

# **Oriental Martial Arts Rehabilitation**

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## **Abstract**

The rehabilitation options for people who are disabled with moderate to severe traumatic brain injuries, often accompanied by spine and other severe physical injuries, are very limited. In response to the needs of this population, the author has developed OMAR (Oriental Martial Arts Rehabilitation), a pragmatic program for rehabilitation based on the oriental martial arts and status dynamic concepts derived from Descriptive Psychology that are intended to increase behavior potential. Some of the resources from oriental martial arts that are used as components of OMAR are briefly described, and an understanding of the severely disabled in light of status dynamic concepts is presented. A description of OMAR with a group of clients with moderate to severe TBI and/or spinal cord injuries is presented, and its applicability to other settings is explored.

This chapter will describe three important considerations in the decision to apply Oriental Martial Arts (OMA) to rehabilitation efforts on behalf of persons with moderate to severe injuries. First is the prototypical situation (and thus world) encountered by individuals who have suffered serious traumatic brain injuries often accompanied by spine and other injuries. Second is a description of a clinical program for treatment of these conditions conceptualized from Descriptive Psychology as a dramatic loss in behavior potential and

implemented via Oriental Martial Arts Rehabilitation (OMAR). Third, preliminary data on the benefits of such a program for one group of aftercare clients are provided, and ideas for research to evaluate the efficacy of the program will be identified.

## **The World of the Newly Injured Person**

Imagine that you are driving home from work and are involved in a serious motor vehicle accident. When you wake up, you find yourself unable to move and are told that you'll never walk again. You don't believe it. You're 25 years old and never thought this could happen to you. But over time you find that you still cannot walk and continue to have very limited use even of your upper extremities; you have a urine bag attached to the side of your wheelchair; you develop bed sores easily; and you need to take ten different medicines each day. You are told that you have a moderate to severe traumatic brain injury (TBI). You have a tough time remembering things or even talking to people; you are not "all there"; and you are treated as one with impulsive and potentially dangerous behavior. Your losses in functions resulting from the spine injury were rather immediate, recognized within days and weeks of the event, but your losses related to your brain injury unfold over a much longer period.

After you have transitioned from acute medical care to the rehabilitation hospital and then transitioned to placement back into the community, your treatment slows down dramatically or stops. You are told that your brain will stop healing after one and a half or two years, no matter how hard you try, and that your gains will be limited from there on in and you have to accept this new status. You may be considered a social services problem, and you will likely receive some subsistence maintenance, e.g., through Social Security or emergency aid, but your rehabilitative treatment for the most part is over. All or most of your insurance has been used up by the acute phases of care, and there is little left for further rehabilitation. You are facing indigent financial and health maintenance care for the rest of your life. You question how

much your life might change for the better, and then ask yourself “What is this world of mine?” in light of such uncertainty. The long-term resources and options available to severely disabled people with brain and spine injuries are extremely limited.

Among rehabilitation health care professionals serving survivors of severe injuries there exists considerable consensus that the recovery period is quite variable, and neither the time to recover nor the extent of recovery from that event can be predicted on the basis of the severity of one’s physical injuries alone. At this juncture, where would you go for help? What kind of help would you seek out and what path would you want to follow? In response to the ongoing needs of this population, OMAR (Oriental Martial Arts Rehabilitation), a pragmatic program for rehabilitation based on the oriental martial arts and status dynamic concepts, was developed.

## **Oriental Martial Arts**

The Oriental Martial Arts (OMAs) developed along distinctive paths, most notably in Japan, Korea and China, with meditative and other teachings originating in India, and Chinese Mahayana Buddhist priests disseminating these and their own teachings to Japan and Korea and other countries of the orient. These were developed according to Chinese philosophy emphasizing such values as respect for one’s teacher, and the importance of following “the path” espoused by one’s teacher, and harmony within the social order. Over the course of more than a thousand years, each of these countries developed their own OMAs according to their individual needs and cultures, and many of these OMAs have proven effective for various applications, most notably in preparation for combat and actual combat (Draeger, Donn. & Smith,1980). The OMAs have been brought to the Western world in various guises and with relative emphasis on mindfulness and focus vs. fighting and self-defense. But among the various martial arts disciplines practiced throughout the orient, most notably including those indigenous to Japan, Korea and China, there exists a high level of commonality

in the thinking and practices based on the common roots of these cultures in the teachings of Confucius and Tao emphasizing the importance of such values as mutuality and respect, especially honoring and respecting one's teacher, and abiding by a well circumscribed social order. In this chapter, important teachings and components from each of the OMAs can be applied beyond the purposes of teaching competition, fighting, and self-defense and turned instead toward the tasks of rehabilitation psychology.

*A personal note*

As a young Japanese child growing up in the U.S. in the 1950's, as a mudansha (martial arts student), I was taught the wazas (martial arts techniques) of Kodokan judo by the first and second generation Japanese senseis (martial arts teachers) released from the 'relocation camps' after World War II. These techniques were taught for relaxing our minds and bodies, through appropriate breathing; visualizing our wazas for use against our opponents; meditating; and doing our kiai's (yelling from the abdomen with strength) for the purpose of conserving energy before competition and enhancing fighting skills. In practices, each night my fellow mudansha and I engaged in stretching out and calisthenics routines, followed by hundreds of repetitions of our wazas, or techniques, which included the use of guided imagery and visualization, plus vigorous free style workouts in which we tried out these techniques. Our senseis were constantly reminding us to breathe properly and maintain good posture as we practiced our wazas. Our ending routines following these workouts would include Tai Chi and other stretching out and cooling down movement routines, followed by brief group meditations in which we reviewed in our minds what we had learned that evening.

Mental and physical toughness were encouraged, and if we complained about hurting somewhere, after the sensei quickly assessed that the problem wouldn't be exacerbated by further exertion, he would say "I don't see no blood" and tell us to get back to practice (while they would discretely ensure there were no real injuries) and the pain would almost invariably go away,

likely creating an association in most of us between exercise and having less pain. The underlying unspoken message was that it is better to approach life with strength than weakness. We had to practice our wazas over and over again, correctly, so that we could increasingly complete combinations of movements automatically, without thinking, relying on muscle memory.

