

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

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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 was printed in *Energy & Character*: No 34, Sept 2006 under a slightly different title. The article has been revised, brought more up-to-date, and has been added to since then.

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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 paper² 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

¹ “The Ethics of Touch”: A PDF download is available on www.courtenay-young.com

² Version 1.5: published *Energy & Character*: Vol. 34, Sept. 2005, pp. 50-60 (revised Oct. 2010)

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 take³ 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 'basal' 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 I*
- *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),
- *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

³ Young, Courtenay: "150 Years On: The history, significance and scope of Body Psychotherapy today": published in *Journal of Body, Movement & Dance in Psychotherapy*, Vol. 1, No. 1, 2006, pp. 5-20; and in Cpt. in Corrigan, J. (ed.) *About A Body: Proceeding of 2005 UKCP Conference*, (2006) Abingdon, Taylor & Francis, pp. 83-94

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 was also the President of the EABP (at the time I originally wrote this article) 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 sometimes 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 – if it was inappropriate to do so. 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; it must be supported and defended; but it is only one of many interventions. 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 ‘epicurean’ concept here in the sense that there are many simple and effective values, methods and tools that are sometimes being neglected as some 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, American and Australian 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 (that sees touch as abhorrent) has gone unchallenged for far too long. CBT has stolen a march on us in that it has become *the* (nominally accepted) “evidence-based” psychotherapy method. Systemic psychotherapies focus too much on solution-based methodologies. As professional associations (bodies) in Body Psychotherapy (or Somatic Psychology), 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. This work is absolutely essential and I deal with it in more detail elsewhere.⁴

⁴ Young, C. (2010a). “The Science of Body Psychotherapy Today: Part 2: The Current Situation.” *USABP Journal*, Vol. 9, No. 1, June 2010, pp. 5-14.

Young, C. (2010b). “The Science of Body Psychotherapy Today: Part 3: Appropriate Science.” *USABP Journal*, Vol. 9, No. 2, Nov 2010, pp. 37-47.

Some chapters and articles have been written about doing Body Psychotherapy without touch.⁵ One of these advocates was being very careful about using touch because the client has already been traumatised and their symptoms might have worsen.⁶ These sorts of articles are really not enough, and they are not publicly widespread enough. As a profession, we have to write at least one major published article in an external, cited, peer-reviewed 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 maybe even in conjunction with the current four university Masters and PD programs in Somatic Psychology (Naropa, CIIS, JFK in Berkeley, and Santa Barbara).

One could start with Tiffany Field's (2003) 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 word article written in APA style. If we don't, we are only 'playing' at being professional, so we might as well pack up, go home, and/or disappear with the Dodo, or go and get a better paid job in Information Technology or Digital Processing, or something else.

I believe that we have to 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 on this topic at the USABP Conference in Tuscon (in 2006) and told part of his story there: apparently he was being prosecuted by the Arizona state authorities for touching his clients, and – in due course – I would hope that we could publish not only more details about this case but also 'cases' that support the use of professional touch (possibly suitably disguised) or that could form a 'body' of case law and precedent that might be needed in similar cases. This issue about touch is becoming a large part of our current professional reality. Another part is that we do not

⁵ 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.

⁶ Rothschild, Babette: "Body Psychotherapy without touch: applications for trauma therapy": in Staunton, Tree (ed) (2002): *Body Psychotherapy*; Hove, Sussex UK, Brunner-Routledge.

‘need’ to touch our clients in order to good Body Psychotherapy with them.

To Touch or Not To Touch

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.^{7 8} 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 properly 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 contribution of relationship factors to outcome when they purposefully tailor their provision of the core conditions to the client's definition.⁹

So let it be clearly understood that emotional ‘contact’ with a client is an essential and effective component in any psychotherapy, and bear this in mind, especially in later mention of ‘this’ technique or ‘that’ method of “non-contact” Body Psychotherapy work.

