexities associated with DE and related interlocking systems of oppression that may be experienced by clients on a mind, body, emotional, spiritual, relational, community, structural, and political level. One of the objectives was to develop a somatic empathy social work conceptual practice model. As a consequence of this project, I developed a SW practice model that I coined "The SHAME Spiral," which can be used by practitioners in hospital settings. It can be used in the community as a tool when assisting clients by considering all dimensions of who they may be and how they choose to self-define in their life. Practitioners may use this tool as a reference point to consider all dimensions of how clients may be affected by oppression and everyday trauma. This model could provide valuable insight into how clients may be affected by oppressive systems and structures leading them to the use of food to cope with everyday interactions.

In the first part of my paper, I will discuss the discursive connection I feel exists between disordered eating (DE) and interlocking systems of oppressions. The term "discursive connection" in this context refers to multi-layered societal discourse, which may get compounded and projected upon clients through

oppressive societal systems and structures. Clients may feel they have no control over these systems, including the pathology and diagnosis of “eating disorders” particularly in the hospital setting. I have chosen to discuss this topic because it relates strongly to my work interests. I will discuss why this subject is of particular interest to me in the field of social work (SW). I will share my philosophy of practice and discuss the term “disordered eating” as a discourse as it relates to the discursive connection described above. I will describe how clients are often categorized, labelled and pathologized in the medical world. I feel this type of discourse similarly takes place outside the medical realm. However, for the purpose of my project, I chose to focus on the medical system. I will explain the derivation of the label in terms of treatment, and how it has been understood by practitioners such as psychiatrists, medical doctors, nurses, occupational therapists and social workers. I will draw upon Foucault's notion of *power* to control, dominate and oppress others. I believe Foucault is relevant because he argued that medical professionals including the “psi” professions (psychologists and psychiatrists) hold a lot of power and use it to their own advantage in oppressing others. One cannot function without the other. It is like a “capillary web of power” that is interconnected. The result is a type of discourse that contributes to oppressive relations. Those most vulnerable are further silenced and marginalized.

While looking at the relationship that I feel exists between disordered eating, oppression, somatic empathy, and embodied practice in this context, I

look at behaviour and the client/practitioner relationship. To put it simply, somatic empathy is a process. Somatic empathy is another way in which practitioners can try to understand clients by using their own body as an antenna to sense how clients may be feeling. Here it is absolutely critical not to presume that a practitioner will know how to do this. In order for a practitioner to practise somatic empathy with clients, she must be well grounded in embodied practice. Moreover, somatic empathy does not occur just because a practitioner decides that she wants to listen to what her body tells them. In this context, Tangenberg and Kemp posited social work practitioners should approach practice as embodied helpers considering the following dimensions and what they call:

1. The experiencing body, which is focused on the physicality of everyday life;
2. The body of power, which is centred on the physicality of oppression and marginality and often based on race, ethnicity, socioeconomic positioning, gender, sexual orientation, age, disability, physical appearance, and illness; and
3. The client body, which is reflective of the bodily experiences of those viewed as clients or “the patient” who participates in relationships with social workers (2002, p. 9).

Similarly, I feel that practitioners must practise with deep respect, sensitivity, care, compassion, consciousness, authenticity and transparency. This means the way in which a practitioner acts, speaks and carries herself

energetically. When I speak about the energetics of how a practitioner carries herself, I am referring to nervous system regulation and breathing as a homeostatic tool which can help to restore the body and system to a sense of equilibrium, centeredness or groundedness. Zwillich posited that nervous system regulation is comprised of breathing that helps to “maintain the stability of the body’s internal environment” (2000, p. 5). In my view, nervous system regulation is comprised of a deep level of body awareness including a felt sense of knowing, feeling, and sensing, which must be congruent with the practitioner’s sense of values of practice, intentions and ethics. Nervous system regulation also reflects the practitioner’s ability to be fully present interpersonally.

In this paper, I draw upon ideas put forward by Tangenberg and Kemp (2002) and their notion of embodied practice, which merges scholarship related to the humanities, social sciences, and social work. Like Tangenberg and Kemp, I broke down these concepts into three main dimensions of the body, which helped me to organize, frame and inform my own concepts, including how I think about the body in terms of clinical social work practice.

I argue that the experience of power and oppression is related to DE when it is experienced through a symbiotic relationship (interlocking systems of oppression as defined in the opening paragraph and related to Tangenberg and Kemp’s second dimension “the body of power” of embodied practice (2000, p. 9). This oppression is perpetuated by larger structures, systems, and by the professionals who operate within them and may be translated to the felt

experience of shame to the client and thus experienced viscerally (in the guts/core; or first dimension of embodied practice in terms of the “experiencing body” (Tangenberg & Kemp, 2000, p. 9). In this context, I believe that if clients are labelled “patient” (third dimension of embodied practice and the notion of “the client body” and “viewed as patients” (p. 9) by medical professionals including social workers, then not consulted in decision-making (exclusion of social work ethics related to autonomy, agency and self-determination), and treatment plans, the consequences are serious. Clients are ultimately oppressed and dominated by the larger systems, structures and professionals who operate within them (second dimension, “The body of power,” p. 9). Hence, I feel that these types of systems send implicit messages to clients that they are in fact “less important” than the professionals who direct their health and medical care. In turn, clients may experience a sense of disempowerment that affects thoughts, feelings, behaviours, and perhaps shame in terms of a behavioural response related to disordered eating and/or the need to use food as a coping mechanism.

