

“To Touch or Not to Touch: That is the Question”: Doing Effective Body Psychotherapy without Touch.

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The Background to Professional Touch:

Firstly it is important to state that both the US Association for Body Psychotherapy (USABP) and the European Association for Body-Psychotherapy (EABP) have very clear guidelines on ethical professional touch. I wrote an extended essay¹ that looks at some of the issues raised with professional and ethical touch and some of the phobias and difficulties that surround this type of work. This paper is therefore coming – not from the perspective that there is anything wrong with professional touch in Body psychotherapy – but quite the opposite: it implies Body-Psychotherapists are perhaps the only people who should be allowed to touch their clients in psychotherapy, because they have been especially trained to do so, and are usually much more aware of the dangers, difficulties and contra-indications than most other professional therapists.

Professional touch is a topic with very many strong feelings attached, particularly in USA; there is fear, anxiety and confusion existing with conflicting codes, laws and mores – in a particularly litigious culture. However, there is also something so significant and rich about the use of touch professionally in both body therapies and in body psychotherapy that we are not prepared to contemplate giving up this whole field of work, and surrender to the prevailing negativities, nor to get lost in confusions and contradictions. In this respect this article and workshop might seem initially to add to the confusion, because on the one hand I am supporting the use of touch whole-heartedly, and on the other I am advocating ways in which body psychotherapy can use methods, which do not involve touch. This is not an either ... or ... situation, but a both ... and ... situation. We need to be both much clearer about the fact that we can use touch and when we can use touch, and therefore also clearer about what we can do if we don't use touch.

What is particularly significant as a starting point is that, for several hundred (and possibly as much as 6,000) years, we have been living in a culture where the human body has generally been denigrated or denied. This has been increasingly apparent in the last 100 or so years. I have written about this position that I take² and I will just recap a little on some of these points, before I move onto the main theme: working as a Body-Psychotherapist without touch. As a part of this cultural distortion, the human body has been seen over recent years as:

- *As a repository of sin by various religious groups*
- *As holding 'baser' impulses to be sublimated by Freudian analysis*
- *As a disgusting sexual object by the Victorians*
- *As a disposable asset to the military, especially in World War 1*
- *As something to be treated, medicated or 'fixed' by the medical profession*
- *As something to be perfected and controlled through diet and exercise*
- *As a dysfunctional object incapable of bearing a child unassisted*
(with the increasing 'medicalization' of childbirth),

¹ A PDF download is available on www.courtenay-young.com

² Young, Courtenay: 150 Years On: The history, significance and scope of Body-Psychotherapy today: Cpt. in Corrigan, J. (ed) *About A Body: Proceeding of 2005 UKCP Conference*, (2006) Abingdon, Taylor & Francis

- *As something often exploited by multi-nationals selling cars, medicines, alcohol, domestic products & cigarettes*
- *As something to be 'transcended' by belief, prayer, drugs, free love, or meditation*
- *Increasingly as an object of scientific research by biology & neuroscience*
- *And ... recently as something to be used politically by suicide bombers.*

These trends all inform and reinforce this strong societal attitude to the body: that it is crude, base, disgusting, the source of disease (dis-ease), to be controlled and not to be trusted, disrespected, objectified, even dangerous, and our own body is often seen as ugly, or unsatisfactory, with uncontrollable urges or addictions, and, after all that, it finally lets us down when it gets sick and old. Whereas, by contrast, societally our minds are beautiful: logic is clean and pure; our thoughts can understand the workings of the universe, and we can even seek enlightenment or transcendence (before or after death) through religious belief, discipline, meditation, or various other ways of transcending our bodies. The sellers of many different products capitalise on these thought forms. So I am sorry that I have some news for you: you have a wonderful body, a miraculous one, and you are stuck with it for the whole of your life. Furthermore, how you treat it may determine your lifespan: your life is actually in your hands (a very body-oriented metaphor).

Apart from being untrue, the above examples of distorted societal thinking indicate that we are nearly all hugely disconnected from our bodies on a cultural level. Look around you and see whether modern cities, factories and lifestyles respect our bodily needs. In this context, any client or professional work with the body really needs to take these attitudes significantly into account: and it could be naïve, rash, bordering on stupid, and potentially harmful (to yourself and others) not to do so. So, as professional body psychotherapists, in this sort of culture, we may have a problem! There are places where we can “make it all right”; where we can circumvent some of these problems. If you work at Esalen, Omega, or Harbin Springs in the USA; or Findhorn or Zist in Europe; if you practice in a gym or health club; live in Haight Ashbury or Greenwich Village or some Scandinavian countries; then you can probably avoid many of the attitudes and constraints about the body. If you have a medical qualification, a professional massage qualification, or a similar ‘licence to touch’, you can probably get away with touching your clients, but you are also effectively cheating, as you are using a different qualification to substantiate your work as a body psychotherapist.

Currently I work in the National Health Service in Britain, as a “psychological therapist” and “counsellor” in doctors’ surgeries and clinics. The National Health Service is the world’s second largest employer (the largest is the Chinese Army); and, unless you are specifically entitled to do so (i.e. you are a nurse, doctor, physiotherapist, etc.), it is assumed that you will not be touching your patients. My immediate superiors all know that I am trained and qualified as a body psychotherapist (it is clearly stated in my C.V. along with my other qualifications as a teacher, economist, occupational health & safety officer, etc.) and they also know that I do not touch my NHS clients: I am employed to use “evidence-based” methods (*usually understood to be Cognitive-Behavioural Therapy*) and I have also told them specifically that I do not touch. Here is a lovely piece of poetry that summarises something of this perspective.

Dare I come into touch? For this is further than death. I have dared to let them lay hands on me and put me to death. But dare I come into this tender touch of life? Oh, this is much harder....

“The Man Who Died” by D.H. Lawrence

Previously I was working for many years in a very rural area of Scotland, where people are pretty phobic about touch: yet at the same time I also lived in a New Age spiritual community where people came from all over the world, there were many alternative therapists, and people also hugged each other (and trees) in plain view. Life is full of contrasts!

I am also the current President of the EABP and a founder member of the USABP. I am politically active in establishing psychotherapy as an independent profession and writing the ethics and training standards of that profession, so I have been involved in advocating the use of professional touch in psychotherapy for over 20 years. How can I reconcile all these extremely different positions without losing my professional integrity? I hope that I can do this by doing excellent body psychotherapy without necessarily touching my clients.

This perspective has a wider relevance. This sort of approach could mean that we might all do body psychotherapy safely and effectively, without touching. Does this mean that our critics have won and that in future we do not need to touch? Not so! Touch is an incredibly powerful intervention, but only one of many. I want to respect it as such and use it fully totally and professionally, perhaps as a last resort, or perhaps if nothing else works, or perhaps as the apex of a longer piece of work leading up to this precise form of contact. There is a somewhat epicurian concept here in the sense that there are many simple and effective values, methods and tools that are sometimes being neglected as people can rush into touch too fast and too soon. This brings me to the main theme of the paper.

Body Psychotherapy without Touch:

This section focuses on professional body psychotherapy practice without using any form of touch. Before, I get into this section in any more detail I would like to make a plea to my European and American colleagues. At some point soon, you/we all collectively must make the “case” for professional and legitimate touch in psychotherapy: we cannot avoid doing this, despite the subject of this workshop. The analytical paradigm in psychology and psychotherapy has gone unchallenged for far too long. CBT has stolen a march as (the nominally accepted) “evidence-based” psychotherapy method; systemic psychotherapies focus too much on solution-based methodologies. As professional bodies, we need to collect and collate our current research on body psychotherapy and then notice where the gaps are and fill them with specially sponsored research projects.

Some chapters and articles have been written about doing body psychotherapy without touch.³ One of these advocates being very careful using touch because the client has already been traumatised and their symptoms may worsen.⁴ These articles are not enough, and they are not publicly widespread enough. We have to write at least one major published article in a professional psychology journal collecting together the basic arguments and evidence for justifying our work with touch. This is absolutely essential, and there will probably have to be more than one. It will have to be done in conjunction with a number of different modalities within body psychotherapy, and even in conjunction with the current four university Masters and PD programs in Somatic Psychology (Naropa, CIIS, JFK in Berkeley, and Santa

³ Rubenfeld, Ilana: “The Listening Hand: To Touch or Not To Touch”, in USABP 3rd National Conference Proceedings: Baltimore, MA, June 2002: although this article actually advocates a particular form of ‘listening’ touch.

⁴ Rothschild, Babette: “Body psychotherapy without touch: applications for trauma therapy”: in Staunton, Tree (ed) (2002): *Body Psychotherapy*; Hove, Sussex UK, Brunner-Routledge.

Barbara). One can start with Tiffany Field's excellent book on *Touch*, which lists lots of wonderful evidence on the beneficial effects of touch; add in some trauma research findings from people like Bessel van der Kolk; make specific reference to some of the new discoveries in neuroscience; cite any specific body psychotherapy research projects, like Petonatti's work comparing Rubenfeld Synergy with other techniques for effective pain relief on a population of nuns; and cook that lot together into a seminal 5,000 work article written in APA style. If we don't, we might as well pack up and disappear with the Dodo, or go and get a better paid job in Information Technology or Digital Processing, or something.

I believe that we have defend our ground. We have to consider making statements like: "*How come that you do not understand how and why we can touch effectively and competently, when there has been so much written about this already?*" or "*If you are concerned whether my professional practice is ethical or not, then you will have to prove that it is not, successfully, for I do not have to defend what I have been trained to do proficiently.*" We may have to consider preparing a legal defence for our members now, rather than when somebody decides to prosecute or sue one of them. One young male psychotherapist attended my workshop in Tuscon and told part of his story there: apparently he is currently being prosecuted for touching his clients and I hope to publish more details (suitably disguised).⁵ This is becoming a part of our current professional reality: another part is that we do not need to touch clients in order to good body psychotherapy with them.