So, in this paper, I would also like to look in more detail at some specific “non-contact” methods.

⁷ 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.”

⁸ 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”

⁹ 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).

Some of these include: 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 really involve physical touch in any significant way whatsoever.

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 in Lisbeth Marcher’s “Bodydynamic” psychotherapy, or in European developments of Jack Painter’s work, now being called Psychotherapeutic Postural Integration) this “body-reading” is built-up into a whole diagnostic method. Let me also 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)¹⁰

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

¹⁰ Lowen, Alexander: *The Language of the Body* (1958) Macmillan, New York, NY.

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)¹¹

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.¹²

My own view is that some of these perceptions implicit in Body Reading depend on the somewhat outdated ‘adjustment’ model: that psychotherapy 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-oriented therapy. It shares the ground with Rolfing, the Alexander Technique, Cranio-Sacral Therapy and Heller-Work. Excellent as these therapies may be, I don’t think that this approach forms a

¹¹ Keleman, Stanley: *Emotional Anatomy* (1978) Center Press, Berkeley, CA

¹² Totton, Nick: *Body Psychotherapy: An Introduction* (2003) Open University Press, UK.

part of 'good' Body Psychotherapy. It tends to: privilege the somatic over the psychological; ignore the protective function, the aetiology of the 'survival' pattern; and see body structures more 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' in the 'patient' 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 occasionally '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 in their position, etc. 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: the 'body' of the client. This is very useful information, and it 'fleshes out' what they are telling me verbally and vocally. But I very rarely 'use' that information in the therapy itself: I very rarely point out that "you are doing this or that. I will certainly encourage the client to increase their own perception of their body (more on that later).

Anything more than that, I could 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 'life' problem and know that they may need some specialist help for some general issues in connection with their body; or they bring a specific body problem into the therapy, and realise that it may be connected to (or caused by) a deeper psychotherapeutic dynamic. In the latter case, I might therefore 'read' their body and give my insight or thoughts on this, but they would then be asking me for that specialist work, I would not be imposing it on them.

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 and some meditational practices. 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's), it is taken as a pre-requisite that you (the

therapist) have to be reasonably well 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 personal 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 yourself and thus also when it happens within your client: things like – the subtle 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”; Arnie Mindell’s¹³ concept of an ‘edge’ – a psycho-somatic resistance; a ‘hardening’ or ‘softening’ of the features, or the body position; a ‘discharge’ of emotion; and then a 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 absolutely require the trainees to experience significant amounts of Body Psychotherapy themselves, not just to keep others in employment, not just as a form of apprenticing; not is this a residue of the earlier model of a “training analysis”; but to try to build-up, and build-in, this level of somatic 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 (become) physiologically: there may also be psychological symptoms as well. Regular relaxation and a gradual shift from sympathetic functioning towards more relaxed and gentle (parasympathetic) activity, have a hugely beneficial effect on general health, as well as on emotional health and the capacity to self-regulate. I often quite strongly suggest or recommend to clients that they undertake some form of regular relaxation ‘practice’: Autogenic Technique, Tai Chi, Transcendental Meditation, other forms of meditation,¹⁴ listening to music,¹⁵ 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

¹³ Arnold Mindell: *Process Oriented Psychotherapy*: (1982). *DreamBody*. Boston, MA: Sigo Press & Hove, UK: Routledge (1984) – plus other publications.

¹⁴ This can be a formal meditation or a ‘mindfulness’ practice as advocated by Thich Nhat Hahn in *Peace is Every Step*. (see more on meditation later).

¹⁵ It must be music that really relaxes or ‘blisses’ you out: Chopin, Bach, Mozart, etc.; Boccharini & Albinoni do it for me!