The sensei never asked “How do you feel?”, and we were scolded for engaging in any chatter unrelated to our task at hand, so that we could become better judokas, or judo players. Neither the mudansha nor their parents ever criticized or argued with the sensei, and losing your temper and verbally or physically acting out of anger or frustration were unthinkable and grounds for dismissal—for the evening, from the club, or even from the sport itself. Winning was important but the message was that winning was not everything; if we engaged in bad behaviors at, or away from the dojo, even in other areas of our lives having nothing to do with the martial art, we were aware that this could bring shame to the club.

From the earliest age, we were aware that each of us was part of a larger social order, not just when working out or competing, but at all times, e.g., bowing in and out to the dojo (practice hall), practice mat, or opponent—all as a matter of respect. As we received our promotions, marked by new color belts and often accompanied by certificates signed by the sensei, we were told, “With promotion comes responsibility,” and with that promotion, particularly at the level of brown belt or above, the mudansha almost immediately acted more confident and focused. We were taught techniques effective for keeping our minds focused, calm, and centered, and our bodies strong and well-rested, and controlling our minds and behaviors accordingly. This was all taught to us in an integrated, step-by-step, and comprehensive manner by our senseis in judo whom we respected and honored in our humble and deferential roles of mudansha who knew little but were eager to learn “the way”, and to be shown “the path”. These were some of the norms and rituals we mudansha lived under at our club, and within our specific

martial art, but it was not so dissimilar to the thinking and routines practiced at other clubs across the orient and throughout the world.

Based on my prior training, interest and experience as both a sensei and as psychotherapist (giving me the relevant competencies to be a Sensei-therapist), I believed that the thinking and practices of the martial arts could be used to help serve survivors of traumatic brain and spine injuries as well as those with psychological disorders related to anxiety, depression, dissociation, and pain. Traditional psychological therapies have been found to offer some, but limited, benefit to severely brain injured individuals, and many such individuals are resistant to “psychological” remedies. After all, their problems are physical, not mental.

### *Applications of OMAs to rehabilitation*

A literature review on the application of martial arts to rehabilitation from physical and psychological illness revealed about 50 articles with references to one of the OMAs but these papers, by and large, had limited development of the rationale for such therapeutic uses and incomplete specification of the components of a comprehensive approach to using the marital arts in a rehabilitative mode. In this chapter we intend to provide both—a detailed description of the OMAs and a rationale for their application to rehabilitation with spinal cord and TBI survivors.

Among the studies and case reports to date are a few that have evaluated some sort of OMA as a therapeutic technique to enhance the well being of those with chronic conditions such as destructive aggression and violent behavior (Twemlow, & Sacco, 1998; Twemlow, Sacco, & Fonagy, 2008), epilepsy (Conant, Morgan, Muzykewicz, Clark, & Thiele, 2008), severe TBI (Shapira, Cherlouche, Yanai, Kaner, & Szold, 2001), multiple sclerosis (Husted, Pham, Heklking, & Niederman, 1999), and severe cervical stenosis (Massey & Kisling, 1999). The results of these few studies suggest that such treatments hold some promise,

but the studies suffer from small numbers of subjects, lack of controls, and failure to specify the important treatment components.

### *Important Components of OMA in Rehabilitation*

Understanding the essential components in OMAR is important. Most of the components and thinking utilized by OMAR represent commonalities among the various oriental martial arts which allow therapeutic approaches incorporating the use of OMAR to transcend old thinking and barriers to effective utilization for rehabilitation purposes. Whether the OMA discipline is Chinese Kung Fu or Japanese Aikido is of less relevance than the quality of the sensei, and ability of that sensei to serve the rehabilitative needs of a particular group through the application of that discipline's thinking and techniques. Rather, my focus in developing OMAR has been to identify and include tools and techniques that contribute to increasing behavior potential. These social practices include:

*Posture.* One cannot attain proper breathing or practice the wazas (specific routines) of the OMA without first learning proper posture. The mudansha-client is instructed to sit on the front edge of his chair or wheelchair without back support, back and head held straight up but with shoulders dropped and relaxed, sinking into one's hara (abdomen), knees apart and hands resting upside down on one's legs. In OMAR the postures most frequently used involve sitting in a chair but also include the ground positions of seiza (the formal position of sitting at attention), and anza (cross-legged in what Americans refer to as the Indian position).

*Breathing.* Abdominal breathing common to most of the OMAs, a variation of Japanese Fukushiki Kokyu breathing, is also known as "nighttime" or "baby" breathing. This is the basic form of breathing common to most of the OMAs, slowly and steadily in through the nose and slowly and steadily out through the mouth in order to maximize one's energy and ability to sustain the performances required for workouts and competition.

*Mokuso Meditation.* The purpose of meditation is to empty one's mind and be able to focus on one thing. Mokuso is a brief form of meditation traditionally practiced at funerals and at the conclusion of martial arts classes, sitting on a chair or on the floor in seiza with one's eyes nearly closed and looking down at a spot in front, with eyes allowing only a sheen of light, with Mokuso meaning to be mindful of the person who passed away, or of something you learned in class. As one learns the proper posture and breathing required for relaxing one's mind and body, and then engages in the various OMAR exercises, one learns how easily one is able to enter into a meditative state. As one sensei often tells his students, "With proper posture and breathing, it is almost impossible not to meditate" (Schechter, 2007).

*Stretching out procedures.* The stretching out routines used in OMAR involve the upper body above the waist, derived from the paradigm of a traumatizing car accident, hands on the steering wheel with mind and body "frozen" in time and space at the point of the trauma, with accompanying "muscle memory" of that event. These techniques, proceeding from hands to neck, begin with the hands (hand mirror, stop, fingers pull back), to upper arms across the chest, backward and forward shoulder rolls, to the neck turtle stretches out of the shell, to riding the horse; they follow posture and breathing but come before attempting the Kiai.

*Kiai.* To yell from the abdomen with strength, inner strength; used in combat in the OMAs to completely focus one's mind and body on a single point in time and space; used psychotherapeutically to help clients become unstuck or unfrozen from their post-traumatic states of fear, anger and anxiety. When this is performed properly with force from the abdomen 5 to 10 times, clients will typically sweat or have a sheen on their skin from expelling the heat out, report feeling light-headed, or even dizzy, and 5 minutes later shrug their shoulders, and be able to say "I don't care, this is not my fight." Benefit is also reported from the use of the "Silent Kiai" for those who have difficulty yelling out, particularly

women, or others, who may not be able to practice their loud Kiais at home, in their cars or in other settings accessible to them.

