Hakomi: Strengths & Limitations:

Indications and Contraindications for the Use of Hakomi with Clients with Significant Clinical Disturbances

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Editor's Note: This article is very special in that it announces the publication-in-progress of *a new textbook on Hakomi Therapy* written by Hakomi Faculty members from around the world, in which it will be included as a chapter. Chapters covering the theory and practice of Hakomi Therapy were begun in the summer of 2005. Editors Richey Heckler, Ph.D., Greg Johanson, Ph.D., and Halko Weiss, Ph.D. anticipate chapters being completed by the end of summer 2006, and the entire manuscript being ready for publication by the spring of 2007. The text, which integrates Hakomi into mainline psychological literature, will join ***Body-Centered Psychotherapy: The Hakomi Method*** by Ron Kurtz, ***The Body Reveals*** by Ron Kurtz and Hector Prestera. ***To the Core of Your Experience*** by Dyrian Benz and Halko Weiss, ***Grace Unfolding: Psychotherapy in the Spirit of the Tao-te ching*** by Greg Johanson and Ron Kurtz, and ***Experiential Psychotherapy with Couples: A Guide to the Creative Pragmatist*** by Rob Fisher as core texts of the Hakomi Method.

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ABSTRACT: Discusses risks and contraindications of doing experience-near work with clients dealing with serious structural deficits. Recommends the Operational Psychodynamic Diagnostic (OPD) for intake and assessment purposes. Notes need to maintain defenses in clients without an accessible sense of Self/Witness to separate and objectify ego states. Discusses and offers a number of case studies that illustrate ways to help clients anchor their outer world and everyday consciousness, as well as improve self-regulation through self-awareness. Remarks on importance of the security function of the therapist.

Introduction

Lending support to the notion that body-oriented approaches can be seen as offering opportunities otherwise not available in the treatment of clients with early disturbances and weak psychological structures, Maaz has recently (2005) suggested that the royal road to the pre-verbal unconscious is the body itself. The application of body-oriented approaches, however, is not without risk. If not appropriately practiced and carried out, body-oriented approaches could lead to re-traumatization (Van der Kolk, 1989), inappropriate touch (Bodella, 1980; Hunter, 1998), the collapse of defense mechanisms, and/or "malign" regression (Marlock, 1991; Young, 2003). Hakomi, a body-centered, experiential approach to psychotherapy, incorporates the use of touch alongside the practice of mindfulness, assisted self-discovery, experiments in awareness, and "missing experience" (Kurtz, 1990). This article will discuss the indications, contraindications, and risks involved in the utilization of the Hakomi method and Hakomi's use of touch with clients with early-onset clinical disturbances.

For the purposes of discussing clinical disturbances, this article will utilize an approach to developing and discussing clinical diagnostic pictures in terms of (and in relation to) clients' hypothesized psychic structure, an approach that has been described by Maaz (2005) as well as others. Interest in this approach, which has been enjoying increasing pop-

ularity in Germany and other German-speaking clinical settings, has given rise to a new practice-relevant instrument, the "Operationalized Psychodynamic Diagnostic" (ODP) instrument (ODP Task Force, 1996). The ODP, which will serve as the framework for this article's discussion of clients' psychological organization, is oriented towards looking at disturbances and symptoms from within the developmental context from which they are hypothesized to derive. In contrast to the systems of clinical diagnosis that have their roots in Otto Kernberg's work on character pathology (Kernberg, 1996), the ODP "does not limit its focus to a typology of character pathology; instead, it places primary emphasis on the relationship between experience and behavior as expressed in psychic organization, where the deciding factor is the degree to which experience and behavior have come to be integrated in the psychic structure" (Galuska, 2005).

The OPD task force (1996) has put forth a descriptive system to accompany the ODP that describes the axis of "structure" as follows: Psychic structure can . . . be describeed through the use of four dimensions that can be used to describe both object relationships and the relationship to the self:

> **Perception** (self and object-relational perception):
> - the ability to be self-reflexively aware
> - the ability to accurately perceive others

> **Regulation** (self and object-relational regulation):
> - the ability to regulate one's own impulses, affect, and self-esteem
> - the ability to regulate one's relationships with others

> **Communication** (self and object-relational)
> - the ability to communicate with oneself
> - the ability to communicate with others

> **Connection** (self and object-relational directed connection)
> - the ability to make use of good inner objects for the purposes of self-regulation (the ability to develop and dissolve relationnships with inner objects as appropriate for self-regulation?)
> - the ability to develop and dissolve relationships with others.
>
> --(ODP Task Force, 1996).

