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Contents

Editorial	2
News review	4
Interview	6
David Peters interviews body-psychotherapist Babette Rothschild	
Events	11
The new anatomy: is the ego more than skin deep?	13
Roz Carroll	
Craniosacral touch and the perception of inherent health	19
Howard Evans	
The sense of touch – a philosophical surprise	24
Bevis Nathan	
Cytoskeletons – the beautiful matrix	28
Touch therapies: the curious researcher	32
Peter Mackereth	
Breathing, chronic pain, touch and the body-mind	39
Leon Chaitow	
Persistent pain	46
<i>Extract from 'Family Health Guide – New Medicine'</i>	
From the frontline	51
William House	
Research summaries	52
Reviews	55

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Editorial

David Peters

Editor-in-chief



The power of touch: bringing body and mind together

The bodies practitioners touch are likely to be full of feelings, and sometimes manual interventions can feel quite invasive. But we perform them because we believe an examination could reveal something important, or that skilled manipulation could promote healing; sometimes we touch to comfort or support. Often, the emotional consequences of our touching are what determine whether a manual encounter will help or harm. This issue of *JHH* contains papers exploring the power of touch, and what it has to tell us about a more holistic approach to the practitioner-patient encounter.*

Whether in the technical probing and palpating of a doctor's clinical examination, the intimate physicality of nursing tasks, or a chiropractor's careful adjustments, healthcare and touch go hand in hand. Yet even the most mundane medical touch involves more than just contact between dumb mechanical objects. In living bodies, being touched triggers cascades of biochemical changes, and sparks off electrical impulses and shifts in biomagnetic fields. What's more, since the body is – as the phenomenologists put it – *lived*, touch can summon up feelings and memories, sometimes unexpectedly. The act of touching initiates a two-way flow of information; a multi-layered flow affecting two sets of mechanical, biochemical, emotional and cultural bodies. In the following pages in his article *The sense of touch – a philosophical surprise*, Bevis Nathan considers the extraordinariness of touch, and the way it lays a foundation for our sense of being in the world.

Given that our emotional and physiological stability are rooted in mother-touch and attunement, might it be that subtle sensitivities to touch and emotional 'resonance' persist? Knowing that the skin is a personal boundary as well as a sense organ, psychotherapists are wary of touching their clients for this very reason. Psychoanalytic therapists know the considerable potential for practitioners to 'catch' moods and emotions from their patients even where no direct contact is involved. They call this counter-transference. Neuroscience is providing a way to make sense of this, with the discovery of 'mirror-neurons' in the brain whose function it is to mimic the activities of those we

are with; a subliminal resonating which suggests we are hard-wired for empathy. This has great relevance for all who touch professionally or work with emotions. For if mirroring is a fundamental human activity embedded in our neurobiology, it implies that counter-transference is more than just a psychological process, and that some kind of resonance-like body-to-body communication is involved. So practitioners who work on the body need to be aware that touch entails an exchange of emotional as well as physical energies. Therefore – as body-psychotherapist Babette Rothschild tells us in this issue – health professionals need to sense and use boundaries consciously: Effective therapy and the avoidance of harmful exchanges of intention and emotion depend on this ability. As she reminds us, context is everything where touch is concerned. For when we touch, things happen not just between two bodies, but between two people. These events implicate the practitioner's feelings and intentions, and form a social dimension, where consequences, responsibilities and ethics have to be considered.

In the act of touching, consciousness, conscience and culture intertwine: something that nursing research has kept in view. Yet though nursing and body-oriented psychotherapy have become deeply curious about touch, mainstream medical research and practice have largely ignored its impact on body and mind. Though medicine views touch as merely part of its technical procedures, massage researchers have shown that touch affects us physiologically. And thanks largely to the Miami Touch Research Institute we now understand more about how gentle touch improves autonomic regulation, immune functioning, respiratory function, cardio-vascular health, and even infant development. This should lead medicine to take touch more seriously, for though our understanding of touch and the human mind-body has been a jigsaw with too many missing pieces, the neurobiology of emotion now helps us sketch the picture on the lid. And the picture is very different from the Cartesian one that sundered mind and body. For instance it appears that emotions are not – as Antonio Damasio convincingly explains in his book *The feeling of what happens*¹ – something inside the head. And neuroscience confirms something fundamental observed about our emotional development which was

first described by psychoanalysts: a baby's feelings are powerful unfamiliar bodily processes, autonomic turmoil they must struggle to make sense of. Infant mammals crave touch and contact because it makes these overpowering sensations, and bodily existence itself, feel safe. Functional MRI brain scans map the neurobiology of what psychoanalyst Donald Winnecott witnessed: babies with 'good enough mothers' deal more easily with emotion because their brains are better at regulating autonomic arousal. This trait persists beyond childhood, and could crucially determine a person's susceptibility to illness.² In her article *The new anatomy: is the ego more than skin deep?* Roz Carroll writes about the way our sense of self arises out of the body; and how input from skin and muscles creates the boundary and schema for the body-mind to make sense of itself, while the mother's body enables the baby's body to regulate itself.

A baby deprived of touch grows more slowly, has a sluggish immune function, and a fore-brain that remains relatively immature. So no wonder the human need for touch is deep and enduring, and why touch can calm, and be so powerful a trigger for the healing process. Because the body is a verb – something lived; a notion preserved in all traditional medicine systems. For rather than cutting the body up to understand it, they observed the strange ways living bodies behave in sickness and in health, and in drawing their conclusions, it never occurred to them that mind and body could be separated. The body-oriented psychotherapies – those other outsider healthcare disciplines – are equally rooted in that same felt-sense of embodiment and an awareness of the body as alive and lived. They have kept body and soul together, just as traditional medicine systems have, and they too are fascinated by vitality. Both groups describe the body's felt-sense in terms of flows and blocks, harmony and balance, and use the same 'energy' language. Yet the growing popularity of methods such as mindfulness practice, yoga, craniosacral therapy, EMDR, and emotional freedom technique among psychotherapists suggests increasing acceptance of the idea that distress isn't just in our clients' heads. But it takes a very special skill to touch that distress in the body, then contain and transform it. Howard Evans, reflecting in this issue on *Craniosacral touch and the perception of inherent health*, points out that certain kinds of touch therapy, but craniosacral therapy par excellence, depend on a highly developed sensitivity to subtle shifts in bodily tensions and rhythms, and the therapist's ability to sense still points in this flow.

Effective psychotherapists too develop their ability to quietly notice and contain emotions that their clients cannot. Similarly sensitive body therapists, by stilling themselves, may contact and mobilise the body-mind's inherent potential for self-healing. The parallels seem striking and a re-owning of the lived body would be an important shift not just for psychotherapy, but for our

whole model of healthcare, which has kept subjective illness and physical disease so strictly apart. Once we realise that our client's lived body is very often awash with embodied emotions we begin to notice breathing patterns disturbed by thoughts, feelings or memories; postures sculpted by mood or temperament. This idea of two-way traffic – mind affecting body, body affecting mind – may be novel to the mainstream, but it's old news to the holistic health worker. Nevertheless, neurobiology is helping illuminate some mysterious and challenging aspects of complementary and body-centred clinical practice, in particular their work with post-traumatic stress disorder and persistent pain. Leon Chaitow in his article *Breathing, chronic pain, touch and the body-mind* raises the question of where patients with medical undiagnosed physical symptoms fit into our medical system. The symptoms of 25–40% of patients referred to hospital outpatient clinics are not fully accounted for by organic disease: patients with fibromyalgia, irritable bowel syndrome and chronic pelvic pain, for example. Leon explores the current understanding of such complex multi-symptomatic conditions and how commonly breathing pattern disorder may have a bearing on their problem.

Unless medicine comes to understand the emotional body more, and the ways it disturbs mind-body healing processes, its ability to restore health and wellbeing rather than treat established disease will remain very limited. In order to be better able to trigger self healing, holistic mainstream healthcare will eventually incorporate the best of complementary medicine and embodied psychotherapy, dance and movement therapies. In a few pioneering centres, such as the Regional Cancer Centre at the Christie Hospital in Manchester where Peter Mackereth works, this already happens. Peter draws on his experience there, in his paper *Touch therapies: the curious researcher*.

* To encourage greater understanding between all the disciplines who have a stake in this expanded vision of healthcare, the BHMA and Confer organised a conference in London in November 2007. The Power of Touch brought innovative practitioners together to explore these themes and the potential for a more psychologically-aware approach to bodywork and a more body-aware approaches to psychotherapy. Our conference aimed to advance an integrated bio-psycho-social understanding of touch, presenting new developments in neuroscience, holistic understandings of the mind-body systems and psychology. This issue of JHH collects the papers these practitioner-researchers contributed to this event.

References

- 1 Damasio A. *The feeling of what happens: body, emotion and the making of consciousness*. London: Heinemann, 1999.
- 2 Su Gerhardt provides a useful digest of research into attachment neurobiology in her book *Why love matters: how affection shapes a baby's brain*. Abingdon: Routledge, 2004.

News review

Climate and health – a call to action

A Climate and Health Council has been formed to mobilise health professionals and health managers to take action to limit climate change. It has been launched with help from the *British Medical Journal*.

It will feed into the United Nations Climate Change Conference in Bali in December, together with a set of specific requests to the countries participating.

'Given the importance of climate change to global health, we believe the health voice must argue loudly for international support for a global implementation framework, to replace the Kyoto protocol,' say the council's co-chairs Robin Stott and Mike Gill.

They are asking for signatories to a declaration and call to action. For more information go to www.climateandhealth.org.

National strategy on health for health professionals

A national strategy on health for health professionals will be led by Professor Alastair Scotland of the National Clinical Assessment Service (NCAS). It is one of seven work-streams established as part of the programme to reform the UK's system for regulation of health professionals.

As *JHH* has often reported, all too often health practitioners deny that there is a problem and fear the consequences of admitting to one. The result is that practitioners may seek help only when it has reached a point where their livelihood and registration may truly be under threat. On the other hand, many of the high profile health problems in health professionals, particularly in doctors and dentists, focus on mental

health and substance misuse. These are eminently treatable.

One of the most important challenges is to ensure that a framework to guide services for health professionals commands the confidence not only of the professions themselves and their employers and contractors, but also that of patients and the public.

Little Orchids bloom with health

The Little Orchids centre in Co. Londonderry, an 'exceptional nursery' which transforms the lives and opportunities of toddlers with special needs and gives support and respite to their parents, has won the top prize (£2,500) in the 2007 Northern Ireland Integrated Health Awards run by The Prince's Foundation for Integrated Health.

The awards put the spotlight on the best examples of health projects which treat people 'holistically', which means taking account of their emotional and psychological wellbeing as well as their physical health, and looking at how people's environment can help and hinder health.

Two other projects were highly commended in the awards. The Mater Green Gym project, run by the charity Conservation Volunteers Northern Ireland in partnership with Belfast's Mater Hospital, helps people with severe, long-term mental illness who are being treated by psychiatric services in North & West Belfast. The project gets the patients involved in conservation work, with the benefits of healthy physical activity, co-operation, social interaction, volunteering, teamwork and boosting self-esteem. The other runner-up, Rethink Northern Ireland, based in Belfast, was commended for its self-management programme which involves self-help groups for people who have experienced severe mental distress

such as schizophrenia. The programme helps them to live more positively, to identify the changes they want to make in their lives and to believe in their ability to achieve their goals.

HPC case study appeal

The Health Professions Council is seeking case studies for inclusion in their UK-wide media campaign to promote the importance of choosing a regulated health professional. It is looking for registrants who have treated a patient who has come from an unregulated health professional following less than adequate treatment.

If you or anyone you know might be willing to help, please email your name, profession (if applicable), a brief summary of your experience and your contact details to: casestudies@hpc-uk.org.

Help on what integrated health is

The Prince's Foundation for Integrated Health is launching a new website in December focusing on bringing some clarity to the muddy waters of exactly what integrated health is.

Some people still see 'integration' in health as little more than referral to complementary practitioners from a doctor's surgery. The Foundation plans to show how our health comes from dozens of factors in our lives – worthwhile work, fresh air, a good built environment, a sense of community. It also looks at how patient choice and access to stress-relieving therapies can help us when sick.

The site will carry interviews with many of the innovators in the field: from individual GPs who run integrated surgeries, to campaigners and patients, to scientists who are making new discoveries about the roots of health. It will highlight some

of the best integrated schemes from across the country. It will also debate the difficult issues: is it really possible to offer integrated health on the NHS? What part does placebo play in medicine, and how should we respond to its effects?

Blogs, polls and 'leave a comment' functionality will mean that readers can make suggestions, query evidence and ask questions. The Foundation hopes that it will become the online 'home' of integrated health in the UK – a place where healthcare workers can go for fresh thinking, debate and inspiration.

New integrated medicine charity

Integrated medicine pioneer Dr Rosy Daniel and a group of trustees have formed a new integrated medicine charity to create a 'visionary integrated health resource'. This is pitched as 'a world class facility offering inspiration and a multiplicity of life-enhancing experiences to improve health and well-being and create an uplifting sacred space through the synergy of beauty, nature, the creative arts, ecology and holistic healing'.

It will be set in the heart of the English countryside within organic land and promises:

- a school of integrated medicine and integrated medicine research
- a clinic of integrated medicine with day and residential care facilities
- assisted living accommodation for integrated care of the elderly, with 'spiritual midwifery' for end-of-life transitional care
- pro-active health education for prevention of illness and generation of positive health
- healthy recreation for the wider community where young people of all ages can enjoy the creative arts, inspirational performances, ecological and self-development courses, exhibitions of art and exemplary environmental practice

and the opportunity to explore and work with the natural world.

Dr Daniel and her colleagues hope to achieve this vision through key partnerships with Britain's leading integrated medicine providers, educators and researchers; ecological agencies; horticultural visionaries; facilitators of creative arts and self-development; and inspirational architects and landscape designers.

To find out more, contact Dr Daniel at doctors@aphorpcentre.com.

Natural menopause kit

If you or a patient are going through the menopause, there is plenty of help around – including healthy eating, regular exercise, dietary supplements, complementary therapies and positive thinking. Now, you can also try Maryon Stewart's holistic programme – the Natural Menopause Kit – to ease your menopause symptoms and improve your overall health.

Maryon's Natural Menopause Kit includes a magazine-style workbook, a full length feature film on DVD and a hormone testing kit. It addresses solutions for some of the biggest midlife health concerns, including building strong bones, boosting your memory, easing hormone-related stress, bloating and weight gain and, above all, making informed choices about treatments.

'Not all women can, or want to, take HRT, so it is important that they are able to help themselves with measures based on sound medical advice,' says Norma Goldman, founder and director of The Menopause Exchange, an independent information service on the menopause and midlife issues. 'Maryon's National Menopause Kit contains sensible nutritional and lifestyle recommendations so that women can make informed choices about the treatments they use.'

The Natural Menopause Kit is available from www.askmaryonstewart.com or call 01273 609699.

READER'S LETTER

Having read the report *Medicine as if People Matter* (JHH May 07)

I feel inspired to write to congratulate members of the focus group for their perception and understanding, and for getting right to the point of what healthcare is all about, *people*, and the benefits of nurturing, valuing and empowering them. These are the values to which I aspire in my work with Emotional Freedom Techniques (EFT), which provides the perfect tool for this. In my voluntary work with an ME support group, I see so much evidence of medicine forgetting that people with ME/CFS are people with feelings and needs, when they send them away to deal with their suffering in isolation because medical science with its limitations has yet to devise a test to prove what is 'biologically' wrong. I therefore particularly welcome the group's identification of people with long-term conditions and people with medically unexplained physical symptoms as patients whose needs are poorly met in the NHS, and the proposal that the mission of the BHMA should be to do work that supports these groups. I feel proud to be a member of such an organisation and fully support this 'Medicine as if people matter' focus. A big thank you to all involved.

Jacqui Footman, EFT & NLP Practitioner/Trainer, North Devon www.free2Bme.co.uk.

The body and its boundaries in therapeutic relationship

David Peters interviews body-psychotherapist **Babette Rothschild**



I have found it safest to approach trauma therapy in a similar way that I approach driving an automobile. My logic stems from the observation that both driving and trauma therapy involve controlling something that can easily go out of control. It is not a good idea to proceed with directly addressing a traumatic incident – accelerating trauma processes in the mind and body – unless both therapist and client know how to find and apply the brakes: stop the process if it becomes too uncomfortable or destabilizing.

Summary

Mirroring is a fundamental human activity embedded in our neurobiology, and explains why practitioners may 'catch' emotions from their clients. So 'counter-transference' is not just a psychological process: body to body communication involves the exchange of physical energies too, especially where bodywork is concerned. If bodyworkers are unclear about their own physical boundaries, they would do well to learn how to sense, create and use boundaries better, because effective therapy and the avoidance of harmful exchanges of intention and emotion depend on this ability.

David Peters (DP):

One of the British Holistic Medical Association's concerns is values-centred healthcare practice and how to stay heart-centred. We swim against the current of impersonal practice, because we believe that who you are matters a lot, and that how you relate has a huge impact on all treatment outcomes. I know you are someone whose roots in bodywork go back at least 30 years. You bridge the fields of touch-based therapies, psychodynamic psychotherapy, body-centred and trauma work, and your clinical experience and understanding of neuroscience advances has led you to develop a core of techniques that I believe are important for anyone whose work aims to help people. So how can we learn and teach about the reality of person-to-person entanglement? There is a good side and a bad side to it and the bad side is re-traumatised patients and practitioners with vicarious traumatization; something that affects many mainstream health practitioners, did we but know it.

So what is your 21st century understanding of how people affect one another deeply in healthcare consultations?

Babette Rothschild (BR):

Well, I think there are several levels of understanding. It's important to pay attention to some of the 20th century and 19th century accounts of transference and countertransference. But we have a 21st century understanding of the neurophysiology of communication and empathy, and that's been catapulted forward by the discovery of mirror neurones.

DP: That was the research with the grasping monkeys wasn't it?

BR: Yes, in Italy in the mid 90s. Researchers studying grasping behaviour in monkeys were trying to nail down which neurons fired when a monkey grasped a piece of food. Their instruments could tell that a particular neuron or neurons would fire when the monkey grasped a raisin or a peanut. Then one day during

the break, while the monkeys weren't eating, a researcher casually walked by and picked up a piece of the food. *The same monkey neurons that had fired when the monkey grasped food fired when he watched the researcher grasp food.* And so it appears certain neurons in our brains respond to behaviours in others as though we were doing the behaviours ourselves.

So, for example, when you are watching downhill skiing on television, your thighs tighten up without you thinking about it. That's the activity of mirror neurones: your brain recognising the stress that's on the skier's thighs, as he manages those moves, and so your thighs tighten up in a kind of empathy. So your body seems to know what another body is doing and feeling. No one has talked about this in relation to pornography but I suspect that's one of the ways that pornography works.

DP: The study of the yawning reflex and the smiling reflex aren't new, but I understand some researchers are taking it further than just a body-to-body reaction, and looking at how these mirroring interactions also affect us emotionally.

BR: That's right. And if you put 20th century research on psychology and social psychology on emotion and facial feedback and postural feedback together with mirror neuron theory (which I have done in my third book *Help for the helper*) then it makes it pretty easy to understand how, when we are sitting together with another person, our facial responses, our breathing responses, our postural responses, allow us to 'suss' the other person consciously and unconsciously. And we can do this at a distance, without even having to be touching them.

Take breathing: I think a lot of massage therapists and craniosacral practitioners synchronise their breathing with clients – sometimes deliberately. But a lot of therapists who never work with the body know that if they slow down their own breathing, an anxious or panicky client will calm down. Breathing can be a very powerful communication tool without any words having to be exchanged. But I do think there is more to it when you are working with massage or craniosacral therapy.

And another non-verbal intervention that I have found helps people is when the practitioner focuses on making more of a boundary at the hand-body interface. It's very important for practitioners to be able to choose consciously either to separate themselves or to merge at this boundary. And I'm finding that when they develop more choice about how they work at that boundary, a lot of communication – unconscious and sometimes conscious – begins to happen. As yet I don't have

a scientific basis for saying this, but I am working with it, and bodyworkers tell me it seems to hold water.

DP: Does that mainly involve thinking about the boundary and imagining where it is?

BR: That's a part of it but it's also most importantly a matter of physically *feeling* it. I've found that a lot of people who work with massage or craniosacral therapy don't have the defence of a consciously made boundary at the surface of their hands.

DP: And possibly they don't even want one.

BR: And possibly they don't even want one! But my point is that practitioners *should* be able to create that boundary with their hands – and have the choice of using it. The trouble is, if you don't develop the ability, then when you really need the boundary, it won't be available to you. But once you've developed the ability, you can choose whether you use it or not. And there is power in being able to choose.

DP: So as well as exchanging various forms of biophysical energy – pressure, electrical and magnetic energy and pulsations from the body – we have all this potential for mental-emotional entrainment and its benefits and hazards. I should think all experienced bodyworkers have experienced old shocks as clients relax or as they make some sudden association between your touch and embodied memory. Given that this quite commonly happens, why don't we hear more about the downsides of mirroring in touch-based therapies?

BR: Well, you know, in the trauma fields we are getting more and more information on that, and my book *Help for the helper* is far from the first and won't be the last word on the topic. But in bodywork, I think people who are very committed have been hesitant to consider the downsides, perhaps through fear of what they might have to stop doing or do differently; or because these ideas don't fit with their philosophy. My point of view is that practitioners should have lots of tools to choose from, and should give clients tools so they can choose too.

DP: Bodyworkers might say touch is all they need.

