SOCIAL WORK AND BODY THERAPY

by

LESLY DERKSEN

A thesis
Presented to the Faculty of Graduate Studies
in partial fulfillment of the requirements for the degree of
Master of Social Work

University of Manitoba
Winnipeg, Manitoba

June, 1985

SOCIAL WORK AND BODY THERAPY

BY

LESLY GEORGE DERKSEN

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

OUTLINE

LIST OF FIGURES

The body's
life is the life of
sensations and emotions.
The body feels,
real hunger, real thirst,
real joy in the sun or snow,
real pleasure in the smell of roses
or the look of a lilac bush;
real anger, real sorrow,
real tenderness, real warmth,
real passion, real hate, real grief.
All the emotions belong to the
body and are only recognized
by the mind.

D. H. Lawrence (1955)

INTRODUCTION

Social work is a broadly based multifaceted profession which assumes responsibility for a wide range of services using a variety of techniques and theoretical perspectives (Strean, 1978). "Clinical social work", the area this paper is concerned with, has become the preferred term for that part of the profession which deals with direct services to people. The purpose of clinical social work has to do with the "maintenance and enhancement of the psychosocial functioning of individuals, families, and small groups by maximizing the availability of needed intrapersonal, interpersonal, and societal resources" (Cohen, 1979, p. 30). Developmental, preventive, and therapeutic services are all important aspects of clinical social work.

While social work encompasses many models of practise in numerous settings, there is a strong common core of philosophy, purpose, knowledge, and techniques which identify the profession. The primary concern of social work is the social context within which family or individual problems occur and change. Out of this central focus on social functioning has arisen a body of values as well as a body of knowledge. These, in turn, have generated an appropriate repertoire of intervention techniques.

The basic values of social work are in harmony with humanistic values. "The ultimate value of social work is that human beings should have opportunities to realize their potentials for living in ways that are both personally satisfying and socially desirable" (Northen, 1982,

p. 27). There is an optimistic belief that people can and will grow and change in their attempts to achieve personal and social ideals. One of social work's primary values is a belief in the inherent dignity and worth of the individual, regardless of sex, age, race or social, political, intellectual or sexual orientation (Compton & Galloway, 1979). This means that each person should be accepted as a whole person who is in a unique process of development and maturation. Each person should have use of resources necessary for survival as well as for the development of personal potential. Another major value is the right of client self-determination (Levy, 1983). Clients are considered to have a right to choose their own goals and live their lives in the way they wish, provided that the exercise of those rights does not infringe on or hurt the rights of others. "To deprive [the client] of that right is to deny his dignity and worth" (Biestek & Gehrig, 1978, p. 4). A concomitant goal is that of client participation in the helping process. The client and social worker are ideally part of a collaborative process in which the social worker helps clients achieve their potential by relying on and maximizing the strengths of the client. In short, social work is humanistic in that it has a commitment to the welfare of the client as a whole person and to the participation of the client in the decision making process. It has an optimistic view of people's abilities to change, grow, and mature and a commitment to help people achieve their potential.

In order to practise in harmony with these basic values, the social worker needs a great deal of knowledge about people. Multiple perspectives are required in order to understand the wide range of

human needs and problems as well as the numerous conditions which may hinder or block a person's development. Concepts from the psychological, biological, and social sciences pertinent to effective social work intervention are required. Theoretical perspectives which organize this mass of knowledge are also necessary if it is to be used coherently and effectively.

General systems theory, out of which has emerged ecological systems theory and the life model of social work practise, has provided one theoretical orientation proving useful to social workers (Stein, 1971). According to Germain (1979), "this perspective is concerned with the growth, development, and potentialities of human beings and with the properties of their environments that support or fail to support expression of human potential" (pp. 7-8). The systems perspective brings a wide-angle lens focus to social work. It avoids viewing problems from only an external or internal causation framework, seeing rather that problems arise out of a dynamic interplay between people, groups, or environments.

General systems theory is a theory of holism. According to Battista (1977), "the holistic paradigm constitutes the basic assumptions of general system theory and general system theory constitutes the theoretical formulation of holistic assumptions" (p. 66). The essential concept of ecological theory is that any system consists of a set of elements that are related to each other in such a way that change in one part of the system results in changes in other parts. This interdependence implies an active ongoing process of transformation. While the parts of the system are organized and

integrated in a complex, interdependent, and fairly stable way, the whole is more than the sum of the parts. Feedback within the system is a circular or simultaneous process which tends to maintain the dynamic balance, or homeostasis, of the system. It is the nature of the organization of the system which determines the results of the system. The holistic paradigm of general systems theory sees the universe as an interconnected system which contains systems within systems within systems, etc.

The impact of systems theory on social work has led to a broadening and deepening in understanding the scope and nature of the profession. Speaking from an ecological viewpoint, Northen (1982) asserts that "the practitioner needs a holistic understanding of people as they interact within their families, other social systems, and their broader networks of social relationships" (p. 301). This holistic understanding comes out of a realization that "there are interconnections between biological, economic, and social-psychological components of human functioning" (Northen, 1982, p. 26). Cohen (1979) reflects this perspective when he writes that "the concept of the individual as a biological, psychological, and social being is indivisible" (p. 26). Meyer (1976), in a discussion of an ecological theory of social work, states that "the accepted traditional social casework view of the person-in-situation" (p. 137) presents a now untenable dichotomy between the social and the psychological. She acclaims a systemic viewpoint in which "there is no inner or outer, but rather an operational field in which all elements intersect and affect each other . . . all having reciprocity and feedback with each other"

(1976, pp. 138 & 135).

One of the major strengths of systems theory is its function as a theory-model which establishes "a framework for a complex and changing set of theories and models needed for the ever-evolving nature of social-work practice. It therefore favors an eclectic orientation to practice theories" (Siporin, 1980, p. 525). Because social work is eclectic in that it utilizes knowledge from many disciplines, such as physiology, social psychology, sociology, psychology, and anthropology, systems theory can provide a crucial role in helping integrate the wide spectrum of knowledge and the various models of practise used by social workers. "Body therapy" is one of the many areas of knowledge and practise which could be incorporated into social work by the use of ecological systems theory.

This thesis is concerned with the theory and practise of body therapy, one of the areas of knowledge which is based on a holistic paradigm. It is this writer's belief that the assumptions underlying the theory and practise of body therapy are consistent with an ecological approach to social work. Body therapy not only offers rich insights into intrapersonal and interpersonal functioning, but also provides a diversity of models for intervention.

Chapter one of this thesis examines some of the connections between body and mind. Several aspects of body-mind integration are discussed, including a holistic view of health, and the relationship between body structure and personality traits. A psychological and transpersonal model, that of the chakra system, is presented as a paradigm by which to categorize and analyse the various therapies. The

body as an energy system is emphasized.

Chapter two reviews the literature of some of the major body therapies. The basic concepts, therapeutic processes, and goals of each therapy are discussed. Relevant research is presented as part of a critique of these therapies.

Chapter three deals with a number of issues arising from the practise of body therapy. The ramifications around the use of touch and catharsis are reviewed. Body therapy as a placebo is considered. There is also a discussion of how adaptable these therapies are to different treatment situations, as well as the possible hazards involved in their use. The role of the body therapist is considered.

Chapter four discusses the possible impact of body therapy on social work. Factors which may lead to its inclusion or rejection within social work are examined. Areas of similarity and dissimilarity between body therapy and social work are considered.

CHAPTER ONE

THE BODY-MIND CONNECTION

A. A HISTORICAL VIEW

In examining the present emphasis on the unity of body and mind, it is useful to briefly sketch how body-mind unity has been viewed in the past. Historically, body and mind have been seen from either a "monistic" or "dualistic" perspective. Monism views reality as one unitary organic whole with no independent parts. Because the universe is considered to be one interconnected system, all manifestations are assumed to be the expression of one substance. "Matter and energy, space and time, living and nonliving are all viewed as transformations within the same heirarchically ordered unity" (Battista, 1977, p. 65). A monistic conceptualization of a person assumes that all the sundry parts of that person comprise a unity.

Dualism considers reality to be comprised of two irreducible elements or modes. Thus, a dualistic view of the world divides the world into different compartments. According to Berger (1972), "man has consistently categorized his experience, creating dichotomous realms of mind and body, spirit and matter, psyche and soma, psychological and physical, partitioning life into divisions and subdivisions" (pp. 191-192). Throughout history, there have been shifts in emphasis between monistic and dualistic views of reality.

Descartes' (1596-1650) proposition that mind and body are separate

entities which influence each other's actions has been a strong influence on modern psychology. This view is known as interactionism. Descartes viewed the human body as a machine whose behavior and structure could be entirely understood by mechanical principles and the mind as the locus of thought and consciousness. He believed that "the mind and the body are united in a peculiarly intimate way and that each acts upon the other . . . in the pineal gland of the brain" (King, 1972, p. 36). Descartes did not engender a satisfactory explanation of how the material body interrelates with the immaterial mind.

The interactionist view of Descartes was followed by the parallel concept of body-mind relation espoused by Liebnitz, who saw mind and body as not interacting but following parallel paths. While they are not affected by each other, what happens in one also happens in the other because they are ruled by the same laws. Berger (1972) comments that the "adoption of this concept led to a further concentration on the study of mental processes and to an effort to be rid of the body" (p. 194).

In some of Freud's early thinking appeared concepts related to the more recent developments in body therapies. However, he later abandoned much of this line of thought. Freud maintained that "the instincts are the source of the energies on which the mind-body processes depend, and that the human organism is a mind-body entity" (King, 1972, p. 51). He believed that emotions resulted in physical changes. One of his early crucial insights was that a relationship existed between neurotic symptoms and unexpressed emotions. "Neurosis is caused by . . . psychological traumas. Any experience which calls

up distressing affects . . . may operate as a trauma if there has not been 'an energetic reaction to the event that produces an affect' sufficient to discharge it" (Breuer & Freud, 1895, pp. 6 & 8).

Freud realized, as early as 1893, that blocked emotion needed to be re-experienced in order to remove the symptom. "Neurosis is cured by successfully . . . bringing clearly to light the memory of the event(s) by which it was provoked and in arousing its accompanying affect; the patient must describe the event(s) in the greatest possible detail and 'put affect into words'" (Breuer & Freud, 1895, p. 278). By 1894 Freud saw that emotional energy could move with varying intensity over the body like an electric charge. However, by 1938 the concept that the discharge of energy could remove the strength of psychic illness was lost sight of, as Freud moved to stressing intellectual understanding and even persuasion instead of experiential recall. "Quite often we do not succeed in bringing the patient to recollect what has been repressed. Instead of that . . . we produce in him an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory (Freud, 1938, p. 358).

Under Freud's influence, the "dualistic conception of human nature became firmly entrenched in contemporary psychological theory" (Rappaport, 1975, p. 49). Since Freud, most psychological theory and practise has given little weight to the existence of the body, concentrating mainly on mental experiencing, the mind, and the brain. Therapists have been encouraged "to be good listeners, but not good observers. They [have been] trained to work with talking but not with moving (Murphy, 1976, p. 41).

B. A HOLISTIC APPROACH TO BODY-MIND INTEGRATION

There is now emerging a new emphasis on the importance of the body. Even more significantly, the body and mind are being seen as an integral whole (Deliman, 1982). The roots of this departure from the traditional psychoanalytic path stems from the work of Reich, whose fundamental thesis was that there is a functional identity of the body and the mind. This emphasis on the body has led to a broad conception of the unity of the person and has engendered a surge of interest in a variety of new and old body therapies.

Kraft (1978) defines this emerging view of body-mind integration as

> a holistic approach to psychology, counseling, and psychotherapy which has its foundation in humanistic and transpersonal theory. This approach deals with the whole person--mind, body, and spirit--in an effort to facilitate a harmonious integration or balance of the individual. Mind-body integration as a holistic approach is concerned not only with an individual's psychological conflicts, but also with the reflections of these conflicts on the bodily level as manifested as chronic muscular tension (p. 29).

The most basic assumption of the body-mind approach, on which the body therapies are based, is that the person is an indivisible whole. Every cell in the body is "both structurally and functionally related to every other cell in your body" (Dychtwald, 1977, p. 25). Thoughts, beliefs, and fears exist in a dynamic relationship with the mind. The mind and body interrelate through a "circular feedback system with each bit of information and experience feeding back through tissue and then

becoming information and experience once again" (Dychtwald, 1977, p. 24). This dynamic feedback process makes "a person's body, his behavior, what he talks about, his attitudes, dreams, perceptions, [and] posture . . . all parts of a unitary whole" (Kurtz & Prestera, 1976, p. 4). Thus, one aspect of a person cannot be changed without changing or influencing all other aspects of a person.

Every aspect of a person is seen as an expression of the core of his or her being. It is assumed that the body never lies, indeed, "it is incapable of lying" (Keleman, 1981, p. 66). The "tone, color, posture, proportions, movements, tensions and vitality of the body express the person within" (Kurtz & Prestera, 1976, p. 1). According to Ferguson (1980), "our bodies become walking autobiographies" (p. 255) reflecting all our present and past tensions, conflicts, and joys. Lowen (1975) asserts that "a person is the sum total of his life experiences, each of which is registered in his personality and structured in his body" (p. 57). Schutz (1971) adds that

> all experiences are recorded in the body and all are available for recall--in the nervous system, in the muscles, in the way the body is held and moved, in the expression on the face, the chronic muscle tension, restrictions of breathing, aberrations of circulation, digestion, and excretion, the patterns of illness, and the acuteness of the senses (p. 165).

The body-mind perspective assumes that we can change our bodies over time as a result of our characteristic approach to life. Not only are our bodies shaped and affected by our heredity, environment, physical activity, and nutrition, but also by our emotional and

psychological experience. Our feelings and attitudes strongly and directly affect how we grow, develop, breathe, and move. "Just as we partly form ourselves with physical activity, so do we mold ourselves with selective emotional activity and experience" (Dychtwald, 1977, p. 22) as well as with our attitudes and psychological choices.

The body-mind perspective also assumes that psychological conflicts are felt in the body in the form of tense and contracted muscles. When the conflict is prolonged and unresolved, the body may develop chronic muscular tension patterns. As Rolf (1977) expresses this point, "an individual in trouble unconsciously modifies his flesh, solidifies his mental attitude into biological concrete" (p. 37). This gradual changing and realignment of the body over time is possible due to the elasticity and malleability of body tissues. "The human body is an energy system which is never a complete structure, never static . . . a flexible, fluid energy field that is in a process of change from the moment of conception until the moment of death" (Johnson, 1977, pp. 1 & 2). The end result of this never-ending state of re-organization is that our life stories become "written" in our muscle tissues.

> When we are troubled, the madness is in our bones, in the way we walk and move, in the way we carry objects from one location to another, in the way we use space in relation to other people. Our body is warring against itself. . . . the forces to carry out an action are battling the counterforces to prevent an action (Murphy, 1976, p. 36).

Change, from the body-mind viewpoint, must go beyond the intrapsychic and mentalistic. Because "no condition exists in the self

which does not have a physical representation in the body. . . . change or growth, to be real, must occur in the physical domain" (Rappaport, 1975, p. 66). Green, Green, and Walters (1970) hypothesize that "every change in the physiological state is accompanied by an appropriate change in the mental-emotional state, conscious or unconscious, and conversely, every change in the mental-emotional state, conscious or unconscious, is accompanied by an appropriate change in the physiological state" (p. 3). From a body-mind perspective, maximum change occurs when the body, feelings, and intellect all change together. A change in one level of a person without a change in the other parts is incomplete. An intellectual insight not accompanied by changes in the body and emotions will likely lead to little change. Conversely, a body change which is not accompanied by corresponding changes in thought and feeling may be real. However, "there is a danger that the body will eventually return to its former condition because the original cause of the body aberration still exists" (Schutz, 1971, p. 175).

Given this view of change it is not surprising that body-mind therapists do not completely trust verbal responses. "Words are a substitute for action, at times a very necessary and valuable one, but at others they are a block to the life of the body" (Lowen, 1975, p. 322). Words, used as a substitute for feeling, may diminish and abstract life. Furthermore, a person may lack memory, and therefore words as well, for events which happened at a pre-verbal stage of development. This is not to say that words are not important, for reliving an experience at the level of the body needs also to be

verbalized so as to concretize it at the level of consciousness.

The body-mind approach trusts the inherent "wisdom of the body", a phrase coined by Cannon (1939) to describe how the body takes responsibility for regulating itself in many situations where the conscious, rational mind is not aware of what is good for the whole person. It is assumed that the wisest approach is to trust the natural organismic self-regulation process of the body (Riebel, 1984). Thus, body-mind therapy attempts to have people become aware of and contact their "deeper organismic sensations and inclinations and natural primary needs and wants" (Brown, 1973, p. 102). To listen to the wisdom of one's body it is necessary to be free from chronic severe energy blockages, to have a spontaneous free flow of energy, to have a core system of self throughout the body, and to be perceptually aware of one's bodily sensations, images, and feelings (Brown, 1973). As this process happens, the body spontaneously moves toward health and healing. While the body is geared toward self-healing and its own preservation, it is recognized that the body has its limits. It can only function healthily when it is properly cared for. "The areas that are choked of life and energy will become less vital, more fragile, more dis-eased, and therefore more prone to injury and sickness" (Dychtwald, 1977, p. 71). It is the responsibility of the individual to listen to and heed the signals the body gives about its needs, so as to avoid irreversible damage.

The body-mind approach views people as energy systems. There is a major focus on energy flow, energy blockages, and energy transference as part of the therapeutic process. Body therapy uses breathing,

movement, muscle manipulation, and body postures as methods to bring about the non-verbal release of energy blockages. The goal is a body that has a free flow of energy coursing through it. This aspect will later be discussed more fully.

C. A HOLISTIC APPROACH TO HEALTH

Since the theory and practise of "holistic medicine" emerges from an approach to body-mind consistent with and related to the theory and practise of body therapies, it is helpful to examine its basic tenets.

The term "holism" was coined in 1926 by Smuts (1982) to identify a philosoply of body-mind unity. A holistic view of medicine decompartmentalizes the study and treatment of people, seeing people as indivisible totalities (Otto & Knight, 1979; Shontz, 1975). The term "holism" used in this context is compatible with general systems theory in that it denotes a living organism as more than a sum of its parts and implies an interdependent system in which a change in one part of the system results in change in another part of the system. The holistic concept of health attempts to overcome the body-mind dualism which has characterized western medicine for a long time. It includes "an appreciation of patients as mental and emotional, social, and spiritual, as well as biological and physiological beings" (Gordon, 1981, p. 114). The practise of holistic medicine is not defined by a particular set of techniques, but by its overall broad view of the person, sickness, and health. "Holistic health is not a change in what is being prescribed, but a more radical change in attitudes and

perceptions. As such, it is part of a larger recognition of the underlying relatedness of all life" (Einzig, 1981, p. 12).

A holistic perspective assumes that all states of health and all disorders are psychosomatic (Bakal, 1979; Pelletier, 1977, 1979, 1980). According to Ellerbroek (1973), "a 'disease' is determined by all the psycholinguistic and behavioral events in the life history of the patient, including his total interaction with his field, within and without" (p. 261). This means that healing involves much more than getting rid of the specific symptoms of a disease. It involves an integrated approach in which the whole person is treated. An example of this approach is that of Simonton who uses creative visualization and psychotherapy as a powerful adjunct to the chemotherapy treatment given cancer patients (Simonton & Simonton, 1975; Simonton, Simonton, & Creighton, 1978).

In accord with humanistic philosophy, the holistic health approach views each person as a unique and complex interaction of body, mind, and spirit. Each person shares in the responsibility for regaining or maintaining health. The patient is seen as an active participant in the healing process (Gross, 1980). It is assumed that "we have the capacity to understand the psychobiological origins of our illness, to stimulate our innate healing processes, and to make changes in our lives that will promote health and prevent illness (Gordon, 1981, p. 117).

All people have within themselves enormous latent powers and unused resources. When the individual is seen through the energy system paradigm, it is realized that "individual energy systems can . . .

become conduits of therapeutic power and healing" (Otto & Knight, 1979, p. 9). The physician or "healer" becomes a facilitator of the healing process. Whatever the skill of the healer, the attainment of health and wholeness is the primary responsibility of the person seeking healing. The healer helps people make themselves well by assisting them in tapping their own healing resources.

A holistic approach sees health not merely as an absence of disease, but as a "level of fitness and physical-emotional harmony that affords maximum resistance to disease and supports a sustained joy of living" (Bloomfield & Kory, 1978, p. 20). The promotion of good health and the prevention of disease is emphasized. Since life is seen in an integrated way in the holistic approach, the quality of life is examined by looking at a person's lifestyle, values, and aspirations. Symptoms are seen as pointers to the areas of distress and disharmony in the body. The symptom may point to an underlying problem of a social or psychological nature. If that problem is not alleviated, the symptom being treated may simply be displaced by a new symptom.

A holistic approach views illness as a creative opportunity for people to learn about themselves and their basic values. "Symptoms . . . can serve as a warning that something needs to be explored or changed in one's life. . . . One message of nearly every illness is that we need to pay more respect and attention to the demands of our body" (Jaffe, 1980, pp. 28 & 30). Disease can be painful and disrupting, but it can also serve as an effective and essential adaptive process (Coffey-Lewis, 1982; Miles, 1978). People are helped to tolerate the psychological dimensions of pain and use it creatively for their

growth. Disease is seen as a neutral occurence in that, whether the disease appears or not and "whether its course is positive or negative, depends in part on the patient's cognitive interpretation of his illness, i.e. how the patient integrates the problem within the framework of his or her own structure of beliefs" (de la Pena, 1983, p. 3). The belief system of patients, their family, friends, and physician is an extremely important factor in the treatment of illness (Wolf, 1981). A positive hopeful system of belief is a very powerful force in the healing process (Taylor, 1981).

Weiner (1974) aptly summarizes the holistic approach to health when he writes that

> to heal man is to heal the mind body split . . . the healing remains palliative when directed only at the mind in psychotherapy or at the body organs in medicine. It is always the bodymind, not the body or the mind, that requires treatment. . . . we must reunite man's body and mind or rather recognize that he is in truth a bodymind, if he is to survive (p. 46 & 52).

D. BODY STRUCTURE AND PERSONALITY

One of the major assumptions of body-mind integration is that there is a strong relationship between body structure and personality. In reviewing the literature in this area it is important to note that most of the conceptualizations about the body come out of observations of white English Americans. Since different cultures vary significantly in their non-verbal language, it is likely that there

would also be differences in the expressions and meanings of body patterns.

Hippocrates divided people into four types: sanguine, melancholic, phlegmatic, and choleric. He specified the usual dispositions of temperament and suseptibility to various diseases of each type. Since Hippocrates there have been many other attempts made to correlate behavioral and physical characteristics.

Kretschmer (1921) described three types of people: asthenic, a thin bony type of person with a predisposition toward schizoid psycho-pathology; pyknic, a more fatty, massive person who tends towards a more active psycho-pathology; and athletic, a person with an incompatible mixture of the previous two types of physique and temperament.

Another of these systems, constructed by Sheldon and his associates in the 1940s, used statistical techniques to attempt to relate physical type and personality characteristics. Sheldon proposed three main types of body structure: endomorphy, in which the emphasis in the body structure is on the digestive viscera; mesomorphy, in which the structures of bone, muscles, and connective tissues are emphasized; and ectomorphy, in which the structural emphasis is on linearity, fragility, flatness of chest and delicacy throughout the body. Sheldon rated each of these three types of physique for each person on a scale of one to seven and then correlated this with a list of 60 personality traits clustered into three groupings. This study produced a positive correlation of +.80 between the physical and personality characteristics listed (Sheldon & Stevens, 1942). While Sheldon's

methods have been strongly criticized, his system was an advance over previous attempts which tended to place body types in mutually exclusive categories.

The constitutional psychology of people such as Kretschmer and Sheldon has opened the doors for the current interest in the relationship between body structure and personality traits, as exhibited by the new body therapies.

Body therapies view the body as a malleable structure in a continual process of change. As mentioned before, it is assumed that all our life experiences have an impact on our body. Given that we each develop a customary way of approaching the world, our bodies become shaped in a way consistent with our feelings about ourselves and our experiences in the world. In this way, our personality and our body come to reflect each other. Rolf (1963) states this strongly when she writes that "the physical body is actually the personality rather than its expression" (p. 69). Salkin (1973) adds that "the physical posture and movements are the externalization of the inner psychic experience" (p. 15).

One way to explain how the body and personality reflect each other is through the concept of conflict. Muscle tension may be caused by a bodily conflict when one part of us wants to use the muscle and another part wants to prevent the action. The muscle, prepared for action, cannot discharge its energy. Schutz (1971) explains what may then happen:

> The body becomes increasingly tight as these tension patterns multiply and along with the muscle restrictions may come other

> physical symptoms. The body is pulled out of alignment with excessive pressure put on various organs: the blood vessels become constricted, thus lessening the blood supply and nutrition to various parts of the body; breathing gets constricted, thereby reducing oxygenation of the blood; endocrines and nerve plexes are under unnatural pressure; and generally the body becomes weakened, more susceptible to illness, lacking in energy, and less supple, graceful and economic in motion (p. 36).

If this pattern of tension chronically repeats itself, the tension literally becomes "embodied" in the muscles. The muscle, which becomes chronically tense, serves as a block to keep the conflict of painful feelings from conscious awareness. This results in a reduction or stoppage of the flow of life energy to that part of the body. Given that each person tends to tense certain specific parts of the body in a response to muscular tension, "posture and feeling become so fused that one readily leads to the other. . . . therefore, a body posture which has become habitual, beginning as a reaction to a certain mental state, may actually come to sustain and perpetuate that state" (Rama, Ballentine, & Ajaya, 1976, p. 4). Furthermore, each person's unique "tissue states and . . . patterns of contraction or weakness in muscles and organs paint for us the history of that person's life, and, for the initiated, reveals their sociological and psychological history. That is to say, there is a clear connection between somatic motility and the structure and adaptability of the personality" (Keleman, 1980, p. 34).

Body structure and personality are interrelated from the time of

conception. The physical and psychological health of the mother has a profound effect on the development of the child. Kurtz and Prestera (1976) comment that

> if, in the uterus and early extra-uterine environment, we were poorly nourished, we will find it emotionally difficult to receive any energies. Somewhere within us the experience of not receiving full warmth and love is imprinted. We will be untrusting, unable to open ourselves to the available nourishment around us (p. 73).

Furthermore, we emotionally and physically respond to the myriad messages we receive from the people around us as we grow up and develop our self-concept. We may respond by repressing those parts of ourselves we get negative messages about and enhancing the areas we are praised for. This all has an effect on how we hold our bodies and how the different parts develop.

Johnson (1977, 1983) identifies four factors which influence the way our bodies develop. First, our unique personal history, including our birth experience, illnesses, accidents, the way our parents taught us to use our bodies, as well as our emotional response to all these events, has a powerful impact on us. Second, our culture, with its definitions of what comprises beauty, may influence us to distort our bodies to conformity with a stereotypical cultural ideal. Third, we each respond to the pull of gravity on our bodies in our own unique ways. Fourth, we are shaped by our intentions: "how we choose to deal with our environment, our fears and other emotions; the types of activities we choose; the life-style we create; the food we eat; our programs of exercise and stress reduction" (p. 11).

Dychtwald (1977), in his book called Bodymind, assumes that "the shape of the physical body is reflective of the psychological body that is housed within it" (p. 27). The linkages he proposes are a result of his extensive personal observations rather than the result of a systematic scientific study. Dychtwald describes five major splits which may occur in the body-mind: right/left, top/bottom, front/back, head/body, and torso/limbs. To determine whether people have one of these splits it is necessary to look at their overall proportions and patterns of movements. "Different preferences and qualities will be reflected in the structure and functions of the top and bottom halves as well as the right and left halves of the bodymind" (Dychtwald, 1977, p. 39). Dychtwald compares the way we mold our body-minds to the way in which a football team functions. Like a football player, we locate the position which best utilizes our strengths and abilities. "All the working out and practicing we do, whether it is purely physical or purely emotional, tends to mold our bodyminds in ways that are simultaneously expressive and definitive of ourselves and our unique life positions" (Dychtwald, 1977, p. 39).

Dychtwald (1977) also describes the various meanings suggested by the way each body part is held, seeing each part as a metaphor of the personality. For example, he states that massive, over-muscled legs suggest a person who has difficulty with change, movement, and spontenaity. A receding jaw usually is indicative of withheld sadness or anger, while a jaw protruding forward reflects a defiant attitude. Dychtwald believes that feelings we have repressed may become lodged in various muscle tissues. Because specific feelings tend to collect in

similiar areas of people's bodies, each specific body part has certain emotional memories and feelings associated with it.

Kurtz and Prestera (1976), in their book The Body Reveals: An Illustrated Guide to the Psychology of the Body, also correlate physical attributes and psychological characteristics. Their premise is that "each part, due to its unique place in the functioning of the organism, reveals something different about our total structural, mental, and emotional patterns" (p. 42). The body comes to reflect what the heart feels and the mind believes, revealing the total being. Like Dychtwald, they describe what may be indicated psychologically by the various structural configurations of the body. A valuable aspect of their presentation is the series drawings showing the various shapes a body part may have. They indicate a normal, ideal type as well as progressive deviations from the norm. However, they caution that there are no easy formulas. Looking at individual segments is useful but limited. Each aspect of the personality can only be understood by interaction with that person. "While it is true that each part reflects the whole, it is the dynamics of the whole that determine the meaning of the individual segments. . . . though the body speaks, it must always be the whole person to whom we listen" (Kurtz & Prestera, 1977, pp. 102 & 105).

King (1972), in her dissertation called "An Investigation of Selected Associations Between Personality Traits and the Human Muscular-Skeletal Structure", attempts to correlate body parts with personality traits. King's study consisted of mailing a list of 47 hypothesized associations between particular body parts and personality

traits to 141 recognized professional body therapists who acted as judges to ascertain the measure of agreement for each item. The population reference was white, middle-class, adult, and either American or British. Considering all 47 items and all the judges, the level of agreement for the hypothesized associations was 73 percent at the .01 level. King reports that there was no significant difference between the different body therapies in the level of agreement. She cautions that the results of the study indicate the beliefs of the judges, but do not prove the truth or falsity of the specific hypothesized associations. King concludes that the fairly high level of agreement with the hypothesized associations "holds promise for the use of body structure in understanding personality" (p. 156).

King's work, as well as that of Dychtwald, and Kurtz and Prestera, can provide information about possible relationships between personality characteristics and body structures. However, all their observations are based, not on rigorous scientific research, but on the accumulated wisdom of much observation of and experience with many bodies. These hypothesized associations do not take into account possible cultural differences. However, they do provide a tentative and rich picture of what the structure of the body reveals about the personality.

E. A HOLISTIC PARADIGM--THE CHAKRA SYSTEM

There are a number of systems, developed in the East over a period of thousands of years, which offer comprehensive holistic paradigms

describing how the body functions. Acupuncture and yoga are two of these systems which explain the functioning of the body in terms of energy movement (Duke, 1972; Mann, 1973; Worsley, 1982).

The chakra system is another ancient holistic construct which incorporates the full spectrum of existence and consciousness. It is a rich psychological and transpersonal paradigm based on an energy model of the body. Since all therapies have their place within this paradigm, it provides a useful means for comparing and evaluating the various therapies. "The chakra system offers psychology the opportunity to become an integrated science" (Kraft, 1978, p. 11).

According to ancient Hindu literature, a powerful energy, Kundalini energy, flows within the interior of the spine from the base of the anus to the top of the head (Leadbeater, 1979). Two other important energy channels having to do with male (Ida) and female (Pingala) life forces begin at the base of the spine and coil up the spine, crisscrossing at seven major locations (see Figure I). Each of these intersections is called a chakra, a Sanskrit word meaning "wheel". According to people who can see such things, the chakras are described as fast moving vortices of energy composed of "shifting colors, sounds, and densities, rather like liquid convolvulus flowers or the surface shape of water spiraling in a whirlpool" (Schwarz, 1978, p. 90).

Chakras can be viewed as the centres through which energy is received and transmitted as it moves in and out of the body. "Each chakra has a characteristic color and frequency of vibration associated with the quality of the energy it is concerned with" (Schwarz, 1980, p.

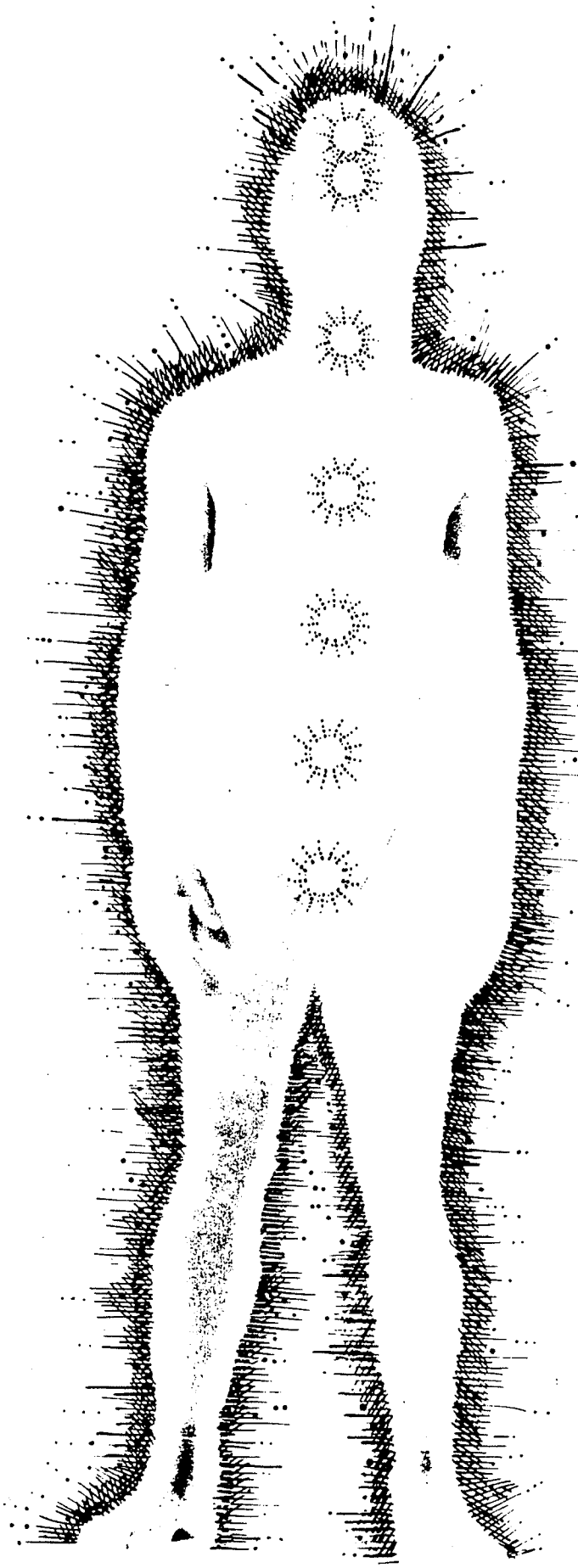

FIGURE I: THE SEVEN CHAKRAS

13). There is a progression in the frequency of vibration of the chakras with the lowest vibration coming from the first chakra at the base of the spine and the highest vibration coming from the seventh chakra at the top of the head. Each chakra also relates to specific areas of behavior as well as emotional and psychological development. Furthermore, each chakra relates to one of the seven major glands of the body in a way not yet understood by science (see Figures II & III). As Breux (1981) writes, "each chakra has a special relationship with a particular inner realm and psychological function, and supplies vital energy to specific physical organs, endocrine glands, and nerve ganglia" (p. 263).