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'¹⁶ can be used as a powerful tool for tracking one's own embodied experience, as are various types of physically oriented meditation; listening to your breathing; or doing an exercise such as the "Felt Sense of Self".¹⁷

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 interest and care of the therapist experienced by the client; and the capacity for the therapist to just "be there" for the client. Fine: but 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. This has been all very flattering – but what exactly are we doing 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 not many people really know 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 a therapeutic approach '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 observe, 'analyse', indicate, and follow up these 'characteristic' patterns in the client's body, so we help the person become aware of their emotions and their expression (or lack of expression). These patterns are often sub-conscious. By helping this emotional material to become conscious, the person then becomes more aware of their habitual 'character patterns', and perhaps also the origin of these. The increasing

¹⁶ Gendlin, Eugene: *Focusing-Oriented Psychotherapy*, (1998) London, Guildford Press. See also: www.focusing.org

¹⁷ A meditational exercise: downloadable from the 'Articles' page of my website: www.courtenay-young.com

awareness helps to ‘wake up’ the repressed material: the long-standing tensions and holding patterns became anaesthetised (because they were painful) and now – with attention and awareness – they begin to ‘wake up’; to become painful again, so that we can change them; to soften (where they were hard) and to become more hyper-tonic (where they were slack). There is a gradual adjustment and re-adjustment process.

Originally, Reich used a form of touch (actually quite invasive touch) to bring the long-held tension to the person’s awareness. It was an (apparently) exceedingly painful therapy process. But it doesn’t have to be done that way. Gerda Boyesen used a much more gentle form of massage, derived from Bülow-Hanson’s work, though her “Deep Draining” techniques (similar to Rolfing) were also quite painful – in the moment. However, if touch is inappropriate, or not allowed, just bringing the holding pattern to the person’s awareness can be sufficient to start the ‘waking-up’ process. Body Reading (described earlier) might be a part of the therapist’s tool-kit: but it is being used here to facilitate the client’s process, not to analyse them and categorise them.

Reich also stated that the various ‘rings’ of “armouring” should be worked with sequentially. He identified several ‘segments’ of the body where there was often a grouping of holding patterns that together constituted a “block”: viz: eye block, throat block, etc. He felt that if the (body) emotional energy ‘held’ was released by working with that block and then that energy could not flow in and out of that area healthily, it would create secondary problems. So he advocated working sequentially, down the body, from the eye segment down eventually to the pelvis. His declared goal was ‘orgastic potency’ and the sexual area should be left to last. There is a good description of this type of Reichian therapy (as practiced by the Orgonomist, Ellsworth Baker) by Orson Bean.¹⁸ This sort of sequential working also helps us become aware of how the person can begin to change or moderate these holding patterns, where they have become dysfunctional, and which ones they want to keep, for natural healthy protection. Reich also worked with the ‘patient’ in their underwear (as did Alexander Lowen in his Bioenergetic Analysis) so he could see the holding patterns in their body. This is now usually considered as unnecessary and even improper.

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 really necessary and bringing these tensions and patterns to consciousness (awareness) verbally and through other means, is almost as effective and is also less intrusive or invasive.

¹⁸ Bean, Orson. ((1971). *Me and the Orgone*. New York: St Martin’s Press.

Perhaps it is worth mentioning here that Dance Movement Therapy (or Psychotherapy) – whilst it is not a Body Psychotherapy, and they don't use Reich's concepts and work – also seeks to increase the client's movement repertoire, and thus reduce their holding patterns. The therapist also very rarely touches the client in this therapy – unless it is with some sort of 'contact improvisation' type of dance.

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)¹⁹

Sometimes 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 somatic feedback.

It is a way of making contact and amplifying the client's (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 – as therapists – are not looking just at their position and movement, or their somatic organization, but we are taking in the person's whole 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

¹⁹ Keleman: op. cit.

even their aura. We are also feeling it in our own bodies: this is through the ‘somatic resonance’, using the facility of mirror neurones.²⁰

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 and dynamics. 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 more fully 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)²¹

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

²⁰ Wikipedia: http://en.wikipedia.org/wiki/Mirror_neuron also Rizzolati, G. & Craighero, L. (2004). The Mirror-Neuron System. *Annual Review of Neuroscience*, Vol. 27, pp. 169-192.

