THE COLLECTIVE BODY:
Health and Healing from a Community Psychology Perspective

> *Symptoms cannot always be healed by local medications directed to specific parts of your body, because the body problems you suffer from are, in a way, not solely your own – they also are found in relationship and community problems, in the past and even in the future.*
>
> ~Arnold Mindell, *The Quantum Mind and Healing* (2004, p. 14)

In many ways, it is quite common sense to think that well-being, physical and mental health rely upon more than individual factors. We are, in fact, walking creatures of nature. We grow, thrive and wither in direct relationship to our environment as demonstrated by the food we put into our bodies, the air we breathe, and the nourishment of our surroundings or lack thereof. Indeed, as Mindell emphasizes in his somatic-based approach to individual and collective health, healing, and change, "Not only do the human and natural environments touch us, but what happens within us changes our world" (2004, p. xv). Although the reciprocal influence between individual and social worlds seems to be recognized across fields of discipline, the bio-medical approach driving current methods of physical and mental health derives from an individual clinical view of health determinants. This bias toward the individual "underlies medical training and biomedical science, and provides the framework for the treatment, cure, and amelioration of disease" (Brunner & Marmot, 2006, p. 8). Likewise, individually-based conceptions of problems and approaches to change dominate psychological theory and practice. Clinical psychology focuses on the behaviors, cognitions and emotions of the individual, sometimes broadened to include interpersonal and family systems approaches, yet generally neglects and/or is unequipped to negotiate the larger implications of community life and long-term social issues (Orford, 1992).

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

How does everyday life and living in the world relate to personal health and well-being? How does a recognition of social issues influence the field of psychology? And what would a psychological approach that takes community life into account look like in practice? These questions capture the complexities of psychology and health, and point toward the areas this paper seeks to address. First, this paper presents an overview of community psychology: its origins, principles, and approach to individual and social change. Next, I examine the psychosocial determinants of health, which indicate that a purely individualistic approach to psychological well-being is inadequate, short-sighted, and potentially detrimental. This leads to a discussion of community psychology and public health recommendations. Finally, I explore World Work as a unique application of a somatic-based approach to individual and collective health, healing, and change.

Community Psychology

Community psychology grew within the United States during the civil rights and feminist movements of the 1960s – a time of significant social unrest, as well as attempts to respond to the need for change in social consciousness. This *zeitgeist* – or spirit of the times – motivated some researchers and practitioners within the field of psychology to address issues of social inequality and expand the dominant set of social norms, upon which human behavior and psychopathology are based, to include greater cultural relativity (Heller, 1989; Rappaport, 1977). Whereas clinical psychology tends to work directly with individual behavioral, cognitive, and/or emotional change, community psychology represents a shift from this predominantly individualistic orientation to view the person-in-context, bridging the psyche and social, private and public worlds (Orford, 1992).

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

Highly influenced by social psychologist Kurt Lewin, community psychology builds upon his foundational theory that behavior is a function of person, plus environment, plus the interaction between the two (Lewin, 1951). Community psychology criticizes traditional psychological approaches for neglecting the inter-connection and mutual dependence between individuals and other areas of their immediate and more distant circles, such as workplace, school, community, media, housing conditions, labor market, and social stratification. Community psychologists argue that such a myopic intra-psychic focus risks neglecting the larger causes of individual problems (Rapport, 1977), blaming the victim (Ryan, 1971; Joffe & Albee, 1981), and perpetuating the status quo (Orford, 1992). Thus, community psychology strives "to correct this individualistic bias by…consider[ing] people within the contexts of the social settings and systems of which they are parts or influence them" (Orford, p. 6).

The recognition of a dynamic reciprocal influence between the individual and the collective embeds the principles and practices of community psychology. Orford (1992) outlines eight principles central to the theoretical understanding and practical approaches of community psychology: 1) Causes of problems stem from the long-term interaction between individuals, social settings and systems, influenced by the structure of social support and social power; 2) Levels of analysis range from the micro to the macro; 3) Research includes quasi-experimental, qualitative, action, and case-study methods; 4) Practices are located near relevant, everyday social contexts; 5) Services are proactive, including community needs and risk assessments; 6) Practice emphasizes prevention rather than treatment; 7) Attitudes promote formal and informal ways of sharing psychology; and 8) Relationships with non-professionals encourage self-help and collaboration. These principles demonstrate how community psychology stretches beyond the personal world of the client, isolated offices of private practice, and professional identity of

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

psychologist-as-expert. Such an orientation reflects the belief that "psychological expertise resides principally amongst the residents of a community themselves and amongst the many human service workers who have special helping roles within the community but who have little or no special training in psychology" (Orford, p. 10). Community psychologists "put on their boots" and step out into the community as members, consultants, and collaborators.