Because the chakras are seen as reflecting our mental, physical, emotional, and spiritual condition at any given point in time, it is said to be possible to ascertain a person's degree of health by observing the nature of the energy flow through the chakras. While there is always some flow of energy through the chakras as long as a person is alive, the flow may not be balanced. Both an excessive and a deficient flow of energy may lead to disease. According to Schwarz (1978), "underactivity [of the chakras] represses all bodily functions because the organs are not fueled well enough to work properly. Overactivity burns up the nutrients that feed the organs. In either case the effect is the same: We do not receive the nourishment we need to continue to generate and be creative in our lives" (p. 89). The object, then, is to balance and regulate the flow of energy through the chakras in order "to allow the life force to flow uninterrupted throughout the body, so that the organism can heal itself and

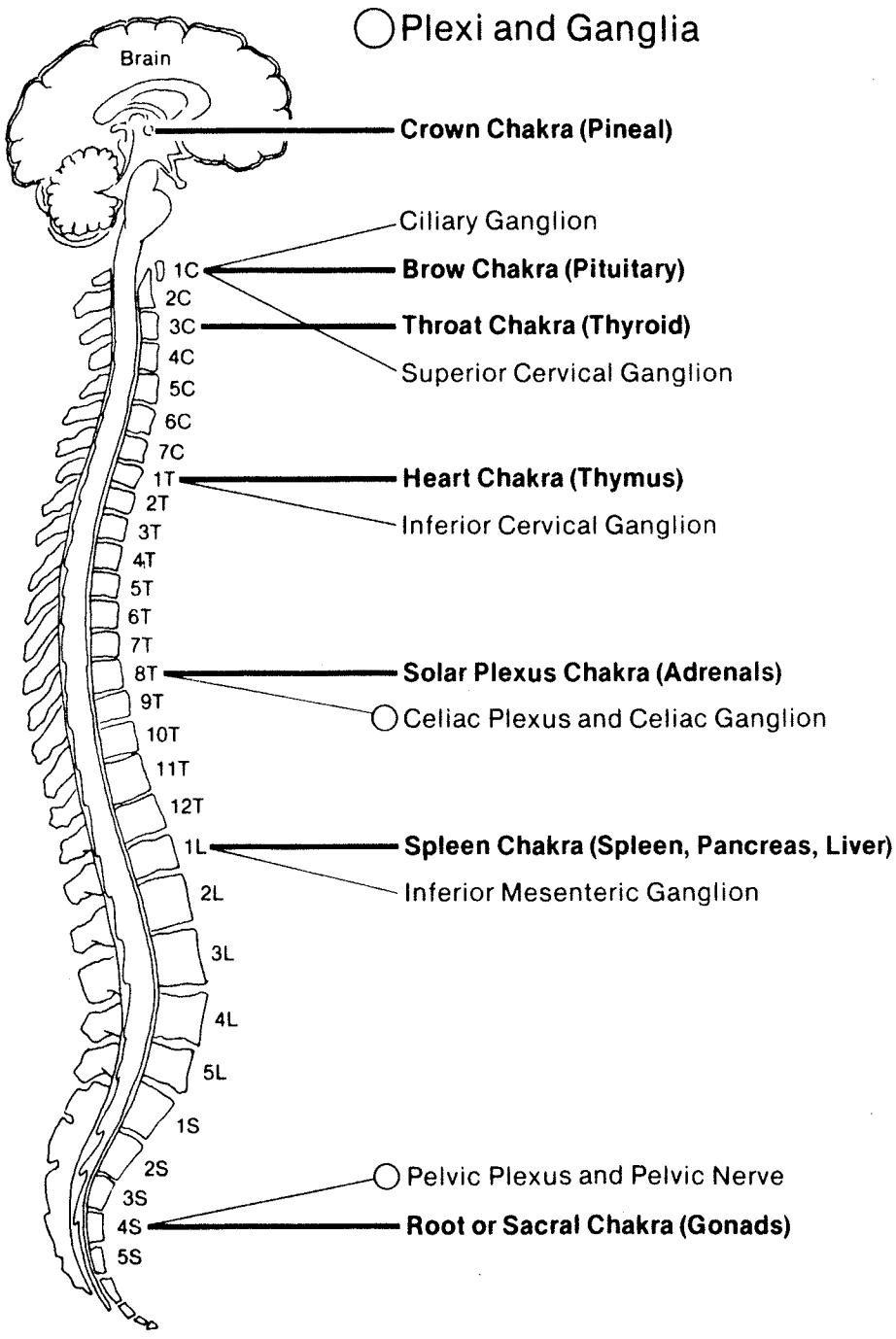

FIGURE II

SPINAL CONTACTS OF CHAKRAS
(ENDOCRINE GLANDS RELATED TO THE CHAKRAS)

name	base center	spleen center	solar plexus	heart center	throat center	brow center	crown center
location	base of the spine	half way between pubis & navel	just above navel	center of the chest	middle of the throat	middle of the forehead	top of the head
function	sex	health	power	com-passion	creativity & self-expression	para-normal powers	libera-tion
endrocine influence	ovaries gonads	liver pancreas spleen	adrenal gland	thymus gland	thyroid gland	pitui-tary gland	pineal gland
color	red-orange	pink	kelly green	yellow gold	sky blue	indigo	purple
symbol	square	pyramid with cap-stone off	circle	cross	chalice	6-pointed star	lotus
sound	LA	BA	RA	YM	HA	AH	OM
element	earth	water	fire	air	ether		
dominant sense	smell	taste	sight	touch	hearing		
planetary influence	saturn	jupiter	mars	venus	mercury	sun & moon	
emotion	frustra-tion rage passion	anxiety well be-ing	power desire fear guilt doubt	joy grief	inspira-tion repres-sion	obses-sion ecstasy	bliss
related illness	hemorrhoids sciatica prostate ovarian uterine	diabetes cancer	ulcers gall-stones	stroke angina arthritis	thyroid flu	schizo-phrenia kidneys	psychosis

FIGURE III

CHART OF THE SEVEN CHAKRAS

experience optimal health and well-being" (Koenig, 1981, p. 45).

The chakras are described as highly complex and intricate. Rama et al. (1976) give some idea of the richness inherent in these energy centres:

> The intuitions and understandings of literature, of art, of mythology, of religous symbolism, of physiology, physics and metaphysics all come together at a central focus in the centers of consiousness called the chakras. All understanding is distilled here. . . . by immersing oneself in this inner experience, an understanding of the coordination between the various aspects of oneself and the universe begins to grow. . . . each center pulls together different aspects of the external and inner worlds into a coordinated, but difficult to describe, whole (pp. 224-225).

The location of the chakras implies a progression in the pursuit of human development and potential. Each progressive level needs to be unblocked and developed before moving to the next level.

> The seven chakras are seen, not as elements to be ignored or avoided, but rather as creative challenges to be cultivated and transformed. In this fashion, evolution through the chakras and the various powers and attributes that each chakra represents can be seen as the natural and organic development of human life through its various levels of consciousness and bodymind awareness (Dychtwald, 1977, p. 88).

The first chakra, called the base or root chakra, is located in the anal region at the base of the spine. It is the seat of the physical life force known as the kundalini. The base chakra

influences sexual activity and creativity, as well as the male-female sex glands. Thus, it affects sex drive as well as reproduction and secondary sexual characteristics. This chakra has to do with basic needs for survival and self-preservation. People whose energy is blocked in this chakra may be fearful of being physically or psychologically hurt by others, or may be inclined to strike out and hurt others in some way. Such people have difficulty giving and receiving, tending to hoard and possess that which they contact. "Emotionally and psychologically, this chakra is concerned with the most primitive fears and the most extreme degrees of pathology" (Rama et al., 1976, p. 229). When the energy of this chakra is flowing freely, the procreative energy which is transmuted by this centre "can be used to enhance all forms of creative activity, personal growth, health, healing, intuition, and intelligence" (Gunther, 1983, p. 19).

The polarity of this chakra is between annihilation and survival, attacked and attacker, or the devil and the divine. A synthesis of these polarities results in a quality of earthiness and solidity.

The anal region has to do with taking in, processing, and giving out. According to Freud, the anal stage of development is crucial in progressing to healthy emotional maturity. People who have difficulty being free-flowing, spontaneous, and creative often express their tensions in the anal area. This may result in the buttocks being held tight and chronically contracted, the pelvis floor being drawn up, or tension in the stomach and lower back. "This armoring seems to suggest that unresolved anal conflicts and unhealthy survival-level interactions will hamper further development and maturation as the

life energies ascend through the bodymind" (Dychtwald, 1977, p. 97).

Sullivan has dealt with the experience of being dominated by the energies and consciousness of the first chakra when he describes the psychotic experience of being preoccupied with the fear of annihilation while living in a paranoid world (Rama et al., 1976). A therapy, such as behaviorism which works towards the systematic desensitizatiion of phobias, is also linked to this chakra.

The second chakra, called the spleen chakra, is located midway between the pubis and the navel. This chakra is connected to the liver, spleen, and pancreas--organs which have to do with digestion, metabolism, immunity to disease, and the detoxification of poisons. Located near the sexual organs, the spleen chakra has to do with sexual and sensual pleasure as well as the survival of the species. Healthy sexual functioning is a sign of vitality in this area, while a preoccupation with sexual experiences and sensual pleasures characterizes people whose energy is blocked here. A sign of problems in this area is when another person is seen as "a sexual object rather than as a companion, friend, competitor, or as someone to be feared as was the case when the first chakra was predominant" (Rama et al., 1976, p. 222).

The polarity of this chakra has to do with maleness and femaleness. Its synthesis involves becoming aware of, prizing, and incorporating the characteristics of the opposite sex each one of us has.

The psychology of Freud, Jung, and Reich relates to the genital chakra. Freud viewed all motivation as based on sexuality, with the

highest stage of development being the genital stage. Jung, both a colleague and competitor of Freud, dealt with the integration of the anima, the feminine side of the man, and animus, the masculine side of the woman. Both the anima and animus archetypes are usually repressed. Thus, a major goal of Jung's therapy is the intrapersonal and interpersonal integration of one's maleness and femaleness. Both Jung and Freud believed human nature to be bisexual. Reich, who was also strongly influenced by Freud, held that "sexual consciousness and release suggested the highest of all possible developments in the human organism" (Dychtwald, 1977, p. 108).

The third chakra, the solar plexus chakra, located just above the navel, is related to the adrenal glands which strongly influence the sympathetic nervous system, heartbeat, digestion, muscular energy, and circulation of the blood. This chakra comprises the centre of emotion and power. It has to do with the polarities of domination and submission, superiority and inferiority. People whose energy in this area is unblocked are able to accept their feelings as well as the feelings of others. They can be dynamic and assertive with their own power without dominating others. Blockage in this area leads to attempts to dominate and control others, seeing them as either superior or inferior to oneself.

Adlerian psychology focuses primarily on the third chakra (Dass, 1971; Rama et al., 1976). Adler believed that the feelings of inadequacy and inferiority experienced as a result of one's childhood experience of relative helplessness results in attempts to overcome the feeling of inferiority by gaining superiority. He saw people as

being overly concerned with issues of power, competition, domination and adequacy, attempting to mask feelings of inferiority by creating a pseudo sense of superiority.

The fourth chakra leaves the instinctual and material areas of life, moving to a concern which transcends the individual. The heart chakra, which is located in the centre of the chest slightly above the diaphragm, is the transition point between the lower and upper chakras, and represents the polarity between one's lower and higher natures as well as the polarities existing between the right and left sides of the body. This chakra, the centre of nurturance, is associated with feelings of love, compassion, and empathy. It is "the source of boundless love and compassion, rather than one dimensional sexual or sentimental romatic passion" (Gunther, 1983, p. 21). The heart chakra influences the thymus gland and the lymphatic system whose function is to help the body resist disease.

Blockage in the area of the heart chakra is expressed through a self-protectiveness which results in muscular armoring used to defend against hurt or attack. However, this armoring also traps feelings of warmth and caring inside. A free flow of energy through the heart chakra is characterized by the ability to express empathy, sensitivity, compassion, and selfless love. This love can be described as "the unrestricted experience of life. Its existence is continuous, but we experience it only to the degree that we have allowed our bodyminds to be open, integrated, and balanced" (Dychtwald, 1977, p. 150).

Rogerian therapy, with its emphasis on "unconditional positive

regard", non-judgementalness, and empathy, is related to the heart chakra (Rama et al., 1976). Bioenergetics is also associated with this chakra since its goal is to integrate heart, mind, and genitals, and enable love to flow from the heart (Lowen, 1975).

The fifth chakra, the throat chakra, is situated in the throat, the area where food and air are received by the body. This chakra affects the thyroid gland which regulates metabolism, the balance of the nervous system, and muscular control. Physiologically and psychologically, the throat chakra has to do with accepting and receiving nurture.

> When consciousness is first focused at the throat chakra, one's role is still that of the receiver of 'grace'. The ability to receive grace is a step above the capacities of the heart chakra where one is limited to being compassionate, to sharing as a separate being with a limited other. Now, instead, one is able to accept from an inner, unlimited source. Eventually, through the experience of receiving this grace, one's consciousness moves towards the next center (the one above the throat chakra) and the realization that giver and receiver are one begins to dawn (Rama et al., 1976, p. 262).

The throat chakra is the first "spiritual" chakra since it is the point at which people start to comprehend their relationship to themselves as well as the universe. The ego longs and searches for growth, greater potential, and "nurturance from above" (Rama et al., 1976, p. 257). The polarity of this chakra is between being closed or open to one's higher self. Its synthesis has to do with the ability to

grow and evolve.

The psychology of Maslow (1954, 1968, 1971) relates to this chakra. In fact, there is remarkable similarity between Maslow's conceptualizations of human development and the chakra system (Rama et al., 1976). Maslow views people as possessing a heirarchy of needs ranging from such basic needs as food, shelter, sleep, sex, safety, and security, to the higher needs for love, esteem, and belonging. When these fundamental needs are realized, a still higher order of needs for growth and development emerges. These needs for beauty, truth, goodness, justice, meaning, order, simplicity, perfection, self-sufficiency, and transcendence, come out of an intrinsic motivation every one has to become whole self-actualizing persons.

The sixth chakra, the brow chakra, is located between and slightly above the space between the eyebrows in the centre of the forehead--the area known as "the third eye". According to the ancients, this centre influences the pineal gland. However, it may also involve the pituitary gland, which affects all of the other endocrine glands. The development of heightened self-awareness and expanded mental powers is involved here, as is the ability to see intuitively in ways physical eyes cannot see. This intuition

> is a stable, reliable function of the higher levels of consciousness and awareness from which a wider range of information is accessible. There intellect and emotion flow together and become integrated, permitting a new kind of knowing . . . which both depends on and promotes self-realization. Intuition unquestionably comes from the highest source of

knowledge. It dawns bit by bit with the growth of consciousness (Rama et al., 1976, p. 265).

At the level of development of "the third eye", an increasingly intense recognition of the unity of all things emerges. "Here is the source of ecstacy, extrasensory perception, clairvoyance, clairaudience, heightened intuition, and the paranormal powers" (Gunther, 1983, p. 23). This is the gateway to the "psychic" and mystical realms. Recent parapsychological research suggests the presence of additional senses and abilities open to us (Rama et al., 1976). These heightened capacities have to do with the sixth chakra. The polarity involved here has to do with the right (Ida) and left (Pingala) aspects of the personality. Integration of these polarities results in an inner vision as well as access to intuition.

The seventh chakra, the crown chakra, is located at the top of the head. It is connected to the pineal gland, which was thought by the ancients to be the seat of the soul. Medically, however, the pineal gland seems to have no function. It "atrophies in most people by the age of thirteen because it is not used. Indeed it cannot be used until all the other energy centres are balanced and fully functioning" (Schwarz, 1978, p. 95). The crown chakra is associated with the highest level of human development. "In mystic lore, when the lower energies are balanced, refined, and raised to this region known as cosmic consciousness, unconditional enlightenment beyond name, form, thought, or rational experience takes place. It is this highest frequency that is the source of the halo that surrounds the head of spiritually evolved beings" (Gunther, 1983, p. 24). At this level,

awareness is expanded to the point that transcends words and all distinctions having to do with ordinary consciousness are meaningless. Experience is characterized by a "cosmic consciousness", a complete oneness with the universe. Since this chakra transcends the limitations of the psyche, it goes beyond modern psychology. However, this highest of chakras provides a vantage point and a

> key to a framework in which the functioning of the mind becomes intelligible, and all aspects of experience can be integrated into a unified theory. Furthermore, the nature of this state is so fundamental to the nature of man's being that to be completely successful any psychological theory must at least be compatible with its existence (Rama et al., 1976, p. 272).

A study which points to the objective existence of the chakras was done by Hunt, Massey, Weinberg, Bruyere, and Hahn (1977). By making an EMG recording of the major chakra points in conjunction with the verbal descriptions of an "aura reader" while subjects were being "Rolfed", it became possible to correlate different wave forms with the different colors in the various chakra locations. This study concluded that chakras frequently were the colors described in the metaphysical literature, chakra activity was related to the content of a person's imagery, individual chakra patterns were apparent, and certain chakras were related.

F. AN ENERGY MODEL

Given that the chakra paradigm is based on a view of the body as

an energy system, a brief discussion of the energy model is in order. The concept of an energy field existing in conjunction with the material, empirical world is a pervasive belief which extends into antiquity. Many ancient systems of healing assert that there is one fundamental energy which gives life to the organismic and from which all other bodily functions are born" (Brint, 1981, p. 40). This energy was called "Chi" or "Qi" by the Chinese, "Prana" by the Hindus, "Orenda" by the American Indians, "Mana" by the Polynesians, "bioplasma" by Russian researchers, and "Orgone" by Wilhelm Reich (Rama et al., 1976). Western science has not widely accepted the concept of biological energy, and the subtlety of this energy has made it difficult to be empirically verified. However, Eastern systems, such as yoga and acupuncture, provide a comprehensive heirarchical description of how energy operates both intrapersonally and in the external world (Duke, 1972; Mann, 1973; Worsley, 1982).

Energy circulates through the body as a dynamic force in constant flux. Such a concept of energy is essentially equivalent to what is described as "life". Chang (1978) declares that "for all practical purposes, it can be stated that life is an indication of energy within the body" (p. 46). Although inanimate matter appears to be completely solid, it is energy which contains the electrons, neutrons, and protons within each atom. Inanimate matter, then, is seen within the energy model as merely energy at a different rate of vibration than that of other forms of life. As a result, it is assumed that "energy . . . is the absolute basis for all forms of life and matter in the universe" (Chang, 1978, p. 46).

An assumption of the energy model is that energy flows freely in a healthy body (Bauman, 1982). For this to happen, all the energy centres, the chakras, need to be functioning in a balanced free state which permits the energy to flow unimpeded. The condition of the chakras is crucial because "through their interrelation and interaction with all the endocrine glands, [they] maintain normal function of all the body's organs" (Schwarz, 1980, p. 18). Energy is composed of opposites, such as yin and yang, feminine and masculine, negative and positive, or inward and outward. Since these opposites are inseparable, one cannot exist without the other. Both are necessary for movement. In a person who has a healthy flow of energy the opposites are in a balanced state of equilibrium or homeostasis. "Balance is the natural state of the universe" (Miller, 1975, p. 85).

A second assumption is that the flow of energy can be slowed or blocked by attitudes and feelings, and that this results in damage to the body. While the chakras can never be totally blocked as long as life exists, they can be blocked to the extent that only a small amount of energy may get through. "If one of the chakras slows down in its actions, if it is in a state of inertia, the energy flow is impeded and organs will begin to show signs of illness. . . . one way of looking at illness is to characterize it as stagnant energy, energy that is not being heightened and transformed" (Schwarz, 1980, pp. 18 & 85). Disease may occur when energy flow is excessive, deficient, or poorly modulated in a part of the body (Worsley, 1982).

Dr. Kargulla (1974), a neuropsychiatrist who has extensively studied the ability of a "sensitive" to "read" the energy fields of the

human body, discovered that the sensitive could accurately diagnose physical maladies by being able to observe the energy patterns of patients. This sensitive was also able to predict illnesses due to the energy imbalance which preceded the physical ailment because "the energy field seen in the envelope surrounding the human organism is a modified form of the energy flowing inside the body" (Pierrakos, 1974a, p. 62). Kargulla (1974) states that "any disturbance in the physical structure itself is preceded and later accompanied by disturbances in this energy body or field" (p. 161).

A third assumption is that withheld or blocked energies are located at specific places in the body. We can trap energy by holding on to some part of it and not allowing it to flow freely. The places in our body where energy is static may feel inert, dark, or heavy rather than loving, light, or complete. While people may hold different energies in their own unique locations, they tend to store their particular emotions in similar parts of their bodies. For example, sadness may be held near the heart, while fear may be held in the belly. "Places that hold energies are separated as if by a wall from the natural flow in the rest of the body. Whenever an energy occupies space in the flesh, no other vibration can pass through. Therefore, when you hold energies, your body's total capacity for channeling energy is diminished" (Miller, 1975, p. 89).

Dychtwald (1977) compares the flow of energy to the flow of a river whose path is determined by the rocks, vegetation, and debris in its path. In the same way, the emotional blocks and unexpressed feelings structure the way our energy flows. Each part of our body can

restrict the flow of energy, resulting in an accumulation of energetic debris at the site of the blockage. An accumulation of this sort results in stress, armoring, and an increased propensity to ill health and disease. A jamming of the central nervous system may occur which results in "chatter" in the mind (Kurtz & Prestera, 1976).

Energy is trapped by both muscle tension and mental tension. Fearful and anxious preoccupations consume large amounts of energy. Much energy is also wasted in attempting to keep troubling issues out of awareness. While an enormous amount of energy is available to us, we often use only a fraction of it due to our unwillingness to give up control of all that we are repressing (Tiller, 1974).

SUMMARY

An approach to social work which operates from an ecological perspective observes the behavior of people in their environments from a systemic viewpoint. This systemic perspective can be used by social workers to analyze the macro levels of a person in society or the micro levels of the intrapersonal. This is because, due to the nature of systems, a progression of different levels of varying degrees of complexity may be simultaneously operative.

This chapter has presented a view of the person as a complex interplay of interconnected and interdependent parts. The intellectual, physiological, social, psychological, and spiritual aspects of a person can be separated for the purpose of discussion, but are functional parts of an indivisible whole. The chakra paradigm is

one way of ordering the progression of some of the layers which make up this whole. Beginning with the most basic needs of a person, it systematically moves to the level of cosmic consciousness. This holistic way of conceptualizing people has many ramifications in terms of our view of health and pathology as well as how we intervene in the lives of our clients. The next chapter describes a variety of therapies, loosely designated as "body therapies", which are based on a holistic view of the person. Further chapters discuss the issues this perspective and these therapies present to the profession of social work.

CHAPTER TWO

LITERATURE REVIEW

This chapter reviews the literature on nine body therapies: Reichian therapy, Bioenergetics, the Alexander technique, the Feldenkrais method, Structural Integration, Focusing, Primal therapy, Polarity therapy, and Spontaneous Body Experiencing. These therapies are considered in terms of their central concepts, views of health and sickness, goals, and therapeutic processes. Special note is made of how they fit within the energy model and the chakra system. A critique of each therapy is also presented.

A. REICHIAN THERAPY

Wilhelm Reich (1897-1957), an Austrian psychoanalyst, was initially an enthusiastic follower and devoted colleague of Freud. However, by the late 1920's, Reich's controversial theories resulted in his breaking with Freud. After a number of years of exile in Europe as a refugee from Nazi Germany, Reich settled in the U.S.A. in 1939, where he began his life work with "orgone" energy. During the early fifties he became labeled as a quack. In 1954 he was sued by the Food and Drug Administration for mislabeling his orgone accumulator as a cure for cancer. Following a tragic series of events, Reich was imprisoned and died in a penitentiary in 1957, a tired and bitter man (Mann, 1974).

Reich is considered to be the father of most present day body oriented and deeply emotional therapies (Hoff, 1978). "Many of the

most popular growth techniques . . . are in a way direct descendants of the Reichian approach to the bodymind for within each of these approaches lives a deep appreciation for the interconnectedness of mind, body, and emotions" (Dychtwald, 1977, p. 109). While Reich began from a Freudian perspective, his work took him far beyond Freud and led him into keen conflict with the psychoanalytic establishment.

Central concepts

The fundamental assumption undergirding Reichian therapy is that "mind and body constitute a functional unity. . . . Both function on the basis of biological laws" (Reich, 1973, p. 379). This concept of physical and psychological unity means that ego structure and bodily attitude, as well as character and muscular armoring, are functionally identical. A corollary of this assumption is that past and present are not dichotomous: "The entire world of past experience [is] embodied in the present in the form of character attitudes. A person's character is the functional sum total of all past experiences" (Reich, 1973, p. 145).

A second concept central to Reichian therapy is the function of the orgasm in sexual fulfillment. Reich, like Freud, believed that repressed sexual energy is the basis of neurosis. Reich assumed that a full orgasmic discharge rid the body of excess energy, leaving it no energy to support neurosis. He characterized a full orgasm as an immense build-up of energy followed by a total involuntary convulsive discharge which feels pleasurable and satisfying. "In the orgasm, we are nothing but a pulsating mass of plasm" (Reich, 1973, p. 348). If

the orgasmic release is incomplete, perhaps due to orgasm anxiety or chronic armoring, surplus sexual energy becomes pent-up. This "sexual stasis", having nowhere else to go, becomes translated into neurotic symptoms. These neurotic symptoms or defenses militate against the free expression of orgasmic energy, and so a vicious cycle is set up.

Reich's formulation about body and character armor comprises a third basic concept. Reich's observations that psychoemotional blocks and conflicts become lodged in the muscular tissue of the body as "body armor" was perhaps his most important discovery (Kraft, 1978). Body armor is a protective muscular shell used to defend the person against harm or hurt from the outside as well as protect against painful or fearful internal emotions. The thicker the armor, the less the flow of feeling and life through the person and the weaker the orgasmic reflex. This armoring can be built up throughout life, starting with the suppression of childhood impulses. It results from specific events over time: "Every muscular rigidity contains the history and meaning of its origin" (Reich, 1973, p. 300). Reich described seven segments in the body where armoring most frequently occurs: the ocular, oral, cervical, thoracic, diaphramic, abdominal, and pelvic areas.

While muscular armoring is the physical aspect, character armoring is the psychic aspect of the complete defense system. These two aspects operate together, for "the psychic structure is at the same time a biophysiological structure" (Reich, 1973, pp. 300-301).

Reich described three levels of personality. At the center of one's being is "a core of natural, self-regulating orgone energy or primary drives which, if allowed to function smoothly, develops the

organism into a rational, decent, and loving human being" (Corey, 1980, p. 31). Reich viewed people who express this core as basically good, and rational, moving towards wholeness, gentleness, community, and a loving passion. Around the core is a middle layer made up of a complex of defense mechanisms and secondary drives. When the natural primary impulses toward love and growth are suppressed, that which is "evil" or "destructive" emerges. "Human problems come from frozen energy--energy that is held, dammed up, restrained from pulsing out its rhythms and transmitting its life wisdom into our actions" (Grow, 1978, p. 208). Around the middle layer of the personality is the third layer, the personal facade, comprised of family, social, and cultural expectations and mores that a person presents to the world.

View of health and illness

Health, for Reich, is orgastic potency, a total body experience which includes love, tenderness, spontaneity, sensuality, and effortless rhythmic friction. "Involuntary bioenergetic convulsion of the organism and the complete resolution of the excitation are the more important characteristics of orgastic potency (Reich, 1942, p. 95). The orgasm maintains health when it discharges all the person's excess energy.

Reich's (1973) utopian ideal for pople is embodied in his description of the "genital character". Such a person is "conspicuosly good and gentle" (p. 158) with a "simple and natural . . . attitude toward the world, toward one's own experience, [and] toward other people" (p. 183). Genital characters are free self-regulating

individuals who are in harmony with themselves because they have eliminated "the struggle against an instinct which, though inhibited, was constantly obtruding itself" (p. 180). They possess a natural self-confidence based on sexual potency. For genital characters, sexuality is not seen moralistically, but as an experience of pleasure. Work becomes pleasureable and there develops a "growing immersion in social activity to which one [is] fully committed" (p. 176).

Reich (1973) believed that sexual stasis is the root cause of most disease:

> The disturbance of genitality is . . . the symptom of the neurosis. The severity of every form of psychic illness is directly related to the severity of the genital disturbance. The prospects of cure and the success of the cure are directly dependent upon the possibility of establishing the capacity for full genital gratification (p. 110 & 96).

Thus, for Reich health and neurosis are intimately linked to sexual functioning.

Reichian therapy focuses more on health than on illness, more on the cause of the problem than on the symptom. The main task of the therapist is "to find out and correct all that disturbs the central basis of health . . . [and] to heal the damage to the central life functions" (Raknes, 1970, pp. 168 & 169). This approach is compatible with that of the holistic health movement.

Goals

The ultimate goal of Reichian therapy is to "dissolve neurotic

character structure and muscular armoring at the deepest biological levels, to restore free, natural energy flow, and, finally, to establish 'full orgastic potency'--the ability to build up and release full energy at the moment of orgasm" (Hoff, 1978, p. 205). To do this, the armoring process must be reversed. As the armor is dissolved the layers of repressed emotions are progressively released and drained off, starting with the most recent layers and moving towards the earliest layers of repression. While there is cathartic discharge as the armoring is shed, Reich believed this discharge to be an incomplete goal of therapy. Catharsis needs to be combined with insight so that the defenses will be less readily reconstituted. Reich ultimately came to believe that, because liberated people cannot thrive in a repressive society, to change people must also mean to change society (Caspary, 1983).

Therapeutic process

In Reichian therapy, an accurate biopsychiatric diagnosis is essential so as to understand the structure of a person's armor (Konia, 1975). In the initial interview the therapist ascertains the presenting problem, the level of past functioning, and a history of the client's sexual functioning.

Deep breathing and deep massage of spastic areas are two major techniques used by Reichian therapists. The two done in conjuction with each other are a powerful route into the unconscious and can produce strong emotional release. Because the face is a prominent area of emotional expression, the armoring in this area is attacked by

working with facial expressions. Other techniques involve pushing down on the chest while the client exhales or screams, working with the gag reflex, maintaining "stress positions", and engaging in active "bioenergetic" movements together with breathing and sounds.

Although he used "unorthodox" techniques to facilitate cathartic release and reduce rigidity and tension, Reich continued to use many of the principles of psychoanalytic therapy. He stressed the importance of insight, interpretation, and cognitive restructuring. He saw that defenses "are labyrinthine and require complex strategies for dissolution rather than simple breaching through gimmickry" (Nicols & Zax, 1973, p. 107). He believed that both body work and character analysis are indispensable and complementary. "The body work gives teeth to the character work, but it is the character-analytic understanding that gives the whole process of the therapy intelligence, meaning, and direction. Without this understanding, no matter how forcefully and diligently the body work is pursued, the therapy will bog down and founder at every turn" (Hoff, 1978, p. 211). While verbalization is a crucial aspect of therapy, Reich stressed the value of working non-verbally, because words are often used to block affect.

View of Energy

Reich's highly controversial view of energy is central to his therapy as well as to his world view. To him, the entire universe is a dynamic force field of primordial life energy which he termed the "cosmic orgone ocean". This ocean, which encompasses all time and space, is manifested in the smallest of atomic particles as well as the

largest of galaxies. "The atom is cosmic energy released from matter, while matter is cosmic energy converted into form or structure. It follows, then, that the structure of the living cell is an expression of cosmic energy. . . . People are energy and energy is people" (Corey, 1980, p. 29). This cosmic energy, which is fluid, self-regulating, and self-governing, guides all processes for growth in the universe.

Because Reich believed that this cosmic life energy is predictable, functioning by definite laws or principles throughout the life cycle, he established what he called the "common functioning principle". Reich postulated that this primary life principle consists of a continuous four beat pattern of tension-charge-discharge-rest. Energy builds until the charge peaks, at which point there is an energy discharge, a state of rest ensues, and the cycle repeats itself. When a person is healthy, this four-beat pattern involving contraction and expansion functions smoothly and continuously, providing a constant fluid flow of energy to the body. This natural flow of life energy was called "streaming" by Reich.

Emotional expression was seen by Reich as a manifestation of the energy of the body. Consciousness or self-awareness results from experience of an intense flow of bioenergy. Reich believed that people have an innate yearning to become merged and reunited with the cosmic energy.

Reich's view of character development stemmed from his conceptualization about the role of energy. He assumed that the core of an infant is pure orgone energy which expresses itself in natural needs, feelings, and impulses. If the infant's needs are met and it is

permitted to express itself freely and not have its feelings stifled, it can develop healthily. However, character defenses arise when the natural needs of the child conflict with external prohibitions. This results in a blocking of energy and the beginning of armoring. Reich's premise was that the more naturally a person functions, the more fluid will be the flow of energy, and the more healthily and positively such a person will be able to interact with the environment.

Reichian therapy, based on an energy model, is a powerful therapy which has had a strong influence on the body therapy movement. Hoff (1978) claims that this therapy

> provides quicker, surer access to areas of the unconscious that used to be virtually inaccesible. Profound, convulsive emotional releases, and even repressed memories from the earliest periods of life, emerge spontaneously, without special effort, simply as a by-product of the throughgoing softening of the resistance. The free-flowing energy that has been liberated pushes into the remaining blocks, further weakening them, and setting in motion a process of spontaneous dissolution of armoring that ultimately reaches down to the deepest levels of biological functioning, and paves the way for the full development of the orgasm reflex (p. 210).

The associated chakra

Because of his overarching focus on the function of the orgasm, Reich is concerned primarily with the second chakra which has to do with sexual and sensual pleasure.

A critique

The enormous value of the Reichian system is the development of techniques to release deeply held energy, thus allowing people access to their most repressed bodily feelings (Dublin, 1976a). These techniques place this therapy at the forefront of the human potential movement, where personal growth is the objective and new approaches and techniques are eagerly sought (Kelley, 1972). However, Reich's major weakness lies in his obsession with the orgasm. The problems of people in our culture are so great that they cannot be comprehended or dealt with solely on the basis of developing an adequate orgasm reflex (Lowen, 1976b). The orgasm is only one activity among a complex, multi-faceted array of human experiences. The criterion for successful treatment being the achievement of a low-grade orgasmic reflex during the therapy hour is very limiting. Such an achievement is no guarantee that people will be able to attain consummatory orgasms with their lovers. Reich puts too little stress on the interpersonal nature of healthy, exciting lovemaking. He almost completely overlooks the psychological and emotional aspects of intimacy.