The ODP discusses structural disorders in terms of levels of psychological integration along a continuum, describing an inverse relationship between the level of psychological integration and the severity of psychological disturbance, such that the most severe disturbances occur within the context of the lowest degree of psychological integration.

> The 'structure' axis traces the level of psychological integration from the well-integrated psyche found in a 'healthy' individual through decreasing levels of fair, and then low, psychological integration, and finally to psychological disintegration. The psychological organization of a neurotic represents a fair to good degree of integration; that of a borderline represents a fairly low degree of integration; the psychological structure of a psychotic represents a psychological disintegration (Galuska, 2005).

Within the context of an established therapeutic alliance, the ODP is very helpful in assisting in the process of determining a client's level of structural integration, assessing, for example, a client's ability to both be and remain connected to the experience of reality, differentiation of self and object, and the maturity level of clients' defense mechanisms (Maaz, 2005). As such, the utilization of this type of approach to client work highlights the importance of considering clients' level of structural organization when considering potential therapeutic interventions. In the case of depression, for example, it is important to utilize therapeutic approaches aimed at specifically targeting the opportunities and strengths available to the client given the coping mechanisms available at their level of organizational integration.

The risks of employing Hakomi therapeutic processes with clients with underdeveloped psychological structures

One assumption generally held by clinicians is that a relationship that is experienced by the client as a healing relationship – one that can provide both a safe space and a feeling of being accompanied by a competent guide through the processes of self-exploration, working through, and the creation, experience, and integration of corrective experiences – is what will make this work possible. Most of the clients that come to us are generally able to form and maintain therapeutic relationships. Having said this, however, only fairly-well integrated individuals respond with excitement and relief to therapists' assumptions about these relationships enabling a "cooperation with the unconscious" or connecting with, experiencing, processing, and working through repressed emotional content. For those who have deficits in psychological structure based on difficult experiences very early in life, or for those destabilized by the active experience of trauma, the thought of lowering defenses against difficult content, becoming mindful, willingly opening oneself to inner space, and listening-in and allowing oneself to be surprised what happens, is both scary, and in some situations, actually dangerous. For these clients, all the steps that lead to mindfulness and living in and experiencing the present moment are not only difficult, but also rarely helpful.

In these contexts, these types of clients will either strengthen their intra- and interpersonal defenses in order to protect against threatening situations and leave therapy, or will run the risk of "decompensating." Depending on the client's psychostructural makeup, opening oneself to emotional experience and the accompanying psycho-

physiological arousal can lead to a taxing and/or partial or complete overwhelming of the client's processing capabilities, or even to an experience of being destroyed, flooded, disintegration, or extinguished. These clients' original defenses and coping mechanisms were able to maintain enough stability in these clients' very fragile inner systems to be able to function under normal circumstances. The strategies typically prescribed by Hakomi, however, could put these clients at risk.

The paradigm of uncovering and working through has been repeatedly discussed as contraindicated for traumatized clients (Petzold & Josic, 2002). Major life stressors and experience-activating and defense-weakening interventions have also been discussed as resulting in the collapse of coping systems and a shift to a more significant crisis state or a chronic increase in symptom severity in clients with other forms of structural vulnerability and disturbance (Rudolf, 1996). For clients with personality disorders, as well as clients who are severely depressed and/or suffer from phobias, this increased vulnerability is explainable by deficits in self-determination and affect regulation. "Given that the disordered difficulties are ego-syntonic (i.e., not accessible to the self-perception of the individual author of the experience), it is difficult for the patient to see their own contributions to the difficult situations" (Rudolf, 1996, pg. 178).

Given the above guidance, therapeutic work contracts that incorporate experience-activating, experimental, and body-oriented approaches are not suited for clients that are organizationally/structurally fragile. These clients do not have enough inner structure accessible to be able to process and integrate the meaning of the material that would arise, nor would they be able to tolerate the degree of psychophysiological arousal that would accompany the same material. This means that the foundation of the explorative Hakomi method, its mindful exploration of the experience of the present moment, would not be possible to implement from the outset of therapy. The practice of mindfulness with closed eyes, and even the invitation to physical relaxation, triggers the fear of having to give up and/or lose control, a control that is often maintained through muscular tensions.