One of the key contributions of community psychology relates to Bronfenbrenner's "Nested Systems" (1979). This concept arose out of his theory of development-in-context (or the ecology of human development), an understanding that individuals develop through interpersonal relationships that are themselves part of various systems, at ever growing levels, which are also in relationship with each other. Bronfenbrenner refers to four main levels of social organization: 1) Micro-level, everyday systems with which individuals engage and have direct experience (ie, home, work, school); 2) Meso-level, two or more of an individual's micro-level systems and their connections (ie, family and school, hospital and patient's family, the two families of a couple); 3) Exo-level, systems that influence individuals and their micro/meso levels, yet which individuals do not experience directly (ie, governing bodies, a parent's place of work, local water department); and 4) Macro-level, large scale systems that determine mainstream values and social structures of with individuals and their micro/meso/exo levels operate (ie, current rates of unemployment, gender roles in society, definitions of productivity) (Orford, 1992). Although not necessarily obvious, these coexisting levels directly and indirectly influence the daily life and long-term development of individuals, contributing to an evolving construction of personal and collective reality.

Bronfenbrenner's contribution of level-awareness challenges the field of psychology to attend to the outer layers of reality alongside internal ones, in that these many layers are inter-

connected and influence each other. The approaches of community psychologists allow for and encourage the freedom of movement between these levels of thinking. They view psychological problems not as individual in nature, but reflective of larger social issues, for which level thinking is essential. Community psychology recognizes that rates of distress are not random, but indeed are patterned according to demographic and social groups, such as socio-economic status, gender, employment versus unemployment, and marital status (Orford, 1992). These patterns suggest that working only at the individual, intra-psychic level misses the larger levels at work. Personal troubles are connected to social issues. The main risk of an individualistic focus is that it is not sustainable. Without reaching the *causes* of the causes of distress, the deeper core goes untouched and continues…throughout the lifetime and throughout generations.

Psychosocial Determinants of Health

Research within public health echoes this need for a more complex and holistic understanding of the nature of physical and mental health and illness. In "Social Determinants of Health" (2006), Marmot and Wilkinson look beyond physiological measurements, medications and behaviors, in order to address the "causes of the causes" behind well-being and disease. Presented to the United Nations as a guideline for international public health policies, this collection of articles examines the social determinants of health from multiple angles, including (among others) early life, gender, race, sexuality, and aging. Their essential finding indicates that "health follows a social gradient: the higher the social position, the better the health…But the social gradient in health is not confined to those in poverty. It runs from top to bottom of society, with less good standards of health at every step down the social hierarchy" (Marmot, 2006, p. 2).

Thus, everyone's experience of health and disease is directly impacted by his or her position within the social hierarchy. Social hierarchy implies differences according to social

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

status. This means that different positions (defined according to various qualities of identity, such as employment, education, gender, race, class, age, and ability, for example) receive different appraisal. Externally, this value translates to the presence or absence certain rights and privileges; internally, this value may be experienced as varying degrees of safety, ease, self-esteem, and power. Such privileges and their vicarious external and internal repercussions reflect what Marmot refers to as the social gradient of health. This recognition mirrors community psychology's principle of reciprocal influence, indicating that so-called individual experiences are actually deeply inter-woven within the social reality in which each of us lives.

Marmot and Wilkinson (2006) identify material resources, behaviors, and psychosocial experiences as the causes of the causes of disease. These areas relate to objective reality, as well as subjective experience. Material resources include the quality of one's living conditions, whether or not there is food, clean water, health care, etc. Behaviors related to material resources also influence the risk of disease (such as diet, which affects cholesterol and blood pressure levels, leading to heart conditions). Although genetic make-up may also predispose individuals to certain physical and mental vulnerabilities, the psychosocial approach "emphasizes subjective experience and emotions that produce acute and chronic stress which, in turn, affect biology and, hence, physical and mental illness" (Marmot, 2006, p. 3). For example, within the United States, black men from deprived areas have a life expectancy 20 years less than richer white men (Ibid). Marmot explains,

> The major contributors to this excess mortality are violent deaths, HIV/AIDS, and cardiovascular disease. Poverty of material conditions does not provide a ready biological explanation for these causes of shortened lives. We need a richer understanding of how the social environment affects health (p. 3).