BR: I remember a conference in the late 80s, early 90s, a Reichian colleague saying 'Well I have to really touch my client! How can I work with anybody if I can't touch them?' And I think that showed a lack of options; not a lack of commitment or caring, but she didn't know any other way to work. So if I'd come along and said 'Look, touching will benefit some clients, but not all, and sometimes touch will

even upset and disorganise certain kinds of client,' I think that would have been a very threatening concept for her.

DP: Can you tell me more about some of these options?

BR: OK, one option is different kinds of touch so that you don't always use the deepest kind of touch or the most unbounded kind of touch, but can also use touch to *make* a boundary rather than dissolve the boundary. If you think about it, a lot of the people who come to us have trouble with the boundaries out in the world, right? And if in the work with them we are only doing unboundaried work, how are we helping them? For example physical therapists in Scandinavia working in psychiatry sometimes do their touching work explicitly to help the client have more of a boundary. So though we usually think of touching and boundary-making as being antithetical, actually touch and boundary-making can be great partners and can be used to develop skills both for practitioners and patients.

DP: I suppose until somebody presents you with the notion of boundaried and unboundaried work most bodyworkers probably won't have considered these issues. So can you give us some examples of unboundaried touch?

BR: Well, I would say any time when the therapist can't feel the surface of their own hand, and the client can't feel the surface of their own body, and in that sense they are merging. That certainly happens in some kinds of cranial touch – and maybe in many other kinds of bodywork that's hands on.

DP: I guess so, and though in deep massage you could say you were really making the boundary obvious by the presence and pressure of your hand, in fact you could be intruding inside the patient's boundary.

BR: Right. And especially with somebody – patient and/or therapist – who already has boundary problems, that boundary won't be clear.

DP: And so that's obviously the case with somebody who has been traumatised and by definition their boundaries have been disrupted.

BR: Right. And of course patients (even more so therapists) won't usually suspect they have a pre-existing boundary disruption. I will give you an example. Years ago when I was living in Denmark, I was a consultant for a centre for working with traumatised and tortured refugees (in Copenhagen which was that movement's birthplace) where they use a team approach with a psychologist, a social worker and some kind of bodyworker. So I was a

consultant to the bodyworkers there, and I was trying to put this concept of the boundary across, and how sometimes when you are already touching somebody they actually can't feel their boundary. So I walked from a distance towards one of the therapists and I said 'Where do you feel a boundary?' and he said to me spontaneously 'Whoa, step back you are too close, I can't feel my boundary yet', and I said 'What did you say?' (because I wanted to drive home the point that sensing the boundary happens spontaneously once you're alerted to the possibility that it exists). Later, when we talked about this experience I said 'You know, some of your clients – not all of them but some of them – when you are already beside them or touching them and you say 'Is this ok, is this ok? Is this ok?', are going to say 'yeah, yeah, yeah' but really you are already too close for them to be able to feel their boundary.

DP: So what's the answer?

BR: Well with some patients you may want to start by being further away from them, so that both of you feel your boundaries; and then being slower in your approach, maybe over several sessions, so that they begin to feel the boundary more, until they can be more in control of what you are doing with them. And you too can more clearly experience your own boundary, and that will help you self-regulate and let you sense how things are affecting you.

DP: So in a session with somebody who is traumatised, you might not begin to touch at first; you might just experiment with 'Am I too far... am I near enough... am I the right distance from you?'

BR: Right! Then when you do go on to touch, you might tentatively negotiate trying it on different areas of the body. 'So when I touch you *where* on your body do you feel calm; when I touch you *where* on your body do you feel agitated? In what way do you feel more calm or agitated? Is it OK if I press hard or if have a very light touch or somewhere in between? If I move when I am touching you, if I am stationary when I am touching you...?' All those things are important in the dynamics of the treatment.

And with some people who have problems with boundaries, one of the best things you might do before you go in to touch them and really work with their bodies, is teach them how to stop you. So they know how to turn away from your touch or move your hand away; so they feel more in control of what is going on. I think one of the problems with some kinds of bodywork is that patients lie down passively while the therapist does what they want. But when you are doing that with somebody

who has been traumatised, the potential for re-traumatising is obviously huge. And even if you are not technically re-traumatising them, the potential for them to space out and dissociate is also very great. A lot of people when they get massage, they fall asleep. How often is that because they are really relaxed and comfortable and trusting and how often is it because they are actually dissociating? I don't know the answer, but I am sure it happens a lot.

DP: I am sure you are right. But you are asking questions about bodywork that I have never heard anybody ask before. But to return to the other point you made about the 19th and 20th century understanding of boundaries: that's something we have been teaching on a postgraduate course at Westminster called the therapeutic relationship. We use psychodynamic notions to help bodyworkers understand the emotional mix-ups caused by projective identification, transference and counter-transference. And they often say they find these very helpful ways of thinking about what's going on when things get difficult. Do you think psychodynamic object relations knowledge helps bodyworkers to think about and put some language around what goes on in the touch therapy transaction?

BR: Absolutely; with the proviso that they update their understanding of projective identification (PI) with a 21st century understanding of the brain. Because the old concept of PI can be dangerous to clients: the really classical understanding of the client putting things into the therapist. But if you understand mirroring as neurophysiological, you won't blame the client for putting feelings into you; that it's your brain responding to your client, not the client doing stuff to you, but you who are taking stuff up. And you can be in control of that.

DP: And we do this all the time, because we are constantly picking up resonances. I think that's inevitable in human society but we haven't understood yet how we regulate or dysregulate one another. So what's your advice for us when we pick up a projection or we have resonated deeply with something counter-transferential and disturbing? What should we do? How do we clear it?

BR: I think you have to step back, and that's where our basic tools of mindfulness and body-awareness can help us separate out what's ours and what's theirs. Sometimes you just have to track back to the point of asking 'where did I pick that up and how was I vulnerable to it?' It's not an easy set of skills to acquire, but I think anybody working with other people needs to have them, and I think we are getting better and better at learning them.

DP: I think the neuroscience helps. Has the science got so far that we can ask about the anatomy of what's resonating when we get a problematic resonance? You said mirror neurons are part of the picture, but it's a body-wide process isn't it?

BR: It's a body-wide process; but rather than relying on the objective neuroscience at this point, I think we need to use mindfulness to discover the processes at work inside ourselves. Because mirror neurons can be triggered by breathing patterns, by facial expression, by changes in posture or movement. Anybody can be vulnerable to mirroring from all these as well as other senses, but individuals probably are more prone to picking up on one or the other. So when I do *Help for the helper* workshops I have people pay attention to their own particular vulnerability, and help them pay attention to what they are conscious and unconscious of; in particular how absolutely normal it is for humans to mirror. For example I always ask students to go out to a café and watch couples talking, and observe how, when one smiles the other often smiles, and when one frowns the other frowns. And how often postural changes synchronise: one crosses their legs, then a few seconds later the other crosses their legs. And especially to notice the breathing: if one person is breathing heavily, the other will breathe heavily; or if one person's breathing is shallow, the other's breathing will be shallow. I do this to give students an observational tool totally outside the clinical situation, because then they will start bringing that awareness into their therapeutic work, and begin to notice that when the client smiles, they smile, or when the client is crying their face is screwed up in a similar kind of expression; if the client takes a deep breath and sighs, that they do so too.

DP: Something I have recently had my attention drawn to is that when I am with a client who is talking in a dreamy dissociated way, I also begin to talk in a dissociated tone, which is the very opposite to what would draw them back in to their boundary. So our chameleon-like communication may actually become a counter-therapeutic force if we are not very careful. I think you are suggesting that many different aspects of our neuromuscular frameworks can resonate, and that autonomic destabilisation may follow.

BR: Yes, and once again mindfulness and body-awareness come in very handy, not only to let you recognise and track what's happening in your client's autonomic nervous system, but also to track it in your own. Because our ANS systems may mirror too. And clients have to keep their arousal low enough so they can integrate what you are doing in

the work with them, but the therapist also needs to keep their arousal low enough in order to think clearly. Because if you lose your ability to think clearly, all sorts of things can go awry. This tracking is a mindfulness process, and it requires you to sit back and take a break. So while you give your client a moment to track what is going on in their body, you can be checking out your own at the same time. And I really recommend people take little 30 second breaks periodically to check in with themselves during the consultation.

DP: And it's necessary because otherwise we may just get drawn off into other people's dream-time?

BR: Right – and if you do that, you will lose your own ability to think clearly, and that is where you are really going to take on someone else's unconscious emotional material and be unable to distinguish what is yours and what is theirs. And that is when you get into trouble. Taking on stuff from other people isn't a problem as long as you know you are doing it and what it is; where it becomes a problem is when you don't have awareness of it and you confuse it with your own. So if my client is really sad and I am not paying attention to the resonance, and I am mirroring their feelings into myself, then when they leave I could be left feeling desperately sad or depressed. I might start wondering where that feeling is coming from, and then start remembering when my mother died, or maybe how my relationship broke up. This kind of 'empathy' becomes completely confusing when you can no longer distinguish clients' feelings from your own. Then you are in trouble.

DP: Yet so few of us are taught the simple fact that emotions can be catching! Developing a proper boundary with our mental and body awareness is a sort of a psychological barrier nursing. But here is a question about 'difficult' or 'heartsink' patients. I think they are usually patients who leave doctors feeling desperate or anxious or depressed or terrified. But they are also patients who have a dissociative disconnection between their emotions and their generally unexplained physical symptoms. (I think early trauma may figure in many such patients' stories, and there is some evidence to suggest that's often so). So the GP colludes with the patient's overpowering need for a diagnosis and so refers to a specialist (sometimes repeatedly) until the patient is not only 'difficult' and 'heartsink', but 'thick-file' too! So the loop that began with two anxious people not knowing what the hell is going on in the room turns into a hospital full of people not knowing what is going on with that person, and the person getting

increasingly distressed because no one has thought to explain that their symptoms might be due to autonomic hyper-arousal. So I think high frequency consulting is a big issue, and the problem is made worse because a lot of traumatised people just aren't acknowledged as being traumatised.

BR: Well, what you just said is important: some people do need help to calm themselves down, but going for massage or bodywork that goes deeply into musculature won't help them calm down if they are among the many people who actually need to increase their muscle tone in order to calm themselves down.

DP: In which case they might need the kind of bodywork that helps them establish a boundary and a physical practice that helps them to increase tone or to discharge.

BR: Not discharge, to increase tone. People like that do not usually benefit from discharge because discharging loosens their boundary. If you think about emotional discharge, by definition it requires a decrease in boundary. So if somebody who is already quite boundary-less does more and more discharge they get more and more muddled. For those people, at least initially, reducing discharge, increasing containment, and increasing muscle tone will help them get under control. Only then might emotional discharge become useful.

DP: That makes sense. In our health centre, instead of doing massage, a massage practitioner would sometimes help somebody to do relaxation and breathing.

BR: Well relaxation and breathing would be very helpful for some. But some people find that doing deep breathing and relaxation will actually make them more anxious and more dissociated. And those people should be increasing muscle tone rather than decreasing it. My measure for people is calm or not calm rather than relaxed or tensed. I am looking for people to increase their calmness. If relaxation is the route to that, fine. If increasing tone is the route to that, then that's also fine. I don't care whether they are relaxed or not. I care whether they are calm.

DP: So what kinds of tonifying activity do you think of?

BR: That depends on the person and how they are built, but anything that increases muscle tone; push-ups, sit-ups, weight training. And for people like that the exercises should be non-aerobic, because increasing breathing rate and heart rate can also set them off, if it recalls an embodied memory of a traumatic event.

DP: OK. When somebody freezes during consultation I might actually try to unfreeze them by having them push against my hands. Or sometimes I have people stretch their arms or push their feet into the floor, or even push against me.

BR: Well, if those movements increase muscle tone that will help them. But if they encourage discharge, I don't think they will. For people like that, I don't think discharge is useful because again it decreases the boundary. And for some people pushing against the other person will be fine. But for someone abused it could trigger them into trauma, which is why it's better for them to push against their own body, like pushing against their own hands.

DP: We could be forgiven for feeling a bit despairing about ever getting quite sensitive enough to all the different possibilities there are in touch and body-centred consultations. But it is potentially a minefield isn't it? And I think we who are in body-work need to pay much more attention to our own mindfulness and to the boundaries of our clients.

BR: Well that's certainly my recommendation and, you know, the field is still fairly new. And in the old

days, people dived in without any consideration of these things and some people got sort of crazy from it and we are learning over time. We are certainly doing a lot better than we were doing in the 1960s.

DP: Yes, that was a great time for discharge and letting it all hang out, wasn't it? I have to say I think this is the time for integration. I hope so.

BR: Yeah, me too.

Babette Rothschild, MSW, LCSW, has been a practitioner since 1976 and a teacher and trainer since 1992. She is the author of three books, all published by W.W. Norton: *The body remembers – the psychophysiology of trauma and trauma treatment*; *The body remembers CASEBOOK – unifying methods and models in the treatment of trauma and PTSD*; and *Help for the helper – the psychophysiology of compassion fatigue and vicarious trauma*. After living and working for nine years in Denmark she returned to her native Los Angeles. There she maintains a small private practice while continuing to lecture, train, and supervise professional psychotherapists worldwide. She can be reached at babette@trauma.cc, www.trauma.cc. Her latest book *Help for the helper* is reviewed on page 55.

EVENTS



NOVEMBER

28 **Chiron. the wounded healer. An expert seminar at the Bristol Cancer Help Centre.** £75. See www.bristolcancerhelp.org.uk.

DECEMBER

1 **Exploring hand reflexology.** Christie Hospital NHS Foundation Trust, Manchester. £75. 10% discount introductory offer to BHMA members. Contact Peter Mackereth or Kathryn Harrison on 0161 446 8236 or email Peter.Mackereth@christie.nhs.uk.

1–2 **Resolving anxiety and panic states.** Christie Hospital NHS Foundation Trust, Manchester. £125. 10% discount introductory offer to BHMA members. Contact Peter Mackereth or Kathryn Harrison on 0161 446 8236 or email Peter.Mackereth@christie.nhs.uk.

3 **Researching into the arts and complementary therapies in healthcare.** A St Christopher's Hospice Education Centre event. £75. Email education@stchristophers.org.uk.

5–6 **NICE annual conference.** Details at www.nice2007.co.uk.

11, 12 & 13 **14th Annual Symposium on Complementary Health Care.** University of Exeter. See www.pms.ac.uk/compmed/symposium or email B.Wider@exeter.ac.uk.

JANUARY

21 **North West Regional BHMA Network Group.** Christie Hospital Rehab Unit, Manchester.

To publicise your event send details to Edwina Rowling at erowling@tiscali.co.uk. Deadline for next issue: 31 December 2007

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DAY 1 will focus on the surroundings in which we practise and how important they are for enabling person-centred healthcare. Keynote presentations will be given by **Dr Sam Everington** and **Dr David Reilly**. Sam Everington, who is currently a council member of the British Medical Association, is a GP at *Bromley by Bow*, a community regeneration project where enterprise, education, environment and health go hand in hand. David Reilly is lead consultant physician at the *Glasgow Homoeopathic Hospital* which has set out to create a place of beauty and healing, and in so doing offers a new model for a better healing environment.

DAY 2 will focus on patients and practitioners, and how to make **people** once again the healthcare system's over-riding concern. There will be presentations and workshops exploring what medicine needs more of – healthcare that integrates mind, body and spirit; better information and communication; mindful practice and a return to the values that first inspired us to become practitioners. **Speakers include Claire Rayner, president of the Patients Association, and Bob Sang, Professor of Patient and Public Involvement.**

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Programme may change without notice

The new anatomy: is the ego more than skin deep?

Roz Carroll

UKCP registered body psychotherapist

Summary

The ego – our sense of self – arises out of the body.

Sense input from skin and muscles creates the

boundary and schema for the body-mind to make

sense of itself. The infant's

skin ego is bound up with touch, and with the comfort

and contact needed for it to feel good inside its skin.

The mother's body enables the baby's to regulate itself.

As voluntary control of movement develops, the

muscle ego, which can deal with the world of objects,

and tolerate separateness, emerges.

I am a body psychotherapist, trainer and author. I started out as a biodynamic massage therapist nearly 20 years ago, and have maintained a constant interest in the role of touch in human relationships. My recent publications include chapters in *How does psychotherapy work?* (2005, ed. Ryan) and *About a body: working with the embodied mind in psychotherapy* (2006, ed. Corrigan, Payne & Wilkinson). I am now working on a book in which I hope to pull together the threads of neuroscience, 'new anatomy' and contemporary relational psychotherapy. Many of my articles are available on www.thinkbody.co.uk.

In the history of philosophy and pre-Freudian psychology, the word 'ego' (which is Latin for 'I') has usually meant the 'self', especially as distinct from the world and other selves. In psychoanalysis, the ego is the name for that conscious aspect of the psyche that most immediately controls thought and behavior, and is most in touch with external reality.

What is the ego?

If what we call the ego is that part of the self which has adapted to the social environment, then how does this sense of self develop? Current developments in neuroscience are helping map the ways that psychological process are embodied. This new knowledge has consequences for our long-held notions of ego as a mental function. In the language of complexity science, the ego is an emergent property of the highly complex (physical) human organism. At a certain level of complexity, self-regulation evolves to a level where the capacity for self-consciousness is emergent. But self-consciousness is also a product of socialisation: our ego functions derive from the capacity of the organism to know its own boundaries, to store information from experience, and to adapt to its environment. In a rudimentary way, these capacities are present in most forms of life. As we move from simple

organisms to animals these capacities become more developed and in humans they crystallise out at a further level of organisation, which is referred to as the ego.

'The operations that we call mind are derived from the structural and functional ensemble [of the whole body] rather than from the brain alone... The body is the ground reference... A feeling [is not] an elusive mental quality attached to an object but rather the direct perception of a specific landscape: that of the body'.

Antonio Damasio

Damasio tells us that the brain needs a body to process the overwhelming complexity of self-in-relation. So can we get more specific about, for instance, how the structure and function of the skin and the muscles can add to our understanding of ego?

A 'healthy' ego has acquired a unified representation of itself. This unified awareness is based on

The new anatomy: is the ego more than skin deep?

perceiving the environment via the senses (exteroception), but also on a sense of the state of internal organs (interoception), as well as through experiencing its own muscular state (proprioception).¹ The psychologist Gibson generalises the concept of proprioception, generally understood as the perception of one's own body state as: ego reception, as sensitivity to the self, not as one special channel of sensation or as several of them. He maintains that 'all the perceptual systems are proprioceptive as well as exteroceptive'.¹ Building on this he argues that awareness of the persisting and changing environment is concurrent with the persisting and changing self (proprioception in this extended use of the term)... Oneself and one's body exist along with the environment, they are co-perceived.² The 'healthy' ego is embodied, relational, capable of reflection, expression and action.

Recent psychology has painted the baby as more skilled and functional than we realised. The work of research psychologists Stern and Trevarthen³ suggests that the infant has a coherent and integrated core sense of self from very early on. Infants' perceptions move through many modes of perception and experience the intramodal connections, as affect (feelings and moods) in the body, which appear from the start to be imaginatively drawn together by the baby. That the infant organism behaves as though 'hard-wired' and totally dedicated to seeking relationship from the other and has extraordinary sensitivity to cues, to appropriate responses and meaningful interactions is now clearly established. Trevarthen comments: 'The feelings they project into the engagement seem to take on a life of their own, as if both adult and infant are tracking the experience of an imagined protagonist'.⁴

Developmental neuroscience is beginning to elucidate how the infant's rapidly growing brain is shaped by its experience of the environment. In particular, the mother acts as a regulator of the baby's emotional arousal through her touch, tone of voice and facial expression. In a process whose stages are now more clearly understood, the baby/toddler learns increasingly to self-regulate emotionally, with the mother's ongoing support. The baby internalises both the good experiences and the failures, neglect and even abuse, as patterns which actually affect the overall function of the brain-body: serious failures in the attachment relationship create hyper-arousal states which can trigger a cascade of changes not only in brain-related functions but crucially in bodily self-perception too.

As these formative social interactions occur and recur, they actually shape the way brain and body form. They become structuralised within the organism. This

of course is of great interest to body psychotherapists who have always spoken of ego-defences in bodily terms: for instance of visceral, tissue and muscle armouring. Recent neuroscientific work that seems to support these notions reveals how trauma is associated with the neural and chemical dysfunctions that can reduce a child's capacity to cope with stress, to learn and to relate.⁵ These embodiments of distress (we could think of them as cerebral armouring) can actually exert a protective influence over the way life's events are perceived, by limiting our openness to new experience.