Furthermore, the emphasis on the orgasmic discharge of energy as the only cure for neurosis is a panacea which dismisses altogether the higher needs of people as described by Maslow. "The orthodox Reichian point of view not only dismisses growth-motivated needs, but, in addition, dismisses psychological kinds of deficiency-motivated needs as somehow irrelevant to the whole process of freeing oneself from one's psychopathological hangups" (Brown, 1973, p. 108). Brown (1973) further challenges the notion that the purpose of armoring is to

prevent the full experience of the orgasm reflex, and that armoring mainly consists of seven rings of chronic muscular rigidity. According to him, "such a conception of the body's total armoring masks more than it reveals of what the true patterns of energy blockage and muscular rigidity probably consist of" (p. 109).

B. BIOENERGETICS

Bioenergetics was begun by Alexander Lowen, a student of Reich. While Bioenergetics is clearly and firmly based in the Reichian tradition, there has been considerable variance from some of Reich's basic principles (Lowen, 1976a). For example, Lowen does not follow the Reichian pattern of dissolving the seven rings of muscle armoring, starting from the head and proceeding downward to the pelvis. Lowen places less emphasis on direct body contact methods than does Reich, relying more on do-it-yourself type of exercises. Verbal analysis is more highly stressed. Also, there is a shift from Reich's overarching emphasis on orgastic potency, to pleasure as the therapeutic goal. While analysis of sexual conflict is a salient goal of Bioenergetics, the same preoccupation around sex that Reichian therapy has is not present (Lowen, 1965).

Central concepts

Lowen and Lowen (1977) broadly describe Bioenergetics as "a form of therapy that combines work with the body and the mind to help people resolve their emotional problems and realize more of their potential

for pleasure and joy in living" (p. 5). Bioenergetics is based on three main interrelated components: energy, character, and grounding.

Reich's thinking is permeated by the concept of libido, or biological energy he called orgone. The concept of energy is also central to Bioenergetics. Lowen's (1975) basic assumption is that "energy is involved in all the processes of life--in moving, feeling, and thinking--and that these processes would come to a stop if the supply of energy to the organism were seriously interrupted" (p. 64). Keleman (1976) compares people to a "huge energy chamber that receives, transforms and discharges (externalizes or redistributes) energy which we metabolize and convert into feelings, expressions, and movement" (p. 193). This energy flows in and through the body in a way analagous to the flow of blood which vitalizes and cleans the body. As it follows various channels through the body it may produce a wide variety of emotions which defy the boundaries of anatomy. Given that most of the body is either water or structured water, the movement of energy may be experienced as currents or waves. "Nerves mediate these perceptions and coordinate responses, but the underlying impulses and movements are inherent in the body's energetic charge, in its natural rhythms and pulsations" (Lowen, 1975, p. 52). This flow of energy through the body accounts for its aliveness, spontaneity, and emotional vitality.

The energy system of the body is seen as interacting with and being affected by a larger energy field. "The energy in our bodies is in contact and interacts with energy around us in the world and in the universe" (Lowen, 1975, p. 67). How we are affected by this larger

energy field depends on our own internal energy state.

Lowen believes that there needs to be a balance between the body's energy charge and discharge. A level of energy appropriate to the needs and demands of the body is required. If the body is to grow, surplus energy is necessary. Breathing is central to the charge and discharge of energy. As Pierrakos (1974b) writes, "breathing is the bellows of life. . . . It can produce energy to invest in emotions or can create blockage to the movement of feelings" (pp. 99-100). Because of the need for equilibrium, if the energy charge of the body is increased, there must also be a greater energy discharge, perhaps through increasing the expressiveness of the other parts of the body.

Like Reich, Lowen views disturbances in the energy flow as blocks. These blocks, also known as "chronic muscular tension" or "deadness", are noticeable in areas where the motility of the body is reduced. Such blocks are associated with disturbances in cognition and sensation. If a feeling or attitude, such as fear, is present in the body over a lengthy period, it may become deeply structured in the body as part of that person's character. "Chronic holding or tension patterns lose their effective or energetic charge and are removed from consciousness" (Lowen, 1975, p. 102).

A second major theme of Bioenergetics is the concept of "grounding". Lowen found this concept so valuable that he shifted his focus from the Reichian concentration on orgastic potency and the orgasm reflex to a concentration on how well people are grounded through their legs and feet. Grounding, a prime objective of Bioenergetics, is both a literal and figurative process. It literally

has to do with how one's feet make contact with the earth. How this contact is made suggests the degree to which a person is dependent or independent, confident or unsure, and constricted or liberated. Grounding also denotes an energetic process. People who are grounded must be able to feel their feet touching the ground. This is only possible if the feet contain a charge of energy and there is an energy exchange between the feet and the ground. Lowen admits that he does not understand how the energy connection between the ground and the feet works, but emphasizes that grounding provides a safety valve for the discharge of excess energy. There is also a relationship between the degree of grounding and the intensity of feeling a person can tolerate (Lowen, 1975). For Lowen (1976b) "grounding means getting a person fully in touch with reality: first, the reality of the ground on which he stands; second, the reality of his body which is the condition of his being a person--a somebody; third, the reality of his sexual nature; and fourth, the reality of his life situation" (p. 43).

A third basic tenet of Bioenergetics has to do with "character". The formation of character results from a dialectical process between the ego and the body. "The ego image shapes the body through the control the ego exerts over the voluntary musculature" (Lowen, 1975, p. 144). When a person inhibits some feeling indefinitely, the ego capitulates and the energetic charge behind the feeling is withdrawn. The holding of the feeling becomes unconscious and the muscle remains contracted. A result of this process is that the expression of the inhibited feeling becomes impossible because of the chronic spasticity of the musculature. The suppressed feeling does not disappear, but

remains in the body beneath the realm of consciousness. Under a high charge, such as seen in a murderous rage or hysterical outburst, it may break forth.

Another consequence of the inhibition of feeling is that the energy flow of the body is progressively decreased as more material becomes buried. Chronic muscle tension diminishes the depth of breathing, which further reduces the energy flow. This affects the person's self-image and thinking. A pattern of "denials, rationalizations, and projections . . . geared to an ego ideal" (Lowen, 1975, p. 137) is employed by the psyche to avoid confronting the suppressed feelings.

The Bioenergetic view of personality is a fourth central concept. Lowen (1975) describes the personality as being comprised of four basic layers of defenses. The outer layer of the personality, the ego, contains psychic defenses such as denial, blaming, projection, and rationalization. The second layer, made up of the musculature, contains the chronic muscle tensions which support the ego defenses and protect against the third layer comprised of emotions. The layer of feelings encompasses suppressed feelings such as rage, sadness, terror, or despair. The core of the person, the fourth layer, holds the feeling to love and be loved. The goal of Bioenergetic therapy is to penetrate and open up the outer three defensive layers so that loving impulses can flow from the heart.

Lowen (1967, 1975) has described five different character types, each with its own psychological and muscular defense patterns. The five types are called schizoid, oral, psychopathic, masochistic, and

rigid. While space does not permit a full discussion of these types, a brief description of their energetic dimensions is useful.

In the schizoid character the extremities of the body are not energized and are not connected to the person's core. The person's energy is held frozen in the core by muscle tensions which prevent the energy from suffusing the outer parts of the body. There is a lack of integration between the upper and lower halves of the body due to the split in the body's energy. The oral character is energetically undercharged. There is only a weak flow to the peripheral areas. The psychopathic character has a disproportionate amount of energy at the head end of the body. The energy flow downward below the diaphragm and waist is blocked while the head is overcharged. The masochistic character structure is fully charged energetically, but the charge is tightly held. Because of this the peripheral areas only receive a weak charge, thus limiting the expressiveness of the body. The movement of energy is choked off in the waist and the neck. The rigid character allows feeling to flow but limits its expression. The peripheral areas of the body have a fairly strong charge, but the tension, which is stored in the long muscles of the body, produces a degree of rigidity. Lowen emphasizes that there are no pure character types. All people employ a combination of defenses.

The result of this whole process is that the life histories of people become indelibly imprinted in their bodies. Just as a woodsman can reconstruct the development of a tree by studying its growth rings, so can a person trained in reading the body determine a person's history by examining the body (Lowen, 1979).

View of health and sickness

According to Bioenergetics, healthy people are free of internal barriers such as ego defenses, repressed feelings, and chronic muscular tension. As such, they are not estranged from themselves, others, or the natural world. They are capable of giving and receiving love since their core impulses can flow from their hearts. They can genuinely express their feelings. They are at ease and have a sense of well-being. A healthy person knows "that pleasure and joy depend on good body feelings and . . . is sufficiently in touch with his body to sense their absence and to take appropriate measures to restore them" (Lowen, 1976a, p. 185).

The healthy body "is characterized by a life of its own. It has a motility independent of ego eontrol which is manifested by the spontaneity of its gestures and vivacity of its expression. It hums, it vibrates, it glows. It is charged with feeling" (Lowen, 1967, p. 209). There is a brightness to the eyes, a warmth to the skin, and a gracefulness and softness of movement. The healthy person is engaged in an on-going process of self-discovery which involves a commitment to the life of the body as well as the mind.

Health also has to do with ease of self-expression and energy movement. Keleman (1976) defines maturity as "the ability of the tissue, the ability of the total organism, to be motile, take in, contain, transform and discharge energy and substance in an ever deepening manner" (p. 196). Kirsch (1976) adds that "the more the individual perceives his own feelings and can choose the mode and manner of self-expression, the healthier he is. The more he functions

on a self-regulating energy economy in contact with his body the healthier he is" (p. 225).

Ill health or dis-ease has to do with the converse of the above description. Strong ego defenses, as manifested in the five character types, energy blocks, and a withdrawal from the life of the body are all symptoms of ill health. The mental and physical levels of functioning are in conflict. According to Bloom (1977), the source of most symptoms and suffering is "the diversion of energy away from growth and creative, reality-based work and toward maintaining defensive patterns. When the body is freed the mind is freed, and vice versa" (p. 174).

Goals

An overall goal of Bioenergetics is to help people "regain their primary nature, which is the condition of being free, the state of being graceful and the quality of being beautiful. . . . Freedom is the absence of inner restraint to the flow of feeling, grace is the expression of this flow in movement, while beauty is a manifestaton of the inner harmony such a flow engenders" (Lowen, 1975, p. 44). This involves opening a person's heart to life and love and integrating body and mind (Boadella, 1981).

A central goal is to remove blocks and attain a free flow of energy through a cathartic experience. Through such a discharge the traumatic experiences of infancy can be released. Bloom (1977) claims that traditional psychoanalysis and bioenergetics have the same ultimate goal, that is, "the growth to maturity that is possible only

when psychic energy is liberated from archaic, obsolete bodily tension patterns" (p. 174).

The therapeutic process

Bioenergetics uses various mind and body oriented techniques to attain its goals. A thorough developmental history is taken, and a careful analysis which considers body structure, specific tensions or blocks, and character formation, is made. Analytical methods focusing on such things as history, current relationships, and the therapeutic relationship, are employed. The body itself is the focus of intense attention. Many specific exercises and positions have been developed as techniques to increase the energy flow of the body and remove the blocks (Lowen & Lowen, 1977). These exercises are also used to relieve symptoms, to help a person relive traumatic experiences, to express repressed emotions, and to increase one's sense of well-being (Bellis, 1981). In conjunction with the exercises various techniques are used to deepen respiration so as to further free the body. Because of the deep catharsis which may result from these exercises, the therapist and client need to have a strong trusting relationship.

Lowen is clear that producing catharsis or working with muscular tensions alone is insufficient. Insight is also needed if there is to be lasting change. "A change in the personality can be sustained only if there is sufficient insight as a result of a thorough working through of the problems" (Lowen, 1975, p. 327).

The associated chakra

Bioenergetics is most closely related to the heart chakra, which represents a high level of integration and fullness of being. Lowen focuses on opening the heart so that love can flow from the depths of a person. Interestingly enough, the six-pointed star which is the symbol of Bioenergetics is also the symbol for the heart chakra.

Critique

A review of the literature on Bioenergetics produced only two studies to report. A study done by Johnson (1976) compared psychoanalytic, behavioral/eclectic, and Bioenergetic therapies using assessments done by patients who had undergone at least six months of therapy in one of these approaches. Bioenergetics was reported to have more of a spiritual quality than the other therapies. This quality was linked to a heightened sense of physical well-being.

Pierrakos (1974b) reports that Bioenergetics can be applied beneficially in a group context. The group provides a supportive environment in which people can learn to express and accept each other's negative and destructive feelings. The power of the group lies in its accepting, non-judgemental attitude and in the intermingling of energy fields. "If a participant expresses his poignant emotions fully, there is a resonance effect on the energy fields of the rest of the group" (p. 103).

The strongest criticism that has been made of Bioenergetics is that it over-emphasizes energy flow and is obsessed with the sheer discharge of energy (Bellis, 1976; Brown, 1973; Dublin, 1976a, 1976b). Bioenergetics is "too inclined to treat the sheer quantitative

mobilization of the energy economy as possessing some intrinsic magic healing worth" (Brown, 1973, p. 109). The dramatic cathartic effects which can be fairly easily produced by the stress positions into which Lowen places people, may release superficial muscle tension but do not necessarily tap the deep inner feelings of a person. "Sheer energy mobilization is meaningless to promulgate change or growth of personality unless accompanied and preferably triggered off by the spontaneous eruption of deep inner feeling" (Brown, 1973, p. 109).

Another of the criticisms of Bioenergetics has to do with the standard positions, activities, and words clients are taught (Nicols & Zax, 1977). Instead of the therapist facilitating a spontaneous exploration of clients' inner experiencing, the client becomes subject to standardized structured procedures. Furthermore, the character or analysis aspect of the therapy "is a highly didactic informing of the patient that he has such and such repetitive character patterns because an analysis of his body reveals such and such rigidities in the muscular armoring. . . . The therapist assumes a God-like sovereignity of informed opinion and command" (Brown, 1973, p. 110).

Lowen may well be overstating the relationship between character and muscular armor. His assumptions in this regard appear oversimplified and too pat. While a formulation such as "raised shoulders are related to fear" may be a useful hypothesis, it must be confirmed or disconfirmed for each individual. Lowen's assumption that all emotional conflicts result in a distortion of the movement of the body is an unsupported overgeneralization. Psychological conflict is a complex phenomenon not easily reducable to simple generalizations.

The development of the higher levels of consciousness, as symbolized by the fifth and higher chakras, is given little attention in Bioenergetics. The techniques of Bioenergetics are quite appropriate to the lower levels of development, but may be "quite inimical and anti-growth enhancing when relied upon during the higher phases" (Brown, 1973, p. 111). As higher states of development are attained there may not be an increase in outward liveliness and action. Instead, there may be "a unitary harmonization of energy deployment which gives more importance to a balanced disposition of energy flow together with a peaceful integratedness of disposition" (Brown, 1973, p. 111). The danger is that the emotional release will be seen as the end-point rather than the beginning in the development of the person (Lasater, 1979).

C. THE ALEXANDER TECHNIQUE

Fredrick M. Alexander (1869-1955), born in Australia, developed his method as a result of a serious personal problem. An actor by profession, he was plagued by a loss of voice. Unable to find help from doctors, he sought the solution to the problem by intensely studying his neck and head movements in a three-way mirror. He eventually discovered that his loss of voice had to do with a backward and downward movement of his head. His discoveries about how he used his own body led him to develop a systematic technique to help people replace habitual poor use of the body with more efficient use.

The Alexander technique can be viewed as an important body

therapy. While its focus is primarily on effecting postural changes so as to produce an integrated body, it also presupposes that "it is impossible to separate 'mental' and 'physical' processes in any form of human activity" (Alexander, 1969, p. 161). Although Alexander practitioners do not strongly emphasize the psychological aspects of their technique, other therapists have related the physical aspects of the Alexander technique to the psyche.

Central concepts

The Alexander technique, developed by its originator over a period of almost sixty years, can be summarized as

> a method of showing people how they are mis-using their bodies and how they can prevent such mis-use, whether it be at rest or during activity. This information about USE is conveyed by manual adjustment on the part of the teacher, and it involves learning of a new mental pattern in the form of a sequence of words which are taught to the patient or pupil, and which he learns to associate with the new muscular use he is being taught by the manual adjustment. He learns to project his new pattern to himself not only while he is being taught but when he is on his own (Barlow, 1973, pp. 172-173).

Six major concepts form the core of the Alexander technique. The first of these has to do with use and functioning. "Use" has to do with how we use our bodies each moment of our lives. The manner in which we use ourselves affects our functioning. "Use implies movement, and movement implies the balancing and rebalancing of the body in

space" (Ottiwell, 1980, p. 68). Alexander emphasized that, because we are all responsible for how we use ourselves, we can also control and change our habitual patterns of use. He believed that some forms of use are better than others in terms of functioning. Good use tends "to raise the standard of functioning and improve the manner of reaction. A bad manner of use, on the other hand, continuously exerts an influence for ill, tending to lower the standard of general functioning" (Alexander, 1941, p. 8). Faulty use affects all aspects of a person, resulting in mental and physical ill health.

A second major concept has to do with Alexander's belief that the human organism interrelates as a whole unit and therefore can only be changed as a whole. This view came out of his realization that the problem with his voice resulted from the faulty response of his entire body. Because Alexander considered the physical, emotional, and intellectual aspects of a person as inextricably linked, he would not attempt to merely fix the troublesome part of the body, but would attempt to integrate all parts into a functional unity.

"Primary Control", a third concept, was the phrase Alexander used to refer to the critical relationship of the head, neck, and torso. Since he believed that how these parts are related determines one's level of functioning, he put a great deal of emphasis on this relationship in his technique. "Primary Control refers to a head balanced freely and easily on the end of the spine so that the anti-gravity function of the back is not interfered with by undue neck tension" (Ottiwell, 1980, p. 68).

A fourth concept has to do with the unreliability of the senses

which Alexander (1969) called "debauched kinaesthesia". Because perception is related to the functioning of the body, if the body is not functioning rightly, one's perceptions become skewed. This leads to a distortion in how we view ourselves, and blocks our awareness of our bad body habits. The result is that "our bad habits, such as slumping or breathing through the mouth, most of which operate unconsciously, will come to feel familiar and indeed will become indistinguishable from ourselves" (Gelb, 1982, p. 55). Alexander stressed that as our sensory perception becomes more accurate, we are able to more clearly determine what our true needs are and what is right for us.

"Inhibition", a fifth concept, became the basis of Alexander's reeducation methods. Relearning is possible because, when a stimulus is received, the immediate muscle response is inhibited so as to provide time to adequately prepare for and choose the ensuing activity. Such inhibition is a positive force which is necessary to sustain life. "Inhibition maintains the integrity of the responding organism so that a particular response can be carried out economically without involving inappropriate activity in unrelated parts" (Jones, 1976, p. 149). While inhibition is often an unconscious process, bringing it to conscious attention enhances the learning of new habits and the discarding of those that are unwanted. When inhibition operates at the level of the unconscious, a "set" is established which automatically links stimulus and response. This set is then resistant to change. When inhibition brings the operation of a habit to conscious awareness, choice is restored and the response can then be made under optimal

conditions.

A sixth concept has to do with ends and means. Alexander used the notion of "end-gaining" to explain why people create unnecessary muscle tension while preparing for action. "End-gaining behavior is the habit of focusing so intensely on the goal, or end, to be gained that the means employed to gain it are ignored (Masters & Houston, 1978, p. 9). Because people overly focus on their goals, and not on the means whereby those goals are achieved, they tend to exert an unnecessary amount of energy and may also damage their bodies in the process of attaining their goals. Alexander (1969) stressed that for any successful work on the part of the pupil, "he must refuse to work directly for his 'end' and keep his attention entirely on the 'means whereby' this end can be secured" (pp. 15-16).

View of health and sickness

Alexander's (1918) view of health and sickness is linked to use and mis-use. In his first book, entitled Man's Supreme Inheritance, he espoused the view that people have a basic perfection (use) which has been marred by a combination of personal stupidity and environmental stress (mis-use). "His whole theme during his lifetime was of an endowment of properly functioning reflexes that the corporeal sin of mis-use, induced by the overstimulating newness of the environment, had clouded over. In this view, a system of perfectly adequate reflexes had to be restored by learning to inhibit wrongly acquired conditioned reflexes" (Barlow, 1973, pp. 61-62).

To Alexander, bad use involves haphazard movements of the body.

The result of mis-use may be that internal organs become cramped, circulation decreases, bone and muscle structures become misaligned, and malfunctioning results. "When mis-use patterns are never relinquished, but are present even at rest, we are confronted with a state of pervading disease and strain that stops life from being lived as it should be" (Barlow, 1973, p. 76). To forcibly attempt to correct mis-use, without an awareness of how to change in a healthy way, may result in further abuse of the body.

Barlow (1973) argues that mis-use should be considered a stress disorder which "habitually involves bodily systems beyond the relevant ones, and in which the organism does not return to a balanced resting state after activity" (p. 103). Such a disorder may simultaneously involve emotional, physiological, behavioral and structural changes. Because of all these changes that may occur as a result of mis-use, Barlow links mis-use with neuroticism: "The inescapable fact remains that all neurotic people mis-use themselves. . . . increased neurosis goes hand in hand with increase in mis-use" (pp. 135 & 117).

The Alexander technique implies that proper use will result in our personal evolution. We can regain our lost state of wholeness. For Alexander this means good use, that is, "moving the body with maximum balance and coordination of all parts so that only the effort absolutely needed is expended" (Barker, 1978, p. 18). The criterion for good use is not what is considered socially acceptable, but what makes for the least stress to the body.

Alexander stressed the prevention of sickness rather than its cure. Fundamental to prevention is the teaching of better life habits,

meaning teaching an improved use. If sickness does occur, however, the sick part of the body must not be viewed in isolation from the rest of the body. In sickness or health, the principle that use affects functioning is operative.

Goals

The aim of the Alexander technique is to create ease throughout the body without producing further distortions (Barker, 1978). This requires the restoration of a "natural function" in which there is a balanced flow of energy as each part of the body interrelates harmoniously with the rest. This involves maximizing the lengthening of the spine during all activities, so that the bones and muscles are better balanced. Ensuring that the means used are the best way, rationally and physiologically, to meet our ends is a further goal.

The therapeutic process.

The therapeutic process begins with an initial examination by the teacher to determine what patterns of wrong use are manifested in the body of the pupil. Instruction in the Alexander technique is done on an individual, one-to-one basis, with the instruction specifically tailored to each student. Lessons may last from one-half to one hour, with at least fifteen, and possibly many more, lessons. During these lessons clients are taught to prevent current mis-use and learn healthy use patterns. Because it has taken a long time to learn faulty habits, reversing them also takes repeated experiences of the alternatives. Pupils are encouraged to continue to teach themselves the new skills.

The lessons end when the client spontaneously discovers that he or she is choosing good use most of the time.

While activities such as walking, sitting, or standing are used to teach the technique, what is important is not the particular exercise. What is important is that "the message and experience are conveyed that there is a manner of use that is fundamental to all good movement" (Ottiwell, 1980, p. 68). Attempts are made during the lessons to get people in touch with what they are doing, and to desist from doing what they do not want to do. People are taught to take responsibility for their present condition without feeling guilty or regretful. Awareness of mis-use provides the opportunity to change.

Change is seen within a developmental model. There is no compulsion to change. The habitual tensions or "armoring" serve to protect the person's vulnerabilities. The Alexander technique, unlike Primal therapy, does not deprive a person of these defenses as long as they are needed by the person. "Lessons in the technique release an organic process of change that gradually replaces old habits with new habits which are flexible and can themselves be changed. The process of change is not mindless. It can be directed by intelligence into paths that lead to the best development of the individual's own personality" (Jones, 1976, p. 14). As trust develops between teacher and pupil, the more deep-seated and unconscious tension patterns may be released by the pupil.

View of energy

The Alexander technique does not view the body in terms of an

energy model. The concept of energy is rarely mentioned.

The associated chakra

The Alexander technique, the Feldenkrais method, Structural Integration, and Focusing, are not full therapeutic systems because they do not include a theory of personality and psychological functioning. Because these four therapies deal with specialized techniques, they are not easily placed within the chakra system. In general, because their focus is at the level of the body they would be associated with the first three chakras which are oriented towards biological matters of self-maintenance and survival.

Critique

Jones (1963) has produced experimental evidence to support Alexander's claim that in balanced use of the head, the quality of body movement changes in a positive direction. Using before and after electromyograms, X-ray photographs, and multiple image photography of seven normal adults, Jones reported that, as a result of the Alexander technique, the subjects' "patterns of movement can be seen to change in the direction of greater simplicity and greater uniformity from subject to subject. Head trajectories are consistently higher and shorter" (p. 66).

In a further study, Jones (1965) compared therapist guided movements with the habitual movements of six subjects. The indices used to analyse the movements were the forward thrust of the head during movement, the degree to which the trajectory of the head did not

follow a straight line, and the time required to raise the head above the starting level. The reported results were that, "in the quided movement, head thrust decreased, rise time was shorter, and head trajectory approached more closely a straight line" (p. 202). When a group of "normals" was compared with a group having neurological diseases, it was possible to distinguish "normal" from "abnormal" movements at a confidence level of .01 or better. Jones concluded that "by these criteria, the quided movements are not only different from the habitual, they are better" (p. 202).

While the Alexander technique operates from a body-mind perspective, it is an incomplete therapy in that it encompasses no model of psychological functioning and deals only with the body, assuming that there will also be emotional and mental changes as the body changes. No attempt is made to uncover and work with the psychological dynamics which may be a factor in the mis-use of the body. As a result, the bodily patterns may be changed, but the underlying problems may not be touched, thus leading to further manifestations of symptoms.

Alexander's thesis that people have an innate true perfect nature which can be uncovered can lead to the assumption that there is one perfect template of human form towards which to strive. However, as Barlow (1973) declares, "there is no reason to suppose that we are born with a perfectly ordered set of pre-existent natural reflex patterns, and that by refraining from interfering with them all will be as well as it can be. . . . Personal selection has to replace natural selection" (p. 62).

D. THE FELDENKRAIS METHOD

Moshe Feldenkrais, born in Russia in 1904, emigrated to Israel as a teenager. He earned a doctorate in electrical engineering, specializing in high-energy physics. The first person in Europe to hold a black belt in judo, he was also proficient in soccer. A severe knee injury which occurred while playing the latter sport led Feldenkrais to intensely study anatomy, physiology, psychology, and anthropology in a successful attempt to recover the damage done to his knee. Feldenkrais called the technique of neuromuscular integration he subsequently developed, "Functional Integration", although the therapy is better known as the "Feldenkrais method". This method can be defined as "a technique of body manipulation by which the teacher gives his subject an awareness of his neuromotor system in terms of a fixed set of movement patterns he habitually uses and habitually avoids, thus giving him the experience of new, alternative movement patterns he may begin using" (Rywerant, 1978, p. 24). Although the methods of training are very different, the goals of the Alexander technique and the Feldenkrais method are entirely consistent (Don, 1979).

Central concepts

Basic to Feldenkrais' (1964) thinking is the unity of body and mind. He unequivocably asserts that "the unity of mind and body is an objective reality . . . they are not entities related to each other in one fashion or another, but an inseparable whole while functioning" (p. 47). The four basic modes of the waking state--movement, feeling, sensation, and thought--are inextricably linked to each other and to

the musculature in a reciprocal arrangement. Change in any one area involves subsequent changes in the other areas, given that the whole nervous system is involved in every act.

Change, to last, must involve the body and the mind simultaneously. "Radical changes cannot be expected without reforming muscular and postural habits. . . . The whole self, diet, breathing, sex, muscular and postural habits, must be tackled directly and concurrently with the emotional reeducation" (Feldenkrais, 1949, p. 163). Feldenkrais (1964) has chosen to approach the unity of the muscles and the mind by working with the body because "the muscle expression is simpler, it is concrete and simpler to locate. It is also incomparably easier to make a person aware of what is happening and therefore yields faster and more direct results" (p. 49).

Key to Feldenkrais' method is the concept of movement, which is seen as the essence of life. Every emotion or thought is expressed in some way through movement via the mediation of the nervous system. Movement, as reflected in the facial expression, posture, and voice, indicates the condition of the nervous system. "Movement is the best clue to life" (Feldenkrais, 1979, p. 25).

Changes in the patterns of movement must also involve changes in the nervous system. "Improvement in action and movement will appear only after a prior change in the brain and the nervous system has occurred. That is, an improvement in body action reflects the change in the central control, which is the exclusive authority" (Feldenkrais, 1972, p. 36). This relationship is due to the physiological construction of the brain. "Owing to the close proximity to the motor

cortex of the brain structures dealing with thought and feeling, and the tendency of the processes in brain tissue to diffuse and spread to neighbouring tissues, a drastic change in the motor cortex will have parallel effects on thinking and feeling" (Feldenkrais, 1972, p. 39).

Feldenkrais views movement as the basis of awareness. Without movement there is no awareness. To him, we live in four possible states: awake, asleep, conscious, and aware. While consciousness is merely a higher level of wakefulness, "awareness is consciousness allied with knowledge" (Verin, 1981, p. 52). Awareness involves being attentive to our internal processes as well as to the outside world. Awareness can only be experienced. It cannot be taught. For it to be experienced, a learning situation must be constructed which stimulates awareness while also creating problems which demand a heightened awareness to solve. Gaining awareness is crucial because a movement learned with awareness can then also be altered by virtue of that awareness.

The role of learning, central to the Feldenkrais method, is linked to the central nervous system. Because there is a short pause between the stimulus received from the nervous system and the physical manifestation of that stimulus, it is possible to hide the stimulus from outward expression. Thus, a desire to laugh may be suppressed if the laugh is considered socially inappropriate. This delay makes change and learning possible, because a new response can be substituted for the habitual movement.

Because no change can take place in the muscles without a prior change in the motor cortex, changing the patterns in the motor cortex

may result in major changes in thinking and feeling. Feldenkrais (1976) believes that "from the very start of our lives, our nervous system is not bound by any reality: it is a tabula rasa when we come into the world" (p. 20). As we grow and develop, patterns suitable to our surroundings are developed. These patterns, which become habitual, need not remain so. People can "rewire" their established connections by moving with awareness. As Feldenkrais (1981a) states, "You can, at any time of your life, rewire yourself, provided I can convince you that there is nothing permanent or compulsive in your system except what you believe to be so" (p. 117). Because the limits to a range of movement are not located in the muscles but at a higher level of organization in the nervous system, established patterns of movement can be changed by a neural reorganization. This may be done by the use of new movements which change old patterns, or simply through the use of the imagination (Cubley, 1976).

View of health and sickness

Feldenkrais (1949) shuns any perjorative descriptions of people. He does not speak of people being neurotic or diseased, or having specific behavior disorders. Rather, problems in functioning are seen as "the result of faulty and exaggerated technique of habit formation" (p. 163). The fault is in poor teaching and faulty learning. Thus, the focus is placed, not on treatment, but on re-education. "It is a question of teaching and learning and not of disease and cure" (p. 163).

Several general norms of health and normality are proposed by

Feldenkrais (1964). The head should be able to move freely, being limited only by the structure of the skeleton. The muscles should operate effficiently, expending the least possible energy for any given act. The posture should be organized in such a way that it can easily begin any movement. While standing erect, "there should be no sensation of doing, holding, or effort whatsoever" (p. 59).

Goals

The Feldenkrais method aspires to replace old habits of behavior and movement with awareness in action, that is, the ability to make simultaneous contact with skeleton and muscles as well as the environment. The aim is not to achieve complete relaxation but to be able to exert oneself in an effortlessly efficient manner. This is achieved, not through increased muscular strength or flexibility, but through increasing consciousness about how the body functions.

The therapeutic process

Although he is a great teacher, Feldenkrais (1981a) claims that he teaches nothing, that he is not a therapist, and that his touching of people has no therapeutic or healing value. However, essentially what he teaches is learning to learn. He instructs people how to replace habitual, ineffectual, "parasitic" movements with movements which are free, unhampered, and use a minimum of energy.

The Feldenkrais method involves two different approaches, one for individuals and one for groups. In individual teaching, the instructor uses his or her hands to manipulate the different segments of the

pupil's body into the desired alignment. The focus is not on the identified symptom as such but on improving the breathing, the head-neck relationship, the configuration of the spine and thorax, as well as the positions of the pelvis and abdomen. When the position of the spine and head is improved, the identified problem tends to dissipate.

The first lesson begins with the person lying on his or her back so as to reduce the effects of gravity and free the nervous system. A successive series of approximations of the desired changes are made over the course of 30 to 40 daily lessons of 35 to 45 minutes each. After that, lessons are held two to three times a week until the complaint has disappeared. The instructor, constantly determining what works and what does not work for a particular client, uses slow unobtrusive movements, focusing continuously on the pupil's world of feelings and images (Rywerant, 1978). Verbalization is kept to a minimum and emotionally loaded words are avoided. A suitable ambience is created so that the pupil will feel safe enough to allow changes to happen (Feldenkrais, 1981b; Rywerant, 1983).

The second approach, called Awareness Through Movement, involves a wide variety of group exercises which express the working principles of the Feldenkrais method. Groups of 30 to 40 people are taught to focus their awareness on their bodies. Many variations of various exercises are used until mastery of the exercise is achieved. The focus is on maintaining the right atmosphere for learning to take place. The group is repeatedly requested to deliberately not produce their maximum efforts so that they can progress without tension or anxiety. The

focus is on having fun while trying new movements. People are not given an absolute standard to achieve, but are encouraged to try the suggested motions to see how they fit for them. The means of achieving a goal is stressed rather than the goal itself. All the exercises aim to produce mental and physical coordination as well as good erect posture. "The lessons are designed to improve ability, that is, to expand the boundaries of the possible; to turn the impossible into the possible, the difficult into the easy; and the easy into the pleasant" (Feldenkrais, 1972, p. 57).

One technique involves working with only one-half of the body during the lesson, and leaving the other half as it is. The sensation produced in the one-half of the body worked on may be transferred to the other half of the body by means of mentally scanning the body image. This scanning consists of "listening and becoming aware of the difference of sensation in the kinaesthetic of the muscles of the two halves and the sensation of change of orientation in space" (Feldenkrais, 1964, p. 55).

The change which is aimed for as a result of these exercises is far-reaching: "What is involved here is a change in the dynamics of our reactions, and not merely replacing one action by another. Such a change involves not only a change in one's self-image, but a change in the nature of our motivations, and the mobilization of all the parts of the body concerned" (Feldenkrais, 1972, p. 40).

View of energy

Feldenkrais briefly mentions the concept of physical energy, but

does not view the body through an energy model.

Critique

The Feldenkrais method is scientifically more complex and explains more thoroughly how the nervous system relates to changes in the muscles and bones than do the other body therapies. There is a good balance between having the body discover what feels normal and right for itself and working towards an erect balanced posture with a freely moving pelvis. One of the strong points of this method is its simplicity and profoundity. Using easy ingenious exercises, it is possible to open people to profound levels of the self in a very short period of time. One instructor can direct hundreds of people at one time to perform easy movements which show instant results.