²¹ Samuels, Andrew: *The Plural Psyche: Personality, Morality and the Father* (1989) Routledge, London.

Body Language

It has been estimated (possibly erroneously) 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 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.”*²² 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 changes²³; ‘Eye Contact’ – a very powerful non-verbal tool of communication: ‘Para-language’ – the non-verbal voice cues of accent, articulation, tempo, emphasis, etc and ‘vocalization’ characterizers, qualifiers and segregates, etc. and the ‘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; ‘Kinesics’ – communicating non-verbally (see Mead & Bateson’s work); ‘Posture’ – how we communicate by how we stand and position our body; and ‘Proxemics’ the physical space in communication; ‘Haptics’ – touching in communication (like a “High 5”); ‘Chronemics’ – how time is perceived in communication; and even “Adornment”: which include clothing, makeup, pens, broaches, belts, hats, etc. Therapeutic goals can be served when therapists

²² Fast, Julius: *Body Language* (1971) Souvenir Press, London

²³ Blatner, 2002 About Non-verbal Communications: General Considerations. www.blatner.com/adam/level12/nverbl.htm

increase their awareness of these forms of non-verbal communication and educate their clients about them as well.²⁴

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 there is a whole area of study about the interaction of verbal and non-verbal communication, where patterns of repeating, conflicting, complementing, substituting, regulating and accentuating or moderation are played out.²⁵

So far, nothing of any of this really 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 type of body language 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 and social studies.

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 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 Birdwhistell²⁶ has developed one; so have Ekman & Friesen^{27 28}, 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.

²⁴ 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>

²⁵ Wikipedia: Non-verbal communication: http://en.wikipedia.org/wiki/Nonverbal_communication

²⁶ Birdwhistell, Dr. Ray: *An Introduction to Kinesics* (1952) University of Louisville Press,

²⁷ 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.

²⁸ Ekman, P. & Friesen, W.V.: *Facial Action Coding System*. (1978) Consulting psychologists Press, Palo Alto, CA.

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 all of 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.²⁹ 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 can distort it, especially the diaphragmatic 'block'. The person's breathing pattern can thus be used as a 'gateway' to their unconscious and it also can have a profound affect on the person's Autonomic Nervous System (ANS) and their Sympathetic-Parasympathetic balance. Their breathing 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 their intercostals muscles and, especially with people prone to anxiety and panic attacks, not breathing out properly. Panic attacks are 'caused' physiologically by a build-up of Carbon Dioxide in the blood stream (because of the anxious person not breathing out properly) and this is registered by the hypothalamus in the limbic (emotional) system of the mid-brain, and being seen as an emergency (suffocating).

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, or hypo-ventilation, that can cause some significant degree of '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'³⁰ or Stanislav Grof's 'Holotropic Breathwork'³¹ that seem to focus on hyperventilation or other forms of (distorted) breathing pattern, even though I have received a number of sessions in Holotropic Breathwork 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

²⁹ Young, Courtenay: op. cit. Available in PDF format: www.courtenay-young.com

³⁰ Orr, Leonard & Ray, Sondra: *Rebirthing in the New Age* (1977) Celestial Arts

³¹ Taylor, Kylea: *Exploring Holotropic Breathwork: Selected articles from a decade of the inner door* (2003) Handford Mead

become more of a belief system or a sect. I have heard people ‘into’ Rebirthing make statements like: “*I have been re-birthed for three years now and I have another four years to go,*” and on their website³² there is a checklist for the number of Rebirthing sessions one has had, with one check that exceeds 500 sessions.

