Christine Caldwell & Rae Johnson

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Rae Johnson, Ph.D., RSMT, RSW, is Chair of the Somatic Psychology Program at the Santa Barbara Graduate Institute, former Director of the Body Psychotherapy Program in the Somatic Counseling Psychology Department at Naropa University, and founding Coordinator of the Student Crisis Response Programs at the University of Toronto. She has a particular interest in somatic approaches to interdisciplinary research.

Serge Prengel, LMHC is the editor the *Relational Implicit* project (http://relationalimplicit.com).

The following is a transcript of the original audio. Please note that this conversation was meant to be a spontaneous exchange. For better or worse, the transcript retains the unedited quality of the conversation.

Serge Prengel: Hello, I'm with Christine Caldwell and Rae Johnson. So Christine and Rae, maybe do you want to say a few words of introduction about who you are before we start this conversation?

Christine Caldwell: Sure, this is Christine and I am the founder and former chair of the Somatic Counseling Psychology Department at Naropa University. Germaine to this particular conversation, I have a background in publishing and research, in the research area both qualitative and quantitative. My first research was a quantitative correlative study of personality characteristics and movement behavior. And then my doctoral work was qualitative, looking at the traumatic experience of people in addictions recovery. And currently I'm biting my nails worrying about whether or not I'm going to get a $250,000 grant to study the somatic basis of compassionate love.

S P : Wow

Rae Johnson: And I'm Rae Johnson, I'm the chair of the Somatic Psychology Department at the Santa Barbara Graduate Institute. And I have been a researcher for about the last 12 years, I've been the principal investigator on four research studies, both mixed methods and qualitative approaches, all of them having to do with movement therapy, Somatic education, Somatic Psychotherapy. I've also for the last over twenty years been a clinician. So I feel as though, like Christine, I wear both hats and it's because of the fact I feel as though I can relate to both the clinical perspective and the research academic perspective that I'm most interested in the topics.

Bringing up an important point that both of us are both academics and clinicians. For my part I've also been in private practice for about thirty years.

S P: So you're in a great position to talk about the divide, the misunderstandings that sometimes can occur between clinicians and academics.

R J: Maybe I'll- this is Rae again, maybe I'll take this one just to start us off. I was aware when we met at the most recent USABP conference that a good number of our members, I think quite rightly, feel some distance from research and from academic work. Because in practical terms they haven't necessarily been involved in that kind of work since they finished their degrees. And for some of them, these degrees did not necessarily involve being a principle investigator or original research. And I think that there can be…that research can be difficult, complicated, elitist, inaccessible, and that research can dictate theory and policy and practices that I think, clinicians often vary appropriately and often challenge not being sufficiently related to the on the ground experience of with working with people. So I think that historically there's some disconnect between the two different cultures. And because I feel like I'm a card carrying member in both cultures I would really like to see the intersections between the clinical perspective and the research perspective identified because I think that there is a lot of common ground.

S P: So I think it really helps, I want to just let it sink in. It seems like there is a different dimension that is introduced by talking about different cultures. And a sense of looking at the intersection of these two cultures as opposed to looking at it as an opposition or a struggle.

C C: That's a good point and it's actually an excellent clinical point because we see in an individual client how they can have conflicts with different aspects of their own personality, and that that conflict is actually not real, it's manufactured. And it's the same here. There's really a beautiful synergy that can occur between clinical work and research work. Even if a researcher never becomes a clinician or a clinician never becomes a researcher, there's still a tremendous amount of synergy between them and I think one of the ways which Rae and I are appreciating being asked to do this interview is that we see there being a kind of unifying principle between the two that were calling research mind. And that research mind, which you know, I'm not sure the name will survive for very long as such, we might want to think of a more poetically nice name (laughter). But theres a way of approaching the clinical experience and the research experience that are actually more than companionable. They actually stem from, I think, the same root. And you know, as academics we tend to call those roots things like critical thinking and such, and yet there's a way which I first developed those skills by really working hard to become a good clinician.

S P: So I just want to put a footnote about process here that what we have started to do is to acknowledge and validate the feelings of antagonism, suspicion, discomfort there can be between clinicians and researchers. But having acknowledged it we can move onto the similarities and to something that is not just a synergy but some underlying force that is very powerful, that drives both activity, that clinical thinking, that clinical thinking in a positive sense.

