

The martial arts and embodied distress tolerance in psychological therapy

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Abstract

Objective Conflict is common within the psychological therapy space. This paper explores the potential effects of anger upon the therapeutic relationship, types of anger, and how therapists successfully engage with and act skilfully in the face of client anger, including critical and rejecting feelings by the therapist towards clients. We will then introduce the concept of social safeness as affording engagement and action in the context of compassion, before considering the role of the martial arts in managing the self and others as part of talking therapies. We conclude that the literature points to the utility of what we have termed *radically embodied compassion*, which involves training the whole of the therapist, rather than solely their intellect, so that they are able to tolerate and work with the fullest range of human experience.

Keywords: martial arts, psychotherapy, anger, distress tolerance, compassion.

I. Introduction

The quality of the client–therapist alliance has historically been seen as a reliable predictor of positive clinical outcome independent of the variety of psychotherapy approaches and measures applied (Ardito & Rabellino, 2011). A significant portion of the therapist role is to help clients through experiences he/she may find highly upsetting, and which have likely resulted in the development of a series of compensatory defensive/safety strategies over time. Gilbert (2007) notes that in the face of helping clients confront such threats, therapists can enact many roles including educator, validator, boundary-setter, soother, morale-enhancer, container and safe-base. The skilful management of these various roles, in relation to the

expression of anger in the therapy space and how therapists may best prepare for this, is the topic of this paper.

The potential effects of anger upon the psychological therapeutic relationship

It has been argued that working with conflicts, distress and misunderstandings, often denoted as alliance ruptures, is an important element of psychotherapeutic work (Barber, Muran, McCarthy, & Keefe, 2013). Working with or resolving such ruptures can re-establish and strengthen a collaborative therapeutic relationship and may also be method of change in its own right.

This can be considered important as the therapeutic relationship/alliance has been usefully defined by Bordin (1979) as a functional agreement by both parties as to the tasks and goals of the therapy as well as the important interpersonal bond between patient and therapist. Ruptures from this perspective can therefore be seen to exist given problems within any of these areas (Safran & Muran, 2000) and anger can disrupt all three.

While clients can of course become overtly angry in therapy it is perhaps more common that they instead rely on strategies that protect against the appropriate expression of emotions or unmet psychological needs. Such behaviours can be thought of as ‘markers’ for a rupture (Safran & Muran, 2000) and taken to indicate to the therapist the alliance has been negatively impacted upon, even if not otherwise stated.

Clients can manage ruptures by subtle avoidance of their internal experience, reduced engagement in ongoing interactions, by becoming compliant (*withdrawal* rupture markers; Eubanks-Carter, Muran, & Safran, 2014). Others can make at times dismissive comments that criticise either the therapist or treatment/therapy (*confrontation* rupture markers; Eubanks-Carter et al., 2014) and are of significance here.

Types of anger

Pascual-Leone et al (2013) describe at least three particular types of anger that present in therapy, which can be thought of as ‘I hate me’, ‘I hate you’, ‘I hate everybody’. They argue that perhaps the most common expression within therapy is when anger is directed toward the self. Such anger principally involves chronic self-criticism accompanied by a sense of contempt or disgust with one-self. As has been noted elsewhere (see Gilbert, 2010) the emotional tone with which self-critical thoughts are expressed is a highly salient feature in such self-directed anger.

In contrast I Hate You, while also common in therapy, can be seen as rejecting anger directed externally toward another, mostly as a defence against the internal experience of underlying feelings of vulnerability. In terms of the interpersonal, this defence can be the process of anger towards the other who is perceived as providing insufficient love or care (i.e., I’m angry at you for not loving me). Such forms of anger can be considered automatic defensive responses to otherwise unexpressed emotions such as fear or shame, and are related to unmet needs (Greenberg & Goldman 2008). While the feeling of being vulnerable is an initial response to circumstances, it is felt to be overshadowed by secondary anger as a result of a quick-fire non-conscious cognitive-affective cascade (Paivio, 1999).

Building on Linehan's (1993) work, Korman (2005) emphasises the negative reinforcing role anger can play, in that it can displace other painful emotions. In such cases anger can be a short-term means of emotion regulation, typically with unintended consequences. Patients are typically unaware of the function of such two-step processes. Such defensive anger can then become a conditioned behavioural response elicited by feelings of fear and shame. While functional, in an immediate sense, such strategies ultimately prevent patients from realising their unmet needs for interpersonal security and often acceptance (Paivio, 1999). Put another way, such angry responses as a reaction to perceived interpersonal threat (including rejection), while leaving clients feeling briefly powerful, take them further from their fundamental relational needs.