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 properly 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.³³ 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 then 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”.³⁴

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 of 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:

³² www.rebirthingbreathwork.com

³³ Lowen, A. & Lowen, L.: *The Way to Vibrant Health* (2003) Alachua, FA: Bioenergetics Press: Ex. 63: p. 100

³⁴ Personal contact: in training at Gerda Boyesen Centre, London, 1979-1983

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 Hall³⁵ and he identified four main ‘zones’: intimate distance, personal distance, social distance and public distance: each zone can be further subdivided 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’ properly prepared for them; how 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 or comforted 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 to do so?

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 therapy work of the moment is confrontational (face-to-face) or is collaborative (alongside); 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. The awareness of proxemics can be used to assist the therapy directly, or to highlight positive or negative transference attitudes.

As a therapist, we also 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 coming 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

³⁵ Hall, Dr. Edward T.: ‘Proxemics – a study of Man’s Spatial Relationship’ In *Man’s Image in Medicine and Anthropology* (1963) International Universities Press

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.³⁶

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.

³⁶ Fast, Julius: *Body Language* (1971) London, Souvenir Press

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? Then told to leave when the ‘dictated’ 50 minutes is up? Their cycle of process may not be complete yet. How can we, as therapists, give out different messages – that the clients are really the important people in the room? How can we help people re-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.³⁷ 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 sometimes like to ask clients a whole list of things that I call my “Initial Interview Format”. Much of it is fairly standard for any 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.

I can also 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 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. They could write some of these answers out before they come, but then I would not experience them telling me: all the non-verbal communication would be lost.

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 (quite strongly) that we would not really get anywhere in lessening his anxiety states until this habit changed quite radically. In Scotland one of the favourite soft drinks is a concoction called “*Irn Bru* –

³⁷ Available as a downloadable PDF file in the ‘Articles’ section of Courtenay Young’s website: www.courtenay-young.com

made from girders.” (that is a sort of advertising 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 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’ without taking the caffeine content into consideration!

In this process, I am also very 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; so that helps soften the therapeutic ‘professional’ dynamic.

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.³⁸ I usually suggest a minimum of about 45 minutes, 3-4 times a week to start with for the average person. I explain that, it does not matter how fit they are, they just need to bring their metabolic rate up to a level where they effectively become hot and sweaty. I describe the Autonomic Nervous System fairly simplistically and how the flight-fight mechanism is an adrenalin-based survival technique, designed to save your life through exceptional activity. The increase in metabolic functioning really helps them to ‘burn off’ some of the stress hormones (adrenalin, cortico-steroids, etc.) that are the by-products of any unresolved stress. I also suggest 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 punch-bag in the garage; throwing rocks on the beach; pulling into a lay-by and hitting the steering wheel; at times, using the voice as much as you can and as loud as possible as well as the body. These are emotional exercises people can do almost any time, anywhere – if they are careful, and safely. Combined with regular relaxation, they provide an

³⁸ NHS Clinical Guidelines: *Depression and SSRIs*: Dec 2004

effective self-help rebalancing of the client's Autonomic Nervous System, which is an excellent start to any therapy – Body Psychotherapy or otherwise.³⁹

Self Image

Many people, but particularly women in the first instance, 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 the message that most women fail to measure up to the current (fashion model / film star) 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, ... but only if you buy their product. Sandra Bartky⁴⁰, Susie Orbach⁴¹ and Dorothy Smith⁴² have all written well about these topics. As a counsellor or psychotherapist, you may often be the only person an ordinary women 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. This is endemic in, and supported by, the Protestant work-ethic in society. 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 dynamics 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 she

³⁹ Young, C. (2000). Re-Balancing the Autonomic Nervous System: A Necessary Pre-requisite To Effective Counselling & Psychotherapy. *International Journal of Psychotherapy*, Vol. 12, No. 2. July 2008, pp. 24-35.