Another aspect of this discussion speaks to the therapeutic relationship itself. The interactional style of early-deficit clients is likely to strain relationships with others, and makes constructive interpersonal relationships difficult, or even impossible (Rudolf, 1996, pg 178). With this in mind, I will now provide examples of client work scenarios that present challenges to the Hakomi-oriented therapist and highlight the challenges and potential pitfalls to be aware of when engaging in these types of client work.

For individuals with borderline features, defense mechanisms such as splitting, projection, denial, and idealization serve to protect against the disintegration of the self. ("The self" is used here to refer to the psychoanalytic sense of an intrapersonal structure of the ego, or "I.") Self- and other images fall into "all-good" and "all-bad" parts, where the negative aspects are also projected outside the self. The relationships that are entered into by someone with these types of relational habits – splitting, idealization, demonization, and/or projection – are very difficult for those they enter into relation with (Rudolf, 1996). If the severity of the disorder is significant enough, the level of distress, fear, frustration, etc. leads to unbearable tension and arousal that tends to prevent clients with these problematic patterns from being able to "observe" these phenomena. These clients are in a timeless experience of elevated stress that is only made manageable through dissipation efforts such as movement, self-injury, or the use of soothing substances. To respond to these clients in therapeutically helpful ways presents a special challenge to a therapist's own inner stability.

For those with more narcissistically-colored personality structures, the fear that a deeper connection with others would expose both the clients' feelings of worthlessness and the helpless neediness of a fragile self tends to lead these individuals to protect against deeper relationships. This tendency will also apply to their relationships with their therapists. A client with this type of organizational structure will tend to try to devalue and control their therapist in order to be able to "maintain a sense of grandiosity against all attempts at reality testing" (Rudolf, 1996, pg. 178). As uncomfortable and difficult as this type of limited relationship is for the therapist striving for a "real connection" with their client, it serves to maintain the "survival" of the client in the narrow sense of the word. This type of protection and stabilization system cannot be jumped out of or exploded – given the client's deficiencies in internal structure, this would lead to the disintegration and compensation of the client's fragile self.

Thinking about the above in connection with the Hakomi approach to therapeutic process (an exercise that can be facilitated by looking at the steps outlined in the Maya Shaw's process-chart in chapter VI, 8), the inner logic of Hakomi can be seen to suggest where modifications might be necessary in order to continue to be helpful to clients without sufficient access to the resources that are prerequisites for the work, such as past positive experiences and/or processing abilities.

A special characteristic of the therapeutic relationship as formulated in the Hakomi approach, for example, is found in the therapist's interest in making self-awareness accessible to the client when exploring the barriers of the defense mechanisms. Examples of this are found in a Hakomi therapist's creation of experiential probe experiments set up by asking, "what happens inside when you hear, 'You are safe here,'" or "what happens inside when you hear, 'You are welcomed with all my heart!'" An individual who has developed healthy internal structure will be able to understand the experimental setting and make use

of the evoked experience to study their own self-organization and their own relevant inner reactions (such as thoughts, feelings, pictures, memories, and impulses).

An individual's psychostructural limitations become apparent, however, in their ability to engage in imaginative exercises. "As-if" experiments require a translation effort on the part of the ego that enables the client to see the meaning of the therapists' offered scenarios as opportunities to study their personal reactions as opposed to a singular interpersonal interaction. I have often experienced that in work with clients with structural limitations, invitations to engage in self-observation could not be followed, and not only as a result of defenses protecting against content that threaten self-integrity. It became clear that these clients could not understand or experience the experimental "as-if" situation as such, even with additional efforts towards clarification. The Hakomi probes that are most easily misunderstood are those stated in the first person, such as "I am always here for you." Similar difficulties can be found when taking over a voice. This can trigger significant irritation on the part of the client with structural limitations (e.g., "why are you talking to me like my mother did?").

Nonverbal experiments incorporating touch or body-oriented techniques make these clients' structural limitation-based difficulties even clearer. For clients with structural limitations, an experimental touch could be interpreted as a direct relationship-statement. Utilizing the technique of taking over a client's shoulder tension could be interpreted as a relational statement, and lead to a habituated response, such as "that feels good," or "that's awfully nice of you," with the client interpreting the touch as a sign of personal support or compassion instead of as an opportunity for mindful experiential reflection (such as "wow – I'm noticing that my stomach is getting warm and I'm noticing myself begin to feel joyful").