Unfortunately, although the Feldenkrais method has a strong neurological and physiological basis, it lacks a psychological model. While Feldenkrais believes that psychological change will naturally result once the body can move freely, this is a simplistic view. Unless psychological issues are properly dealt with, they may continue to wreak havoc on the body. Furthermore, the Feldenkrais method, like the Alexander technique, has no concept of people's evolutionary potential as being more than a physical or mental one. As King (1972) states, "Feldenkrais does not deal fully with the intricacies of consciousness nor does he relate in an integrated way physical and mental development on the backdrop of man's spiritual nature" (p. 119).

E. STRUCTURAL INTEGRATION (ROLFING)

Rolf (1886-1979), trained as a biochemist and a physiologist, developed her system of deep tissue manipulation over a period of 45 years. Like Reich and Feldenkrais, she believed that the muscular structure contains the memory of a person's emotional and psychological events. Given her knowledge of physiology, she concentrated her therapeutic endeavor on the muscles, the connecting tissues, and the fascia (the fine, white network which wraps all the tissues).

Although the methods of Structural Integration seem to have little in common with those of the Alexander technique, the effects and goals of both methods are similar. While the Alexander technique seeks to realign body structure by engendering appropriate movements under the direction of the instructor's hands, Structural Integration attempts to achieve this balance by directly realigning the structure of the body (King, 1972).

Central concepts

Structural Integration is built on the assumption that "the body is not only an instrument of man's self expression, it is himself" (Rolf, 1977, p. 37). As a result, "physical personality is not something separate, strange, or different from psychological personality, but part of an internally covarying psychophysical entity" (Rolf, 1977, p. 22). Because body structure is thought of as the manifestation of personality, the structure and movement of the body is seen as inextricably linked to a person's feelings and attitudes. There is a reciprocity between the physical and psychological.

"Although psychological hang-ups occur they are maintained only to the extent that free physiological response is impaired at the glandular, visceral, myofascial, and other levels . . . To the extent that . . . physiological flow occurs, the individual is less 'hung up'" (Rolf, 1977, p. 280).

Structural Integration is truly a body therapy in that it chooses to work directly on the body in order to effect over-all change. Direct methods of intervening in the body are used because they are "the easiest, quickest, and most economical way of changing the coarse matter of the physical body" (Rolf, 1977, p. 23). It is assumed that, because of the interconnectedness of the body-mind, physical change in the body as a result of the therapy will also result in psychological changes. "Psychological hang-ups are recorded and perpetuated in the physical body in flesh and bones. As long as such hang-ups persist in physical bodies, psychological release is interfered with" (Rolf, 1976, p. 135). The liberation of the physical body also results in psychological liberation. Thus, Structural Integration attempts to change the personality by changing the structure of the body.

Basic to Structural Integration is its conception of human tissue as plastic, malleable, and in a constant state of re-organization (Rolf, 1973, 1977, 1981). The plasticity of the physical structure of the body allows for distortions to occur, but also allows for these distortions to be reversed. Distortions may result from the habitual misuse of the body, starting from infancy. Parental example and environmental factors, such as diapers and school desks, play their part. Distortions also result from small and large injuries. The

whole body is affected by any distortion or injury, since the body attempts to maintain a state of balance.

The physical structure of the body is the prime focus of Structural Integration. Rolf (1979) argues that "structure manifests itself in behavior" (p. 53). This means that all parts of the body are in relationship to themselves and their environment, and that the way these parts are arranged affects how people function in their worlds. Rolf describes the body structure as made up of four major blocks stacked on top of each other. These are the head, chest area, pelvis, and legs. The larger blocks are made up of smaller elements. Whenever these blocks are not perfectly vertically aligned, the body is less stable and strain results. "For a strain-free system . . . there must be a vertical alignment of each block's gravitational center; there must also be no rotation or tipping of the segments" (Rolf, 1977, p. 33). Structural Integration therapists analyse the body, using the metaphor of blocks, in order to uncover the distortions and aberrations.

The effect of gravity on the structure of the body is a major consideration. Rolf (1977) declares that "the gravitational field of the earth is easily the most potent physical influence in any human life" (p. 30). Gravity is people's greatest friend or foe. If a person's physical structure is symmetrical and balanced, gravity enhances and vitalizes the aggregate of body segments. However, if the body is off balance and at war with the force of gravity, "gravity wins every time" (Rolf, 1977, p. 30). Unfortunately, "in most bodies, the blocks are out of alignment and instead of gravity working for us, we

use a lot of valuable energy just getting our misaligned bodies from place to place" (Seldon, 1979, p. 90). Stresses, aches, and pains result when bodies are imbalanced.

View of energy

Energy is an important concept in Structural Integration. A person is seen as "an energy field, rather than as a mass of matter--a field which lives within a greater energy field, the field of the earth" (Rolf, 1979, p. 55). The energy field of the earth, known as gravity, interacts with the human energy field. When the body is properly aligned and its various tissues move freely, there is "a unity between the field of the individual and the field of the earth" (Rolf, 1976, p. 129). Under these conditions the gravitational field enhances the person's energy field. When the body is "random" and unbalanced, and its tissues are tense and strained, the flow of energy through it becomes progressively weaker. Once the pattern of physical disintegration starts, the energy of the earth relentlessly batters the body, resulting in an ever increasing malfunctioning of the body and a dissipation of the person's energy. While each organ and system of the body has its own self-contained energy field, the appropriate interaction of these systems, rather than the optimal functioning of any one system, is essential. "This means that man's over-all vital or psychic competence is determined not by the individual energy of any one component . . . but by the functioning of all as they interrelate in the total somatic individual" (Rolf, 1977, p. 201).

View of health and sickness

Structural Integration defines health in terms of structure and function. The structure of a healthy body is vertically aligned around an imaginary axis which runs through the body from the bottom of the feet to the top of the head. Around this axis the energy and mass of the body is substantially symmetrical. A spine with shallow curves is connected to a horizontally balanced pelvis. Arm movement is balanced and feet and knees move straight forward on parallel tracks. Such a balanced body can move in a light, easy, and seemingly weightless manner.

The tissues of a healthy body function in the way they were designed to function. Muscles glide over each other freely. Flexers flex while extenders extend. The separation and differentiation of muscles, tendons, and ligaments is possible. Energy and tone flow throughout the freely moving fascia. Muscle tissue is soft but resilient. A healthy body is adaptable, vital, and resilient. Furthermore, "a sense of well-being, of peace and of creative capacity, is the individual's awareness of integrated physiological function" (Rolf, 1976, p. 135).

Rolf calls the unhealthy body "random", meaning that the various segments of the body are out of alignment with each other. In the random body strain between the body segments changes the person's patterns of movement. A given movement may elicit a response not only from the appropriate muscle but also from inappropriate muscle units. The result is "a jangle of response, altering or even inverting the movement intended" (Rolf, 1973, p. 73). Such barriers to movement

require exhausting amounts of energy to overcome. When the strain on the body is located at one spot, the body compensates by spreading the strain around through the fascial system. The fascia then thickens, shortens, and becomes congested, giving rise to further tension and difficulty of movement throughout the body. The "fixation of the flesh interferes with the energy flow that is the essence of life" (Rolf, 1977, p. 27). When something physical or emotional interferes with the flow of fluids or energy to an organ, that organ deteriorates and eventually ceases functioning. Other parts of the body attempt to compensate, but they too tire and expire. Rolf (1977) concludes that "much, if not all, chronic organic disease starts as functional inversion or perversion" (p. 27). Because the body-mind is a unit, physical problems result in psychological problems and vice versa.

Goals

Rolf (1978) declares that her goal is not symptom relief of physical or mental ailments. She is much more interested in having people attain "whatever psychological as well as physical potential is latent in any given human" (p. 37). More specifically, the goal of Structural Integration is to change random bodies into truly vertical, balanced bodies that move along straight lines. To do this attempts are made to remove old postures, stress patterns, and ways of bodily relating to the world.

The therapeutic process

Structural Integration is a form of deep tissue massage. The

entire body is systematically massaged over a period of ten sessions usually held once a week. Each session concentrates on loosening and lengthening specific muscles and fascia, so that this tissue can resume its normal position. The therapist forcefully uses fingers, knuckles, and elbows to free the muscles and release chronic tension. While there may be pain as part of the process, it disappears when the pressure is removed. This pain frequently involves an emotional release. While parts of the body are being massaged, people "often recall specific traumatic episodes associated with particular parts of the body; with or without such recall, the release of chronic contractions has an emotionally purgative effect" (Pierce, 1978, p. 200). The therapist allows the feelings to emerge but does not work with them because it is believed that the beneficial results will come from the body work alone and not from having a conversation. There is an optimistic note to the process of therapy because it is assumed that damaged tissue can be revitalized and restructured. "There is no concrete in the flesh; it's all moving, breathing, changing tissue, always ready with the least bit of support to rid itself of all the poisons from the past" (Johnson, 1977, p. 49). Because the body is seen as a unit, it is considered important to massage the whole body instead of just the troublesome parts.

Critique

Structural Integration is well suited to research "since it is directly manipulative and since the alterations in body structure are held to occur quickly and to be measureable" (Ornstein, 1972, p. 238).

A number of studies have now been done. Beckett (1975), in a study comparing 27 Structurally Integrated subjects, 28 psychotherapy subjects, and 35 control subjects, indicated that "in 5 out of 11 subtests of the Shostrom Personal Orientation Inventory, Rolfed subjects showed significant psychotherapeutic gain, as compared to control subjects" (p. 5098-B). However, the psychotherapeutic gains from Structural Integration and psychotherapy were similar. A study done by Townsend (1977) comparing a group of 38 Structural Integration subjects with 35 control group subjects concluded that the Structural Integration subjects showed a significant increase in their scores in the area of self-regard, the ability to develop and maintain meaningful relationships, the capacity to accept aggressive feelings, and the ability to function in the present. Hunt and Massey (1977) used an analysis of EMG recordings of 11 subjects before and after each of 10 Structural Integration sessions to investigate changes taking place during the course of the therapy. These authors reported that Structural Integration produced a "profound effect upon central nervous system organization toward balanced and decreased energy expenditure. . . . [and] improved organization and greater balance in the neuromuscular system with extensive positive implications for motor efficiency" (p. 210). A further series of studies of Structural Integration subjects done by Hunt, Massey, Weinberg, Bruyere, and Hahn (1977) reported that "the extensive neuromuscular findings all pointed to improved neuromuscular organization, producing a more coherent energy flow, capable of overcoming resistance smoothly with greater force and less effort" (p. 189). A significant lowering of anxiety,

improved balance, and a more holistic, intuitive mode of information processing by the brain was reported.

The primary criticism leveled at Structural Integration is that it is an incomplete therapy. Because it is purely a physical and mechanical procedure, it cannot be considered a form of psychotherapy. While restructuring and freeing the tissues of the body is one significant aspect of total health, Structural Integration falls short in that it does not have a model of psychological functioning. "This results in a more superficial approach to psychological health" (Lasater, 1979, p. 115). Structural Integration assumes that the liberation of the body will lead to more productive, satisfying lives for people. The error in this assumption is that "the difficulties that caused the problems in the first place will somehow automatically be resolved" (Nicols & Zax, 1977, p. 122). As people become more open as a result of the therapy, they have to achieve a new level of integration in their lives. However, the reintegration process may not necessarily lead to an improvement, and may require psychotherapeutic guidance. Thus, in some situations, Structural Integration could be ideally used as an adjunct to psychotherapy.

F. PRIMAL THERAPY

Arthur Janov developed Primal therapy in the late 1960s after working for 17 years as a psychiatric social worker and a psychologist. The therapy was called "primal" because it involves the reexperiencing of early traumatic events. Although Janov claims to have developed "a

unique theory", he borrows heavily from other sources which he scantily acknowledges, namely early Freud, early Reich, and Gestalt therapy. Freud's early thinking in which he related repressed feeling to mental aberration and emphasized the significance of early childhood experience in neurosis are concepts central to Janov. Reich's abandonment of a body-mind duality in favor of an understanding of neurosis as a pathology of the whole person came three decades before Janov adopted this approach. Like Reich, Janov sees defenses as "psychobiologic", and thus more than simple mental phenomena. Janov invented a new label and renewed an emphasis on deep catharsis, but it was Reich and Perls (Gestalt therapy) who first utilized the techniques for deep emotional release which are used in producing "primals".

Central Concepts

Primal therapy is a deep emotional release therapy which Janov (1970) describes as "a dialectical process in which one matures as he feels his childish needs, in which a person becomes warm when he feels his coldness, in which one becomes strong through feeling weak, in which feeling the past brings one wholly into the present, and in which feeling the death of the unreal system brings one back into life" (p. 385). Central to this process is the concept of "Pain", the pivotal point of Primal therapy. The fundamental assumption of this therapy is that much pain will be experienced by people throughout the course of their development from the prenatal period to adulthood. The mind uses various defenses to repress the memory of the pain so as to enable the person to function more efficiently.

The prenatal and birth period is seen as perhaps the most traumatic event of life and is the beginning of serious repressions. The intrauterine environment, which is a reflection of the mother's state of being, shapes the foetus' physical and psychological growth. The foetus develops "body memory" which can react to and store input, including pain. "The Pain is held down in the nervous system and forms part of the deep unconscious, and so the barrier between the conscious and unconscious begins its life in the womb" (Janov, 1983, p. 27). It is possible, therefore, that because neurosis is "a physiologic disease", it can begin in the womb.

The birth experience itself holds enormous possibilities for trauma as it "is the closest we will come to death for the rest of our lives until we are truly at death's door" (Janov, 1983, p. 33). The memory of our birth remains forever engraved in our body memory and becomes the basis for symptoms and neurotic behavior. The more profound the nature of pain stored during the birth process, the greater the potential for later catastrophy. Janov (1983) traces the origins of such major disturbances as cancer, epilepsy, and psychosis back to the birth experience.

The process towards neuroticism begins when the infant's basic needs for food, warmth, and stimulation are unmet for any length of time. The infant will first do whatever it can to get its needs met, but if it is not successful enough in doing so, a separation between needs and feelings, called a "split", takes place. "The organism splits to protect its continuity" (Janov, 1970, p. 22). These unmet needs, called "Primal Pains", become sublimated, and create a force to

be met symbolically throughout that person's life. Each denial and suppression of needs results in the child becoming increasingly unreal. Dual selves emerge. "The real self is the real needs and feelings of the organism. The unreal self is the cover of those feelings" (Janov, 1970, p. 24). When the unreal self is greater than the real self the person is deemed to be neurotic. The event which shifts the balance in favor of neuroticism is termed the "Primal Scene". This event is "a time in the young child's life when all past humiliations, negations, and dispositions accumulate into an inchoate realization: 'There is no hope of being loved for what I am'" (Janov, 1970, p. 25). The primal pains which keep transpiring for people on a continual basis each become stored in the body as laminated layers of tension. Neurotic symptoms are the ways people have of draining off the tension which results from the repressed pain. Some of these symptoms take the form of psychosomatic ailments.

Primal therapy states that it is important to distinguish the three areas of the brain involved in the storage of primal pain. The inner brain, thought of as the first level of consciousness, mediates visceral functioning. Pains occurring in the first few months of life are stored there. The middle brain, known as the second level of consciousness, processes emotion and stores the emotional traumas of childhood. The outer brain, the third level of consciousness, has to do with intellectual functioning. It is there that pains experienced after the age of five become lodged. The deeper the pain is located the more difficult it is to dislodge. Therapy involves a gradual progression from the third level of consciousness to the first level

(Janov, 1975a).

The concept of defenses is important to Primal therapy. "A defence is a set of behaviors which automatically function to block primal feelings" (Janov, 1970, p. 58). These defenses, which operate continuously, are psychological and physiological as well as voluntary and involuntary. The neurotic uses defenses as an adaptive and survival mechanism. According to Primal therapy, all defenses are neurotic.

View of health and sickness

Janov's (1970) concepts of health and sickness permeate his thinking. To be healthy means to be "normal", that is, "a defence-free, tensionless, nonstruggling person" (p. 136). The normal person is integrated, stable, self-accepting, relaxed, and genuine. Such a person lives in the present, is non-exploitive of others, and derives life's meaning from honest feelings. "Natural man", says Janov (1971), "is nonindustrial, noncompulsive and nondriving, 'unambitious' in the neurotic sense, and simple" (p. 213).

The post-primal person, even healthier than the normal person, is "a new kind of human being" (Janov, 1970, p. 159). The real self of such a person, an "open psychophysiological system, undivided, and functioning wholly . . . responds as a totality--ideas and bodily processes--to events in life" (Janov, 1972, pp. 197 & 196). The priorities of post-primal people reflect their wants and needs. They do what they want without being driven. They often change jobs to something more "real". There is less regimentation, less sex, and less

struggle, but more feeling. Interestingly, most post-primal people do not want children (Janov, 1973).

Janov waxes eloquent when he discourses on the type of society which would be the result of primal consciousness. Such a society would not have violence or war. There would be little need for drugs, physicians, hospitals or prisons. Institutions would be created which allow free choice, which fulfil rather than exploit needs. Laws in such a society would be few, as primal people are incapable of being dishonest and do not need to be constantly governed. Unfortunately, Janov does not describe how society could arrive at such a laudable state. Given that the primal person is not well adapted to survive in the present neurotic society, and "has no political ambitions, indeed, very few ambitions except to live a life of peace" (Janov, 1975a, p. 452), it is difficult to imagine how the primal society would emerge (Rose, 1976).

According to Janov's thinking, there are few "normal" people around and even fewer post-primal people. Most people are neurotic from an early age. Neurosis is a "pathology of [the] whole man, physiologically and psychologically" (Janov, 1972, p. 161). Neurotics are compulsively driven but eternally dissatisfied. They are constantly engaged in struggle for its own sake but are never satisfied with reaching their goals. They are rarely able to find pleasure without artificial aids and cannot be themselves. Neurotic relationships are characterized by phoniness and exploitation of others. Since the body is part of the personality, neurotics often look neurotic.

Goals

The goal of primal therapy is to enable people to become "normal" non-neurotic real people as described above. This involves permanently lowering the chronic tension level of the body by dissolving the deep energy blockages and by eliminating the armored muscular sheaf around the body. Primal pains must be reexperienced in order to consciously connect past feelings with present insights about their significance.

The therapeutic process

Janov's approach is designed as a frontal attack on the defenses. He asserts that "the only way to eliminate neurosis is with overthrow by force and violence" (Janov, 1970, p. 102). The therapeutic process is oriented in that direction right from the start. Prior to the first session the client is deliberately made anxious and upset so as to weaken the defenses and make the pains more accessible to experience. Drugs of any sort, such as nicotine, caffeine, or alcohol, are banned. The initial part of the therapy usually involves a three week "intensive" during which the person is seen individually every day for five or six days a week for as many hours a day as the client can reexperience past events. After the intensive, the client joins group sessions which last several hours each and are held a number of times a week for some months.

The essence of the therapeutic process involves a progressive stripping away of layers of defenses, moving from the more recent ones to the ones more deeply buried. The essential experience by which this happens is the primal, a spontaneous "total feeling-thought experience

from the past" (Janov, 1970, p. 86) which completely engulfs the person. During the primal the person intensely relives painful and traumatic childhood experiences through a deeply cathartic expression involving screams of anguish. The "Primal Scream", which results from wracking feelings of pain, is the beginning of the process towards health. "It is not the scream that is curative . . . it is the Pain. The Pain is the curative agent because it means that the person is feeling at last. At the moment that the patient feels the hurt, the Pain disappears" (Janov, 1970, pp. 90-91).

To facilitate the release of the primal scream, deep breathing techniques coupled with the making of sounds, are used to penetrate the barrier of the defenses. Insight is also used. These insights emerge after a person experientially feels what has emerged from the unconscious. Such insights produce total change because they are organismic.

Janov (1972) rejects the notion of transference. The primal therapist is directive but does not interpret the client's experience or behavior. Various therapists are used interchangeably during sessions, and therapists and clients may exchange roles on occasion. The role of the therapist is primarily that of a facilitator.

View of energy

While Janov's (1970) early writing barely mentions energy, in his latest book (1983) he expands on the concept to a limited extent. Janov (1970) links primal feelings and energy, viewing "the original Primal feelings as essentially neurochemical energy which is

transformed into kinetic or mechanical energy impelling constant physical motion or internal pressure" (p. 51). In his latest work, Janov (1983) describes energy as "a real and material. . . . biochemical and electrical force that can be objectively measured" (p. 67). Energy, which involves the activation of the muscles, blood, and brain, is consumed in the process of repression. When pain is repressed in the three different layers of the brain, the energy component is not. Energy is discharged in a manner unique to each level of consciousness.

> Early on, when the system is not fully developed, the discharge is almost totally visceral (first level); as physical and muscle coordination and emotional expression develop, the energy can flow into body wall or muscle release (second level) where we can become tense physically so that the muscles are tensed up; and finally, when the neocortex (third level) is fully developed, ideas can absorb and discharge the energy (Janov, 1983, p. 227).

When the trauma of birth is repressed, an excess of energy develops in the infant. This energy is first funneled into the viscera, where it later becomes converted into ideas, which give rise to the neurotic's obsessive-compulsive thoughts. In adulthood, every level acts as a defense for the next level. As each level is unable to repress the excess of energy, the next level becomes involved. The goal of Primal therapy is "to change this transformed energy back into its original state, so that there will no longer be an inner force pushing the person toward compulsive action" (Janov, 1970, p. 51).

The associated chakra

Because the crux of Primal theory and therapy centers around the traumatic pain of the birth experience which reverberates throughout life, this therapy deals primarily with the first chakra, located in the anal area. A person who has energy centered here is concerned about being psychologically or physically hurt, and tends to hurt or injure others. An intense global anxiety which poses the danger of annihilation is associated with the first chakra (Rama et al., 1976). These are precisely the kind of issues which result in the primal scene when the continuity of the organism is at stake. Primal therapy also relates to the first chakra because it "does not deal with meaning. . . . Its sole reference point is what the patient is feeling inside" (Janov, 1972, p. 156). Brown (1979) critiques Primal therapy because it "ignores completely the many-staged developmental process of higher individuation and self-actualization by its adoption of a one-dimensional, animalistic, survival-motivated ideal of healthy adult functioning" (p. 88).

Critique

The evidence to support Janov's (1970) extravagant claim that Primal therapy "is the cure for neurosis" is modest at this point. Janov (1971) does not depend of the rigor of scientific methodology to bolster his claims, for "if something feels true, it is likely to be true" (p. 201). He classifies the traits of skepticism, caution, and objectivity as "neurotic virtues" (p. 201). Nevertheless, Janov (1971) published the results of an outcome study done by Corriere and Karle.

Favorable outcomes were indicated by the 25 clients sampled on the basis that their pulse, blood pressure, and rectal temperatures decreased and their brain wave patterns were altered as a result of Primal therapy. However, the representivity of the sample is not described and raw data is not produced whereby to ascertain the degree of change. Karle, Corriere, and Hart (1973), using an experimental group of 29 clients and a control group of 10 people, did a study of the effects of Primal therapy using the same criteria for success as the study previously cited. They concluded that if the changes observed were maintained, "it would mean that post-primal patients are physiologically different from pre-primal patients" (p. 121). They also proposed the rather startling hypothesis that what is considered a normal pulse, temperature, and EEG is actually a neurotic one, since these measures are lower in post-primal persons. Nicholson (1977), in a doctoral disseration, studied four persons undergoing Primal therapy who served as their own controls. His conclusion was that three of the persons who succeeded in primaling decreased their body temperatures, but these decreases were not statistically significant. In a recent study, Dahl and Waal (1983) followed 11 clients over a period of two years. Although criticism could be raised about the lack of a control group and bias in the sampling, the researchers found "that 8 out of 11 patients were definitely improved on all outcome criteria, clearly indicating structural personality change" (p. 162). They concluded that primal therapy "seems to be a promising treatment for neurotic patients" (p. 162).

In general, these studies manifest some serious weaknesses. The

small sample sizes, the lack of controls, and the sampling biases are obvious problems. Also at issue is the criteria used to determine successful therapy. Kaufmann (1974) comments that "Janov's assertions that the reported decreases in pulse, blood pressure, and altered brain wave patterns in post-primal patients signal the advent of a new man borders on absurdity" (p. 58). These measures can be altered by other activities as well, such as biofeedback, yoga, or transcendental meditation. Physiological data is of little significance without data from other therapies.

Primal therapy raises a number of other concerns. One is that "the phenomenon of pain has been elevated in the theoretical framework to an almost magical, God-like, salvation-yielding status. The term primal pain seems to settle and end the disputes, the doubts, and the questions" (Brown, 1979, p. 72). This focus on pain leads to a distorted approach to emotional life. In the experiencing of their emotions clients are conditioned not to validate their needs for love or for other deep feelings besides pain. "Any purportedly deep feeling experience that does not bring up Pain is a pseudofeeling--a nonconnected acting out" (Janov, 1970, p. 69). All such feelings are to be discharged in a primal as soon as possible. Lonsbury (1978) proclaims that "in atttempting to reduce loved feelings to 'Pain' feelings, primal therapy suppresses an independent and positive role for love in resolving prior feelings of being unloved" (p. 26). There seems to be no room for an I-Thou relationship. Even the love of parents for a child tends to be seen as bondage to the needs of another.

Although Janov asserts that the bent of the human organism is towards being real, Primal therapy is not optimistic about the human condition. Janov denies the possibility of the adult finding satisfaction for what was needed but not received as a child. Clients are taught that their unsatisfied childhood needs must be lived with since those needs will be permanently frustrated. The painful realization of adulthood is that "once all the primal pains have been exorcized and externalized, to hope for need satisfaction is to perpetuate the neurotic struggle and search begun in childhood" (Brown, 1979, p. 87). Thus, the most we can expect as adults is to avoid getting stuck in our old needs. We must look after our own interests as best we can. Furthermore, there is a hopelessness about attempting to change society through the process of reproduction. Since "in this society there is no normal way to bring up a normal child. . . . child-rearing is left to the neurotics" (Janov, 1973, p. 192).

Janov's dismissal of the transference relationship between therapist and client is another issue of concern. Janov squelches attempts by the client to establish a real relationship with the therapist because this is seen as a symbolic seeking for love and a form of neurotic acting out. Because the client-therapist relationship is superfluous to treatment, therapists are used interchangeably. In this regard Yassky's (1979) advice is well taken:

> I would suggest that with primal and with all reconstructive therapies, that (1) a strong viable enough bond ('working alliance') must be established as well as (2) a strong enough ego must first be developed in the patient in order to sustain him and

allow him to endure the painful regressive experiences that are necessary in order for significant personality change to take place (p. 23).

The theory and practise of Primal therapy is not flexible. The danger is that the therapist may "orchestrate the feelings of patients to conform to theory" (Nichols & Zax, 1977, p. 143). The relentless pursuit of the birth primal as the ultimate cathartic event may lead clients to convulsively thrash and scream in a desperate attempt to do what the theory states is necessary. For those who have attained the magical goal sought, the danger is that they will see themselves as part of an elite group distinct from the "sick" or ordinary members of society. Kelley (1972) contends that "in this area of life, where man is struggling for knowledge, there is no elite who have discovered the way, only those who pretend or kid themselves that they have" (p. 71).

Janov's goal is to destroy all a person's defenses. The question is how a person can survive in a highly neurotic world without defenses. Effective functioning in our world means that sometimes feelings and impulses must be blocked. Furthermore, Janov does not discuss the dangers and implications of a massive assault on the defenses. "He blithely assumes that once the original traumas are lived through, complex neurotic behavior patterns, which every patient has built up over the years are automatically replaced by 'normal' behavior" (Strupp, 1973, p. 117). Janov basically assumes that this is a therapy for all people under any conditions.

G. FOCUSING

"Focusing" is a therapeutic technique developed by Dr. Eugene Gendlin (1969, 1978, 1979) as a result of his investigation to determine why various therapies are effective or ineffective. The results of his studies indicated that successful clients, that is, those who showed concrete changes in life as well as in psychological tests, could be easily identified within their first two therapy sessions. What made for success was not the therapist's technique or the content of the therapy, but how the clients talked and what they did inside themselves. The level of experiencing or affect was the critical variable related to therapeutic success.

Central concepts

Focusing views the body and psyche as one system. The body is seen as an expression of a person's total being and life experience. "It physically lives all the complexity one can know, and more. The physical body is much more than physiology knows. It is our complex interaction of living" (Gendlin, 1979, p. 343). The body is also seen as the unconscious, for many aspects of unconscious processes are implicit in bodily experiencing, shaping any given aspect of speech or behavior. Furthermore, the body is viewed as embracing the cosmos: "Your physically felt body is in fact part of a gigantic system of here and other places, now and other times, you and other people--in fact, the whole universe" (Gendlin, 1978, p. 77).

Gendlin optimistically assumes that, because the body is a complex system oriented to maintaining life, it always tends to move in the

direction of feeling better. "Once your body is allowed to be itself, uncramped, it has the wisdom to deal with your problems" (Gendlin, 1978, p. 75). When we feel "bad" or "wrong", the body is giving us messages that there is a discrepancy from the standard it considers "perfect". The body possesses an unerringly full sense of what is life giving for us and what is not, and will immediately attempt to repair itself when something goes wrong.

Focusing is a method which attempts to tap the inherent wisdom of the body. The essence of this method has to do with a kind of bodily awareness called a "felt sense" that profoundly influences one's life. This felt sense "is felt in the body, yet it has meanings. It has all the meanings one is already living with because one lives in situations with one's body. A felt sense is body and mind before they are split apart" (Gendlin, 1978, p. 165). The felt sense is not a mental experience but a physical bodily awareness of the essence of a situation, event, or person. As such, a felt sense is a holistic complex composite of many thoughts, feelings, and perceptions which are not fully formed. It may remain fuzzy, eluding concise description. As Gendlin (1978) describes it, "one has a felt sense when one can feel more than one understands, when what is there is more than words and thoughts, when something is quite definitely experienced but is not yet clear, hasn't opened up or released yet" (p. 126).

Although the felt sense begins to emerge as an undifferentiated whole, it is made up of many different facets. Becoming aware of some of these facets is called "undifferentiating". The content that emerges is shaped by the entirety of one's life as well as by the

present process. It is not necessary to decipher all the myriad aspects or all the different facets of the felt sense.

When the right words or actions are found to express this felt sense, a "carrying forward" of the experiencing process occurs, accompanied by a noticeable change in the body. The body may ease a little, and feel better. There is an inward assent, a physical sense that the words that fit the felt sense are right. "There may be a long audible sigh of relief, a sudden loosening of some tight facial grimace, a quick, comfortable relaxing in the posture" (Gendlin, 1978, p. 38). As the felt sense becomes differentiated, new thoughts and feelings emerge, and the carrying forward process is repeated. Many progressions of carrying forward may be necessary to solve a problem.

Basic to focusing is its optimistic expectation that people can change for the better. People are seen, not as fixed, static structures, but as "living processes". Focusing "envisions a person as a process, capable of continual change and forward movement. The 'problems' inside you are only those parts of the process that have been stopped, and the aim of focusing is to unstop them and get the process moving again" (Gendlin, 1978, p. 67). The content of the problem is not nearly as important as the process involved.

View of health and sickness

Gendlin (1979) defines a malady as "living by the values of others", and health as "being in touch with one's own flow of life" (p. 351). The determining factor in health and sickness is not what is experienced but how one responds to the experience. Beyond these

general statements, no attempt is made to classify neuroses or catalog pathologies. In fact, Gendlin deliberately avoids diagnostic categories, believing that they may mislead rather than help and may "get in the way of responding humanly to human beings" (p. 363). The basic therapy process is the same for people who carry different medical labels, although certain details may change depending on the condition of the person.

Goals

The goal of focusing is to experience the felt shift. Only when this occurs is the body able to free itself and move to a more healthy state.

The therapeutic process

Gendlin has popularized and made his focusing technique easily accessible to many people by providing a brief systematic description of the six stages involved in learning how to focus. First, the person is asked to clear a space. This involves being quiet, listening to the inner self, and allowing whatever comes to awareness to emerge. As problem issues arise, they are mentally listed and surveyed with detachment. Secondly, one problem is picked and focused on in a detached manner. The person attempts to feel the problem as a whole without trying to do anything about the problem. The felt sense of the problem may be murky and vague. Thirdly, the quality of the felt sense is maintained until some word or image fits it just right. This word or image is called a "handle". Finding the handle coincides with a

slight shift in the body that affirms that the handle is right. The fourth step involves going back and forth between the felt sense and the handle to determine how well they resonate with each other. If there is a perfect fit between them, there should be a felt response, such as an inner release or a deep breath, to confirm that the handle is right. This change is allowed to happen before moving to the next stage. In the fifth step the person directly asks the felt sense what it is. The answer is allowed to emerge without the use of the conscious thinking processes. The answer is accompanied by a body shift. The last step comprises welcoming whatever came to the person through focusing. Gendlin (1978) states that "whatever comes in focusing will never overwhelm you if you can have the attitude we call 'receiving'. . . . Take the attitude that you are glad the body spoke to you, whatever it said" (pp. 61,60). After going through these six steps, the person can repeat the process if so desired. Many cycles of focusing may be required before the problem is resolved. Outward action complements and aids the focusing process.

Gendlin (1979) sees the therapeutic process as a blending of mind and muscle in a bodily experience. Because what will emerge from this bodily experience is unpredictable, and because the focus is on the on-going inner processes rather than the content, the steps of the therapeutic process cannot be clearly delineated. Gendlin emphasizes that the technique in and of itself is not beneficial. What is important is that the technique be used experientially rather than passively.

The process of focusing is "oriented toward expanding a person's

sense of who he is, by healing the inner split between a part of him he defines as 'I' and a part of him he treats as 'other'" (Welwood, 1980, p. 132). Focusing expands people's sense of self by connecting their rational aspects with their subverbal felt experiences. It is therefore a way of integrating the unknown dimensions of the self with the familiar aspects. Focusing cultivates an awareness of and respect for the body, and helps us "appreciate how we each possess a core of strength and sanity underneath all our problems and unwholesome patterns" (Welwood, 1980, p. 132).

View of energy

Focusing does not deal with the body as an energy entity.

Critique

A number of studies have been conducted on the efficacy of focusing. Gendlin developed "The Experiencing Scale" (EXP), a seven stage standardized rating scale designed to determine the degree of affect occurring during a therapy session. He used independent raters to score the level of experiencing (feeling). Summarizing a number of studies he conducted, Gendlin (1969) concluded that "high experiential level during interviews is significantly correlated with positive outcome" (p. 12). He cautions that from his research it can only be concluded that the two variables are associated and not that there is a causal link.