As can be experienced in the therapy space, those expressing anger are often unable to articulate in a way that makes sense of their experiences and reduces the chances of this happening again (Linehan, 1993). Pascual-Leone et al. (2013) argue that due to low levels of emotional awareness, and issues with regulating associated physical arousal, client explanations of such experiences can then further descend into confusing and strong outbursts of anger. This reduction in meaning-making, which has been termed a capacity to mentalise both ones own and the internal states of others, likely then further fuels ongoing problem/maladaptive anger.

As Twemlow, Sacco and Fonagy (2008) have argued those who inflict violence and are felt to struggle with or be unable to mentalise do not usually respond to verbal therapies alone. They suggest the movements in physically based activities, such as yoga and martial arts, combined with psychodynamic psychotherapy are important in helping such clients. We therefore turn to current thinking on therapist engagement with strong emotions before considering what martial arts might additionally offer therapists, as well as clients, as they work with client problem anger.

How therapists successfully engage with and act skilfully in the face of client anger

Safran and colleagues have developed a useful model for working on rupture resolution as part of therapy (Safran, Muran & Eubanks-Carter, 2011; Safran, Muran, & Samstag, 1994). Safran and Muran (2000) argue that patient and therapist must engage in a sequence of critical tasks that explore the patient's ongoing internal experience. In essence the therapist tries to observe the various ways in which the patient might avoid asserting themselves, or expressing their emotions, to inform subsequent intervention.

Initially, the therapist is required to bring the patient's attention to a perceived confrontation or withdrawal marker. The patient can then be helped to consider and work with any reluctance or unhelpful beliefs around expressing his/her feelings or needs linked to the rupture, by examining any underlying fears (and hopes) that might arise. For example, patients might become silent, turn away from the therapist, or state they would rather not discuss the rupture further. Other patients might instead become subtly hostile or dominant. Such responses, thought elicited when it may not feel safe to express one's vulnerable or angry emotions toward a therapist, can be considered as fight or flight reactions. A patients' ability to communicate their current internal states allows the therapist to link with (or attune to) the patient's experience of the rupture and so begin to make efforts to address and so repair it.

Viewed in this way, secure attachment can be thought of as a pattern of successful rupture repairs, over time, with one's caregivers (Tronick, 1989).

Securely attached patients afford repair in therapy by expressing whatever emotions have been elicited by the rupture and, importantly, what they might wish to do about in response. In contrast so called Avoidant attached patients can struggle to convey their internal states, while Pre-occupied attached patients are felt to leave little space for the therapist to make sense of their experience (Safran & Muran, 2000).

Secure attachment however does not mean rupture free therapeutic encounters. Rather, it seems to relate to the ability to non-defensively express one's present experience to afford exploration and so the successful repair of rupture states.

Miller-Bottome et al. (2018) note two challenges in repairing a rupture to the working alliance in therapy. The first relates to the reluctance patients demonstrate in discussing their difficult experience of the alliance, as indicated by either withdrawal or confrontation rupture markers. The second, in terms of insecurely attached patients, is their typical mode of communicating current experiences which may be in more or less open and collaborative ways. Therefore, working to change these communication styles may occur more at the non-conscious, procedural level of the therapeutic alliance, possible through capitalising on has been termed "moments of meeting" between patient and therapist (Stern et al., 1998). Therapist implicit positioning in response to client displays of confrontation/anger may therefore inform such experiences and we argue has the potential to afford therapeutic gains. At such times frank openness and highly developed/embodied distress tolerance on the part of the therapist may be a context that affords this.

Twemlow et al. (2008) suggest physical embodiment as a therapeutic link to the kinesthetic centre of readily disturbed attachment experiences. Embodying the mind, in this sense, requires the therapist to provide a safe, containing context for the work. By combining physical and psychological links in the consciousness of the patient (i.e. embodiment), Twemlow et al. (2008) argue can help make sense of the distressing thoughts and affect that lead to anger and ultimately physical violence. From the psychoanalytic perspective, martial arts training for patients can offer the context for corrective emotional experiences that afford the process of embodiment through attachment to a safe, powerful, and predictable adult role model (i.e. one's teacher).

However, rather than looking at martial arts as therapeutic tool for clients we are instead interested in their role from the perspective of the therapist. Indeed as Twemlow (2001), in discussing training for psychotherapists from a Zen perspective has argued, "a therapist who can 'roll with the punches' is more likely to be a useful role model for the patient as a means of handling day to day reality". Twemlow (2001) goes on to argue that a psychologically healthy albeit technically highly trained psychotherapist may still not be prepared for the demanding task of helping patients. As such, the whole self must also be trained and in particular the ability to tolerate one's own and others anger.