Similar warnings apply to inner-child work. On the one hand, when I am working with attentiveness towards "missing experience" in the sense of providing missing parenting or facilitating missing maturation processes, I tend to slip into the role of the protective parent part. In this role, I will, for example, let the "child" feel physically held, and to explore what it feels like to be protected. In these situations, there is a danger that instead of integrating this protective parent role into their own structure as a role that they can perform for themselves, a dependent relationship can arise in which the client becomes dependent on the therapist (as helper-ego) to perform this role. There is an additional danger in playing this role when working with significantly traumatized individuals, such as those who were sexually abused as children: If the therapist goes into the role of the good adult, this can lead these clients to feel frighteningly small and powerless, recalling the process by which the powerless sense of being a victim became stabilized. Inner child work, then, and the role of the magical stranger, as originally taught, must be modified and must always be approached with great caution.

One modified approach to inner child work that can be helpful is to leave all contact with the inner child to the adult part of the client, such that the adult part will speak to the inner child on the therapist's behalf. Such an exchange might go as follows:

> Therapist: "Could you ask little Lisa if she wants to show us more today?"
> Adult Lisa: "She says no more for today – but she likes that we believe her!"

This, then, is a three-way conversation between the therapist, inner child, and the adult part of the client. From the perspective of developing self-empowerment and self-regulation, this approach keeps the client both in charge and in control, and serves to minimize the risk of a traumatic regression into a feeling of powerlessness.

One final note regarding physical touch. The literature on dream research has taught us that physical touch can trigger so-called "body memories" that reside and have remained in procedural and implicit memory and have not been made available to the meaning-giving explicit memory. These body memories can, in turn, trigger automated flashbacks that can re-traumatize the client (Levine, 1997; Yehuda & Farlane, 1997). Given this, the use of physical touch should be approached with a great deal of caution when therapeutically accompanying traumatized clients through their work.

In summary, the defense mechanisms of individuals with structural deficits in personality should be considered as efforts to protect and maintain stability for a self that is highly fragile. These defenses should not be undermined "until the underlying vulnerable structures have been enabled to retroactively mature and this work has been consolidated" (Rudolf, 1996). The Hakomi approach taught in our trainings is only applicable when all of the below prerequisites are met by the client in question:

1. An alert, reality oriented consciousness free of significant distortions or perceptual lim-itations is available to the client.
2. The client possesses both the ability for and openness to introspection, self-observation, and mindfulness.
3. The client is capable of de-identifying with particular patterns of experience from time to time in the service of expanding their inner observer / observing ego. (In the case of the presence of judgmental critical parts / overly harsh super-ego parts, for example, these must first be able to be made conscious before judgment-free mindfulness can be practiced.)
4. The client is able to enter into a therapeutic relationship, with all that that implies. At a minimum, the client must be able to understand the "as-if" invitations to self-exploration as such.

Further considerations for accompanying clients with structural limitations

Intake / diagnosis

In order to responsibly proceed with Hakomi's body-oriented, experience-evoking approach in a manner that is mindful of this approach's destabilizing effects, the pursuit of a thorough intake process before actively commencing a course of therapeutic treatment is highly recommended. An approach to intake that is both respectful of and does not run counter to Hakomi's founding principles can only be begun here, and represents a challenge for all practicing Hakomi therapists.

The process of diagnosis will continue throughout the progression of therapy, such that diagnosis becomes both more differentiated and more precise as the therapeutic work unfolds. Clinical experience can also refine the therapist's perception, as can the therapist's ability to remain in good contact with herself, her client, and the process unfolding in the present moment. By being attentive to all three of these dimensions, the therapist can track the developments in the both the intra- and inter-personal fields of the client as well as in the arena of therapist-client countertransference. A continual attentiveness to the development of the client's inner and outer experience, processing, and behavioral possibilities is the deciding prerequisite that enables therapists to respond with interventions that are well attuned to clients' actual psychological states.

For some clients, therapy will not progress much beyond providing a stabilizing effect for some time; this will, however, typically be experienced as a significant improvement in these clients' quality of life. For other clients, once stabilization has taken hold, the goal of psychological maturation and consolidation can be pursued, which in turn can lead to the possibility of then pursuing insight-oriented uncovering work. In these cases, it is important to make decisions in a responsible, collaborative, manner, such that clients ultimately determine the direction of the work as well as the approaches and interventions utilized in the service of their therapeutic goals.

