Alternative Paths to Mindfulness: An Integration of Dialectical Behavior Therapy (DBT) with Feldenkrais Method® Awareness Through Movement® (ATM®)

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Key words

Dialectical behavior therapy (DBT), awareness through movement (ATM), Feldenkrais method, self-image, borderline personality disorder, trauma, mindfulness, self-regulation, emotion regulation, distress tolerance.

Objective

This paper presents a theoretical model integrating Dialectical Behavior Therapy (DBT) with Awareness Through Movement (ATM) to promote an encompassing treatment model combining cognitive, behavioral, and emotional processes with kinesthetic awareness to improve mindfulness, emotion regulation, and distress tolerance.

Method

The paper reviews the principles of Dialectical Behavior Therapy (DBT) skills training as they overlap in goals and diverge in contribution with Awareness Through Movement (ATM), advancing forward an integrated mind-body treatment model for psychiatric conditions, and in particular trauma treatment. The paper first reviews the principles of DBT, particularly as they relate to the physiological aspects of emotion regulation; it then reviews the principles of ATM and how they relate to DBT skills training and their relevance to trauma treatment. Finally, it discusses the integration of the methods and the benefits ATM can bring to the process of healing.

Introduction

I propose that Awareness Through Movement, a comprehensive somatic education approach that shares principles with Dialectical Behavior Therapy, can deepen and ease DBT skills training and acquisition when practiced parallel to DBT training.

There is now clarity from evidence based research that mind-body therapies can be effective and contribute to symptom reduction in a variety of psychiatric and medical conditions (Astin, 2004; Brower, 2006; Sunder, 2015). We often refer our patients as an adjunct to psychotherapy and DBT skills-training, to mindfulness stress reduction programs, meditation groups, and yoga. Nevertheless, we have yet to develop a robust and sophisticated treatment integrating cognitive behavioral therapies (CBT) with psycho-physiological mind-body tools, nor have we developed refined criteria regarding which mind-body adjunct therapies fit particular populations.

In addition, while mindfulness meditation as a stand-alone mind-body treatment is correlated with multiple positive health outcomes, evidence from recent research suggests that for a subset of patients, mindfulness meditation has negative effects, in particular increased fear, anxiety, anger, flooding, and dissociation (Britton, et al., 2019; Lustyk, et al., 2009; Schlosser, et al., 2019; Wilson, et al., 2019). Therefore it is imperative to develop and integrate mindfulness practices that do

not elicit these negative effects for this vulnerable subset of patients. Awareness Through Movement offers such an option.

DBT and Mindfulness

One of the most important goals of DBT is to help patients regulate emotions and cope with distress by increasing awareness to allow a perceptual shift and to interrupt a habitual reaction to internal or external stimuli. To do so, it is necessary, over time, to acquire the tools to quiet the mind, step back, and reassess options of response.

DBT was first geared towards chronically suicidal patients that met borderline personality disorder (BPD) criteria. DBT is a sophisticated cognitive behavioral therapy method with mindfulness training at its core (Linehan, 1993). Currently the model is applied, with adjusted protocols, to many other psychiatric disorders such as depression, addiction, and eating disorders (Linehan, 2015).

Mindfulness, or conscious awareness, is at the core of DBT philosophy and design and is probably the most powerful tool patients learn as they move through DBT's four treatment modules: Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. In fact, because the Mindfulness module is crucial to the therapeutic process, it is repeated at the end of each module before the skills training group advances to the next one.

Parenthetically, mindfulness in DBT is not to be equated with mindfulness sitting meditation training. While the latter can enhance awareness, awareness can be achieved utilizing other practices as well. Furthermore, mindfulness sitting meditation does not necessarily carry the same benefits across populations (Linehan, 2015; Schlosser, 2019).

The wise mind

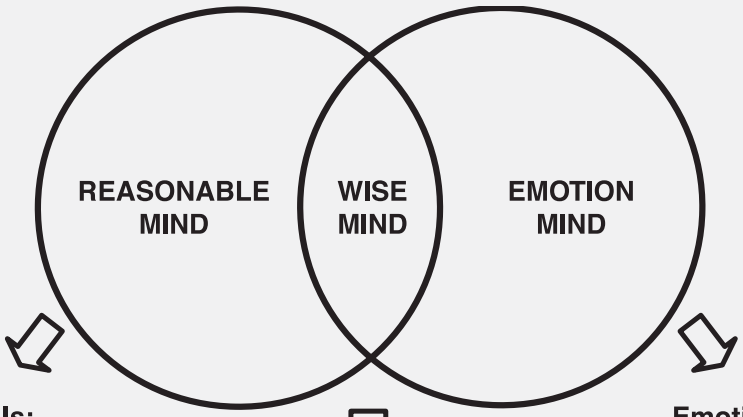
In DBT protocol, *mindfulness* or *conscious awareness* is labeled as *wise mind*, rooted in cognitive-affective theory, and described as the ability to integrate *emotion mind* and *reasonable mind* information toward *effective response* or *action*. **[Fig 1]** *Effective action* is differentiated from impulsive habit, and wise mind perspective over time is internalized as a recourse to provide response choices when contending with challenges. From a soaring bird's point of view, a patient can begin to imagine and ultimately arrive more effortlessly and intuitively at an un-blending between the self and their reaction to stimuli, and may observe that thoughts, feelings, and actions are malleable and adaptive. As the treatment progresses, this creation of a contemplative space avails the opportunity to respond effectively, as opposed to react impulsively or rigidly (Linehan, 2015).

To create these dialectic shifts between *emotion mind* and *reasonable mind*, into a *wise mind* integration, it is necessary to slow

MINDFULNESS HANDOUT 3

(Mindfulness Worksheet 3; p. 83)

Wise Mind: States of Mind



Reasonable Mind Is:

Cool

Rational

Task-Focused

When in *reasonable mind,* you are ruled by facts, reason, logic, and pragmatics. Values and feelings are not important.

Wise Mind Is:

The wisdom within each person

Seeing the value of both reason and emotion

Bringing left brain and right brain together

The middle path

Emotion Mind Is:

Hot

Mood-Dependent

Emotion-Focused

When in *emotion mind,* you are ruled by your moods, feelings, and urges to do or say things. Facts, reason, and logic are not important.

Fig 1 From *DBT Skills Training Handouts and Worksheets*, Second Edition by Marsha M. Linehan, p. 50. Copyright 2015 by Marsha M. Linehan. Reprinted with permission of Guilford Press.

down and help the patient to *observe* and *describe* their internal experience while being fully present in it (labeled as *participate*). The quality of these observations are encouraged to be considered with focused attention (labeled as *one-mindfully*—one thing at a time), with *non-judgement* and ultimately result in *effective response*.