*Tai Chi.* Such movements are taught and practiced throughout Asia and used in many of the OMAs as cooling down routines following vigorous workouts. I typically teach and use three Tai Chi routines including “moving the rock,” “forward stretching,” and “double breathing.” These follow the talk therapy portion of my sessions, which deals with strong emotional states such as fear and repressed anger, and find these effective in helping clients get “unstuck” or “unfrozen” between mind and body.

*Manners, etiquette, aesthetics and conduct.* The OMAs are typified by their adherence to rituals and traditions emphasizing mutuality and respect, self-control and recognition of a social order beyond one’s personal aggrandizement and accomplishments. Samurai mastered calligraphy, the tea ceremony, the folding of robes and other arts to increase focus and mind control, and followed a strict code of conduct, following “the way of the samurai.” In modern times, sensei and mudansha alike bow to each other and to the matt and entrance to the club demonstrating humility, appreciation and mutuality showing they are a part of a larger social order. Talking about these various concepts in the didactic portions of each session increases the sense of connectedness between the client and the larger community in which they aspire to become full-fledge members.

In addition to the specific techniques described above, important procedures and practices are necessary. These include the ordering and sequencing of routines, (e.g., the necessity of learning some procedures before others) and the importance of practicing the wazas repeatedly so that the mudansha-client can “own the wazas” and therefore have them available permanently. Mudansha-clients can learn and begin using the meditation before learning the full stretching out procedures even though they cannot expect to get full benefit from this thinking and these procedures until learning and using the stretching out routines, and Kiai.

Although a rationale can be given within the martial arts perspective for the potential effectiveness of OMAR, it is

important to give readers a perspective from within a psychological world view with particular focus on the potential applications of these procedures and ways of thinking to rehabilitation psychology, specifically using status dynamic concepts from Descriptive Psychology. (For more information on status dynamics, see Ossorio [1976, 2006a]; and Bergner [2007].)

### **A Status Dynamic Analysis**

I am not only a life long student-teacher of one oriental martial art and student of another, I have also been a licensed clinical psychologist in private practice for more than twenty five years who for more than twenty years has specialized in matters of rehabilitation from physical and psychological trauma. I have considered myself a status dynamic therapist during my time in clinical practice, and I had the privilege of studying with the late Peter G. Ossorio, who was my dissertation advisor and supervisor for licensure.

It is possible to understand persons with acquired TBI, other physical injury, and/or psychological disorder using status dynamic concepts. Survivors typically live in a world in which they have significant limitations and restrictions on their Behavior Potential (BP) with BP defined as the ability to meet one's Basic Human Needs. They have experienced a life altering "event" which has resulted in significantly reduced Behavior Potential (BP), which operationally and status wise, is the disability. This event by definition results in significant restrictions on the ability to engage in the Social Practices available to them in their community, resulting in significantly restricted Behavior Potential, and a significant loss of Behavior Potential which over a period of time results in a pathological state or disability (see Table 1 for the General Model of Acquired Disabilities underlying this approach).

The basis for this disability can be physical, psychological or a combination therein but by definition is associated with a significant loss of behavior potential. Especially in the case of the moderate to severe TBIs and spinal cord injured, these losses for the most

part are considered permanent and irreversible losses of Behavior Potential. Examples of the things that survivors cannot do often include driving or driving only with a special apparatus and new license. Such individuals often require considerable assistance in getting dressed, in bathing themselves, and in the handling of elimination. Many things that they took for granted prior to their event now seem impossible or very difficult to accomplish. For those with primarily a psychological disorder, the loss of behavior potential may involve not being able to keep a job, inability to maintain close relationships (e.g., conflict, divorce, and isolation), or performing poorly in school because of problems concentrating.

### **What OMAR provides**

The status other people give survivors does not put them in a good place, and in fact can leave them close to nowhere. Following disabling TBIs, high rates of divorce, drug and alcohol abuse, social isolation and reliance on social services are seen (Brooks, 1984; Ponsford, Sloan, & Snow, 1995; Sherer, Madison, & Hannay, 2000). The system available to the moderately to severely disabled is for the most part a closed system, with almost no way out. Pre-accident, these clients occupied a place in the world in which they were strong and independent, able to act and function actively in a broad world; post-accident, they have become weak and dependent and find themselves passive recipients in a world of nurturance and caring. Metaphorically, these clients may return to needing their mothers again in ways previously not considered. Furthermore, there is the practical reality that entitlements are usually contingent on being continuously disabled, and if an individual can do more, benefits could be endangered.

To remain eligible for the benefits that go with being disabled there are clear roles for the disabled to play and strong sanctions for those who don't play their roles. If the client gives up the role of helpless invalid, e.g., attempts to be more independent, he/she might fail (for example, in falling down and "making

more problems”), resulting in the new status assignment of “trouble-maker”, a person with the really bad attitude—possibly a personality disorder, and, perhaps as even incorrigible.

The goal of OMAR conceived in status dynamic terms is to make real changes in the potential for behavior that survivors have in their worlds. They should end up being able to do things that they could not do at the beginning of treatment, and they should see themselves in a different light—not merely as disabled and injured but as having a status from which they have some control over their lives and some ability to participate in the social practices of their worlds. Survivors can be taught “the way” to maintaining a sustainable path for status change/transformation to reconstruct their world, a path which they can sustain in the face of various attacks, setbacks, and temptations. They need to have descriptions of their worlds accessible to them, acknowledging unknown behavioral possibilities, worlds which give them a viable place.

In light of this status dynamic understanding, the therapist looks at the ways we create a world, a world which gives ourselves, and others, viable places in it. The Sensei-therapist uses the metaphor and imagery of a warrior to achieve a transformation in the client’s world by increasing the possibilities that s/he has in that world. The outcomes are real world transformations; as such, they are the essential tools of this therapeutic intervention. The Oriental Martial Arts Rehabilitation approach provides the Sensei-therapist with greater access and leverage to the extent that it adds a dimension of greater reality compared to other forms either of talk or of exercise alone.