Recently I was describing to some colleagues within EABP what it is like for myself as a body psychotherapist to work in the NHS in a "non-contact" setting, and someone commented: "*But Courtenay, you are touching your clients. You are touching them with your eyes, your voice, and your presence.*" He was right! There is a special significance in the use of the words "touch" or "contact" – they can be used both physically and emotionally. Clients have noticed occasionally, and commented, that they have been 'touched' by a tear in my eye - as well as me being 'touched' by their story. Emotional rapport is a hugely significant factor in psychotherapy and several of the meta-studies on efficacy rate this factor higher than the method or type of psychotherapy.^{6 7} What seems to work best is that the client needs to be emotionally "touched" by the therapist: empathy, warmth, rapport, respect, genuineness, flexibility and what David Boadella calls "resonance" are all significant factors in the emotional component of the therapeutic relationship, which, to be effective, must be received by the client.

Successful therapeutic relationships are those in which the definition of the therapist-provided variables is extended to fit with the client's own unique experience of those variables -- the client's definition of therapist-provided warmth, empathy, respect, and genuineness. For practice, therefore, clinicians stand the greatest chance of enabling the

⁵ Appendix 1: available on Courtenay's website: www.courtenay-young.com in 'Articles' section.

⁶ Grunebaum, H.: A soft-hearted review of hard-nosed research on groups: *Int. J. of Group Psychotherapy*; 1975, 25(2): "A therapist's behavior is considered more important than his belief system."

⁷ Hubble, M.A.; Duncan, B.L.; Miller, S.J (eds): *The Heart & Soul of Change: What Works in Therapy* (1999) APA: "along with psychosocial factors ... 70% of total outcome variance is accounted for when a strong therapeutic relationship (empathy, warmth, encouragement of risk-taking) is combined with a successful incorporation of client factors in the treatment process"" "Paying more attention to the relationship itself is significant." "Whether a relationship is therapeutic is to be found in the eye of the client and not in a specific set of relationship conditions offered by the therapist"

*contribution of relationship factors to outcome when they purposefully tailor their provision of the core conditions to the client's definition.*⁸

So let it be clearly understood that emotional 'contact' with a client is an essential component in any later mention of 'this' technique or 'that' method of non-contact Body-Psychotherapy therapy work. However, in this paper, I would also like to look more at more specific non-contact methods. Some of these are: body reading, body awareness, vitality and affect attunement, relaxation and anti-stress techniques, emotional anatomy, body language, non-verbal communication, awareness of psychophysiology, radical psychosocial education, self-esteem techniques, movement awareness, therapeutic intent, and body boundary building, and they can all form a coherent and effective part of good body psychotherapy practice and none of them involve touch.

Body Reading:

A number of body psychotherapies practice the technique of "body reading". By this we mean a close observation of the client's body, how they hold themselves, how they breathe, how they might move, where tensions are held, and what emotions we might perceive in their bodies. This "body reading" is obviously open to different interpretations, depending on our theoretical and training background, upon our level of clinical experience, upon how appropriate it is to 'observe' the client in this way, and upon our own personal perceptions and projections: do we happen to notice 'this' more than 'that' whereas someone else might notice 'that' rather than 'this'.

In some body psychotherapies, like European developments of Painter's Therapeutic Postural Integration, this "body-reading" is built-up into a whole diagnostic method. Let me offer a couple of quotations from two different sources:

He had round florid face and a full body. When he took his clothes off, I was shocked at the pair of thin spindly legs and narrow hips that were revealed. The conclusion was inevitable that the seeming security and strength of the upper half of the body was a compensation for the weakness below. His main activities were confined to the upper half of the body and were essentially oral in nature. The functions of energy discharge were severely restricted and the discharge of energy in movement and sex was greatly reduced.

(Lowen)⁹

The emotional stance of the dense structure: The dense person says "make me," "don't humiliate me," or "I can't". Structurally he is compacted and pulled in, a statement of stubbornness and daring. Pulsation is aborted. Peristalsis is short, curtailed, seeking release from pressure. The dense structure is like a squeezed accordion. The dense type pushes away by projection onto others. He makes himself smaller by pulling in, holding in, holding protects himself from himself. He appears to be impotent. His feelings are based on holding on or pushing down. The dense person is caught between resisting dependency and being cautious about total independence. □

(Keleman)¹⁰

⁸ Hubble et al: op. cit: p.417: The editors, in a chapter *Directing Attention to What Works*, draw attention to Batchelor & Horvath's view of a successful therapeutic relationship (Cpt 5).

⁹ Lowen, Alexander: *The Language of the Body* (1958) Macmillan, New York, NY.

¹⁰ Keleman, Stanley: *Emotional Anatomy* (1978) Center Press, Berkeley, CA

I wonder how relevant these views are still today: How effective are they? How would you like to be so categorized? How would you like your body to be “read” in this way? Nick Totton (2003) writes:

*Body psychotherapists tend to have highly developed skills of observing and interpreting the body. Many sets of categories are used for this, including Reich's original model of seven bodily segments and distinctions between left/right, top/bottom, front/back, etc. depending on the therapist's specific orientation (so to speak), they may also consider the client's capacity to ground, to centre or face, to 'sky'; whether their structure is over- or under-bound, swollen, rigid, dense or collapsed; or where they appear to fit into a set of character structures. They may also use much more intuitive and inexplicit ways of grasping the 'individual signature of the body'. For example, they may work with metaphor and imagery, perceive the client as a particular animal or plant, ask themselves 'what sort of child do I see in this adult?' and hold their own body in the posture of the client, to see what it feels like. Conger distinguishes three levels at which we can read the body: the 'initial signature', self-conscious presentation, showing either disguise or vulnerability; the 'shadow signature', the pattern of defences; and the 'core signature', the 'essential nature' which 'does not need fixing'. Some body psychotherapists have an ability to 'read off a client's history in some detail from looking at their body. This may work on an intuitive level – there is a considerable mystique around this talent – or be highly analytic, as with Lisbeth Marcher's Bodydynamic system which looks at each muscle group's position on a scale of rigidity/flaccidity and relates this to a precise childhood sequence of muscle activation.*¹¹

My own view is that some of these perceptions implicit in Body Reading depend on the somewhat outdated ‘adjustment’ model: that therapy is a corrective treatment, which realigns the body and thus brings the mind back into a healthy condition. This is allopathic thinking; a form of corrective body therapy. I don't now think that this is good body psychotherapy. It privileges the somatic over the psychological; it ignores the protective function, the aetiology of the ‘survival’ pattern, and sees body structures as neurotic or pathological rather than as adaptive. It also assumes a huge privilege for the practitioner – the ‘knowledge’ and ‘power’ to ‘diagnose’ what is ‘wrong’ and to ‘re-adjust’ it. But in order to re-adjust, or cure, perhaps one has to have a predetermined conception of what is ‘right’: and is this not a trap? I also happen to feel that this is an imposition of a ‘method’ into the client's therapeutic process, and an imposition of a hierarchy as a form of counter-transference.

Whilst I personally do not do that sort of specific “body reading” with a client, I certainly ‘read’ or am aware of their body as they come into the therapy room, sit down, and start interacting. I am conscious of their breathing, their motility, changes of their position. I try and connect what they are saying with how they are ‘being’ in their body and allow all these impressions to build up, usually over several sessions. They inform my relationship with the person. Anything else, I would argue, is not very accepting of the client's history; is not very humanistic or client-centred in orientation; and is quite impositional on their psychodynamic and somatic process. It also assumes that they have come to you to be helped or fixed, rather than with any specific agenda. This may be true in medical clinics, but it is not often my experience as a body psychotherapist; it is usually a question that they both have or come with a specific problem and know that they need specialist help for some more general issues.

¹¹ Totton, Nick: *Body Psychotherapy: An Introduction* (2003) Open University Press, UK.

Body Awareness:

Increased body awareness is often a significant part of one's basic training in body psychotherapy and is quite common to all body psychotherapies, as well as many body therapies. However it is achieved, it has to be personal and experiential as well as theoretical or as a learned technique. Essentially, the theory goes as follows, in order to be aware of the subtle energy within someone else's body (your client), it is taken as a pre-requisite that you have to be attuned to this type of energy within your own body (a form of proprioception). So you have to be in contact with yourself in order to be in contact with others.

If you have not had a significant amount of body therapy, or if you have not experienced a lot of body psychotherapy on yourself, then you will be much less likely to notice various aspects of somatic experience happening within the client: the welling-up of an emotion; the sense of an energetic charge (heat, tingling sensations, the 'streamings', etc), an inner block, conflicts between various somatised emotions, the concept of "ripeness", an 'edge', a 'hardening' or 'softening', a 'discharge', then subsequent re-integration and so forth in your client. This sort of awareness is so important in body psychotherapy that many schools and training standards require the trainees to experience significant amounts of body psychotherapy themselves, not just to keep others in employment, but to try to build-in this level of awareness.

Furthermore, if you are a fairly stressed out person, as many of us are, then you will have almost 'forgotten' how to relax. A very important part of body awareness is an awareness of your internal autonomic state: How aroused (sympathetic)? How relaxed (parasympathetic)? Often it is only when people enter into a course of body psychotherapy, or therapeutic massage, some yoga forms, etc. do they fully realise how 'up-tight' they have been physiologically. Regular relaxation and a gradual shift from sympathetic towards more parasympathetic have a hugely beneficial effect on general health, as well as on emotional health and the capacity to self-regulate. I often quite strongly recommend some form of regular relaxation practice: Autogenic Technique, Transcendental Meditation, other forms of meditation,¹² listening to music,¹³ etc.

The somatic and emotional changes that can happen within any type of psychotherapy sessions can be a very significant part of our efficacy as body psychotherapists. If we are sensitive as therapists to these changes as they happen in our clients, because of our own experiences, then we have a very powerful method of working. If we are not looking at our client's bodies, or we are not aware that a sudden flush or paling of the skin might be a clear statement of what the client is feeling, or what is happening within the client's process, then we are cutting ourselves off from a whole channel of potentially significant information. Body sensitivity and awareness in our selves, as therapists, allows the ability to respond to and with someone else, in therapy, a form of on-going empathic somatic resonance.