Mindful cognition or *wise mind*, enhances a patient's agency and inner authority, and leads over time to intuitive and spontaneous *effective choices* (Linehan, 2015). Working with patients on adopting and internalizing a *non-judgment* attitude offers patients an opportunity to examine response choices without being caught in feelings of inadequacy or shame.

Similarly, teaching patients *radical acceptance* of reality can prepare a patient to address a challenging situation with a *willing* response. *Willingness* is defined as the ability to tune into *wise mind*, leading to *effective action*. Contrary, a stance of *willfulness*, or refusal to accept reality as is, perpetuates habitual, forceful problematic responses opposite to "what works" (Linehan, 2015, p. 342).

While these skills may seem straightforward, they present significant challenges for many BPD patients. Often patients lack the ability or skill to express their full experience and self-validate. Stressful situations and difficult environments inhibit and paralyze patients in communication with others. Vulnerability, shame, lack of trust, varied degrees of dissociation or unawareness of one's physical and emotional experience become barriers to communication (Linehan, 2015; van Der Kolk, 2015).

Borderline Personality Disorder—A spectrum of symptoms and underlying trauma

BPD patients frequently present with a spectrum of symptoms depending upon the type of BPD they have. Briefly, these symptoms as delineated in the literature include severe emotional dysregulation (i.e., rapid shifts of mood states from anger outbursts to deep despair and depression), impulsivity, self-harm, a distorted sense of self and identity, feelings of chronic emptiness, disrupted and chaotic relationships (idealization and devaluation), chronic suicidal ideation, and a sense of the world as a threatening place in which one cannot feel safe, in which there is no one to trust, and where one is likely to be abandoned, rejected, or harmed.

Patients are often dissociative and cut off from themselves and their body, the body being a vessel carrying memories of abuse into one's present life. Further, the body becomes a battleground of self-harm, neglect, hate, ambivalence, a container of pain. The genesis of the disorder, besides biological predisposition, is often traced to traumatic early childhood experiences and subsequent compounded trauma.

BPD patients often develop or already have related disorders both physical (autoimmune or pain disorders) and psychiatric (e.g. chronic depression, anxiety, and dissociation). Patients turn impulsively and habitually to using unhealthy coping skills that in the past provided some measure of immediate subjective relief, but which are not adaptive in the present (Linehan, 2015; van Der Kolk, 2015).

Many BPD patients arrive to therapy with high adverse childhood events (ACE) scores. The correlation between ACE score and the likelihood later in life to develop medical problems such as autoimmune or pain disorders is high. In turn, such medical problems influence patients' daily living not only physically but also psychologically (Cattane, et al., 2017; Chang, et al., 2019; Chapman, et al., 2007; Porter, et al., 2019).

DBT and physiological regulation of emotion

Learning to name and regulate emotions

Tuning into the information the body provides is akin to having a compass in the ocean and a direction to sail towards. Linehan (2015) educates patients to the physiological aspects of each emotion, thereby increasing physical awareness and improving a patient's ability to identify an emotion often presenting physically before it presents verbally. In providing patients with the language necessary to physically describe an emotional state, along with the cognition attached to it, the possibility of self-regulation and use of self-care skills is enhanced.

Linehan describes how each emotion corresponds to biological changes and experience, body and facial language, and physical sensations (Linehan, 2015, pp. 232–240). For example, in describing *anger*, biological changes and expression involve muscle tightening, teeth clamping together, hands clenching, feeling a flush face, etc. In describing *fear* or *anxiety*, biological changes and expressions are breathlessness, fast heartbeat, choking sensation, muscles tensing, clenching teeth, feeling clammy, freezing, shaking, etc. Multiple skills are offered on how to regulate emotions physiologically. For example, the "opposite action to emotion" skill, used when feelings don't fit the facts or when acting on your emotions is not effective, the patient is invited to defuse an emotional response through the use of imagination, changes in posture, and changes in body chemistry.

Linehan's (1993; 2015) model of the cognitive-affective processes as taught to patients demonstrates the relationship between vulnerability factors, triggering events, subsequent interpretations, and physiological changes, resulting in action and emotion state which in turn impact