The process of self-organisation is made even more complicated because it involves different sensory systems and physiological system. The two kinds of nervous system – central and autonomic – speak different languages as it were, and both of them interact with a third peptide-based information network. What is more, human infant sensory systems develop at different rates, and the interaction and competition between sensory systems also varies at different stages in development. To further complicate the picture, the infant requires particular kinds of experience at particular times – relational, sensory, motoric, affective. Furthermore, organisation, disorganisation and re-organisation are intrinsic to the process of the infant's ego development, and integration between bodily systems can happen at the same time as other systems are becoming less integrated (splitting). For instance mental representations of the self could be becoming more integrated even while representations of the relationship between self and others is disintegrating. In optimal circumstances, such crises would be followed by increased levels of organisation, but with chronic attunement difficulties, when splitting becomes more pervasive and deeply entrenched, the ego becomes increasingly dissociated from its bodily anchor. In the words of body psychotherapist Nick Totton 'relationship damage is functionally equivalent to embodiment damage'.⁶

The 'skin ego'

In body psychotherapy we have the paired ideas of a 'motoric ego'ⁱⁱ and a 'perceptual ego'. The 'perceptual ego', includes the sensory and tactile functions of skin; the muscular aspect of the ego (motoric) are related to the muscles' ability to act or hold back, to express or repress. Through muscles we mirror and internalise parental models, prohibitions, and cultural styles as unconscious identifications with the body attitudes and postures of others. Where we feel in harmony with ourselves, the muscles can embody grace, physical skills, and vitality. When conflicted, patterns of muscular tension

i Proprioception is used here in the widest sense to refer to all the information the body reflects back to itself about itself. See the 'Body-mind' chapter in Totton.⁶

ii I have elaborated on the theme of the motoric ego, and also on the autonomic nervous system as a barometer of emotional intensity and internal conflict in articles on my website. See Carroll.¹⁸

portray this directly as the impulses and inhibitions pull against each other. Enduring conflict reduces blood flow, hardening and fixing muscle tension into what body psychotherapists think of as patterns of armouring. Reich saw this 'character armour' as an embodiment of the vicissitudes of the child's first seven years.⁷

Freud said the body ego could be regarded as 'a mental projection of the surface of the body'.⁸ Esther Bick took this up, suggesting that the baby's skin functions passively as a boundary but that the baby does not initially differentiate what is inside from what is outside.⁹ Before this can happen it has been able to internalise the experience of self-regulation, and this we now realise at first depends greatly on the regulation provided by what Winnecott called 'good enough mothering'.¹⁰ But the skin is obviously much more than a symbolic boundary. The development of the 'skin ego' belongs primarily to the earliest months of life. The baby's skin is sensitive, soft and energetically 'open', and in fact the attachment needs of the baby are focused primarily through eye and skin contact. Harlow's experiments in the 1950s showed that the need for comfort contact often supersedes hunger for food. The mother's body can down-regulate or up-regulate a baby's high arousal – its anxiety, excitement, distress. Reich conceived this interaction as an expansion of the mother and child biosystems



Nursing: Alex Grey, Sacred Mirrors. www.alexgrey.com.

reaching for one another.¹¹ And so the baby, nourished by comfort, contact and soothing experience, starts to feel good 'inside' their own skin.

Neuroscience is learning how the mother acts as a regulator of the baby's homeostatic system via their endocrine, autonomic and central nervous system inter-activity. Body contact not only reassures the baby but actually helps organise its developing nervous system. Touch, for example, promotes the growth of myelin, the insulating material around nerves, and boosts hormone secretions that influence growth, digestion, and learning. And because skin contact

“ A young baby's curiosity is channelled via tactile exploration ”

requires physical closeness, it facilitates the effects of other proximal senses, particularly smell, and the perception of rhythm and vibration in the other. The adult's heartbeat, breathing and vocal rhythms, as they comfort the baby, become associated as a gestalt, with a sense of safety and familiarity. As the baby becomes a toddler, this is superseded to some degree by more distal senses – sight and hearing – which encourage independence. A young baby's curiosity is channelled via tactile exploration, especially with the highly sensitive mouth and hands, and the receptors on the surface of the body that register changes in temperature, pain and pressure. The skin is intensely sensitive because of its abundance of nerve endings. The author Dean Juhan¹² emphasises that because the skin and cortex originate in the same embryological layer, tactile experience is essential for cortical growth and development. Both skin and cortex are characterised by sensitivity and the ability to handle complex patterns of stimuli. The cortex is the home of 'higher' mental operations, including complex abstract and long-term thinking. Skin receptors function optimally with light contact and are capable of very refined perception, but these sensations are transcribed en route to the cortex as they are cross referenced with information from other senses including proprioception,ⁱⁱⁱ and thereby organised into meaningful patterns.

Reich has suggested that '...for the infant, the environment with its innumerable stimuli can be nothing but a chaos in which the sensations of its own body are a part. [Initially] everything pleasurable became part of an expanding ego; everything unpleasurable became part of the [contracting] ego. As time goes on, this condition changes [...] parts of the environment which are pleasurable (eg the mother's nipple) are recognised as belonging to the outer world. Thus the child's ego gradually crystallises from the chaos of internal and

ⁱⁱⁱ In body-mind centering the lightness and sensitivity of the cortex is contrasted with the groundedness and weight of the evolutionarily older parts of the brain. See Hartley.¹⁹

The new anatomy: is the ego more than skin deep?

external sensations and begins to sense the boundary between ego and outer world'.⁷

A young baby's skin is more continuous with the energy fields around it than an adult's. Having been in symbiosis with the mother in utero, the tendency is still to coalesce with her. In psychoanalytic terms this merging is the correlate of blurred or softened psychological boundaries. Yet gradually the baby begins to develop a sense of its own boundaries through repeated experiences of touch in the context of attuned responses from the care-giver. The baby begins to acquire a sense of its own skin as a physical boundary, in connection with a stable and empathic maternal presence, and to associate this with the sight of part of its own body. By the age of five months or so the baby will recognise itself in the mirror, an early example of thinking, which indicates its knowledge of itself and of others as separate people. This stage of development is founded on and crucially enhanced by social interaction and cross-modal perception. The Kleinian analytic tradition emphasises how the 'containing' function of the mother is crucial to the emergence of thinking processes, but it is inter-subjectivity, rather than just being related to, that is the containing factor. For the infant this experience is very much bodily and has to do with perceived qualities of sensory contact, and a kind of multi-sense dialogue that flows between mother and baby.

But there is an illusory aspect to this early ego experience: the skin boundary delineates an individual body and separateness but the very young baby remains absolutely dependent on others; the visual seamlessness of the skin-boundary conveys an impression of completeness, perfection and intactness, that can contrast starkly with the baby's inner experiences of turbulence and conflict. Lacan calls this 'the lure of spatial identification'.¹³ The skin ego – as yet unsupported by the developing motoric ego – is a fragile one. The skin ego cannot actually do anything. Unlike the motoric ego, it is not a vehicle for agency or will, and its condition changes involuntarily. As emotional states and the environment activate the autonomic nervous system, the skin blushes, sweats, blanches or itches. These fleeting modes of self-regulation also have a communicative impact: skin conditions such as acne, psoriasis or urticaria, whether or not they have psychological origins, can have severe psychological effects, because by their external appearance they may seem to portray something about the self.

The skin serves a barrier function in several ways: it helps regulate body temperature; it keeps harmful substances from getting into the body; it is one of the exits for toxic substances to leave the body; it operates as the last physical layer with which the body contains its energy; the skin's fat cells act as 'shock absorbers'. As body-therapists we observe a correlation between thin-skinned 'nervous' characters and the apparently

greater equanimity of those with more layers of fatty tissue under the skin. We also feel how skin porousness varies, and how this reflects an individual's relationship to their physical/social/energetic environment. The pianist Maria Joao Pires claimed that she could control the flow of emotion through her body. Damasio reports an interesting experiment which measured her skin conductance while she listened to Chopin's Nocturnes. When she was 'allowing feeling', it was full of peaks and valleys. When she deliberately reduced her emotional response, her skin conductance graph was virtually flattened.¹⁴

So the skin has psychological correlates. Openness of skin may reflect vulnerability, pleasure or excitement. When we have a heightened sense of being exposed – embarrassed, touched by something, sexually aroused, self-conscious, or extremely sensitive – we may experience it directly as an energetic charge in the skin. Conversely, when people close down in order to protect themselves, it may be felt at skin level: a withdrawal of energy deeper into the body is characteristic of shock, or schizoid withdrawal and deep depression. This kind of 'thick skin' is a defence against further shock, loss or disappointment. We can deliberately toughen up (for instance by toning our skin, or sealing our energetic boundaries) when we know we must not let someone 'get under our skin'. Esther Bick likened this kind of defendedness to a false self and locates it in patterns of muscular contraction which she refers to as the 'second skin'.⁹ This fits with the Reichian view of muscular armour as a defence protecting the deeper core, but misses the point that the muscle system also has a healthy supportive function. In fact some clients do literally have 'thick skin' – layers of connective tissue defence, which tend to coincide either with a loose connection to the muscle underneath, so that there is a split between the two layers, or its opposite, a sort of rubbery quality that pushes away contact.

The 2-d and the 3-d ego

In reality, of course, the skin does not operate separately from other parts of the body. The concept of the skin ego helps distinguish a set of ego functions that may be derived from the physiological function of the skin and the part it plays in the development of thought and emotion. In line with general principles of development, we see that any trauma will impact most on the system that is most sensitive at that stage. And so in the crucial early life phase of separation-individuation, the infant's skin boundary may be especially vulnerable. Lack of sufficient 'holding' and/or a particular trauma in infancy may leave someone with chronically blurred boundaries. Such underdevelopment may cause an individual to overuse tactile sensors, be 'hypersensitive' and easily

overwhelmed by emotional and sensory stimuli.

This seems particularly the case in narcissistic individuals, who crave constant reinforcement at skin level, want to be metaphorically and literally stroked, are preoccupied with appearance and terrified of being penetrated psychologically. Their grandiosity is a sort of puffing up, and when their bubble is burst (like a balloon filled with air), the narcissist feels overwhelmed by a sense of humiliation and despair.

The skin is a surface, and the skin ego is a two-dimensional projection, a superficial image, particularly so when reinforced visually rather than by experiences of skin pleasure through contact. Yet it is through interoception and proprioception – senses of the whole, moving body – that we monitor the deeper register of our internal life. There is a price to pay when body image is substituted for body experience – as it often is in our culture – because perception of the interior of the body gets split off. One explanation for the motivation to self-harm may be to enact and depict an internal feeling of rupture or disarray by cutting the skin.^{iv}

	Skin Ego	Muscle Ego
<i>Senses via</i>	<i>exteroceptors</i>	<i>proprioceptors</i>
<i>Stimulus</i>	contact/ environment change	movement/pressure
<i>Experience</i>	sensation – modalities	kinesthetic
<i>Range</i>	open/closed	tension/relaxation
<i>Quality</i>	sensitivity/insensitivity	excitability/stability
<i>Priming</i>	birth to 18 months	in-utero–7 years
<i>Development</i>	threshold setting	developmental sequence, skills
<i>Control</i>	involuntary	voluntary/involuntary
<i>Body map</i>	2-d surface projection	3-d dense complex projection
<i>Psych function</i>	Merging/separating	agency, expression, repression
<i>Identity</i>	inner/outer	introjected/projected
<i>Need</i>	dependant-receptive	dependant-will/ independent
<i>Container</i>	delineated/defined	differentiated/bound

By contrast the motoric ego, which develops over a longer period, is a three dimensional vehicle for social interaction. Analysis of videos shows ‘how infants move their bodies, especially their expressive organs, in

responses, both contingent and provocative, to the expressions of another person. [The behaviours which define the infant’s subjectivity] the way they look, express their feelings in face and voice, how they gesture or move in rhythmic cycles to accept or reject contact (and regulate intimacy and intensity) are homologous with adult intentional activity, including conversation’.¹⁵ Motoric development, increasing in complexity and refinement, parallels social and emotional development. In these interactions, from early birthing and feeding movements, through crawling, walking, and manipulation of objects, children discover their capacity for agency in the world. With delight, they find out what they can ‘do’ in the world and to objects. With difficulty, they face the frustration and limits of what they can’t do, either because they haven’t mastered it, or because it is prohibited. There is much more potential for developing robustness in this phase of ego development – there is a direct engagement with physical matter and gravity. In the wrestling, poking, pushing, twisting, and more intricate manipulations – folding, eating, tying shoelaces – there is a real opportunity to find out about reality. And it embraces another level of social learning – what happens if you hit someone, or lick them, or stroke them.

Pleasure experienced through the skin is essentially receptive; we delight in (or perhaps avoid) a certain quality of contact, texture and movement across the surface of our body. But pleasure in muscular action is intrinsically linked to engagement and agency, and with a sense of vitality. Unlike the skin, muscles have volume and weight. Packed with proprioceptors registering tension, pressure and position in space, the muscles create a constantly updated dynamic and dense map of the body – especially as we move, and through our capacity to express and to act. Of course, we may also experience our psychological blocks, inhibitions and conflicts as deadness and tension in the body.

In reality, muscles’ activity is intricately entwined with information flow from sensors in the skin and muscle. Sensory and motor functions form a continuous loop: motor actions focusing sensory attention, and sensory attention influencing movement. The images created by sensory stimuli are flat projections unless muscular activity embodies them. Boadella has suggested a relationship between low muscle tone – which reflects passivity in relation to the world and its objects, and an over-active, but two-dimensional fantasy life¹⁶ and Damasio concludes that a balanced input from skin and musculature enables the brain to create the boundary and schema without which the body-mind has no proper context for making sense of itself.¹⁷

^{iv} Cutting also stimulates the production of endogenous opioids which temporarily numb pain, so it has a parallel with using drugs.

The new anatomy: is the ego more than skin deep?

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Craniosacral touch and the perception of inherent health

Howard Evans

Part-time lecturer, University of Westminster

Summary

Certain kinds of touch therapy, but craniosacral therapy **par excellence**, depend on a highly developed sensitivity to subtle shifts in bodily tensions and rhythms. The craniosacral therapist learns to sense **still points** in this flow. In the therapeutic relationship – for psychotherapists as well as bodyworkers – less can often be more. Effective psychotherapists develop their ability to quietly notice and contain emotions that their clients cannot. Similarly, sensitive body therapists, by stilling themselves, may contact and mobilise the body-mind's inherent potential for self-healing.

Key words:

Relaxation, inherent health, stillness, breath of life

In 1992, inspired by Stanley Keleman's approach to somatic psychology, I started training in integrative psychotherapy. I worked as a masseur to pay for the training. After just one year of psychotherapy practice I realised that I preferred the quietness of massage to the words of psychotherapy. I also began to suspect that even without words skilful massage offered a very effective way in which to work with the organisation of the patient's thoughts and emotions. I continue to explore massage as a form of silent psychotherapy.

*Be still, and know that I am God
(Psalms 46:10)*

Introduction

According to Ron Kurtz, the founder of The Hakomi Method of body-centred psychotherapy:

*'In a study of master therapists, like Milton Erickson, Virginia Satir and others, it turned out that they held certain assumptions in common. The most surprising, to me, of these was the assumption that there is no real problem. The client may feel there is a problem, but the master therapist "knows" there isn't.'*¹

The implication of this statement encapsulates for me the essence of craniosacral work. Craniosacral therapy and osteopathy from which it derives are based on the belief that the human body is an intelligent and self-regulating system, at the heart of which lies health – an inherent health that is never lost.

We could tell our patients this but it would have as much effect as a psychotherapist telling a client there is no problem. The important aspect of Kurtz's statement is not that the master therapist believes that there is no real problem but that they 'know' it.

In craniosacral work the same is true. The craniosacral therapist does not simply believe that there is an inherent health at the heart of the patient's system, but knows it through direct and repeated experience.

We could argue forever as to whether or not inherent health exists but the curious fact is that when I sense it in my patients they sense it too. When they relax into its stillness with me an often quite extraordinary process of healing unfolds.

Background

In 1988 an osteopathic adjustment of my left sacroiliac joint left me housebound and in intense pain for several months. My visiting doctor couldn't help me; his painkillers

made me wheeze. My physiotherapist neighbour couldn't help me; her methods were just too painful for me to bear. When I was able to walk rather than crawl I had x-rays taken but they revealed nothing of significance.

A year later and still in pain I overcame my fear of osteopathy and submitted myself to the hands of a highly recommended practitioner. The first session was reassuringly relaxing with nothing of the high velocity thrusts I had come to associate with the work. During the second session something miraculous happened.

I was sitting on the table while the osteopath gently held her hands around the back of my neck. Suddenly I entered a dream state and felt the inside of my spine relax throughout its length. In that moment I had a flash of memory of a forgotten accident in which I landed with great force on my right buttock. That accident no doubt caused the conditions that my first osteopath sought to relieve with his adjustment. In that moment of recall my pain completely disappeared.

More remarkable than that sudden healing was the extraordinarily peaceful atmosphere that permeated the osteopath's room. We were both moved close to tears.

Years later as a masseur I experienced similar moments while working with patients. These moments seemed to arise spontaneously and always included a sense that the atmosphere in and beyond the room had changed, as if permeated by a quality that can only be described as love or compassion. These moments always brought with them a profound and rapid process of healing in the patient.

It was the wish to understand experiences like these that led me to study craniosacral therapy. In 1995 I had the good fortune to train with Franklyn Sills. The course drew largely on the work of William Garner Sutherland, the originator of osteopathy in the cranial field, and John Upledger who originally coined the term craniosacral therapy to describe his approach to cranial work.

The great benefit of training with Franklyn Sills was that he didn't simply demonstrate techniques but entered into a real session. It soon became clear that there was another level of work going on – one that wasn't being talked about and had little to do with the actual techniques of craniosacral therapy. It was that level that interested me because that was what drew me to the work in the first place.

The development of craniosacral work

Since 1995 much has changed in the world of craniosacral therapy. If we turn briefly to the life journey of its founder, William Garner Sutherland, we will see that since its conception that has always been the nature of the work.

In 1899, as a student of osteopathy, Sutherland was struck by the thought that the cranial bones did not fuse, as was generally believed, but remained forever mobile at the sutures. From then until the late 1920s he developed this idea and experimented with the application of osteopathic technique to the cranial bones.

In the early 1930s Sutherland turned his attention from the cranial bones to the dural membranes within. He perceived a continuity of the membranes from where, within the skull, they contain and support the brain, down to the sacrum as the dural sheath surrounding and protecting the spinal cord. He described this membrane envelope as 'tadpole like' and named it the core link. His work deepened to include the resolution of tensions organised by this membrane system.

In the late 1930s Sutherland's attention was drawn to the cerebro-spinal fluid (CSF) within the core link and to the palpable fluctuation of that fluid. From here he developed his theory of the primary respiratory mechanism (PRM). This theory was based on five palpable phenomena, which he collectively called the cranial rhythmic impulse (CRI). These five phenomena are:

- the inherent motility of the brain and the spinal cord
- the inherent fluctuation of cerebro-spinal fluid
- the inherent motility of the intra-cranial and intra-spinal membranes
- the mobility of the cranial bones at their sutural articulations
- the involuntary mobility of the sacrum between the ilia of the pelvis.

They are said to occur with a rate of between six and twelve² (or 8–14³) cycles per minute. The theory of CRI became and remains the foundation of osteopathy in the cranial field. Various theories have been advanced over the years to explain its cause.

Sutherland originally thought that rhythmic contractions and dilations of the ventricles within the brain caused a wave of movement through the cerebro-spinal fluid. However in 1943 he described the 'breath of life', sensing it as an external force generating the movements of CRI within the body. Sutherland's choice of term was no accident. As a Christian it was natural for him to acknowledge God's presence as the creative force of nature.

In the last years of his life Sutherland abandoned his classical osteopathic techniques altogether and started to work directly with the healing power of the breath of life expressed as an ordering force, known as 'potency', throughout the fluids of the body. Thus was born Sutherland's appreciation of the body as a self-correcting system.²

After his death in 1957, Sutherland's students Rollin Becker and Robert Fulford continued to develop this approach to osteopathy. James Jealous, another

osteopath, augmented the work with Eric Blechschmidt's theories of embryological development.

Blechschmidt suggested that an external force creates the spatial orientation within which the fluids of the embryo organise. This generates an ordering matrix that governs the further development of the embryo. For Jealous and his colleagues this external force is that same breath of life to which Sutherland referred.²

Jealous borrowed from Blechschmidt the term 'biodynamic' and called his particular approach to osteopathy the biodynamic model of osteopathy in the cranial field (BOCF).² In this approach it is believed that the ordering matrix generated by the breath of life remains forever present, manifesting as inherent health at the core of the human system.

As well as generating the rhythmic movements of CRI the breath of life is also said to unfold at slower rhythms. Unlike the variable rhythm of the CRI these slower rhythms are stable. They are not palpated but sensed.

One of these is known as the tide or the long tide. Sills refers to it as 'an expression of the intention of the breath of life to create a human being' and goes on to say that it is perceived as 'a direct organising intention within and around the patient'.³

Another is referred to by osteopaths as CPM² and by Sills as the mid-tide. Sills says that when the practitioner perceives the mid-tide within the patient 'potency, fluids and tissues can be clearly perceived to be a unity, or a unit of function'.³

Perception as a therapeutic skill

Since 1983 when John Upledger published his book *Craniosacral therapy* and established the work as a discrete therapeutic modality distinct from the osteopathic world from which it emerged, there has been an ongoing debate as to what exactly craniosacral therapy is and just who is fit to practise it.

From the perspective of the osteopathic community, training for the work should be at the level of that undertaken by an osteopath – that is to say the same level of training in anatomy, physiology, pathology and differential diagnosis as that expected of a medical doctor.

If the practitioner's intention is to test for and correct dysfunction in the various aspects of the primary respiratory mechanism I would wholeheartedly agree with this position. There is abundant need for this kind of highly specialised diagnostic and therapeutic work and it should remain firmly within the hands of osteopaths and others with an equivalent level of knowledge.

There is, however, a whole other level to the work, a level that I touched on accidentally in my work as a

masseur and that I sensed was taking place when I sat in class as Franklyn Sills demonstrated his work. This is the level of working directly with the intelligence and inherent health expressed through the fluids of the body. This is the level that I believe should be shared with all therapists regardless of their approach.

As we can see from the brief history of the development of cranial work by Sutherland it is actually multi-layered: encompassing the bones, the membranes, the fluids and the mystery of expression of the breath of life.

Sutherland's personal journey of discovery and its continuation in the hands of all practitioners who undertake the work is, perhaps, not so much to do with the acquisition and application of theory and techniques as the development of the perceptual and relationship skills of the practitioner.