Such an extreme discrepancy in length and quality of life demonstrates that the world around us has an embodied impact – both physiological and emotional – that is patterned according to socio-economic status and related to, but extending beyond, actual access to resources.

What then are those factors which extend beyond material conditions to influence health? Brunner and Marmot (2006) identify three psychosocial factors that contribute to the likelihood of developing and dying from chronic disease: organization of work, degree of social isolation, and sense of control over life. Organization of work speaks to whether or not one is employed, as well as the position one occupies within the workplace. Social isolation addresses the sources or lack of support in one's life and experience of social cohesion. Social isolation also encompasses social exclusion from education and work opportunities due to low social status, racism and discrimination. Sense of control stems from one's actual access to social power, as well as the relative experience of being able to influence one's environment. These areas impact one's everyday experiences of stress and distress.

The impact of stress can best be understood by examining humans' physiological responses to danger (Rothschild, 2000; Brunner & Marmot, 2006). The fight-or-flight response is triggered by perceived or actual threat. When the possibility of danger is near, the body responds with a cascade of bio-chemical reactions which accelerate the heart rate, divert blood from internal organs to the extremities, and increase alertness. These physiological reactions more readily prepare an individual to attack or run. In emergency situations, this survival response is adaptive, appropriate, and can literally save one's life. However, if activated too often and too long, the fight-or-flight response becomes maladaptive, turning into a chronic state of hyper-arousal with debilitating effects on one's physical and mental health. These long-term deleterious effects include depression and related mental health concerns, increased risk of infection,

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

diabetes, harmful cholesterol and fat levels, high blood pressure, and related risks of heart attack and stroke (Brunner & Marmot, 2006).

It is tempting to try to cure these physical and mental health symptoms by treating them with medications and individual life changes. Severe trauma indicates the need for an in-depth individualized method of treatment (Rothschild, 2000). However, when dealing with the debilitating and deadly effects of everyday chronic stress, such an approach fails to address the underlying causes and larger social issues influencing these systemic patterns of disease. One's sense of well-being extends beyond the intrapsychic and even interpersonal levels of reality. Whether or not one feels safe, a sense of belonging and power while moving through the many contexts of life depends on the wider layers of community life as well, as illustrated by Bronfenbrenner's micro/meso/exo/macro levels of nested systems. As Stansfeld pinpoints (2006), "What is striking is not only the recognition of the power of psychosocial influences on health, but also how intensely social the most powerful sources of stress seem to be" (p. 355). Thus, the impact of chronic states of arousal requires a far-reaching and collective approach to health, healing and change.

Prevention and Intervention

Community psychology and public health concur in their findings that "chronic anxiety, insecurity, low self-esteem, social isolation, and lack of control over work appear to undermine mental and physical health" (Brunner & Marmot, p. 28). Following these indicators of chronic stress and distress, researchers in these fields have identified three main psychosocial areas which prevent illness and promote health: social support, social cohesion, and sense of control or empowerment (Marmot & Wilkinson, 2006; Orford, 1992). Social support and social cohesion provide the antidote to social isolation. Social support comprises both structural and functional

aspects, including "resources provided by other persons," as well as "information leading the subject to believe that he [or she] is cared for and loved, is esteemed and valued and belongs to a social network of communication and mutual obligation" (Stansfeld, 2006, p. 148). These sources of support provide protective factors that decrease material and emotional vulnerability, as well as the likelihood of perpetual fight-or-flight responses. Social cohesion brings "mutual trust and respect between different sections of society" (p. 162). Again, this quality has both objective and subjective qualities, yet underlies one's a community experience of safety, belonging, and interdependence.

Finally, a sense of power – the experience of being able to control one's environment – tips the balance between whether stress is experienced as positive or negative (Brunner & Marmot, 2006). If a person feels an underlying purpose and potential for reward behind their efforts, then the experience of "stress" is perceived as emotionally and intellectually stimulating. However, "Ill health is associated with prolonged exposure to psychological demands when possibilities to control the situation are perceived to be limited and chances of reward are small" (p. 14). Without a sense of one's ability to impact the surrounding world, stress is experienced as just that – a wearing toll to one's body, mind and spirit. Actual social avenues of power, as well as internalized resources, provide critical building blocks for overall health and well-being.