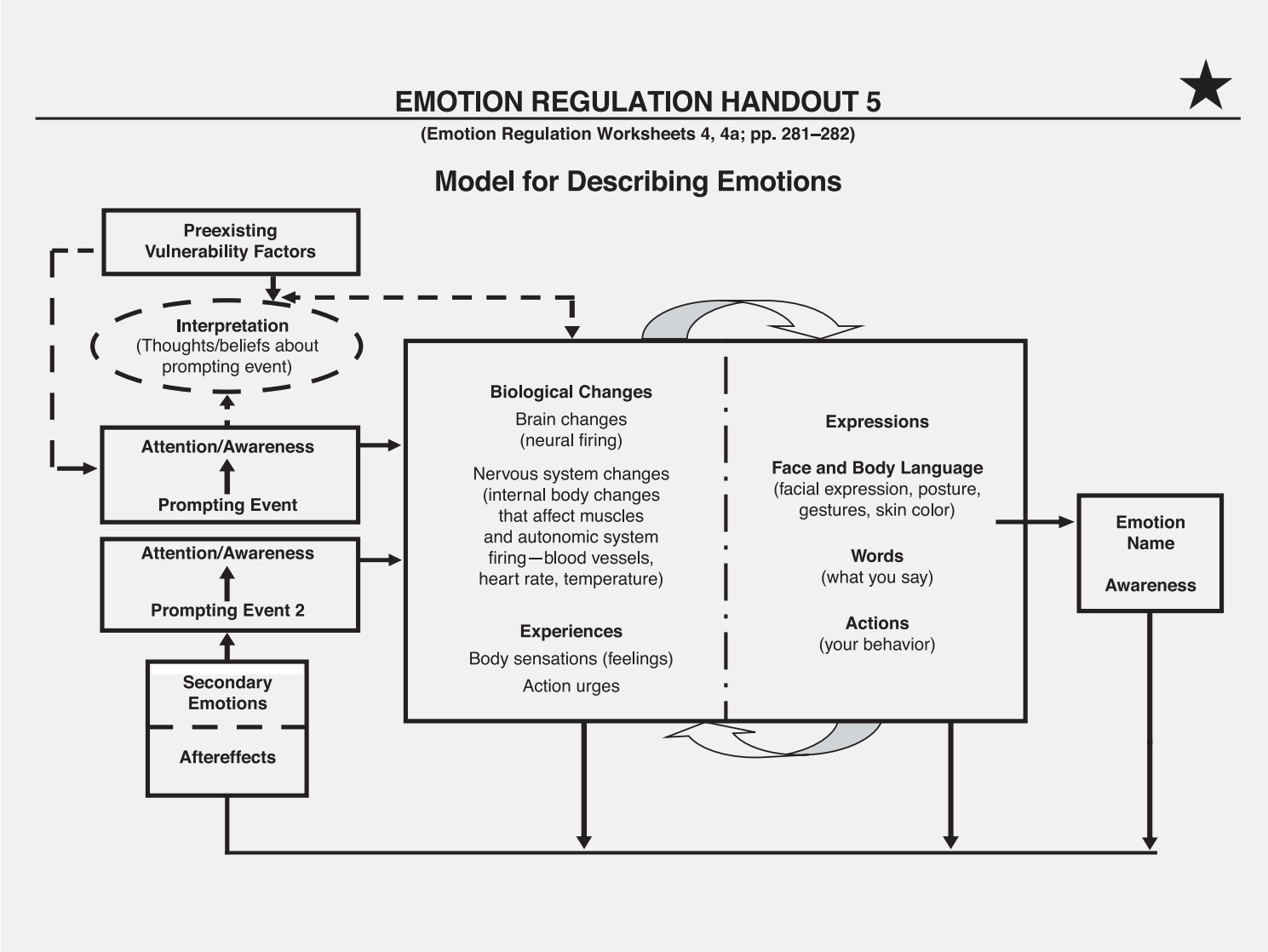


Fig 2 From *DBT Skills Training Handouts and Worksheets, Second Edition* by Marsha M. Linehan, p. 213. Copyright 2015 by Marsha M. Linehan. Reprinted with permission of Guilford Press.

subsequent events and elicit secondary emotions and aftereffects of emotions. **[Fig 2]** Patients are invited to consider emotional and cognitive states as influenced by distorted perceptions that have been reinforced over time (also known as automatic or distorted thoughts and core beliefs, or myths).

The patient is offered a vast array of options on how to process and respond to internal-external stimuli and is encouraged to practice non habitual behaviors and alternative cognitions as well as options for how to self-regulate physiologically.

Rooting emotions in the body and learning to tolerate distress

Many of the DBT skills involve attention and mastery of physical sensations which can contribute to self-regulation. In DBT Mindfulness practice and in DBT Mindfulness of Emotion skills, observing and describing physical experiences is essential, particularly since BPD patients have a distraught relationship to their bodies, a vessel that carries painful memories of abuse by others, and by the patient themselves. Awareness of the physical experience of an emotion as described in the emotion regulation module opens the door to self-regulation by focusing attention and employing physiological skills such as relaxation to ultimately allow better cognitive processing.

DBT skills-training places emphasis on the physical care of one's body to decrease vulnerability to negative emotions and habitual impulsive and destructive action. Examples include addressing physical illness, exercise, and sleep hygiene, while avoiding harmful substances, addressing disordered eating, and so forth. Further, significant time is spent teaching various relaxation and meditation methods and specific tools to deal with nightmares.

In the Distress Tolerance Module, which focuses on crisis survival skills for tense situations or those that cannot be changed immediately, physiological processes are emphasized in defusing powerful emotions and facilitating effective responses. The practice of *half-smile* for example, involving the relaxation of the facial muscles, letting the jaw drop and attempting a small half smile is often applied to defuse anger, thereby opening the door to tolerate powerful negative emotions and disallow them to lead to problematic reactions. In practicing *half-smile* a feedback loop to the parasympathetic nervous system defuses physical tension and softens the emotional experience (Linehan, 2015, pp. 347–349).

Similarly, *willing hands* which involves relaxing one's arms, hands and fingers, diffuses tension and facilitates entrance into a willing state that is vital for effective action (Linehan, 2015, pp. 347–349). In addition, patients are encouraged to practice distress-tolerance with imagery,

using visualization tools to create a safe space, opposite emotions, dissolving negative emotions, and so forth (Linehan, 2015).

Other physiological skills in the Distress Tolerance module involve *self-soothing* through stimulation of the five senses to reduce the intensity of a negative emotion: listening to music, lighting a candle, buying flowers, tasting a new or favorite old flavor, caressing a pet or wearing soft clothing. Physical awareness when self-soothing with pleasurable activities increases positive emotions and reduces vulnerability to negative emotions and self-harm, or, at the very least, postpones such harm and avails the possibility of new thoughts/feelings/behaviors to emerge.

Another set of physiological skills in DBT aims to interrupt urges of self-harm by creating experiences of pain that are not harmful, such as holding an ice cube, using a rubber band on one's wrist, or taking a very hot/cold shower (Linehan, 2015). It can be a challenge to engage patients with psychiatric suffering in conscious and positive behavioral activation. The suffering becomes the central focus of a patient's life, consuming most of their attention, and the tendency is to turn against the body.

I believe that while DBT is geared towards shifts in cognition-emotion-behavior-physiology, the way it addresses the body is incomplete. The experience of being in the body is damaged in patients with BPD due to past abuse and/or disrupted attachment, and given that the disorder often involves physical self-harm behaviors, direct therapeutic intervention needs to be added to the DBT paradigm in order to shift and heal the person's connection and relationship to their body.

As such, I believe that a movement method which parallels but is independent of DBT skills training, structured, nuanced, and delivered under safe and non-judgmental conditions, a method that enhances awareness and mastery of physiological processes, will allow a smoother learning of DBT skills. Furthermore it will allow a process of change in how patients regard themselves in totality, in other words a change in self-image.

Awareness Through Movement

Awareness Through Movement lessons constitute a sophisticated movement language grounded in cognitive-affective theory as it relates to perception and self-image. Through the choreography of each lesson the student learns new ways to self-organize, solve problems, and self-regulate. The teacher guides the students in a process of kinesthetic and cognitive self-inquiry and instruction throughout each lesson. During this process specific principles and strategies are emphasized with the intention of improving one's self-image and learning how to self-regulate (Feldenkrais, 1980; Feldenkrais, 1990).