Kiai, to yell from the abdomen with strength, or inner strength, is a behavior that encompasses the thinking and practice common to many of the OMAs. From the perspective of the complete lay person without any experience or familiarity with the OMAs, it might well be assumed that the purpose of the Kiai, like any kind of yelling, is either to scare one’s opponent, or for its cathartic value of releasing repressed emotions and letting it all out, like any old scream. From the perspective of a traditional psychotherapist, the Kiai, viewed as

a scream, may be acknowledged as bringing temporary relief and good feelings but may question the exercises' therapeutic value to the extent that engaging in screaming and other cathartic exercises, like breaking dishes, may be associated with long-term increases in violent ideation, aggression and loss of control. From the perspective of an OMA sensei, the Kiai must be mastered because it provides a better focus of one's mind and body, and one's energy, on a specific point in time and space in order to maximize one's complete focus on the task at hand, for example, while initiating a strike or a throw. From the perspective of the OMAR Sensei-therapist, based on his or her dual training, and roles in the martial arts and in mental health, and able to rely on the requisite judgments and sensitivities that the Kiai, with training, can be a powerful clinical tool for treating various psychological disorders, particularly those associated with strong negative emotional states such as traumatic fear and repressed rage.

The Sensei-therapist, in showing "the way" forward, teaches the Mudansha-client that using the Kiai as part of a general, systematic, and integrated rehabilitation curriculum can, when mastered through instruction and practice, help one become strong again. The result is getting back on the path to regaining one's lost behavior potential. The Kiai can also prove clinically useful as an alternative to ingesting prescribed tranquilizers or other psychotropic medications, or attempts to "self-medicate" through the use and abuse of alcohol and illegal drugs.

As the Sensei-therapist, status intervener, it is important to recognize that the survivors cannot play the parts they used to play but a significant intervention is to make it real for them to do what they *can* do—which is a lot different from the society they are used to dealing with that often casts them as hopeless and helpless invalids. Clients learn to contrast that role, the status assignment of the hopeless invalid, with their performing what they can do as survivors, the part of Wounded Warrior—wounded, but nonetheless still a Warrior.

## OMAR

OMAR (Oriental Martial Arts Rehabilitation) is a clinical program for rehabilitation based on the oriental martial arts and grounded in the status dynamic understanding of Descriptive Psychology. The role and status of the OMAR instructor is that of a Sensei-therapist, one who heads clients in the right direction, on “the path” of taking control and instilling hope and confidence by giving the tools, teaching “the way” to help them achieve increased focus and control over their mind and body. The explicit goal of mind and body unification, or coordination, is a critical concept within the traditional OMA's (Tohei, 2001; Iedwab & Standefer, 2000). The Sensei-therapist works with survivors who are seeking ways to continue their rehabilitation on their own. OMAR brings to Mudansha-clients a re-integration of the body and mind that results in increased Basic Human Need Satisfaction and therefore increased Behavior Potential (BP). The program is designed to establish a basis for measured increases in levels of genuine competency and self-worth by focusing on what Mudansha-clients can do, rather than what they cannot do. The Sensei-therapist's overriding message is that it is better to approach life with strength than with weakness. If Mudansha-clients are motivated to learn “the way”, there is the implicit promise and expectation that they will become able to do more than they can now do, and in some cases may even end up doing things no one, including themselves, thought possible. OMAR applications explicitly refute the victim role, explaining that regardless of the circumstances of their trauma or how much they have lost, embracing a victim status may entitle them to a pity party but ultimately has no future and no positive path (Bergner, 1973). Clinically, the Sensei-therapist recognizes that Mudansha-clients are stuck, at times even frozen, and need to learn “the way” and get on “the path” toward getting themselves unstuck, or unfrozen.

The role is not to coddle; rather, this role is an archetypal one that focuses on regaining what was lost (“You were defeated and now you must recover and return to your previous status”). The Sensei-

therapist instructs the mudansha-client survivors in the ways to recovery by teaching how to control one's mind, reducing scattered and undisciplined thinking, and mastering techniques which will make both the mind and body stronger and more relaxed, allowing for optimal recovery and functioning. Clients often complain about losing the "taste of life" or of having lost their life force or spirit; one of the goals of OMAR is to assist Mudansha-clients to regain this life force by focusing simultaneously on their emotional, spiritual, and physical rehabilitation. Clients will often report feeling mentally and physically "stuck", or "frozen" and it is critical that the Sensei-therapists intervention be formulated around showing them "the way" to getting and keeping themselves "unstuck" on their own in order to minimize psychological dependency on the Sensei-therapist. Clients are given "homework" consisting of the exercises and routines required for them to eventually master and own the skills that they are instructed to practice several times each day and night. Mudansha-clients are given home exercise routines which include the self-monitoring of posture and breathing, meditation, upper and lower body stretching out routines, kiais, including which exercises are best done in the morning, at night or at other times. Later, they will be instructed by their Sensei-therapist as to other times and situations to use these procedures, e.g., before riding in a car or confronting other feared or anxiety provoking situations.

OMAR, of course, is not in any way meant to replace a traditional psychotherapy group, but rather, to provide an alternative path for survivors to maximize their Behavior Potential. According to a status dynamic formulation, successful clinical outcomes following these OMAR individual and group interventions should result in increased Basic Human Need Satisfaction (Aylesworth & Ossorio, 1983). Among such would be a greater sense of self-worth because they were now able to do things that they could not do before, a greater sense of hope because there was a meaningful place for them in their new world, etc

We borrow from OMA those statuses and methods believed to be effective, not just to assign them statuses or to practice methods having to do with martial arts, but rather to assign them

statuses within a reconstructed world that gives them the behavior potential they need. OMAR is an action-oriented approach in which people are required to do more than sit around talking about what they think and feel, and how they got to where they are now. OMAR provides a structure for giving clients positive statuses. The sense in which OMAR is psychological is that the Sensei-therapist provides Mudansha-clients with a “path” which they can use to fundamentally change their place in the world, teaching “the way” to acquire and maintain that new status.