Gendlin's therapeutic 'focussing'¹⁴ can be used as a powerful tool for tracking one's own embodied experience, as are various types of physically oriented meditation: listen to your breathing. In a verbal psychotherapy setting (without any specific body psychotherapy training) much has been written of the quality of 'presence' of the therapist being particularly efficacious: the quality of attention; the

¹² This can be a formal meditation or a 'mindfulness' practice as advocated by Thich Naht Hahn in *Being Peace*.(see more on meditation later).

¹³ It must be music that 'blisses' you out: Chopin, Bach, Mozart, etc.; Boccharini does it for me.

¹⁴ Gendlin, Eugene: *Focusing-Oriented Psychotherapy*, (1998) London, Guildford Press. See also: www.focusing.org

interest and care of the therapist experienced by the client; and the capacity for the therapist to just “be there” for the client.

I have had clients comment to me on the difference they have noticed, having had previous counselling experience, between that experience and the experience of working with me: they say they are ‘struck’ by the level of attention, interest and involvement compared with the (implied) more laid-back, purely affirmative, just reflective, ‘presence’ of the other counsellor or therapist: a benign witness, rather than someone who is also ‘engaged’ in their process. All very flattering – but what do we do with this increased level of body attention and awareness?

“Character Analytic Vegetotherapy”:

I have chosen to use this phrase as (i) it was what was used in my original training; (ii) it relates to the Reichian history of Body-Psychotherapy; and (iii) it gives me an opportunity to describe something, as no-one really knows what the phrase means and it is also used quite differently by different Body-Psychotherapists, even though most Body-Psychotherapists use these principles.

It describes following the pattern of that person’s emotions: as they are repressed or expressed emotionally; or as they are expressed somatically. A stiffening of the jaw muscles might indicate an emotional expression (like anger) being held back; a crossing of the arms or legs might indicate a self-protective feeling, implying a perceived threat. As we follow these, so we help the person become aware of their emotions and their expression (or lack of expression). This is often sub-conscious. By helping this emotional material become conscious, the person becomes more aware of their habitual character patterns, and then the origin of these. It also helps us become aware of how the person can begin to change or moderate these, where they have become dysfunctional.

Some neo-Reichian Body-Psychotherapies still involve the use of touch in CAV, using slight contact and pressure to highlight the physical tension from the chronic muscular holding patterns: however this is not necessary and bringing these tensions and patterns to awareness is almost as effective and also less intrusive or invasive.

Vitality and Affect Attunement:

Another aspect of these two ‘non-contact’ methods of working is a form of reading of or attunement to the client’s vitality and ‘energetic’ affect within their body. Here we are not so concerned with the physiology, position or posture of the body, but of what it feels like to be in that body, what the client is doing with their body, how they are being in terms of dynamic emotional qualities, how they are feeling emotionally and expressing this (or not). This type of awareness can often be described in quite picturesque or metaphorical language.

“Freedom is his call, martyrdom his reward. Empathy is his mark, betrayal his fear. Appreciation and approval are his need. To acquire he struggles indeed. Independence is his dream, to be at peace his desire. His secret is to be at one with another, yet individual: to be rooted, to belong, to be accepted without isolation.”□

(Keleman: on Dense Structures)¹⁵

The therapist consciously or unconsciously, openly or covertly, tries to contact, get in touch with, and ‘attune’ to the client’s emotional expression. S/he then ‘mirrors’ and ‘reflects’ some of these affects back to the client as a form of feedback.

¹⁵ Keleman: op. cit.

It is a way of making contact and amplifying their (largely unconscious) patterns and vitality, and it can help restore some of the social attunement that did not happen in the client's family of origin. Whilst this can be seen in almost any human interaction, it is important in psychotherapy and especially significant and effective in many forms of body psychotherapy, as well as in other therapies, like Alexander Technique and dance movement therapy. We are not looking just at their position and movement, or their somatic organization, but we are taking in the emotional expression and content; the person's basic energy patterns and flows. Whilst the input is largely visual, we are also 'perceiving' more of what is happening within the client's body, persona, or even their aura.

I am sure that many of you already use some or all of these methods already, or similar methods. One of the major effects that all these influences have is to give us a more 3-dimensional perspective of the client, their body and particularly of their internal energetic, somatic and psychological processes. I am not separating out the interconnected body-mind here: I am identifying the two different aspects of its nature and stating that I believe that therapy happens best when both (or all) are fully involved; when we (as the therapists) are aware of the interplay between the body and the mind, in both the client and in ourselves. As we 'receive' more from the client in these ways, so we have more information to work with: as we feed back this information, these observations and these responses, the therapy gets richer and deeper and the client becomes more aware of their own internal processes. This is, for me, one of the main possibilities and goals of body psychotherapy.

This level of awareness can even develop into somatic transference and counter-transference, where the client 'dreams up' (in transferential reactions) aspects of their own story in the therapeutic encounter and projects these onto the therapist. We can 'screen' and 'filter' these, noticing them and commenting on them back to the client, and we can also allow them to affect us, understanding them experientially and somatically and embodying these aspects of their process. Often there are aspects within our own bodies that are triggered by their affect. This is our somatic counter-transference, and we have to be as aware of it as any other aspect of counter-transference. We can track it and use it constructively. Analysts, like Andrew Samuels, and other different psychotherapists, are becoming much more aware of the power of embodied transference and counter-transference and this awareness can often be a useful point of contact between different disciplines currently separated methodologically by the barrier of touch.

'Embodied' is intended to suggest a physical, actual, material, sensual expression in the analyst of something in the patient's inner world, a drawing together and solidification of this, an incarnation by the analyst of a part of the patient's psyche and ... a 'clothing' by the analyst of the patient's soul. (Samuels)¹⁶

The use of these three techniques alone is almost sufficient in themselves to identify someone as a body psychotherapist. But there is more, much more!

Body Language:

It has been estimated that about 90% of all human communication is non-verbal, and much of that is known as "body language". There have been popular TV programmes telling us how politicians use their body language. Alexander Lowen's

¹⁶ Samuels, Andrew: *The Plural Psyche: Personality, Morality and the Father* (1989) Routledge, London.

first book was popularly called “The Language of the Body”: one piece of research work at the University of Geneva analysing non-verbal communication calculated that there are about 1,000,000 items of such in any 50-minute therapy session. This is all active communication: dynamic noticeable and recordable changes in muscles, facial gestures, or in position, or posture. It has also been made into a science called ‘kinesics’: “*Body language can include any non-reflexive or reflexive movement of a part, or all of the body, used by a person to communicate an emotional message to the outside world.*”¹⁷ And I would add, “...or about themselves.”

Deaf people, for whom verbal language is a very limited form of communication, are particularly good ‘readers’ or interpreters of non-verbal language. But the true value, especially in therapy, is the blending of verbal and non-verbal and the degree of compatibility between these two. Whilst the language of ‘touch’ or tactile communication is primary in early mother-baby contact in all primate species; non-verbal language is the next facility developed; vocalised sounds come third.

Other forms of non-verbal communication include forms of “Somatic Expression”: like blushing, perspiring, changes in breathing, flushing, muscle tension (constriction or expansion), moisture in eyes, blanching, flaring of nostrils, unconscious movement of body parts, visceral experience, numbing, and temperature changes¹⁸; “Eye Contact”: “Para-language”: “Non-lexical” vocal communications suggesting emotional nuances, like inflection, intensity, tone, pitch or pauses: Facial Expressions, like smiling or frowning: “Gestures, often unconscious or unintended modes of non-verbal communication and include, amongst many others: raised eyebrows, narrowing eyes, touching one's face, folding arms, pursing lips, self-hugging, or changes in breathing: and even “Adornment”: which include clothing, makeup, pens, broaches, belts, hats, etc. Therapeutic goals can be served when therapists increase their awareness of these forms of non-verbal communication and educate their clients about them as well.¹⁹

We have active socially learned (or genetically programmed) responses to many of these non-verbal communications. They are in two parts: the delivery of the message and the reception of the message. If the appropriate social ‘signal’ is given and the corresponding ‘response’ is not made; then there is a startle, or a stop in the flow of the ‘communication’: one often needs to respond to a smile by another smile.

So far, none of this refers to aspects of body language as mentioned in Keleman’s *Emotional Anatomy*, or Reich, Lowen and Pierrakos’s basic character structures, or in Lisbeth Marcher’s muscle testing, or in similar, more static, specific statements about character covered in the Body Reading section: this is more general, even universal, more immediate, more fluid and dynamic – a non-verbal communication that is happening all the time, even if someone else is not present. Not only body psychotherapists are using such awareness of body language in therapy: it is used a lot in Gestalt psychotherapy, as well as increasingly in other psychotherapies.

Using the client’s emotional (and often unconscious) body language, by drawing their attention to it, encouraging the client to ‘read’ their own symbolic language, increasing their awareness of possible ‘double-messages’ or indications of defensiveness, is becoming a legitimate branch of psychotherapeutic work. None of

¹⁷ Fast, Julius: *Body Language* (1971) Souvenir Press, London

¹⁸ Blatner, 2002 About Non-verbal Communications: General Considerations.
www.blatner.com/adam/level12/nverbl.htm

¹⁹ Adapted from: Zur, O. & Nordmarken, N. (2004): *To Touch Or Not To Touch: Rethinking The Prohibition On Touch In Psychotherapy And Counseling*:
<http://www.drzur.com/touchintherapy.html>

this involves contact or touch. Body psychotherapists are often already quite expert in this, because of the additional body awareness and sensitivity, and because it is naturally within our field; so maybe we should also be claiming this as one of our areas of professional expertise.

Further studies of non-verbal communication involve learning special notations. Dr Birdwhistell²⁰ has developed one; so have Ekman & Friesen^{21 22}, the “Facial Action Coding System”. Alternatively or additionally, using two cameras and modern split screen photography, one can see both client and therapist at the same time and record and ‘track’ the non-verbal signals and their responses. This gives us a very powerful research, analytical, demonstration and teaching tool. But we, as body psychotherapists, do not seem to be using it very much or very often, which is a great pity.