Principles and strategies of ATM

Bringing in the whole self, inside and out, body, brain, and cognition. Learn how to sense yourself.
Harnessing your attention to what you do, think, feel, and sense within yourself.
Learn something new moment to moment—observe, be curious, experiment. Notice your experience, look with fresh eyes and a beginner's mind.
Adopt a perception of choice and discover new possibilities and options. Notice your habits, keep some and also create new ones.
Become effective by learning to reduce effort. Slow down. Learning to reduce effort and go slow will help you to make finer distinctions and observations of your experience.
Learn how to relax musculature. Reducing effort, breathing, and slowing down will assist you in the process.
Learn without self-judgment, with self-acceptance and self-compassion.
Choose easy, slow, and pleasurable movement. Notice what feels pleasant. Adopt a mindset of learning through progressive approximation to your goals. Find your flow and groove.
Rest. Learn when you need to rest. Observe how rest improves your learning, your mood and your ability to feel stronger during the lesson and beyond.
Learn self-care by taking breaks, slowing down, making small movements, staying away from ambition and perfection, or using imagination when movement is not available.
Use imagination to inspire you and propel you to experiment with new possibilities.
Create a new story about who you are, a new narrative and perception of yourself. Become comfortable in your own skin.

The Method's overarching goal is to improve a person's self-image by using movement. According to Moshe Feldenkrais (1904-1984), the originator of the Method, "we act in accordance to our self-image" (Feldenkrais, 1990, p. 3) and thus, improving the self-image is paramount

to behavioral change and improvement in global well-being. Self-image, in Dr. Feldenkrais' language, consists of our body image, what we sense physiologically and kinesthetically, how we feel and think, and how we act. It impacts our view of ourselves and the world. Self-image forms through formal and self-education, childhood experiences, cultural background, heritage, historical events a person has experienced, biology and genetics (Feldenkrais, 1990; Feldenkrais, 2002; Feldenkrais, 2010; Feldenkrais, 2019).

There is no need for fitness or high levels of physical coordination in order to participate in ATM lessons. People as young as teenagers and as old as nonagenarians may often attend the same class, each with a wide range of medical limitations and motor issues.

Where ATM and DBT intersect

The cornerstone of ATM lessons, similar to DBT, is to enhance awareness rather than focus on the "right or wrong" way to move. There are no prescriptive expectations of how one's body should be organized. Correction and judgment are taken out of the equation, whether it comes from the teacher or the student, and emphasis is placed on radical acceptance of the self kinesthetically, emotionally, and cognitively. The lessons offer instruction in movement possibilities which are often unfamiliar to students, aimed at sharpening the acuity of global awareness and the ability to sense one's self, which result in experimentation with new movement and thinking options that are potentially more fluid, flexible, and effortless (Feldenkrais, 1990).

ATM lessons follow an anatomical mapping allowing students to track and become aware of how they are organized, how their spine, joints, and musculature relate to one another, how they move together, and what the barriers are for moving with ease and fluidity (Doidge, 2016; Feldenkrais, 1990). While lying mostly on their backs, neither observing the teacher nor the other students, participants are invited to carefully *observe* their physical response to the instructions. As such, the participants develop in the moment and over time, an awareness of their body and how it moves, learn their particular anatomy, and learn what options they have to ease into effortless, fluid thinking and moving.

There is a graceful choreographic structure to the lessons which is particularly apparent if they are done slowly and with ease. Within each set of instructions the students learn the spatial elements of the body in action in space, level, direction, energy, and time (such as tempo or rhythm). Being able to differentiate between a spectrum of options in movement, such as how to go from slow to fast, from forced and strained to soft or relaxed effort, or from small to large movement, between resting and moving, ultimately affords options and choices in regulating one's body during the lesson and beyond. The lessons aim to introduce non-habitual ways of thinking and moving by increasing

participants' awareness of ineffective habits and introducing alternative options. Between each set of instructions there is an opportunity for participants to rest and internally compare results, thus further increasing the possibility of awareness through sensing.

I propose that Feldenkrais can complement and enhance DBT skills training in providing patients with a movement language that allows both a front and a back door to emotion regulation and distress tolerance. The two methods aim to achieve similar goals: quiet the mind, increase physiological and mental awareness, offer alternative responses of action, shift thinking and movement habits, promote self-acceptance and non-judgment, and improve self-image.

DBT skills training and ATM integration

As mental health clinicians and as Feldenkrais practitioners, one of the things we hope for is that our clients over time feel more *comfortable in their own skin*. In the case of the integration I propose, this is literally the aim.

The integration of DBT with Awareness Through Movement lessons addresses a person on all levels of experience in an un-fractured way. The "body" treatment is not divorced from psychotherapy or skills training, but rather provides patients with an embodied language that offers additional skills to promote emotion regulation and distress tolerance.

DBT skills training and ATM: Common goals

Improve awareness and quiet the mind.
Harness attention and slow the process down in order to observe and describe physical, cognitive, and emotional states. Learn how to shift attention and focus.
Connect sensing to emotion and emotion to sensing. Learn to identify and interrupt physiological patterns of emotion. Learn how to relax musculature.
Attitude of non-judgment and self-acceptance, expanding loving compassion to the self.
Cultivate a stance of curiosity and experimentation.
Learn to work with constraints.

Learn how to develop an internal pace of progress.
Use imagination and visualization to initiate skill activation.
Engage the five senses and develop awareness acuity to the kinesthetic and proprioceptive sense.
Break movement and process of change into small steps.
Learn grounding skills and improve sensing.
Instill positive emotions psycho-physiologically. Learn how to manage emotional and physical pain.
Engage and bring in the whole self to self-regulate emotionally, cognitively, physiologically.
Learn the relationship between mind-body-cognition for self-regulation. Balance and differentiate between resting action and action and between being and doing.
Learn to differentiate between forceful and strained action vs. open and willing action.
Move the whole self effortlessly, efficiently, and skillfully.
Identify maladaptive habits in behavior, movement, and cognition. Offer abundant alternatives to experiment and cultivate new habits. Learn how to learn to facilitate change.

How ATM complements DBT

ATM provides a concrete cognitive and physiological grounding through sensing, a process imperative for dissociative patients, or patients with hyperarousal, constriction, and immobility symptomatology, which are typical physiological responses to traumatic events. ATM lessons can provide an essential physiological and cognitive infrastructure, as well as the vocabulary and the grammar of interoception and kinesthetic sensing. It has the potential to create a space to expand and revise a self narrative particularly as it relates to one's perception of their physical self, central to patients who suffer from BPD.

Through ATM lessons, students learn how to harness attention, slow down, breathe, and relax their musculature, all of which progressively result in "quieting the mind." ATM lessons involve short anatomical instructions usually delivered in a calm, neutral voice.