In their framework, Tangenberg and Kemp defined visceral feelings as a type of body language in the first dimension or “the experiencing body,” described above (2000, p. 9). They argued that this type of language or visceral knowledge is integral to the understanding of the body. Tangenberg and Kemp argued that very little attention has been paid to issues related to the body that transcend actual physical states. In terms of the third dimension or “the client body,” they suggested that little attention has been paid to social constructions of

the body, mind, relationships, and the role of power in determining how bodily knowledge and experience are defined, interpreted, and managed (2002, p. 9). I conclude with implications for social work practice taking up the conceptual model I have developed in this project.

### **Rationale for Project Focus**

I argue from the perspective of both client and practitioner that the information available on disordered eating (as it relates to interlocking systems of oppression, trauma and discourse) is lacking in the social work literature. I am referring particularly to literature concerning the body as it relates to the practice of somatic empathy.

More specifically, somatic empathy entails the relationship between a client's, visceral, physiological experience and the cognitive and bodily experience of the practitioner. According to Levin (2005), the notion of somatic empathy comes from further expansion of the traditional definition of empathy identification with an understanding of a client's situation, feelings, and motives. In an effort to reflect the bodily experiences named by the client, a practitioner may engage in several types of empathy including traditional, critical, and somatic empathy. Somatic empathy is sophisticated in that it includes the practitioner being sensitive and attuned to the felt, bodily sensations of a client as a kind of radar to pick up the felt experience of another.

This process means not just drawing upon empathy in its many forms but also attending to the felt sense of empathy experienced through embodied

practice as Tangenberg and Kemp have conceptualized in their framework (2000). Alternatively, critical empathy is related to viewing things (that may include listening and hearing) with a certain bias, which considers context of experience and, in particular, how experiences of marginality, subjugation, silencing, coercion, and isolation occur to perpetuate oppression. Clark (2003), in challenging traditional ideas of empathy, noted that the idea that practitioners can put themselves into the shoes of the other or see the world through the other's eyes is increasingly seen as presumptuous and even oppressive (p. 247).

In her article entitled, *Somatic Empathy and Vicarious Trauma*, Rand described the phenomenon of somatic empathy and experiencing. Here the idea of "experiencing" is similar to Tangenberg and Kemp's notion of "the experiencing body." It is linked with the relationships between practitioners and clients and the idea of "the client body" (2000, p. 9) and what they may be experiencing as a result of past trauma or experiences. Levine (2005) postulated that the symptoms of trauma are the effect of dysregulation of the autonomic nervous system (ANS). He argued that the ANS has an inherent capacity to self-regulate that is undermined by trauma. Levine suggested that the inherent capacity to self-regulate could be restored by the procedures of somatic experiencing (pp. 31-33). Somatic experiencing is a modality that helps clients to process affect related to earlier trauma that may be stored in the body within the context of a safe place. A safe place for example could be a private room provided by the practitioner for therapeutic interaction and expression with little to no

interruptions. Confidentiality is observed by the practitioner unless harm is imminent and likely to occur either to the client or to someone else.

Confidentiality may be broken for legal reasons where files are requested by the court. The practitioner may also provide safety in how they bring themselves to the therapeutic relationship in the context of containment and in their ability to hold what the client has shared. Rossiter (2000) describes this as the ability for the practitioner to “bear witness” to the client’s experience. Rothschild (2000) speaks about client safety in terms of the practitioner’s ability to maintain very highly attuned to boundaries. I will expand more on this subject in the section “Critical Reflection on Practice” and further describe what I mean by applying boundaries and the idea of “applying the brakes”, a concept put forward by Rothschild. According to Rand, somatic empathy may be a useful tool that involves the practitioner’s use of her or his somatic experience as a therapeutic tool. This means that, as a practitioner, she is attuned to physiological and somatic feelings happening within her own body system. As a result of this attunement or awareness, a practitioner embodies sensitivity to the client’s somatic experience and his experiencing body, which helps him to gain deeper insight into the physicality of daily life.

It is important to be aware that the practitioner may not necessarily be picking up the actual somatic experience of the client. While listening, hearing and trying to be as attuned as possible to the client, the practitioner may use her body like an antenna to sense what the client may be feeling in his own body.

Both the practitioner and client are encouraged to track their bodily experiences.

Levin (2005) suggested that with regard to somatic empathy, the therapeutic goal is about empathic attunement and reaching a felt sense of understanding between client and practitioner, described above. In order for a practitioner to practise in this way, it is essential that the practitioner has done her own personal work; a regulated nervous system is critical, and she must be able to differentiate between what is hers and the client's. Regulation would be achieved through the processing of the practitioner's own experiences of trauma. Failing to do so would miss a critical component of what is necessary for the somatic empathy process to be ethical.

Levine (2005) postulated that the symptoms of trauma are the effect of dysregulation of the autonomic nervous system (ANS). He argued that the ANS has an inherent capacity to self-regulate that is undermined by trauma. Levine also noted that the inherent capacity to self-regulate could be restored by the procedures of somatic experiencing (pp. 31-33). It is important to note there are several different modalities that may assist clients to process trauma or the affect that lends itself to a dysregulated nervous system. However, for the purposes of my project, I was encouraged to narrow my scope; hence, I chose to focus on somatic empathy and experiencing.

Information regarding somatic empathy and experiencing in social work is limited compared with the extensive literature in the field of psychology. Social work researchers and practitioners such as Tangenberg and Kemp (2002) tend to

have a more inclusive perspective than psychologists by including contextual factors. Their practice is often informed by a qualitative, strengths-based, person in the environment perspective (PIE). Tangenberg and Kemp argued that the body is both physical and sociocultural; that it not only includes specific, personal, corporeal experiences but also experiences that are socially and culturally constructed and reflective of larger social arrangements (p. 10). For example, the SW perspective takes into consideration the client, and surrounding systems and structures and considers how each dimension affects the other. Conversely, the field of psychology, and particularly the biomedical model, often focuses on the psychological, diagnoses and treatment-based paradigms. The literature is written from a positivist and objectivist viewpoint and is pathologically centred (Creswell, 2003).