Angry, critical and rejecting feelings by the therapist towards the client

Pope and Tabachnick (1993) suggest anger and even hatred is common from therapists towards clients, and that training is barely adequate in this regard. Being on the receiving end

of expressed hostility from clients is not an uncommon occurrence for therapists (Hill et al., 2003), which can be readily experienced as personally threatening and engendering a whole range of feelings including anxiety/fear, anger, hurt, guilt and shame (Matsakis, 1998). Furthermore, therapists can differ in both their anger-proneness and the discomfort that they feel with their own anger in response to angry clients (Sharkin & Gelso, 1993). Both of these therapist variables can be detrimental and destructive to the therapeutic process, either in acting out such reciprocal (countertransferential) angry feelings or avoidance of being able to engage with and explore clients' potentially problematic anger. Indeed, further research suggests that therapists tend to respond to clients' hostility with hostility (Binder & Strupp, 1997). These dynamics can be especially damaging for clients who have experienced and survived (complex) relational trauma, of which anger is often a prominent issue and source of continued suffering (either under or over-controlled), and such therapist reactions (either overtly hostile-critical or avoidant-dismissive) may replicate those of their early attachments that compound the original trauma (Dalenberg, 2004). This not only increases the likelihood of clients' disengagement from therapy and treatment drop-out (Hill et al., 2003), but also likely continued and worsening emotional, psychological and social difficulties and functioning.

Accordingly, some excellent training programmes have been developed to specifically help therapists work with and resolve such therapeutic ruptures, impasses and re-enactments, such as Alliance-Focused Training (AFT; Eubanks-Carter, Muran & Safran, 2015). However, psychotherapy training has largely neglected to consider other creative means of which to help therapists develop and entrain distress tolerance and conflict resolution skills in a more (radically) embodied manner. For this, we turn to and consider the powerful potential of traditional martial arts training as an embodied expression of distress tolerance to anger, and in turn how martial arts might be a vehicle to the cultivation of radically embodied compassion.

Social safeness as affording engagement and action

Compassion Focused Therapy (CFT: Gilbert, 2009) points to the important role of social safeness in mitigating feelings of threat. Social safeness, as defined in CFT, is a warm, calming affective experience of feeling cared about, reassured by and connected to other people (Gilbert et al, 2008; Kelly & Dupasquier, 2016). Safeness is thus associated with a physiological state of calmness and affiliation and (relative) absence of threat, not only giving rise to states of contentment (passive safeness) but also the corresponding openness and freedom to explore (active safeness). There are parallels here between Porges (2007) Polyvagal Theory and the evolution of the Social Engagement System, where the neurophysiology of affiliation and associated safeness is proposed to operate through the parasympathetic nervous system, specifically the phylogenetically later myelinated (ventral) vagus nerve.

Safeness, in this sense, is often conveyed non-verbally by others and is therefore highly relevant in terms of therapist responses to angry clients. If clients can begin to sense a therapist maintaining an embodied stance of safeness in their posture, facial expression, voice tone and eye gaze/contact, over time this is more likely to correspondingly activate affiliative processing systems in clients that down-regulate threat-processing systems and hold this in balance. Such therapeutic presence and communication of safeness through non-verbal and verbal social signalling is proposed to activate a corresponding neuroception of safeness in the client that

over time down-regulates threat processing and inhibits defensive behavioural safety strategies (Geller & Porges, 2014). This affords an opportunity for both therapist and client to remain socially connected and engaged when the client is angry/upset/threatened without becoming overly defensive (i.e. aggressively attacking, cutting-off, withdrawing, submitting and/ or shutting down), with such affiliative dyadic regulation affording an opportunity and integrative space to transform this problematic and/or destructive anger into more constructive forms of anger (Butler et al., 2017; Kramer et al., 2016; Meloy-Miller et al., 2018; Twemlow, Sacco & Fonagy, 2008). Such affiliative signalling and its skilled usage and timing has been shown to be crucial in (co) managing relational disaffiliation in therapy (Muntigl et al., 2013; Muntigl & Horvath, 2014), in that this co-stimulates cooperativeness, corresponding alignment and more harmonious interactions.