These three areas of social support, social cohesion, and power fuel community psychology strategies for individual and collective change. Interventions aim at prevention rather than treatment, drawing upon a social activist and political style. In contrast to psychological approaches that focus on treating people after their problems have developed, community psychology takes a proactive stance toward systemic change as opposed to reactive waiting. Through needs assessment, they seek to understand how problems develop within communities,

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

evaluate the needs that exist and which are not being met, thus anticipating problems and preventing them where possible. Their methods include education, sharing psychology with worker in the human services through formal and informal means, consultation, understanding and changing organizations, encouraging self-help and non-professional help, and empowering the community as a whole (Orford, 1992). On the wider scale, interventions aimed at prevention may also include economic and fiscal policies, town meetings, redistribution of health services, and systems of social support and social cohesion (Marmot & Wilkinson, 2006).

Although the emphasis on prevention and systemic change is crucial to individual and collective health, community psychology admits that it lacks a theory or set of constructs for working at the community level itself. It misses direct engagement with the psychology of the collective – the embodied experience carried by individuals and reflected in their socially patterned experiences of health and illness. Where then can we find a method to bridge individual and collective experience and actually work with the psychosocial factors influencing the health of the whole?

World Work: Community Psychology in Practice

This final section provides a brief overview of World Work, an application of Process Work (also referred to as Process-Oriented Psychology) meant to address issues of global conflict and diversity at every level, and their concurrent manifestations in individual and collective health. Process Work views illness and distress as requiring "Rainbow Medicine," a multidisciplinary approach to health and healing (Mindell, 2004). Rainbow medicine includes self-management, support, advocacy, and world work (Pierre Morin, Personal Communication, 10/24/07). Self-management may involve allopathic and alternative approaches to medicine, as well as behavioral/cognitive/emotional changes, which include psychological awareness and

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

empowerment. Support relates to resources, experiences, and relationships that help one to overcome isolation, creating a sense of belonging, connection, and ability to face life challenges. Advocacy acknowledges the need for leaders to work on behalf of marginalized groups, as well as activating one's own sense of leadership, to increase community awareness and make changes on the social level. World Work and open forums create a space for the community to gather and address the psychosocial issues embedded in conflict and diversity.

Arnold Mindell, the founder of Process Work, refers to our bodies as "vehicles for history" (Personal Communication, 9/28/07). The unfinished issues of our ancestors live on through embodied patterns of distress – the body symptoms that ail us. Although we may suffer in the moment, this suffering actually extends through time. Often experienced as stress or anxiety, these symptoms reveal the residue of chronic unprocessed irritants, troubles and/or trauma. Just as unconscious aspects of our identity show up in night-time dreams, physical symptoms also indicate marginalized experiences that have yet to be resolved by oneself, one's family, one's culture, and/or the world at large (Mindell, 1995, 2004 & 2007; Christine Caldwell, Personal Communication, 10/17/07). Like community psychology, Process Work views individual symptoms of distress and illness as requiring more than an individual approach because they reflect interpersonal and community issues, as well as history itself. As noted throughout this paper, although individual symptoms are usually approached from an individual perspective, personal experience is very much connected to the world at large. Proprioception – how we sense and feel in our bodies – relates to the environment around us. Thus, symptoms connect to community issues, not just personal problems. Relieving those symptoms requires healing, change and prevention at the collective level.

World Work intends to work with community psychology by bringing out and engaging with those marginalized collective experiences (Arnold and Amy Mindell, Personal Communication, 9/6/07). Doing so often brings a sense of relief that is experienced as healing on both individual and collective levels, as well as learning and resolutions that guide future directions (Mindell, 1995; For further accounts, refer to www.deepdemocracymovement.net). World Work is based on the principle of deep democracy, a respect and appreciation for all voices and levels of reality as essential for collective health and wholeness (Mindell, 1995). These levels include: 1) Consensus Reality, including social issues, facts, stories, and objective forms of power; 2) Dream Land, the field (or atmosphere), embedded with roles, marginalized experiences, and feelings; and 3) Essence, the subtle feelings and pulls deep beneath the other layers of reality, that are beyond divisions, and offer a sense of common ground.