Cherry (1978), in a study comparing a focusing group with a control group, found no significant differences between the groups when

measured on The Experiencing Scale. The study was limited by the short time devoted to focusing training as well as by the short time during which focusing was repeatedly measured. Henry (1978), comparing an experimental group of subjects receiving focusing training with a control group receiving weekly therapy, determined that "the clients' level of focusing and pre and post differences in EXP were significantly related" (p. 2986-B). Don (1977) used a computer to analyze the EEG readings of subjects while experiencing "felt shifts" as well as "negative shifts" as identified by the subjects. Proceeding on the basis that the slower the brain wave patterns the higher the level of brain functioning, Don noted that "the felt shift and the reorganization of conscious experience is a multi-leveled phenomenon, involving a reorganization of concepts, a choice of principles consistent with these concepts, the selection of programs in keeping with these principles, as well as the appropriate reorganization of all lower levels of the heirarchy consistent with these changes" (p. 163).

Weddig (1974), discussing the use of focusing in experiental group psychotherapy, recommends it as an excellent tool to circumvent resistance to deeping an emotional experience. Instead of analysing the resistance, focusing can be used to facilitate "a breakthrough or a bypassing of defensive blocks, impasses or ego censoring, such that, the individual is able to get in touch with the underlying, previous unconscious aspects of his feeling life and repressed memories" (p. 289).

Focusing can be a useful approach to various therapeutic approaches. However, given that it is more a technique than a complete

therapy, it is best used as an adjunct to other therapies.

H. POLARITY THERAPY

Dr. Randolf Stone, born in Austria in 1890, developed a life-long interest in natural healing, becoming a chiropractor, naturopath, and osteopath at a young age. His dissatisfaction with the Western view of the body, illness, and health resulted in an extensive research of the traditional medical practices of other cultures, especially acupuncture, Chinese herbal medicine, and Indian yogic healing methods. Over his career of sixty years, Stone evolved a unique synthesis of Eastern and Western techniques, utilizing diet, exercise, positive mental attitudes, and physical manipulation to attain and maintain health.

Central concepts

Intrinsic to the practise of Polarity therapy is the concept of energy movement in people and throughout the universe. "We invision life energy as it flows through the bones, the nerves, and all the cells to be like a wireless radio or television. However, it is a more radiant form of energy which travels everywhere. There are no limits as to the conduction of this universal energy" (Pannetier, 1981, p. 127). Everything in the universe is seen as having a positive and negative pole, with an energetic flow between the two poles. This energy is neither intrinsically bad or good, although it can be well-directed or mis-directed.

According to Stone, the human body is an energy field with energy flowing between the polarities. The polarity patterns in the body coincide with the electromagnetic principles found throughout nature, such as when the positive and negative poles of a magnet are brought together, an attractive current flows between them. The body is energetically charged with positive charges at the top of the body and on the right side, and negative charges at the bottom of the body and on the left side. Like the magnet, "polarity energy is directed magnetically along its lines of force to align and establish the vital polarities of the body" (Gordon, 1978, p. 25).

When the energy flow between the positive and negative poles is balanced and flowing freely, a neutral charge is produced. This continual free flow of positive-neutral-negative energy is called the "triune function". "According to Polarity theory it is of the utmost importance for an individual's energy to be balanced, for only when the triune function is operating effectively is one able to be in the state of harmony required for good health" (Feiss, 1979, p. 65).

The primary life-force energy which builds and sustains all the others is said to be located in a fine white line which flows through the sixth ventrical of the brain and down the spinal cord. This energy is "stepped down" or transformed within the chakras so that it can be utilized for specific life functions (Schwarz, 1980). In the Polarity system, the five elements of ether (spirit), air, fire, water, and earth are seen as the major facets which comprise life energy. Each of these elements correspond to a particular chakra, body part, and body function. For example, the element of air is associated with the heart

chakra, the lungs and the heart, respiration, and compassion (Binik, 1978). The life-force made up of the five elements is described as "the animating current of life and a physiological reality in the body" (Gordon, 1978, p. 18). It flows through the entire body, charging every cell it touches. Various things, such as stress or tension, can weaken the flow.

Polarity therapy operates from an assumption of body-mind-spirit unity. The physical, mental, emotional, and spiritual aspects of a person are viewed as merely different manifestations of the same energy. Thus, blockages in any one area will affect all other areas. Polarity therapy describes blockages as occurring in a number of ways. One of the most common blockages is in the "character armor". Like Reich, Polarity therapy believes that psychological conditioning and early traumas inhibit the free flow of emotions and lead to a tightening of sets of muscles as well as connective tissues. This blocks the flow of energy through specific parts of the body. "Furthermore, an individual's unique pattern of chronic blockage will generally show up in chronic character attitudes . . . which interfere with the direct experience of life in the moment" (Binik, 1978, p. 101). Another common blockage of energy results from a dietary imbalance which results from not only a poor choice of foods, but also from their quantity, quality, or combinations. How the eating is done and what emotional state the person is in while doing it are important factors in the assimilation of food energy.

View of health and sickness

Polarity therapy is based on a health model. It is assumed that the nature of the body is to heal itself. To do this, however, it needs a favorable environment. Such an environment is created by eating healthy foods, exercising regularily, and maintaining positive thoughts and feelings. Because we have control over how we treat our bodies, we are responsible for our own health or illness. We can make ourselves sick and we can bring ourselves back to health.

Polarity therapy does not concern itself with treating disease or the effects of disease, or even attempting to determine the cause of the disease. No one specific body part is concentrated on because all parts are seen as interconnected. The focus is rather on releasing blocks to energy flow within the body so that a balanced flow of life energy can result. When such a free flow occurs, nature can do the healing because "each cell has a 'mind' and knows its function and will perform normally when nourished by the natural flow and balance of this energy moving through the body freely" (Pannetier, 1981, p. 128).

Goals

The primary goal of Polarity therapy is to harmonize body, mind, and spirit so that good health and stability can be experienced. For this to happen, clients are encouraged to take responsibility for their own health and rely on themselves to do what they know is necessary for self-healing. They are taught to view life positively, to be happy, and "to cheerfully accept everything that comes to one" (Pannetier, 1981, p. 128).

The therapeutic process

Five major tools are used in the practise of Polarity therapy in order to help a person attain and maintain an optimum level of health. The first of these is love. Love is considered to be the most powerful energy available because love is God and God is love (Vlamis, 1978). Love is utilized as a primary healing force by creating an affirming, loving, nurturing environment for the client. The second tool involves generating positive thoughts and attitudes. Because Stone believed that physical problems are due to blockages of mental and emotional energy, he attempted to create and enhance people's positive feelings about themselves. To do this he had people give themselves affirmations. Body manipulation, the third tool, involves the gentle use of the hands of a trained practitioner to release the blocked energy in the body. Careful attention is given to the placement of the hands and to the direction of energy flow between them so that the client's movement of energy will be facilitated. While the type of touch used is similar to that of acupressure, the specific points and map of the body used are unique to Polarity therapy. The fourth tool, easy stretching postures, are employed so as to enhance the circulation of the blood and improve the flow of energy. The postures employ a process which is natural, progressive, and non-forceful. The last tool involves an emphasis on diet and nutrition as a way of maintaining health and energy. A diet of natural foods, fruit, vegetables and grains is recommended. Stone developed a number of special diets and recipes to facilitate the cleansing of various body parts. In summary, Polarity therapy is a "complete and powerful method of holistic healing

that utilizes diet, exercise, physical manipulation and proper mental attitude in an interdependent manner in order to help an individual reach and maintain her optimum level of health" (Feiss, 1979, p. 66).

The associated chakra

This therapy stresses the over-all importance of giving and receiving love, and strongly attempts to create a loving atmosphere during the therapy. Because of the primacy of this emphasis on nurturance, Polarity therapy is mainly associated with the heart chakra.

Critique

The appeal of Polarity therapy lies in the simplicity of its methods, the versatility of its application, and the breadth of its concerns. The specific body manipulations, clearly described by Gordon (1978) in his book, can easily and quickly be learned by most people. Results are reported to be quick. The therapy can be applied in many settings with people of all ages in all conditions. Gordon (1978) suggests that Polarity therapy could be used by doctors before or after medical treatment, in hospitals to alleviate pain and reduce tension, in jails and institutions, as well as in schools. It is a non-invasive therapy with no negative side effects. Unlike some of the other therapies, such as Rolfing or the Alexander technique, Polarity therapy advocates a more comprehensive view of health by including diet, exercise, and cognitive restructuring as part of its treatment regime. Given that the goal is to establish a healthy lifestyle, if this is

accomplished the person is likely to experience an enduring change.

The weakness of Polarity therapy lies in the same area as a number of the therapies described earlier in this paper. This therapy does not acknowledge the need to deal with the root causes of psychological problems, assuming that such problems will take of themselves once the energy blocks are removed. To deal with this lack, some form of psychotherapy may be mandated as an auxiliary therapy for persons taking Polarity therapy.

I. SPONTANEOUS BODY EXPERIENCING

Spontaneous Body Experiencing, also described as "a non-directive approach to bio-energy", was developed by Aime Hamann in conjunction with a group of therapists in Montreal, Quebec, in the early 1970s. This form of body therapy has almost nothing written about it--only two short unpublished essays (Hamann, 1976, 1977). It evolved during the last decade and is being practised in several Canadian cities. It is the form of body therapy being practised by the writer.

Central concepts

Central to Spontaneous Body Experiencing is a deep respect for the body. The intellectualization of the body is circumvented by engendering a process which allows the body to express its own unique internal processes. The fundamental strategy of this therapy is to

> approach the human organism without any preconceived notion of man, of the universe, and of cosmic energy. To start from

> nothing. To let the organism guide us. To create the conditions (and this is the crux of our work) that will allow the body, the human organism, in its totality, to reveal to us its secrets of and by itself. To become students, the taught rather than the teachers of life, of the body's energy, of its manifestations, and of its different modes of expression (Hamann, 1977, p. 2).

Spontaneous Body Experiencing posits that everything in us is comprised of energy and movement. "The human organism is a global energy structure, an energy programme, which is superimposed on the anatomical structure" (Hamann, 1977, p. 12). This energy structure, which is unique to each person, is an incorporation of our biological and hereditary histories. "The human body, especially during the first years of life, reacts as if it were a single cell, very globally. Events affect it, inscribe themselves in it, change it" (Hamann, 1977, p. 12). Because all aspects of a person form a unity, our personal choices and life experiences result in an on-going change to our external and internal structures.

One of the assumptions of Spontaneous Body Experiencing is that of "body memory". It is thought that our bodies have imprinted in them all of our life experiences, even those of infancy and foetal existence. Somewhere in the depth of our genes, which contain the mysterious program of our lives, is inscribed all of our past. Painful life experiences, often suppressed by people, may become "stuck" or "lodged" within the muscle tissues of the body. Attempts are made to hide the pain inside by presenting a mask or front to the world. As Hamann (1977) expresses it, "between the spontaneous expression of

energy of the foetus and infant that we were and the artificial rigidity or false ease we manifest, have intervened countless angers, incommunicable sorrows, censured desires. . . . Between what really happens in our depths and what has the right to be mentioned before others, is a world of difference" (pp. 15 & 14).

The memory of the body is revealed in therapy as an organismic process of energy release is allowed to occur. This energy release follows anatomical channels and reveals the complex organization of energy within people. For example, tension in the jaw could suddenly release into feelings of rage. The withheld history of the body gradually begins to express itself through movement, sound, and imagery. "The programme recorded in us begins to unfold, in the beginning, in a manner seemingly devoid of meaning. But little by little, we realize that what is happening is related to us, to all we are in life" (Hamann, 1977, p. 14).

View of health and sickness

According to Hamann (1976), health is related to movement. The body engages in numerous functions. It breathes, nourishes itself, reproduces itself, feels, imagines, thinks, speaks, and acts. The common denominator of all these activities is movement. The ease of the body's motility is a clue to its state of health. The more the human organism is unified and integrated in its movements, the more it is capable of pleasure. By contrast, all that blocks movement diminishes the capacity for pleasure. Divisions and tensions in the body result in a rigidity of movement as well as a separation of the

self from itself and others.

Health is related to respiration. Breathing is the rhythmic global movement of the living organism. Full, deep breathing allows us to be open to life. However, because all of our traumas and past life experiences affect our breathing, our breathing may become constricted. For example, when we become fearful our breathing becomes shallow. An energetically tense and divided body in which respiration has been repressed and in which the motor and expressive capacities have been lessened, will not be able to taste the fulness of life, desire, or pleasure of which it may be capable.

The healthy person is able to fully experience both pleasure and suffering. Pleasure is defined by Hamann (1976) as not a matter of "fun" or "pleasures", but as the capacity to be unified and integrated within one's self and in one's relationship with others. That which encourages the harmonious development of the human organism, thereby increasing its capacity for pleasure, is life-giving. By way of contrast, all that deprives the body, creating tensions and blockages, works towards its destruction. What makes for pleasure, then, is the criterion of what makes for health.

Pleasure and suffering are interrelated. The less a person is capable of experiencing pleasure, the less is that person able to carry the suffering inherent in all of life. To be able to feel pleasure is to be able to experience all of life, including its inevitable pain.

The therapeutic process

The therapeutic process employed by Spontaneous Body Experiencing

is anti-technical. It avoids preconceived diagnostic, psychological, or medical categorizations, preferring to create the conditions under which all of life can express itself through its own unique process.

What is done in this therapy is very simple. The client is asked to lie on his or her back on a narrow mattress with eyes closed and is told to make no voluntary movements, not even to scratch. The client is also instructed to relinquish control of anything which may occur within, at whatever level that may be. These two conditions aim at cutting people off from habitual movements they may make to suppress budding emotion. Because the aim is to avoid mental effort, it is not required that attention be focused on any one part of the body. If the therapist is working with only one client, he or she sits by the client's head and maintains a light touch to both sides of the face. If the therapy is being done with a group, people work in pairs, taking turns lying on the mat and providing the touch to the head, while the therapist may touch the client's feet or other parts of the body. The clients may lie on the mat for 45 to 60 minutes or longer, depending on the discretion of the therapist.

What happens during the session is unpredictable and varies with each person. As people relinguish control of themselves, an organismic process is initiated. This process is

> a global phenomenon . . . which progressively involves the whole organism in its neuro-muscular tissue as well as in its modes of expression. As a result of the touch presence . . . there occurs, at a given moment, within the organism, a release which could best be described as movement. Voluntary control lets go little by

> little. What is involuntary and autonomous can, therefore, appear and replace what is voluntary. Inner life, which is movement, makes its appearance in the form of movement (Hamann, 1977, p. 9).

As the person lies on the mat, emotions, memories, pains, or sensations may emerge. At some point small autonomous, involuntary, uncontrolled movements begin which may eventually build into a state of total body vibration or movement accompanied by the making of sounds. What happens is that the body begins to spontaneously release muscular and emotional blockages. The vibration or movements of the body are a result of energy passing through the musculature. "When there is great resistance and the muscles are very tight, then the twitching becomes very large and sometimes painful. It is the energy attacking or breaking through where the musculature holds" (Bauman, 1982, p. 170). The person may relive hurts, fears, or traumas which have been long suppressed. Sometimes there is a conscious awareness of the relationship between the organismic process and specific past events. Other times no specific meanings emerge to link the organismic processes and past or present events.

As the therapy proceeds, there is a progressive deepening of the organismic process. Experiences from all ages of life emerge, including those of the intra-uterine period and the birth experience. Furthermore, "the organismic process reveals an energy structure; that is, the body's movements appear in a definite order" (Hamann, 1977, p. 11). During this process the person is conscious of and responds to outside stimuli. It is possible to stop and start the process fairly easily as a person learns how to do this.

Touch is central to this therapy. It is hypothesized that the quality and quantity of touch is critical in shaping life. Children develop in accordance with how they have been touched. "To re-establish contact with another person by touch is to go directly to the origin of one's life, beyond language certainly, but beyond the other senses as well. It reaches the person in the structures of his personality, provided, of course, that he truly gives his life, his energy the potential of emerging" (Hamann, 1977, p. 5). The type of touch used in Spontaneous Body Experiencing is neither a caress nor an intervention. It is simply a non-demanding presence, a being-with the other person.

While the organismic process is essentially a nonverbal one, words become an indispensable part of the process. Because everything in our lives is relational, words are imperative for the therapy to continue. In this writer's practise of this therapy, the mat sessions are followed by a sharing of experiences and a verbal therapy session where any number of a variety of therapeutic strategies may be employed.

The associated chakra

Because Spontaneous Body Experiencing allows the organism to express itself at a variety of levels, it is not associated with any one chakra. Given that the chakra system implies a progression of psychological and spiritual development, it can be postulated that people will gradually move up through the various chakras as they become progressively more liberated from their internal blockages.

Critique

Various aspects of Spontaneous Body Experiencing are similar to a variety of other therapies. Like psychoanalysis, free association is used. However, this associating is done, not at a verbal level, but at an experiencing level. Spontaneous Body Experiencing can be likened to Primal therapy because the energy release which may accompany the organismic process is similiar to Janov's descriptions of Primal therapy. Spontaneous Body Experiencing has been called "Rogerian bio-energetics" because the therapist adopts the kind of role advocated by Rogers. The use of touch reflects aspects of Polarity therapy. These similarities are not surprising because the human organism and its energy does not change from one therapy to another. What changes is the perspective brought to the organism. This perspective often determines what will occur.

The uniqueness of Spontaneous Body Experiencing among the body therapies lies in the simplicity of its technique and the intensity of its results. It is the least prescriptive of the therapies, allowing the therapeutic agenda to be determined by whatever spontaneously emerges from the organismic experiencing process. As such, it follows the recommendation of Nicols and Zax (1977) that "to be most useful, theory should serve only as a guide, and therapists should remain flexible enough to work with whatever material their clients produce, without insisting that it fit the straitjacket of their belief in what 'really counts'" (p. 104). Spontaneous Body Experiencing is versatile in that it can be used with a wide spectrum of clients, individually or in groups as large as 16 people. It can be done with a therapist or

with a friend, and can be combined with other therapeutic strategies. In this writer's experience, this therapy tends to quickly flush out the critical life issues a client has and is especially good for people who tend to over-intellectualize.

Hamann (1977) cautions, however, that this therapy is not easy. It is

> difficult, demanding, and also, very long. . . . The price is high. One has to accept living in one's inner madness, or better yet, letting it express itself as it is inscribed in the depths of the vibratory universe that we are. . . . This approach can become . . . a way of discovering the laws of life itself precisely because it receives life as it is. And then, it seems to me, that life, expressing itself, can reveal to us and teach us its wisdom" (p. 17).

CHAPTER THREE

PRACTISE ISSUES

This chapter examines a number of issues involved in the practise of body therapy. These have to do with the role of catharsis in therapy, the effects of touching, the placebo effect, indications and limitations, as well as the role of the therapist.

A. CATHARSIS

The use of catharsis is prominent in a number of the body therapies, namely Reichian therapy, Bioenergetics, Primal therapy, and Spontaneous Body Experiencing. Catharsis may also accompany Structural Integration, occurring spontaneously as muscle tension is removed.

Use of catharsis in therapy has a controversial history. Psychoanalysis began with an investigation into how catharsis could be used to cure hysterical symtoms. Freud wrote of his early work with Breuer that "we led the patient's attention directly to the traumatic scene in which the symptom has arisen, endeavored to find the mental conflict inherent in it and to release the suppressed affect" (quoted by Heider, 1974, p. 33). Freud called this the "cathartic method". Heider (1974) likens this method to people being like tea kettles with boiling water inside and a cork in the spout. Energy is represented by the steam which is trapped inside the corked kettle. Any behavior which increases the heat of the fire, punctures the kettle, or pops the

cork, results in a dramatic release of energy. In Freud's terms, the kettle is called repression while the steam is called libido. In Freud's early work, the task was to free the libido.

Catharsis, as used by the body therapies under discussion, is based on a common assumption which originated from Reich's work. People are seen as energy systems. Dysfunction occurs when the free flow of energy is blocked from its natural channels. Restoring the energy flow, possibly with a strong cathartic discharge, restores healthy functioning. An example of this is when tears are suppressed in an attempt to control sadness. Maintaining such control reduces one's ability to feel. When the tension is broken down or the emotion intensifies to the point of bursting forth, the tears flow, the tension is released, and feeling and movement are freed. While suppression of certain feelings is necessary at times, the problem arises when the release of tension is never permitted. This produces chronic tension which results in a loss of ability to feel, move, and experience.

Catharsis can be produced in a number of ways. To continue the metaphor of the tea kettle, the walls of the kettle may be attacked by reducing the resistance to free expression. Or the heat may be turned up by intensifying the impulse toward expression. Or the kettle, the cork, and the steam may all be triggered at once by a specific action. Bioenergetics uses stress positions to trigger catharsis. Janov uses the deprivation of sleep, sensory bombardment, and prolonged excitation to attain dramatic release of feelings. Various degrees of catharsis occur spontaneously as a part of Spontaneous Body Experiencing.

A number of benefits can be produced by catharsis. Heider (1974)

claims that "catharsis is the most frequent and valued tool for entry into transcendental realms of experience. . . . During this period, healing and personal growth take place more quickly than usual" (pp. 31 & 27). Catharsis may result in peak experiences as described by Maslow (1962). The eyes become clear, the body is radiant, relaxed, and yet energized, and there is a sense of profound well-being (Heider, 1974).

Catharsis, as used by the body therapies, may be useful in producing attitude changes. Often attacking a problem at strictly the cognitive level is insufficient to produce changes. Emotional arousal may be needed to facilitate a change in attitudes. "Under heightened emotional arousal people search out explanations for their feelings, and this makes them more suggestible" (Nicols & Zax, 1977).

Catharsis can also be used as a means to give people the distance they need from their emotions so that they can more objectively perceive what is happening. Cathartic discharge often accomplishes this more effectively than does an intellectual discussion. This is because "accurate perception and clear thinking are enhanced following emotional discharge, because catharsis is more effective than suppression for distinguishing between thoughts and feelings" (Nicols & Zax, 1977, p. 226).

Most of the support for the efficacy of catharsis comes from anecdotal accounts. Although it has been promoted by various therapies, "no one has demonstrated that catharsis alleviates or prevents psychosomatic disorders or is a critical variable in successful psychotherapy" (Nicols & Zax, 1977, p. 195). According to Nicols and Zax, only one study has been conducted which has quantified

catharsis and related it to psychotherapeutic outcome. While the results of this study corroborated the effectiveness of the techniques in generating catharsis, the question of the therapeutic value of catharsis was less conclusive. Only some of the outcome criteria were significantly affected by catharsis. However, Nicols and Zax (1977) comment that "the fact that catharsis patients improved significantly on both of the behavioral measures employed tends to confirm the beneficial impact of cathartic therapy" (p. 194).

A number of the body therapies which operate in the context of a group may use catharsis to great advantage. One person's experiences may trigger emotional responses in other group members (Pierrakos, 1974b). The group can be used to give permission to people to express their deep feelings. While new group members may be frightened by observing an intense discharge of feeling, they can see that people come out of it on their own, generally feeling alot freer and lighter.

There are a number of cautions and dangers in the use of catharsis. Heider (1974) observes that the powerful emotional release of catharsis is often followed by ecstacy, then depression, and eventually a return to the normal state. As the ecstatic experience fades, the person may be deeply disappointed at the loss of what felt like permanent enlightenment. Caution is needed in producing catharsis, for while it easily produces peaks, there is no guarantee that lasting change will be thereby produced. Karle, et al. (1973) note that "even if abreaction is the physiological curative process other processes must operate to sustain physiological normalization and still other processes must convert tension reduction into changes in

the way a person lives his life" (p. 121). Catharsis is not therapeutic in and of itself "unless it occurs in a setting of expectance and understanding and can be integrated into the patient's view of himself and the world. . . . [it] can be antitherapeutic, humiliating, and devastating to the remaining resources of the individual" (Bellis, 1976, p. 137).

A hazard of cathartic therapy is that it can easily lose its focus. Most clients enter therapy to be cured of a presenting problem. It is easy in verbal therapy for the focus to be deflected from the presenting problem to the etiological construct of the therapist. Instead of an emphasis on outcome, the focus may be put on process. Because catharsis is exciting and tangible, it may become valued in itself even apart from behavioral change.

Catharsis generally needs to be incorporated as part of a broader therapeutic strategy if it is to be used to produce fundamental changes. It must be seen as a tool and not as the overall goal of therapy. While affect certainly plays a part in long-standing behavioral disorders, its role is not exclusive, and the cure requires more than its release.

Some of the dangers of catharsis lie not so much in the technique or theory involved, but in their possible misappropriation. Not all therapists and not all clients should engage in this type of therapy. Intense catharsis can disrupt psychological defenses and requires a therapist who can create an atmosphere of strength and safety while sensitively accompanying the client through the process. Heider (1974) picturesquely describes the therapist's role as "that of a midwife,

present only to assist and sometimes to induce a natural process but ill-advised to attempt to stop a birth process once initiated" (p. 37). He also warns that forced confrontation should not be used by the leader to precipitate catharsis. He advises that "it is preferable to allow the participant to confront the anxiety over a period of time than to perform a caesarean and take the infant from the womb" (p. 38). The therapist must be comfortable in handling intense feeling and in temporarily increasing the feelings of upset in people who are already feeling distressed.

Clients generally initially face the possibility of strong cathartic discharge with great trepidation. Sensing their internal turbulence, they fear facing their inner madness if they give up control. They often hold back because they are afraid that if they let themselves go they may be embarrassed or worse yet, may erupt into a murderous rage. Because facing such fears and exposing deep emotions produces a high degree of vulnerability for people, they need to be worked with sensitively.

It is appropriate that people entering a highly cathartic type of body therapy be screened. People with certain medical conditions, such as epilepsy, high blood pressure, and cardiac problems, as well as persons who have major problems knowing what is or is not real should be cautious about engaging in extended pillow-pounding, sobbing, or screaming. While most people are heavily guarded emotionally, there are those whose egos are only weakly defended who give vent to more feeling than they can handle in a given situation. Because of this, "it is critical that the therapist who aims for catharsis be able to

provide a very safe and protective atmosphere in order to relax the defenses of the normally defended person, and to protect the less well-defended person who too easily exposes private feelings" (Nicols & Zax, 1977, p. 226). Furthermore, something needs to be done regarding the feelings expressed. As Kiesler (1973) comments, "emotionality in the group should be examined as a process, so as to avoid mislabeling and useless or hurtful transfer of learning" (p. 29). If growth and personality change are desired goals, then the therapist must deal with such issues as from where the emotions emerged, the validity they have, and what learning can come out of the catharsis.

Carthsis can be dramatic, convincing, and contagious, especially in a group setting where a great deal of energy may be mobilized. Because of its power, it can give an aura of truth to whatever is said or done by the therapist. Because of this, therapists using catharsis must be scrupulously ethical in their relationship with the group and must ensure that the power of the group is not used to overwhelm the defenses of the individual.

B. TOUCHING AND BODY THERAPY

Physical touching between the therapist and client is an integral aspect of most body therapies. How important a part touch plays varies with the therapy. While Focusing does not demand the use of touch, Structural Integration cannot be done without it. Touch, in some of these therapies, is done while the client is partially nude. Given that touch has historically been excluded from psychotherapy, the use

of touch by the body therapies requires some discussion.

Freud has had a great impact on the question of touch between therapist and client. He was heavily influenced and constrained by his culture which de-emphasized the mother-child bond and which was insensitive to infantile needs. During the 1880s the medical establishment highlighted the danger of over-indulging the child, believing that many problems with babies resulted from the well-meant interference of overly loving parents. Because one of the ways of "spoiling" a child was thought to be the cradle, a concerted attack on the use of the cradle led to its eventual demise (Montagu, 1978). This cultural mileau, as well as Freud's own personality and his perceived need to be rational and "scientific", led him to eventually eshew the use of touch in therapy, although he went through a period where touch was an integral part of his practise (Edwards, 1981; Older, 1977). He came to believe that the thrapist should not add anything of himself or herself to stimulate the client, and rejected physical contact as seductive and dangerous (Forer, 1969). As a result, it has been "the Freudian movement which provided a theoretical rationale for understanding the unconscious meanings of body contact and the taboo against touching and which institutionalized the taboo in psychotherapy" (Forer, 1969, p. 229). That this taboo is still strong in the psychoanalytic establishment is illustrated by the advice of Langs (1973), a Freudian psychiatrist who warns against any physical contact between a therapist and client other than a handshake at the commencement and termination of therapy. According to Langs, any physical contact between a male therapist and female client involves a

gratification of the sexual needs of the therapist, while touching a same sex client may precipitate homosexual panic in the client.

Social work reflects the psychoanalytic orientation in its perception of the use of touch between the social worker and the client. Kadushin (1972), writing about the social work interview, states that "occasionally, in moments of great stress, the interviewer will reach over and briefly touch the interviewee in a gesture of comfort and sympathy. Aside from this and attempts to translate the meaning of a firm or flabby handshake, tactile communication in the dyadic interview is almost nonexistent" (p. 264). More recently, Strean (1981), a Distinguished Professor at the Graduate School of Social Work of Rutgers University, derogatorily describes "exercises in handholding and other types of sexual foreplay" (p. 166) as being a part of encounter and sensitivity groups. Furthermore, he claims that participants are "seduced into holding hands" (p. 166). Clearly Strean views touch only within a sexual context.

Reich was an incisive critic of his society, especially of the psychoanalytic establishment's attitudes toward the body and interpersonal intimacy. He found it difficult to understand how psychoanalysts could attempt to plumb the depths of the personality while retaining an aloof, reserved stance. Reich's insistence on the importance of being touched was a bold and prophetic stance which called people back to the recognition that there are fundamental human needs which must be met for healthy development. Although current research into the effect of touch within psychotherapy is still in its infancy, the role of touch in therapy is gradually becoming more

accepted and prominent (Hubble, Noble, & Robinson, 1981). There is some evidence to suggest that therapists use touch more than they will openly acknowledge because touching violates currently accepted theory and practise (Borenzweig, 1983; Older, 1977).

One of the reasons for the greater acceptance of touch can be linked to the encounter movement of the 1970s which strongly emphasized use of touch (Bogdanoff & Elbaum, 1978). In conjunction with the effects of the encounter movement, proliferating research on humans and animals has increasingly pointed to the critical necessity of touch for survival and growth. Other helping professions, such as nursing, are also increasingly coming to emphasize and value the healing elements of touch (Feiss, 1979; Kreiger, 1979, 1980).

Montagu (1978) has compiled powerful documentation relating to the need for touch throughout life, especially during infancy. He summarizes numerous studies to demonstrate that normal functioning is impaired when adequate touching is not provided. He asserts that

> the infant's need for body contact is compelling. . . . The early development of the nervous system of the infant is to a major extent dependent upon the kind of cutaneous stimulation it receives. There can be no doubt that tactile stimulation is necessary for its healthy development. . . . If that need is not adequately satisfied, even though all other needs are adequately met, it will suffer" (pp. 192 & 190).

A failure to meet the infant's needs for nurturing parenting, that is, close physical contact, cuddling, rocking, holding, and caressing, may result in many deficits for that infant throughout life. These include

a failure to establish contact relations with others, inadequacies in tactile and affective behavior, psychosomatic disorders, deficiencies in social communication, atypical movements and postures, as well as a physical, psychological, and behavioral awkwardness. To provide the need for tactile stimulation, even in adults, "may serve to give them the reassurance they need, the conviction that they are wanted and valued, and thus involved and included in a connected network of values with others" (Montagu, 1978, p. 226).

The body therapies, by virtue of their physical orientation, are in a strong position to use touch for healing. Because many people have not received the intensity of body contact they needed as infants and children, they remain emotionally deprived at some level. Touch can be used in therapy to tap and meet those deep levels of need. As Brown (1979) writes,

> The giving of direct touch quickly triggers off, deep within the core regions of the metabolism, the forgotten longings for being held and nurtured by a mother or father not always available. The very physical proximity of the therapist to the patient will often awaken very early feeling vibrations that characterize the circuit of connectedness between mother and child during the earliest months. There is an almost magic-like power of direct physical touch between one organism and another which acts as a form of catalyst in terms of regressing a patient to early feelings of childhood in which there is no separation between subject and object or between child and parental figures" (pp. 86-87).

Touch, properly and sensitively used by a therapist, can enable people

to spontaneously regress backward in time to the experiences of childhood when they erected their defenses as protection against the chronic nongratification by their parents of their basic needs for nurture. Once these experiences are made accessible, attempts can be made therapeutically to resolve and move beyond the issues they present. Touch can also be used in therapy to move a person to the higher levels of psychological needs as defined by Maslow. "Every neurotic suffers according to Maslow from an acute deprivation and frustration of childhood needs for safety and love. . . . The dissolution of a patient's character-muscular armoring cannot be completed without first gratifying all hitherto unsatisfied childhood needs for safety and love" (Brown, 1979, pp. 85-86).

Physical contact between the therapist and client is much more intense than the distance of visual or verbal interaction. As Lowen (1967) writes, "if a therapist touches the patient with hands that are warm and tender, he establishes a deeper contact than words or looks could achieve" (pp. 248-249). Appropriate physical contact gives the client a great deal more information about the quality and depth of the therapeutic relationship than do words. While "verbal contact alone leaves one in a limbo of isolation from one's own body and from other persons. . . . contact between two bodies emphasizes the boundaries of self and other, and permits a psychological and bodily experience of fusion with (and new substance from) another person which words cannot provide. . . . Taking in something new from others is energizing; it extends the boundaries of self; it is ego-stretching" (Forer, 1969, p. 230).

Touch can serve many purposes. It can be used to symbolically parent a client, to convey acceptance, and to provide a concrete connection with the external world when a client feels out of touch with or threatened by that world (Mintz, 1969). As Montagu (1978) states, "taking almost anyone's hand under conditions of stress is likely to exert a soothing effect, and by reducing anxiety give both the taken and the taker a feeling of greater security" (p. 226). Touch is also a basic way of providing presence and comfort. Older (1977) warns that "by forbidding touch, we as therapists cut ourselves off from a very basic way of making contact and providing comfort. In some cases it may be the only way" (p. 198). Furthermore, touch may encourage self-disclosure in therapy because of the increased intensity between client and therapist that touch produces (Silverman, Pressman, & Bartel, 1973; Wilson, 1982).

Touch can be used as a rich source of information for the therapist about the client. By touching a client, the vitality, softness, or hardness of the tissues, and the quality of the skin can be ascertained. There is a close connection between touching and knowing.

Because of the many meanings touch has in our culture, the type of touch the therapist uses is crucial. There are many strong cultural taboos which militate against people touching each other except in clearly defined ways (Goffman, 1971). When touching is done, it is often seen to have sexual overtones. As Older (1977) graphically states, "beneath the rock of the touch taboo lurks the snake of the sex taboo" (p. 198). The unfortunate inability to discriminate between

sexual touch, which is expressly designed to stimulate sexual arousal, and nurturant touch, which is the expression and sharing of non-sexual love, minimizes the likelihood that people will be able to experience nurturant touch as adults outside of a sexual relationship. The therapist needs to be cognizant of the strong possibility of confusion between sexual and nurturant touching on the part of the client.