Tangenberg and Kemp (2002) argued for the importance of bringing the body back into social work focus and practice. The humanities and social sciences, therefore, have helped to bring to the fore rich works informed by a multitude of various perspectives that seek to re-center the body as a focus of theoretical and practical concern (Ceronetti & Moore, 1998; Clark, 1999; Stensland & Malterud, 1999; Williams & Bendelow, 1998).

I have compassion for those struggling with disordered eating because of my own experiences of oppression, trauma and associated bodily symptoms, anxiety, panic and system dysregulation. I have dealt with physiological symptoms and shame related to DE my entire life, including behaviours of

anorexia nervosa and bulimia, and the outcome of obesity. DE has similarly affected my family of origin including my mother, six sisters, and brother. I have worked with clients who have lived with DE. As I explored this topic, I examined somatic empathy, which I have found to be a body-centred approach rather than an intervention model. However, I did look at intervention models such as DBT, Dialectical Behavioural Therapy, Cognitive Therapy, Individual and Group Therapy as treatment approaches. These approaches gave me insight into the treatment of DE and assisted in the development of the practice model I created.

### **Practitioner Feedback**

Practitioner feedback for this project was obtained during the planning, development and execution stages of the project. This feedback came from 18 practitioners who included (1) SW PhD, (1) PhD Ed, (1) M.Ed, (14) MSW (hospital-based), and (1) MSW (Community).

The feedback from SW practitioners was essential in the development of my model, facilitation of my project presentation at Lions Gate Hospital and for the enrichment and shaping of my model. Practitioners were consulted for their feedback and reactions to my ideas to ensure that the model is understandable to practitioners and is relevant to practice. Prior to my presentation, one practitioner (my mentor in hospital social work) suggested I email a list of definitions (that is, somatic empathy, the difference between disordered eating and eating disorders, discourse, oppression, my definition of interlocking systems of oppressions, interpersonal neurobiology) prior to my presentation. I did this

and practitioners commented that they found this useful. They suggested I include some practice exercises and visuals. From the 18 practitioners involved in this process, I received useful and valuable feedback. One of my practitioners indicated that they still had difficulty understanding somatic empathy. It is important to note that a couple of practitioners were not able to make it at the start of my presentation, which is when I provided the definitions.

The development of the somatic empathy SW practice conceptual model meant that DE and, in particular, the complexities associated with the relation of DE to a number of factors (such as trauma, oppression, interpersonal neurobiology) were illuminated. The resulting model may be a useful tool for social work practice and knowledge construction in the area of DE.

### **Background and Influences**

I approached the project as a woman, a survivor of trauma, and subject of a discursive system of interlocking oppressions where I used food to cope with the dysregulation related to unprocessed trauma. I am White, able-bodied, married, middle-class, Christian, French-Canadian and a heterosexual social work practitioner. As a result of these subjective identities, I hold a type of mainstream power and privilege, which affords me certain advantages both personally and professionally. However, my roles in society are not static but change with every interaction with my clients and in different situations. I feel it is essential to examine power, values, beliefs and assumptions related to DE,

interlocking systems of oppression, trauma, and discourse related to the mind, body, emotional, spiritual, relational, community, structural and political level where clients are concerned.

According to Rothschild (2000), developing a deeper understanding of how the mind and body work together is essential in the treatment of trauma (p. 5). This type of understanding about how the mind and body work together is essential in regard to disordered eating and how it relates to experiences of oppression and trauma. The ability to survive traumatic and/or oppressive situations in everyday life demonstrates tremendous resiliency (Burstow, 2003). Much of what I believe as a practitioner is based on a social work and a strengths-based post-structuralist and feminist-based perspective. This approach to working with clients is contrary to a medical model that is pathology-based and centred on labelling, pathology, diagnoses and treating the disease. My approach to social work practice is focused on the client and on resiliency, coping and hoping, mirroring the model I have developed.

### **Critical Reflection on Practice**

As a SW practitioner, my practice is guided by values and metaskills comprising care, compassion, connection, congruency, creativity, and supportive containment. Supportive containment means that, as a practitioner, I act as a vessel, providing a sense of trust and safety to the client as I engage in supportive assistance and therapy. (In the hospital setting, therapy takes place only in outpatient clinics or when a person is in hospital for an extended period

and there is a greater opportunity to provide supportive therapy). I am aware of appropriate boundaries in exploring where the client wishes to go within safe parameters. I apply a boundary to prevent harm or retraumatization. Rothschild (2000) described attending closely to boundaries as a way to prevent harm, assisting clients to put on the brakes. She maintained the practice of practitioners' assisting clients to draw "simple body awareness can be used to reduce hyperarousal and halt persistent panic attacks" (p. 115). I strongly uphold values tied to self-determination, dignity, respect, trust, equity, and love (Gerhardt, 2004). I believe it is essential to be transparent, genuine, and attuned to the client. It is necessary to dialogue with and acknowledge what my clients say within parameters that are safe (private and comfortable space, confidential, contract re therapy). This is negotiated and agreed upon by the practitioner and client and relates to time frame, goals, plans and type of therapy. Goals are discussed, negotiated and agreed upon by client and practitioner, as I bear witness to their lived experience (Rossiter, 2000). I agree with Davies's (1991) post-structural viewpoint in terms of seeing clients as embodied speakers. Davies argued that clients must have access to a subject position in which they have the right to speak and to be heard (p. 66). I believe in listening carefully to clients. This includes somatic empathy and using a felt sense of attunement and understanding, described in the introduction, to what they have to say (Morton, 1985). It means a practitioner tries to meet clients by responding with caring words in a tone of voice that is soothing.