R J: I think that for me the way I understand that shared perspective actually goes back to an attitude of curiosity, humility that for me over the years I discovered that if I was not genuinely curious in a very open-minded way about my clients experience, I was going to get in their way and impair their unfolding process. That I needed to be absolutely interested, absolutely attentive, but not pushing the river. I needed to situated in that relationship such that I could ask questions that were genuinely curious. Not leading questions, not lets direct this client over here because we have a suspicion, but what's that like? Particularly when you're inquiring about some past experience, when you're inquiring about inherently complex, subtle and nuanced that you can't possibly know in

advance exactly what it's going to be like for a client. You need to be curious, and you need to be helpful and you need to assume that you're not even with very highly tuned perceptions know exactly what its like to be in their body. So you really do rely on that capacity to ask very real questions. And to do it in a way that supports them that facilitates their ability to answer and to articulate what's going on. I think that that's the same process when asking a research participant, particularly in a qualitative study, "What's going on here?". You don't want to be asking them leading questions, you don't want to be imposing your hypothesis on them. You actually want to lead them to a place that they may not be able to get to themselves…to facilitate the exploration and articulation of an experience that's meaningful to them. With the assumption, and I think this is perhaps the piece that is unique to researchers, you facilitate the articulation of that experience with the understanding that the articulation of that experience is useful not just to them as a research participant, but to a whole bunch of other people trying to understand this phenomenon. That's where clinicians maybe ordinarily would stop, "Ok good, maybe you've got something that's useful for you. I understand that we're together in this experience, fabulous, and maybe that's enough." For a researcher it's, "No, I need to find, now I need to figure out a way to communicate what you've communicated to me and frame it in a context that makes it intelligible and relevant to a whole bunch of other people.

C C: Nicely put.

S P: Yes, very nicely put. So as I'm hearing it, I just think that maybe there is of course that major difference, but maybe the difference in a way is one of degree, in the sense that the clinician still has to maybe articulate that lesson in such a way that they can also you know use that knowledge for themselves with other people or so there is always that activity of researcher that exists in a clinician in terms of acquiring new knowledge through clinical practice.

R J: Yes, yes, uh huh. We're benefiting from the results of our own research…as do therapists benefit from the process of doing therapy, one of our well-kept secrets (laughter).

S P: Christine will you add something to what Rae has said or just anything that's sparked up by these comments?

C C: Yeah it's funny because as Rae was speaking I was remembering a class that I'm actually teaching for Santa Barbara this weekend. We've been online previous to the class meeting and I've been asking the students online about good therapeutic experiences they've had and bad therapeutic experiences, and from there to extrapolate what they think are the characteristics of a good therapist. And what I'm struck with are the terms and characteristics that the students came to could just have easily been applied to a researcher as well as a clinician. So I think there's a lot we can really take heart with there. And certainly a researcher is going to apply the same root that we're talking about differently and one of the issues is particularly that the open mindedness that Rae is talking about and the curiosity and the non-attachment to outcome is very very crucial in research. One of the things that will kill good research is when you want a result to come out a certain way. And so instead of wanting to learn something, you start to want to prove something you already think is true. And we know how that gets us in trouble clinically and it also gets us in trouble from a research standpoint. So this idea for me about how I have one foot in research and one foot in clinical work, I feel I like part of the way I can do that is rest in this root that has to do with non-attachment with a real passionate curiosity and an open approach to the situation in time.

You know, a clinician is highly trained and is very specifically trained. And it's the same thing with researchers, there are certain protocols that we have to create in any research project that are crucial for a valid and reliable outcome. And in a sense its like a clinician has a code of ethics and so does a researcher. There's a way in which you pulled yourself certain framework so that you really, a lot of the rules of research are to create a framework that keeps your own counter-transference from intruding. Really, you know in research they call it bias, implicit or explicit bias, but in clinical terms its called counter-transference, it's the same animal really.
And to me because I took that sort of small left turn into research, I think it made me into a better clinician because it really made me very alert to when I was getting in the way of my own work.

S P: So that's very helpful as you point out. So actually some of the things that have different names have the same similarity of essence. Biases and counter-transference are so similar that actually instead of focusing on the language of each discipline, you really are talking about intellectually the same operations.