⁴⁰ Bartky, S. *Femininity and domination: studies in the phenomenology of oppression*. (1990) New York, Routledge

⁴¹ Orbach, S. *Hunger strike: the anorectic's struggle as a metaphor for our age* (1993) London, Penguin

⁴² Smith, D. *Texts, facts and femininity: exploring the relations of ruling* (1990) New York, Routledge

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 then got a sudden image that we labelled as a “*Dragon-Bitch-Queen: Nobody messes with her*” and then she 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 could notice it and was able to help her work with it. I believe there are 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 body imagery like this. Arnold Mindell writes of this well in his early books about the ‘Dreaming Body’.⁴³

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*⁴⁴ (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).⁴⁵ Some people have very high scores, so I sometimes tell them I think they deserve a medal for still being upright and walking around.

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 of stress. This can help reduce some of the guilt that people feel for “not being able to cope”. I describe something about

⁴³ 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

⁴⁴ Holmes & Rahe: *Development of the social readjustment rating scale*. 1967

⁴⁵ Available as a PDF download on the ‘Articles’ page of Courtenay Young’s website: www.courtenay-young.com

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 employees⁴⁶ 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 OCDs⁴⁷, 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 questionnaire⁴⁸ as well, and, if appropriate, get them to fill in a BDI (and/or BAI) or a PHQ-9⁴⁹, 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. I am a strong advocate of guided self-help.⁵⁰

This is within the context of working in GP surgeries or for Employee Assistance Program (EAP) companies, giving brief psychotherapy and counselling to patients or employees. The primary

⁴⁶ 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.

⁴⁷ Over the Counter Drugs: abusing non-prescription medicines (eg: solphedine, etc.).

⁴⁸ CORE: Clinical Outcome Research & Evaluation: www.coreims.co.uk

⁴⁹ Beck’s Depression Index, or Beck’s Anxiety Index (both were used as standard measures in the NHS). PHQ-9 is the Patient Health Questionnaire (9 Questions) screening for depression.

⁵⁰ Young, Courtenay (2010). *Help Yourself Towards Mental Health*. London: Karnac Books.

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 an inherent 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'.

This is not to say that this sort of work cannot be very effective. My current average is 5.6 sessions for about 100 referrals within a year and my effectiveness is currently being researched by looking at (analysing) the completed CORE forms.

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, or a slap on the back, and, with women, an occasional chaste hug on arrival and departure, but only for people who are well-known. Most people in Scotland are usually quite 'staid'⁵¹ and a hand-shake is the extent of formal contact. I have now been living here, for the most part in a very conservative rural area, for nearly 25 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

⁵¹ 'Staid' - sedate and settled in habits or temperament, sometimes to the point of dullness.

can be encouraged to give their own process sufficient time and respect in order to allow it to shape itself. Thomas Moore⁵² 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 Movement⁵³ can be a very useful format or method of exploring these aspects of themselves. Here the therapist just ‘witnesses’ the person’s non-directed movement (often done with their eyes closed) and then relates this back to them non-judgementally, but also reflectively. Tai Chi is another way of integrating one’s process somatically.

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 interchanges on the chair or the couch can miss out on some important aspects of these forms of self-expression; their diversity, depth, dynamics 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 within those parts of that person’s process that we are privileged to share. A new journal explores the relationship between Body, Movement & Dance in Psychotherapy.⁵⁴ 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 even explore their visceral imagery as it emerges in wet paint or clay (Art Psychotherapy).

EMDR

Eye Movement Desensitization & Reprocessing is a relatively new technique, discovered (invented) 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 especially from phobias to trauma and panic attacks. The person ‘tapping’ certain areas of their body