As I examine the relationships between disordered eating as a discourse and interlocking systems of oppression and trauma, I differentiate between oppressive and often traumatic, pathology- and shame-based medical models. Tangenberg and Kemp's (2002) SW-embodied framework assists me to conceptualize the somatic empathy model I introduce in this paper. It comprises my personal framework centred on client strengths, resiliency, care and attunement. Tangenberg and Kemp (2002) suggested that their embodied approach is in stark contrast to dominant Western society approaches to DE and the guiding assumption that "[Clients] should be able to control their bodies, that the rational self can act as a brake on the body" (p. 11). Therapy based on CBT is an example of one type of "rational approach" whereby the mind is trained to stop thinking of food and/or hence compulsive eating, so the behaviour may be disrupted. They go on to explain that social workers "can assist in the process of getting the body back in line by providing education, skills training, and positive social support" (p. 11).

The outcome of this project is the creation of a new social work practice conceptual model embodying somatic empathy. It is hoped it will encourage practitioners in hospital and community settings to access training in somatic empathy and use it with clients who have DE. It is important to note that for practitioners to practice ethically they must do their own personal work and learn how to regulate their own systems so as I explained earlier, they understand what is theirs versus their clients'. Unfortunately this cannot be

ensured in the hospital setting. However, from my experience and what I have seen over the past two years working in the hospital setting, my colleagues uphold ethical practice. As an informed practitioner, I can underscore the importance of doing one's own personal work in a move toward system regulation and empathic attunement among fellow practitioners.

Selected practitioners were involved in the development of the model as consultants. They were invited to a public presentation and invited to provide feedback. A brief concept related to the idea of a somatic model is illustrated below and named the *Shame Spiral*.

### **Project Plan**

My project plan has been to develop a somatic empathy social work practice model and create a diagram to illustrate the model, as in this paper. I have included a list of articles that I have drawn upon in the development of my model. In addition, I have included literature related to research that supports the philosophy of practice in my model as it relates to trauma, oppression, disordered eating, somatic empathy and interpersonal neurobiology. I feel I have described somatic therapy as it touches elements of human beingness and our interdependent energetic connectedness (Schwartz, 2005). I have included literature that supports the importance of hospital practitioners developing an understanding of somatic empathy. It is my hope that the exploration of this subject and development of a new somatic empathy SW conceptual model will encourage practitioners who work in the area of DE to access training in somatic

empathy.

The conceptual model I have developed focuses on the importance of being present for those we serve. In addition to the use of somatic empathy, the use of critical empathy is of great significance particularly as it relates to the first dimension “experiencing body” of Tangenberg and Kemp’s framework of embodied practice (2002) as a rationale for using this type of model. The use of critical empathy pertains to the second and third dimensions of Tangenberg and Kemp’s ideas. It relates to clients’ physical and overall well-being with regard to how they make sense of the world. Critical empathy presumes that there are constraints in understanding the experience of the ‘other’ because subjective experiences differ based on many differences in how people are currently and have been historically socially positioned. It also relates to how bodily or visceral knowledge is expressed and understood with regard to patterns, systems and structures of the minutiae of everyday life (Tangenberg & Kemp, 2002, p. 13). According to Tangenberg and Kemp, it is important how social workers gain access to, value and extend validation of the lived experience of the body (p. 13). As well as offering support and empathy, social workers are embodied helpers. This means a practitioner is connected with all dimensions of themselves. The body’s sense of knowing, feeling, and sensing is privileged above the mind extending care and providing empathy in the therapeutic relationship. This model is described as bringing all dimensions of the practitioner including mind, body, emotion, spirit and relationships that form the practitioner’s subject self to the

helping relationship. The community and other macro systems (including political and organizational structures, policies and procedures) are included in the practitioner's subject self and affect the interaction of the practitioner and client.

In this context, I see the embodied helper as a practitioner who practises with care and mind and consciousness. This means that the way in which a practitioner acts, speaks and carries herself energetically (nervous system regulation with a deep level of body awareness including a felt sense of knowing, feeling, sensing) must be congruent with her values of practice and intentions. This means that a practitioner practises ethically, attuned to her own experience of system regulation. As I explained earlier, it is critical for a practitioner to do her own personal work and be able to differentiate between what is hers and what is theirs. These aspects work together symbiotically and are the basis of support, somatic empathy and applied interventions, which take place as the embodied helper bears witness to the lived subjective experience.

An attempt was made through the review of literature to include in the model a beginning level of introduction to interpersonal neurobiology. Other factors included a mapping of its relationship to the confluence of shock, relational, energetic and accumulated stress, and socially and culturally produced trauma (Haist & Mortimore, 2010). This conceptual model describes the social, political, economic, cultural and global context wherein trauma may occur in terms of experiences or events and is perpetuated (Burstow, 2003). Within this framework, I discuss the significance of family, social networks, and community

systems in facilitating change and supporting the healing process. I identify ethical issues that are present in practice when working with trauma, including the ethical requirement for self-care.