The Sensei-therapist helps them to create more viable places in the world for themselves, enabling them to see that they can carry this off. “This is the way it needs to be; this is what the world needs to look like and what each person’s status needs to be.” A powerful status assigner is needed to make the shift happen and make it stick. What the Sensei-therapist does, at a minimum, is to get Mudansha-clients to play a different part. They move from playing the part of the invalid who is severely limited to that of a survivor who can *do something on his or her own*, and in the best cases, do things they never imagined themselves doing. This can involve benefits such as being more flexible and stronger, being more focused and completing one’s thoughts, or entering different worlds such as attending church, a Tai Chi class, or getting on a bus and going somewhere on one’s own for the first time.

The survivors are always presented as having a choice (Bergner, 1973): to attain and live at their highest level of competency which is as the Wounded Warrior, or at the much lower status and lesser place in the world as the Helpless and Hopeless Invalid. Staff at rehabilitation hospitals have long known the importance of approaching rehabilitation in terms of choice and a sense of self-control. They would communicate to the adult survivors of severe injuries, “Yes, this terrible thing happened to you but now, what do you want to do with the rest of your life?” OMAR provides another approach to make that basic appeal more effective. Research has shown that greater internal locus of control is associated with more favorable rehabilitation outcomes in the brain injured (Izaute, Durozard, Aldigier, Teissedre, Perreve, Gerbaud,& Laurent, 2008). Greater internal locus of control

has also been associated with greater use of complementary and alternative medicine treatments (Sasagawa, Martzen, Kelleher & Wenner, 2008). Greater self-control is an essential goal of OMAR.

The selection, sequencing, timing and development of the components in OMAR have been refined with approximately two thousand clients in clinical applications over the past twenty years. The basis for deciding whether a particular routine or thinking should be included or excluded is first and foremost based on sensei-therapist asking the question “Would this serve the Mudansha-client, and, if yes, how so?”

### *OMAR in Action*

This section discusses the application of OMAR to a group of clients in an aftercare group setting recruited from an informal gathering provided for individuals with moderately to severely disabling spine or brain injuries. Several years ago, when I proposed initiating an OMAR group for residents with spine injuries at a local rehabilitation hospital, I was told by their staff that one of their greatest unmet needs related to the dearth of programs and options available for their moderate to severe traumatic brain injured aftercare survivors, many of whom had spine and other major injuries as well, and I was soon thereafter introduced to a community self-help group.

*OMAR Group Participants.* Volunteers for the OMAR group came from the Hang Out Group, a community self-help group of more than 100 survivors of moderate to severe brain injury, many also with spine and other injuries who had finished traditional treatment and who remained chronically disabled. After designing a twelve week OMAR curriculum and working out the logistics for the group, I presented a lecture to a group of about 65 potentially interested survivors. In this initial pre-framing lecture, I discussed how my clients and others had benefited from participation in the martial arts in their rehabilitation efforts, while sharing an awareness of their frustrations at the limited options available to them. I discussed the alternative path that OMAR can provide to recovery. In this presentation, one could hear a pin

drop—which went against my understanding and expectations, and against the stereotype that these people can't control themselves because of their brain injuries. The pre-screening interviews were conducted with those who expressed further interest in joining the group which was about 30 of the 65 or so Hang Out group members who had attended the pre-framing lecture a couple of months earlier. Criteria for inclusion for survivors were: Ability to articulate a goal, ability to understand auditory information, and ability to follow simple instructions. In addition, their family or professional caregivers had to be supportive enough to transport them to the group session and to encourage them to complete their daily homework assignments. Not all such family members and professionals were. Some felt that they were already doing more than they could handle and may have seen OMAR as just another addition to their “to do” list.

In the present study, OMAR was taught to a small group of 12 rehabilitation hospital aftercare survivors who were severely disabled with moderate to severe traumatic brain injuries (TBI), two rendered vent-quadruplegic by their spine injuries. These 10 male and 2 female Mudansha-clients were taught “the way” by the Sensei-therapist at the OMAR dojo, or facility. Eight of the 12 completed all of the pre- post interview questions.

I had anticipated that I could work with a group of 12 to 15 survivors at a time, but the severity of the injuries of these Mudansha-clients made me see this as perhaps too large an estimate of ideal group size.

Who are these people? Let me share just five brief, but typical, descriptions of the world-transforming events experienced by members of our Hang Out OMAR group resulting in their acquired disabilities. Some of their desired OMAR outcomes are also included.

- 16-year-old girl driving just three months, returning from a concert with her girlfriends, hits a retaining wall. Her car flips over three times, and she has a severe TBI and spine injury. Now 26 years of age, her desired OMAR outcome? “To be more functional, more physically integrated.”

- 28-year-old man on a motorcycle, sitting at a stoplight, is hit in a multiple car pile-up, initiated by a kid in a pick-up truck. The man is in coma for 9 months and comes out with a brain injury. Now 39 years old, what he wants? “To control my emotions and not eat so much.”
- 20-year-old male, slips on ice while drunk at home at his sister’s wedding party, resulting in brain injury and quadriplegia. Now 28 years old, what he wants? “To get back into society.”
- 17-year-old boy, high school student, with his mom in an amusement park, when another kid in park hits him so hard that smashes his spinal stem, resulting in brain injury and quadriplegia. Now 28 years old, his desired outcome? “More focus.”
- 22-year-old man, Ivy league graduate, who is in a skiing accident and then a 5-week coma. He is told that mentally he will never achieve at the level of a 6-year-old, but he rejects it: Now 30 years old, “I’d never admit that I had a disability.”

These individuals had in common the misfortune of an event resulting in serious injury. These events were unanticipated and random. Survivors did come disproportionately from a population of “Invincibles”, high-testosterone young males more frequently engaged in risk-taking behaviors. Such individuals tend to reject the status assignments given to them by the standard system for treating such injuries. They complained of feeling “stuck”, “frozen in neutral”, and of frustrations with problems with self-regulation (weight, insomnia, balance and coordination), low self esteem, lack of focus and concentration. Many were taking multiple medications and were aware that their life expectancy post accident had been significantly reduced due to the greater rates of infections and other complications related to their severe and complex injuries. What they often said they wanted was some connection to what they did before their traumatic events, including getting out and doing something physical, exercising and connecting with people in some significant ways (beyond playing video games all day).