The lessons are interesting and the movements are non-habitual and

novel enough to attract and hold one's curiosity, so that the possibility of drifting away or dissociating is minimized. Thus, patients in ATM lessons hone the skills of shifting and focusing attention, a crucial skill in mindfulness. They learn to move with intention, using breath to facilitate and ease complex and difficult movements; they learn how to relax musculature to ease skeletal movement; and throughout they gain appreciation of their unique body organization and its innate ability to expand and ease movement. Participants learn the preparatory stages that precede an action such as thinking, imagining, or visualizing an action before it is being performed, thus improving self-regulation before and during action.

Many of the above benefits mirror the skills taught in DBT mindfulness instruction. Thus, moving between ATM lessons and DBT skills training is fitting and, I believe, more effective. As a person becomes more capable of sensing themselves, they will become, over time, better able to internalize and intuitively apply skills to change how they respond or react to internal or external stimuli. Further, being able to self-regulate physiological and mental experiences can only increase one's sense of mastery, inner authority, and ultimately one's self-efficacy.

ATM blends very well with teaching mindfulness, emotion regulation and distress tolerance skills, and it provides concrete sensing experience of the skills. For example, in teaching willfulness vs. willingness in distress tolerance, sensing the difference between the two approaches in movement, and sensing what impact a forceful and willful movement has on the body is a tangible learning. Being able to identify when one is trapped in that pattern is both freeing and functional.

Integrating ATM into a DBT training program

The delivery of care utilizing this integration can take many forms. For example, an eight-week ATM series with an addition of one workshop day, the same length as in an initial mindfulness stress reduction training program, can be taught while patients are also attending DBT skills training. Alternatively, full or brief ATM lessons can be combined with DBT skills training and delivered in two hour segments in either group or individual settings.

Workshop series with specific learning goals are common in the Feldenkrais Method and mesh well with DBT skills training. For example, one can teach a thematic series or workshop on "sensing, grounding, and expanding," on "softening the shoulders," on how to "quiet the mind," on "how to change habits," and so forth. Examples of such workshops can be found in the work of David Zemach-Bersin (Zemach-Bersin, 2023) and Carol Kress (Kress, 2023).

It is also important to spend time on the manner of how the class opens and to give time at its end to process the sensing experiences to refer back to therapy. Finally, the scan in each lesson and the resting period between each set of instructions to process, compare sides, and

observe changes, as well as integrate the movements, are vital and part of teaching self-care and self-regulation. I believe that the majority of the basic ATM lessons are appropriate to teach, as long as the overall pedagogy and language of the Feldenkrais Method is maintained throughout the instruction.

ATM and trauma

There are important potential benefits of using ATM for patients with BPD and trauma. The following discussion also strengthens the impetus for integrating it with DBT skills training.

There is increasing consensus about the limitations of traditional psychotherapies for addressing the profound physiological aspects of trauma (Levine, 1997; van Der Kolk, 2006). Finding a method that can heal how the body reacts to internal or external sensory input is an important aspect of healing trauma.

When traumatized individuals meditate "they report of feeling disgusted with themselves, helpless, panicked, or experiencing trauma-related images and physical sensations. Trauma victims tend to have a negative body-image—as far as they are concerned, the less attention they pay of their bodies, and thereby, their internal sensations, the better" (van Der Kolk, 2015, pp. 11–12). A number of authors in the mental health field have focused on researching yoga and its positive impact on patients with trauma, depression, and suicidal ideation (van Der Kolk, et al., 2014; Nyer, et al., 2018; Streeter, et al., 2017; Streeter, et al., 2020). The studies utilized "trauma informed yoga," Iyengar yoga and coherent breathing. Adverse effects, not surprisingly, were musculoskeletal pain (Nyer, et al., 2018).

Currently, one of the only studies available on ATM lessons for a psychiatric population was focused on eating disorders (Laumer, et al., 1997). The results indicated "increased contentment with regard to problematic zones of patients' body, and acceptance of their body" (Hillier, et al., 2015). Further comparative studies of ATM with other mind-body studies are needed.

Trauma in the body

The physiological responses to trauma vary from individual to individual and broadly fall under fight, flight, or freeze responses. If an injury is overwhelming and sustained, as opposed to fleeting and relatively benign, the cascade of physiological experience will correspond in intensity (Levine, 2008; Yehuda, 2000).

Physiologically, the symptoms fall under the categories of hyperarousal, constriction, dissociation and denial, helplessness, immobility, and freezing (Levine, 2008, pp. 14–16). These responses are normal in that they are expected and protective to an individual under

threat or attack; nevertheless, the longer they persist when the threat or attack is removed or the situation is no longer acute, the more restrictive they become to everyday life and to one's self-image.

Furthermore, in unresolved trauma, a persistent symptom involves the compulsive repetition of the same habitual reactions mentioned above when they are no longer necessary. Thus, finding a way to help patients regulate physiological responses to sensory input, post injury, is vital. Van der Kolk (van der Kolk, 2006) discusses at length how patients, particularly those with interpersonal PTSD, are stuck in arousal and "experience the present with physical sensations and emotions associated with the past. This, in turn, informs how they react in the present " (p. 13). Being "stuck" in hyperarousal, hypervigilance, constriction, dissociation or immobility, maintains and worsens one's overall health (Levine, 2008).

ATM—an antidote to "stuckness" and an overactive mind

Moshe Feldenkrais' ultimate goal in creating ATM was to help people improve their self-image through movement, as it is held in the body, and ultimately as it is held in the brain and mind; it was not intended as exercise. ATM offers an antidote to being "stuck" in hyperarousal, constriction, freezing, helplessness, immobility, and dissociation by increasingly providing grounding, inviting curiosity and experimentation, all the while emphasizing acceptance of one's self, mind and body.

Frequently, participants walk away from ATM lessons with multiple insights into how a lesson brought awareness to a memory embedded in the body and in a particular movement habit, or an insight between a habitual and painful physical posture to painful childhood or adulthood event. When integrated with DBT these insights, both movement-related and cognitive-affective in nature, can have a powerful effect in addressing the psycho-physiological process of self-regulation and self-care (Doidge, 2016; Feldenkrais, 1990).

By increasing awareness through kinesthetic sensing, students discover that habits are malleable over time while respecting inherent structural constraints they may have, allowing them to continuously work towards self-acceptance. Furthermore, learning how to relax and soften musculature while in movement, both in the lessons and in the world, provides an exceptional life skill in dealing with challenges. Softening allows for neuro-skeletal processes to take place without holding and interfering with the fluidity of movement both in the lesson and beyond.