The significance of family, social networks, and community systems in facilitating change and supporting the healing process is examined (Siegal, 2003). I consider ways in which power, my subjective values, beliefs and assumptions guide how I work with individuals, groups and/or communities (Foucault, 1977, 1980). Finally, I have provided an analysis of new ideas related to interlocking systems of oppression and the perpetuation of a felt sense of shame and oppression which clients often experience in the mind, body, emotional, spiritual, relationships, and community, structural and socio-political dimensions. I will explain what I mean in more detail in the section: My Definition of *SHAME* Acronym. The eight primary dimensions listed here are examined in terms of the relationships with one another and how they interact, causing clients to feel a sense of powerless. The resultant loss of control or experience of a sweeping feeling of shame I have named a *SHAME* Spiral.

It is my hope that the result of my work will be shared through publications and presentations at conferences. Finally, my ultimate goal for this project is that it provides a basic understanding of neurobiology, described by experts such as Levine (2005), and its relationship to the confluence of shock, relational, energetic, accumulated stress, and trauma caused socially and culturally (Haist & Mortimore, 2010).

## **Methodology**

For this project, I have examined the literature related to models used to treat trauma and disordered eating. I have examined the Polyvagal theory (Porges, 2004) and the description of interpersonal neurobiology in the theory. I have described to practitioners my understanding of the theory in terms of how practitioners may notice different nervous system states among their clients. I have similarly looked at the literature related to some of Rothschild's (2000) ideas related to trauma, somatic empathy and the body as a resource. Research on DE has demonstrated that it is often linked with dominant discourse such as what can be found in medical settings and pathologizing, labelling (diagnosing and treating the patient), discrimination, marginalization, trauma and oppression. Numerous individuals living with DE turn to coping mechanisms that reflect addiction. Based on the research undertaken thus far, the framework of my conceptual model is:

### **SHAME Acronym—Understanding Others**

**S**—Safety

**H**—Hyper/hypoarousal

**A**—Affect relates to the amygdala (consider autonomic nervous system (ANS) and system dysregulation; does a client seem as though they want to run away? Scared? Does their tone of voice match their body language?)

**M**—Mobilization (includes modulation/immobilization; how do clients mobilize? However, dysregulation is linked to immobility, particularly

immobility with fear.)

### **E—Explicit/ Implicit Memory**

This somatic empathy practice model is a basic conceptual model. I view it as a tool to guide both the practitioner and the client to a place of somatic awareness. I propose that visceral (Tangenberg & Kemp, 2002) feelings that emerge in the body may be experienced as a felt sense of shame when the body is in a state of hypoarousal. I am curious to examine how a sense of shame might be perpetuated by Western society through labelling, pathologizing and the discourse associated with DE, interlocking systems of oppression, and the ideals we attach to beauty, which are projected back to the individual. It is the shame about the shame. Tangenberg and Kemp (2002) argued that for clients to speak about their bodily experiences it depends on multi-faceted levels of factors such as social positioning, degree of conceptualized power, cultural values and clients' lived experiences. Moreover, the authors argued that clients who have experienced oppression are unable to locate language outside dominant discourse and those who fear stigma may end up keeping silence.

I would suggest that for practitioners to assist clients who are activated (triggered emotionally and/or viscerally) or who experience anxiety or panic, it is necessary to understand the elements of activation. I believe it is crucial to assist clients to draw awareness to their body or toward a sense of knowing or understanding where manifestations of shame occur or are triggered through hyper and hypoarousal and may manifest in the body (Rothschild, 2000).

Rothschild argued that emotions are psychophysical rather than strictly psychological, which means that emotions are not strictly experienced in the mind but also in the body and that there is no separation between one's physiology and how one psychologically experiences the world (p. 5). It is my suspicion that the psi professions and others may not accept this view which is vastly informed by understandings of neuroscience. (Levine, 2005; Rand, 2003; Rothchild, 2000). I agree with Rothschild for the most part; however, I would argue that experiences of trauma experienced in the body through system dysregulation are more physiological than psychological. Interpersonal neurobiology is similarly revealing that emotions are experienced psychophysically.

As well as drawing upon the conceptual model I am putting forward, I feel it is important for practitioners to be aware of other forms of body awareness tools and models that may help to conceptualize my model better, particularly for somatic empathy and experiencing. These models include somatic awareness, somatic empathy (Rothschild, 2000), and somatic experiencing (Levine, 2005; Rand, 2003). Other modalities that focus on the physiological level are bodywork, systems-centred training, and one-on-one psychotherapy, art therapy, and group therapy re cognitive and behaviour. In the process of somatic awareness training and development, both practitioners and clients may develop the ability to draw on their implicit and explicit understanding of their own bodily experiences. These experiences may include trauma and/or oppression, which

(Burstow, 2003) described along a continuum of everyday experiences. This continuum mirrors Tangenberg and Kemp's (2002) conceptualization of second dimension of embodied practice, which looks at "the body of power" (p. 9). This body of power is centred on developing an understanding of how oppression, marginality and agency affect (Burstow, 2003, p. 13) "the experiencing body," and the first dimension of Tangenberg and Kemp's notion of embodied practice (p. 9). Therefore, as a quick reference point or guide to understanding the experience of activation related to trauma, both clients and practitioners may draw upon a simple *SHAME* acronym to understand what may be happening in the moment or in one's daily, subjective life and lived experiences.

### **Definition of SHAME Acronym**

***Safety*** refers to safety considerations. Is the client feeling safe in this moment? (A practitioner provides a space where a client feels safe from harm; ability for a practitioner to act as a container and apply appropriate boundaries for the client.) It is important to consider cultural implications including diversity and marginalization.