### *OMAR Methods*

The OMAR group Mudansha-clients came to understand the value of relying on ancient and proven sets of procedures and ways of thinking. Every club at which a martial art's discipline is taught has a dojo, which means simply the place (jo) in which "the way" (do) is taught. Our OMAR dojo was created by everyone sitting around in a big circle in the group room of a church and each time setting out our sign which read "The Hang Out OMAR Dojo" and then bowing into the group, in unison, at the beginning and end of each session, with one of the mudansha, a TBI retired sergeant yelling out at the beginning and end of each class "kiotske"(attention) followed by "rei"(bow). At the conclusion of each class we would press a button on our plastic Darth Vader "Star Wars" statue, gifted from one of the survivors which said "Impressive, most impressive; but you are not a Jedi yet."

Each of the 12 one and a half to two hour OMAR group sessions was made up of two separate components from the set curriculum: the didactic followed by the experiential. The first part was a lecture on the thinking and background of the oriental martial arts, topics such as what it means to be Bushido, to live by the code of a Samurai, of honor and commitment to serving and protecting others; the concept and practice of Mushin ("No mind, no thought, no motivation") that of the 16<sup>th</sup> century samurai Miyamoto Musashi; and laying out the ground rules for our OMAR workout sessions. The second part involved the "hands on" teaching of the wazas, or techniques, always beginning with a review of proper posture and breathing, progressive upper body stretching out routines, then to the Kiais, and Mokuso meditation.

Ground rules for the OMAR group, laid out in the first session included the following: no whining, no talking about the past, and no sharing of feelings or emotions. These ground rules reflected my judgment and sensitivities in my role as their Sensei-therapist, one who is competent to show them

“the way” to maximize their behavior potential by operating at their highest level of competency and staying on “the path”.

Such ground rules tend to have positive consequences that include the elimination of meaningless chatter, and reducing noise that might interfere with the Mudansha-clients consolidating their new status, which allows greater clarity and focus with regard to the desired outcomes from OMAR group participation.

A graduation ceremony, classical within the martial arts, followed the 12 sessions. It involved the mudansha-clients demonstrating their wazas to the larger, self-help community group followed by an awards ceremony in which each mudansha received his or her yellow belt and an official certificate from the Hang Out OMAR Dojo, acknowledging their new status.

### *Results and Discussion*

*Narrative outcomes.* The desired outcome was giving the group members a real and long lasting status change, one in which the gap between the person’s potential for engaging in a full range of meaningful social practices and their actual ability to do so was reduced. Here is an example: After 8 of our 12 sessions in which a consistent theme was what it means to be Samurai—a duty defined as both to serve and to guard, one quad took a major action which exemplified the Samurai ethic in a dramatic and unexpected way. When he realized that the other quad whose battery was running down would be left outside stuck in the hallway and away from the dojo and the Hangout group, he rescued him by dropping out of his chair and onto the ground, and offering his chair to his fellow warrior for the entire two hour session. As another example, when asked after four sessions if any of the Mudansha-clients would be willing to assist in demonstrating the OMAR wazas at the State’s annual brain injury rehab conference, all refused, however, three showed up at the presentation unexpectedly and assisted in instructing the entire conference group. Other examples could

be given of the growing ability of the members to think of others rather than being focused on their own problems and limitations.

*Pilot data.* There are two small sample sets of data that address the effectiveness of aspects of the OMAR program and its rationale. First are data from 8 members of the Hangout Group for whom complete data at two time points were available. Second are data from 33 participants [who volunteered from the total attendees of about 80] in the BIAC annual Vail Conference (Brain Injury Association of Colorado).

The Hangout group received the complete set of 12 sessions of OMAR over a 6 month period and data were collected after the fourth session and after the final (12<sup>th</sup>) session in December

Six questions were asked anonymously on the Hangout Evaluation for OMAR: For the first 4, the response alternatives were 1 = *Not at all*, 3 = *moderate so*, and 5 = *Very much so*. The questions were 1. Do you feel like these OMAR sessions have helped you overall? 2. Do you think these exercises have made you less tense? 3. Do you feel like you are more in control of your emotions since you started doing OMAR exercises? 4. Do you think you have more focus and are better able to pay attention now than you could before you started the OMAR group? 5. Do you do these OMAR exercises outside of our group sessions? Yes or No. 6. If yes, how often? Once a day, several times a week, or once a week or less.

Three additional questions were asked in the post questionnaire not asked in the pre-test. These were 1. Do you feel like these OMAR sessions have given you increased mental and physical energy? 2. Do you feel like these OMAR sessions have made your world bigger than it was before? and 3. Do you feel as though you now have more to give to others than when you first started?

Following the twelve group OMAR sessions, most of the Mudansha-clients reported practicing their OMAR techniques daily, and all reported a strong sense of benefit, including increased mental and physical energy, having “a world bigger than it was before,” and “having more to give to others” than when they first started. Because the desired outcome of the OMAR application

with this group was to affect an increase in the survivors' behavior potential, i.e., ability to engage in the social practices available to them in their community, these outcomes, although from a small sample, nonetheless suggest the possibility of positive psychotherapeutic outcomes for an OMAR based intervention.

*Data from a Brain Injury Conference.* Those in attendance and participants in the OMAR-derived relaxation sessions were primarily TBI survivors, family members and caregivers, professionals/service providers. The primary purpose of the presentation was to let TBI patients, family members and providers know about the potential of OMAR-related techniques. Volunteers answered four questions about their stress levels (anonymously) and two demographics—gender and status—prior to a 15 minute session devoted to the rationale for OMAR with three specific types of techniques being taught and practiced. These were proper posture and breathing, the Kiai (strong yell from the abdomen), body centeredness, and the Tai Chi exercises, then volunteers completed the same questions concerning the same stressor. This is, of course, a pre- post study with no control group, but the changes were indicative of reductions in their chosen stressor and afterwards many expressed an interesting making contact with members of the Hangout group, three of whom came up to the front and helped with the demonstrations.

## Overall Discussion

In this chapter, I have tried to accomplish three things: (a) to provide a detailed rationale for the use of Oriental Marital Arts in the rehabilitation of spinal cord and TBI patients, (b) to provide a psychological rationale for these therapeutic interventions drawing on the concepts and ideas of status dynamic therapy derived from Descriptive Psychology, and (c) to illustrate how such an intervention would work by providing the outcomes from a small scale intervention with 12 such survivors, eight of whom provided complete data.