Slow, soft, small movements, and attention to breathing while moving result in quieting the nervous system, affording better learning and self-regulation, restoring the neuro-balance between the parasym-pathetic and sympathetic nervous system. The latter is consistently a challenge with psychiatric patients, when often the degree and intensity of arousal, such as in rage or anxiety, becomes a functional hindrance to self-regulation and skills training. Engaging the body and developing

non-verbal skills to self-regulate and self-care physically provides concrete tools, more easily performed and used in everyday life, not just in the lessons, but also generalizable to everyday life challenges.

Learning occurs under safe conditions, in slow motion and through slow approximation of desired shifts, while respecting a participant's limits and constraints. The movements are small and the slow pace allows time to observe and hone the skill of observing. Similar to DBT in which chain behavioral analysis offers an almost painstaking invitation to observe the minutiae of reactions to events, unrushed and non-judging, ATM emphasizes an invitation to move softly (as opposed to harshly), gently, with small and progressively differentiated movements. Feldenkrais emphasizes non-judgement in moving, as well as moving away from normative criteria of posture or physiological organization. Learning begins and remains in a student's present organization of their body without a prescriptive end point.

Students who have difficulty with a particular set of physical instructions in a lesson are encouraged to visualize and imagine the movements in their mind's eye instead, which can enable them to achieve some, if not all, of the movements. This skill is also fundamental in multiple psychotherapy practices which use visualization as a powerful tool to varied ends.

Creating safe spaces within the self and with others through ATM

Throughout an ATM lesson self-care and self-regulation to avoid harm is consistently emphasized. Students are instructed to rest when they need to. Sometimes these pauses actually provide the student the opportunity to learn to allow themselves to rest.

Participants are encouraged to approach the lessons without forcing a movement that might result in injury in mind and body. Many of the lessons are on the floor for this reason, affording greater ease of movement without forcing a participant to contend with gravitational forces while providing sensory feedback from the ground. In this way, the lesson enhances awareness of one's body in the front, the back, as well as the internal mapping of what is in between, creating a three dimensional richer awareness of one's self.

The lessons, when conducted within a community of other students, offer a fertile ground for affiliation and since students do not observe each other and the lessons are interoceptive in nature, comparisons and competition are not part of the equation. This is particularly important in trauma, as trust and individual boundaries have frequently been violated.

Often in psychiatry or medical treatment, patients (and providers at times) expect immediate and lasting results and achievement of goals as fast as possible. Without fast results, patients often walk away with either self-blame or blame of others, and a sense that they cannot be helped (Yehuda, 2000). Being able to create safe conditions for learning and developing self-trust mitigates the latter responses.

This is very true for ATM lessons, with the added advantage that each and every lesson concretely offers a non-verbal nurturing experience of mastery and control and, most importantly, of joy. As participants discover in each lesson a new precious tidbit about themselves, they come to realize how much they underestimated their own innate ability to move more fluidly and flexibly. Taking this message into their world is exceptionally powerful, invigorating, and empowering.

ATM, DBT, trauma and neuroplasticity

It is instructive and informative to revisit Moshe Feldenkrais' principles of cognitive and mind-body science as they relate to movement and his overarching goal to help a student to a better self-image. Some of the core principles, revisited by Doidge (2016), remain fresh to today's development of cognitive science theories and research: A brain cannot think without a body; differentiation improves brain maps and function recovery; awareness is a result of slow and minute observations; awareness and differentiation are key to learning; use of forceful movement inhibits learning; strained conditions do not allow learning; there is no right or wrong way to move—rather people can improve how to better move to restore ease in functionality; movement in one part of the body involves the entire self; nonfunctional habits can be unlearned and new habits can be formed (pp. 168-176).

Doidge (2016), in discussing the neuroplastic ability of the brain to heal itself post trauma, disputes the theories of localization, as did Feldenkrais. In the localization view, there is no direct correspondence between mentalization (thoughts, memories, skills) and localized specific brain regions. According to Doidge, mentalization activates much broader circuits, distributed across a "coalition of neurons." Healing involves a learning process that can address both dead neurons from brain injury and re-training surviving neurons (Doidge, pp. 105–108).

This process of *correction of general functions and glia* in post-trauma uses the neuroplastic capacities of the brain and involves four stages: *Neuro-stimulation* of neurons through, for example, movement or sound or mentalization which help activate dormant neurons, as well as quieting misfiring neurons in a "noisy brain"; *Neuro-modulation*, which restores the homeostasis between excitation and inhibition by activating the parasympathetic system; *Neuro-relaxation*, which can avail energy to recover, such as recovering sleep; and *Neuro-differentiation and learning*. Once the brain excitation is quieted, attention can be shifted to learning (Doidge, 2016, pp.108–113).

Doidge (2016) addresses the impact of ATM on the brain's neuroplasticity: ATM involves *neuro-stimulation* by introducing novel non-habitual movements, engaging all five senses in addition to the kinesthetic sense; further, as the lesson progresses, with small and gentle movements engaging the breath, the musculature becomes less tense and forceful, leading to relaxing the sympathetic nervous system.

This *neuro-modulation* is essential in learning awareness, self-regulation, and the inhibition of the flight or fight response. Further, the conscious use of breath in movement, for example, can allow for *neuro-relaxation*, which avails brain energy to restore function. The lessons emphasize activation and rest, the latter availing a person, among other benefits, better sleep, an important factor mediating brain health. This overall physical rest frees psycho-physical energy to bring attention and awareness required for *neuro-differentiation*, which is essential to the learning process. In the *neuro-differentiation* stage "the brain is rested" and therefore "the patient is able to pay attention again and is ready for learning, which involves the brain doing what it does best: making fine distinctions, or differentiating" (Doidge, 2016, p. 112). In ATM lessons, clients are consistently encouraged to begin making distinctions in movement, cognitive processes, and emotion.

Conclusion

The integration of DBT and ATM in one block of time or as a concurrent series offers multiple benefits. By incorporating direct experiential somatic intervention, ATM can reduce the physiological hyperarousal and discomfort of being in one's body, a typical experience of patients with BPD and trauma histories. The decrease in sympathetic nervous system arousal can then facilitate patients' ability to access wise mind in their DBT work, among other DBT skills.

Further, it can provide patients a space to create alternative richer narratives of themselves and others to improve self-image and function. The ability to sense and identify the physical manifestations of an emotional state and realize the cognitive narrative that goes along with it can open doors to change. In addition, the ability to tolerate, learn to shift, and self-regulate sensations offers a path to emotional freedom. Addressing a patient, on all levels of their being (i.e. somatic, emotional, cognitive, and social) can facilitate robust health outcomes.