Jealous says: 'Osteopathy has shamefully hidden its greatest mystery and resources. I believe that to acknowledge a higher wisdom at work and to sense rather than palpate is at the soul of osteopathy.'⁴

There are two important aspects to this statement. One concerns the perceptual skills of the practitioner. The other refers to knowing that at the heart of the human system there is inherent health.

Of the first Jealous said that he 'discovered that his therapeutic results improved in proportion to the extent to which he could free himself from conscious rationalization'.⁵

This idea is not unique to craniosacral therapy. Freud, in 1912, referred to the state of consciousness required of the psychoanalyst when he talked of 'evenly poised attention'. This is described as:

*'...as complete a suspension as possible of everything which usually focuses the attention: personal inclinations, prejudices, and theoretical assumptions however well grounded they might be.'*⁶

Theodor Reik, a student of Freud, called it 'listening with the third ear'.⁶

Fritz Smith, the creator of 'zero balancing' refers to a 'witness state of observation' in which the practitioner is 'uncritical, non-judgemental, expectation-free and uninvolved with an active thought process'.⁷

Dr Milton Trager who founded the Trager approach to bodywork, referred to this state as 'hook-up' and insisted that the practitioner must work on developing this state of consciousness in order to stimulate it in someone else.⁸

In craniosacral work it is referred to as the 'neutral'. This is a state of stillness and openness; of reception rather than transmission; of listening rather than doing.

The second aspect of Jealous' statement is perhaps what makes craniosacral work unique as a body therapy. This aspect is the acknowledgement of the inherent

health of the patient and the practitioner's intention to work with it.

The 'neutral' of craniosacral work is not simply a passive and receptive state but involves an alive and active intention to perceive the intelligence and health at the core of the patient's system. Curiously, this does not involve a focusing of attention but a widening of the therapist's perceptual field so as to relate to the whole of the patient and the surrounding environment.

With practice we may experience what Sills refers to as the holistic shift.⁹ Suddenly the sense of relating to the intelligence organising our patient's body becomes a reality and not just an idea. We may sense an extraordinary stillness as a presence in the room. We may even sense that the stillness extends beyond the room as if the whole world outside has engaged with the process.

When we experience the holistic shift we know that our patient has entered a neutral state too. Jealous says of this:

*'With enhanced perceptual skills, the practitioner eventually perceives a sense of neutral, which is experienced as a homogenisation of tissue, fluid, and potency – the fluid body, where nothing under the fingertips can be discerned as a separate entity... The neutral cannot be conceptualised; it can only be experienced. It is here that "holism" becomes more than a philosophical concept, it can be appreciated as an actual sensory perception.'*¹⁰

As we settle into the neutral with our patient we see them change. They slip into a deep relaxation. We see their eyes slowly rolling from side to side under the lids. We feel their breathing settle into a relaxed and natural rhythm. As our observation becomes ever more subtle and receptive we might notice colour changes in their skin. We may see the lines of their face soften and the shape of their body change, as the muscles quite literally become more fluid. We may catch ripples of movement through their muscles, perhaps spontaneous twitches and adjustments.

Sometimes we feel their relaxation deepen still further. Our patient's eyes settle and sink into their sockets. We hear the beginnings of a snore developing in their throat. We sense a potential in the air like that just before it snows or storms. With experience we come to know that these signs herald profound shifts within our patient. Often we will observe broad movements throughout their entire fluid body. We come to know that in those brief moments the patient often revisits and resolves highly traumatic past events.

Over time as we question our patients we realise that there are many common qualities to this state. Although the patient feels very relaxed they rarely experience themselves as asleep. Instead they have a sense of great awareness and peace.

Many patients describe images of the past arising and passing like dreams. Many describe inner sensations such as heat or cold or fluid passing through their bodies. Many describe an awareness of inner light and colour.

Time and again I have watched in awe as the patient's body resolves an injury or adjusts a postural imbalance. Time and again I have heard patients describe the experience as religious. Time and again I have worked with patients undergoing treatment for cancer or even in the terminal stages of a disease who come out of a session with a deep sense of peace and wellbeing.

Therapy as enquiry

'Life is not a riddle to be solved but a mystery to be lived.'

Paul Koralek

Despite many years working with craniosacral therapy it continues to enthral and surprise me. I constantly question what it is that I do and what it is that is happening as I work. My practice is a work in progress as is my description of the work.

I can rationalise the concept of the neutral as can any therapist working with an awareness of the therapeutic relationship. I have always believed that in any therapeutic relationship the patient is more aware than the therapist, simply because they have more at stake.

In psycho-analysis it was long ago suggested that beneath the ordinary aspect of the relationship lies a direct communication between the unconscious of the patient and the unconscious of the therapist.⁶ In body therapy this unconscious dialogue may be even clearer, freed as it is from the fog of words and conducted as it is through the body, our primary means of communication before words.

When I bring my hands in relationship to my patient I have no doubt that they are reading my intentions and assessing whether or not I am fit to share their story. If my intention is to apply my techniques my patient will do his or her best to humour me.

If my intention is to relate to my patient at the level of their inherent health and intelligence an altogether different process takes place. Now my techniques are subtle invitations to talk. When the patient's body accepts to tell its story all I need do is keep quiet, listen and follow the story as it unfolds.

Although I use the term 'craniosacral' to describe my work I wonder if the master therapists to whom Ron Kurtz referred had not themselves intuited the same truth. To them, at the core of the patient there is no real problem. To me at the core of the patient there is inherent health.

Clarification of terms

Osteopathy

According to the website of the General Osteopathic Council of the UK osteopathy is a way of detecting and treating damaged parts of the body such as muscles, ligaments, nerves and joints. When the body is balanced and efficient, just like a well-tuned engine, it will function with the minimum of wear and tear, leaving more energy for living.¹¹

Osteopathy in the cranial field – also called cranial osteopathy

Cranial osteopathy is a refined and subtle type of osteopathic treatment that uses very gentle manipulative pressure to encourage the release of stresses throughout the body, including the head.¹²

Biodynamic osteopathy in the cranial field (BOCF)

The approach to osteopathy taught by James Jealous. Jealous 'characterised traditional osteopathy as a science based on anatomy, whereas BOCF is a science based on embryology'.⁵

Craniosacral therapy

The term used by John Upledger to describe the work that he teaches outside the osteopathic community.

Craniosacral biodynamics

Franklyn Sills' approach to craniosacral therapy. This draws on the work of William Garner Sutherland, Randolph Stone, Rollin Becker and James Jealous.

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The sense of touch – a philosophical surprise

Bevis Nathan

Osteopath

Summary

Touch is the most basic way of experiencing the world. But touching cannot be comprehended in a generic theory of the senses, because in many ways it is distinct from the other four. These differences are crucial enough to suggest that tactility (the felt sense) is the basis for a better model of body perception and emotion. A phenomenological view of flesh-as-lived provides insights into the nature of feelings and empathy, and suggests ways for improving our understanding of human constitution and therapeutic relationships.

Although the title of my talk at the Touch conferenceⁱ was *What happens when you touch someone?* I felt that as well as answering this question, it was important for us to remind ourselves of what we have learned about touch, point out some flaws in our education, and suggest a more useful model. The subject of touch – and its curious omission from bodywork curriculae – has always fascinated me. In fact this absence drove me to research *Touch and emotion in manual therapy*, a book presenting evidence that the effects of manual therapy are organised primarily by unconscious, central nervous system processes, rather than peripheral mechanical ones.

Key points

- Constitution and relationship are crucial concepts when it comes to understanding therapeutic processes and relationships.
- There are two kinds of touch – technical/procedural (involving knowledge) and expressive (involving feelings and emotions).
- Traditional medical models deal with touch as though it were entirely procedural, ignoring and denying expressive touch.
- The sense of touch is distinct from the other four senses in several important ways (the body as a whole is the organ of touch, to touch is also to be touched, touch needs no medium of transmission).
- Touch is the primary sense, and the tactile sense is the primordial way of experiencing life.
- An understanding of touch informs our understanding of embodied constitution and relationship.

Constitution and relationships, and the omission of the study of touch

Medics and healers of all sorts use their science and art to describe and

make sense of the human constitution, and its processes of health and illness. Clearly, then, without a coherent theory of human constitution any theory of health and illness would be incomplete and confused. Once articulated, a working theory of human constitution should allow concepts of health and illness to be deduced from it. But for a working theory comprehending how human beings heal or promote healing in another, we also need a coherent theory of practitioner-patient relationship. Since the therapeutic relationship is the milieu for such healing transactions, we need theories of interaction that explain how healing processes arise. Some interesting examples of relationship theory have been put forward for instance by Balint¹, Neighbour², Reilly³, Lately⁴, and of course the body of literature exploring psychotherapeutic models.

All therapeutics aims at bringing about changes within the constitution; changes that are affected to some degree by relationship (save self-healing, though arguably here too). Touch is not only the interface of most healing arts relationships, but in ways that I hope to show, an understanding of human touching may also lead us into a deeper

ⁱ The Power of Touch – November 2007, University of Westminster

understanding of constitution and relationship. Obviously, it is through our bodies that we practitioners meet our patients and touching is a metaphor for how we reach toward and affect one another. It is equally clear that, indeed, touching is essential to therapeutics in massage, osteopathy, chiropractic, physiotherapy (currently to a lesser extent), and that touching is a powerful element in the therapeutic relationship that develops in these but also in many other forms of healing practice. Yet outside the clinic, in 'ordinary life', touch is something quite different, for here touch is not about techniques or healing procedures, but about expressing and enacting emotions, attitudes, relationship, antipathy, intimacy. Ordinary touch reveals something of what people feel about one another.

So we can distinguish two aspects of touching: procedural or technical touch which is based on an understanding of touch as a therapeutic approach to physiological modification, or which is intended to do something to a person; and expressive or experiential touch which is a form of social and interpersonal behaviour – to do with feelings, relationships, keeping-in-touch or being with a person. But is procedural touch ever wholly without emotional impact, given that procedural touch is such a rare event and happens against a background of this more common and ordinary type of expressive touch?

Two forms of touch – procedural and expressive

Let's consider procedural touch as though it were a specialisation depending on a view of human constitution that sees the body as a machine. This view has been attributed to medical science, which has rarely studied the interpersonal elements involved in its forms of treatment – which may be why touch rarely surfaces as a medical research topic. Is this also because touch is something that living people do to one another, whereas medicine's therapeutic deeds can be seen as something done to mindless bodies or physiological systems? This mindset seems not to think of its procedural touching as touching at all, preferring the term 'palpation', perhaps because 'touching' implies a degree of intimacy inappropriate and unnecessary in technical medicine's forms of doctor-patient transaction. Yet this situation surely reveals a shortcoming of the medical model and its ambivalence about the role and relevance of the therapeutic relationship. But inevitably relationship *is* involved. So I want to suggest that by understanding touch better we may develop a more complete view of human constitution and relationship, and that once we have a clearer view of what we are and of how we relate, we practitioners will be in a position to make more sense of our therapeutic modality, what our procedural

touching represents, and how constitution and relationship together inform our therapy.

If we take the example of psychotherapy: for psychotherapists intimacy and its risks are very much on the agenda. And so they have generally avoided touch, seeing this physical separation as on the one hand making a crucial 'boundary', and on the other as a precaution against re-traumatising patients who might have been abused previously in intimate relationships.⁵ The exception to this has been in the body-psychotherapy disciplines, although their emphasis is on the body-self, and not necessarily upon touching *per se*.⁶ As for manual medicine practitioners, manipulative and massage therapists, or other body-workers who touch and handle patients, we might think of them as having a deep understanding of touching – and indeed they are taught a lot about the particular techniques of procedural touch – but in fact we are taught very little about the implications and meanings of touch and touching. This bias towards procedural touch so dominates our views of manual therapeutics that we rather avoid the word 'touch', and deny ourselves the full exploration of touch as a phenomenon. What would happen then if we were to stand back, take a view of the whole therapeutic transaction, and admit that we are practitioners who *touch* people?

Touch as a sense

We have the Greeks to thank for many of our ideas about what humans are. Plato's view of the human constitution included what he called gnostic faculties – the different ways by which we come to know things through:

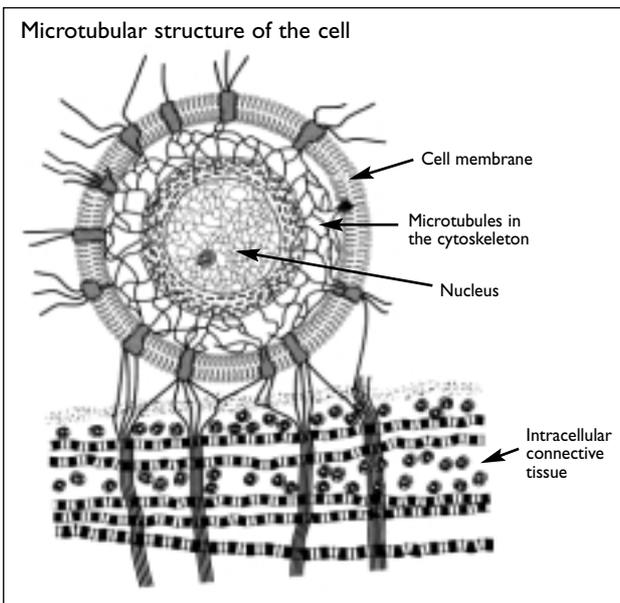
- sensation – by which we receive basic knowledge of our interaction with the physical world
- instinct – by which combinations of repeated sensations are unified and then prompt us to know things
- estimation – knowledge *that* something is the case
- reason – knowledge *why* something is the case
- intuition – the knowing of wholenesses of ideas and concepts.

Aristotle's view of the five senses gave us the idea of the object we perceive, the medium through which we sense, and the bodily organ involved. The traditional view is that a sensation involves a pathway by which certain kinds of physical information is received by special organs. This 'knowing' is then interpreted using cognitive faculties, and 'coloured' (attributed qualities) by affective (feelings) faculties. However, Aristotle had to admit that touch did not fit into this overall scheme, because touching has no specific sense organ, and touching is more than just a 'gnostic' faculty, for it is also

a deed. So these and other features mean touch does not fit a generic theory of senses: it is the whole body that feels. This fact renders the sense of touch radically different from its four, now more distantly related, cousins.

Nonetheless, my own physiology textbook where I learned about touch showed a Ruffini end-organ, a sensory axon, and a nerve cell – the traditional view being that the organ of touch is the skin. It is true that the skin's capacity for registering sensation is extraordinary, but we can also feel ourselves being hugged, and this is not skin sensation; nor is the experience of deep soft-tissue work.

The inner fullness of our bodies can be pleasurable (or disturbing) to feel; children especially love their limbs or torso simply being squeezed. But we can also feel our own heartbeat, breathing, guts moving, swallowing, facial expressions; we also feel ourselves walking, running, turning over in bed, writing, typing, speaking, laughing, using the loo, making love. So how should we categorise sensations like these? Since they surely have more in common with touch than with other senses, I propose we should include such kinaesthetic awareness of bodily solidity in action, as part of a world of embodied and touch-like experiences and messages from the body that we can call tactility.



Messages from the body

At this point we should recall that in recent years our picture of the cell's structure has been revolutionised. Most of us were taught that cells are sacks of cytoplasm, in which float little bags of nuclear material, and that cells communicate with one another through chemical messages organised mainly by gradients, diffusion, ionic pumps, enzymic activity, and so on. But we now know that the interior of each cell is anything but amorphous;

that an intricately organised network of microtubules communicate directly between the nuclear material and the cell membrane and on into other cells and the extra-cellular environment. Specialised proteins – integrins – in the cell membrane organise the micro-tubular connection of each cell with its neighbour. It is no exaggeration to say that every cell in the body and its genetic material is in direct, mechanical (but, note, non-neurological, and non-chemical) contact with every other. Jim Oschman calls this the living matrix⁷ and speculates that it could help explain how some practitioners are able to touch any part of the body and sense the whole. This discovery brings new meaning to the notion that the organ of touch is the whole body, and it implies a degree of integrated, energetic wholeness that can enhance and beautify our view of our bodily constitution.

But to return to Aristotle. Perplexed by the sense of touch, he tried to solve his problem by suggesting that the *medium* of the touch-sense is flesh, but the *organ* of touch is the heart. The heart everywhere symbolises affect, sentiment, feeling, emotion, attitude, and also core experience. So why would he come up with such an extraordinary suggestion, unless he were referring to the striking parallels between how we experience (and describe) emotions and how we feel tactile sensation? Although other kinds of sensation can trigger emotional phenomena and feelings, perhaps none do so as much as tactile ones. Might this be because the lack of a medium through which touch is communicated inevitably implies intimacy when we are touched? (More of this later). Aristotle seems to be pointing to the intimate relationship between touch, as the most inward sense, and the emotional faculty of the soul. Tactile experiences, he clearly tells us, are *heartfelt*.

Toucher and touched merge

We have established that touch is the different sense: the organ of touch is the whole body; to touch is also to be touched oneself. These unique features of touch are clues about the nature of empathy, for when we touch one another, both of us perceive the tactile sensation, and we both experience simultaneously the touch of another. Another point to consider, though it applies to other senses, is that when I touch myself, I become both the object of my perception and the means of perception, within a single perceptual act. The body is unique among objects, because the body not only discloses itself but it also discloses the world of other objects to us.

Flesh makes activity and perception possible; is both object and subject; is the 'I' in contact with the world. Attempts at analysing flesh without its 'I' can only yield incomplete, artificial and unreal descriptions. Flesh seen without its 'I' is not how living flesh is. Flesh is lived.

Living flesh therefore is never just another object in the world, because it is the means whereby we make and know our world. This is the phenomenological viewpoint, and it may help us find a language for studying embodiment and developing a new view of mind-body constitution.^{8, 9, 10} Phenomenologists insist that scientific examination of physiological processes can never describe the body as it is lived, and that touching is never just a mechanical act because flesh is not inanimate material. In fact, recent philosophers have argued that the very nature of reasoning itself depends upon metaphors derived from the body.¹¹

So we cannot regard touch as a sense in the same way as other senses. No intervening medium is needed for touch. Water is needed for tasting, air for smelling, light for seeing and pressure waves in a fluid for hearing. It is true that the other senses require degrees of proximity, especially smell and taste, but touch is unmediated, direct, tangible, intimate contact. Aristotle noticed that with sight or sound that:

‘...we perceive because the medium produces a certain effect upon us, whereas in the perception of objects of touch we are affected not by but *along with* (my italics) the medium; it is as though a man were struck through his shield where the shock is not first given to the shield and passed on to the man, but the concussion to both is simultaneous.’¹²

The organs for seeing, hearing, tasting, and smelling are highly developed, whereas tactility and its anatomical apparatus are far less specialised. Touch is the first, and most basic way, of experiencing the physical world. In fact a person’s body is their immediate physical world, and we experience it and our bodily interactions with others through a *felt* sense. These primordial feelings of being are so fundamental that we easily fail to notice them – our felt, fleshly sense of embodiment – because we are so busy thinking.

Instead of seeing this felt sense as just another alongside the rest, we should consider it the foundation of all lived experience, the sense from which all other sensations, thoughts and feelings emerge and derive their meaning. Merleau-Ponty relates an extraordinary experiment that supports this notion:

*‘If a subject is made to wear glasses that correct the retinal images [ie invert the image], the whole landscape at first appears unreal and upside down; on the second day of the experiment, the landscape is no longer inverted, but the body is felt to be in an inverted position. From the third to the seventh day, the body progressively rights itself, and finally seems to occupy a normal position, particularly when the subject is active.’*¹⁰

So vision relies on the felt sense of embodiment and tactility for its orientation. The felt-body, tactile sense stays the right way up and vision is made to conform

to it, in order to make normal activity possible. The philosopher Edith Wyschogrod, in her wonderful paper *Empathy and sympathy as tactile encounter*¹³ reinforces the idea that touch and ‘tactile revelations of the environment’ are our most fundamental kinds of experience, and that the tactile sense modifies other senses, perceptual acts and their significance.

‘The body, with its sensitivity to pressure, temperature and surface qualities, together with its kinaestheses – its felt respiratory movements, its pulse, its hands’ capacity for manipulative endeavour, its motility – is the primordial ground of existence as incarnate... the manner in which touch yields the world is the most primordial manner of our apprehension of it... If the primordial manner of being of the lived body is to be understood as tactile, then tactility cannot be included under a generic theory of sense but provides its ground.’

Far from being a perceptual mode, tactility is a profound and primary whole-person experience at the level of our essential bodily being.