Breathing & Breath Work:

Since many of us are living with constant stress and some with unresolved trauma, it is not unlikely that our breathing patterns are disturbed or distorted. The client’s breathing pattern is hugely significant in body psychotherapy and Reich was one of the first to re-focus on this: others preceded him and have gone on to develop this work much further and with great subtlety.²³ Reich described a healthy ‘breathing wave’ and Alexander Lowen developed Bioenergetic exercises to help people improve their breathing pattern and discharge some of the emotional ‘blocks’ that distort it. The person’s breathing pattern can thus be used as a ‘gateway’ to their unconscious and it has a profound affect on the person’s Autonomic Nervous System (ANS) and their Sympathetic-Parasympathetic balance. It is also under semi-voluntary control, which makes for a wonderful therapeutic tool. It can be a very powerful one, if used properly. When it feels appropriate, even in a doctor’s surgery, I sometimes encourage the client to focus on their breathing and become more aware of how they are (often not) using the intercostals muscles and, especially with people prone to anxiety and panic attacks, not breathing out properly.

However a ‘caveat’ or word of warning is probably needed here. Body psychotherapists and other therapies that focus on the client’s breathing as a major part of their technique can create states of extreme hyperventilation that can cause some significant damage. So, let me take a risk and state a purely personal prejudice here: I do not feel at all comfortable with some of the more regressive therapies like Leonard Orr’s ‘Rebirthing Breathwork’²⁴ or Stanislav Grof’s ‘Holotropic Breathwork’²⁵ that seem to focus on hyperventilation or other forms of (distorted) breathing pattern, even though I have received a number of sessions and trained with Grof in several aspects of this technique. It is absolutely certain that these methods can be used to help the client break through into other or altered states of consciousness, and that this can possibly be therapeutic. But, by itself, these sorts of technique are not proper psychotherapies. Rebirthing has become more of a belief system or a sect. I have heard people ‘into’ Rebirthing make statements like: “*I have been re-birthed for*

²⁰ Birdwhistell, Dr. Ray: *An Introduction to Kinesics* (1952) University of Louisville Press,

²¹ Ekman, P. & Friesen, W.V.: ‘Nonverbal behavior in psychotherapy research’. In Shlien, J. (ed): *Research in Psychotherapy: Vol 3.* (1968) Washington D.C.: American Psychological Association.

²² Ekman, P. & Friesen, W.V.: *Facial Action Coding System.* (1978) Consulting psychologists Press, Palo Alto, CA.

²³ Young, Courtenay: op. cit. Available in PDF format: www.courtenay-young.com

²⁴ Orr, Leonard & Ray, Sondra: *Rebirthing in the New Age* (1977) Celestial Arts

²⁵ Taylor, Kylea: *Exploring Holotropic Breathwork: Selected articles from a decade of the inner door* (2003) Handford Mead

three years now and I have another four years to go,” and on their website²⁶ there is a checklist for the number of Rebirthing sessions one has had, with a check that exceeds 500.

I have also had to work very hard with people for quite long periods, effectively in crisis, to help them reintegrate themselves following a Holotropic Breathwork weekend after the visiting practitioner has left town and the person’s psyche is still somewhat shattered by the strength and strangeness of their breathing-induced transpersonal processes that are still not integrated. These techniques are wonderful tools to have when the client’s process takes them to these particular places, or when the re-birthing or altered state happens naturally as a part of their psychotherapeutic process. I do not regret any of moment of the work that I have done personally with these techniques, but I use them on clients very, very rarely and very, very cautiously. We can limit ourselves if we focus on any one particular method too exclusively – to the client’s detriment.

What I do encourage quite often is a form of deep relaxed breathing. It is a development of Reich’s concept of the ‘breathing wave’ or Alexander Lowen’s basic lying-down breathing.²⁷ The client lies on the floor on their back and breathes in and out, focusing on expansion of the belly and then the chest on the in-breath and relaxing the chest and then the belly on the out-breath. After 5 minutes or so, the knees are raised and bent so the feet are flat on the floor about 18 inches apart. Breathing continues with the knees moving together on the in-breath and apart on the out-breath. After 10 minutes or so of this, the client rests for a while on their left side, in the standard ‘recovery position’. The use of the knees in this way, which engages the psoas muscle, connecting the inner thigh to the back of the diaphragm, and brings the person’s pelvis and their sensuality or sexuality into their breathing pattern. Ebba Boyesen calls this exercise “the Jellyfish”.²⁸

Another form of breathing exercise is just to focus on your breathing: nothing else. Listen to the breath coming in; listen to the breath going out. Be aware and allow any changes in the amount of air, or the depth or frequency of the breathing. Liken the sound of your breath to waves on the beach, if you like. But just listen to your breathing. Be aware that it is your body that is breathing: your whole body.

Proxemics & Territory:

Proxemics is the study of how we use, and claim, the physical ‘space’ around us. Some of the early research in this work was pioneered by Dr Edward Hall²⁹ and he identified four main ‘zones’: intimate distance, personal distance, social distance and public distance: each zone can be further sub-divided into a ‘close’ and a ‘far’. Studies of how people position themselves and relate in different situations, and how others perceive them and relate to them show very strong psychological components at work. Depending on the setting and the relationship between the people involved, the distances we adopt in these zones are either appropriate or inappropriate. Men and women will adopt different distances depending on their cultures and relationships.

However, in the body psychotherapist’s therapy room, we are mostly concerned with the client coming into our ‘space’. Do we have a ‘space’ prepared for them; how

²⁶ www.rebirthingbreathwork.com

²⁷ Lowen, A. & Lowen, L.: *The Way to Vibrant Health* (2003) Alachua, FA: Bioenergetics Press: Ex. 63: p. 100

²⁸ Personal contact: in training at Gerda Boyesen Centre, London, 1979-1983

²⁹ Hall, Dr. Edward T.: ‘Proxemics – a study of Man’s Spatial Relationship’ In *Man’s Image in Medicine and Anthropology* (1963) International Universities Press

appropriate is it; can it vary, or is it always the same chair, couch, table or mattress? Does the therapist sit between the client and the door, or does the client sit nearer the door? How exposed or trapped does the client feel by the shape of the chair, couch, or sofa? Have you ever suggested to the client, “*Where would you like to sit?*” How free are they to get up and move around in the session? How free are you?

Some of the work now being done in this sort of spatial relationship in therapy is called “Postural Dynamics Systems”. It is very interesting; it is not just confined to body psychotherapy. Michael Heller gave an excellent presentation at the EABP Conference in October 2004 in Greece on how this is being used in psychoanalysis. Alvin Mahler, a humanistic psychotherapist from Toronto, also works in this way, changing the therapist’s position to the client in relation to what is happening in the client’s therapy and whether the work of the moment is confrontational or is collaborative; involving disclosure or reflection; contemplative or discursive, etc. Choosing where and how we sit (or stand, or move) in the therapeutic relationship profoundly changes the nature and the dynamics of that relationship. This can be used to assist the therapy directly, or to highlight positive or negative transference attitudes.

As a therapist, we have implicit rank and power and the client often has, or feels that they have, less rank and they feel less powerful: they are – after all – the one with the problem. Where a person sits depends on their rank: who chooses to sit where, depends on their rank. So how close do we sit? Do we sit sideways on? How do we use eye contact and space? How intensive is this, how invasive is that? When we say, “*You have the space*” – do we really mean that, or do we control the space – as well as the time? Do we start to adapt to the client’s ‘space’, or do we impose ours? All of these are issues that can and perhaps should be explored in the therapist’s training. It is too easy just to do it the one way: people are different.

I worked over several years with one client who was working with sexual abuse issues. Sometimes she would be silent for significant and considerable periods of time, maybe even 20 minutes of total and absolute silence. Having established that this was her pattern, I found that even when she moved away and maintained the occasional phone contact, a telephone therapy session, sometimes these periods of protracted silence would persist: it was her ‘space’, her ‘time’ in contact with me. It was not easy for me to be silent for so long, but it was very important for her as she said that it was helping her to find herself and sort out her emotions in the presence of a man, and working out how much she could trust this man in front of her not to invade her ‘space’.

Different cultures handle space very differently. To Americans, the body is very private and uninitiated body contact is distasteful, even abusive. However in Eastern cultures, people will happily push and shove publicly, although they tend to be much more private personally: an invasion of that ‘home’ space is taken as an insult. They will often withdraw into impassivity, which an American or European would find insulting, even passive aggressive. Here is just one example of cultural differences:

At a movie house in a German-American neighbourhood I waited in line recently for a ticket and listened to the German conversation about me as we moved forwards in neat and orderly fashion. Suddenly when I was just a few places from the ticket seller’s window, two young men who, I later learned, were Polish walked up to the head of the line and tried to buy their tickets immediately. An argument broke out around us. ‘Hey! We’ve been on line. Why don’t you?’ ‘That’s right. Get back in line.’ ‘To hell with that! It’s a free country. Nobody asked you to wait in line,’ one of the Poles called out, forcing his way to the ticket window. ‘You’re queued up like sheep,’ the other

one said angrily. 'That's what's wrong with you Krauts.' The near riot that ensued was eventually brought under control by two patrolmen.³⁰

There are another examples taken from research done in psychiatric hospitals. How aggressive a mental patient is to someone often depends upon the rank of the other person: it is a test of dominance. In any mental hospital one or two patients will attain superior rank by aggressive behaviour, but they can often be cowed by one of the attendants. In turn, the attendant is beneath the nurse, and she, in turn, is subordinate to the doctor. The patient is at the bottom of a pyramid and aggression might be their only accessible source of power.

Social rank often depends on how we use body language, space and territory. As therapists, we are often trying to help people gain a greater sense of self-esteem and self-worth. How do we do that, if we claim rank over them, unconsciously, every time they are allowed into our space? How can we, as therapists, give out different messages – that the clients are the important people in the room? How can we help people claim their space?