The touch of the therapist must be non-sexual and non-erotic (Wilson, 1982). Lowen (1975) advises that "a therapist's touch has to be warm, friendly, dependable, and free of any personal interest to inspire confidence in touching" (p. 92). Touching which is sexual merely amplifies the client's fears about physical contact and reinforces the taboo against touching. "Any sexual involvement of the therapist is a betrayal of trust in the therapeutic relationship that subjects the patient to the same trauma he experienced in the parent-child relationship" (Lowen, 1975, p. 93). The therapist must be able to differentiate between sensual, supportive, gentle, hard, mechanical and feeling touches. If the therapist cannot distinguish between nurturant and sexual touch, touch should not be used (Edwards, 1981). On the other hand, if the client associates the release of pleasurable feelings with sexual feelings towards the therapist, "this becomes an ethical issue only if the therapist fails to help the client deal with these interpersonal transference feelings as a distortion of the real intrapsychic experience" (Leland, 1976, p. 216).

An illustration of the degree of sensitivity needed in the use of touch can be found in the practise of Spontaneous Body Experiencing. In one group this writer conducted, a large proportion of the female

clients had been sexually abused as children. Some of them felt highly vulnerable, not only because of the enormous pain they were facing as a result of their abuse, but also because, by wearing bathing suits, they were exposing more of their bodies than they felt comfortable with. Lying on a mat with eyes closed, they also knew that they would be touched somewhere on their bodies by the male leader. In such a situation of extreme vulnerability, if these female clients would not feel safe with the therapist or would feel at all improperly touched, they could quickly feel that their earlier sexual exploitation was being repeated. Unless the touching in such a situation is done very sensitively in an atmosphere of safety, it would only serve to mobilize the defenses it was intended to dissolve.

The use of touch in body therapy brings up other ethical issues besides that of sexuality. Because there appears to be a significant difference in crossing the ego boundaries, as is done in verbal therapy, and the physical boundaries, as is done in body therapy, the therapist carries a more intense responsibility when the client's body is directly involved. As a result, Leland (1976) advises that therapists should inform their clients of what they intend to do prior to the therapy. "This may mean describing exactly what I wish him to do, describing what it is that I intend to do and/or informing him of the potential physical and emotional risks involved" (p. 216). Clients also need to be informed of the degree to which the body will need to be exposed. While this may dilute some of the force of the therapy, it will protect both the client and the therapist. The clients may feel invaded or violated if they are not made aware of the proposed process

and allowed to choose whether or not to allow it to occur. If stress or pain are involved, therapists should demonstrate with their own bodies what is requested. Because informed consent is a crucial issue in malpractice suits, a client's prior knowledge of the risks involved is essential. Although physical damage as a result of body therapy is not likely, it is possible. The responsibility is on the therapist to foresee possible dangers and screen out people who may pose too high a risk.

Research on the effects of touch in psychotherapy and body therapy has barely begun to explore the many factors involved. Touch has different meanings depending on the context in which the touch is given, the intensity of the relationship between the therapist and client, the sex of the therapist and client, and the location of the touch on the client's body. To date, the few studies which have addressed these issues have been very limited in their scope and somewhat inconsistent in their conclusions.

Pattison (1973) divided 20 female college students into four groups. One male and one female counsellor each followed a touch procedure with five clients and a no-touch procedure with another five clients during initial intake interviews. This study found that the use of touch was significantly related to client self-exploration, although touch did not significantly alter the clients' perception of the conselling relationship. Comments of clients who were touched, however, "indicated that there was some kind of meaningful impact on the client in terms of rapport building. Counselors reported feeling a closer rapport with clients whom they touched" (p. 173).

Alagna, Whitcher, Fisher, & Weiss (1979) constructed a study (N=108) to evaluate the interaction of touch with the sex of the client as well as the sex of the counsellor. This study was "the first to show that touch between counselor and client is positively related to the client's attitude toward the counseling experience" (p. 470). While clients of both sexes responded positively to touch, the strongest positive effect occurred between opposite sex pairs of counsellors and clients. A further study done by Stockwell and Dye (1980) used an experimental design (N=108) in a natural counselling setting to evaluate the effects of touch by the counsellor on the clients' level of self-exploration as well as their evaluation of the counselling. Stockwell and Dye did not find that counsellor touch had a significant effect, a finding at odds with the studies done by Pattison and Alagna, et al. A study on the use of touch in psychotherapy done by Hubble, Noble, & Robinson (1981) concluded that "the counsellor's use of touch significantly affected the client's perceptions of the counsellor's expertness" (p. 535). Clients who were touched viewed the consellor as possessing more expertise than did clients who were not touched.

It is clear that much more research on the effects of touching between therapists and clients needs to be done. Clinical experience points to the efficacy of touch used appropriately in the therapeutic relationship. Further research can help delineate what factors make for positively and negatively perceived touching. Body therapists must use great sensitivity in their touching of clients, bearing in mind the cultural and ethnic differences around the use of touch, as well any

other factors which affect how touch is perceived by the client.

C. THE PLACEBO EFFECT

Given that the various body therapies, based on differing assumptions and utilizing varying therapeutic processes, all claim positive results in working with clients, it would be useful to know what common active ingredients in these therapies produce the desireable outcomes. This same question can be raised regarding the vast armamentarium of techniques and interventions that have been employed by the medical and psychotherapeutic establishments over the years as part of the science and art of healing. One issue which has a bearing on all therapeutic outcome is that of the placebo effect.

A placebo may be described as "any treatment (or any part of a treatment) which does not have a specific action on the patient's symptoms or disease but which nonetheless may have an effect on the patient" (Benson, 1979, p. 58). The placebo effect is therefore the changes in the patient, symptoms, or disease produced by the placebo. Such an effect may or may not occur and may be beneficial or harmful.

Although at various points throughout history the placebo was the most doctors were able to offer their patients, the medical establishment at present generally disdains the placebo effect (Benson & Epstein, 1975). This disdain arose out of controlled drug investigations in the 1950s. While these studies recognized the power of the placebo and established controls for it, they usually did not analyse the placebo itself as a therapeutic intervention, since

nontreatment controls were not used. The remarkable benefits of the placebo effect were simply ignored.

The power of the placebo has tended to be dismissed or ignored over the years. As O'Connell (1983) states, "although the placebo's power has been persistently at work for thousands of years, its remarkable properties have been relegated to a marginal status: it has been variously regarded with amusement, annoyance, incredulity, or indifference. Few have been mystified or intrigued by it; even fewer have divined its theoretical significance" (p. 337). Pelletier (1977) argues that the disdain for placebo effects in traditional medical practise is not justified because "the existence of curative placebo effects is well substantiated in the treatment of a wide variety of diseases ranging form hay fever to rheumatoid arthritis" (p. 14).

Present research has shown the placebo effect to be extremely powerful. O'Connelly (1983) claims that "it is the basis for nearly all healing in Western or non-Western medicine and psychotherapy" (p. 337). Shapiro and Morris (1978), in their definitive scholarly review of the subject, agree that most drugs and treatments are essentially useless, and that medical history is primarily the history of the placebo effect. Furthermore, in regard to psychologically oriented therapies, they openly propose that "the placebo effect is an important component and perhaps the entire basis for the existence, popularity, and effectiveness of numerous methods of psychotherapy. . . . The placebo effect may have greater implications for psychotherapy than any other form of treatment because both psychotherapy and placebo effect function primarily through psychological mechanisms" (p. 369). Were

such an assertion widely recognized as valid, most aspects of medical and psychological theory and practise would be revolutionized.

It has been recognized in the practise of medicine that a number of conditions affect the power of the placebo. Physicians or "healers" have an enormous influence on the effectiveness of the treatment as a result of their belief systems, expectations, and methods of communication with their patients. Those who are attentive to their patients and communicate an enthusiastic belief in the efficacy of the treatment they prescribe produce the most positive placebo effects (Lesse, 1964). The psychological condition of patients also influences their response to both active drugs and placebos. "The higher the level of patient concern and the greater the discomfort, the more likely relief from a placebo will occur. Moreover, patients' expectations and conviction in the efficacy of the method of treatment exert strong influences on the amount of relief afforded by a placebo" (Benson & Epstein, 1975, p. 1226). The treatment mileau also affects the response of the client to therapy. While both physician and patient contribute to the placebo effect, it is likely that their relationship is the most important variable (Fish, 1973; Shapiro, A., 1961, 1970). The placebo effect is not merely the result of taking an inert medication but is a part of the entire doctor-patient interaction. "There can be no doubt that the placebo derives its power from the vast potential of the emotional relationship between the omnipotent physician and the needs of the patient" (Fischer & Dlin, 1956, p. 505). If the patient does not respond well to the relationship with the physician, the placebo effect may produce

negative results.

Several developments have led to an examination of the relevance of the placebo in psychotherapy. The first of these was the medical discovery that under desireable conditions chemically inert substances could produce positive changes. The second discovery was that welcomed psychological change could result from ritualistic procedures enacted under suitable conditions. The third realization was that "the act of psychotherapy, per se, under suitable conditions and in appropriate contexts, is itself a placebo which eventuates in therapeutic change according to the same principles and logic as those changes engendered by the purely physical placebos" (O'Connelly, 1983, p. 338).

It can be argued that psychotherapy is a placebo because it possesses all the characteristics of placebo induced change. The power of the placebo is not in the healer, the client, the pill, or the procedure, but "in an unusual relationship and a specific kind of information exchange between a healer and a sufferer, contextualized therapeutically" (O'Connelly, 1983, p. 339). Change occurs in psychotherapy by virtue of the client's optimism and faith in the healer's methods and by the prescribed intervention which is congruent with the expectations of the client" (Benson, 1979; Fish, 1973).

The rather startling implication of seeing psychotherapy (or body therapy) as a ritual utilizing the placebo effect, is that

> any intervention will get results as long as the qualities of faith, hope, and therapist competence, including Roger's necessary and sufficient conditions, are present. Change is accordingly not dependent on true theories or even established psychological

> knowledge, assuming these are possible. It is dependent only upon belief in methods, and a shared acceptance of the framework on which they rest. . . . Effectiveness is constant across all psychotherapies: each evokes the placebo effect under the correct conditions" (O'Connelly, 1983, pp. 339-340).

Thus, it becomes important for the therapist to determine which treatment modality will produce the appropriate and optimal stimulus for each patient (Shapiro & Morris, 1978). For example, some people may react best to drug stimulus, while others may require the stimulus of body therapy.

O'Connelly (1983) has suggested an eight stage process which can be used to maximize the effects of the placebo. The first step is to contexualize. Staging is an important part of therapeutic power. In body therapy this could involve the particular setting used, the special clothes required, the specialized language, and the appropriate fees. The second step is to humanize. The power of any placebo is greatly enhanced by the warm, empathic, unconditional type of relationship described by Rogers (1957). Such a relationship is rewarding to the client and makes likely the emergence of trust and confidence. The third step is to optimize. This involves maximizing the effect of the placebo strategy by first eliminating all other possibilities for a cure. The fourth step is to temporize. This tactic involves a promise of treatment only after other, covertly therapeutic, tasks are performed. If clients improve as a result of doing the preliminary tasks, they can be told that they did it on their own. If there is no improvement, hope and expectancy in the promised

treatment is intensified. The fifth step is to symbolize. The healer and the client must share a common symbolic framework. For example, the voodoo rituals of a Haitian witchdoctor would not be appropriate for a Canadian businessman. The sixth step is to re-cognize. Cognitive labels and beliefs condition behavior. The effects of the placebo can be partially explained by the transformation of such labels and beliefs in therapy. The seventh step is to ritualize. Ceremony and ritual enhance the potency of the placebo by building the motivation, expectations, or confidence of the client. For example, part of the ritual of Spontaneous Body Experiencing as a group experience involves changing clothes, lowering the lights, lying down, and being touched. The eighth step is to prescribe. Because it is the treatment which is primarily responsible for the placebo effect, the treatment must be clearly labeled and presented as such. In body therapies the treatment could be catharsis, focusing, "centering", becoming grounded, primaling, and so forth. What precisely is prescribed is not as important as the prescription itself.

Instead of trying to avoid or explain away the effects of the placebo, body therapy, like any other therapy, can attempt to maximize the use of placebo principles. Given that body therapy accepts the unity of body-mind, there should be no conflict in utilizing the impact of a placebo on a person's cognition and affect in order to facilitate behavioral or intrapsychic change. Furthermore, the evidence about the power of the placebo suggests that all healing is essentially self-healing: "As the placebo effect so vividly demonstrates to us, changing our expectations or fundamental assumptions can profoundly

affect our experience of health and well-being. Healing comes as a direct result of perceiving ourselves as a whole" (Ingrasci, quoted by Ferguson, 1980, pp. 249-250). Ideally, the body therapies can help people exchange belief in the power of the pills or the techniques to belief in the healing powers which lie within, as it is these powers that the placebo effect taps. "The billions of dollars spent for impotent over-the-counter remedies, for painkillers and tranquilizers, and for solace from physicians can be saved by a medical system which restores faith and hope not in drugs and physicians, but in each individual and his body" (Jaffe, 1980, p. 63). The goal in maximizing the power of the placebo is to release blocks to change so that the client can become free, creative, and autonomous. When clients assume responsibility for their behavior, they no longer need to be held captive by their symptoms, and can dispense with body therapy (or psychotherapy) as a placebo no longer needed.

D. INDICATIONS AND LIMITATIONS

While the body therapies may be conducted in a variety of settings with a diversity of clients, they do have their limitations. The different therapies vary in the kind of setting they demand and the type of problems with which they are effective. Some therapies, like Focusing or the Alexander technique, could be used with practically everyone. Others, like Primal therapy and Bioenergetics, demand greater caution around their use. This section discusses the cautions and limitations as well as the types of clients and settings best

suited to body therapy.

The clients

At the outset it should be made clear that body therapies are not a panacea. They need to be used with the same professional knowledge and caution necessary for the effective use of any other type of therapy. It must also be emphasized that "no technique is therapeutic in itself. No response to a therapeutic intervention is therapeutic in itself either, unless it occurs in a setting of expectance and understanding and can be integrated into the patient's view of himself and the world" (Bellis, 1976, p. 137). Body therapies are extremely powerful and can be used to quickly penetrate the innermost core of a person. Like the scalpel which is deadly when clumsily or ignorantly wielded, so body therapy techniques can also be destructive if not applied with care. Techniques are limited by the compassion, empathy, and understanding with which they are used.

Body therapy, above all, must operate in the context of a deep respect for the client consistent with the humanistic belief in client self-determination and self-responsibility. It is the contention of this writer that even though people obstensibly come to therapy for the purpose of facilitating a change process, they have the right to not change and to not accept the therapist's prescription for change. Therapy must be a voluntary collaborative process conducted with the informed consent of the client.

People who seek body therapy, usually do so because of some specific symptom or felt need. To engage in therapy, of whatever kind,

tends to make a person feel vulnerable due to fear of the unknown, fear of change, and fear of facing the known or unknown "ghosts" within. This vulnerability needs to be acknowledged and respected, as people's fears and resistances are there for a good reason. To forcefully batter these resistances down may produce spectacular "breakthroughs" which "may be paid for later by increased resistance, severe anxiety, or in some cases even psychotic breakdown" (Hoff, 1978, p. 210). Brownell (1981) uses the apt analogy of a seed whose shell comprises a hard protective armor around the fragile embryo of life inside. Breaking the seed open and leaving the contents exposed to the elements is certain death to the inner life of the seed. But if the seed is planted in warm, moist earth, the shell softens naturally, falls apart, and the seedling emerges. As it roots itself in the earth, it can push itself up into the air and become interdependent with the environment.

It must be remembered that body therapy involves a process which needs to be done gradually, one step at a time, according to the openess of the client and the discretion of the therapist. Even Janov (1975b), who uses Primal therapy in an attempt to rid people of all their defenses, cautions that this must be done slowly and methodically. To force people to open up faster than they are ready to may be disintegrating to the person. "What is disintegrating is to be overloaded with feelings so that they cannot be fully experienced" (Janov, 1975b, p. 429). This may result in undue fear or hostility, a fixation on the therapist, or nightmares. For this not to happen, the therapist must create an ambience of safety in the therapeutic setting and be sensitive to the degree of pressure on a client which is helpful

without being counterproductive.

People come to therapy with their own ideas about how they wish to be helped. "They also bring an aesthetic sense of what is relevant and tasteful for them, and a set of values about what is appropriate" (Bellis, 1981, p. 24). The therapist needs to respect these values and bring help to clients within their frames of reference, if that is at all feasible.

Age and stage in life are also factors in the appropriateness of body therapy. Therapies which mostly involve changing external body movements, such as the Alexander technique or Feldenkrais method, or manipulating muscles, such as Structural Integration, are likely suitable for almost anyone because they do not involve actively breaching a person's ego boundaries or defenses. Therapies which penetrate the depths of personality, such as Spontaneous Body Experiencing or Reichian therapy, need to be used with greater caution. Children should not be subject to such therapies, while they may be used with caution on some adolescents (Rosen, 1977). Bellis (1981) comments that "no children or adolescents have the experience to see that their own character is getting in their way" (p. 24). If therapy is undertaken with adolescents, it needs to be done within a recognition of the family context of the client. Furthermore, given that adolescents are in the developmental process of individuating themselves from their parents, and their ego identities are not strongly formed, to have them engage in therapy which involves fundamental changes to the personality may exacerbate the already confusing issues with which they are grappling. The aged may also

experience limitations around body therapy. They may come looking for relief of psychological pain but may not have the desire to face the deep tragedies of their lives. "It may be cruel at times to challenge patients to face realities which they cannot change; I think it is the duty of the therapist to help such patients to find meaning in their lives, rather than to focus primarily on their failures" (Bellis, 1980, p. 24).

The setting

Those who use body therapies, especially the therapies which make use of catharsis, need to engage in them in an appropriate setting. Clients, as well as therapists, will likely feel self-conscious and inhibited if they are not assured of privacy when they cathart. A scream which comes from the depths of a person is penetrating and may be unnerving to those outside the office who hear it. Thus, if the therapy involves a lot of noise and activity, adequate soundproofing and privacy is necessary. Also, because clients sometimes work in a state of semi-dress, they need to be able to do this without embarrassment or awkwardness.

When work is done in a group or institutional setting, the therapist must be cognizant of the contextual realities. A body therapy group can generate an enormous amount of energy. It is hazardous to release this energy in a setting which does not have the resilience to absorb it. The decibel level of a group in which many people are experiencing catharsis simultaneously is not to be underestimated. While the clients may be comfortable with this, anyone

who overhears it may be anxiety filled. If this occurs within an institutional context, a negative reaction to the practise of the therapy may occur.

Indications for body therapy

It is conceivable that the Alexander technique, the Feldenkrais method, Structural Integration, Focusing, and Polarity therapy could be used in a wide variety of settings with almost any kind of client. While these therapies may be effective for various ailments, they are not strongly symptom oriented. They approach the body as a whole, believing that the symptoms will disappear if the entire body functions harmoniously. These five therapies are relatively gentle in their approach, and do not aim for deep personality change, although that could be a by-product of the therapies. Reichian therapy, Bioenergetics, Primal therapy, and Spontaneous Body Experiencing fall into a different category. They all involve the use of techniques which probe the depths of a person in an effort to flush out the underlying blocks which are hindering a person's growth. Because of this, it is appropriate to attempt to distinguish the type of clients best suited to this therapeutic approach. Unfortunately, little has been written on this aspect of these therapies.

Body therapy can be an effective approach for people who have difficulty expressing their emotions. While verbal therapy can be used to help a person express emotion, "a client's characterological attitude and the bodily expression of that attitude fend off many verbal techniques" (Brownell, 1981, p. 253). Furthermore, verbal

techniques presuppose that a person has a conscious memory of past events. Emotions and experiences never expressed during the preverbal and prememory stage of a child's or infant's life cannot be touched through verbal therapy, with the exception of hypnotherapy. These events, which may have profoundly affected a person's life, can be made accessible through the use of body therapy.

In discussing who is a suitable candidate for Bioenergetic therapy, Bellis (1980) advises that "any somatic complaint or failure of body function or any psychological complaint that can be related to the body in a way that has meaning to the patient is usually a sufficient entree to Bioenergetics" (p. 22). Such a criterion would also hold for the other body therapies. More specifically, Bellis claims that Bioenergetics is effective for persons with psychosomatic problems, gastrointestinal disorders, hypertension, chronic back tension, visual problems, skin disorders, depression, and schizoid characters, provided one is prepared to enter into a long relationship with them. Rosen (1977) reports that, in his experience with Primal therapy, it has been most effective when the major symptom has been anxiety or depression, including suicidal depression. Although primal therapy does not focus on psychosomatic symptoms, it is reported to often result in a decrease in gastrointenstinal symptoms, colds, headaches, epileptic attacks, and asthma.

Limitations and cautions

Bellis (1980) cautions that Bioenergetics is not equally useful for everyone. Clients who have specific phobias are better treated

through systematic desensitization while obese persons are better treated in the context of a group. Sexual disorders may require the use of marital therapy.

There are differing opinions about using a body therapy approach to treat persons who fall into such diagnostic categories as clinical depression, schizophrenia, psychosis, or borderline personality disorder. Rosen (1977) reports that Primal therapy is of dubious merit for borderline personalities. Reich, however, was willing to treat psychotics, but warned that great care needed to be taken in treating schizophrenics. He cautioned that, while "they are amenable to treatment involving catharsis of deep layers of emotion . . . the potential for harm exists if the therapist does not provide necessary control" (Nicols & Zax, 1977). Bellis (1980) contends that, although an acute schizophrenic reaction can sometimes be managed if the therapist and client have a strong relationship, at other times hospitalization or medication may first be required. He further suggests that in working with borderline personalities, care needs to be taken not to overload the client by allowing too much feeling too soon, as this "will only reactivate regressive adaptations and acting-out" (p. 24). Baker (1967) advises that people should be excluded from Reichian therapy if they lack the ability to resynthesize their defenses after they have been penetrated in therapy. Body therapy becomes hazardous when the limits of the social setting, the patient, or the therapist are exceeded. For example, a person with a coronary condition should not be overly agitated or heart failure may occur. Body therapy must not be done in isolation from other

disciplines. Therapists need to be willing to work collaboratively with other health professionals, refer when necessary, and seek guidance from outside of themselves as required.

For the protection of the therapist as well as the client, screening of clients prior to therapy is strongly recommended. A checklist can be given to prospective clients so that they can indicate what type of physical or psychological problems they may be having, and what issues they wish to explore during therapy. It may be advisable to require a physical medical examination prior to doing body therapy.

Therapists may also elect to have clients sign a legal waiver absolving the therapist of liability in the event that injury or ill effects accrue to the client as a result of the therapy. Other professionals, such as medical doctors and nurses, who work directly with people's bodies have extensive training and operate under clear ethical quidelines. Because body therapists have no licensing requirements which must be met and have no restrictions on their practise, apart from the restrictions specific therapies may impose, they must set their own standards. Body therapists, who may be working as private practitioners, must ensure that they adhere to acceptable professional standards.

Respect for body tissues and for people is paramount in conducting body therapy. Therapists should maximize their knowledge of anatomy, physiology, and pathology so that they know the limits of body tissues and know how to recognize physical danger signals. In terms of respect for people, therapists must not zealously coerce someone into therapy, and must not raise false hopes.

E. THE BODY THERAPIST

In any therapy the personality and skills of the therapist are a significant factor in the therapeutic outcome. In body therapy, the therapist is possibly in a more critical position than in verbal therapies because of the close body contact that is involved. Such contact penetrates the social and psychological boundaries, moving into a person's intimate physical space.

In doing body therapy, a number of personal qualities are desireable for therapists. One of the foremost qualities needed by a therapist in conducting body therapy is self-knowledge. Therapists must come to know and accept their own humanity. According to Pelletier (1980) this means a therapist needs "to become acquainted with his own emotional nature, his personality conflicts, his strengths and weaknesses, and generally to engage in a process of self-exploration" (p. 432). This process is critical because therapists cannot lead clients down the path of self-knowledge any farther than they have been themselves. Unless therapists have experienced and acknowledged their own complex mix of tensions and emotions, they will not be well aware of them in the clients and will thus be limited in their therapy (Chaiklin & Chaiklin, 1982). Bellis (1976) strongly emphasizes this when he writes that "if the therapist . . . has not felt in himself and come to possess his own incestual feelings, his homosexual feelings, his murderous rage, his fear, his terror, his horror, he is to that extent limited in his ability, no matter what technique or method he uses in dealing with his patients" (p. 150). Therapists may be able to work cognitively with patients

without having worked through their own powerful feelings around sexuality or rage, for example. It becomes much more difficult, however, for a body therapist to work intimately with a client using expressive techniques without being personally self-aware and self-possessed. "A therapist has to know himself, to be in touch with himself before he can be in touch with his patient" (Lowen, 1975, p. 93).

The danger in therapists having serious unresolved feelings of their own is that countertransference may develop and contaminate the therapy. Countertransference has to do with the roles therapists unconsciously play and the illusions they hold about themselves which are not to be challenged or shattered by the client (Lowen, 1967). For example, if a male therapist encounters a whiny self-pitying martyr-like woman who reminds him of his mother, and he still has unresolved feelings of anger towards his mother, the client will become part of the therapist's problem with his mother. Or "if a therapist was made to feel stupid at home, then when his patient challenges his intelligence, the therapist may come down on the patient, be defensive and not allow the patient an aggressive act so necessary for his health. In short, the therapist may treat the patient just as his father and mother did, reinforcing the neurosis" (Janov, 1975b, p. 425). Lowen (1967) underscores Janov's statement when he proposes that "to whatever degree this countertransference exists, it will constitute an obstacle to the patient's recovery" (p. 251).

In order for therapists to know themselves, and therefore to know others, they need to engage in an on-going process of self-exploration

through self-therapy. This may be accomplished through "such disciplines as meditation, centering, psychotherapy, self-review, or review and discussion with consultants and colleagues, and with reading" (Paul, 1973, p. 44). The journey of self-discovery is never complete and there is no land of promise where one eventually arrives. Because pain and hardship are part of the journey, it is advisable to obtain a guide who can lend support and direction when the going gets rough. When one is a client, one can better identify with one's own clients.

Body therapists need to be far enough advanced in their own journey of self-discovery to have a solid sense of self. Lowen (1975) picturesquely states that the therapist must be "sufficiently grounded in the reality of his own being so he can serve as an anchorage for his client when the waters get choppy" (p. 106). Therapists must be "real" people, that is, people who do not hide behind roles, but who reveal their humanity to the client. "What a therapist offers . . . is the reality of his own being and his own existence, an existence broad enough to comprehend the confusion and anxiety of the patient without sharing it. The patient's assurance of help lies in the therapist's dedication to truth, the truth of his own personal being, the truth of the patient's struggle, and the truth of the body" (Lowen, 1967, pp. 250-251). Therapists can help clients discover the truth of their bodies, that is, to become aware of their bodily expressions and attitudes, only if therapists know the truth of their own bodies.

Besides a solid sense of self, a commitment to the truth of the body, and a quest for self-knowledge, body therapists require many

other personal qualities. Courage and sensitivity are needed to guide people deeper into experiencing their pain. Strength and determination are required to not abort the process by rescuing clients in a premature attempt to make them feel better. Faith and trust in the "wisdom of the body" is needed as well as the expertise to intervene and guide the process when necessary. Enthusiasm, self-confidence, and a willingness to become intensely involved with clients is essential (Ellerbroek, 1973). Humility in the face of one's limitations is paramount. Daring and risk in adapting the particular forms of therapy to each person is important. Kurtz and Prestera (1976) remind therapists that

> a person's patterns always contain pain and fear. They are intimate, and the embodiments of much suffering. Skill is required and compassion is essential if one is going to make contact with them and help dissolve them. A long time in the making, they do not yield easily. Force does not work, but tenderness, respect, loving understanding, and a commitment to be honest will often be enough. Strength and courage are needed to break free (p. 11).

Given that body work is often very emotionally intense, therapists must learn how to be emotionally present with clients without being emotionally drained by them (Lanza, 1983). Therapists must also be able to meet their own personal needs outside of their work with their clients.

Body therapists must be able to create a therapeutic atmosphere. This includes "the ambience, space and soundproofing of the room, and,

most important, the demeanor, skill and confidence of the person of the therapist" (Leland, 1976, p. 217). It is the responsibility of the therapist to maximize the sense of safety and confidence clients may feel in his or her presence.

Persons doing body therapy need to be thoroughly grounded in the theories of body work. They need to maximize their skills through whatever training is available and must have personal experience with the therapy they conduct. They must also operate within an ethical framework such as that established by the National Association of Social Workers in their code of ethics (Lemmon, 1983).

Therapists who do body therapy in groups have additional responsibilities due to the nature of a group. A group can be used very powerfully to convey acceptance, nurturing, and affirmation to its members. A group can also be destructive when there is, among other things, scapegoating, inappropriate reassurance, favoritism or tyrannizing by the leader, or inappropriate self-disclosure. Paul (1973) has outlined a number of responsibilities a therapist needs to assume when leading a group in order to keep it constructive. The therapist must respect, and have the group respect, the right of a group member to remain silent, to deviate from the beliefs of the majority, or to set limits on his or her self-disclosure. The leader must not attempt to persuade or intimidate people to change or adopt the leader's values. People need to be given the freedom, within broad parameters, to seek and establish their own values. At the same time, the leader must avoid exploitive actions by himself or herself or by the group. Group members must not be allowed to be physically or

emotionally destructive to each other under the guise of individual freedom. The leader should encourage that which promotes growth, seeing the potential for growth and transcendence in each person. "He [the leader] values highly the search into oneself; the struggles to recognize and inwardly experience one's emotions in their full range; the risk of disclosing one's thoughts, feelings and impulses; and the opportunities for bridging the distance to the Other, with its chances of mutually enhancing outcomes" (Paul, 1973, pp. 45-46). Furthermore, the leader does not do for people what they can do for themselves.

Brownell (1981) exaggerates slightly when he describes the body work therapist as requiring "the heart of a Schweitzer, the brain of an Einstein, the courage of a Columbus, and the wisdom of a Solomon" (p. 255). Somewhat more realistically, he concludes that

> bodywork is not for the beginning therapist, the faint of heart, the technician, nor the collector of gimmicks to 'open up a person' or to 'break down defenses'. It is for the well-trained, seasoned, cautious, but risking professional who has a great deal of self-confidence and faith and yet one who knows when and where to obtain supervision or consultation" (p. 255).

CHAPTER FOUR

BODY THERAPY AND SOCIAL WORK

This chapter examines some of the factors which mitigate for and against the inclusion of body therapy as one of the theoretical and practise models utilized by the social work profession.

A. FACTORS SUGGESTING INCLUSION

Social work is clearly compatible with the body therapies in a number of major areas. It can be argued that the body therapy model could logically mesh with the theoretical orientations, practise models, knowledge bases, and values of social work.

The definition of social work

Perhaps the logical place to start in examining the relationship between body therapy and social work is with the definition of social work. However, starting here is fraught with uncertainty because social work is notoriously difficult to define. In fact, Mishne (1982) declares that "there is no universally accepted definition of social work that clearly establishes what it does as contrasted with the other helping professions" (p. 553). Furthermore, Gilbert (1971) proposes that the unifying theme of the profession is its "continuing search for a distinctive, unifying, and ever-illusive identity" (p. 401). The result of social work's "amoebalike tendencies in reference to

definition, boundaries, and consequences [is] that social workers . . . must map out their directions and terrain with an unsteady hand and a clouded eye" (Simon, 1977, p. 394).

Although no universally accepted definitions of social work exist, many attempts have been made to define the profession. The O'Hare conference on conceptual frameworks proposed that the purpose of social work is "to promote or restore a mutually beneficial interaction between individuals and society in order to improve the quality of life for everyone" (Brieland, 1981, p. 79). Such a definition is extremely broad and could embrace many kinds of therapeutic modalities. Clinical social work is the specialization of social work under which body therapies could be subsumed. A clinical social worker has been defined by the Board of the National Association of Social Workers' Register of Clinical Social Workers as a person who is "by education and experience, professionally qualified at the autonomous practise level to provide direct, diagnostic, preventive, developmental, supportive and rehabilitative services to individuals, families, and/or groups whose functioning is threatened or affected by social and psychological stress or health impairment" (Meyer, 1983b, p. 31). This definition, although more clearly focused than the previous one, is also broad and could include a considerable scope of interventions. Body therapies can easily be included in the practise of social work according to this definition, for they directly provide preventive, supportive, and rehabilitative services to people whose social and psychological health is stressed or impaired.

Values

There is a strong similarity between the values of humanistic philosophy, social work and body therapy. "The most basic tenet of humanism is that man is free to choose and that therapy should be directed toward enhancing that freedom and encouraging personal responsibility" (Noble, 1977, p. 182). Humanism also affirms the uniqueness and importance of human life. "It stands for respect for the worth of persons, respect for differences of approach, open-mindedness as to acceptable methods, and interest in exploration of new aspects of human behavior" (Sutich, quoted by Lasater, 1979, p. 311). Humanism views people as being more than a sum of their parts. It is argued that "not only is it impossible to understand men by examining them in bits and pieces, it is equally impossible to understand them apart from the contexts in which they choose to live their lives" (Noble, 1977, p. 168). Humanistic philosophy sees people as having a positive potential for growth and wholeness. It is assumed that people are born with an innately good, positive, self-actualizing nature. Self-destructiveness occurs when this inborn organismic valuing process is rejected as a result of people falsifying their own values in order to accept the values, experiences, and beliefs of others. Conversely, to be healthy involves uncovering that self-actualizing nature, "to move away from the facades, oughts, pleasing others, and to move toward self-direction--being more autonomous, increasingly trusting and valuing the process which is himself" (Rogers, 1961, p. 168). Such a view of health and illness means that people must take responsibility for their own states of

health and illness.

For the purpose of comparison, it is interesting to list the fundamental values undergirding social work. Strean (1978) identifies the six values most commonly mentioned in the social work literature as the following:

1. Belief in the dignity and worth of the human being regardless of his or her social, psychological, intellectual, or political orientation, sex, race, or age.
2. Belief in the human being's ability to grow and change toward social and personal ideals related to a liberal-humanistic concept of human betterment.
3. Client self-determination.
4. Acceptance of each client and client-system as unique.
5. Helping others develop or recover the capacity for self-help.
6. Client participation--the human potential is always taken as a given by the social worker, and therefore he accepts the client as an interacting partner in a professional relationship that will psychosocially enhance him (pp. 30-32).

It is clear that all of these values articulated by the social work profession are in harmony with the humanistic perspective.

Social work has reflected humanistic concerns throughout its history. "It is humanistic in its commitment to the welfare to the client, its concern with client participation and decision making in the process, its regard for the client as a whole person, and its commitment to the protection of his rights" (Northen, 1982, p. 29). Siporin (1980) observes that "the humanistic values of equality,

democracy, justice, altruism, social responsibility, and mutual aid . . . are publicly and ritually professed by the social work profession" (p. 521).