Anchoring in the "outer" world and in everyday consciousness

For clients with structural limitations, anything that supports the stable perception of "outer reality" is helpful, even if this sometimes means just a shift of a matter of degrees between the restructuring of the body-self and the risk of destabilization, for example:

1. *Connecting body awareness and emotion through conscious perception*

The defenses of narcissistic clients often possess an alexithymic quality. According to the results of recent neurobiological research (Damasio, 2000), the brains of alexithymic individuals are not able to bring feelings in relation to signals from the body. It has also been found to be possible to create new synaptic connections (such as to the amygdala) through conscious experience of evoked bodily sensations and emotions in the present moment (Thielen 2002, 2003). Mindfulness and accessing, then, can serve in these cases to provide a helpful reconstructive purpose.

2. *Experiencing the body and the body's boundaries*

Case 1: During a long-term course of psychotherapeutic treatment, a 30-year-old woman who was sexually abused as a child became aware of the fact that she would leave her body and become passively permissive whenever her partner was interested in being sexually intimate with her; further, this was true even when she, too, was interested in being intimate. As an intervention, we explored in-session how she might be able to experience the original traumatic situation in a different way, a way that incorporated her body. Through learning, among other things, a way to tense up her back muscles, open her eyes, and continue to breathe normally, she was able to remain in reality and to pull herself into the physical present when becoming aware of the pull towards her old defensive behavior.

3. *Experiencing and exploring one's own power, resources, and response options*

Case 2: When confronted with conflict-laden situations, a young man of simple nature routinely began to stutter, panic, and dissociate. This client had been physically abused by his father up until the age of 18, and had now come into possession of a powerful physical presence of his own. Given that the client began to dissociate (in connection with a racing heart, shortness of breath, and feeling numb) as soon as he came in contact with difficult memories, an uncovering approach was not feasible. He could not observe his inner world without getting sucked into a painful psychological swamp. He could, however, access his experience in the present moment; as a result, he was capable of coming to realize how powerless he would feel in these types of conflictual situations. In these situations, he experienced himself as he did as a 10-year-old child in relation to his father. We tested his real strength through his pushing his hands against mine. He began to recognize his own strength, and found himself enjoying the moment in which my own strength faltered in relation to his strength. He was then able to take this experience into the conflict-laden scenarios and remind himself of his own strength through the process of briefly pushing his hands against one another or tensing up his arm muscles. Using these techniques, he was able to prevent himself from slipping into the trauma-driven repetition of his old coping mechanisms. As a result, he learned to improve his breathing and reduce his stuttering.

4. *Perceiving and testing reality (such as the meanings of the reactions of the therapist)*

Case 3: Client: "Did you laugh because you're amusing yourself at my expense! Therapist: "No, I'm just excited about how good an experience you had this weekend at home."

Improving self-regulation through increasing self-awareness

1. Differentiating the inner observer from the inner critic

When the ability for self-observation is present to some degree, this can be used in the service of becoming aware of automatic inner and outer reactions, and perhaps even in the service of changing or regulating these (Schore, 1994). When introducing this method to improve self-regulation, it is important to underscore the difference between the inner observer and inner critic and give the client tools to help them not confuse the two.

Case 4: During a long-term course of psychotherapeutic treatment, a female client in a deep depression became aware of the reason why she would repeatedly describe difficult childhood experiences despite the fact that this would lead her to feel worse afterwards. (Re-traversing the memories of these experiences would always stir her up and lead her to question herself.) This repetition, she realized, was focused on understanding, a quality that had not been present earlier, and had been sorely missed. While commenting on her understanding, however, she would simultaneously make skeptical comments that served to block the integration of the same. As she became aware of this, she began to get mad at and reprimand herself, which led her to feel event worse. In the end, she would sink into the familiar state of depression. Over time, she became more and more able to be aware of her need for understanding and to either trust in her insights or note when they did not seem to fit. At this point, although further developmental and healing work remained to be done, the realization that she was seeking understanding helped her be more understanding of and compassionate with herself. She learned to modify her behavior so as not to be insensitive to those around her; instead of repeatedly taxing her friends' compassion with repetition of the same stories, she found a way to both ask for and receive what she really needed; compassion and understanding.