Crucially, engaging with, tolerating and working with anger (whether others or one's own) requires an immense amount of *compassion* (Kolts, 2012). Although there remains some disagreement around the definition and precise nature of compassion, scientific research is beginning to coalesce around compassion as a motive that evolved out of and operates through caring and affiliative motivational systems (Gilbert, 2015). From this perspective, compassion is defined as “a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it” (Gilbert & Choden, 2013). Compassion thus involves and requires two separate but inter-related psychologies: (1) *Engagement*, the ability to turn towards, tolerate and empathically engage with suffering (rather than turn away from/avoid/deny or be indifferent/callous/cruel about); and (2) *Action*, to acquire the wisdom and skills to take wise and effective action in addressing or preventing suffering.

In the case of anger, compassion can provide us with the emotional strength to be aware of and not blindly act out the darker and more destructive sides of our nature, harness and transform it into something more constructive and/or a force for good, but also refrain from inflicting further suffering on others or ourselves. This may require taking strong action to protect ourselves or others in the face of significant threats, but importantly not motivated by the desire for revenge, dominance and/or deliberate infliction of further harm through cruelty. These forms of anger have been referred to as assertive anger (Kramer et al., 2016), pro-social assertiveness (Twemlow et al., 2008), benevolent indignation (Butler et al., 2018; Meloy-Miller et al., 2018), compassionate wrath (Masters, 2000) and fierce compassion (Salzberg, 2012). Equally, compassion gives us the courage and (relative) fearlessness to help others suffering with problematic forms of anger to do the same, by embodying and imparting the wisdom of how to skilfully tolerate, express and regulate it.

The role of the martial arts in managing the self and others

Research suggests that training has been associated with increases in positive self-image (Richman and Rehberg 1986; Finkenberf 1990), in the ability to tolerate pain (Focht et al. 2000) and enhance self-regulation (Lakes & Hoyt, 2004).

However, as Hackney (2011, 2013) has pointed out the martial arts may also help develop personal virtues such as courage, temperance, wisdom and benevolence, which may be highly relevant to therapy. Training in the martial arts involves risk, and courage enables action/responsiveness in response to fear (Hackney, 2006), as well as the ability to continue

despite pain. Moreover, Barnfield (2003) has found that students of the martial arts report reduced aggressiveness, potentially light of their instructors modelling self-control and moral behaviour in class.

With that said, it may be important to distinguish traditional martial arts, exemplified featuring an emphasis on the psychological, spiritual, and non-aggressive elements of the particular style from more modern arts (for example mixed martial arts), which tend to downplay such elements in favour of skilful aggressiveness and competition (Fuller, 1988). Many traditional martial arts discourage, disallow and ‘train out’ competition as this as seen as only serving to fuel egoism, self-concern/self-interest and disregard for others (Foster, 2015). Furthermore, many traditional martial arts emphasise the central importance and purpose of martial training as to ultimately become a more compassionate and fearless human being (Hackney, 2011; Kamen, 2017), in the service of preventing and ending our own and others’ suffering, and learning to live in harmony.

Sporadic literature has emerged over the last thirty years regarding the potential utility of the martial arts to psychotherapy (Weiser, Kutz, Kutz & Weiser, 1995), even less so as applied to the development and practice of psychotherapists (Gleser & Brown, 1988; Seitz et al., 1990; Twemlow, 2001; Fagianelli & Lukoff, 2006; Rosenberg & Sapochnik, 2006; Twemlow et al., 2008; Oulanova, 2009; Friedman, 2016). However, some of the research provides some important insights into how traditional martial arts may greatly enhance many important therapeutic skills and competencies that are essential in tolerating distress, working with and through conflict to successful resolution and thus beneficial therapeutic outcomes.

For example, Faggianelli and Lukoff (2006), in their interview study of Psychotherapists experienced in Aikido, note that one of their participants reported “[Martial arts] practice is a practice to learn a certain state of being. Aikido is no longer what you do on the mat, Aikido is what you do. In Aikido you have some crazy attacker coming at you, and your goal is to be relaxed and centered and calm and able to absorb and join with, just be there with that energy, in a way that can accept and redirect it. A lot of what you do in therapy is the same thing – just be there and not be overwhelmed by what’s going on, and that has a very calming effect.”

The transferable benefits of such martial practice(s) to everyday (non-martial) life situations has been encapsulated and supported by first-person accounts of Aikido practitioners applying the (embodied) principles of Aikido to everyday relational conflicts and challenges (Foster, 2015). These principles include blending, fluidity or fluid *ukemi*, and positioning/stance (Foster, 2015). Furthermore, Foster (2015) contends that martial training may well influence and sharpen a capacity for *somatic metamorphism*, which is defined as a mode of deploying the body to make sense of non-martial challenges in everyday life, as well as conditioning the body to blend with aggressors using minimal energy and auspicious timing (Foster, 2015).