The humanistic value base which permeates much of social work practise is also strongly reflected in the values on which the body therapies are founded. The body therapies all agree that people are more than the sum of their parts and that they are indivisible totalities. Such a view is basic to humanism and is increasingly being reflected in social work beliefs, notably in the application of ecological theory to social work practise. Fundamental to humanism, social work, and body therapy is the belief that a person is comprised of a unique and complex interrelationship of many parts which make up a whole, and that this whole person is to esteemed, valued, and assumed to be able to take responsibility for his or her own choices. Both social work and body therapy share in the humanistic assumptions that people are intrinsically good and have the capacity for change and growth. The growth process is seen as resulting from a mutual interaction between the helper and helpee. Thus, it can be seen that body therapy and social work both are strongly anchored on a humanistic value base and are therefore compatible with each other at that level.

The diversity of social work

Another reason why body therapy could be accepted by social work has to do with the diverse nature of the profession. Unlike other professions, such as medicine or law, social work did not evolve from a coherent purpose. "Casework, from which the preponderant social work

methodology derived, evolved from voluntarism, philanthropy, and agency-based apprenticeship. Its ideological roots were in religous, charitable, and essentially sentimental views of services, expectations of client behavior, and problem definitions" (Meyer, 1983a, p. 6). The diversity of the roots of social work has resulted in a profession which embraces many theoretical and practise models. While this can be a very positive and enriching characteristic which could facilitate the inclusion of body therapy under the overarching umbrella of social work, it also creates difficulty when it comes to providing a sense of coherence to the profession.

Social work encompasses a broad and varied knowledge base. In the absence of an integrative theory of people in relationship with their environments to serve as a base on which to anchor themselves, social workers have adopted many theories or portions of theories from disparate frameworks (Billups, 1984). For example, psychoanalytic theory, ego psychology, role theory, cognitive and learning theories, and communication theory are all part of the knowledge base used by social workers. This plethora of theories has resulted in some social workers choosing and following one particular theoretical orientation, with others adopting an "eclecticism that embodies a smorgasboard of seemingly unrelated concepts" (Goldstein, 1980, p. 174). Thus, while the precedent has been established for the inclusion of many theoretical orientations into social work practise, the danger is that body therapy could be added to a conglomerate of theories with little attempt made to integrate it into a broader framework.

Whatever knowledge base social workers choose to adopt, it is

clear that their need for knowledge is immense and growing. As social workers become involved in increasingly diverse settings, such as industry, politics, health care, the courts, and private practise, new knowledge is constantly required. "Behavioral, economic, sociological, organizational, physiological, and other utilitarian knowledge for social workers has expanded geometrically" (Alexander, 1977, p. 407). Goldstein (1980) explicates the wide scope of knowledge demanded when she writes that "it becomes necessary for each practitioner to be expert in understanding individuals, their environment, the surrounding society, and transactions that take place between people and environments. One might well ask, what else is there?" (p. 173). Whether or not the social worker practises body therapy, an understanding of its assumptions and theoretical orientation to people in their environments is an area of knowledge which can enrich social work analysis.

Ecological systems theory

Finding a common definition and conceptual framework by which to integrate all the diversity which is called social work has been a major and seemingly insurmountable task. However, because knowledge in and of itself is of limited utility unless it can be conceptualized as part of a unifying theoretical framework and because the drive for synthesis appears to be an innate human need, there have been many theoretical and practise models proposed and utilized by social workers over the years. Meyer (1983b) observes that the process of building practise models has "evolved without plan since 1917, building

accidentally upon experience and knowledge" (p. 734). Although many models have emerged and over one dozen practise models are presently being used, Meyer (1983a) is not optimistic that attempts to link the models will be successful.

> It becomes quite obvious that when traditional casework, group work, community organization, and family treatment methods and social reform efforts are placed alongside each other, each with methodology derived from different knowledge bases and purposes evolving out of different contexts and perspectives, any effort to join them at their foundation would be futile (p. 7).

In spite of Meyers' (1983b) pessimism that "a model based upon a holistic theory of (biological, social, and psychological) man and woman will produce the practice principles to carry out the dictates of the theory", she recommends that "the search to develop incremental, interdisciplinary knowledge must continue" (p. 733).

General systems theory, or what is now also called "Ecological Systems Theory", provides social work with one way of theoretically organizing the various facets of the profession. It also offers a means by which to conceptualize how body therapies can be incorporated and utilized within social work practise. Some of the basic assumptions and implications of general systems theory mentioned in the introduction of this thesis will be expanded upon as part of this discussion.

Ecological systems theory, an overarching global theory, has enabled social workers "to gain a larger perspective, a more unitary and comprehensive unit of attention, for a holistic and dynamic

understanding of people and the socio-cultural-physical mileau" (Siporin, 1980, p. 516). Under the umbrella of this theory it is possible to simultaneously understand and interrelate various dimensions and levels of a given case or situation, whether that involves an individual or a community. Shafer (1969) explicates how social work method and process relate to systems theory when he explains the heirarchial levels of systems:

> For the individual, his molecular, cellular, and organ subsystems make up the heirarchy of his biological subsystem. Similarily, his memories, his thought, and the residuals of his experiental life make up his character structure or psychological subsystem. The interrelationship of these two subsystems comprises the total individual and represents his structure which, in turn, influences his behavior or functioning. What evolves from behavior and functioning is the pattern of development and becoming. Thus complex forms develop from simple forms (p. 31).

Because no one theory can adequately account for the complexity of intrapsychic, interpersonal, and social processes which impact on the adequacy of the functioning of a person or group at any point in time, "it is necessary to have a broad perspective that incorporates knowledge about the interrelationships among biological, psychological, and sociocultural influences on individual and group functioning" (Northen, 1982, p. 303). Ecological systems theory provides a needed broad perspective as well as a basic helping approach for the social work profession. It avoids fragmentation by providing a way to organize discrete phenomena into coherent relationships. It enables

social workers to organize knowledge from various disciplines, to note the gaps and inconsistencies in that knowledge, and to generate new hypotheses, all while working with an active case. "It enhances predictive ability while it fosters the utilization of more diverse and creative interventions" (Stein, 1971, p. 157). Under the general rubric of ecological systems theory, specific theories, methods, and techniques as well as specialized helping approaches can be used. Psychodynamic, cognitive, problem-solving, behavioral, and body therapy approaches are among those which could be incorporated.

The concept of person-in-situation is at the core of social work practise (Stein, 1971). The difficulty with this concept is that the connective "in" or "and" denotes a dichotomy, based on the divergent theoretical bases of sociology and psychology, between the person and the (social) situation. Meyer (1976) advocates that, "while keeping both sets of knowledge systems separate and intact, our task is to intertwine the useful person-in-situation concept in such a way that the hyphen is no longer needed" (p. 138). This, she believes, can be accomplished through a systemic view in which "there is no inner or outer, but rather an operational field in which all elements interact and affect each other" (p. 138). Such a perspective is compatible with a body therapy approach which stresses the melding of the divisions of body and mind and a blending of the physical, social, biological, and psychological aspects of human functioning.

The application of systems theory to social work deals with an analysis of causes while avoiding unidirectional cause-effect thinking. Through the concepts of feedback and equifinality it is assumed that

the same initial condition could lead to different results, while different initial conditions could lead to similar results. Taking the focus off trying to find one specific cause for a problem helps to avoid placing blame on any one person. "Such a perspective avoids blaming the victim, and places responsibility on systemic relationships, rather than upon any evil motives of men" (Siporin, 1980, p. 516). The principle of equifinality also means that the same goal can be attained in a variety of ways. This implies that "the therapist can choose from a myriad of possible interventions. The therapist's task is to determine which parts of the system are more accessible to change and thereby establish priorities for intervention" (Grieve, 1983, p. 220). Because intervention at any one point of the client's system generates ripple effects throughout the whole system, change can be engendered by a variety of approaches.

To determine how best to intervene in a given situation requires a process of assessment. "Because an ecological approach to intervention is multi-factorial and is addressed to systemic attributes and intersystem relationships, social workers have been encouraged to develop and utilize a strong and varied repertoire of assessment instruments and helping interventions" (Siporin, 1980, p. 518). This means that problems should not be defined to fit certain methods or techniques, but that the intervention should match the problem. The broader the knowledge base and the wider the strategies, roles, and techniques a social worker possesses, the greater the likelihood that the appropriate resources can be brought to bear on a given problem in a purposeful and planned way. As Siporin (1980) states,

"comprehensive, systemic approaches to programs and cases need social work and interdisciplinary teams with many different kinds of knowledge and skills" (p. 518).

It is interesting to note the increasingly broad focus being brought to the social work assessment process. The Charity Organization Society, which originated in England in the mid-nineteenth century, was the forerunner of the social work profession. This society used the "friendly visitor" to assess the needs of individuals and families to determine whether they were worthy of financial assistance. Attempts were made by the "friendly visitor" to understand the social events which were inducing poverty for the client. In the 1920s, the Social-Settlement Movement provided another setting for social work practise. The focus of this movement was also primarily centered on bringing about social changes at various levels so as to help the poor. In the 1920s, "social work made a rapprochement with Freudian psychoanalysis, and the client's feelings, thoughts, fantasies, and memories became important to the social worker in assessing and intervening in the client's life-space" (Strean, 1978, p. 9). There was an increasing recognition that social problems related to personal and interpersonal problems. By the late 1920s, the basically socio-economic orientation of social work was modified into an approach which could be called "psychosocial". The main principles of the psychosocial approach were delineated in the 1950s and 1960s. Based on a Freudian conceptualization of personality, this approach concerned itself with both the social context and the inner realities of a person (Strean, 1978). Recently, the psychosocial perspective has

been extended and elaborated to include the biological aspects of a person, thus becoming the "biopsychosocial" approach. Such an approach recognizes that "there are interconnections between biological, economic, and social-psychological components of human functioning" (Northen, 1982, p. 26). More specifically stated, "sensitivity to the interactive effects of biological function on the behavior or condition under investigation is always necessary and sometimes critical. . . . When biological dysfunction is in process it is inevitable that psychosocial effects will also be experienced" (Cohen, 1979, p. 27).

Thus, the historical trend in social work has been towards an increasingly broad assessment of the client's situation. The more comprehensive the assessment analysis becomes, the more readily can the orientation being brought by the body therapies be incorporated into the social work assessment process. The emerging emphasis in social work on the biological dimensions of a person in relationship to the social and psychological aspects is compatible with the body therapy emphasis on the body as a reflection of psychological and social forces (Johnson, 1983). Because of this, it can be anticipated that the trend in social work theory could increasingly move towards an acceptance and incorporation of the assumptions of body-mind integration on which the body therapies are based.

Use of the ecological systems theory in social work has other implications for the inclusion of body therapy into social work. Siporin (1980) declares that the systems orientation "encourages the social worker to be theoretically and technically eclectic, in the best sense of the term. This means to take and test the best of the

various schools of therapy . . . as they are consistent with the basic social work value system and conceptual framework and as they are validated through practise experience and research" (pp. 516-517). Given that body therapy can be subsumed under a general definition of social work and is in harmony with its basic values, body therapy could be employed as part of the "eclectic" approach advocated by Siporin. Body therapy could add a new and rich theoretical and practise model to those already commonly used by social workers. It could deepen the quality of the assessment as well as provide tools to intervene at a level so far neglected by social workers. While the depths of the intrapsychic and interpersonal processes have been plumbed by social workers, the actual physical body of the client has rarely been touched.

Ecological systems theory suggests that analysis and intervention can take place at a variety of levels. What is most important is to determine at what level(s) to intervene, and how to do so. For example, a lonely, depressed, tense woman could receive a variety of therapeutic interventions if she chose to see a social worker. A cognitive verbal approach could attempt to uncover the reasons for the depression and try to remove the causal factors through verbal means. A behavioral approach could be employed to reward the woman for engaging in non-depressive behaviors. Or a body therapy approach could use muscle manipulation and catharsis to free the tension and release the emotional blockages causing the depression, providing that the depression resulted from such blockages. The particular approach used would depend on the assessment by the social worker, the knowledge and

skill level of the social worker, as well as the therapeutic setting.

Social work operates at a number of systemic levels, among them the intrapsychic, the interpersonal, and the interfaces between people and their environments. Ecological systems theory, as mentioned, provides a means to conceptualize and organize interventions at these various levels. Body therapy, too, is a multi-leveled theory. The body is seen as a complex interrelationship of tissues, cognition, and emotion. That change in any one part of the body will affect other aspects of the body is assumed. It is also assumed that people's bodies are affected by their physical, emotional, and cultural environments, and that changing the structure and functioning of the body will affect one's environment to some degree (Dychtwald, 1977).

Furthermore, the energy model of the body utilized by body therapies is also compatible with systems theory. Systems theory sees living systems as organized in a heirarchical manner, that is, "they are nested in one another in the same way that a set of Chinese boxes fit inside one another--from the smallest to the largest" (Germain, 1978, p. 537). In like manner, the energy model views energy flow as occurring at many interrelated levels (Mishra, 1981). The cells, organ systems, and different segments of the body all have their own energy dimensions and movements. The energy flow at the level of the body connects as well with the larger energy fields contained in the universe (Tiller, 1974). Energy flow in one area of the body may be affected by the energy blockages in another area of the body. Restoring flow will enhance the whole person. Thus, energy, as a manifestation of living systems, has some of the same characteristics

as the properties of living systems as described by systems theory.

B. FACTORS SUGGESTING EXCLUSION

Although this writer has argued that the body therapies could be integrated into the practise of social work at a number of levels, this has not taken place. In fact, there is little indication that body therapies are being recognized or accepted by the social work profession or that social workers even have any significant knowledge about the body therapy approach. Bilodeau (1979), who perused 3,437 articles from social work periodicals over a period of 10 years, reported finding only three articles on Transactional Analysis, one article on Gestalt therapy, and no articles on Reich, Bioenergetics, or body therapy. This writer's review of the social work literature has corroborated the dearth of material discussing any aspect of body therapy, the impact of humanism, or the influence of the human potential movement on the social work profession. There are a number of possible reasons why this may be so.

Differing models

As has been previously mentioned, a plethora of models of practise based on differing theoretical orientations have been generated within social work over the years. These models can be either viewed as providing a rich choice of diverse interventions, or as comprising a confusing jumble of ill-fitting approaches. This lack of cohesiveness within social work makes it difficult to present a clear analysis of

why body therapy has not been incorporated into social work. While several reasons for this come to mind, such as the conservatism of social work, institutional resistance to new, potentially disruptive approaches, and the traditional lack of body contact between social worker and client, these reasons are only the manifestations of a more fundamental difficulty. This difficulty is a reflection of some basic differences in the model proposed by the body therapies and the models generally employed within social work.

In order to analyze these differing orientations, a broad framework is needed to provide an over-all perspective. While ecological systems theory can provide a unifying theoretical framework, it is limited in that it does not present a unified theory of behavior, and is fairly abstract (Germain, 1978). A more practise based model helpful for the purpose of this analysis has been proposed by Kuypers (1984) in a paper entitled, "Choice in Social Work Practice: Dialogues on Health, Error, and Change". Kuypers proposes that, given the wide eclecticism of social work, the making of choices in regard to models of intervention is central to the profession. The making of these choices is not a neutral or an easy process, particularily so because they are made subjectively without the direction of an external and/or universal frame of reference. According to Kuypers, whether or not practitioners are aware of it, their choices in practise relate in some way to three distinct areas of theory having to do with health, error, and change. To explicate the assumptions underlying the choices makes it possible to make more knowledgeable choices and to expand one's repertoire of choices. It also enables one to weigh the theoretical

models in terms of the emphasis they place on the areas of health, error, and change.

The model outlined by Kuypers (1984) is divided into the three quadrants of health, error, and change (see Figure IV). Health has to do with what is seen as the ideal state of being. Depending on the model followed, it may be stated in terms of global human potential, such as in humanism, or as more discrete, limited goals, as in behaviorism. However health is conceptualized, it has a strong impact on how problems and goals are defined. The error quadrant involves an explanation of why there is an absence of health. Error may be seen as resulting from many sources, such as faulty learning or energy blockages. In the change quadrant, the focus is on how change will transpire, whether by establishing the appropriate conditions so that the changes can occur naturally, or by engaging in forceful interventions.

"When all theory domains are present, problem definition may be grounded by universal conceptions of health and by specific considerations of context and history, goals may be focused on processes which promote and maintain error, and interventions may serve to influence these processes" (Kuypers, 1984, p. 6). Most theoretical and practise models, however, do not equally emphasis the areas of change, error, and health. In some theories one area is dominant while the other areas are given little consideration. Other theories stress two of the areas, while only weakly considering the third. When a theory does not contain a balanced emphasis of the three major areas, there are six possible combinations of emphasis which may result.

This illustration is used with the permission of Dr. Joe Kuypers, 1984.

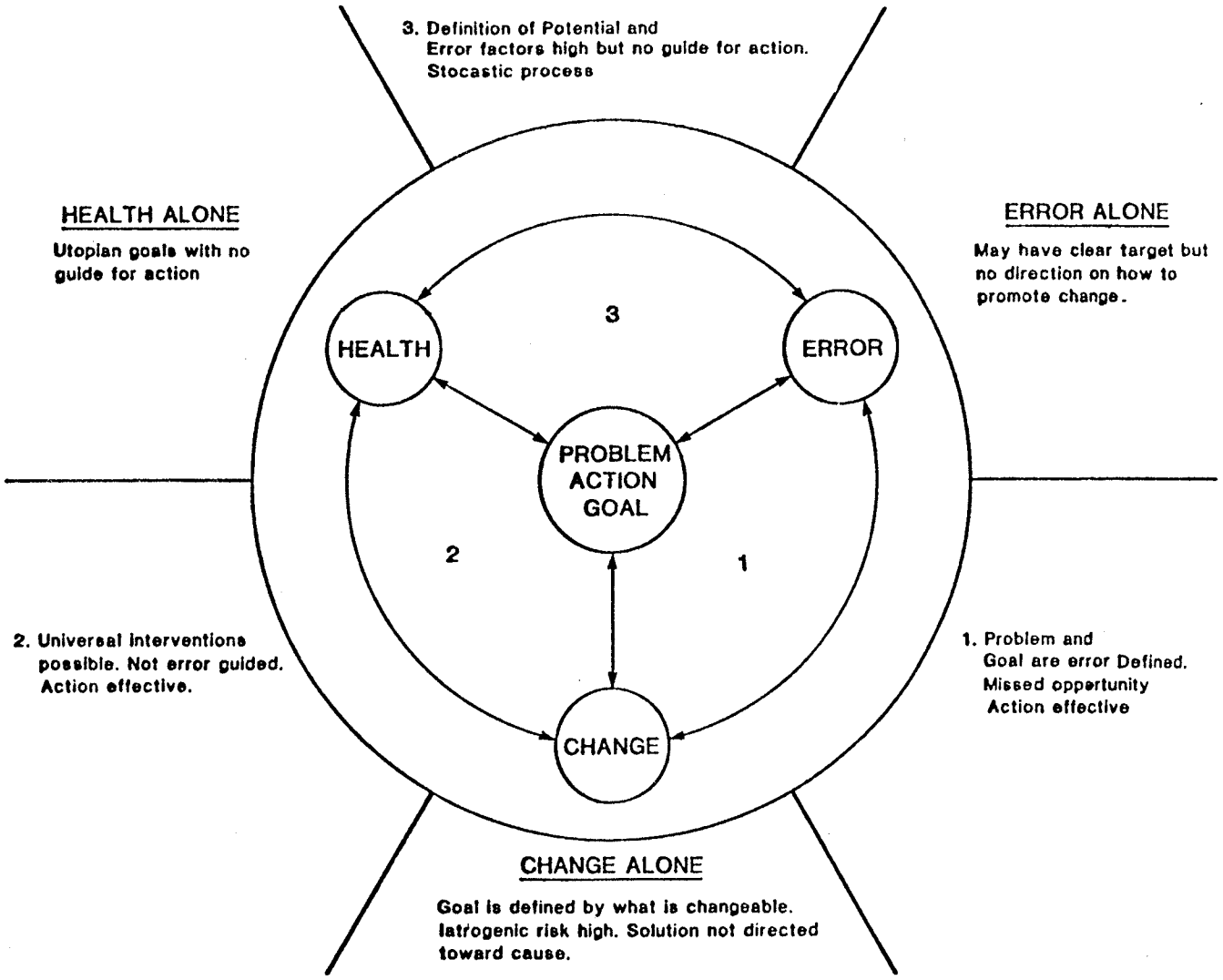

FIGURE IV

TOWARD A THEORY OF PRACTICE

When a theory of health is dominant, there is a clear focus on what comprises health but a lack of awareness of what produces ill-health and how health is to be achieved. An exclusive focus on health makes it impossible to plan effective corrective actions because the etiology of the problem is not understood. For example, a weight loss program may view health as maintaining a "normal" weight, error as overeating, and change as dieting. Health, as defined by an appropriate weight, is focused on without an awareness of the psychological dynamics which may be underneath the compulsion to overeat. Thus, the proposed intervention is incomplete.

When a theory of error is dominant, there is clarity about the factors which make for error, but a limited sense of what comprises health and how it is to be achieved. Because problems are defined in negative ways, the goal focuses on erradicating the problem without proposing healthy alternatives. For example, in the child welfare system, families often define one particular child as the locus of the family's problems. The solution is to get rid of the problem and restore "normal" family functioning by putting the child into placement. The social worker is often subjected to great pressure by the family as well as by other professionals to accept this kind of error based assessment and intervention. Unfortunately, with the primary focus on error, health tends to go unnoticed.

When a theory of change is dominant, the focus is on facilitating change without a clear sense of what makes for error and what comprises a healthy alternative. Methods of change are promulgated without a definition of what is to be changed and why it needs to be changed.

Technique becomes glorified and interventions are made on the basis of what technique is presently in vogue, or what the practitioner knows how to do. Because change may be produced for the sake of change, the iatrogenic risks are high. It is an emphasis on the change domain that Strean (1981) is criticizing when he writes about "the emergence of therapeutic interventions determined by fashion, created very often by people whose work is insufficiently based on clinical studies but who nonetheless propose therapies insufficiently measured against the criteria of usefulness" (p. 167). To this Billups (1984) adds that "in thinking of practice chiefly as a method-specific activity, social workers become easily trapped in a double error of prediagnosing problems and predetermining interventions" (p. 174).

The error factor when one theoretical area is emphasized at the expense of the rest is considerable. When two areas are stressed the danger is not as severe, as a broader perspective is utilized. When the theory of health and error are dominant there is a strong understanding of what makes for health and error, but little awareness of how to bring about change and whether or not change will occur. This situation may arise when a practitioner has a strong academic background but little experience. The ability to analyze may be high but the ability to intervene is low.

When the theories of health and change are dominant a clear statement of health is coupled with the techniques necessary to attain the goal of health. Approaches which take a preventative stance toward health, such as the holistic health movement, fall into this category, as do many of the programs of the human potential movement. The error

which produces the problems is little emphasized, while positive change is stressed.

When theories of error and change are dominant change stragies are brought to bear on the error producing forces. A healthy alternative is not specified as the goal is to alleviate that which is causing the distress.

An analysis of the differing emphases on change, error, and health by social work and body therapy provides some indications as to why the former has not incorporated the latter. The difference, broadly stated, between social work and body therapy is that social work focuses primarily on the error and change domains while body therapy emphasizes the health and change domains.

One of the important factors influencing social work's emphasis on error and change has been the impact of psychoanalysis. Back in the 1920s during the early years of social work, the "friendly visitor" soon realized that changing a client's environment or giving advice was not particularily effective in changing such things as self-destructive behavior or a low self-image. The social worker required a theory that provided more than an analysis of social factors resulting in maladjustment. Psychoanalysis was embraced as the solution, for it provided a way of explaining the internal processes of clients. During the 1930s through to the 1950s psychoanalysis and social work maintained a close relationship. Social workers came to use such useful psychoanalytic notions as transference, resistance, defenses, anxiety, and the unconscious. During the 1960s and 1970s social work and psychoanalysis became more distant as other theoretical

orientations gained in preeminence. There was a shift from a focus on ego functioning to an emphasis on diagnosing families, dyads, and groups (Strean, 1979). However, the legacy of the psychoanalytic influence remains strong. "Psychoanalysis and ego psychology have contributed greatly to the theoretical underpinning of basic social work skills" (Strean, 1978, p. 27).

The focus of the psychoanalytic Freudian model has been on the error domain. As Shapiro (1983) comments,

> from a Freudian perspective, mental health problems are really innate and built into the structure of the organism. Freud believed that the ego uses various defence mechanisms such as repression, reaction formation, intellectualization, sublimation, projection, and regression, to protect itself from the instinctual demands of the id. The etiology of disease or mental health problems is thus held to lie with the instinctual impulses of the id and the ego's attempts to repress them" (p. 442).

The adoption by traditional social work of the psychoanalytic model led to what has become known as a medical model or disease metaphor of practise, which retain Freudian theory's strong emphasis on the error domain. The theme underlying the individualized focus of psychodynamic theory "was the notion that the individual is the respository of negative baggage" (Weick, 1981, p. 140). Furthermore, "the disease model implicit in the study-diagnosis-treatment formulation employed by caseworkers. . . . presupposes pathology at the outset" (Stein, 1976, p. 163). The concentration of the psychological that this model entailed "led practitioners to seek causation of problems within the

person, so that people in states of trouble, conflict, maladaption, disturbance, etc., were viewed as 'sick' or 'responsible' or inadequate to meet the demands of society" (Meyer, 1976, p. 130).

The focus on the health domain is not strong in psychoanalytic theory. Given that historical Freudian thinking starts from a basically bleak picture of human nature, the best that can be done health-wise is to create the optimal conditions possible for the ego, that is, to lessen the error factor. This is done in psychoanalytically oriented therapy by understanding and uncovering early traumatic events, recovering repressed memories, and making the unconscious conscious. The healthier the person, according to Freud, the less material is repressed in the unconscious and the more self-awareness one possess about the past.

The effect of the Freudian approach on social work resulted in social workers focusing on and attempting to ameliorate the effects of the internal pathology of their clients. "The process of treatment or intervention dictated the need to locate the internal cause and eradicate it. Social workers [who] saw the disease or defect as residing in the individual . . . developed techniques to treat the person. The failure of a technique to eliminate the defect was often attributed to the individual's intransigence in responding to the outside force" (Weick, p. 141). Thus, the result of the Freudian influence on social work was to focus the change process on the error dimension with only a weak emphasis on the health dimension.

While social work has become less identified with the psychoanalytic tradition with the advent of new approaches, the focus

in social work has remained more heavily weighted on error than on health. One example of this is the problem-solving approach developed by Perlman (1957) and expanded by other theorists such as Compton and Galaway (1975). Undergirded by theories of ego psychology, role theory, and learning theory, the problem-solving model assumes that all of life is a problem-solving process and that an inability to deal with a problem is the result of a lack of motivation, opportunity, or capacity to solve the problem. Thus, the error is the identified problem while the change process involves assisting the individual, family, or group to maximize their choices and resources in solving the problem.

The behavior-modification approach has also become a dominant influence in social work. It is similar to the problem-solving approach in that it focuses on change and error rather than on health. While space does not permit a detailed discussion of the health, change, and error emphasis of the many models used by social workers, a cursory examination of the models of crisis intervention, psycho-social therapy, and clinical social work all confirm that the over-all emphasis of social work practise is on error and change rather than on health and change.

Weick (1981) advocates that social work greatly expand its view of health, rather than seeing it merely as the mirror image of disease. She proposes that health be seen as a "qualitative expression of the interaction among environments . . . [and] as the product of the on-going mutual interaction between the physical and social elements" (p. 142). Such a definition implies that behavior is a health issue

and that an assessment and diagnosis of health encompasses a person's overall state of health and well-being. This means that "both physical and social factors need to be appraised to determine in what ways an individual's health can be enhanced" (p. 142). To move from a pathology based to a health based perspective Weick suggests that, although the notion of healing is an alien concept to social workers, they view clients as possessing the ability to heal themselves, since Weick assumes that people have remarkable powers to change themselves.

> To recognize one's ability to change as a personal power reinforces the notion that people have the ability to act upon themselves in a way that strengthens them. This is an essentially radical perspective because it puts individuals directly in touch with the power to affect their lives. The power within, because it is based on a view that links internal and external factors, can lead to possibilities for change outside the individual (Weick, 1981, p. 142).

This "radical" view of health espoused by Weick is an integral part of the way body therapies view health.

In contrast to social work, body therapies strongly emphasize the health domain. Each therapy has specific change tactics designed to attain and maintain health. While there is some articulation of error, this aspect is not strongly emphasized. Figure V outlines the views of health, error, and change of each of the body therapies discussed in this thesis.

Body therapies are health focused in that they are founded on an optimistic view of people's ability to grow, change, and mature. They

THERAPY	HEALTH	ERROR	CHANGE
REICH	"Genital character" Full orgastic potency Free, natural energy flow Sexual liberation	Chronic muscular armoring Sexual stasis Character armoring	Deep breathing, massage Insight, interpretation Stress positions, catharsis Character analysis
BIOENERGETICS	Well grounded Capable of giving and receiving love Self-discovery Free movement of energy Free of internal barriers such as ego defenses, repressed feelings, and chronic muscle tension	Chronic muscular spasticity Conflict between mental and physical levels Ego defenses Energy blocks Withdrawal from life of the body	Breathing Catharsis Insight Bioenergetic positions
ALEXANDER	Good "Use" Minimum energy used with maximum balance and stability Balanced energy flow Harmonious interrelationship of parts "Primary Control"	"End-gaining" "Debauched kinaesthesia" "Mis-Use"--haphazard movements Inefficient use of energy	Teaching how to prevent mis-Use and how to learn healthy patterns of movements
FELDENKRAIS	Well organized body posture Effortless efficient use of energy Ease of movement "Awareness in action"	Ineffectual "parasitic" movements Poor teaching and poor learning	Teaching and re-education of body-mind Physical manipulation of body to improve position of parts Various exercises to expand body awareness

FIGURE V

HEALTH, ERROR, AND CHANGE DIMENSIONS OF BODY THERAPIES

THERAPY	HEALTH	ERROR	CHANGE
ROLFING	Body vertically and symmetrically aligned Light, easy, efficient movements Free flow of energy	Random body out of alignment Muscular blocks Habitual misuse of body	Systematic realignment of muscles and bones by means of deep tissue massage
PRIMAL	Defense free, tensionless, nonstruggling, integrated, stable, authentic, genuine, self-accepting	"Primal Pain" "Primal Scene" Neurosis--a pathology of the whole person	The "intensive", insight Catharsis, deep breathing The "Primal" experience Dissolving deep energy blocks by progressively stripping away layers of defenses
FOCUSING	In touch with one's own flow of life	Living by the values of others	"Focusing"--a blending of mind and muscle in a bodily experience
POLARITY	Balanced free flow of energy	Blockages of energy flow in character armor and body	Release of energy blocks through touch Eating healthy foods Physical exercise Focusing on positive thoughts and feelings
SPONTANEOUS BODY EXPERIENCING	Ease of body movement Capacity for pleasure Freedom for the whole person	Blockages to movement Energy blockages Divisions and tensions in the body	Creating conditions under which an organismic process of energy release can occur spontaneously Touch, verbalization, insight

FIGURE V

HEALTH, ERROR, AND CHANGE DIMENSIONS OF BODY THERAPIES

are undergirded by a humanistic philosophy which assumes that people will move towards health if given the opportunity to do so. An ascending of Maslow's (1968, 1971) heirarchy of needs implies progressive movement toward an increasingly higher level of health:

> In ascending this heirarchy the needs appear to shift from clearly physiological to apparently more psychological in nature, from strong to subtle, from prepotent to less potent and more easily disrupted, from spontaneous to requiring cultivation, from deficiency to sufficiency, from egocentric to selfless, from avoidance to approach, from external to internal reinforcement, from field dependence to field independence, and from frequent to rare in the population (Walsh & Vaugham, 1983, p. 406).

It is interesting to note that although the values of social work are also humanistic in their orientation, social work has not generally adopted theories which espouse a strongly positive view of health.

The body therapies define their focus on the health domain in a number of ways. In accord with humanistic philosophy and the human potential movement, health is seen as potential. The capacity and potential for health is assumed to be inherent within people. It simply needs to be uncovered and encouraged for it to flourish. The belief in the "wisdom of the body" is an example of this thinking. As long as the messages being given by the body are heeded, it is believed that the body will let us know what is needed for it to be healthy. Thus, a therapy like Polarity therapy attempts to create the right conditions so that nature can do the healing.

Health is also defined by the body therapies in terms of balance.

There needs to be a balanced emphasis on all aspects of functioning--social, physiological, psychological, spiritual, and so forth. Health is affected if one part of the person is out of balance with the other parts. Structural Integration, the Feldenkrais method, and the Alexander technique are all methods which focus on the physical alignments and movements of the body in an attempt to create a balance among all body parts. Polarity therapy attempts to achieve balance through eating correctly, exercising, and releasing energy blocks.

The movement of energy is used by most of the body therapies to define health. The free unhampered movement of energy throughout the body is equated with health. "Health can be defined as a condition in which an organism's energy patterns or rhythms are regulated and thus able to flow freely" (Schwarz, 1978, pp. 140-141). Or, phrased more poetically, "health is bliss, wholesomeness, flowing energy in harmony with totality" (Gunter, 1983, p. 109). Conversely, disease is seen as a blockage or imbalance of energy in the body. Reichian therapy, Bioenergetics, and Polarity therapy are among the body therapies which actively attempt to restore a free, healthy flow of energy to the body.

Although they emphasize health more than error, body therapies do have some explanations for error. One of the reasons given for error, faulty learning, is the same reason many social workers would propose. The Feldenkrais method and the Alexander technique both view people's problems with movement as resulting from poor learning.

Error is also seen as resulting from trauma. The body therapies accept the notion of body memory, that is, the belief that all our life experiences are imprinted in our body tissues. If we have experienced

traumatic events at any age, including prenatally, these will affect our person in adverse ways, unless they can be properly dealt with. Primal therapy places a strong emphasis on the early experience of painful traunatic events which result in neurosis.

A third error body therapies refer to could be called "conditioned containment". This refers to the view "that in the course of becoming a member of a culture and of a family and small group, certain inherently healthy aspects of our being are denied expression" (Kuypers, 1984, p. 23). The body therapies would generally agree that many of our emotional and physical problems are based on faulty cultural norms. Johnson (1983), in a discussion of how our bodies are shaped by our culture, declares that "each of our bodies is an artifice, a community project visibly manifesting the values of those implicated in the task" (p. 66).

Thus, while both social work and body therapy come from a compatible humanistic value base, their conceptualizations in the domains of health and error differ significantly enough to make it difficult for social work to accept body therapy as one of its theoretical and practise modalities.