One of my clients (in the NHS) was dreading a visit from her mother; she was going to be touring in a car with her round Scotland for the best part of a week. She dreaded having to be in the confined space of a car, of having to drive, and also be subjected to the verbal darts and barbs that she felt that her mother habitually sent her way. I taught her an exercise to protect her 'psychic space' in this situation, and she came back to the next session quite elated: it had worked. I have written up this exercise (*Re-Building the Auric Boundary*) up in the appendix.³¹ Often, when I work with people who have been quite traumatized, I find that this exercise is particularly very useful for them in such situations, especially if done three times within 24 hours.

Lifestyle Information:

When I am seeing someone for the first time, depending on the clinical setting (as I do a lot of brief counselling work in clinics as well as longer term private psychotherapy), I like to ask clients a whole list of things that I call my "Initial Interview Format".³² Much of it is fairly standard for a clinical psychology practice, but there are also some definite "body-oriented" questions there, as well as some process questions, and the odd humanistic or transpersonal one as well.

So I ask a set of 'Lifestyle Questions' about their 'normal sensory experiences'; about what drugs are used, what diet, what exercise, what relaxation; what self-image aspects are significant for them; what belief systems are important; and I also observe the person's presentation as I am doing this. I am trying to build up as large and complex a picture as possible in as short a time as possible. I am also trying to do it in a way that is acceptable to my current 'bosses' who are quite CBT-oriented; that being the flavour of the decade.

This way, I 'discovered' that one client/patient, referred for extreme anxious states so severe that he could not continue work as a prison officer, was drinking 30 cups of coffee a day. I suggested to him that we would not really get anywhere lessening his anxiety states until this habit changed quite radically. In Scotland one of the favourite soft drinks is a concoction called "*Irn Bru – made from girders.*" (that is a joke). It is essentially corn syrup, fruit flavourings, and caffeine. A woman with chronic depression and a Holmes & Rahe Life Event Stress Index of 960 (the

³⁰ Fast, Julius: *Body Language* (1971) London, Souvenir Press

³¹ Appendix 3: available on Courtenay Young's website: www.courtenay-young.com

³² Appendix 2: available on Courtenay Young's website: www.courtenay-young.com

equivalent to nine and a half close family members dying within an 18-month period) was drinking 6 litres of this 'brew' every day. The sugar content of half a litre is equivalent to six teaspoons of sugar: talk about 'sugar blues'!

In this process, I am also conscious of what someone once called "The Tyranny of Questions" and I try and do all this in a light and chatty way, with the occasional digression or diversion to lighten the atmosphere. The new clients are anyway usually quite nervous – as it is their first session with me.

Exercise:

Some people take very little exercise and nowadays the first recommended intercession for stress and depression is to encourage the patient to increase the amount of aerobic exercise that they do.³³ I usually recommend a minimum of about 45 minutes 3 times a week to start with for the average person. I explain that, however fit they are, they need to bring their metabolic rate up to a level where they effectively become hot and sweaty. I describe a simple form of the Autonomic Nervous System and how the flight-fight mechanism is an adrenalin-based survival technique, designed to save your life through exceptional activity. This increase in metabolic functioning really helps them to 'burn off' some of the cortico-steroids (stress hormones) that are the by-products of any undissolved adrenalin. I also recommend that they start drinking up to 2 litres of water a day, which helps flush all the waste products out.

This sort of exercise can also be used emotionally to work off aggression, to re-build some self-respect, to improve health, to lose weight and to generally keep fit. Given current guidelines on treatment for depression, I believe that suggestions and interventions like this are totally legitimate, albeit somewhat directive, when a person has been referred for brief counselling or psychotherapy even if in order to resolve an emotional problem or to get rid of unpleasant psychological symptoms.

So I, at times, also recommend emotionally expressive exercises for discharging aggression: using an old tennis racquet on a large cushion; fixing up a punchbag in the garage; throwing rocks on the beach; pulling into a lay-by and hitting the steering wheel; all using the voice as much as you can and as loud as possible. These are emotional exercises people can do almost any time, anywhere, safely.

Self Image:

Many people, especially women, tend to have a particularly poor body image. This is often a subject that is almost unmentionable, whether to men (whom they might want to attract) or to women (whom they might be in competition with). The prevailing tenets of the fashion & beauty industry superficially provide opportunities for women to flatter and indulge themselves, but they also covertly depreciate women's bodies by constantly presenting messages that women fail to measure up to the current ideal. Some of the messages are very unsubtle: "*You can have me if you buy this car.*" The recent *L'Oreal* advertisements use a subtle but powerful end statement: "*You're worth it.*" – meaning of course, only if you buy their product. Sandra Bartky³⁴, Susie Orbach³⁵ and Dorothy Smith³⁶ have all written well about these topics. As a counsellor or psychotherapist, you may often be the only person

³³ NHS Clinical Guidelines: *Depression and SSRIs*: Dec 2004

³⁴ Bartky, S. *Femininity and domination: studies in the phenomenology of oppression*. (1990) New York, Routledge

³⁵ Orbach, S. *Hunger strike: the anorectic's struggle as a metaphor for our age* (1993) London, Penguin

³⁶ Smith, D. *Texts, facts and femininity: exploring the relations of ruling* (1990) New York, Routledge

an ordinary woman will meet who she can talk to about such intimate topics and who is sufficiently informed and even prepared to initiate such a discussion.

Many people strive for a degree of perfection, in themselves and in what they do. The concept of “*Good enough*” to these people is almost totally alien. Many people are suffering the break-up of a relationship, and frequently blame themselves for part of this. How do we help such people to claim back their self-esteem? It is important for them to feel important enough to claim their space, reclaim their body, their definition of beauty, reclaim their power, their responsibility, their rights, and perhaps own that it was not all their fault, and then (maybe) they can move on. This, I believe, is also one of the tasks or goals in therapy.

One client, a female schoolteacher specialising in physical education, was being severely harassed by a male colleague: she was also obsessing about her partner’s previous sexual relationships. The stress and distress of these led to an old pattern of self-harm being re-activated and so she was referred for counselling. We looked at her history and the various strategies and patterns that had developed over the years, and, as she talked, I noticed her scratching the inside of her forearms, which were quite scarred. I asked her, “*What would happen if you turned the hand that is scratching outwards, towards the outside world?*” This developed into a motion like a leopard clawing, and there was a twitch of her lip that I encouraged her to develop until she was almost snarling as well. I asked again “*What might happen if you could develop that aggression into a form of self-defence against your attacker?*” She got a sudden image of a “*Dragon-Bitch-Queen: Nobody messes with her*” and then laughed. Over a few sessions, things changed slowly and positively for her. Some of the origins of her self-harming pattern came more to the surface, the difficulties she was having in her current relationship ended, and she stood up more for herself at work, prodding her union to take the rather ineffective head teacher to task about his inability to resolve the harassment of staff that was a continuing issue. This was also having less of an impact for her anyway. It was a very powerful bodily-oriented self-image that emerged from within her: as a body psychotherapist I noticed it and was able to help her work with it. I believe it is forms of empathy, somatic counter-transference, resonance and bodily awareness that can really help a therapist be aware of and help their clients explore their internal imagery like this. Arnold Mindell writes of this well in his early books.³⁷

Stress Reduction Techniques:

Most of the people that I see – and I would even go so far as to say most people – are suffering from a chronic build-up of stress. This is almost undeniable and government organisations like the Health & Safety Executive are increasingly concerned. Life stress can be assessed using measurements like the *Life Event Stress Inventory*³⁸ (often useful as well as an indicator for exogenous depression), I am regularly referred relatively ‘normal’ clients “for depression” who have then scored more than 500 points on this scale (which is the equivalent of most of your immediate family being systematically wiped out within an 18-month period).³⁹ So I sometimes tell them I think they deserve a medal for still being upright and walking around.

³⁷ Mindell, Arnold: *Dreambody: The body’s role in revealing the self* (1984); *Working with the Dreaming Body* (1985); *The Dreambody in Relationships* (1987); London, Routledge

³⁸ Holmes & Rahe: *Development of the social readjustment rating scale*. 1967

³⁹ Appendix 4: available on Courtenay Young’s website: www.courtenay-young.com

In lesser or more diffuse cases, I explain how this sort of life stress is often a phenomenon of modern day living and that our bodies did not evolve to cope with such a build-up. This can help reduce some of the guilt that people feel for “not being able to cope”. I describe something about the sympathetic/parasympathetic ANS balance, the build-up of cortico-steroids, and emphasise the need for aerobic exercise (to ‘burn’ these hormones off), or - if this is difficult - sufficient time and space and effective relaxation techniques to digest some of the stress and tensions. I give examples and suggestions and then will probably not see them for another 3 weeks, such is my case load. When appropriate, I often teach people the principles of the Autogenic Technique (in about 10 minutes), and encourage them to do something like this for twenty minutes twice a day for at least three weeks. Then they can start to experiment and adapt it more to their own needs. The high incidence being recorded of headaches in employees⁴⁰ is also indicative of this sort of modern-day stress affecting people at work.

Another point here is that, if people are being seriously overstressed, and if they are then compensating for this (by drinking 60 units of alcohol per week, or 30 cups of coffee a day, or taking ODCs⁴¹, or using other less legal “substances”), then how is it possible to do effective and pertinent therapeutic work with them in any form of psychotherapy until some of their habitual stress patterns are significantly reduced and some of the compensations used are being tackled? Only then can any underlying, possibly more emotional or psychological, problems become more exposed and accessible.

Often I have to cover all these topics within the first hourly (50 minute) session of maybe only five or six sessions: and that is brief psychotherapy for you! Sometimes I am required to get them to fill in the CORE questionnaire⁴² as well, and, if appropriate, get them to fill in a BDI (and/or BAI)⁴³, as well as taking a presenting case history: such is work in the NHS!

Working Style or Approach:

This is all described from within as much a holistic, eclectic approach to clinical work as a body-oriented one. I am not that “person-centred” in my style, though I hope that I am in my intent. I am very pragmatically oriented: I am very interested in what works for that particular person, at that particular moment, and I am very interested what immediately aids or hinders their process of stress and distress relief, healing, growth or development.