In particular the potential for Aikido to help therapists remain centred while also available to the patient is a familiar theme across the therapy literature. As Faggianelli and Lukoff (2006) note, Bugental (1978) extolls therapists to be physically, emotionally, and relationally with clients. Similarly May has alluded to the ‘total relationship’, Rogers to ‘being present’ and Freud to ‘evenly suspended attention’ during therapy. As in the martial arts, a sense of centre can lead to a more appropriate and perhaps compassionate response in therapy.

Overall, Faggianelli and Lukoff's (2006) participants argued that Aikido affords them an embodied practice of learning how to safely remain calm and centred while engaged with conflict and that such training directly translates into their ability to deal with anger in the therapy space in a genuine, win-win fashion. However, they also noted that learning Aikido, about one's centre and balance and when and how others can become off balance is an act of attention, and fine-tuning this is seen as a lifelong practice.

Indeed, instilling calm amid conflict is a mindful based ability rather than an automatic response, which can be learned through rigorous that over-rides an otherwise instinctive "fight or flight" response. Aikido has an explicit focus on the cultivation of compassion for others (Frager, 1977). Indeed, one of its founding father's most commonly quoted sayings is "to injure an opponent is to injure yourself. To control aggression without inflicting injury is the Art of Peace" (Ueshiba & Stevens, 1992). Positioning oneself in this way means that practitioners can strive to develop distress tolerance towards those who would do harm, despite their overt or implicit aggression.

Martial arts training thus likely has a profound impact on one's physiology and corresponding ability to engage flexibly, skilfully and wisely during therapeutic encounters that are characterised by high (relational) threat. Recent research suggests that martial arts training impacts on specific attentional networks in the brain, specifically the Alert attentional network that indicates that martial arts improves endogenous preparation and performance for uncertain/unpredictable targets (Johnstone & Marri-Beffa, 2018). Crucially, martial artists do not appear to develop threat-based attentional bias(es) in response to repeated exposure to potentially threatening situations (Staller, Zaiser, Körner & Cole, 2017) and exhibit lower trait anxiety when compared to controls. This speaks to the main premise of this paper, that martial arts affords an embodied expression of distress tolerance in emotionally-charged conflict situations.

A further benefit of martial arts to therapy process may also be that they allow one to engage in rapid, flexible and fluid switching between seemingly opposing social-motivational states that facilitates post-conflict reconciliation, growth and learning. Such social switching and post-conflict affiliative behaviours have been observed and documented in primates (Webb et al., 2014), with evidence suggesting that such abilities are predicted by an opponent's level of affiliation and the strength of affiliation within dyads (Webb et al. 2014). This underlying motivation and ability to switch between social-motivational states has been referred and linked to the concept of locomotion, as articulated in Regulatory Mode Theory (RMT; Webb et al., 2017). Locomotion is defined in RMT as a motivation for smooth movement and change from state-to-state (Higgins, 2012; Higgins, Kruglanski, & Pierro, 2003), and movement-based practices such as the martial arts intrinsically involve and entrain such locomotion which is crucial to conflict resolution (Webb et al., 2017). This is supported by research that suggests every peaceable and violent action involves movement-based decisions at a conscious and/or unconscious level (Acarón, 2018), a contention repeatedly made by dance/movement peace practitioners (Eddy, 2009; Serlin, Berger & Bar-Sinai, 2007). Similar to proposed frameworks for embodied decision-making and peace practices (Acarón, 2018), martial arts works at and influences various domains and processes including the motivational (Intention), physiological (Flow/Tension), awareness (Attention), behavioural (Action) and cognitive (Reflection and Evaluation) level.

Conclusion

It is clear that anger has the potential to affect the therapeutic relationship and therefore the effectiveness of talking treatments. Engaging with such themes is a highly relevant element of such work. Much of the existing literature suggests that traditional martial arts are an alternative and powerful means for psychologists, psychotherapists and clinicians to entrain and embody abilities/competencies that are crucial in working with client anger: benevolent motivation, sensitivity, distress tolerance, courage (both dynamic and static) and wisdom. Such training thus builds and affords what we term *radically embodied compassion*, in that it involves the whole person and affords this way of being in social contexts beyond the dojo, be that in the therapy room or in the wider social world. Given the above, we can see that the entirety of the therapist and not just their intellect needs to be trained so that they are able to tolerate and work with the fullest range of human experience.

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