Touch and empathy

Edith Wyschogrod offers an analogy between touching, and empathy and sympathy. She points out that touching is the foundation of both feeling and being felt, and can only happen when the person felt is near the feeler. The parallels with empathy and sympathy are obvious: both are ‘feeling-acts’ involving direct encounters with others; both are affective, relational acts, involving ‘nearness’. The immediacy and mutuality of the touching-touched experience suggests that empathy and sympathy might be more easily understood as tactile-like rather than seeing- or hearing-like. So yet again, touch appears to be fundamental to our humanity, and to our understanding of the healing arts, since empathy and sympathy are such crucial capacities for practitioners. The notion that empathy may be better understood as touch-like is a source of fascinating insights. We know for instance how someone’s touch feels to us, and we know what it feels like when we touch someone else. But we can only imagine how the person touched is feeling our touch. This should prompt us to reflect on our own experiences and attitudes to touch, for they are the source of our imaginings and projections. Do we like touching people, or being touched? How do we feel about nearness and intimacy? When we reflect on the way clients make us feel, using our imagination and empathy, we have to account for projective and counter-transference effects. Acknowledging the parallels between the difficult task

continued on page 30

Cytoskeletons – the beautiful matrix

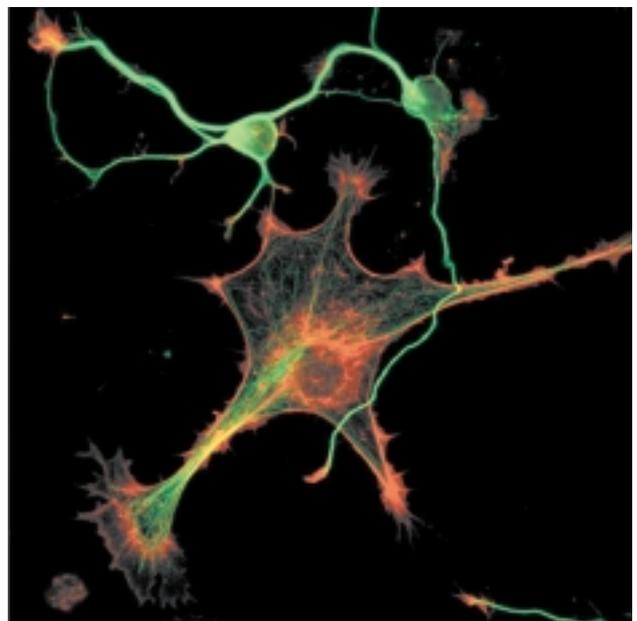
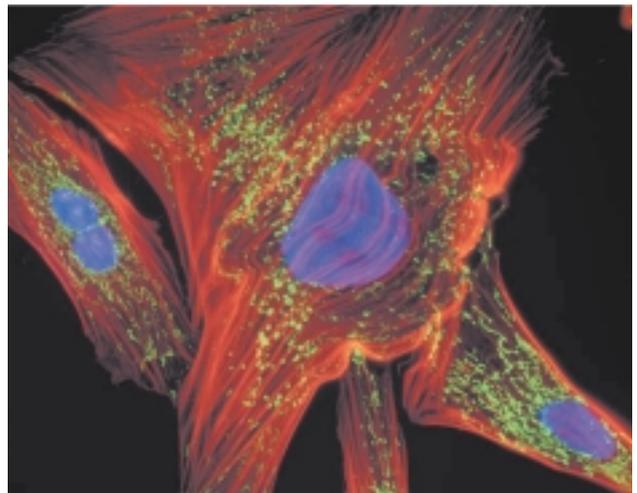
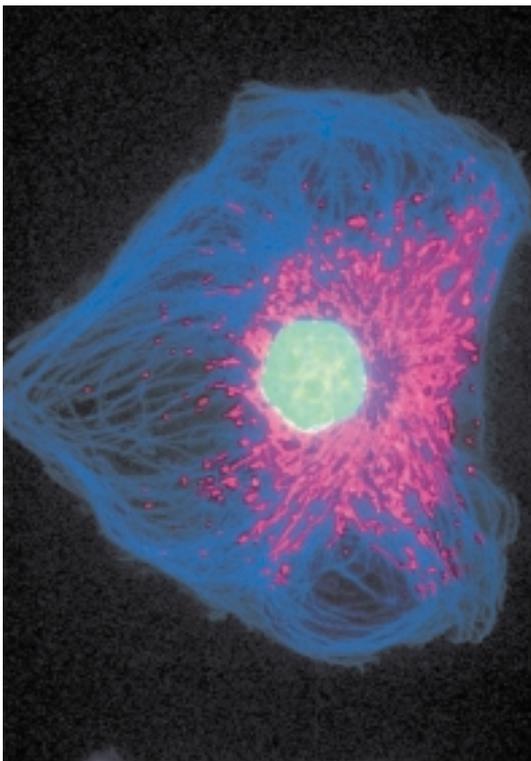
These coloured photomicrographs, achieved using special staining techniques, reveal the extraordinary beauty of the cytoskeleton.

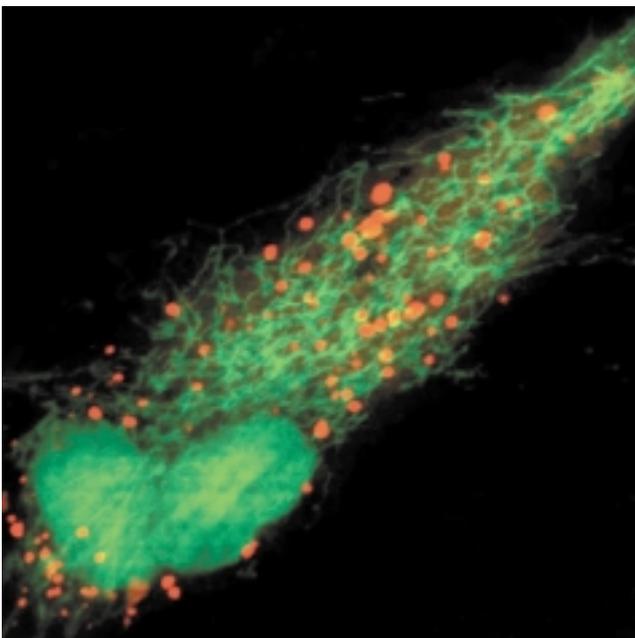
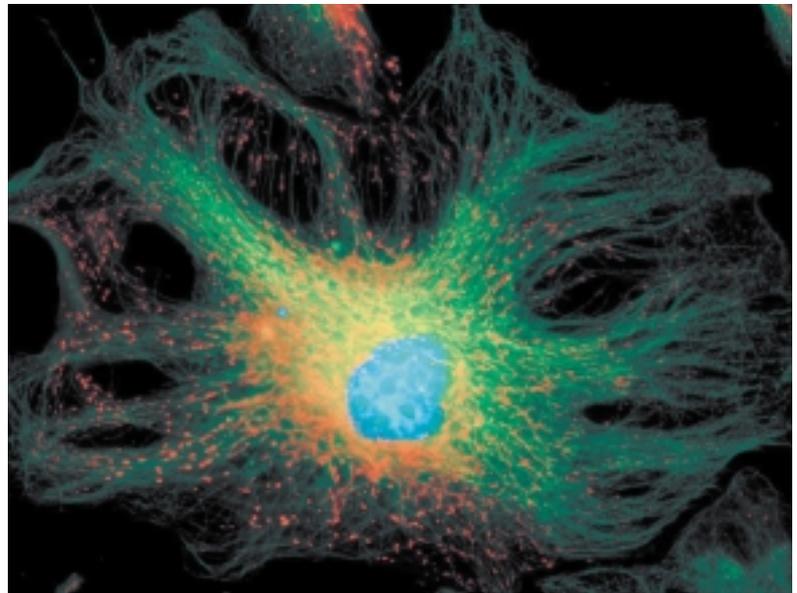
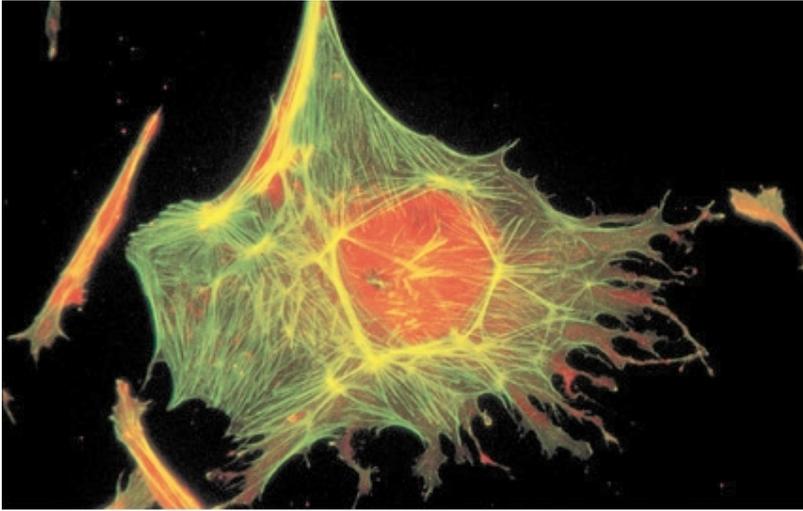
Cells are not amorphous blobs of jelly. Their shape is maintained by an intricate, dynamic scaffolding made of three kinds of protein fibre: actin microfilaments, intermediate filaments (which act as cables), and microtubules (which form cellular support beams). The filaments meet in triangular structures resembling a geodesic dome – an example of what Buckminster Fuller called tensegrity. The cytoskeleton transports substances and information within the cell, and produces motion in flagellae and cilia.

The cytoskeleton also registers mechanical forces acting on each cell through proteins known as integrins, which poke through the cell's surface membrane and are hooked to the cytoskeleton inside the cell. Outside, they latch onto the inter-cellular connective tissue framework forming an extracellular matrix into which every cell in the body is anchored. When integrins move, the cytoskeleton stiffens, activating certain genes, coaxing them to generate RNA and protein messengers

signaling the cell to take action. James Oschman believes this living matrix is the mind-body's most rapid information highway, a transducer that converts pressure, tension, pulsation, and vibration into chemical messages.

- 1 Oschman JL. *Energy medicine*. Churchill Livingstone, 2000.
- 2 Ingber D. The architecture of life. *Scientific American* 1998, January. See: www.childrenshospital.org/research/ingber/PDF/1998/SciAmer-Ingber.pdf





Actin and nuclei in the cytoskeleton of UV-irradiated muntjac skin fibroblasts showing mitochondrial damage (p28 top)

Nucleus and microtubules in a bovine pulmonary artery endothelial cell (p28 middle)

Confocal micrograph of the cytoskeleton of a mixed population of granule neurons and glial cells (p28 bottom)

F- and G-actin microtubules in a bovine pulmonary artery endothelial cell (p29 top)

Bovine pulmonary artery endothelial cells labeled with probes tubulin and the mitochondria (p29 middle)

Porcine primary skeletal muscle cell stained with fluorescent proteins to show endoplasmic reticulum (p29 bottom)

Photos courtesy of Invitrogen. www.invitrogen.com

continued from page 27

of making sense of these feelings, and the challenges involved in understanding how we feel and are felt, may help us with both tasks.

The paradox of mutuality extends into the ways we speak about empathy. For instance to be embodied, to be flesh, is to be physically vulnerable (the Latin adjective *vulnerabilis* means capable of being wounded). And since this vulnerability is an inevitable aspect of bodily existence, our language is full of parallels between bodily vulnerability and emotional vulnerability. It is precisely this capacity for vulnerability that makes it possible for us to experience empathy and sympathy – ‘feeling acts’ which are deeply rooted in bodily fragility and fleshy, kinaesthetic reality. To paraphrase Edith Wyschogrod again: when we call someone ‘touchy,’ we mean they are hypersensitive, easily hurt, over-defended. If I am touched by someone’s kindness, it is because they have in a sense got under my guard, drawn close enough for me not to feel indifferent. The active use of this metaphorical tactility is expressed in phrases like ‘I feel for you’, thereby implying that my body has substituted for yours, so that I feel your pain. But if I remain untouched by another then I refuse to engage in a feeling act which identifies me with the other person’s pain or predicament. To be untouched means refusing to empathise or be compassionate.¹³

Which brings us naturally to the last subject.

Touch in language

The meaning, emotional richness and significance of many words and symbols all depend on our having had tactile experiences. Words and phrases used to indicate emotional experience are commonly used to indicate tactile ones too. The most recent edition of the *Oxford English Dictionary* has six pages devoted to meanings of touch as a noun, verb and noun/verb combination. The sense of touch, more than any other, provides the experiential ground out of which many subtle ideas, words and phrases have emerged. Certain kinds of emotions are felt in the body as are other more obviously physical bodily sensations. Gilbert Ryle in *The concept of mind* writes:

‘By feelings I refer to the sorts of things which people often describe as thrills, twinges, pangs, throbs, wrenches, itches, prickings, chills, glows, loads, qualms, hankerings, curdlings, sinkings, tensions, gnawings and shocks. Ordinarily, when people report the occurrence of a feeling, they do so in a phrase like ‘a throb of compassion’, ‘a shock of surprise’ or ‘a thrill of anticipation’. It is an important linguistic fact that these names for specific feelings such as itch, qualm, and pang

are also used as names of specific bodily sensations. If someone says that he has just felt a twinge, it is proper to ask whether it was a twinge of remorse or of rheumatism, though the word ‘twinge’ is not necessarily being used in quite the same sense in the alternative contexts.’¹⁴

Lawrence Frank is another writer who has commented on our dual use of certain words and concluded that the experience of affect (mood and emotion) is similar to the experience of tactility.

‘...we repeatedly say, “I am touched,” or “I feel” which implies both a tactile and an emotional response. Experiences are described as “touching” while many adjectives such as harsh, rough, smooth, tender, warm, cold, painful, imply a tactile sensation or experience even when used to describe non-tactile events. Without prior tactile experiences, these adjectives would carry little meaning...’¹⁵

The use of ‘I feel’ illustrates particularly the way language fuses affect and tactility. I may feel angry, miserable, frightened, jealous, joyful, these tight shoes, hungry, the warmth of the sun on my face, your lips on the back of my neck etc, etc. This coalescing of sensory and emotional experiences seems so natural to us precisely because to ‘feel’ means to become aware of a bodily state. As Damasio has so elegantly pointed out, whether we *feel* simple body sensations (tactile, bodily fullness, kinaesthetic etc) or whether we *feel* the experience of neural and humoral traffic arising from emotions, what we are doing is becoming aware of body-states through neural maps that are metaphorised, so to speak, into the mental events we call feelings.¹⁶ So the feeling continuum – in both senses of the term – extends from awareness of the most basic and simple body states to the most subtle, refined and complex ones.

Conclusion

Touch is sufficiently different from the other four senses to deserve distinct status of its own. From this perspective touch is the primary and primordial sense which is fundamental to all felt sense. Our understanding of body perception as touch-like helps explain our ways of speaking about feeling and emotions, for emotions too are bodily states. The ideas that have been put forward, although not clinical concepts *per se*, inform the way we make sense of what happens within and between people during clinical transactions, especially (but not exclusively) those that involve touching. Traditional medical models (including those used in complementary and bodywork therapies) emphasise the ‘doing to’ of technical and procedural touching. This emphasis tends to obscure certain ordinary as well as extraordinary features of ‘being with’ which are conveyed by expressive or non-procedural touch. I have offered

these ideas in the hope of encouraging wider and deeper discussion of touch in our field of work, because exploring these features can lend us insight into the relationship of mind and body (constitution) and the nature of interpersonal relationship. The study and practice of healing calls for a full appreciation of constitution and relationship. Philosophy is of no use unless it is of practical value!

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Touch therapies: the curious researcher

Peter Mackereth

*Clinical lead in complementary therapies,
Christie Hospital*

As a nurse, teacher and researcher, I have worked in intensive care, neurology and oncology and along the way completed training in a variety of complementary therapies, including: massage, hypnotherapy, reflexology and acupuncture. Being curious about touch therapies in clinical practice and being challenged by the lack of evidence by sceptical colleagues propelled my own research work.

Summary

In this paper the author shares his own journey of 'becoming curious' and respectful of the complexities of touch therapies, in particular their effects on mind and body. It is an encouragement to others to investigate and explore their work.

Examples of touch therapy research projects are given and a Yin Yang approach to research thinking suggested.

Key words:

curiosity, research, touch

Introduction

Touch therapies, such as massage and reflexology, are experiencing a renaissance in popularity, with growing numbers of therapists being recruited alongside healthcare professionals to deliver treatments in healthcare settings and hospices. Therapists train for a number of reasons, including the desire to humanise patient care and offer choices in managing difficult-to-treat symptoms. The twin challenges, though, are on the one hand to secure funding to sustain and develop services and on the other to provide for research that will build the evidence base and help us understand if and how therapies contribute to healthcare.

The language of research is complex and intimidating enough to exclude many therapists and would-be researcher-practitioners who could contribute to the discussion. Disagreements about research philosophies and ways of 'doing research' divide researchers and fuel endless academic debate about which study designs are appropriate or even essential to determine efficacy. For many scientists and healthcare practitioners the systematic review of randomised double-blind controlled trials is the pinnacle of the best-evidence pyramid.¹ However, massage is a complex intervention (unlike taking a medication) and participants

cannot be 'blinded' to the experience: even if a placebo massage could be devised, research subjects would hardly find it difficult to know whether they were in the treatment or control group! Nevertheless, in the current climate where funds are so carefully guarded, those who allocate public sector resources to massage (or other forms of complementary therapy) will see the absence of RCT evidence as a decision-making problem and a reason for not commissioning services.

Touching and talking

Traditionally, psychotherapists and counsellors – who listen rather than touch – have viewed touch cautiously and seen it as something to be largely avoided. This separation of body and mind has been seen as part of the 'boundary-making' that safeguards this intimate relationship for both the therapist and the client. But of course the exchange of words is only a part of what occurs in the therapeutic space. Living bodies often respond ahead of speaking and thinking; indeed talking may be used to block expression of the emotional self. A patient may experience release of emotions when being touched during massage (see Case Study 1), and in body-psychotherapy, 'being curious' about this material and working with it would be part of the

therapeutic contract. However, when emotions surface during massage or reflexology patients may not have the support they need for making sense of what has been disclosed. Indeed it was after several examples of this in my own touch therapy practice that I began to wonder about triggers for emotional responses and disclosures, and the skills of touch therapists and their boundaries of practice.² It is well recognised that in healthcare practice, patients and practitioners use blocking behaviours to limit and contain worries and avoid disclosure.³ When emotions are released unexpectedly, it requires a certain kind of skill on the therapist's part, as well as knowledge and some clinical supervision, to stay comfortable and clear.

'Curiosity doesn't matter any more. These days people don't want to be transported to emotional territories where they don't know how to react.'

Babenko Hector

Massage can be given with a variety of treatment outcomes in view, and they include psychological as well as physical changes. While every treatment outcome will be unique to the individual – making massage in some ways complex to investigate – this does not preclude investigation of basic mechanism of action, nor the development of measurable outcomes. Although in the past the lack of an evidence base was often given as a reason for keeping these therapies out of mainstream healthcare⁴ research effort is now removing this obstacle to integration. This is important not only for those seeking funding from healthcare providers, but also for those studying or teaching touch-based therapies, for whom research evidence is increasingly needed for facilitating best professional practice.

Case study I

Asha had been attending for massage to help with chronic lower back pain. She had a history of depression and weight gain and was currently off work again. During her third session, as her leg, which had a faint scar, was being massaged Asha began to cry. The therapist stopped and wrapped a large towel around her and then when she was more composed encouraged Asha to talk about how she was feeling.

Asha explained that while being massaged she had an image of being with her grandfather as a child in India. He had been tending to a wound on her leg with herbs and singing to her. In subsequent sessions Asha talked more about her childhood and began to plan a visit to India and see her extended family. During the six weeks of treatment she experienced significant improvements in both back pain and mood, and felt able to return to work.

Curiosity

Research work using a range of tried and tested methods can help us reflect on the theory and practice handed down to us, for we do have to become more critical of these assumptions and therapeutic claims. Potential areas and methods/designs for touch therapy research are listed below. Yet irrespective of demands for quantifiable evidence, massage and other forms of bodywork have been practised for thousands of years and will continue to be popular. Therefore, it could be argued (wrongly I would say) that if teaching and practice of touch therapies are informed by clinical experience, their potential benefits and risks will be self-evident. From this viewpoint formal research is unnecessary, expensive and time-consuming, because paying consumers clearly accept that these treatments work. Patient narratives about massage are important anecdotal evidence which deserves to be heard, explored and analysed, contributing as it does to our growing body of experience and understanding of touch therapies. And doubtless being curious and reflecting on one's own casework is a useful source of information too. Yet some of the most informative accounts would tell of poor practice and treatment failure and it is still rare for this sort of material to reach professional journals. But if we only hear positive evidence that supports our assumptions, then we really are not, in the sense that I am promoting it, being curious.

Potential areas and methods/designs for touch therapy research

Questions/research areas	Examples of methods/designs
<ul style="list-style-type: none"> • How does Shiatsu work in practice (effectiveness) 	<ul style="list-style-type: none"> • Quasi-experimental designs • Outcome studies
<ul style="list-style-type: none"> • Is reflexology any better in managing anxiety than relaxation training? (added therapeutic value) 	<ul style="list-style-type: none"> • Randomised controlled trials eg crossover design comparing two or more different treatments
<ul style="list-style-type: none"> • Who uses massage and why? (picturing) 	<ul style="list-style-type: none"> • Population surveys • Focus groups • Telephone interviews
<ul style="list-style-type: none"> • How does aromatherapy work? (understanding) 	<ul style="list-style-type: none"> • Laboratory research • Explanatory RCTs • Case studies

Adapted from the *Foundation for Integrated Medicine* (1997)⁵

Good enough evidence

'That low vice, curiosity!' Lord Byron

In folklore and fairy tales curiosity has been labelled as a feminine and feline trait.⁶ Is the female more curious than the male? A study by Kashdan and Roberts⁷ did not find a gender difference (males n=45, females n=45) at baseline, but suggested that higher levels of 'trait' curiosity among women led to more positive interpersonal outcomes in an experiment on levels of intimacy. The researchers concluded that curiosity was a neglected research topic and the curiosity-trait may be an important determinant of achievement in the social context, and a driver of personal and intellectual growth and intimacy. Curiosity, then, is something worth nurturing!