⁵² Moore, Thomas: *Care of the Soul* (1992) New York, Harper

⁵³ Authentic Movement: www.authenticmovement-usa.com or www.naropa.edu/movement

⁵⁴ Payne, Helen (ed): *Body, Movement & Dance in Psychotherapy*. 2005, Abingdon, Taylor & Francis:
<http://www.tandf.co.uk/journals/titles/17432979.asp>

reinforces the eye-movements. This supposedly works by affecting the traumatised areas of the limbic system, and effectively re-balancing the different hemispheres of the brain,⁵⁵ however there are several unresolved speculations about this method. There may also be some connections to acupuncture meridians and similar energies. I do not have any great 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, and it is accepted as a recognised treatment within the NHS (usually practiced by Cognitive Behavioural Therapists with little or no understanding of body dynamics), 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. Arnold Mindell uses them as reflections of the person’s inner somatic processes as well:⁵⁶ 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 processes, their inner experiential, moving and changing world, and with what is coming up to the surface (consciousness) 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.⁵⁷ Gestalt psychotherapy often works with

⁵⁵ “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>

⁵⁶ Mindell, Arnold: *DreamBodyWork* (1987) London, Routledge

⁵⁷ 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 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,

images, as does Jungian Analysis, and several other psychotherapies. 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.

Qi Gong are a set of exercises associated with Tai-Chi: these encourage flexibility, centering, balance, and graceful movement, etc. as well as educating the body in some of the basic Tai Chi movements and form.

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 Karate, Tai-Kwon-Do, or 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 in this category, 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"

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

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 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.⁵⁸

In body-oriented psychotherapy groups, I tend to use two forms of guided meditation quite frequently: one is called "*The Body That Brought Me Here*,"⁵⁹ that acts as a simple review of the person's history with respect to their body, and the other is an "*Evolutionary Meditation*"⁶⁰ that acts as an awareness of how our human body evolved.

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.

One theory⁶¹ 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.

⁵⁸ Scientific American 226: 84-90 (1972)

⁵⁹ Available as a PDF download in 'Articles' section of Courtenay's website: www.courtenay-young.com

⁶⁰ Available as a PDF download in 'Articles' section of Courtenay's website: www.courtenay-young.com

⁶¹ Goleman, Daniel: *The Meditative Mind: Varieties of Meditative Experiences*.. Los Angeles: J.P. Tarcher, 1988

Mindfulness

I am also including various “Mindfulness” techniques here that are becoming particularly popular, especially within Clinical Psychology and with Cognitive-Behaviour Therapists (CBT), who are now using these techniques reasonably successfully on their patients or clients, mostly for anxiety and stress reduction and pain control.⁶² This way of working with Mindfulness 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. I deal with this topic more fully in a second article on this topic.

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 became especially popular since the 1970s – that plot a person’s heart rate, electromyogram (EMG); galvanic skin responses (GSR) or electrodermal response (EDR); temperature; or electroencephalogram (EEG); have all been shown to be quite effective to help the person lessen anxiety states, reduce severe stress, or cope better with pain.⁶³ Acupuncture point machines, that can replace needles, are also now available.

There is a computer program called “HeartMaths”⁶⁴ 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 bit on the usefulness and significance of this particular tool. There are also well-established devices like the ‘Tens’ machine⁶⁵ 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

⁶² 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.

⁶³ Biofeedback: www.holisticonline.com/biofeedback.htm

⁶⁴ Being demonstrated at the USABP Conference in Tuscon, June 2005: www.heartmath.com

⁶⁵ TENS: Transcutaneous electro-nerve stimulator pain control unit.

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 suggest a ‘light box’ for some people whose depression seems to be seasonally affected (SAD⁶⁶), especially as we are living in the north of Scotland, with very short winter days, and many of them often with poor weather, “*drich, dreer and drab*”.⁶⁷

Conclusion

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 pre-requisites 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. I repeat, I am not against using touch, but it can be used improperly or inappropriately, especially if the Body Psychotherapist does not have other ways of working or techniques that might be more appropriate at that moment.

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 a 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, feely’ ambience than when 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

⁶⁶ Seasonal Affective Depression

⁶⁷ “wet (drizzly), dull and grey”

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 shown that it is perfectly possible to do effective work as a Body Psychotherapist without necessarily 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.

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