C C: Yes, exactly.

S P: I was noticing something else when you were talking. You mention something like non-attachment to outcome. And of course the words are very evocative of meditative, mystical, spiritual, approaches and in a way they produce a difference sense as me as a listener than words would be scientific, quantitative about the way of conducting research. And maybe there is a vocabulary in creating different attitudes about it when you describe something that feels more spiritual it just engages a different part of me as a person.

R J: I think you've named how important language is to culture. That when we were talking earlier that different cultures within somatic psychology communities that when researches use a particular language you need to research that they don't translate so that clinicians can understand the very shared meaning. That can create a sense of difference across the two cultures. But I think the profession that Christine and I are coming from is that if we pay a little more attention to translating these ideas across those two cultures that we'll find that we've got a lot in common.

S P: Yes that something that's coming out very strongly as we talk, that sense of something that actually you're experience bridges the two cultures and what you're talking about is how you find ways that the same research mind can be of both parts.

There's a concept in research that's really intriguing and it's one of the root issues of research, and in fact when you take a research class you learn this word on the first day. And that word is skepticism. Another word, what science proliferates and science contributes on the back of skepticism, which means that there's a whole kind of bunch of results that occur from this word and that for instance you're expected to be transparent. Your research is expected to be transparent. You're expected to publish how you did it, the methodology, the analogy because you want to be transparent. You want to be able to have that research result survive the skepticism of your peers. And that way the skepticism of your peers helps to validate, and if it can run that gauntlet then it's a good thing. This is a very central concept in research and yet if we translate that word it doesn't translate well to clinical terminology. If I were to take a stab at it, I really think that as a clinician I find that if I take an attitude of neither believing nor disbelieving, of instead engaging with the current therapeutic encounter and what's being said in the therapeutic encounter that's part of what we might be getting at. I think also the way that the word skepticism also translates is in how

we are enjoined on an ethical level as clinicians who always examine our own potential to bias, our own potential for clinical errors clinical blind-spots, clinical biases whether implicit or explicit. And so that in a sense we function well in terms of going into the supervision or self-supervising. By questioning our work, not in a judgmental way but always in an open, curious, and rigorous way. So science really shows us some rigorous ways to examine a project, whether it's a session or research study. And I think clinicians can really benefit from that because frankly I feel like training and research has made me a better self-reflector as a clinician.

S P: So maybe as a little exercise in bridging the culture gap, when you use words like skepticism and critical thinking, the ideas that come to mind can be of a person frowning and aggression and all these negative thoughts. But what you're describing is something can actually be something that's very akin to mindfulness and having the sense that things aren't actually what they are and having the openness to be what they are as opposed to what you think they are.

Beautifully put.

S P: Thank you.

I think also a suspension of judgment and we know as clinicians how important it is to approach our clinical work from the position of not judging. That's not to say not being discriminating. But suspending judgment until we've got enough evidence to be able to say, "I'm reasonably certain that this is what's going on." But we don't say that with too little data (laughter). We wait until session three or four, session number five before we say, "You know based on what you've said and what I've heard and what we've talked about, I feel reasonably certain that this may be one of the things that's going on here. What do you think?" You see what the client has to say, and in fact there's a parallel practice in research that strengthens a research study's outcome as well, and that is to go back to participants in a research study and to say, "Did I capture what you told me? Does this fit for you?" Or to have co-researchers come in and say, "This is how I analyze the data when I analyze the same data that you gathered, yes I get very similar results. The themes that I looked at in what you've done are the same themes that you've identified." So were reasonably sure down, we've got what is called inter-rater reliability. And in a way peer supervision gives us inter-rater reliability on a clinical level. I think that there are really lots of parallel processes going on here.

S P: Yes, it's interesting that there's a sense of instead of going into cognitive or judgmental mode, you're talking about suspending judgment and getting different perspectives as in your supervision.

Yes, I think that I would also like to pick up on another thing mentioned a bit ago, and that's that oftentimes as clinicians we can become intimidated and off-put by research because we have a mindset that is used to just hearing about huge, well-funded big studies that require laboratories, tons of sophisticated equipment and tons of hoo-ha when in reality there's actually some very sweet work that can be done very simply without machines and even without complex statistical mathematical analyses that can be very relevant to our field. I teach research at Naropa in our department and I require that my students go out and do little research projects. And I'd love to describe one.