'CURIOSITY, n. An objectionable quality of the female mind. The desire to know whether or not a woman is cursed with curiosity is one of the most active and insatiable passions of the masculine soul.'
Ambrose Bierce

If valuing curiosity is important to relationships then surely it is doubly so in the hard worlds where research and healthcare meet. Here, the rigorous structures of research are tested by the complex indeterminacy of emotional, physical and spiritual aspects of life and illness. Figure 1 suggests a lateral approach to research thinking, using the Yin Yang concept to explore how differing paradigms might be bridged. But the two lists are not exhaustive; within this model is a great diversity of research methodologies. The interface (the wavy surface between Yin and Yang) is intended to encourage more dynamic interchange about what research might achieve when the worlds of quantitative and qualitative research cross-fertilise. When researchers acknowledge, for example, that quantitative methodology has its qualitative elements and visa versa (the Y-Y dots), then new and better approaches can emerge, research theory and practice improve, and curiosity for further work grows.

Sources of information

Becoming curious about touch therapy research begins when you start exploring what has already been published. The best place to find reliable research by authors with a track record of high quality work will be in peer reviewed journals. How well a study (a report or a research trial or a systematic review) is designed and written up will obviously greatly influence its chances of publication. Less obviously, editors' and reviewers' assumptions about the value of CAM research will shape their decisions about what gets into print. All too often,

reviewers have little background in CAM, because the skills required for reading and reviewing papers are seldom covered in most therapists' training. Happily this is changing as complementary therapy courses become more university based, and students get access to peer reviewed journals, and guidance on literature review and research methods. Here too are opportunities for research work through Masters and PhD programmes that support a growing band of curious researchers who want to develop the much-needed evidence. Not all of these Masters or PhD studies get published however, and there are always some in the process of submission, but you should be able to find them as bound dissertations held by the relevant university library.

Figure 1: The Yin & Yang of research (notice the significant dots and interface)

Yin		Yang
<ul style="list-style-type: none"> • Being curious • Puzzlement • Intuition • Thinking outside the box • Viewing 'placebo' as gold in the rough • Utilising qualitative approaches • Uncovering depth and meaning • Exploring phenomena • Devising new methodologies • Researcher as part of the process • Participant involvement • Choice rather than randomly assigned interventions • Gathering views, feelings and observations • Naturalistic setting 		<ul style="list-style-type: none"> • Being objective • Purposeful • Rational • Placebo not valued • Blinding of subjects & practitioner • Quantitative approaches • Theory driven • Generalisation • Pyramid of evidence • Very defined research area • Researcher separated from the field • Subjects kept at arms length • Randomisation • Inclusion/exclusion criteria • Repeatable and measurable outcomes • Controls in place

'I think, at a child's birth, if a mother could ask a fairy godmother to endow it with the most useful gift, that gift would be curiosity'

Eleanor Roosevelt

Research work

There is now a growing body of touch therapy research. The examples given in Table 1 are far from comprehensive but they do highlight studies in cancer care that gathered physiological and psychological data. The work of Drs Tiffany Field and Marie Hernandez-Reif, at the Touch Research Institutes, University of Miami, is of particular importance demonstrating as it does that biological markers and validated outcome measures can illuminate the effects of massage. Clearly these interventions are more than a 'nice treat', for massage evidently influences diverse biomarkers, including natural killer cell counts and activity, pulmonary function, cortisol, noradrenaline, dopamine and serotonin levels, as well as pain, anxiety, mood and behaviour.^{8, 9, 10} As a researcher with an interest in stress and illness, cortisol was identified early as a possible outcome measure. Abnormal levels have been linked with a variety of debilitating illnesses and it is also well accepted that prescribed corticosteroids can have a profound immunosuppressive effect.¹¹ Cortisol has been found to block maturation of macrophages and is associated with the death or apoptosis of immune cells.¹² This is a measure that can track mood and stress.¹³

Psychological benefits are reported in a qualitative study by Garnett¹⁴ whose interviews of nurse therapists (n=18) explored what complementary therapies provide to patients in hospice settings. The researcher concluded that the therapies offer a 'sustaining cocoon...an emotional inoculation at a time of vulnerability' (p129). Also cited in Table 1 is a very different design, a case study, unrelated to cancer care, but relevant to this paper. Price¹⁵ described the participant, a woman who had experienced abuse in childhood, who received body therapy, incorporating massage and emotional processing, supported by psychotherapy, over an eight-week period. Various physiological and psychological measures were assessed pre- and post-treatments, in parallel with interviews and questionnaires. As well as improvements in most of the subscales, the participant reported 'feelings of safety, emotional connection and psychotherapeutic progress' which she attributed to the addition of body therapy (p228).

It is a challenge for anyone investigating touch therapies and therapeutic outcomes to clarify whether there is a causal relationship between the treatment and the outcome. Some theories of mind/body interaction, useful biomarkers and relevant investigative approaches for researching touch therapies will be discussed in a future paper focusing on placebo response, psychoneuroimmunology and touch therapies.

My curious research

It is important for therapists to have available research designs for evaluating standard practice. My own project began not because I felt the need to change my practice to fit (for example) an RCT, but because an area of my clinical practice was raising more questions than available knowledge of reflexology could answer. Why did these patients feel less anxious after having their feet pummelled and pressed? Why do reflexologists recommend six sessions? Are effects cumulative or can one treatment have effects? Some of these questions were explored through reflecting on and writing up case studies, using a model of concept analysis¹⁶ as well as a small study with patients.¹⁷ As part of my curiosity journey I began an MPhil and attended research methodology modules at the University of Manchester. Having read about Dr Tiffany Field's touch research work with diagnostic groups in healthcare settings, my curiosity led to an email and an invite to attend a research programme at the University of Miami. Two long visits afforded opportunities to meet with other touch therapy researchers, interview Dr Field, observe data collection, provide massages to infants in the neonatal intensive care unit and be a participant in one of the studies comparing light and moderate massage pressure.^{18, 19}

More recently I have completed a five year part-time PhD study (Mackereth PA, Booth K, Caress A & Hillier VF. *Reflexology and progressive muscle relaxation training for people with multiple sclerosis: a crossover trial* [submitted for publication]) using a quasi-experiment incorporating a crossover design to compare therapeutic outcomes from both progressive muscle relaxation (PMR) and reflexology, delivered by nurse reflexologists. Some controls were put in place, which included me as the researcher not performing the treatments. Patients were asked to attend at the same time each week and randomly assigned to one or other treatment for six weeks and then, after a four week break, given the other treatment. Aside from various psychological measures, salivary cortisol levels were assayed before and after each treatment, along with measurements of heart rate and blood pressure. The trigger for choosing PMR as a possible comparative treatment was 'reflexology is no better than a relaxation technique', a comment made by a medical colleague who was curious about benefits claimed by patients who had received reflexology.

My journey into the design of the study, conducting it and analysing the data failed to quench my curiosity; indeed it raised more questions and ideas for future projects! For example in the case study cited earlier a question occurred to me: how often does disclosure of worries and concerns occur during massage sessions? To get a better idea about this, treatment sessions were recorded for evidence and levels of disclosure by

patients. And in fact this proved to be a rich source of data about living with multiple sclerosis, the experience of receiving reflexology and the care provided by health professionals. My research work is ongoing: case studies gathering qualitative data about the experiences of being a carer and the therapeutic outcomes of chair massage²⁰ and a survey investigating complementary therapy services for hospital staff²¹ as well as current audit work on acupuncture for help with smoking cessation.

Conclusion

We all have to become more curious about touch therapies. The future development of therapists, their practice and the safety and wellbeing of our patients all depend on it. It can be enormously fulfilling for therapists to be involved in or even instigate a research project, though the research challenge can seem daunting. But if common sense guidelines are followed and support is available, research is fascinating, albeit hard, work. Importantly, as research expertise in touch therapies grows, there is great potential to encourage working more 'outside the box', because we need more Yin Yang thinking if we are to address the special problems of conducting CAM research, and this could set important new kinds of inquiry in motion within the wider research community.

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Table 1 Examples of touch therapy research (Extracts from Mackereth & Stringer)²²

Study	Purpose/Condition	Method	Treatment/Groups	Outcome measures	Findings	Comments
Grealish et al. ²³	To assess the effects of foot massage on nausea, pain and relaxation in hospitalised patients with cancer	Crossover RCT N=87	1 Two sessions of foot massage; and 2 Quiet resting	HR Pain (VAS) Nausea (VAS) Self-report of relaxation (VAS)	Significant difference in all measures. Improving relaxation and reducing nausea and pain.	No control for medication. No exploration of lasting effects. Numbers in each group not given. 10 min sessions only. Therapists were trained as reflexologists.
Stephenson & Weinrich ²⁴	To assess the effects of reflexology on pain and anxiety in patients with lung or breast cancer	Quasi-experimental Crossover trial N=23	1 Reflexology 2 No intervention period	Pain (SF-MPQ) Anxiety (VAS)	Significant decrease in anxiety following reflexology for both groups. Significant decrease in pain for breast cancer group.	Only 2 out of the 10 lung cancer patients reported pain compared to 11 out of 13 in the breast cancer group. Gender difference in the group and effects of pain relief makes it difficult to interpret results.
Gambles et al. ²⁵	An evaluation of a hospice-based reflexology service	Qualitative study N=34	Reflexology treatments	Semi-structured questionnaires Thematic analysis of the questionnaire data	Positive comments; improved wellbeing, comfort support, able to cope with symptoms and treatment.	Hospice staff and therapist distributed the questionnaire. No demographic details. Sensitive approach taken given the vulnerability of service users in this setting.
Price ¹⁵	An evaluation of adjunct body-oriented therapy for childhood abuse recovery	Descriptive Case study N=1	8 weeks of body-oriented therapy as an adjunct to psychotherapy	Interviews Questionnaire SCL-90-R, POMS, CR-PTSD & Physical Symptom Checklist	Changes across all subscales. Improvements in physical symptom checklist except fatigue. Participant reported safety and body awareness provided profound impact on the psychotherapeutic process.	Body therapy incorporated massage, attendance to safety body awareness education, body/mind integration and session review. Body oriented therapist was the principal investigator. Concurrent psychotherapy
Garnett ¹⁴	An exploration of the use of complementary therapies by palliative care nurses	Qualitative study N=18 nurse therapist	Interviewees practiced mainly massage, aromatherapy and reflexology 16 hospice sites involved	Semi-structured interviews informed by feminist interviewing practice Thematic analysis utilising grounded theory approach	Complementary therapies as facilitating an emotional inoculation and sustaining a protective cocoon, provided by professional caretakers at a time of vulnerability.	Utilised NU*DIST software. Researcher; the author; carried out the interviews. Practitioner perspective only
Hernandez-Reif et al. ⁸	To assess the effects of massage on the immune system, neuroendocrine, and perceived stress of women with early stage of breast cancer	Randomised control trial N=34	1 Five weeks of massage (15 sessions) 2 Standard medical care	STAI, POMS, SCL-90-R, Life Events Questionnaire, NK cells, lymphocytes, Catecholamines	Massage group showed: Short term reduced anxiety depressed mood and anger. Longer term reduction of depression and hostility. Increased dopamine, serotonin values, NK cells and lymphocytes.	Small sample. Only assessed changes over the 5 weeks – need for longitudinal study. Randomisation 'flip of the coin'.

Terms: STAI: State Trait Anxiety Inventory; HR: Heart Rate; VAS: Visual Analogue Scale; MPQ – Short-form McGill Pain Questionnaire; CR-PTSD – Crime-related Post-traumatic Stress Disorder Scale; SCL-90-R: Symptom checklist; POMS: Profile of Mood States; NK: Natural Killer



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Breathing, chronic pain, touch and the body-mind

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Summary

Many people present in primary care with persistent unexplained physical symptoms. Patients with functional somatic syndrome include those 'diagnosed' with fibromyalgia, irritable bowel syndrome, and chronic pelvic pain. The current understanding of such complex multi-symptomatic conditions is explored. A brief overview is offered of a common maintaining feature of FSS – breathing pattern disorder – its effects, and an approach to its treatment.

Introduction

There are both linear and spatial ways of interpreting what happens in life in general, and to the body in particular, where health is concerned. Cause and effect represent the way many people understand the relationships between events (causality) ie one thing causes, or is caused, or is at least strongly influenced by, another.

An alternative way of viewing events is to see them as being part of an infinitely complex continuum, as part of a larger process, linked by synchronistic connective principles. The words synchronicity, or 'simultaneity', may be used to describe this way of viewing patterns and events.

Take as an example:

- Overbreathing (hyperventilation) is commonly associated with anxiety, therefore some people may assume that hyperventilation 'causes' anxiety.
- Anxious individuals commonly overbreathe, therefore some people may assume that anxiety causes hyperventilation.

Or it might be said that anxiety and overbreathing not only influence each other, but that they may be triggered and/or aggravated by many other factors, including hypoglycaemia, increased progesterone levels, sympathetic arousal, toxic factors, adrenal stimulation, pain, metabolic acidosis, climatic conditions, altitude, emotional stimuli, allergic reactions... and so on.

Therefore should we not more appropriately assume that anxiety and hyperventilation are part of a larger continuum, involving all or any of these (and numerous other) factors, interacting with the unique genetic and acquired biochemical, biomechanical and psychological features of the person affected?

Solutions, albeit partial, may therefore be found in many ways, drawn from the vast array of therapeutic possibilities – medication, nutritional strategies, stress-reducing methods, retraining, psychological support, biomechanical mobilisation, and many other approaches, none of which can 'cure' the individual, but all of which might allow or encourage self-regulation. When treatment is seen in this way, it becomes another

feature in the contextual pool of influences interacting within the individual. The therapeutic outcome should, therefore, not be seen as an effect resulting from a cause (treatment), but rather the emergence of (hopefully) positive (homeostatic) change due to reduced adaptive load and/or enhanced functional integrity.

In this paper some of the current understanding of complex multi-symptomatic conditions is explored, after which a brief overview is offered of what is seen to be a common maintaining feature – over-breathing.

The ‘chronic everything’ patient

Patients with medically unexplained symptoms, often involving chronic pain, are common in both primary and secondary care. Many common symptoms presenting in primary care remain unexplained, while 25–40% of patients in hospital outpatient clinics have symptoms that are not fully explained by organic disease.¹

- For example systemic rheumatic diseases are complex chronically painful disorders of variable severity, classified according to their clinical and immunologic manifestation, with specific causes of these diseases often not determined.²
- Available data supports a multifactorial threshold model of causation, ie an accumulation of genetic and environmental influences [and their interactions] that operate in the individual and permit such conditions to manifest.³
- Masuko & Nakamura⁴ note that patients with multiple symptoms such as fibromyalgia (FMS), irritable bowel syndrome (IBS) and chronic pelvic pain (CPP), can usefully be subsumed into what is termed the functional somatic syndrome (FSS). This is defined as a group of related syndromes, characterised more by the symptoms experienced than by structural or functional abnormalities. The diagnostic criteria and/or symptoms of the related conditions of FSS frequently overlap, with co-morbidity a common feature. For example, patients with IBS often suffer from chronic pain, and may well fall into the current definition of FMS.
- Nimnuan *et al*⁵ have investigated a plethora of functional somatic syndromes, including: AFP (atypical facial pain), TMJ (temporomandibular dysfunction), FMS (fibromyalgia syndrome), CFS (chronic fatigue syndrome), IBS (irritable bowel syndrome), NUD (non-ulcer dyspepsia), NCCP (non-cardiac chest pain), MCS (multiple chemical sensitivity), GS (globus syndrome), HV (hyperventilation syndrome), TH (tension headache), PMS (pre-menstrual syndrome) and CPP (chronic pelvic pain). They identified a great deal of overlap in the symptoms reported by patients previously identified/diagnosed with one

or other of these ‘syndromes’, and note that in one survey⁶ ‘almost two-thirds of medical outpatients presented with multiple symptoms’. They argue that ‘an appreciation of the fundamental unity of those syndromes may reduce the potential for iatrogenic harm, whilst encouraging continuity of care’.

- In a similar vein Van Houdenhove⁷ makes a plea that patients with ‘medically unexplained symptoms’, notably the large group with persistent stress intolerance and pain hypersensitivity, who meet diagnoses of ‘chronic fatigue syndrome’ (CFS) and/or ‘fibromyalgia’ (FMS), should receive more streamlined medical care and understanding.

The term ‘somatisation’ is now used less commonly in such cases, with recent publications referring to such patients as having ‘medically unexplained physical (or somatic, or functional) symptoms’. Increasingly evidence is emerging indicating the presence of visceral and somatic hyperalgesia as a common feature of FSS, with central sensitisation appearing to play an important role. This feature of sensitisation appears to be a repetitive aspect of the processes involved in many poly-symptomatic patients.

Understanding of the biological factors involved in many such syndromes is important, and to view these syndromes as purely ‘psychological’, is probably a mistake. Such syndromes do not represent discrete disorders, but overlap in terms of gender, incidence, co-existing psychiatric disorder, aetiology, prognosis and response to treatment. Indeed, there seem to be more similarities between these syndromes than there are differences.⁸

Central sensitisation

Yunus⁹ has defined what he terms a central sensitivity syndrome (CSS) that offers an understanding of common mechanisms in the aetiology of the cluster of symptoms discussed above. He argues that terms such as functional somatic syndrome, and ‘medically unexplained symptoms’, do not explain or identify one presumed common mechanism, central sensitisation. He says:

‘Central sensitivity syndromes (CSS) comprise an overlapping and similar group of syndromes without structural pathology, and are bound by the common mechanism of central sensitisation (CS) that involves hyper-excitement of the central neurons through various synaptic and neurotransmitter/neurochemical activities. CS is manifested as hypersensitivity to various noxious (eg pressure and heat) as well as non-noxious (eg touch) stimuli. Fibromyalgia syndrome (FMS) and similar conditions have been called “functional”, “functional somatic syndromes”, and “medically unexplained symptoms”, among others. *None of these nomenclatures, however, clearly states two essential*

criteria of CSS, ie an overlapping relationship between these syndromes and an appropriate pathophysiological mechanism (eg CS) that is common to them.' (Italics added)

Yunus notes that Gulf War syndrome (GWS) has also not been listed as a separate entity, as it seems to be a mixture of several CSS conditions: FMS, IBS, chronic fatigue syndrome (CFS), multiple chemical sensitivity syndrome (MCS) and post-traumatic stress disorder (PTSD). As with so much in clinical management of these chronic syndromes, the case for an understanding of central sensitisation as a major feature needs to be balanced by other perspectives.

Peripheral sensitisation?

Staud,¹⁰ for example, broadens the discussion by involving the possible involvement in FMS of peripheral nociceptor input as a key feature, along with central sensitisation (as discussed above), and incorporating psychological factors, while also offering thoughts on therapeutic options:

'FM is a chronic pain syndrome that is characterised by widespread pain in peripheral tissues, psychological distress, and central sensitisation. Whereas the role of psychological factors in FM patients' pain has been well established, little is known about the origin of the sensory abnormalities for pain. Deep tissue impulse input is most likely relevant for the initiation, and/or maintenance of, abnormal central pain processing and represents an important opportunity for new treatments and prevention of this chronic pain syndrome. Three important strategies for FM therapy appear useful at this time: reduction of peripheral nociceptive input, particularly from muscles; improvement or prevention of central sensitisation; and treatment of negative affect, particularly depression. The first strategy is most likely relevant for acute FM pain exacerbations and includes physical therapy, muscle relaxants, muscle injections, and anti-inflammatory analgesics. Central sensitisation can be successfully ameliorated by cognitive behavioural therapy, sleep improvement, NMDA receptor antagonists, and anti-seizure medications. The pharmacological and behavioural treatment of secondary pain affect (anxiety, anger, depression) is equally important and may currently be one of the most powerful interventions for FM pain.'

Psychology: the affective-spectrum syndrome model

Evidence for the existence of an affective-spectrum of conditions is supported by a huge multinational study of depression and somatisation, conducted by Simon *et al*,¹¹ involving 25,916 primary care patients from 15

primary care centres in 14 countries. Of these, 10% met criteria for major depression, and half of this 10% reported three or more unexplained somatic symptoms.

Whitehead *et al*¹² suggest that one subgroup of IBS patients have a primarily biological basis for their symptoms, while others have a primarily psychological basis. They suggest that co-morbidity with other disorders, and excessive general somatic symptoms, are markers for somatisation, helping to identify the group with a predominantly psychological IBS etiology, and that patients with IBS – and no co-morbid conditions, apart from a few general physical complaints – are more likely to have a biologic basis for IBS symptoms.

Genetics?

Buskila¹³ has strongly suggested that an explanation involving genetic predisposition exists for the evolution of many of the chronic pain conditions associated with these models of polysymptomatic patients:

'Polymorphisms of genes in the serotonergic, dopaminergic and catecholaminergic systems have been suggested to play a role in the aetiopathogenesis of FMS. These polymorphisms are not specific for FMS, and are associated with other FMS-related syndromes, the affective spectrum disorder or functional somatic disorder. The mode of inheritance of FMS is unknown, but it is most probably polygenic.'

Current thinking therefore seems to favour the involvement of a combination of biopsychosocial features in the etiology of FMS and associated polysymptomatic conditions, incorporating peripheral, central and psychological sensitisation features and processes, possibly overlaid on genetic predisposition.

Is FMS a result of depression – or is FMS simply depressing?

Several major reviews have concluded that whilst there is indeed an association between depressive illness and conditions such as FMS, what this association is remains unclear. There have been suggestions, despite some equivocal evidence, that there exists a direct association,¹⁴ while others feel that both depressive illness and FMS (as well as CFS, IBS, premenstrual dysphoric disorder, migraine and atypical facial pain) may possibly all share a common aetiological step.¹⁵ Williams¹⁶ is clear that 'when depression and pain co-exist, depression is most frequently the consequence of having pain, rather than its initial cause'. He goes further to state: 'The literature on both FMS and pain in general suggests that when depression is co-expressed with FMS, it needs to be treated *in addition to*, but not in place of, FMS'. (Italics added)

That there is a link between FMS (and many other multi-symptomatic syndromes) and depression is not in question. What is strongly asserted by many experts (see above) is that in the vast majority of cases this link is not causal. The link with anxiety and other psychological or emotional states is equally unclear. It is very difficult to imagine that living with the cluster of symptoms associated with chronic pain, chronic fatigue, chronic gut disorders, and many other symptoms, could be other than depressing, and anxiety provoking!