ATM principles and strategies align well with DBT, one of the most effective treatment modalities in psychiatry, and ATM is physiologically more tolerable than yoga and potentially less provoking of anxiety and dissociative processes than meditation. However, future studies comparing mind-body modalities for patients with BPD and trauma are needed to establish effectiveness.

ATM adds to psychotherapy and DBT skills training a more concrete, grounding and encompassing treatment with kinesthetic benefits. It offers an opportunity to explore a deeper understanding of one's self, how one is organized psycho-physiologically, what triggers one has to contend with, and how to facilitate a mindful process of self-regulation and self-awareness. Finally, it has the potential to introduce experiences of joy, playfulness, awe, curiosity, and pleasure being in one's body, as well as opportunities to connect with others.

And thus our patients can move forward in their lives, feeling more comfortable in their own skin.

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References

Astin, J. "Mind-Body Therapies for the Management of Pain." Clin J Pain, 20, no. 1 (Jan-Feb 2004): 27–32. https://doi.org/10.1097/00002508-200401000-00006

Britton, W. B. "Can Mindfulness Be Too Much of a Good Thing? The Value of a Middle Way." Curr Opin Psychol. 28 (Aug 2019): 159–165. https://doi.org/10.1016/j.copsyc.2018.12.011

Brower, V. "Mind-body Research Moves Towards the Mainstream," EMBO Rep. 7, no. 4 (Apr 2004): 358–361. https://doi.org/10.1038/sj.embor.7400671

Carlson, L. "Mindfulness-Based Interventions for Physical Conditions: A Narrative Review Evaluating Levels of Evidence." ISRN Psychiatry. (Nov 2012). https://doi.org/10.5402/2012/651583

Cattane, N., Rossi, R., Lanfredi, M., & Cattaneo, A. "Borderline Personality Disorder and Childhood Trauma: Exploring the Affected Biological Systems and Mechanisms." BMC Psychiatry, 17, (June 2017): 221. https://doi.org/10.1186/s12888-017-1383-2

Chang, X., Jiang, X., Mkandarwire, T., & Shen, M. "Association Between Adverse Childhood Experiences and Health Outcomes in Adults Aged 18–59 Years." PLOS One (Feb 2019). https://doi.org/10.1371/journal.pone.0211850

Chapman, D. P., Dube, S. R., & Anda, R. F. "Adverse Childhood Events as Risk Factors for Negative Mental Health Outcomes." Psychiatric Annals, 37, no. 5 (May 2007): 359–364.

Doidge, N. *The Brain's Way of Healing*. New York: Penguin Books, 2016.

Feldenkrais, M. *Learn to Learn*. San Diego: Feldenkrais Resources, 1980.

Feldenkrais, M. *Awareness Through Movement*. New York: HarperCollins, 1990.

Feldenkrais, M. *The Potent Self*. Berkeley: Frog Books and Somatic Resources, 2002.

Feldenkrais, M. *Embodied Wisdom: The Collected Papers of Moshe Feldenkrais*. Edited by E. Beringer. Berkeley: North Atlantic Books, 2010.

Feldenkrais, M. *The Elusive Obvious: The Convergence of Movement, Neuroplasticity, & Health. Second Edition*. Berkeley: North Atlantic Books, 2019.

Hillier, S., & Worley, A. "The Effectiveness of the Feldenkrais Method: A Systematic Review of the Evidence." *Evidence-Based Complementary and Alternative Medicine*. (2015): 752160. https://doi.org/10.1155/2015/752160

Kress, C. *Developing Connectedness with Carol Kress* [Video]. YouTube. https://www.youtube.com/watch?v=c1rW70q0DIc (June 15, 2023).

Laumer, U., Bauer, M., Fichter, M., & Milz, H. "Therapeutic Effects of the Feldenkrais Method 'Awareness Through Movement' in Patients with Eating Disorders." *Psychother Psychosom Med Psychol*. 47, no. 5 (May 1997): 170–80.

Levine, P. A. *Waking the Tiger*. Berkeley: North Atlantic Books, 1997.

Levine, P. A. *Healing Trauma*. Boulder: Sounds True, 2008.

Linehan, M. *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press, 1993.

Linehan, M. *DBT Skills Training Handouts and Worksheets, Second Edition*. New York: Guilford Press, 2015.

Lustyk, K., Chawla, N., Nolan, R., & Marlat, A. "Mindfulness Meditation Research: Issues of Participant Screening, Safety Procedures, and Researcher Training." *Adv Mind Body Med*. 24, no. 1 (Spring 2009): 20–30.

Nyer, M., Gerbarg, P., Silveri, M., Johnston, J., Scott, T., Nauphal, M., Owen, L., Nielsen, G., Mischoulon, D., R. Brown, Fava, M., & Streeter, C."A Randomized Controlled Dosing Study of Iyengar Yoga and Coherent Breathing for the Treatment of Major Depressive Disorder: Impact on Suicidal Ideation and Safety Findings." *Comp Ther in Med*. 37 (Apr 2018): 136–142. https://doi.org/10.1016/j.ctim.2018.02.006

Porter, C., Palmier-Claus, J., Branitsky, A., Mansell, W., Warwick, H., & F. Varese. "Childhood Adversity and Borderline Personality Disorder: a Meta-analysis." *Acta Psychiatr Scand*. 141, no. 1 (2020): 6–20. https://doi.org/10.1111/acps.13118

Schlosser, M., Sparby, T., Vörös, Jones, S. R., & Marchant, N. "Unpleasant Meditation-related Experiences in Regular Meditators: Prevalence, Predictors, and Conceptual Considerations." *PLOS One*. (May 2019). https://doi.org/10.1371/journal.pone.0216643

Streeter, C. C., Gerbarg, P., Whitfield, T. H., Owen, L., Johnston, J., Silveri, M. M., Gensler, M., Faulkner, C. L., Mann, C., Wixted, M., Hernon, A., Nyer, M. B., Brown, R., & Jensen, J. "Treatment of Major Depressive Disorder with Iyengar Yoga and Coherent Breathing: A Randomized Controlled Dosing Study." *J Altern Complement Med*. 23, no. 3 (Mar 2017): 201–207. https://doi.org/10.1089/acm.2016.0140

Streeter, C., Gerbarg, P., Brown, R., Scott, T., Nielsen, G., Owen, L., Sakai, O., Sneider, J., Nyer, M., & Silveri, M. "Thalamic Gamma Aminobutyric Acid Level Changes in Major Depressive Disorder After a 12-Week Iyengar Yoga and Coherent Breathing Intervention." *J Altern Complement Med*. 26, no. 3 (Mar 2020): 190–197. https://doi.org/10.1089/acm.2019.0234