***Hyperarousal*** refers to a state of increased psychological and physiological tension marked by such effects as reduced pain tolerance, anxiety, exaggeration of startle responses, insomnia, fatigue, and accentuation of personality traits (Dorland Medical Dictionary, 2007). Is a client experiencing hypo-arousal? For example, a state of hypoarousal may be experienced as a sweeping cold feeling experienced viscerally and/or perhaps from head to toe. It

is important to note that not all clients may necessarily feel hypoaroused but may instead move into a hypoaroused state, which is often quite unconscious (that is, clients may not be conscious that they are in this state).

**Affect** refers to the experience of feeling or emotion and voice tone. Affect is a key part of the process of a client's interaction with stimuli. The word sometimes refers to affect display, which is "a facial, vocal, or gestural behaviour that serves as an indicator of affect" ([www.en.Wikipedia.org/wiki/affect\\_psychology.ca](http://www.en.Wikipedia.org/wiki/affect_psychology.ca)). Consider this question: Is the sound of my voice as soothing and as congruent as the words I speak? (If a client is triggered, the amygdala also impacts affect.)

**Mobilization** refers to a client feeling as though he wishes to fight, flight, flee, or freeze (I include freeze as I believe it is essential to consider how a client *may not* feel able or capable of mobilization; look at the spectrum of mobilization along a continuum) and how this lack of mobility may contribute to system dysregulation (Porges, 2004; Rothschild, 2000). Mobilization is an unconscious autonomic nervous system response. It is important for practitioners to consider that not all clients (or practitioners) who experience a freeze state may be able to track it because it is often unconscious. If a client is experiencing a high state of arousal, he may not wish to track it unless he is feeling safe and supported by a practitioner who may be able to do this with him with great care, sensitivity and skill. If a client is in a high state of arousal, tracking may not be the best option but rather just being with the client and offering supportive containment may be

sufficient.

**Explicit memory** is the conscious, intentional recollection of previous experiences and information. We use explicit memory throughout the day (Rothschild, 2000).

**Implicit memory** is a type of memory in which previous experiences aid in the performance of a task without conscious awareness of these previous experiences (Rothschild, 2000).

In my basic somatic empathy conceptual practice model, I illustrate a fluid picture of how an individual is affected in their life by larger, interlocking systems of oppression (see Shame Spiral on p. 34). My intention in creating this model was that the spiral itself would provide a sense of the visceral experience during activation following a trigger and memory of trauma. It may be perpetuated by systems and structures and projected onto the individual. It involves the visceral and or sweeping sense of shame that clients may experience from head to toe. On the individual client's level, I propose that this larger system is experienced on the basis of involving mind, body, emotion, spiritual, relationships, and community, structural, and political systems. In terms of power and subjective experience, it is important to recognize that the interlocking system may change from moment to moment. This means that factors change daily within the societal, institutional and structural context. Clients can feel safe one moment but unsafe the next, depending on their experience and or "everyday experiences of trauma" (Burstow, 2003). These experiences are often psycho-physiologically

and somatically experienced as a “felt” sense of shame. However, triggers for the experience of shame may include distorted thoughts, self-esteem and body image issues, fear, disconnection, and judgement.

Some of these ideas related to oppression have been inspired by Young's (1990) *Five Faces of Oppression*, which I will briefly describe. These include: Marginalization, Exploitation, Powerlessness, Violence and Cultural Imperialism. I have added three more facets of oppression, which include: Stigmatization, Objectification and Intergenerational Trauma. There is no question that stigmatization and objectification contribute to intergenerational trauma. In my model, however, I felt these dimensions deserved a category of their own especially because of the experience of shame, which can be felt on a very personal level. I believe that each of these facets may contribute to oppression, trauma and system dysregulation to varying degrees. The degree depends on the client's subjective experience, which is fluid and never static. These faces of oppression and interlocking systems of oppression may be experienced as multi-layered complex oppression and trauma along a continuum (Burstow, 2003). The oppression may get translated to the client and experienced as shame, as a result of dominant systems and structures (Young, 1990).

I argue that interlocking systems of oppression are closely tied to capitalism and globalization. In terms of capitalism, the rich become richer while the poor become poorer. Clients living on the margins of society are at an economic disadvantage. Vulnerable members of society (women, people of colour, differently abled, gay, etc.) may experience intersectionality in terms of

marginality. In other words, clients may experience multiple levels of marginalization because of their gender, skin colour, ability, age, sexual orientation, socio-economic status, role in society, and so on. Tangenberg and Kemp also discussed some of these levels of marginalization in the second dimension of embodied practice "the body of power," which is centred on "the physicality of oppression and marginality" (p. 9). The result is that they are at higher risk of trauma and oppression and have less voice to assert their needs. An asserting voice or choice may come with certain repercussions such as violence. This population may also lack autonomy in terms of decision-making regarding treatment and accessibility to treatment. When we experience a traumatic event such as 9/11 or natural disasters, these events impact individuals, clients and the world. They affect the economics of a country (for example following 9/11 and the devastation of the World Trade Centre, we saw a collapse in the US Stock and Trade Market which adversely impacted economics in countries around the world including Canada). In turn, when a country is devastated by economic disasters, communities are similarly impacted (not given the same fund allocation because the government has to make up for other lost resources at the top). Of course, then individuals are negatively impacted because they are left with less sustainability. Individuals may turn to other means of survival such as sex trade work, theft, drug trafficking, etc., placing them in more vulnerable positions and at risk of harm. Economic disaster can impart a sense of fear and loss, which is translated into a sense of community dysregulation. I mention this is to describe the far-reaching effects of trauma.

Because of the scope of this paper, however, I will not elaborate on community dysregulation.