Clinical care

The aetiological factors in these disorders are best considered as predisposing, precipitating or perpetuating. Combinations of these factors – possibly including toxicity, nutritional imbalance, poor stress management skills, biomechanical overload, autonomic imbalance, trauma, chronic viral and other infections, endocrine imbalance etc¹⁷ – are particularly relevant and if possible should be addressed in the management plan. In all this it seems obvious that it is necessary to emphasise functional improvement rather than symptomatic relief, and ‘to aim for care, not cure’.¹⁸

A universally useful approach?

The notes on respiratory rehabilitation (below) are not comprehensive, and are not meant to suggest that this approach offers a panacea. However they are aimed at supporting the assertion that few patients involved in these functional syndromes breathe normally, and that disturbed respiratory patterns frequently negatively influence emotions, pain perception, and a variety of other key functions.

- Overbreathing (aka breathing pattern disorders [BPD], the extreme of which is hyperventilation), is largely a female problem that can result in a complex array of symptoms ranging from cardiovascular to digestive, emotional, musculoskeletal¹⁹ and numerous others, including fatigue, ‘brain-fog’ and profound disturbance of levels of calcium and others nutrients.
- Courtney & Cohen²⁰ observe that ‘dysfunctional breathing is being implicated in many conditions commonly seen by osteopaths, including fibromyalgia and chronic pain, and work-related musculo-skeletal problems’.
- The female:male ratio of BPD occurrence ranges from 2:1 to 7:1 (similar to that noted in FMS and CFS) in different studies.²¹
- Relative to men, women have a higher rate of respiration which is exaggerated during the luteal phase of the menstrual cycle. Women may be more at risk because of hormonal influences, since progesterone stimulates respiration, and in the luteal (post ovulation/pre-menstrual) phase, CO₂ levels drop on average 25%. Additional stress can subsequently ‘increase ventilation at a time when carbon dioxide levels are already low’.^{22, 23}
- Frank hyperventilation has been widely studied with regard to its relationship to both physical and emotional symptoms, most notably anxiety and panic attacks²⁴ as well as the connection between such symptoms and conditions such as FMS. It was found that among FMS patients a significantly higher proportion reported lifetime panic disorders, which are directly linked to hyperventilation.²⁵
- Lum²⁶ has discussed a vicious cycle of events: ‘Although Kerr *et al*²⁷ pointed out that the clinical manifestations of anxiety were produced by hyperventilation, it was Rice²⁸ who turned this concept upside down by stating that the anxiety was produced by the symptoms and, furthermore, that patients could be cured by eliminating faulty breathing habits...’ He suggested that given habitual hyperventilation, a variety of triggers, psychic or somatic, can initiate a vicious cycle of increased breathing and symptoms, including anxiety, that can exacerbate hyperventilation, so generating more symptoms and more anxiety.
- The most immediate aspect of overbreathing involves excessive exhalation of CO₂ which in turn depletes carbonic acid levels, producing an increase in alkalinity of the blood. During hyperventilation blood pH rises (normal is ± 7.4), creating respiratory alkalosis.²⁹
- With the onset of respiratory alkalosis there is an immediate disruption in the acid-base equilibrium (as bicarbonate is excreted in a homeostatic attempt to normalise pH), triggering a chain of systemic physiological changes, many of which have adverse implications for musculoskeletal health. There are, as a result, negative effects on balance,³⁰ motor control,³¹ pain thresholds³² and autonomic imbalance, characterised by sympathetic arousal.³³ The processes of central and peripheral sensitisation, discussed earlier, would be enhanced by many of these changes.
- Symptoms as diverse as neck and head pain, chronic fatigue, anxiety and panic attacks, cardiovascular distress, gastro-intestinal dysfunction, lowered pain threshold, spinal instability and hypertension (this is not a comprehensive listing) may be directly caused, or more commonly aggravated and maintained, by breathing pattern disorders such as hyperventilation.³⁴
- Lee & Lee³⁵ have demonstrated a clear connection between respiratory (diaphragmatic) dysfunction and pelvic floor problems (high tone or low tone),

potentially involving associated affects including stress incontinence, prostatic symptoms, interstitial cystitis and chronic pelvic pain.

- Anxiety and apprehension emerge rapidly as a result of (and often preceding) hyperventilation patterns of breathing. The accessory breathing muscles of the upper chest and neck and shoulder region are particularly involved. This evidence of selective regions of muscles becoming constantly activated during periods of emotional distress leads to a picture which explains the ischemia, pain, fatigue and general dysfunction. These changes have strong parallels with the description of the aetiology of myofascial trigger points, as suggested by Simons.^{36, 37}

Why do people hyperventilate?

Lum³⁸ discusses the reasons for people becoming hyperventilators: 'Neurological considerations can leave little doubt that the habitually unstable breathing is the prime cause of symptoms. Why they breathe in this way must be a matter for speculation, but manifestly the salient characteristics are pure habit'. Breathing retraining has been used to correct hyperventilation. Lum reported that in one study more than 1,000 patients were treated using breathing retraining, physical therapy and relaxation. Symptoms were usually abolished in one to six months with some younger patients requiring only a few weeks. At 12 months, 75% were free of all symptoms, 20% had only mild symptoms and about 1 patient in 20 had intractable symptoms.

Effects of hyperventilation

- Reduction in PCO₂ causes respiratory alkalosis via reduction in arterial carbonic acid, which leads to major systemic repercussions.
- The first and most direct response to hyperventilation is cerebral vascular constriction, reducing oxygen availability by about 50%.
- Of all body tissues, the cerebral cortex is the most vulnerable to hypoxia, which depresses cortical activity, causing dizziness, vasomotor instability, blurring of consciousness ('foggy brain') and vision. Many of these symptoms are noted in most cases of FMS.
- Loss of cortical inhibition results in emotional lability.
- Neural repercussions: loss of CO₂ ions from neurons during moderate hyperventilation stimulates neuronal activity, producing muscular tension and spasm, speeding spinal reflexes, and producing heightened perception (pain, photophobia,

hyperacusis) of major importance in chronic pain conditions such as FMS.

- When hypocapnia is more severe or prolonged it depresses neural activity until the nerve cell becomes inert.
- What seems to occur in advanced or extreme hyperventilation is a change in neuronal metabolism; anaerobic glycolysis produces lactic acid in nerve cells, lowering pH, which then diminishes neuronal activity so that in extreme hypocarbia, neurons become inert. Thus, in the clinical condition, initial hyperactivity gives way to exhaustion, stupor and coma.^{39, 38, 40}

Structural effects of hyperventilation

Garland⁴¹ summarises the structural modifications which inhibit successful breathing retraining as well as psychological intervention, including:

- visceral stasis/pelvic floor weakness
- abdominal and erector spinae muscle imbalance
- fascial restrictions from the central tendon via the pericardial fascia to the basiocciput
- upper rib elevation with increased costal cartilage tension
- thoracic spine dysfunction and possible sympathetic disturbance
- accessory breathing muscle hypertonia and fibrosis involving shortening of muscles such as sternomastoid, scalenes and upper trapezius (see *wbiplash* below)
- promotion of rigidity in the cervical spine with promotion of fixed lordosis
- reduction in mobility of second cervical segment and disturbance of vagal outflow.

These changes, Garland states:

'...run physically and physiologically against biologically sustainable patterns, and in a vicious circle promote abnormal function which alters structure which then disallows a return to normal function. In hyperventilation, where psychology overwhelms physiology, if assistance can be given to the individual by minimising the effect of somatic changes [as described above] and if these structural changes can be provided with an ability to modify, therapeutic interventions via breath retraining and counselling will be more effective'.

Recognising over-breathing

Clinical experience suggests that observation, palpation, and the cluster of symptoms associated with unbalanced breathing, can offer strong indications of BPD in such individuals. Additionally the Nijmegen questionnaire provides a non-invasive test of high sensitivity (up to 91%) and specificity (up to 95%). This easily-administered, internationally validated diagnostic questionnaire is the simplest, kindest and to date most accurate indicator of acute and chronic hyperventilation, apart from use of capnography which measures CO₂ levels.^{42, 43}

Rehabilitation

Ample research evidence exists to indicate that arousal levels can be markedly reduced via the habitual use of specific patterns which can be incorporated into breathing retraining.

Strategies that can help to normalise such a cascade of health problems have been shown in many studies to require (for optimum results) a combination of breathing retraining and physical medicine interventions, that focus attention on mobilisation/normalisation of the thoracic cage, diaphragm and accessory respiratory muscles.

Reducing levels of apprehension, anxiety and fear also have the potential for encouraging improvement in breathing patterns, and all the negative symptoms that flow from these.^{26, 44, 45}

There is good evidence that breathing rehabilitation combined with appropriate manual mobilisation methods offers useful ways for achieving reduced anxiety/panic levels, and for improving postural control and somatic complaints, such as low back pain, and conditions such as FMS and CFS.^{46, 47}

Conclusion

BPDs are common, easily recognised, and commonly correctable via retraining and manual soft tissue (and sometimes osseous) mobilisation of respiratory structures. The evidence is that breathing pattern disorders are a feature of most chronic multi-symptom syndromes, where the widespread effects of over-breathing can be seen to be a maintaining feature, that if eliminated or improved, can improve the quality of life of the individual.

Physical therapist and expert in breathing rehabilitation Dinah Bradley, when asked why breathing pattern disorders go largely unrecognised, replied that they are so common that they are thought by many practitioners and therapists to be 'normal', and that to a large extent they were simply not looked at as having the potential to cause the symptoms they so obviously do.³⁹

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Persistent pain

Acute (sudden) pain is the body's warning signal that something specific is wrong. Persistent (chronic) pain is defined as pain lasting for six months or longer. It may be the result of chronic inflammation, as occurs in some kinds of arthritis, or nerve damage. However, persistent pain may also derive from a complex problem involving both mind and body, when the nervous system begins to generate pain signals even though no underlying physical cause is involved. Mind-body therapies are important to treatment, along with painkillers and acupuncture.

Summary

In the second of a series of extracts from 'Family Health Guide – New Medicine', we look at an integrated approach to the symptoms and treatment of persistent pain.

Extracted from Family Health Guide – New Medicine, Editor-in-Chief: Dr David Peters, published by Dorling Kindersley. Contributors: Dr John Briffa, Leon K.Chaitow, Dr Andrew Chevallier, Dr Peter Fisher, Dr Adrian Hemmings, Dr Randy Horwitz & Dr David Kiefer, Professor George Lewith, Michael McIntrye, Kenneth R.Pelletier, Dr Penny Preston.

What are the symptoms?

- Long-term pain anywhere in the body

Why might I have this?

Predisposing factors

- An infection, injury or other cause, even if it has healed
- Being depressed (states of mind and other mind-body issues can affect perception of pain)

Treatment plan

Primary treatments

- Treatment of underlying cause where possible
- Painkillers (for short-term use)
- Other drugs to relieve pain, such as NSAIDs
- Physical treatments eg TENS
- Psychological treatments eg counselling

Back-up treatments

- Corticosteroid injections for joint pain
- Opioid drugs for intractable pain
- Nerve blocks for severe pain
- Antidepressants

Worth considering

- Fish oil supplements
- 5-HTP supplements
- Acupuncture
- Bodywork and movement therapies
- Exercise
- Meditation
- Cognitive behavioural therapy

Why does it occur?

The sensation of pain can stem from injury, infection and many other causes. Some of the most common causes of pain include injuries, rheumatoid arthritis, osteoarthritis, back problems and neuralgia. Sometimes pain is perceived in the wrong area of the body. In angina, for example, pain signals from the heart travel up the sensory nerves of the spinal cord together with signals from the left arm. The brain becomes confused and senses pain in an unexpected part of the body (the left arm, neck or jaw).

Persistent pain and 'gate control'

In some cases it is not possible to identify an underlying cause for chronic pain and there is often no clear explanation for why some pain persists even after the disease or condition that triggered it has healed. However, persistent pain syndromes are very real and incapacitating to those who develop them, having a devastating effect on work and relationships. Persistent pain is increasingly viewed as a disorder in its own right instead of a symptom of an underlying cause.

According to the 'gate control' theory, nerve impulses travelling from the body via the spinal cord to pain receptors in the brain can be influenced by nerve cells in the spinal cord that behave like gates.

By shutting or opening these 'gates', the brain is able either to magnify or to reduce pain signals. Chemicals called endorphins are the body's natural painkillers. They work by slotting into receptors located in the brain, spinal cord and nerve endings, where they block pain impulses. How wide the pain gates open and how much pain information reaches the brain depends partly on the quantity of endorphins that are circulating in the body.

The spinal cord's pain gates can be shut by nerve impulses travelling down from the brain, or conversely they can be opened by messages from the brain. A wide open pain gate results in pain even if nerves coming to the spinal cord are not sending in any pain messages.

Tolerance

Tolerance of pain varies, partly due to an individual's psychological state. This is because emotional states modify the levels of endorphins in the body. The effect of psychological state on perception of pain explains why athletes who are injured in competition are often able to carry on regardless, and how soldiers are sometimes able to fight on in the heat of battle despite devastating injury. Pain is perceived as being worse when people are depressed and better when they are distracted by something enjoyable.

How someone interprets pain and any ideas they may have about it and its consequences affect pain tolerance. Past experiences and associations with pain, along with general life stresses, also play a part in perception and tolerance of pain.

Vicious circle

People with chronic pain tend to immobilise themselves rather than taking exercise that could release the painkilling endorphins that would decrease their sense of fear and depression. Lack of activity also weakens and shortens muscles and causes them to become tense, creating muscle spasms and more pain. This pain-tension cycle can cause deepening depression, helplessness and lower pain tolerance. People in pain also tend to overbreathe, which makes muscles more prone to spasm and alters the way nerve impulses are transmitted to the brain.

Hypersensitivity

Continual pain can make a pain pathway more sensitive to pain impulses, long after the original cause of the pain has been healed. Psychological states are known to directly affect the body: in one experiment, just thinking about painful experiences caused the back muscles of people who complained of chronic back pain to become tense. By expecting the worst when a migraine begins,

people who have regular migraines may tighten muscles and restrict blood flow, thereby making the attack longer and more severe.

Self help

The following measures may help to reduce pain and improve wellbeing:

- Keep a diary to record episodes of pain in order to be able to better identify factors that make it better or worse.
- Avoid becoming tired and take plenty of rest each day.
- Take regular aerobic exercise such as walking, swimming or tennis, as well as yoga or stretching to prevent muscles from becoming stiff.
- Do meditation or relaxation exercises every day.
- Take fish oil supplements (see below).
- Make time for friends and family as well as for enjoyable hobbies and activities that distract you and lift your mood.
- Have regular relaxing massages.

Treatments in detail

Conventional medicine

Treating an underlying cause

Your doctor will arrange investigations to look for an underlying cause of persistent pain, which will be treated wherever possible. Various measures may be helpful in treating persistent pain and there is ongoing research into potential new treatments. For example, research shows that cannabis may relieve muscle pain in multiple sclerosis although prescribing it remains a controversial issue in most countries. You may also be referred to a local pain specialist or to a multidisciplinary pain clinic, if there is one available in your area, where experts in pain management can help to reduce pain levels and restore normal function and wellbeing.

Pain-relieving drugs

Various pain-relieving drugs are available, ranging from mild analgesics to powerful opiate drugs. Non-steroidal anti-inflammatory drugs (NSAIDs) are also helpful in some cases, for example in joint pain caused by inflammation.

Even though they are not primarily prescribed for pain, some drugs relieve certain types of pain in addition to their primary action. Such drugs include the anti-depressant amitriptyline and the anticonvulsant

carbamazepine, both of which may be used to treat the pain of neuralgia.

Drugs for persistent pain can cause a range of possible side-effects: ask your doctor to explain them to you.

Injections and nerve blocks

Corticosteroid injections into joints may help relieve pain in certain joint diseases, such as osteoarthritis. Nerve blocks are another option for certain types of chronic pain. For example, epidurals, in which a local anaesthetic is injected into the space around the membranes enveloping the spinal cord, may offer temporary relief for back pain. Very severe pain arising from surgery or serious injury may be treated with injections of opioids. These drugs are not prescribed for long-term use due to their addictive properties. However, the opioids morphine and diamorphine (heroin) may be prescribed long-term for the intractable pain of some cancers and certain other conditions.

Physical treatments

Various physical treatments are available to help relieve pain, including acupuncture, massage and ultrasound therapy. In transcutaneous electrical nerve stimulation (TENS), electrical impulses are relayed from a portable impulse generator to electrodes stuck to the skin in the painful area. They are left in place usually for about 30 minutes. TENS treatment may relieve persistent pain, such as chronic back pain, for several hours.

Psychological help

Pain is stressful, and your doctor may suggest counselling to help you cope. Cognitive behavioural therapy may be especially helpful (see below). In addition there are organisations that can offer emotional support and practical day-to-day advice. Anti-depressants may be prescribed for the depression which often accompanies persistent pain.

Nutritional therapy

Fish oil supplements

Pain associated with inflammation may be helped by supplementation with omega-3 fatty acids. Excessive consumption of omega-6 polyunsaturated fatty acids (found in vegetable oils and fast foods) and a relative lack of omega-3 fatty acids (found in oily fish) seems to promote inflammation and pain.

Supplementation with omega-3 fatty acids has been shown in studies to reduce inflammatory processes and pain in the body. The omega-3 fatty acids EPA and DHA

at doses of 378mg per day of EPA and 259mg per day of DHA for at least two months have been used in other studies to reduce inflammation. Omega-3 fatty acids can be found in some nuts and seeds and in oily fish such as salmon, mackerel, trout and sardines. Including these foods in the diet may help to control pain. Taking 1–3g of fish oil each day is likely to help persistent pain also.

Fish oil supplements can enhance the action of anticoagulant drugs such as warfarin; ask your doctor for advice.

Tryptophan

The amino acid tryptophan is required for the release of the substance beta-endorphin, which is one of the body's natural pain-relieving compounds. Tryptophan is also needed for the production of serotonin, a brain chemical that may reduce a tendency to sense pain. Supplementation with tryptophan may be able to change the body's pain threshold so that pain is not sensed so readily. Tryptophan exists naturally in foods such as meat, tofu, almonds, peanuts and pumpkin and sesame seeds. Tryptophan supplements are not available over the counter in many countries, including the UK and the USA. However, 5-hydroxytryptophan (5-HTP), which is a substance that tryptophan is converted into before it is made into serotonin, is a good alternative. If you want to see if 5-HTP will benefit you, take 50mg two or three times a day.

Acupuncture

Acupuncture is often used by multidisciplinary pain teams to treat unexplained pain and appears to be an effective treatment. It is said to work by stimulating the release of endorphins and 'closing pain gates' by stimulating nerve fibres that block pain. It may also be helpful in relieving the anxiety and depression that



Acupuncture has a good track record for treating unexplained persistent pain. Fine needles are inserted (here on the kidney meridian) to stimulate nerve fibres.

accompanies long-term pain. It is possible to manage persistent pain using acupuncture, but since persistent pain is not in itself a diagnosis, it is almost impossible for clinical trials to provide evidence in this area.

Almost all acupuncture techniques have been used at some point to treat persistent pain and there is no real evidence to suggest which approaches are best, but it is clear that it is worth persisting with treatment over a month or two to see if pain relief can be obtained. Further treatment may be required if some, but not complete, pain relief is achieved.

Bodywork and movement therapies

Manipulation therapies

Easing pain that arises from the central nervous system may require surgical or other interventions, such as nerve blocks (injections, see above), that aim to interrupt the transmission of pain signals. This is especially true if pain is extreme and/or longstanding.

However, if pain stems from a peripheral source, such as nerves in an arm or leg, some manual therapies (such as neuromuscular therapy and osteopathic soft tissue manipulation) may be able to alter the mechanism giving rise to the pain either through manipulation or soft tissue treatment or a combination of both. Through teaching certain breathing rehabilitation and relaxation methods practitioners can help patients to reduce their general sensitivity to pain.

Deactivation of trigger points

The researchers Wall and Melzack have shown that, whatever other factors are involved, all chronic pain involves trigger points in muscles. They are a factor in the continuing painful state and may even be the primary cause of the pain. Trigger points (particularly sensitive areas in the muscles) can be eliminated by various means, including soft tissue manipulation, local anaesthetic injection and acupuncture. Releasing trigger points allows the circulation to be restored to tense muscles.

Hydrotherapy

This can be both relaxing and invigorating, helping to improve the circulation. There are a number of forms of hydrotherapy from exercising in heated swimming pools to applying cold compresses to the painful area.

Therapy using water, particularly involving supervised exercises in seawater known as balneotherapy, has been studied as a means of relieving general chronic pain. The hydrostatic force of the water is considered to help bring about pain relief. Balneotherapy is often prescribed for people with psoriatic or rheumatoid arthritis, and

can significantly help to relieve pain and improve general functioning.

Exercise

Pain can make people reluctant to exercise but this should be resisted since lack of activity weakens, tenses and shortens muscles which can in turn create more pain. It is easy to fall into a vicious circle. Taking gentle exercise each day, such as walking, cycling or swimming, as your condition allows, helps to promote the release of endorphins, improve sleep, relieve depression and reduce the perception of pain. Start slowly and remember to work within your limitations. A doctor or physiotherapist may be able to advise on suitable activities. As well as aerobic forms of exercise, gentle yoga or stretching at home may be therapeutic.