This is within the context of working in GP surgeries giving brief psychotherapy and counselling. The primary object there is a reduction in symptoms and an improvement in the person’s emotional state: with the implication that most of them get discharged relatively quickly. There is a recognition that the aetiology of the symptoms may not be fully understood, and that there is no real possibility to work with some of their deep-seated problems or chronic neuroses. The longer-term work can take place later, possibly in a different setting, probably paid for differently, and with a different ‘therapeutic contract’.

⁴⁰ In the UK 1 person in 8 suffers from migraines, 6.6 million people report moderate headache-related disability; 90,000 people are away every day from work or education due to headaches; at a cost of £1 billion p.a.

⁴¹ Over the Counter Drugs: abusing non-prescription medicines (eg: solphedine, etc.).

⁴² Clinical Outcome Research & Evaluation

⁴³ Beck’s Depression Index, or Beck’s Anxiety Index (both used as standard measures in the NHS).

This is not to say that this sort of work cannot be very effective. My current average is 5.6 sessions for over 100 referrals within a year and my efficacy is currently being researched by looking at the CORE analysis.

As regards touch, in Scotland there is virtually no culture that supports touch: for men, they almost never experience anything more than a handshake, often on greeting, or the occasional friendly hand to the shoulder on parting, and, with women, an occasional chaste hug on departure, but only for well-known people. Most people in Scotland is usually quite 'staid'.⁴⁴ I have now been living here, for the most part in a very conservative rural area, for nearly 20 years. In my private work as a humanistic, transpersonal and body-oriented psychotherapist, I can say that I have been known to touch a client very occasionally, though it will usually be just on the shoulder or sternum to reassure them, or to help emphasise breathing. They are also always fully clothed. Whilst I used to accept clients for Biodynamic Massage or for Bioenergetic sessions, nowadays I don't, and I either refer them on, or explain my preferences and make an agreement to work more eclectically, without touch. It is sometimes hard to push the river.

Expressive Forms:

In therapy, much happens outside of the therapeutic hour, during the rest of the week. Some of this is integrative, putting together material that has emerged in the previous session; but most is probably 'processive'. By this I mean that the client's process has its own internal dynamic and we, as therapists, are just hopefully tuning into this and assisting it along. They have their experiences, synchronicities, dreams, images, and so forth all the time; they make connections, re-shape relationships, experiment with new forms and ways of self-being and self-expression outside of these sessions. Most body psychotherapists acknowledge this concept. As this type of psycho-dynamic process happens, the client can be encouraged to give their own process sufficient time and respect in order to allow it to shape itself. Thomas Moore⁴⁵ describes this process as 'care' rather than 'cure'.

I often encourage people to keep a journal, if that works for them. Here they can record, in whatever form is relevant to them, something of this 'processive' process, and – as this form of expression develops – so it carries its own intrinsic developmental process.

However, some people are not so literate or literal. Their process is more tactile or visual, then various forms of art therapy can be very helpful in exploring some of the inner imagery and forms that are emerging in the client's process. Others' processes are more embodied and something like Authentic Movement can be a very useful format or method of exploring these aspects of themselves.⁴⁶ Here the therapist just 'witnesses' the person's non-directed movement (often done with eyes closed) and then relates this back to them non-judgementally, but also reflectively.

It is worth mentioning here that the body moves, all the time, naturally; and doesn't always use words, and so therapies that confine their modus operandi to verbal interchange on the chair or the couch can miss out on some important aspects of these forms of self-expression; their diversity, depth and richness.

For others, perhaps it is our duty to refer or to guide the client towards these forms of expression, as they seem appropriate, or as they emerge: alternatively, we may be flexible enough to guide or assist the client towards these expressive forms

⁴⁴ 'Staid' - sedate and settled in habits or temperament, sometimes to the point of dullness.

⁴⁵ Moore, Thomas: *Care of the Soul* (1992) New York, Harper

⁴⁶ Authentic Movement: www.authenticmovement-usa.com or www.naropa.edu/movement

within those parts of that person's process that we are privileged to share. A new journal is coming out next year exploring the relationship between Body, Movement Dance in Psychotherapy.⁴⁷ Being a body psychotherapist does not have to limit us to touch or other body-oriented techniques, and we may need to be able to dance to the other person's tune, almost literally, or explore their visceral imagery as it emerges in wet paint or clay.

EMDR:

Eye Movement Desensitization & Reprocessing is a relatively new technique, discovered by Francine Shapiro. It is now being used as an adjunct to many of the more traditional psychotherapies and is also subject to some controversy. EMDR is supposed to relieve many types of psychological distress from phobias to trauma and panic attacks. The eye movements are reinforced by the person 'tapping' certain areas of their body. This supposedly works by affecting the traumatised areas of the limbic system, and effectively re-balancing the different hemispheres of the brain,⁴⁸ however there are several unresolved speculations about this. There may also be some connections to acupuncture meridians and similar energies. I do not have any personal experience of this technique, but several people that I know are very enthusiastic about it, and it seems to be the 'flavour of the month'.

Whether this can legitimately be considered a body psychotherapy technique or not is even more debatable, but many practitioners, traditional psychotherapists as well as body psychotherapists, are adding it to their repertoire, so it is definitely worth a mention in this context.

Dreams & Images:

Dreams are often used in psychotherapy as indications of the person's inner psychological process. Freud and Jung both used them extensively as reflections of the workings of the unconscious mind. Arnie Mindell uses them as reflections of the person's inner somatic processes as well:⁴⁹ so they can work on many levels. Working with dream images and other body-related imagery can give one an almost direct access into the client's internal psycho-somatic dynamic process, their inner experiential, moving and changing world, and with what is coming up to the surface in that world in order to be dealt with in their conscious processes.

Much has been written about dream work in therapy, but this has not always been related to the body. Increasingly illnesses or somatic are being seen as connected to unresolved psychological processes and, rather than working directly on or around the injured area, working with dreams and body imagery can be a very effective and less invasive way of working therapeutically with the underlying process of the condition (dis-ease).

In the 1970's, the Simontons started using body imagery and created-images in their work with cancer patients, to some considerable degree of success.⁵⁰ Gestalt

⁴⁷ Payne, Helen (ed): *Body, Movement & Dance in Psychotherapy*. 2005, Abingdon, Taylor & Francis

⁴⁸ "EMDR ...(apparently) gradually enables the capacity of higher, cortical, brain functions to override the input from the limbic structures, thereby facilitating limbic down-regulation, reduced kindling and, consequently, an enhanced integration of thalamic, amygdaloid, hippocampal and cortical functioning. This appears to correct hemispheric laterality and allows the brain to maintain balanced inter- hemispheric functioning on its own." Bergmann, Uri: *Speculations on the neurobiology of EMDR*: <http://www.fsu.edu/~trauma/art1v4i1.html>

⁴⁹ Mindell, Arnold: *DreamBodyWork* (1987) London, Routledge

⁵⁰ The Simonton Cancer Center Patient Program is based on a successful model for emotional intervention and support, which Dr. Simonton pioneered in the treatment of cancer patients. It

psychotherapy often works with images, as does Jungian Analysis. Body psychotherapists (can) also use such images, possibly as or more poignantly since (hopefully) we are more aware of the variety of the client's internal somatic dynamics that inform many of these images.

Tai Chi & Qi Gong:

These are very ancient Chinese forms of mediation and they also double up as healthy low-risk exercise and self-defence techniques. They are very grounding and centring and, quite often, I will recommend these for people who do not get on so well with the Autogenic Technique or more passive meditation and who express a need for something a little more dynamic.

Most people have now heard of these forms and it is not so strange now to refer people for something like this. I don't teach these forms myself, but I sometimes recommend that a client try out one or two of the positions or simple movements to see if they might work for them and then they can go and join a class somewhere locally. For younger women, particularly with a lack of self-confidence, something like Thai Kick-Boxing classes can be very invigorating, as well as empowering.

Meditation & Guided Meditations:

Some of the body awareness work mentioned earlier can be added to here as various forms of meditation have been found to be useful in stress reduction and pain control.

Sometimes it feels appropriate to work with a client with a form of guided meditation, usually related to their body or their process at the time. It can be very soothing and relaxing; it can be developmentally inclusive, or directed more to a particular problem. The difference between the trance state in a guided mediation and that within a hypnotherapy session is difficult to determine, so let us not speculate, but just assume a basic similarity. Depending on one's therapeutic style and approach, it is either OK or not OK to work in this way. On one hand, it is quite directive in its structure, but one can establish suitable parameters beforehand and make it more client-directed. Often a "guided meditation" can be very suggestive rather than directed. Such meditations can allow space for the client to insert their own imagery, whilst the main course of the meditation remains guided.

In body-oriented psychotherapy groups, I tend to use two forms quite frequently: one is "*The Body That Brought Me Here*,"⁵¹ and the other is an "*Evolutionary Meditation*".⁵²

At other times I will work more dynamically with a client, building on their own imagery, and on whatever resonance I have with their process into something of a construct in that moment. This usually gives them something to take away and work with until I see them again: often not for another three weeks.

Under this category, I am also including here various "Mindfulness" techniques that are becoming particular popular, especially with Clinical Psychologists and Cognitive-Behaviour Therapists (CBT) who are now using these

evolved from the concept that beliefs, feelings, attitudes and lifestyle are important factors affecting health. The program focuses on the influence of beliefs and belief systems. Participants learn techniques for enriching their lives in order to promote their health; lifestyle counselling, relaxation and mental imagery (creative thinking) exercises. www.simontoncenter.com

Also: Simonton, Carl; Simonton S.M., Creighton, J.L.: *Getting Well Again: The best-selling classic about the Simontons' revolutionary lifesaving self-awareness techniques* (1992) New York, Bantam

⁵¹ Appendix 5: available on Courtenay's website: www.courtenay-young.com

⁵² Appendix 6: available on Courtenay's website: www.courtenay-young.com

techniques reasonably successfully on their patients or clients, mostly for stress reduction and pain control.⁵³ This is a little different from the Buddhist meaning of “Mindfulness” but the meditation techniques are very similar: relaxation, increased body awareness, being in the present, and focussing only on the meditation and going deeper into an awareness of self.