Community psychology primarily operates on the level of consensus reality, addressing health-related issues at systemic and political levels of change. Clinical and other forms of individual psychology emphasize the level of Dream Land, in order to bring more awareness to unconscious experiences and support health-promoting change in thoughts, feelings, and behaviors. Sometimes psychologists and other healing practitioners are able to work with Essence experiences and integrate all three levels (Mindell, 2004 & 2007). However, rarely, if ever, does one find such holistic awareness utilized to facilitate group experiences. World Work provides a method for doing just that.

World Work facilitation draws upon methods for working with collective experiences that parallel these three levels of reality (Mindell & Mindell, Personal Communication, 9/6/07). When a group gathers, the consensus reality level is addressed by identifying and sorting through the various topics a group wishes to address until they reach consensus to focus on one issue or a

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

theme that connects several. Once a consensus is reached, the central roles and polarizations within the issue are identified, as well as "ghosts," which represent the marginalized voices of our experiences. At this Dream Land level, the group begins to "dream" together by speaking and interacting from these various roles and experiences. This may include role-play, but often and ideally evolves into real life stories and feelings. World Work facilitators are particularly alert to the verbal and non-verbal communication between group members, which point toward marginalized and somatized experiences.

Bringing out these background experiences points toward the most challenging and powerful aspect of World Work, for these are the very experiences that carry the substance of collective patterns of distress and disease. Noticing and unfolding non-verbal sources of information bring out "forbidden" thoughts and feelings that often need to be addressed in order for deeper social forces and conflict to truly come out in the open. At the same time, non-verbal experiences also help group members connect with the Essence level of reality. Tapping into these subtle feelings and pulls links momentary interactions to body experiences and the deeper sources of sentient wisdom they carry.

By supporting all levels of reality, World Work helps to bring out the conflicts that divide us, linking current personal issues to collective experiences throughout history. At the same time, World Work methods assist groups to access deeper levels of experience that bridge divisions and provide a sense of interconnection. These ingredients bring together the core principles of community psychology, as well as the findings of psychosocial health factors, and enable somatized history to express itself in a collective forum, working through embodied historical conflict to arrive at transformative experiences of healing and practical steps toward sustainable change.

katje wagner, PhDc, DiplPW • katjewagner@gmail.com

References

Brunner, E. & Marmot, M. (2006). Social organization, stress, and health. In Marmot, M. & Wilkinson, R. (Eds.), *Social Determinants of Health*, (2nd Ed.) New York: Oxford University Press, pp. 6-30.

Heller, K. (1989). The return to community. *Am. Journal of Community Psychology, 17*, 1-16.

Joffe, J. & Albee, G. (1981). Powerlessness and psychopathology. In J. Joffe & G. Albee (Eds.), *Prevention through political action and social change.* Hanover: University Press of New England, pp. 321-325.

Lewin, K. (1951). *Field theory in social science*. New York: Harper.

Marmot, M. (2006). Introduction. In Marmot, M. & Wilkinson, R. (Eds.), *Social Determinants of Health*, (2nd Ed.) New York: Oxford University Press, pp. 1-5.

Marmot, M. & Wilkinson, R. (Eds.) (2006). *Social Determinants of Health*, (2nd Ed.) New York: Oxford University Press.

Mindell, A. (1995). *Sitting in the fire*. Portland, Oregon: Lao Tse Press.

Mindell, A. (2004). *The quantum mind and healing: How to listen and respond to your body's symptoms*. Charlottesville, VA: Hampton Roads.

Mindell, A. (2007). *Earth-based psychology: Path awareness from the teachings of Don Juan, Richard Feyman, and Lao Tse.* Portland, Oregon: Lao Tse Press.

Mullen, P. & Fleming, J. (1996). *Long-term effects of child sexual abuse.* Commonwealth of Australia: Australian Institute of Family Studies.

Orford, J. (1992). *Community psychology: Theory and practice*. New York: J. Wiley.

Rappaport, J. (1977). *Community psychology: Value, research and action*. New York: Holt, Rinehart & Winston.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York: WW Norton & Co.

Ryan, W. (1971). Blaming the victim. New York: Random House.

Stansfeld, S. (2006). Social support and social cohesion. In Marmot, M. & Wilkinson, R. (Eds.), *Social Determinants of Health*, (2nd Ed.) New York: Oxford Univ. Press, pp. 148-171.

katje wagner, PhDc, DiplPW • katjewagner@gmail.com