In brief, the main point I wish to make is that if disaster, war, or genocide take place in a community, it is not just the individual who experiences the impact of the event; an entire community will experience the event and need to heal from the traumatic experience. In my somatic empathy practice conceptual model, I propose eight main levels of integration through which individuals experience trauma and oppression, as follows:

**Mind**—*Stigmatization* may lead to distorted thoughts because of labelling, pathologizing, and exclusion because of mental health barriers and non-acceptance of those with mental health issues by mainstream society; therefore, it is viewed as deviant, different or abnormal.

**Body**—*Objectification* may lead to issues of low self-esteem, self-hatred, body-image issues, and obsession regarding weight, numbers on the scale, bulimia, anorexia and obesity issues. These concerns are encouraged by the media, movies, advertising in popular beauty and fashion magazines, and extremely thin runway models (Brumberg, 2000). Online organizations and/or therapeutic communities such as Pro-Ana and Pro-Bima perpetuate a sense of not measuring up to the ideal of beauty while offering ideas about how to obtain the picture-perfect body (Lawson, 1985). Gender socialization and gender binaries that project the ideal image of the ultimate feminine female versus the masculine male perpetuate a sense of what it means to be a perfect, normal, acceptable, and sexualized human being (Burstow, 2003).

***Emotional—Powerlessness*** (Young, 1990) may lead to a sense of fear about control of one's life as a client becomes regulated, and a painful subject particularly in the medical setting (Phillips, 2007).

***Spiritual—Violence*** (Young, 1990) includes physical, sexual, emotional, and financial problems that may lead to the loss of culture, practices and traditions, a sense of being, disconnection, trust at the core level, sense of mastery, autonomy, self-differentiation, sense of identity. This type of loss could translate into a deep sense of grief.

***Relationships—Exploitation*** (Young, 1990) may lead to judgement, disconnection, and isolation.

***Community—Intergenerational Trauma*** may lead to exclusion, loss of citizenship, decision-making opportunities, disenfranchisement, and displacement. For example, First Nations people experienced and continue to experience tremendous intergenerational trauma as a result of colonization, genocide, residential schools, and during the “sixties scoop.” This was a time when generations upon generations of mostly First Nations children were scooped up and taken away from their family, placed in residential schools and subjected to oppression and trauma. The trauma of being neglected, unloved, and abused is often passed down through the family.

***Structural—Marginalization*** (Young, 1990) may lead to multi-layered oppressive and discursive systems including varying levels of economic disadvantage, racism, discrimination, classism, credentialism, sexism, ableism, heteronormativity, exclusion, and othering (Guillaumin, 1995).

**Political—Cultural Imperialism** (Young, 1990) may be experienced as oppressive policies and laws, capitalism, poverty, starvation, and globalization.

### **LIVED Acronym—Combining the New with Pre-existing Intervention Models**

As part of the somatic empathy practice model, the *LIVED* model refers to the practitioner's ability to listen and especially *how* the practitioner listens to the client's narrative and lived experience. It refers to combining the new model with pre-existing models that the client feels has worked for him or her in the past. It refers to using *voice affect* in a way that is soothing and congruent with the words spoken. It is about assisting the client to find his or her hidden voice. A somatic empathy approach is different from a regular empathy model in the sense that when appropriate, it is a tool in which to find answers or clues hidden in the unconscious body. It is about exploring resources and dialoguing about the next steps not in the role of expert but rather as supportive ally. This *Lived* approach is based on a phenomenological (Greene, 1997) feminist-strengths-based approach whereby the lived experience is privileged and highly valued. This lived approach includes the use of Narratives, Resources, Resiliency and Strengths-based practice, which I feel are key factors in connecting with clients on all levels. Each dimension will be expanded more fully below:

**L—Listen**

**I—Intervention Models**

**V—Voice**

**E—Explore Resources**

**D—Dialogue About Next Steps**

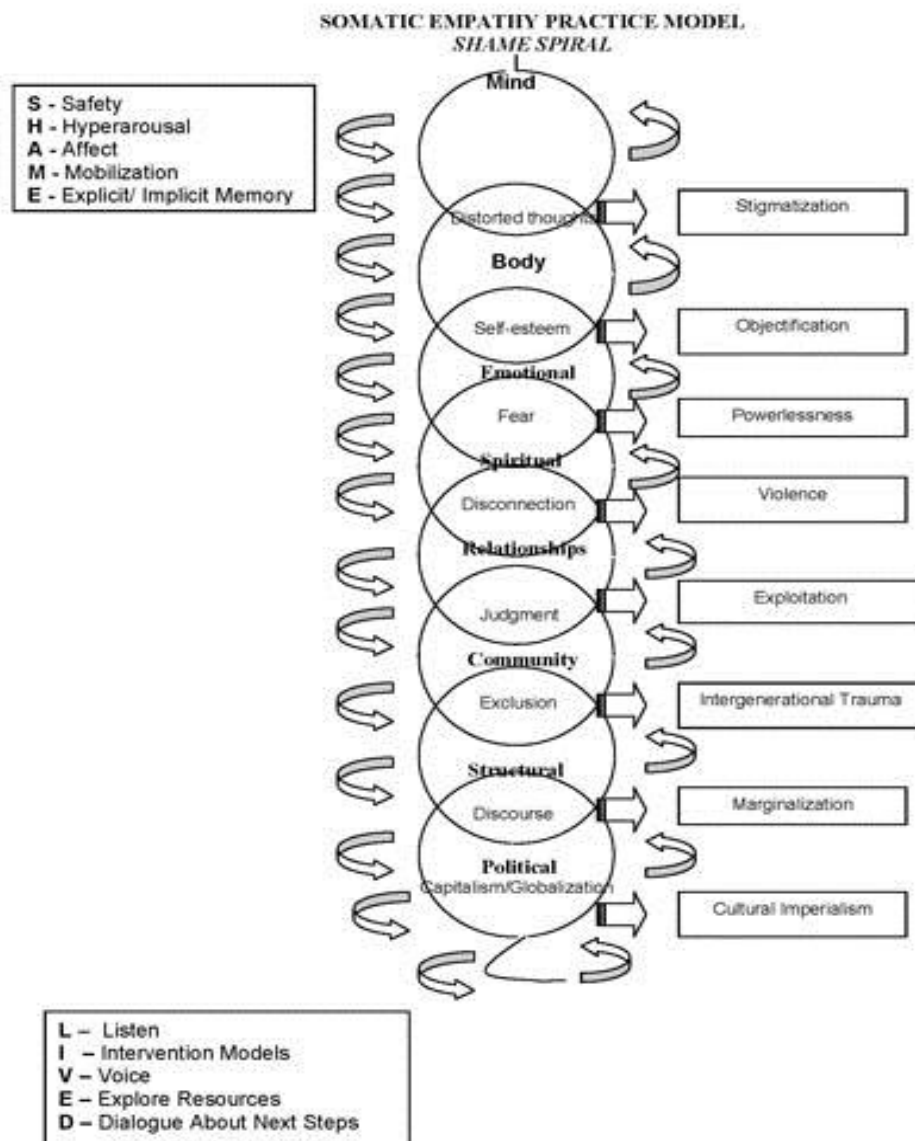
***Listen.*** Nelle Morton (1985) speaks about the importance of listening to someone and hearing what they are saying by hearing one another into speech. She says communities of justice are based in real practices in which a kind of intentional listening and solidarity with others not only allows them to have a voice, but provides them with the support necessary for them to find a voice. Only as the dehumanization and oppression of modernism are answered by those practices that recognize the essential personhood of all involved, and give voice to those silenced by patriarchy, bigotry, and slavery, can a community exist. Communities of justice empower the participation of all in their own self-determination (pp. 127-9). Palmer expanded on Morton's idea of hearing into speech by adding that it means making space for the other, being aware of the other, paying attention to the other, and honouring the other. It means entering empathically into the other's world so that the practitioner is perceived as someone who has the promise of being able to hear the client's truth (p. 46). Listening to a client's truth includes the use of somatic empathy in terms of how practitioners learn how to listen using empathic attunement with the practitioner's body as an antenna to sense the other person's nervous system dysregulation.

***Intervention Models.*** These models are individual to clients and include various cultural and spiritual practices. It is a combination of what has worked for those clients in the past and may include current models such as somatic empathy.

**Voice.** A practitioner must think and be conscious of their voice tone and whether or not its affect is congruent with the words spoken. They must assist clients to find their hidden voice and similarly honour silence as a form of resistance.

**Explore Resources.** Rothschild (2000) described the body as an underutilized resource. Remember that this is really context specific. Sometimes it is ethically problematic to “use the body as a resource” particularly if a practitioner is not skilled enough to practise this with a client who is highly activated. As well, attending to what is occurring in the body may trigger strong vulnerabilities for clients. Tangenberg and Kemp (2002) described the body as being like a capsule that holds valuable information that has been neglected for too long and they argued to have it brought back in. I would argue that the body is a good place to start to explore. Draw some focus where a client is concerned by asking him, particularly in the hospital setting, if he'd like to talk about what he may be experiencing in his body. It must be safe to do so and the client must not be too activated to do so. If this is not possible, at the very least I would try to be attuned to the person's body through the use of somatic empathy. In addition, explore other resources including a client's sense of coping, hoping, resiliency and the new tools that may be added to the pre-existing toolbox (Palmer, 1998). Rothschild (2000) described awareness and the body itself as a resource. She noted, "As a therapeutic tool, simple body awareness makes it possible to gauge, slow down, and halt traumatic hyperarousal, and to separate past from present [and] is a step toward interpreting somatic memory" (pp. 100-01).

**Dialogue About Next Steps.** Morton (1985) contended that dialogue requires listening to the other who serves as a partner in dialogue. She stated that listening helps give voice to that partner and this type of dialogue requires respect for the other (pp. 127-9).



## **Conclusion**

In conclusion, I believe further exploration and research is needed in the area of disordered eating as a discourse and as it relates to interlocking systems of oppression informed by a social work lens. I believe that the introduction of a new somatic empathy SW practice conceptual model could be useful to both practitioners and clients. Using the body itself as a resource in the treatment of disordered eating, trauma and oppression has rarely been explored. Rothschild (2000) contended, "Understanding how the brain and body process, remember, and perpetuate traumatic events holds many keys to the treatment of the traumatized body [emotional, spiritual, relationships] and mind" (p. 5). In the development of this new practice model, I felt it was important to consider Western society's dominant norms, ideologies and systems regarding eating and how they work in the form of interlocking systems of oppression, which are perpetuated on the individual level, translated through a visceral sense of felt shame, and experienced in the body.

The model I have developed is a paradigm based on my personal and professional experience, knowledge, values and beliefs as it relates to discourse about eating and the relation of oppression to trauma and disordered eating, along with my philosophy of practice. I concur with Tangenberg and Kemp (2002) who argued that it is important for social work to recognize the importance of a sense of bodily knowing and the associated realities of everyday life, and involvement with social services and oppression. If this method can be put into practice, the profession will serve the interests of clients more effectively. This

approach to practice may empower the profession to pursue new social policies. It may also encourage strategies that acknowledge the value and complexity of clients' experiences. Further, the approach may stimulate the requirement for resolutions to social issues that comprise various types of epistemology including social work, psychology, psychiatry, and lived experiences.

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