2. Experiencing and valuing the protective mechanisms

Discussing a client's defense mechanisms is a particularly tricky thing to do. The process of bringing the system into consciousness should be approached and discussed from the perspective that these defenses are and have been valuable, and have served a necessary and very important purpose, namely ensuring for the client's protection. Failure to do so can put the internal structures that these defense mechanisms had been protecting at risk and destabilize the client. If this work is possible, i.e., if sufficient structure is present, the client may be able to recognize that these behaviors may no longer be necessary, and can come to be seen instead as optional approaches.

3. Mindfulness

In the interest of completeness, I'd like to call attention to the multiple psychotherapeutic approaches that are currently being introduced and discussed under the nomenclature of "Mindfulness-Based Therapy." Further, these therapies are being discussed in relation to their application for the purposes of stabilizing those with difficult clinical disorders (Grossmann et al, 2004; Sonnenmoser, 2005). For each of these approaches, the client must be capable and interested in at least occasional self-reflection, in building up the "reflexive mind" (Aron, 1998).

Mindfulness and the development of an inner observer are important self-regulation oriented techniques in the trauma-therapies of Reddemann (2001, 2004) and Rothchild (2000, 2003), as well as in John Kabat-Zinn's "mindfulness-based stress reduction" (1991) and in Marsha Linehan's dialectical behavioral therapy (Hayes, Follett, & Linehan, 2004). (For more on trauma work, see Chapter VI, 11, "Working with Trauma" by M. Mischke-Reeds.)

With each of these therapies, the goal is for clients to develop the ability to be able to step back and observe themselves from a non-judgmental stance, such that they are neither overwhelmed, nor going to the other extreme of dissociation, so that they can become more aware of their patterns of action and reaction. In contrast to Hakomi's integrated employment of a state of mindfulness throughout it's therapeutic approach, which includes assisted meditation (Kurtz, 1990), staying with and observing one's own experience, and supported mindful self-study (Johanson & Kurtz, 1993), in these therapies, mindfulness is utilized as one technique among many other clinical interventions.

The security-providing helper-ego function of the therapist

Because of the number and level of unsettling physical symptoms they are dealing with, structurally-deficient clients with anxiety are often not able to engage in mindful observation of their body. In these cases, the therapist can provide psycho-educational information around what different physical reactions normally mean.

Case 5: In the closing session of a long-term course of psychotherapeutic treatment, a female client who had panic disorder and a number of phobias told me the following: "What was most helpful in the beginning was when you explained that all strong emotional reactions result in increased heart rate, both in joy and in fear; learning that this was normal was such a relief." In this case, the therapist is not helping the client explore their own self-organization, but is acting as an expert whose information can serve to help a client better orient themselves and assess their own experience. When this results in a calming response, this, too, can be called attention to through contact; "It's a relief to know that, isn't it?."

Only a secure therapist can provide security

In accompanying clients with structural limitations through their therapeutic journeys, journeys that are challenging for both therapist and client alike, it is therapists' own sense of safety and security within themselves that enables a positive therapeutic outcome. The ability of the therapist to successfully provide a holding environment, to be able to create a therapeutic container that can enable clients to share difficult memories and strong emotions while remaining completely present and without getting overwhelmed, is largely dependent on how well a therapist knows and is in touch with their own boundaries. In situations in which a therapist is feeling overly challenged, unsure, or threatened by the client's or their own experience in the moment, maintaining the therapeutic frame becomes impossible – and yet, this is exactly what these clients need most in these moments.

Case 6: In order to feel safe working with a very physically imposing client's repressed anger and power, I ensured that our sessions took place while other therapists were present in the practice's office. Knowing that I could call out for help if I needed to enabled me to stay calm and remain present in our work.

Because therapists working with structurally-deficient clients are required to take on responsibility for a great deal of the psychological leadership and regulatory functioning, ongoing supervision is particularly important. It is only with supervision, for example, that clarity can be gained around whether feelings of insufficiency are based in countertransference, or if the therapist's feelings are actually indicative of the therapist hitting up against their own personal limits or the limits of their competence. These types of feelings are important to pay attention to, as is the process of distinguishing these feelings' particular meaning(s).

Conclusion

The use of the Hakomi method must be approached carefully with clients with structural limitations and those who are more clinically disturbed. Clinical knowledge about disorders and treatment methods are just as important as being in touch with oneself, the client, and the process as it unfolds. A diagnostic process that continues throughout the course of therapy and supervision will serve and support the therapist well in this type of work, and help to ensure that the therapist will not come to feel overwhelmed or burn out, and will be able to continue to approach even long therapeutic processes with joy and genuine curiosity.

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