Sunder, K. R. "Why Does Mindfulness Create Resilience in Patients with PTSD and Addictions: A Summary of 3,000 Years of Wisdom and Current Evidence Based Science." *J Addict Res Ther*. 7, no. 1 (2016): 1000e134. https://doi.org/10.4172/2155-6105.1000e134

Wilson, B. M., Mickes, L., Solarz-Fantino, S., Evrard, M., & Fantino, E. "Increased False Memory Susceptibility after Mindfulness Meditation," *Psychol Sci*. 26, no. 10 (Oct 2015): 1567–73. https://doi.org/10.1177/0956797615593705

van der Kolk, B. "Clinical Implications of Neuroscience Research in PTSD." *Ann NY Acad Sci*. 1071 (Jul 2006): 277–93. https://doi.org/10.1196/annals.1364.022

van der Kolk, B., Rhodes, A., & West, J. "Yoga as an Adjunctive Treatment for Posttraumatic Stress Disorder: A Randomixed Controlled Trial." *J Clin Psych*. (June 2014). https://doi.org/10.4088/JCP.13m08561

van der Kolk, B. *The Body Keeps Score. Brain, Mind, and Body in the Healing of Trauma*. New York: Penguin Books, 2015.

Yehuda, R. "Biology of Posttraumatic Stress Disorder," *J Clin Psych*. 61, Suppl 17 (2000): 14–21.

Zemach-Bersin, D. *Reducing your body pattern of stress & anxiety* [Video]. https://www.feldenkraisaccess.com/stress-anxiety (2023).

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Zoi Dorit Eliou is a psychologist based in the San Francisco Bay Area. She began her career in mental health as a dance and art therapist and graduated with a degree in psychology in 1994. Her orientation is cognitive-behavioral psychotherapy (CBT) and dialectical behavior informed therapy (DBT). Zoi began her studies in the Feldenkrais Method in 2019 at the Institute for the Study of Somatic Education (ISSE) in San Francisco with Paul and Julie Rubin and graduated from the ATM pilot program in San Diego under the directorship of Arlyn Zones in 2022. During the Covid pandemic she taught ATM to a group of her therapy patients to address stress, social isolation, emotion regulation, and distress tolerance. For more details on her background and current practice please visit dreliou.com.

Katarina Halm, CFT, GCFP™, has an M.A. degree from the Institute of Transpersonal Psychology where she did her thesis on resonance and dissonance in the learning process. She is a Focusing teacher and Feldenkrais® practitioner with a deep interest in how language emerges in our movement, dreams, and daily living. Katarina integrates practical applications of Feldenkrais' "Learn to Learn" with Eugene Gendlin's Philosophy of the Implicit. She graduated from Jeff Haller's Victoria Feldenkrais training in 2007. Katarina's website is thinkinginmovement.ca. She is also active with Feldenkrais Legacy Forum (FLF) working groups and has co-developed the Feldenkrais® Inclusion Initiative with other practitioners and support from the FLF Committee.

The dynamic practice of **Sandrine Harris** weaves together somatic inquiry, creativity, meditation, community connection, and the neurobiological healing of trauma. Sandrine is certified in Somatic Experiencing® (SEP) and the Feldenkrais Method® of somatic education (GCFP). A member of the US Association of Body Psychotherapy, she is also trained in somatic healing (RSMT/E) and educated in neuroplastic pain syndromes. Sandrine incorporates trauma-sensitive mindfulness meditation into her practice. She is a former professional dancer and draws from several movement orientations. Emergent Nature is the name of her collective process, through which she offers international workshops alongside her private practice online & in person in MA and NYC. To learn more: sandrineharris.com.

Gabriel Hartley's art is not about reporting or documenting an idea, rather it is the sensation of looking that is the real subject matter. While the imagery can be perceived as buildings, space, flora, and fauna, the same forms can quickly be seen as something else. The mode of "landscape" is presupposed by the canvas format and scale, within which there's freedom and pleasure for the viewer in interpretation and reinterpretation. Recent shows include Mosslight at Hagiwara Projects, Tokyo; Skies at Seventeen gallery, London and Weatherland at Foxy Production, New York. Hartley holds a postgraduate diploma from The Royal Academy Schools, London and lives and works in Tokyo.

Jay Schulkin, PhD is known for his engagement of a wide range of disciplines and interests. He is the author of 40 books on neuroscience, philosophy, and public policy and over 500 peer reviewed articles. Jay was the recipient of a MacArthur Fellowship and Foundation Grant. He lectured at Cambridge University in addition to doing research and teaching at numerous universities worldwide. Jay is survived by his wife of 33 years, April Oliver, and their two children.

Alan S. Questel, GCFT™ is known for his clarity, creativity, and down-to-earth style of teaching. He brings a depth of understanding, humor, and a gentle human perspective while creating lively conditions for learning. Alan has taught thousands of people in over 20 countries on five continents. Trained by Dr. Feldenkrais (Amherst 1983) he has created numerous Feldenkrais® programs on varied topics including one for pregnant women (Pregnant Pauses). He is author of Creating Creativity—Embodying the Creative Process, Practice Intentional Acts of Kindness, and Like Yourself More.

Senior Feldenkrais Trainer **David Zemach-Bersin** met Dr. Moshe Feldenkrais in 1973 and studied with him for over ten years in the U.S., England, and Israel. He also studied extensively in Israel and the U.S. with Gaby Yaron and Yochanon Rywerant, both of whom graduated from Dr. Feldenkrais' first training program. Other influences on his work include Yang form tai chi, aikido, meditation, systems biology, and phenomenology. He has maintained a private Functional Integration practice since 1977 and is recognized for his contribution to strengthening Dr. Feldenkrais' legacy. A graduate of UC Berkeley with two years of postgraduate work in physiological psychology, David has created numerous audio and video programs for both Feldenkrais Practitioners and the general public and is the co-author of *Relaxercise* (HarperCollins). He is a past President of the Feldenkrais Guild® of North America and a co-founder of Feldenkrais Resources and the Feldenkrais Institute of New York. David has directed seventeen Feldenkrais professional training programs and teaches advanced trainings around the globe. Since 2020, he has been teaching primarily online and has worked to synthesize his thinking and the profound benefits of Dr. Feldenkrais' ideas in programs for both Feldenkrais teachers and the public, most of which can be found at FeldenkraisAccess.com. David would like to acknowledge his debt to Mark Reese and Dennis Leri, whose intellect and friendship he greatly misses. David and his life-partner, Kaethe, live in the Farmington Valley area of Connecticut.

Skeletal Self, Sandrine Harris, 2023

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