In an early study in 1972, transcendental meditation was also shown to affect the human metabolism by lowering the biochemical by-products of stress, such as lactate (lactic acid), and by decreasing heart rate and blood pressure and inducing favourable brain waves.⁵⁴

One theory⁵⁵ about how these forms of meditation work suggests that the key factor is the relationship between the amygdala, (the part of the brain that handles emotions), and the neo-cortex, particularly the prefrontal cortex, which handles reasoning and acts as the inhibitory centre of the brain. The neo-cortex is smart and flexible but slow as it processes information complexly. The amygdala is a simpler structure, makes rapid ‘survival-based’ guesses using immediate perceptions, and triggers an immediate (appropriate) emotional response. The emotional responses are powerful, and usually related to our immediate survival needs. In making these ‘snap judgments’, the amygdala can be prone to error, seeing danger where there is none, which is particularly true in modern society where social conflicts are far more common than encounters with predators. A basically harmless but emotionally charged situation can thus trigger the amygdala's ‘fight or flight’ reflexes before we really know what's happening, causing fear and anger, conflict, stress, anxiety, and also frustration. Regular meditation (ideally 20-30 minutes twice a day) is supposed to help ‘soothe’ the amygdala and allow the neo-cortical processing to catch up, integrating the day's perceptions.

There may well be other reasons why such meditations work.

Neurological & Bio-Feedback:

There are a variety of devices that can record and display “body information” of various sorts and that can be used therapeutically, either to check efficacy of a certain technique, or to help the client develop self-regulation skills in relaxation (generating Alpha rhythms, etc.) Several forms of ‘Bio-feedback’ machines that plot a person's heart rate and galvanic skin responses have been shown to be quite effective to help the person lessen anxiety states, severe stress or cope with pain. Acupuncture point machines, that can replace needles, are also now available.

There is a computer program called “HeartMaths”⁵⁶ available now to check the Sympathetic-Parasympathetic ‘coherence’ with the person's recorded heart rate and, whilst some interesting phenomena are certainly showing up, the jury is out a little

⁵³ See www.umassmed.edu particularly: Kabat-Zinn, J., Lipworth, L. and Burney, R. The clinical use of mindfulness meditation for the self-regulation of chronic pain. *J. Behav. Med.* (1985) 8:163-190.; Kabat-Zinn, J., Lipworth, L., Burney, R. and Sellers, W. Four year follow-up of a meditation-based program for the self-regulation of chronic pain: Treatment outcomes and compliance. *Clin.J.Pain* (1986) 2:159-173.; Kabat-Zinn, J. and Chapman-Waldrop, A. Compliance with an outpatient stress reduction program: rates and predictors of completion. *J.Behav. Med.* (1988) 11:333-352.

⁵⁴ *Scientific American* 226: 84-90 (1972)

⁵⁵ Goleman, Daniel: *The Meditative Mind: Varieties of Meditative Experiences..* Los Angeles: J.P. Tarcher, 1988

⁵⁶ Being demonstrated at the USABP Conference in Tuscon, June 2005: www.heartmath.com

bit on the usefulness and significance of this particular tool. There are also well-established devices like the ‘Tens’ machine⁵⁷ for localised pain reduction.

Again, I have a deep-seated feeling that one can subject the client to ‘this’ or ‘that’ technique or ‘this’ or ‘that’ form of therapy if, and only if, it seems to be appropriate for them at that time and if, and only if, it seems to be part of their general psychotherapeutic process. I would not tend to use these devices ‘normally’ or for every client, though I could imagine suggesting something like one of these in a particular case, or suggesting that they investigate one of these devices on the internet.

I similarly quite often recommend a ‘light box’ for some people whose depression seems to be seasonally affected (SAD⁵⁸), especially as we are living in the north of Scotland, with very short winter days, many of them often “*drich, dreer and drab*”.⁵⁹

These are just a selection of suggestions to indicate how one can work as a body-psychotherapist, hopefully effectively, but without using touch. The main prerequisites are an understanding of the dynamics and physiology of the body and a degree of empathy to assist the somatic resonance that I spoke of earlier.

Conclusion:

Although I trained for four years in various forms of psychotherapeutic massage and neo-Reichian bodywork techniques, I hardly ever use these now: maybe occasionally in a group or workshop setting, or as a demonstration. I then did some post-training placement work for two or three years in adolescent hostels and psychiatric halfway houses, where touch was totally inappropriate with the disturbed adolescent girls, or with people recovering from a psychotic episode, or with some of the psycho-geriatric patients. I was also doing administrative work in psychotherapy training centres and supervising massage clinics.

Although I then lived and worked in an international spiritual community, the Findhorn Foundation (which is a little like Esalen), for the next 17 years where I was the resident psychotherapist, and where there was much more of a huggy, touchy ambience than with Scottish residents in the local area, I worked mainly with guests and staff going into a crisis, or in an emergency, often on a sudden call-out, sometimes in the middle of the night, and sometimes I had never met them before. It was my ‘job’ to do an assessment that included whether it was suitable for them to stay on site and whether their process seemed likely to be containable, or not. There were several alternatives, including the psychiatric admissions ward in the local hospital. I felt that I just could not afford to touch people in such an environment or circumstance. That sort of reassuring contact doesn’t often work and I would have been risking, not just my career, but also risking imposing my somewhat limited methods on their (as yet unknown) psyche. I am not at all sure whether I would want to do this anyway, professionally, ethically, or even as a part of something called brief psychotherapy.

So, these are some of the issues, for me, around working as a body psychotherapist – without being able to touch people. It is not so much the details or techniques that are important (and I am sure there are many that I have not mentioned), but I hope that I have also conveyed how a body-oriented approach could be used in almost any form of psychotherapy. What I really hope for is to have

⁵⁷ TENS: Transcutaneous electro-nerve stimulator pain control unit.

⁵⁸ Seasonal Affective Depression

⁵⁹ “wet (drizzly), dull and grey”

shown that it is perfectly possible to do effective work as a body psychotherapist without using touch, and to have stimulated your thought processes in this direction.

I do not feel limited by touch, nor constrained by not touching. What I hope will be taken as given is that is that, if anybody is using touch in psychotherapy, it is body psychotherapists who are the people who should be touching other people, because they know how to, best of all. However, I also hope that we all can consider, or reconsider, very carefully, exactly how, when and why we touch, and maybe, given these other possibilities, we can give ourselves a little bit of flexibility here, and touch people rather more judiciously, and thus more precisely and effectively when it is appropriate.

I will be happy to answer questions or develop any points further. Please contact me: courtenay@courtenay-young.com

Article Abstract: A look at reasons for, and alternatives to, using touch professionally in Body-Psychotherapy. This paper was originally prepared for a workshop / seminar for the USABP Conference in Tuscon, AZ, in June 2005. It has been added to since that workshop using some of the contributions from the participants. The main part of the paper (without appendices) is being printed in Energy & Character: No 34, Sept 200 under a slightly different title.

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APPENDIX 1:

This is an account of someone who has experienced quite a powerful 'attack' on his use of professional touch. Names and locations have been changed to protect his identity.

Official Notice from:

(State X) Mental Health Boards Disciplinary Actions: in Mental Health Professions Newsletter

"Charles Smith": Unlicensed psychotherapist. Provided services that fall below generally accepted standards of practice: failed to obtain signed mandatory disclosure form. Stipulation and Order: January, 200X.

(This 'Stipulation & Order' implies that certain disciplinary actions were imposed for him to retain his license. He was one of 1900 "unlicensed psychotherapists" in that particular state, out of a total of about 14,000 active counsellors and mental health professionals (excluding psychologists and psychiatrists) under that 'State Board'. Other strictures on the 56 people disciplined that year include: Letter of Admonition; Summary Suspension; Suspension one year; Voluntary surrender; Injunction to prohibit practice; Cease & Desist).

The events leading up to this event are significant. (awaiting account)

APPENDIX 2:

INITIAL INTERVIEW FORMAT

Case History & Information Checklist

- A. Presenting Problem(s):
Referral reason:
Client's view/description:
Any changes or developments:
Why is help being sought? Now?
History of complaint: Onset: Duration:
Difficulties in functioning: precipitating factors: moderating factors: severity:
Any previous history:
Coping strategies: alcohol, tranquillisers, avoidance,
Affect on others: reinforcement, motivated referral, etc.
- B. Demographic History:
Occupation:
Marital status – partner's occupation:
Children: number, names, ages, occupations
Social status, work status, extended family, relations(hips)
- C. Developmental History:
Original family: position in family: siblings: parents:
Overview of early family life:
Significant events:
Educational history: success: failure: trauma: changes: primary, secondary, tertiary:
Occupational history: work: relationships: ups/downs:
Social history: childhood friends: adolescence: long-tem friends:
Psychosexual history
- D. Medical/Psychological History & Attitudes:
Previous psychiatric, psychological, counselling, help:
Other relevant medical history:
Current medication: side effects:
Preventing moods & thoughts:
Reported beliefs significant/consensual?
Any abnormal sensory experiences:
Any oddities? Posture, movement, interjections, memory, dissonance:
Assessment of intellectual/cognitive functioning:
Any need for more specialist assessment/tests:
- E. Lifestyle Questions:
Smoke, drink, drugs (inc. caffeine, chocolate, sugar...):
Diet – water, fruit/vegetables, vitamins:
Exercise: Pleasure/leisure:
Relaxation - physical/mental/meditation:
Attitudes: belief systems:
Self-image:
Presentation: observations:
- F. Formulations:
Goals, aims, understanding:
Motivation, expectations, outcomes:
What differences could help / result?
Therapeutic relationship: contact:
Formulation: process / intervention proposals:
Prognosis.

APPENDIX 3:

RE-BUILDING YOUR BOUNDARY

(Auric Boundary)

This is a very good exercise for people who have been ill or traumatized. They should do this exercise three times within 24 hours. The first time, the only present should be the therapist: the other two times by yourself. You can do tall three times by yourself if you wish. Be very careful of your boundaries immediately after you do it. Spend some time getting used to having this 'new' boundary.