With respect to my goals a and b, I believe that I have provided the most extensive presentation of these as relevant to spinal cord

and TBI survivors and thus provided a resource for others who seek alternative, potentially more effective ways of providing hope and real change for a population with very limited opportunities. With respect to the empirical demonstration, a lot more needs to be done before compelling evidence exists for the merits of OMAR as a therapeutic intervention for such survivors. The existing data are encouraging but quite limited given the absence of a control group, a large enough sample for serious statistical evaluation, and the wide range of severity of symptoms among the members of the Hangout group.

Among the next steps are these: (a) Larger samples with more careful screening for the range of deficits both in the person and in his social support system that has a direct impact on his ability to profit from OMAR, (b) the development of a wait-list control which would provide an ethically responsible delay in treatment thus allowing for effective evaluation of the impact of the intervention but also not depriving any client of access to it, and (c) assembling the staff needed to conduct the research and ensure that data was collected and coding properly. Given the large number of TBI veterans returning from Iraq and Afghanistan at this time, this maybe the right time to secure federal funding for such a rigorous evaluation. At the Rehabilitation Hospital where I initially came into contact with this population, 80% of their admissions were men with a mean age of 25 at the time of their life altering accidents, demographic characteristics not very dissimilar from our active duty military veterans. Many military veterans returning from the wars in Iraq and Afghanistan reject traditional psychological services and any attempt to assign them the status of “psychiatric patient” in need of group psychotherapy, regardless of the extent of that need or of how apparent that need might be to others, just as they will resist their need for psychiatric medications, testing or other services offered. More severely injured survivors tend to resist any and all labels/status assignments. They may treat visiting a psychologist as an admission of weakness or degradation ceremony. “I’m not crazy or stupid.” The sensei, or oriental martial arts instructor, appears to be a more acceptable status than the “therapist” and

hence to have increased access and leverage as a status assigner, especially for this subpopulation of young men and women, including military vets. A large percentage of these young men and women have studied one of the OMAs or for other reasons have belief systems which would believe in the efficacy of such training and would be open to becoming competent in these practices.

On a more personal note, I have attempted over the last 15 years to utilize and integrate oriental martial arts thinking and practices into my clinical work as a rehabilitation psychologist. By relying on Descriptive Psychology in a systematic way and drawing on my own experience in OMAs, I have developed and relied on Oriental Martial Arts Rehabilitation, adapted for psychological rehabilitation purposes. My sense is that OMAR may offer an alternative treatment modality that can appeal to those for whom traditional psychological therapies are inaccessible, and that further work is needed to evaluate the efficacy of the program for populations in need. If initial results are positive then, further refinement and research into which components are critical for its success is justified and should proceed.

### *Lessons Learned*

Several considerations followed the completion of the twelve OMAR treatment sessions and final graduation ceremony including whether the group might not have been better served had the selection criteria resulted in participants with more similar ranges of cognitive and physical impairment. We had intended to teach and practice more extensive physical exercises, including more stretching and strength work; back and forward falls, and rolling falls, and more physically demanding work on the tatamis, or matts available to us. This was not possible, however, because of the broad range of cognitive and physical impairment among our Mudansha-client group members. Some required so much individual instruction or had such severe physical injuries that parts of the original OMAR curriculum were not usable with them. All of the groups' Mudansha-clients requested that their OMAR group to continue in some

form after the graduation ceremony, and it was apparent that these Mudansha-client survivors might well require further opportunities for OMAR group participation if the desired outcome of providing a real and long lasting status change were to be achieved. Learning strategies for maintaining and consolidating these status changes for the OMAR participants is key to a successful outcome.

Having said this, it should be reiterated that this method is not meant to supplant other therapies, but rather to augment other treatments for some, and to offer an alternative treatment for others. But this may provide an alternative to those who do not view traditional psychological therapies favorably or for other reasons are unable to make use of them.

OMAR individual and group sessions can be conducted in various settings, prototypically involving a master level therapist with some minimal level of martial arts training but appreciation and understanding of that OMA, teaching with a local sensei assistant. And there now exists a broad network of OMA clubs and other facilities across the country, even in small towns, which could be used.

## Conclusion

If you think of a person's life as having a narrative structure akin to a play, would you rather see a play about a hopeless and helpless invalid who feels bad about himself, a play in which nothing happens, or would you rather see a play about a Wounded Warrior in which many things can and do happen? Ossorio (2006b) writes: "... to speak the truth is to say of what is, *what* it is" (p.136). To speak the truth is to say of an invalid that he is an invalid, or, to speak the truth is to say that he is a Wounded Warrior. We create the fact of the survivor being a Wounded Warrior by how we treat him.

If we are successful, then that is what he is, a Wounded Warrior. The person may not look that different from the outside, but for the person who chooses the path of the Warrior, it will be the life of a Wounded Warrior even if what s/he can do "objectively" is very, very little. The essence of OMAR is about making a good

status, and a good place in the world, real for severely disabled people, and teaching the path, or the way, for maintaining that status.

## References

Aylesworth, L. S. & Ossorio, P. G. (1983). Refugees: Cultural displacement and its effects. In K. E. Davis & R. M. Bergner (Eds.), *Advances in Descriptive Psychology* (Vol. 3, pp. 45-93). Greenwich, CT: JAI Press.

Bergner, R. M. (1993). Victims into perpetrators. *Psychotherapy*, 30, 452-462.

Bergner, R. (2007). *Status dynamics: Creating new paths to therapeutic change*. Ann Arbor, MI: Burns Park.

Brooks, N. (1984). Head injury and the family. Pp. 123-147. In N. Brooks, (Ed.), *Closed Head Injury: psychological, social, and family consequences*. Oxford: Oxford University Press.

Conant, K.D., Morgan, A.K., Muzykewicz, D., Clark, D.C., & Thiele, E.A. (2008). A karate program for improving self-concept and quality of life in childhood epilepsy: results of a pilot study. *Epilepsy & Behavior*, 12, 61-65.

Draeger, Donn. & Smith, R. (1980). *Comprehensive Asian fighting arts*. Tokyo & New York: Kodansha International.

Husted, C., Pham, L., Hekking, A., Niederman, R. (1999). Improving the quality of life for people with chronic conditions. The example of t'ai chi and multiple sclerosis. *Alternative Therapies in Health & Medicine*, 5, 70-74.