Mind-body therapies

A 1994 study showed that there is a strong link between someone's 'control belief' and their experience of pain. This means the more you believe you can influence or control your symptoms, the less pain you are likely to experience. Specifically, the higher your control belief, the lower the level of pain you will tend to experience. These and a body of other findings provide very strong support for using psychological approaches to control chronic pain that is not cancer-related.

Mindfulness meditation

One of the most innovative studies of the therapy of 'mindfulness' meditation was undertaken by Dr Jon Kabat-Zinn and his colleagues at the University of Massachusetts School of Medicine in the US. Patients with chronic pain were trained in this form of meditation as part of a 10-week stress reduction and relaxation programme. The people in the study found that using this technique they could ignore 'present moment pain'. They also found that their other symptoms, such as depression and negative body image, improved.

At the same time, use of pain-relieving drugs decreased and activity levels and feelings of self-esteem increased. Improvements were mostly maintained for up to 15 months after the initial meditation training and many of the participants continued the meditation practice as part of their daily lives.

Other psychological therapies

A major 1999 review looked at the effectiveness of psychological therapies for persistent chronic pain. Psychological treatments, such as cognitive behavioural therapy, were associated with significant physical and psychological improvement in people who participated

Persistent pain

in the studies. The review concluded that active psychological treatments based on the principle of behavioural therapy are very effective in managing persistent chronic pain.

If you have chronic pain (whatever the cause), try spending 20 minutes each day doing relaxation exercises or meditation. You could also learn biofeedback techniques or have cognitive behavioural therapy.

Important

If you experience persistent pain, see your doctor to determine any underlying cause and for help with managing the pain.

Prevention plan

See your doctor if you begin to experience persistent pain. Many people put off having treatment for their condition, and delay can make the problem worse.

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The next meeting of the North West Regional Network Group will be held on 21 January 2008 at 6pm at Christie Hospital Rehab Unit, Wilmslow Road, Manchester M20 4BX.

For details of the January meetings of the Brighton and Bristol/Bath Groups, please see the website or email admin@bhma.org.

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William House

GP



Menopause morning

If I had thought more about it I might at least have been prepared. As it was, I simply signed up for this course for GPs because I wanted to update my gynaecological knowledge. A few women do come to an older male doctor for their women's troubles, so I am diligently preparing myself for every eventuality. As I take my seat I realise I am one of only four men in the room, and one of them is a speaker and another the guy operating the projection equipment. I exchange polite smiles with the woman next to me, and then look straight ahead. Why am I almost the only diligent male? I glance at the programme. First a male gynaecologist on latest developments. Then two female speakers on sex in later years and 'perils of the peri-menopause'. There are large windows overlooking beautiful Wiltshire countryside on a glorious early autumn day. I am wondering whether I have made a mistake!

The gynaecologist looks nervous. He sticks rigidly to randomised controlled trials and the chemical composition of HRT. Herbal medicines are dismissed in one sentence. I think of challenging him on this one but some instinct tells me to keep quiet. There is polite applause for his overture. He leaves the room. We are down to three.

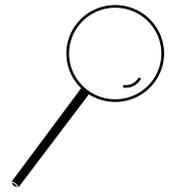
The speaker on sex puts a large carrier bag on a table beside the lectern. She is an older woman and

overweight with silver hair and piercing eyes. She projects a definition of sexual health on the screen. Definitions of health are seldom attempted in the NHS so I am intrigued. Apparently, to be sexually healthy you can do whatever you like provided no one is harmed by it. This is John Stewart Mill's well known 'harm principle' and to my mind far too simplistic for the complexities of intimate relationships. At least she tried! Her verbal message was that doctors should pay more attention to their patients' sex lives, but it was the contents of her carrier bag that penetrated the professional persona of her audience. Apart from one male masturbation aid (looking like a plastic terracotta flowerpot with embossed mermaids) the sex aids (or 'toys' according to your perspective) were for women – which I suppose is understandable given the topic. Some were plastic models of the erect male member (extra large) but most were slick and modern, with discreet control switches, rather like a state-of-the-art mobile phone set for vibration. They are passed around for closer inspection and her slides of coital positions of people with disabilities are accompanied by increasingly frantic buzzing followed by muted squeals amongst the audience as higher speeds are selected. I notice that she counts them back into her carrier bag.

The last speaker, slim with scarlet lipstick and intensely rectangular glasses, is given to superlatives and debunking sacred cows. Contraception, she says, is unreliable unless injected or implanted; abortions in the over-40s are on the increase with 38% of pregnancies aborted (closing on teenagers' 40%) and much of the behaviour of 40–50-year-old women is due to unstable hormones (where have I heard that before?). As she warms to her theme she strays from the moodiness and sexual proclivities of the peri-menopausal woman to the excesses of youth and the increase of oral sex in both. She tells of a teenage girl who 'had five penises at one party' and of the infection risk she is running.

As we queue to leave I am standing next to a slim woman with dark curly hair. By way of small talk, I speak of my disappointment in the definition of sexual health which is based on a misunderstanding of liberty. If looks could kill I would have been dead on the spot, but since they don't, I foolishly go on to ask what she thinks of the girl at the party. At that moment we reach the door and she is gone. Did I say something wrong? I realise I am out of my depth in the perilous waters of the menopause, feminism, and the avoidance of things that really matter. The gynaecologist had got it right: stick to maths and chemistry, then leave the room!

Research Summaries



Over the last four years this page has been compiled with the help of *Greenfiles*, a newsletter of herbal and nutritional research. This publication has now ceased. JHH would like to thank Brenda Cooke and *Greenfiles* for their work.

HRT cancer risk

Women considering HRT should consider the results of The Million Women Study, a trial in the United Kingdom of post-menopausal women which has found that those receiving HRT were, on average, 20% more likely to develop and die from ovarian cancer than women who never received therapy. This report says that since 1991, HRT has resulted in 1,300 additional ovarian cancers and 1,000 additional deaths from this malignancy in the United Kingdom alone. 'The effect of HRT on ovarian cancer should not be viewed in isolation', says the report, led from Cancer Research UK's Epidemiology Unit in Oxford, 'especially since use of HRT also affects the risk of breast and endometrial cancer. In total, ovarian, endometrial, and breast cancer account for 39% of all cancers registered in women in the UK.' The total incidence of these three cancers in the study population is 63% higher in current users of HRT than in those who have never used it.

Beral V et al. *The Lancet*, April 19 2007 early online edition

Tasty turmeric

Curcumin, the yellow pigment of the spice turmeric, may help fight cancer and other diseases. The root of turmeric has long been used in traditional Asian medicine to treat gastrointestinal upset, arthritic pain, and low energy. A study by researchers at the University of Texas found that curcumin can affect cyclin E (present in many human cancers) and enhance cancer-inhibitors.

Aggarwal BB et al. *Biochem Pharmacol* 2007; 73(7)

Harsh soaps blamed for allergies

Over the last 30 years the prevalence of eczema in the UK has increased threefold. The most widely recognised explanation for this increase has been the 'hygiene hypothesis', which argues that people have become too clean, with the result that their immune system becomes oversensitive to infection.

However, researchers at University College London's Institute of Child Health believe there could be a more direct cause. In the journal *Trends in Immunology* they argue that the over-use of harsh products strips away a protective layer of skin, making people more vulnerable to an allergic disease.

For more information see www.ich.ucl.ac.uk/pressoffice/pressrelease_00529

Acupuncture for insomnia

Insomnia is a common sleep disorder with devastating consequences. Even though there are pharmacological and behavioural treatments for insomnia, most patients are treated with medications. More and more people are seeking complementary/alternative treatments. This systematic review examined the role of acupuncture in treatment of insomnia. Despite the limitations of the reviewed studies, all of them

consistently indicate significant improvement in insomnia with acupuncture. The authors believe that further methodologically strong, randomised controlled studies with large sample size are needed to assess the usefulness of acupuncture in treatment of insomnia and explore the possible mechanisms underlying the effects of acupuncture on sleep and sleep disorders.

Kalavapallia R. and Singareddy R. *CTCP* 2007; 13 (3) 2

Walk for the mind...

A new study says physical activity may help alleviate some of the symptoms of bipolar disorder (manic depression). Researchers from the University of Melbourne in Australia say physical activity has demonstrated effectiveness in depression and anxiety, but its potential in the management of bipolar disorder had not yet been fully explored.

Their retrospective cohort study investigated the effectiveness of an adjunctive walking programme in the acute treatment of bipolar disorder. It included all patients admitted over a 24-month period to a private psychiatric unit with a primary diagnosis of bipolar disorder.

All patients were invited to participate voluntarily in a walking group during their admissions. Those who reliably attended the walking group (participants) were compared against those who did not attend (non-participants). The study authors concluded that the results of this trial suggest a therapeutic role of physical activity in bipolar disorder and warrant further investigation with randomised controlled trials.

Ng F, Dodd S, Berk M. *J Affect Disord* 2007; 101

...and the body

Healthy but sedentary individuals who take up a programme of regular brisk walking improve several known risk factors for cardiovascular disease. This review of RCTs looked at six traditional cardiovascular risk variables: body weight, body mass index (BMI), percentage body fat, aerobic fitness and resting systolic and diastolic blood pressure. It concludes that walking increased fitness and decreased body weight, BMI, per cent body fat and resting diastolic blood pressure.

Murphy MH et al. *Prev Med* 2007; 44 (5)

...and the elderly

Another study demonstrates the beneficial effects of exercise on healthy brain aging even in the 'oldest old' and emphasises the importance of increasing physical activity particularly in older women. It analysed data on hours of exercise a week and age of developing cognitive impairment. Less active women had twice the incidence rate of cognitive impairment compared to less active men and almost five times the rate compared to active women.

Sumic AYL et al. *J Aging Health* 2007; 19 (2)

What makes you satisfied?

Why are certain character strengths more associated with life satisfaction than others? Adults in the US and Switzerland completed surveys measuring character strengths, orientations to happiness (engagement, pleasure, and meaning), and life satisfaction. In both samples, the character strengths most highly linked to life satisfaction included love, hope, curiosity, and zest. Gratitude was among the most robust predictors of life satisfaction in the US sample, whereas perseverance was among the most robust predictors in the Swiss sample. In both samples, the strengths of character most associated with life satisfaction were associated with orientations to pleasure, to engagement, and to meaning, implying that the most fulfilling character strengths are those that make possible a full life.

Peterson C et al. *The Journal of Positive Psychology* 2007; 2 (3)

CAM for mental health

Two new studies suggest that integrative therapies are worthy of investigation and may be effective in treating mental illnesses such as depression and bipolar disorder. Integrative therapies with good evidence for mental illness include hypnotherapy, hypnosis, music therapy, psychotherapy and yoga. One study suggests that the chronicity and heterogeneity of this disorder leads to frequent clinic visits and a longer course of treatment and successful approaches may require an arsenal of treatments with numerous mechanisms of action.

Researchers reviewed the categories of drugs used to treat severe depression and several non-pharmacologic options including a number of experimental treatments.

They concluded that improved knowledge and treatment approaches for severe depression are necessary to facilitate remission, the ideal treatment goal.

In the second study, researchers from Xi'an Jiaotong University College of Medicine in China suggested that Chinese herbal medicines possess the therapeutic potential for mood disorders. In a double-blind, randomized, placebo-controlled study, researchers evaluated the efficacy and side effects of the herbal medicine called Free and Easy Wanderer Plus (FEWP) as an adjunct to carbamazepine (CBZ, a drug sometimes used as an alternative to lithium in stopping the symptoms of manic depression) in patients with bipolar disorder. They found that on its own it produced significantly greater improvement on manic measures at week two through endpoint compared to placebo. Compared to CBZ on its own, FEWP with CBZ resulted in significantly better outcomes on the three measures of depression at week four and week eight and significantly greater clinical response rate in depressed subjects but failed to produce significantly greater improvement on manic measures and the response rate in manic subjects. There was a lesser incidence of dizziness and fatigue in the combination therapy compared to CBZ monotherapy.

Zhang ZJ et al. *J Psychiatr Res* 2007; 41 (3-4) & Nemeroff CB. *J Psychiatr Res.* 2007; 41(3-4):189-206

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New and updated materials to help both practitioners and patients cope with stress and enhance their wellbeing

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This two-day intensive experiential workshop is designed to provide healthcare professionals with training in some of the world's most innovative approaches for facilitating physical, emotional and psychological health, healing and growth.

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This workshop will be facilitated by Dr Mark Atkinson, integrated medical doctor and one of the UK's leading experts in mind-body medicine.

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Reviews

I welcome readers' contributions. If you're reading something you want to share, please let me know. You can also contact me if you think there is something – book, DVD, CD, video – that we should be reviewing.

Richard James, Reviews Editor (richard@integrativehealthcare.co.uk)



Help for the helper: the psychophysiology of compassion fatigue and vicarious trauma

Babette Rothschild with Marjorie Rand
WW Norton, 2007
ISBN: 0 39370 422 X



£19.99

Good therapy depends on empathy. But when empathy goes wrong it can undermine the therapeutic process and may even threaten a therapist's wellbeing. We know well that practitioner burnout is a fact of life, and not just for therapists working in war zones and with disaster victims, for it is rife within the NHS.

So for anyone in the medical, nursing and mental health professions who feels they are burning out, there are ideas and solutions aplenty in *Help for the helper*. If you are someone exposed continually to other people's distress, compassion fatigue and vicarious traumatisation could be the diagnosis. In this excellent little book the author successfully explains their origins by integrating current research on the neurobiology of empathy with contemporary ideas from psychotherapy. *Help for the helper* does what it says on the tin: more than a toolkit and a sourcebook on the neurobiology of trauma, it provides applications and exercises for practitioners who want to do something about the negative effects of their work, or simply to maintain their own mental health and wellbeing while optimising their communication with clients.

After opening with recommendations for keeping a common sense perspective on therapy, there follow core chapters focusing on therapist assets and deficits, and the neurophysiology of empathy, arousal, and clear thinking. Subsequently, *Help* introduces the signs of therapist burnout and a range of skills to minimise the impact of working therapeutically with clients. Though directed at psychotherapists, the ideas and exercises will be valuable to any nurse, doctor, complementary practitioner (especially those working with touch) or social worker struggling to make sense of the exhaustion, irritability and cynicism that long-term contact with pain and neediness may eventually engender.

This book is also a goldmine of powerful preventive self-care. It lays out foundational neuroscience explaining how and why we 'pick up' other people's distress and builds up into a self-care toolbox based on ways of 'listening' to your body mindfully. The author uses the same common sense approach and conversational style interspersed with experiential and reflective sections that worked so well in her bestselling classic *The body remembers*. It is equally effective in this new book: material that might otherwise have seemed too technical or specialised is put over with no loss of rigour or relevance.

I recommend *Help for the helper* to any health or helping professional who wants to help their patients and clients while minimising their own risks of stress and burnout.

David Peters

The embodied psychotherapist: the therapist's body story

Robert Shaw
Routledge, 2003
ISBN: 978 1 583912 69 0



£18.99

This book is a response to the paucity of psychotherapeutic literature concerning the therapist's bodily experience within and around the therapeutic encounter. As such it is a welcome attempt to address a gap in an important area. The book will be of interest to psychotherapists, counsellors, and holistic practitioners wishing to integrate a psychological with a physical approach to their work.

The book has developed out of a PhD thesis and has three main strands. The core of the book is a phenomenological account of 15 therapists' (including the author's) bodily experiences while practising psychotherapy. On the whole their approach is integrative, gestalt or humanistic, though there are also a few psychodynamic practitioners. Out of this core is developed the beginnings of a critique of what the author regards as classical psychotherapeutic discourses about the body. Finally there is an attempt to situate the body within a broader cultural and philosophical context in a way that is relevant to psychotherapy. The author tackles these three strands with varying degrees of success.

The first section of the book deals with the third strand and Shaw clearly knows what he is talking about. He writes impressively and knowledgeably, weaving together themes from a wide variety of intellectual discourses about the body and relating them effectively to psychotherapy. My only reservation about this section concerns some of the generalisations about psychoanalysis. Shaw has a tendency to make claims about its practices and theories that appear unsupported either by his own research or references to the analytic literature. This problem recurs in the third section.

The middle section is less problematic, drawing as it does upon a series of interviews with therapists reflecting on their own bodily experiences. These are the sorts of experiences that will be familiar to all but the most dissociated psychotherapists. But it is helpful nevertheless to focus attention on this neglected area.

The final section draws on these body narratives to make a series of suggestions about the ways such experiences can best be incorporated into psychotherapeutic theory and practice. Shaw clearly has his own ideas about this. He suggests for instance that therapists employ the notion of 'body empathy' to describe their bodily reactions to clients. He feels this is a more egalitarian notion than traditional psychodynamic approaches which he regards as predisposed to consider such responses as emanating from the patient. For the same reason he also recommends that therapists judiciously disclose some of their

bodily reactions to patients in order that they can play their part in a co-created therapeutic narrative.

The notion that therapists' feelings (including bodily feelings) often emanate from ordinary empathy rather than projective identification strikes me as valid. Shaw may also be right that some analytical psychotherapists are over-disposed to regard their own countertransferential feelings as emanating from the patient. But to suggest that this is because of some shortcoming in analytic theory is to oversimplify and ignores the whole relational turn in psychoanalysis. In addition, one of the reasons analysts are disinclined to disclose their feelings to their clients is precisely because of their awareness that such feelings may originate as much in themselves as the client. Shaw thus misses a chance to open up an important debate. He is right however to emphasise that psychoanalysis would benefit from a better philosophical grounding of its theories, including its theories about the body.

In summary then this is a thoughtful and welcome book on an important and relatively neglected subject. At times, however, Shaw can't resist taking a rather predictable swipe at a stereotypical view of psychoanalysis from a humanistic perspective and so effectively closes down some potentially fertile areas of 'co-creation'. One final thought; the whole subject of therapists' sexual bodily responses to clients is absent from the interview material (if I may use that word!). This is surprising given the bodily nature of the inquiry and merited more than the passing comment it receives.

Bob Withers

The ethics of touch

Ben E Benjamin Ph.D and Cherie M. Sohnen-Moe
 Sohnen-Moe Associates, 2005
 ISBN: 1 88290 840 6



£19.99

Not only is the subject of ethics huge for those working within the helping and healthcare professions. It is also highly complex, confusing and unfortunately does not come in a 'one size fits all' guide. If you add to this the dimension of physical touch, then ethics and ethical considerations become, well, huger.

Benjamin and Sohnen-Moe's book *The ethics of touch* has explored this complex and interesting subject in a clearly-written, highly engaging and useable text. It is laid out well with chapters covering the main topics, such as boundaries, that you would expect to find in a book on ethics, as well as some topics that are often shied away from, such as sex and intimacy. There are chapters covering: ethical principles; boundaries; the dynamics of effective communication; dual relationships; sex, touch and intimacy; ethical practice management; business ethics; special considerations in cases of trauma; and supervision.

The ethics of touch is not just a theoretical book; it encourages the reader to engage with the topics in an active way. The book contains relevant vignettes, illustrating examples of ethically challenging situations that the reader can study and explore. At the end of each chapter there is also a section offering questions for discussion and activities for the reader to work through. This resource gives the text a workbook feel that will appeal to training providers as well as individuals.

The book also contains very informative and useful appendices with sample client forms, protocols for working with traumatised patients and the codes of ethics for a range of relevant professional associations from both the US and UK.

Ethics is often talked about in training from a litigation perspective; *The ethics of touch* encourages and supports the

reader in exploring ethics from a deeper understanding, where the therapeutic relationship is key, and ethical working is vital to the health of this relationship. Human beings are diverse, complex, confusing and confused. That is why there can never be a 'one-size fits all' guide to ethics. Of course that is also what makes ethics such a wonderful and exciting topic for us to study and explore. *The ethics of touch* is an excellent resource and successfully brings this challenging topic to life.

Justin Haroun

Multidisciplinary approaches to breathing pattern disorders

Leon Chaitow, Dinah Bradley & Christopher Gilbert
 Churchill Livingstone, 2002
 ISBN: 0 443 07053 9

£33.99

This book is co-authored respectively by an osteopath, a physiotherapist and a psychologist. As panic disorder almost invariably includes elements of hyperventilation, the understanding of psychophysiological processes in the aetiology and treatment of disordered respiratory patterns is highly relevant to psychologists working with this patient group, as well as clients presenting with frank respiratory symptoms.

It is appropriate to consider a multidisciplinary approach to treatment, as for hyperventilation in particular the effects of the disorder encompass neurological, biochemical, biomechanical and psychosocial factors, which may interact with each other.

I found Bradley's chapters helpful in suggesting very practical techniques to help clients to learn more adaptive breathing patterns. The relevance of Chaitow's chapters to psychologists is more educative than practical – but they serve a useful purpose in sensitising psychologists to the appropriate recommendation for clients to get concurrent physical treatments.

The psychologist (Gilbert) provides an unbiased overview of relevant emotional, behavioural and cognitive models, as well as some good psychophysiology. It would be hard to find a better review of the field for psychologists.

The whole book is well illustrated and referenced, provides practical case examples and sensible cautions. There are sections on assessment, diagnosis and evaluation, and some brief commentary on techniques such as the Buteyko method, Chinese bodywork and yogic alternate nostril breathing.

The book is concluded with practical suggestions for breathing awareness and exercises, relaxation (including specific muscle relaxation techniques), diet, and just in case you should need it – a nasal wash recipe. I cannot think of anything that they have left out.

Ashley Conway

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