The exercise goes like this:- Imagine that you are going to build a glass dome around yourself at arms length away from yourself at arms length away from your body; all around; up and over; down to the ground; like a glass dome put over Victorian stuffed birds or painted dolls. However you are going to build this from the inside, using your breath (prana energy). You can put what qualities you like into this 'dome' of an energy field: colours, healing, peace, safety, 12-point steel, rainbows, sparkly bits, whatever.

Take a deep breath expanding your chest area. Scoop the energy from your chest as if you are scooping up wet clay. As you breathe out, paint or plaster this energy with your hand on the inside surface of the dome – a little like finger-painting. Notice the area that you have just 'painted'. Breathe in again and repeat the motion, covering a slightly different area this time. Again notice the combined areas.

Carry on doing this and extending the 'painted' area all the way around; up and over; round the back and down to the ground. Make sure that there are no 'holes' or patchy areas. It will take at least 20 minutes. Maybe 30 minutes the first time, or if there are a lot of emotions. If there are emotions, feel them, allow them, breathe through them, let them flow and change, and carry on.

Once you have completed the whole exercise; take some time to notice the difference – if any. Have you just been breathing and waving your arms around; or is there a qualitative difference in how you feel about yourself and the rest of the world? What is this difference? Feel it, don't try to describe it – there are often not good words. It may even be beyond language.

Once you have a feeling for this energy field, imagine that you can change it. It is your energy field, so it is under your control. You can make it like carbon steel so that nothing and noone can get in. You can make it like a glorious castle, or a sacred temple. It can stop negative 'darts' or 'arrows' coming towards you; or it can act as a filter and only let in the 'good' things that you want – if you wish. You can make it obscure so that no one can see you. Or you can make it dissolve and welcome in a loved one, or a child, or you pussycat. You can give it qualities like healing, or peace – just by thinking about it. It is your energy, at your control. Just breathe in and it is solid, clear and present there; just breathe out and it expands, softens or dissipates.

For people who have been severely traumatized, shocked, ill or abused, it is likely that their 'auric' boundaries are very depleted, or have holes in them. So this exercise should be repeated regularly for a while (minimum three times within 24 hours) as part of their self-healing process. It is difficult to work therapeutically with someone if they have no sense of themselves or if they cannot feel that there is a safe space for them selves. This exercise can help to provide that. Try it out. It is only an exercise, isn't it?

APPENDIX 4: LIFE EVENT STRESS INVENTORY

It is quite often the case that an accumulation of very stressful life events in a relatively short period (eg: 12-18 months) increases one's vulnerability to depression, or can even bring it on due to emotional 'overload'. Several life events are suggested below and some sample scores (rated up to 100) are given. Please use this page and write in your 'stress' scores for those events that you have experienced over the last 18 months. For some people, their 'Marriage' was the happiest time of their life and everything went swimmingly; for others it was very, very stressful. So you decide upon your stress score. Two lines have also been left for you to add in any life events not mentioned in the list.

List of stressful "Life Events"	Sample Scores	Your Scores	Any Comments
Death of a spouse, partner or child	100		
Divorce	73		
Marital separation	65		
Imprisonment, jail/hospital detention	63		
Death of a close family member	62		
Major personal injury or illness	54		
Marriage	50		
Dismissal from work	47		
Retirement	45		
Major change health/behaviour of family member	44		
Pregnancy	40		
Sexual difficulties	39		
Gaining new family member	39		
Major business/work changes	39		
Major change in financial situation	38		
Death of a close friend	37		
Change to different line / type of work	36		
Major change in amount of arguments with spouse	35		
Taking out a major mortgage or loan	32		
Foreclosure on a mortgage or loan	30		
Major change in responsibilities at work	29		
Child leaving home (marriage, college, etc)	29		
Trouble with in-laws (or neighbours)	29		
Outstanding personal achievement	28		
Spouse begins or stops work outside the home	27		
End / change formal schooling, or begin college	26		
Major change in living conditions	26		
Change in social activities, personal habits	26		
Trouble with the boss	23		
Major changes in work hours / shifts / conditions	20		
Change in residence, new school / new work place	20		
Major change in amount of recreation / activities	19		
Taking out a smaller loan (hire purchase)	17		
Holidays / Christmas / family get-togethers	15		
Changes in sleep / diet / eating habits	15		
Minor violations of the law	11		
>....	•		
>....	•		
YOUR TOTAL SCORE	=		

If you scored more than 150 points, any minor illness may be due to stress; more than 300 points, your symptoms (often depression, sometimes serious illness, or an increased incidence of minor illnesses) are probably as a result of these stressful life events. Make sure you take appropriate measures to deal with these stressful events properly and reduce current stress in your life.

Adapted from Holmes & Rahe, 1967

APPENDIX 5:

THE BODY THAT BROUGHT ME HERE

Guided meditation: How did your body respond to some of these life experiences of yours? You carry memories of all of these in your body, and all of these helped to shape your body - and your spirit.

Try to allow your body to remember these events:

Pregnancy & Birth: Inter-uterine experiences (you had them, try to allow your body to remember them); or birth: was it natural or Caesarian? Any cord & birth traumas; Was there post-natal isolation? What was your welcome into and your position in the family; your early family atmosphere & feelings

First Movement Memories: of being in the womb; being held, rocked, carried, cuddled, bounced; of being in the pram or buggy; of crawling, then walking; of any early journeys; of falling out of bed; etc.

Environment: of being in fields; mountains; woods; by the sea; in urban; or suburbs; what climate; of the environment, friendly or hostile; safe or not; first impressions of school

Trainings: potty training; reading; riding a bike; swimming; horse riding; tree climbing; playing a musical instrument; dance/ballet; gymnastics and athletics

Messages: sexist ones: boys “don’t cry”; girls “are pretty”; “you are” ... clumsy, intelligent, etc; “my body is” ... nice/nasty; what messages about posture; safety; self-esteem; shame; race; class; family fears; recurrent dreams or nightmares

Sexuality: nakedness; bathrooms; sensuality; what whispers of incest; what types of touch; film images; teenage images/role models; one’s 1st sexual (or non-sexual) affair; different lovers; different experiences of sex; impotence/fertility

Health: being suckled; types of food; weight; strength; flexibility; games and athletics; illnesses; disability; eyesight; allergies; chronic issues; hospitalizations; operations

Traumas & Accidents: family deaths, car accidents, abuse, fractures, hospital operations, natural disasters; near misses; ecstatic experiences;

Maturation: the growth of and changes in your body; childhood; menârche; puberty & adolescence; childbirth; chronic illness; family predispositions; menopause; retirement; aging; nearing death; parts of your body ‘not working’ so well;

What is your Best Body Memory?

What is your Worst Body Memory?

APPENDIX 6:

EVOLUTIONARY MEDITATION

Participants are lying down in a darkened room. This takes about 20 minutes. Try experiencing how your body moves with the different various stages.

You are a single cell amoeba, in fluid, pulsing, in the dark; (let yourself experience floating, pulsing) - you pulse from your centre

Millions of years pass - you have some more cells now, still pulsing, evolving different forms, there is the beginning of an awareness of others; (*experience your pulsation alongside other forms - all pulsing from your centres*)

Millions of years pass - you are now in larger forms, more organised, still mostly in the dark, still in water, with some very different differentiation, still pulsing like a jellyfish; your awareness of light, heat, and movement changes; any tendrils or extensions are still organised from your centre (*now explore how you collect sustenance, how you move*)

Millions of years pass - you are now closer to the surface, light, air; you are more organised, more complex, more differentiated; how do you catch food; avoid being caught; you have a more defined inside & outside (surface); what sort of structure & appendages (limbs, tentacles, flippers); what sort of reproduction do you use; (*try feeling what sort of evolutionary form you favour*)

Millions of years pass - you now have greater awareness, you can tell the difference between water/not water, water/land, in or out; explore these surfaces, boundaries; try moving like this - you now move along a spine, your mouth leads your body; (*try moving from your mouth*)

Millions of years pass - major evolutionary changes happen, you move onto the land; how do you cope with dryness, and temperature changes; you are coping with air (breathing); you are now crawling, coping with surface & gravity; you discover movement using your limbs; what height, weight, do you have; what new food do you eat; (*explore all this movement, these different sensations, wriggle, crawl*)

Millions of years pass - what are your decisions about how to cope with gravity versus getting food; what do you choose as regards size, height, weight, speed; what environment do you choose: air or land, trees or desert; there are other animals around; do you eat them, fight them, fuck them; how do you reproduce, attract a mate, look after your young; (*discover this for yourself, move to these rhythms*)

Millions of years pass - major environmental changes happen: seas rise & fall, years of drought, ice ages; how do you cope, how do you change, what different food, different fur; do you compete or collaborate with others; do you hibernate or go south, use holes or caves, do you go back into the water or not; (*discover your reactions to these environmental changes*)

A few million years pass - serious heat, serious drought, a million years of drought; trees disappear, food disappears; you go to the sea shores; you stay in the water; you eat different foods (mostly shellfish), your brain increases in size; you lose body hair, you gain insulation (fat under the skin); you shed excess salt through tears; you begin to develop language; (*see how these changes feel*)

Thousands of years pass - you start to form small social groups; you hunt and gather, you find new caves, you discover the use of different animals, plants, and herbs; you now explore and travel widely; you adapt to different lands, foods, climates; (*see how all this feels*)

Hundreds of years pass - suddenly there are farms, villages, towns, cities; suddenly there are books, lamps, artifacts; suddenly there are crowds, wars, machines, roads, walls, houses, more wars, clocks, artificial light, factories, phones, motor cars, planes, hospitals, radio & TV, mobile phones, computers, jobs, (*and see what happens to your body now*)

NOW STOP!

Each of these stages is still in your body; still present in your DNA; feel them now; feel them all. How are you with all these things present? What changes have happened to you during this meditation? Discuss these now with another person, take about 5-7 minutes each. Then come back into the group.