Iedwab, C. & Standefer, R. (2000). *Martial arts—mind and body*. Champagne, IL: Human Kinetics Press.

Izaute, M., Durozard, C., Aldigier, E., Teissedre, F., Perreve, A. & Gerbaud, L. (2008). Perceived social support and locus of control after a traumatic brain injury (TBI). *Brain Injury*, 22, 758-764.

Kano, J. (1986). *Kodokan Judo*. Tokyo, Japan: Kodansha International Ltd.

Massey, P.B. & Kisling, G.M. (1999). A single case report of healing through specific martial art therapy: comparison of MRI to

clinical resolution in severe cervical stenosis: a case report. *Journal of Alternative and Complementary Medicine*, 5, 75-79.

Nitobe, I. (1900). *Bushido: The Soul of Japan*. Philadelphia, PA: Leeds & Biddle

Ossorio, P. G. (1976). *Clinical topics* (LRI Report 11). Whittier, CA and Boulder, CO: Linguistic Research Institute.

Ossorio, P. G. (2006a). *The behavior of persons*. Ann Arbor, MI: Descriptive Psychology Press.

Ossorio, P. G. (2006b). Out of nowhere. In K. E. Davis & R. M. Bergner (Eds.), *Advances in Descriptive Psychology* (Vol. 8, pp. 107-143). Ann Arbor, MI: Descriptive Psychology Press.

Ponsford, J., Sloan, S., & Snow, P. (1995). *Traumatic brain injury: rehabilitation for everyday adaptive living*. New York: Psychology Press.

Sasagawa, M., Martzen, M.R., Kelleher, W.J. & Wenner, C.A.(2008). Positive correlation between the use of complementary and alternative medicine and internal health locus of control. *The Journal of Science & Healing*, 4, 38-41.

Schechter, Phillip. 2007. Personal communication.

Shapira, MY, Chelouche,M., Uanai, R., Kaner, C., & Szold, A. (2001). Tai Chi Chuan practice as a tool for rehabilitation of severe head trauma: 3 case reports. *Archives of Physical Medicine and Rehabilitation*, 82, 1283-1285.

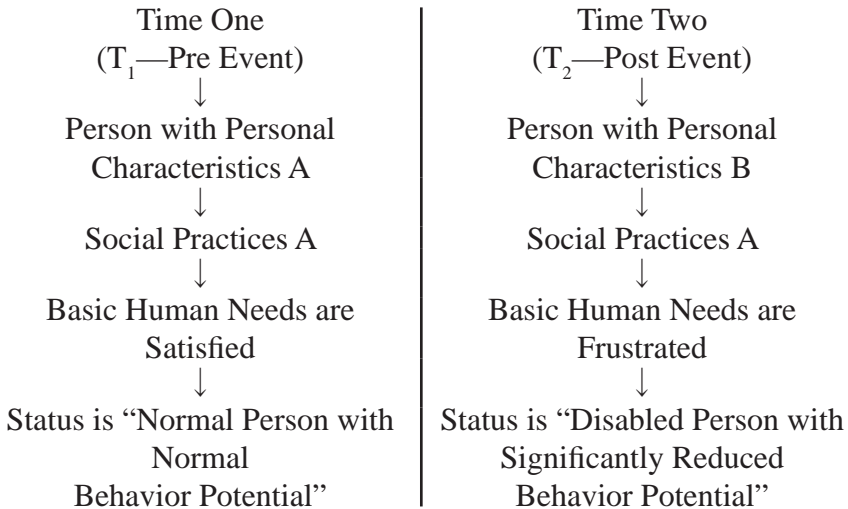
Sherer, M., Madison, C.F., & Hannay, H.J. (2000). A review of moderate and severe closed head injury with an introduction to life care planning. *Journal of Head Trauma and Rehabilitation*, 15, 767-782.

Tohei, K. (2001). *Ki in daily life*. Nokenkyukai: Japan

Twemlow, S.W. & Sacco, F.C. (1998). The application of traditional martial arts practice and theory to the treatment of violent offenders *Adolescence*,33, 505-518.

Twemlow, S.W., Sacco, F.C., & Fonagy, P. (2008). Embodying the mind: movements as a container for destructive aggression. *American Journal of Psychotherapy*, 62, 1-33.

**Table 1: General Model of Acquired Disabilities**



**Author’s Note**

Many of the ideas in this paper have been presented at annual meetings of the Society for Descriptive Psychology. In 1990, I delivered “Kiai: Restoring Personal Power Following Trauma” and introduced the idea of using procedures from martial arts in rehabilitation. In 2000, I presented “Doctors of Uncertain Status: Psychological Treatment with Asians” and discussed the statuses of “Wounded Warrior” with the therapist in the status of sensei/teacher. In 2004, I gave a talk entitled “Hands On”, in which I shared the results of a literature review and guided participants in practicing some of the OMAR exercises and routines. (The “Hands On” talk was also presented to survivors and others at the Brain Injury Association of Colorado’s (BIAC) 2006 fall conference.) My 2007 talk, “Oriental Martial Arts Rehabilitation: Restoring Lost Behavior Potential in Traumatic Brain Injury and Poly-trauma Survivors”, focused on the status dynamic understanding as well as my work with moderate to severe TBI survivors who were members of the Hang Out group and was the basis for this chapter.

Numerous people contributed to this paper along the way, including my martial arts teachers and colleagues, particularly in Kodokan judo, and also my colleagues in the field of psychology, particularly in Descriptive Psychology. Tony Putman's counsel in encouraging me to drop some of the potentially confusing oriental language, hence making these concepts more accessible to outside groups, was invaluable, as was Mary Roberts observations regarding the increased access OMAR could have by shifting from an actor-observer-critic to a dramaturgical perspective. Don Gerber and Jan Nice, of Craig Hospital, who have both made lifelong commitments to serving those with severe disabilities, provided critical feedback, encouragement and direction, and access to the network of aftercare services, with regard to running the OMAR group through the Hang Out self-help group. I would also like to thank the First Mennonite Church of Denver for allowing the generous use of their space to be our dojo, the Denver Buddhist Temple for providing the award certificates, and other support resources. I am also deeply grateful to Keith Davis and Tish Thompson for their extensive editorial assistance.