S P: That would be great.

I had found an article by a man name Hugo Critchley who's out of University of London who is a brain-mapping expert. And he found, I think that this is a very interesting finding for our field by the way, that people who can accurately predict what their heart rate is without putting their finger to their wrist or their neck, who can sit and feel perceptively their heart beat and can tell you the rate of their heart beating. That people that have that kind of sensory acuity are actually more emotionally intelligent and well-regulated. So go figure, we knew this but research actually just validated this in a very sweet way, they did use a bunch of sophisticated machinery for that. But one of my groups of students went out, and we have several departments, we have three different graduate psychology programs, one's transpersonal, one's contemplative, and one's somatic, so what they did is he went out and asked ten somatic students to predict their heart rate, and ten transpersonal psychology students to predict their heart rate. And he found that the somatic students were better able to predict their heart rate than transpersonal students. So he, with absolutely no special equipment, he did it as an assignment for a single class, it really showed that there's something to training that encourages personal embodiment, and particularly clinical training that encourages people to look inside on a physical and sensory level. And we think we might pick something up about that and play with that and try to get that published.

S P: Yeah. But I love the story about how easy it is to have curiosity and just try to figure out a way to carry that curiosity someplace.

Perfect, exactly.

S P: So you know in a way when we were at the conference and we had this discussion with the various participants, one of the questions that came up was, "What kinds of things can clinicians do?" I think in many ways you have given answers, but maybe as we're ending this conversation I think this would be a good time to put them together in a more digested form.

I was struck at the conference in our conversation how many people who self-identified as clinicians research really wanted to engage in research but felt as if they had no forum for doing that. And that one of the wonderful things about the fact that we've got graduate programs in somatic psychology is that it provides the opportunity to do research with some ethical review criteria in place. And one of the things that I'd like to encourage is some increasing collaboration, particularly among our students and clinicians out in the field that for example, one of my students did a research study where they interviewed somatic psychotherapists about a particular kind of experience and when did they know for example that they were in some kind of somatic resonance with the clients. It was very helpful to the student to understand that phenomena better and very helpful to be asked those questions and to have to come up with an answer, to actually have someone sitting down with them for an hour or an hour and a half listening carefully to what their experience was like. So I think perhaps one of the easiest things that clinicians could do is if they get asked by a graduate student if they would be willing to participate (laughter) in a research study is just say yes.

S P: But also that's a very beautiful point about the fact that clinicians accumulate a lot of information we each have it in our own corner, and maybe we exchange it with a few peers during peer supervision and discussion, but that you know that graduate schools research such as the one you mentioned are a way to cross-pollinate, get this information gathered and disseminated in a much broader circle.

Yeah, and I think it's important for clinicians to realize they don't have to conduct a research study to support good research in somatic psychology.

S P: Mmm. They can share.

They can share and they can participate in it

S P: Yes, Okay.

A couple of ideas that I had is one very sort of simple idea is to donate money to the USAPB award fund. This can do nothing but help support research. Another thing I think is a lesson we can learn in DBT and CBT. I think one of the reasons they're enjoying such popularity at this point is that they were actually very committed to research like behaviors from the very beginning. So they have actually all along, not necessarily done formal research, but informal research that helps them to refine their technique until it got really in the form it is today that so many people appreciate. For instance, I know in DBT they for years in these psychiatric hospitals they would do pretest/posttest. So they would interview clients sometimes literally before and after every single session and ask them what worked about this session, what didn't work about this session, where was the turning point for you, where did it feel like it got sticky or confusing. So they actually really had a very strong commitment to just finding out what worked rather than just directly trying to promote themselves. And I think they did that upwards of about 11 years where they really started publishing. And that's an area where it's a little tender for us, but I think that in a sense, we want to potentially relax a little bit about just promoting our work and really go toward the really quality behaviors and activities professional and ethical activities that get so good that it self-promotes.

S P: So at the very least, even if for some people it feels difficult to say, "Does this work or not?", at the very least have a question of what is it that work, what way does it work?

Perfect, yeah.

🖆 *This conversation was transcribed by Corinne Bagish. Transcript was not proofread.*