The conservatism of social work

One of the reasons cited by Bilodeau (1979) for the lack of acceptance of body therapies by social work is the conservatism of the latter. Bilodeau states that social work is slow and prudent, is careful about incorporating radical changes, and tends to maintain the status quo. Such an analysis fits with the view Galper (1975)

espouses: "At the root of social work theory and practice are conservative, or system conserving, assumptions about individuals, the society, and the ways in which change occurs in the society. These assumptions accept what exists at present in society as being, on the whole, both inevitable and proper" (p. 88). This conservatism is enhanced and sustained by what often becomes a close identification of the social worker with the power of the state. Many social workers provide legally mandated services in the areas of child welfare, probation, or parole. Many others have responsibility for disbursing scarce and valued resources allocated by the government for public welfare, mental health services, and so forth. Because of this, it would not be surprising if social workers became a conservative force identified with the power of the state. Galper (1980) argues that all social agencies "operate as mechanisms of social control. They generally provide minimal service to people whose need is substantial. They attempt to cool out, pacify, and isolate potentially disruptive populations. They create and maintain artifical and divisive barriers between people" (p. 191).

The point here is not to debate Galper's "radical" view of social work but to suggest that social work does indeed have a conservative bias which makes it unlikely to quickly accept new, noticeably different therapies.

Institutional resistance

Many social workers are employed by large institutions such as hospitals, welfare departments, school boards, and government

departments. It appears to be the nature of institutions, both large and small, to be cautious in allowing that which may be upsetting or disruptive. Given that a direct touching of the body of the client is not condoned as an acceptable practise by the social work profession, the institution which employs the social worker may well discourage that from occurring. Furthermore, some of the body therapies involve catharsis. This can be very upsetting to institutions if other clients or staff can hear the noise. Unless adequate soundproofing can be ensured, it is risky to engage in "noisy" therapy within an institution due to the complaints which may be received.

The social worker

Engaging in body therapy is a qualitatively different experience than engaging in any other social work practise. Given the "hands-on" nature of body therapy, social workers must be comfortable with the use of touch. They must also be able to handle high emotional intensity on the part of clients, and be willing to direct people to feel and intensify their pain rather than just talking about the feeling. Social work education generally does not provide this kind of training or exposure, and thus social workers have little opportunity to learn the approach. Not only that, body therapy is often personally threatening to the social worker because it sometimes entails going into the depths of one's being--a very frightening prospect indeed.

Summary

This chapter has discussed a number of the factors influencing the

inclusion and exclusion of body therapy into the practise of social work. It has been argued that body therapy could be accepted by social work because it fits within the general definition of social work and because its value base is compatible with that of social work. Given that social work embraces many diverse theoretical and practise models, and that these models can be organized under a systemic point of view, it is logical that body therapy could take its place as one of the systemic models utilized by the social work profession.

Because social work is generally not aware of body therapy and does not utilize its theoretical orientation, explanations as to why this is the case have been proposed. The principle reason forwarded to explain the distance between social work and body therapy has to do with their differing theoretical emphases. Body therapy emphasizes the theoretical domains of health and change while social work stresses the error and change domains. Other reasons cited for body therapy's non-acceptance have to do with the conservatism of social work, institutional resistance, and the lack of exposure to and training in the area of body therapy by social workers.

CONCLUSION

Social work, as it is currently practised, accepts the division between body and mind. According to Weick (1981), the social work profession's "comfortable acceptance of the body-mind dichotomy is an unfortunate distortion. This dichotomy places the mind and its processes in a superordinate role and views the body as a pliable, although puzzling, accoutrement. The body has been the mind's embarrassing appendage" (p. 141). To rectify this dichotomy Weick advocates that, while the prevailing person-in-environment paradigm can remain the central focus of social work, the profession must transcend its present conventional wisdom by strengthening and enriching this paradigm with "a theory of human behavior that gives vitality to the complex interaction between people and environment" (p. 143). Such a concept of environment would incorporate such external social and physical influences as culture, economics, technology, politics, climate, food, noise, and biological rhythms, as well as such internal influences as emotions, thoughts, beliefs, intrapsychic processes, genetic traits, adaptive capacity, metabolism and organ functioning. "Such a theory", Weick asserts, "would work toward a stronger synthesis of person and environment and free workers to practice in ways compatible with the profession's values" (p. 143).

Body therapies, with their integration of body and mind, their holistic approach to health, their awareness of environmental impacts on all aspects of a person, and their well-developed intervention

techniques, contain the potential for enriching and strengthening social work's person-in-environment paradigm of which Weick (1981) writes. Social work, in conjunction with body therapies, could then help fulfill the vision of which Rappaport (1975) speaks: "We can envision a total approach to health--a reunion of the psyche and soma, a merging of the techniques and professions which now separate us into mental and physical beings. When life is viewed holistically, the methods of healing and caring for it will partake of that unitary vision" (p. 68).

REFERENCES

Alagna, F., Whitcher, S., Fisher, J., & Wicas, E. (1979). Evaluating reaction to interpersonal touch in a counseling interview. Journal of Counseling Psychology, 26, 465-472.

Alexander, C. (1977). Social work practice: A unitary conception. Social Work, 22(5), 407-415.

Alexander, F. (1918). Man's supreme inheritance (2nd ed.). New York: Dutton.

Alexander, F. (1941). The universal constant in living. New York: E. P. Dutton.

Alexander, F. (1969). The resurrection of the body. New York: University Books.

Bakal, D. (1979). Psychology and medicine: Psychobiological dimensions of health and illness. New York: Springer.

Baker, E. (1967). Man in the trap. New York: MacMillian.

Barker, S. (1978). The Alexander technique: The revolutionary way to use your body for total energy. New York: Bantam.

Barlow, W. (1973). The Alexander technique. New York: Warner.

Battista, J. (1977). The holistic paradigm and general system theory. General Systems, 22, 65-71.

Bauman, A. (1982). The energy dimension. In Deliman, T. & Smolowe, J. (Eds.). Holistic medicine: Harmony of body mind spirit. Reston, Virginia: Reston Pub.

Beckett, N. (1975). A study in the psychotherapeutic value of structural integration. (Doctoral dissertation, California School of Professional Psychology, 1974. Dissertation Abstracts International, 35(10-B), 5098B.

Bellis, J. (1976). Emotional flooding and bioenergetic analysis. In Olsen, P. (Ed.). Emotional flooding. New York: Penguin.

Bellis, J. (1981). Bioenergetic analysis: A personal view. In Kogan, G. (Ed.). Our body works: A guide to health, energy, and balance. Berkeley, Calif.: And/Or Press.

Benson, H. (1979). The mind/body effect. New York: Berkeley Books.

Benson, H. & Epstein, H. (1975). The placebo effect: A neglected asset in the care of patients. Journal of the American Medical Association, 232(12), 1225-1227.

Berger, M. (1972). Bodily experience and expression of emotion. American Dance Therapy Association, Monograph # 2, 191-230.

Biestek, F. & Behrig, C. (1978). Client self-determination in social work: A fifty year history. Chicago: Loyala University Press.

Billups, J. (1984). Unifying social work: Importance of centre-moving ideas. Social Work, 29(2), 173-180.

Bilodeau, F. (1979). Le travail social et Wilhelm Reich. Canadian Journal of Social Work Education, 5(2 & 3), 76-88.

Binik, A. (1978). The polarity system. In Bauman, E., Brint, A., Piper, L., & Wright, P. (Eds.). The holistic health handbook: A tool for attaining wholeness of body, mind, and spirit. Berkeley, Calif.: And/Or Press.

Bloom, V. (1977). Bioenergetics in group psychotherapy. Group, 1(3), 172-183.

Bloomfield, H. & Kory, R. (1978). The holistic way to health and happiness. New York: Simon & Schuster.

Boadella, D. (1981). The language of bio-energy. In Kogan, G. (Ed.). Your body works: A guide to health, energy, and balance. Berkeley, Calif.: And/Or Press.

Bodganoff, M. & Elbaum, P. (1978). Touching: A legacy from the encounter movement for social work practice. Social Work in Health Care, 4(2), 209-219.

Borenzweig, H. (1983). Touching in clinical social work. Social Casework: The Journal of Contemporary Social Work, 64(4), 238-242.

Breaux, D. (1978). Health and psychic awareness. In Bauman, E., Brint, A., Piper, L., & Wright, P. (Eds.). The holistic health handbook: A tool for attaining wholeness of body, mind, and spirit. Berkeley, Calif.: And/Or Press.

Brieland, D. (1981). Definition, specialization, and domain in social work. Social Work, 26(1), 79-83.

Brint, A. (1981). The microcosmic body: Discovering the implicit. In Bauman, E., Brint, A., Piper, L., & Wright, A. (Eds.). The holistic health lifebook: A guide to personal and planetary well-being. Berkeley, Calif.: And/Or Press.

Brown, M. (1973). The new body psychotherapies. Psychotherapy: Theory, Research, and Practice, 10(2), 98-116.

Brown, M. (1979). Beyond Janov: The healing touch. Journal of Humanistic Psychology, 19(2), 69-89.

Brownell, A. (1981). Counseling men through bodywork. Personnel and Guidance Journal, 60(4), 252-255.

Cannon, W. (1934). The wisdom of the body. New York: W. W. Norton.

Caspary, W. (1983). Character and politics: The social theory of Wilhelm Reich. Calalyst, 4(3), 39-52.

Chaiklan, H. & Chaiklan, S. (1982). Body awareness and its expression: A technique for social casework. Social Casework: The Journal of Contemporary Social Work, 63(4), 237-240.

Chang, S. (1978). Acupuncture: A contemporary look at an ancient system. In Bauman, E., Brint, A., Piper, L., & Wright, P. (Eds.). The holistic health handbook: A tool for attaining wholeness of body, mind, and spirit. Berkeley, Calif.: And/Or Press.

Cherry, M. (1978). The relationship between focusing and experiencing. (Doctoral dissertation, California School of Professional Psychology, 1976). Dissertation Abstracts International, 38(9-B), 4443B.

Coffey-Lewis, L. (1982). Be restored to health: How to manage stress, heal yourself and be whole again. Toronto: Bestsellers, Inc.

Cohen, J. (1979). Nature of clinical social work. In Ewalt, P. (Ed.). Toward a definition of clinical social work. Washington, D.C.: National Association of Social Workers.

Compton, B. & Galaway, B. (1975). Social work processes (rev. ed.). Homewood, Ill.: Dorsey Press.

Corey, C. (1981). Reichian therapy. In Kogan, G. (Ed.). Your body works: A guide to health, energy, and balance. Berkeley, Calif.: And/Or Press.

Cubley, S. (1976). The Feldenkrais technique and yoga. Yoga Journal, (Nov.-Dec.), 40-43.

Dahl, A. & Waal, H. (1983). An outcome study of primal therapy. Psychotherapy and Psychosomatics, 39(3), 154-164.

Dass, R. (1974). The only dance there is. New York: Anchor Books.

De la Pena, A. (1983). The psychobiology of cancer: Automatization and boredom in health and disease. New York: Praeger.

Deliman, T. (1982). The foundations: Introduction. In Deliman, T. & Smolowe, J. (Eds.). Holistic medicine: Harmony of body mind spirit. Reston, Virginia: Reston Pub.

Don, N. (1977). The transformation of conscious experience and its EEG correlates. Journal of Altered States of Consciousness, 3(2), 147-168.

Don, N. (1979). Four self-regulatory therapies in wholistic health. In Otto, H. & Knight, J. (Eds.). Dimensions in wholistic healing: New frontiers in the treatment of the whole person. Chicago: Nelson-Hall.

Dublin, J. (1976a). Beyond Gestalt: Toward integrating some systems of psychotherapy. Psychotherapy: Theory, Research, and Practice, 13(3), 225-231.

Dublin, J. (1976b). Toward a bio-existential therapy integrating three body psychotherapies. Voices: Journal of the American Academy of Psychotherapists, 12(2), 8-14.

Duke, M. (1972). Acupuncture. New York: Pyramid House.

Dychtwald, K. (1977). Body-mind. New York: Jove.

Edwards, D. (1981). The role of touch in interpersonal relations: Implications for psychotherapy. South African Journal of Psychology, 11(1), 29-37.

Einzig, B. (1981). The roots of holistic healing. In Bauman, E., Brint, A., Piper, L., & Wright, A. (Eds.). The holistic health lifebook: A guide to personal and planetary well-being. Berkeley, Calif.: And/Or Press.

Ellerbroek, W. (1973). Hypotheses toward a unified field theory of human behavior with clinical application to acne vulgaris. Perspectives in Biology and Medicine, 16, 240-261.

Feiss, G. (1979). Mind therapies/Body therapies. Millbrae, Calif.: Celestial Arts.

Feldenkrais, M. (1949). Body and mature behavior: A study of anxiety, sex, gravitation and learning. New York: International Universities Press.

Feldenkrais, M. (1964). Mind and body. Systematics: The Journal of the Institute for the Comparative Study of History, Philosophy, and the Sciences, 2(1), 47-61.

Feldenkrais, M. (1972). Awareness through movement: Health exercises for personal growth. New York: Harper & Row.

Feldenkrais, M. (1976). On the primacy of hearing. Somatics, 1(1), 19-21.

Feldenkrais, M. (1979). Man and the world. In Hanna, T. (Ed.). Explorers of humankind. New York: Harper & Row.

Feldenkrais, M. (1981a). The illusive obvious. Cupertino, Calif.: Meta Pub.

Feldenkrais, M. (1981b). Mind and body. In Kogan, G. (Ed.). Your body works: A guide to health, energy, and balance. Berkeley, Calif.: And/Or Press.

Ferguson, M. (1980). The Aquarian conspiracy. Los Angelos: J. P. Tucker.

Fish, J. (1973). Placebo therapy. San Fransico: Jossey-Bass.

Fischer, H. & Dlin, B. (1956). The dynamics of placebo therapy: A clinical study. American Journal of Medical Science, 232, 504-512.

Forer, B. (1969). The taboo against touching in psychotherapy. Psychotherapy: Theory, Research, and Practice, 6(4), 229-234.

Freud, S. (1938). Construction in analysis. In Collected papers (Vol. 5). London: Hogarth Press.

Galper, J. (1975). The politics of the social services. Englewood Cliffs, N.J.: Prentice-Hall.

Galper, J. (1980). Social work practice: A radical perspective. Englewood Cliffs, N.J.: Prentice-Hall.

Gelb, M. (1982). Body learning: An introduction to the Alexander technique. New York: Delilah Books.

Gendlin, E. (1969). Focusing. Psychotherapy: Theory, Research, and Practice, 6(1), 4-16.

Gendlin, E. (1978). Focusing. New York: Bantam.

Gendlin, E. (1979). Experiential psychotherapy. In Corsini, J. (Ed.). Current psychotherapies (2nd ed.). Itasa, Ill.: Peacock.

Germain, C. (1978). General-systems theory and ego psychology: An ecological perspective. Social Service Review, 52, 535-550.

Gilbert, N. (1977). The search for professional identity. Social Work, 22(5), 401-406.

Goffman, E. (1971). Relations in public. New York: Basic Books.

Goldstein, E. (1980). Knowledge base of clinical social work. Social Work, 25(3), 173-178.

Gordon, J. (1981). Holistic medicine: Toward a new medical model. Journal of Clinical Psychiatry, 42(3), 114-119.

Gordon, R. (1978). Your healing hands: The polarity experience. Santa Cruz, Calif.: Unity Press.

Green, E., Green, A., & Walters, E. (1970). Voluntary control of internal states: Psychological and physiological. Journal of Transpersonal Psychology, 2(1), 1-26.

Grieve, R. (1983). Clinical applications of the eco-systems perspective: An eclectic approach. In Meyer, C. (Ed.). Clinical social work in eco-systems perspective. New York: Columbia University Press.

Gross, S. (1980). The holistic health movement. Personnel and Guidance Journal, 59(2), 96-100.

Grow, G. (1978). Wilhelm Reich on emotions. In Bauman, E., Brint, A., Piper, L., & Wright, P. The holistic health handbook: A tool for attaining wholeness of body, mind, and spirit. Berkeley, Calif.: And/Or Press.

Gunther, B. (1978). Energy ecstasy and your seven vital chakras. Hollywood, Calif.: Newcastle.

Hamann, A. (1976). Reflexions d'un psychologue sur le plaisir. Pretre et Pasteur. Nov., 537-548.

Hamann, A. (1977). Spontaneous body experiencing: A non-directive approach to bio-energy. Unpublished paper.

Heider, J. (1974). Catharsis in human potential encounter. Journal of Humanistic Psychology, 14(4), 27-47.

Henry, M. (1978). The relationship between focusing and experiencing. (Doctoral dissertation, California School of Professional Psychology, 1978). Dissertation Abstracts International, 39(6-B), 2986B.

Hoff, R. (1978). Overview of Reichian therapy. In Bauman, E., Brint, A., Piper, L., & Wright, P. (Eds.). The holistic health handbook: A tool for attaining wholeness of body, mind, and spirit. Berkeley, Calif.: And/Or Press.

Hubble, M., Noble, F., & Robinson, S. (1981). The effect of counselor touch in an initial counseling session. Journal of Counseling Psychology, 28(6), 533-535.

Hunt, V. & Massey, W. (1977). Electromyographic evaluation of structural integration techniques. Psychoenergetic Systems, 2, 199-210.

Hunt, V., Massey, W., Weinberg, R., Bruyere, R., & Hahn, P. (1977). A study of structural integration from neuromuscular, energy field, and emotional approaches. A project sponsored by the Rolf Institute of Structural Integration.

Jaffe, D. (1980). Healing from within. New York: Knopf.

Janov, A. (1970). The primal scream. New York: Perigee Books.

Janov, A. (1971). The anatomy of mental illness. New York: G. P. Putman's Sons.

Janov, A. (1972). The primal revolution: Toward a real world. New York: Simon & Schuster.

Janov, A. (1973). The feeling child. New York: Simon & Schuster.

Janov, A. (1975a). Primal man: The new consciousness--Conclusions. In Janov, A. & Holden, E. Primal man: The new consciousness. New York: Thomas Y. Crowell.

Janov, A. (1975b). Therapeutic implications of the levels of consciousness: Dangers in the misuse of Primal therapy. In Janov, A. & Holden, E. Primal man: The new consciousness. New York: Thomas Y. Crowell.

Janov, A. (1983). Imprints: The lifelong effects of the birth experience. New York: Coward-McCann.

Johnson, D. (1977). The protean body: A rolfer's view of human flexibility. New York: Harper & Row.

Johnson, D. (1983). Body. Boston: Beacon Press.

Jones, F. (1963). The influence of postural set on pattern movement in man. International Journal of Neurology, 4, 60-71.

Jones, F. (1965). Method for changing stereotyped response patterns by the inhibition of certain postural sets. Psychological Review, 72(3), 196-214.

Jones, F. (1976). Body awareness in action: A study of the Alexander technique. New York: Schocken Books.

Kadushin, A. (1972). The social work interview. New York: Columbia University Press.

Karagulla, S. (1974). Energy fields and medical diagnosis. In Regush, N. (Ed.). The human aura. New York: Berkeley Books.

Karle, W., Corriere, R., & Hart, J. (1973). Psychophysiological changes in abreactive therapy--Study I: Primal therapy. Psychotherapy: Theory, Research, and Practice, 10(2), 117-122.

Kaufmann, W. (1974). An anatomy of the primal revolution. Journal of Humanistic Psychology, 14(4), 49-62.

Keleman, S. (1976). Bio-energetic concepts of grounding. In Boadella, D. (Ed.). In the wake of Reich. London: Coventure.

Keleman, S. (1980). Working with the body. Voices: The Art and Science of psychotherapy, 16(3), 30-36.

Keleman, S. (1981). Your body speaks its mind. Berkeley, Calif.: Centre Press.

Kelley, C. (1972). Post-primal and genital character: A critique of Janov and Reich. Journal of Humanistic Psychology, 12(2), 61-73.

Kiesler, S. (1973). Emotion in groups. Journal of Humanistic Psychology, 13(3), 19-31.

Kirsch, C. (1976). The role of affect expression and defense in the character. In Boadella, D. (Ed.). In the wake of Reich. London: Coventure.

Koenig, S. (1981). Touch for health. In Bauman, E., Brint, A., Piper, L., & Wright, A. (Eds.). The holistic health lifebook: A guide to personal and planetary well-being. Berkeley, Calif.: And/Or Press.

Konia, C. (1975). Orgone therapy: A case presentation. Psychotherapy: Theory, Research, and Practice, 12(2), 192-197.

Kraft, C. (1978). Eastern and Western approaches for mind-body integration. Dissertation Abstracts International, 39, 4039B-4040B. (University Microfilms No. 7902835).

Kreiger, D. (1979). The therapeutic touch: How to use your hands to help or heal. Englewood Cliffs, N.J.: Prentice-Hall.

Kreiger, D. (1980). Therapeutic touch: The imprimatur of nursing. In Flynn, P. (Ed.). The healing continuum: Journeys in the philosophy of holistic health. Bowee, Maryland: Robert J. Brady.

Kretschmer, E. (1921). Physique and character: An investigation of the nature of constitution and the theory of temperament. London: Routledge.

Kurtz, R. & Prestera, H. (1976). The body reveals. New York: Harper & Row.

Kuypers, J. (1984). Choice in social work practice: Dialogues on health, error, and change. Unpublished paper.

Langs, R. (1973). Psychoanalytic Psychotherapy (Vol. 1). New York: Jason Aronson.

Lanza, R. (1983). The role of the therapist. Family Therapy, 10(1), 57-60.

Lasater, J. (1979). An investigation of the psycho-spiritual dynamics of hatha yoga as contrasted with western body therapies. Dissertation Abstracts International, 40, 4462B. (University Microfilms No. 8005159).

Lawrence, D. (1955). Sex, literature and censorship. London: Heinemann.

Leadbeater, C. (1979). The chakras. Adayar, Madras, India: The Theosophical Pub. House.

Leland, J. (1976). "Invasion" of the body? Psychotherapy: Theory, Research, and Practice, 13(3), 214-218.

Lesse, S. (1964). Placebo reactions and spontaneous rhythms. American Journal of Psychotherapy, 18, 99-115.

Levy, C. (1983). Client self-determination. In Rosenblatt, A. & Waldfogel, D. (Eds.). Handbook of clinical social work. San Francisco: Jossey-Bass.

Lonsbury, J. (1978). Inside primal therapy. Journal of Humanistic Psychology, 18(4), 19-28.

Lowen, A. (1965). Love and orgasm. New York: MacMillian.

Lowen, A. (1967). The betrayal of the body. New York: Collier.

Lowen, A. (1975). Bioenergetics. New York: Penguin.

Lowen, A. (1976a). Bio-energetic analysis: A development of Reichian therapy. In Boadella, D. (Ed.). In the wake of Reich. London: Coventure.

Lowen, A. (1976b). Reich, sex, and orgasm. In Boadella, D. (Ed.). In the wake of Reich. London: Coventure.

Lowen, A. (1979). Human nature. In Hanna, T. (Ed.). Explorers of humankind. New York: Harper & Row.

Lowen, A. & Lowen, L. (1977). The way to vibrant health. New York: Harper & Row.

Mann, F. (1973). Acupuncture: The ancient Chinese art of healing and how it works scientifically. New York: Vintage Books.

Mann, W. (1974). Wilhelm Reich and orgone: The background. In Regush, N. (Ed.). The human aura. New York: Berkeley Books.

Maslow, A. (1954). Motivation and personality. New York: Harper & Brothers.

Maslow, A. (1968). Toward a psychology of being (2nd ed.). New York: Van Nostrand Reinhold.

Maslow, A. (1971). The farther reaches of human nature. New York: Penguin.

Masters, R. & Houston, J. (1978). Listening to the body: The psychophysical way to health awareness. New York: Delta.

Meyer, C. (1983a). The search for coherence. In Meyer, C. (Ed.). Clinical social work in eco-systems perspective. New York: Columbia University Press.

Meyer, C. (1983b). Selecting appropriate practice models. In Rosenblatt, A. & Waldfogel, D. (Eds.). Handbook of clinical social work. San Francisco: Jossey-Bass.

Miles, R. (1978). Humanistic medicine and holistic health care. In Bauman, E., Brint, A., Piper, L., & Wright, P. (Eds.). The holistic health handbook: A tool for attaining wholeness of body, mind, and spirit. Berkeley, Calif.: And/Or Press.

Miller, R. (1975). Psychic massage. New York: Harper Colophon.

Mintz, E. (1972). On the rationale of touch in psychotherapy. In Sager, C. & Kaplan, H. (Eds.). Progress in group and family therapy. New York: Brunner/Mazel.

Mishne, J. (1982). The missing system in social work's application of system theory. Social Casework: The Journal of Contemporary Social Work, 63(9), 547-553.

Mishra, S. (1981). Breath, movement, self-awareness through sensory mechanism. In Kogan, G. (Ed.). Your body works: A guide to health, energy, and balance. Berkeley, Calif.: And/Or Press.

Montagu, A. (1978). Touching: The human significance of the skin. New York: Harper & Row.

Murphy, J. (1976). Muscles and madness. Voices: Journal of the American Academy of Psychotherapists, 12(2), 36-41.

Nicols, M. & Zax, M. (1977). Catharsis in psychotherapy. New York: Gardner.

Nicholson, T. (1977). Primal theory, neurophysiology, and a clinical synthesis of biometric, diary, and videotaped data on primal psychotherapeutic process. (Doctoral dissertation, University of New Mexico, 1977). Dissertation Abstracts International, 38(6-B), 2874B.

Noble, C. (1977). Procedures for promoting behavior change: Humanistic approach. In Blackham, G. (Ed.). Counseling: Theory, process, and practice. Belmont, Calif.: Wadsworth.

Northen, H. (1982). Clinical social work. New York: Columbia University.

O'Connell, S. (1983). The placebo effect and psychotherapy. Psychotherapy: Theory, Research, and Practice, 20(3), 337-345.

Older, J. (1977). Four taboos that may limit the success of psychotherapy. Psychiatry: Journal for the Study of Interpersonal Process, 40, 197-204.

Ornstein, R. (1972). The psychology of consciousness. New York: Penguin.

Ottiwell, F. (1981). The Alexander technique: A matter of choice. In Kogan, G. (Ed.). Your body works: A guide to health, energy, and balance. Berkeley: Calif.: And/Or Press.

Otto, H. & Knight, J. (1979). Wholistic healing: Basic principles and concepts. In Otto, H. & Knight, J. Dimensions in wholistic healing: New frontiers in the treatment of the whole person. Chicago: Nelson-Hall.

Pannetier, P. (1981). Polarity therapy. In Kogan, G. (Ed.). Your body works: A guide to health, energy, and balance. Berkeley, Calif.: And/Or Press.

Pattison, J. (1973). Effects of touch on self-exploration and the therapeutic relationship. Journal of Consulting and Clinical Psychology, 40, 170-175.

Paul, L. (1973). Some ethical principles for facilitators. Journal of Humanistic Psychology, 13(1), 43-46.

Pelletier, K. (1977). Mind as healer, mind as slayer: A holistic approach to preventing stress disorders. New York: Delta.

Pelletier, K. (1979). Holistic medicine: From stress to optimum health. New York: Dell.

Pelletier, K. (1980). Toward a holistic medicine. In Flynn, P. (Ed.). The healing continuum: Journeys in the philosophy of holistic health. Bowie, Maryland: Robert J. Brady.

Perlman, H. (1957). Social casework: A problem-solving process. Chicago: University of Chicago Press.

Pierce, R. (1978). Rolfing. In Bauman, E., Brint, A., Piper, L., & Wright, P. (Eds.). The holistic health handbook: A tool for attaining wholeness of body, mind and spirit. Berkeley, Calif.: And/Or Press.

Pierrakos, J. (1974a). The energy field. In Regush, N. (Ed.). The human aura. New York: Berkeley Books.

Pierrakos, J. (1974b). Observations and techniques in bioenergetic group therapy. In Milman, D. & Goldman, G. (Eds.). Group process today: Evaluation and perspective. Springfield, Ill.: Charles C. Thomas.

Raknes, O. (1970). Wilhelm Reich and orgonomy. Baltimore, Maryland: Penguin.

Rama, S., Ballentine, R., & Ajaya, S. (1976). Yoga and Psychotherapy: The evolution of consciousness. Honesdale, Penn.: Himalayan International Institute of Yoga Science and Philosophy.

Rappaport, B. (1975). Carnal knowledge: What the wisdom of the body has to offer psychotherapy. Journal of Humanistic Psychology, 15(1), 49-70.

Reich, W. (1942). The function of the orgasm. New York: Pocket Books.

Reich, W. (1973). The function of the orgasm: Sex-economic problems of biological energy. New York: Simon & Schuster.

Riebel, L. (1984). A homeopathic model of psychotherapy. Journal of Humanistic Psychology, 24(1), 9-48.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 27, 95-103.

Rogers, C. (1961). On becoming a person. Boston: Houghton Mifflin.

Rolf, I. (1963). Structural integration. Systematics, 1(1), 66-84.

Rolf, I. (1973). Structural integration, a contribution to the understanding of stress. Confina Psychiatrica, 16, 69-79.

Rolf, I. (1976). Structural integration: Counterpart of psychological integration. In Olsen, P. (Ed.). Emotional flooding. New York: Penguin.

Rolf, I. (1977). Rolfing: The integration of human structures. New York: Harper & Row.

Rolf, I. (1978). The vertical: An experiential side to human potential. Journal of Humanistic Psychology, 18(2), 37-39.

Rolf, I. (1979). Structure: A new factor in understanding the human condition. In Hanna, T. (Ed.). Explorers of humankind. New York: Harper & Row.

Rolf, I. (1981). Rolfing: Gravity, an unexplored factor in a more human use of human beings. In Kogan, G. (Ed.). Your body works: A guide to health, energy, and balance. Berkeley, Calif.: And/Or Press.

Rose, S. (1976). Intense feeling therapy. In Olsen, P. (Ed.). Emotional flooding. New York: Penguin.

Rosen, D. (1977). A primal primer for psychiatrists. American Journal of Psychiatry, 134(4), 445-446.

Rywerant, Y. (1978). The creative process as seen in functional integration: Some reflections on a techinque. Somatics, 1(4), 24-26.

Rywerant, Y. (1983). The Feldenkrais method: Teaching by handling. San Francisco: Harper & Row.

Salkin, J. (1973). Body technique: An educational and therapeutic approach to body image and self-identity. Springfield, Ill.: Charles C. Thomas.

Schutz, W. (1971). Here comes everybody: Bodymind and the encounter culture. New York: Harper & Row.

Schwarz, J. (1978). Voluntary controls: Exercises for creative meditation and for activating the potential of the chakras. New York: E. P. Dutton.

Schwarz, J. (1980). Human energy systems. New York: E. P. Dutton.

Seldon, B. (1979). The body-mind book: Nine ways to awareness. New York: Julian Messner.

Shafer, C. (1969). Teaching social work practice in an integrated course: A general systems approach. In Hearn, G. (Ed.). The general systems approach: Contributions toward a holistic conception of social work. New York: Council on Social Work Education.

Shapiro, A. (1961). Factors contributing to the placebo effect: Their implications for psychotherapy. American Journal of Psychotherapy, 18, 73-88.

Shapiro, A. (1970). Placebo effects in psychotherapy and psychoanalysis. Journal of Clinical Pharmacology, 10(2), 73-78.

Shapiro, D. (1983). A content analysis of eastern, western, traditional and new-age approaches to therapy, health, and healing. In Walsh, R. & Shapiro, D. (Eds.). Beyond health and normality: Explorations of exceptional psychological well-being. New York: Van Nostrand Reinhold.

Shapiro, O. & Morris, L. (1978). The placebo effect in medical and psychological therapies. In Garfield, S. & Bergin, A. (Eds.). Handbook of psychotherapy and behavior change (2nd ed.). New York: John Wiley.

Sheldon, W. & Stevens, S. (1942). The varieties of temperament: A psychology of constitutional differences. New York: Harper.

Shontz, F. (1975). The psychological aspects of physical illness and disability. New York: MacMillian.

Silverman, A., Pressman, M., & Bartel, H. (1973). Self-esteem and tactile communication. Journal of Humanistic Psychology, 13(2), 73-77.

Simon, B. (1977). Diversity and unity in the social work profession. Social Work, 22(5), 407-415.

Simonton, O. & Simonton, S. (1975). Belief systems and management of the emotional aspects of malignancy. Journal of Transpersonal Psychology, 7(2), 29-47.

Simonton, O., Simonton, S., & Creighton, J. (1978). Getting well again. New York: Bantam.

Siporin, M. (1980). Ecological systems theory in social work. Journal of Sociology and Social Welfare, 7(4), 507-532.

Smuts, J. (1982). The origins of holism. In Deliman, T. & Smolowe, J. (Eds.). Holistic medicine: Harmony of body mind spirit. Reston, Virginia: Reston Pub.

Stockwell, S. & Dye, A. (1980). Effects of counselor touch on counseling outcome. Journal of Consulting Psychology, 27, 443-446.

Strean, H. (1978). Clinical social work: Theory and practice. New York: The Free Press.

Strean, H. (1979). Psychoanalytic theory and social work practice. New York: The Free Press.

Strean, H. (1981). A critique of some of the newer treatment modalities. Clinical Social Work Journal, 9(3), 155-171.

Strupp, H. (1973). A new messiah. Contemporary Psychology, 18(3), 117-119.

Taylor, P. (1981). The doctor who believes in miracles: A visionary inside the system. New Age, Aug., 32-39 & 54.

Tiller, W. (1974). Energy fields and the human body. In White, J. (Ed.). Frontiers of consciousness: The meeting ground between inner and outer reality. New York: Julian Press.

Townsend, D. (1977). The effect of body integration on psychological functioning. (Doctoral dissertation, University of Pittsburgh, 1976). Dissertation Abstracts International, 38(1-B), 383B.

Verin, L. (1981). The teachings of Moshe Feldenkrais. In Bauman, E., Brint, A., Piper, L., & Wright, A. (Eds.). The holistic health lifebook: A guide to personal and planetary well-being. Berkeley, Calif.: And/Or Press.

Vlamis, G. (1978). Interview with Pierre Pannetier. In Bauman, E., Brint, A., Piper, L., & Wright, P. (Eds.). The holistic health handbook: A tool for attaining wholeness of body, mind, and spirit. Berkeley, Calif.: And/Or Press.

Weddig, T. (1974). Focusing and crisis-fantasy in experimental psychotherapy. Psychotherapy: Theory, Research, and Practice, 11(3), 289-291.

Weick, A. (1981). Reframing the person in environment perspective. Social Work, 26(2), 140-143.

Weiner, H. (1974). Toward a body therapy. Psychoanalytic Review, 61(1), 45-52.

Welwood, J. (1980). Reflections on psychotherapy, focusing, and meditation. Journal of Transpersonal Psychology, 12(2), 127-141.

Wilson, J. (1982). The value of touch in psychotherapy. American Journal of Orthopsychiatry, 52(1), 65-72.

Wolf, S. (1981). Introduction: The role of brain in bodily disease. In Weiner, H., Hofer, M., & Stunkard, A. (Eds.). Brain, behavior, and bodily disease. New York: Raven Press.

Worsley, J. (1982). The meridan dimension. In Deliman, T. & Smolowe, J.

(Eds.). Holistic medicine: Harmony of body mind spirit. Reston, Virginia: Reston Pub.

Yassy, A. (1979). Critique of primal therapy. American Journal of Psychotherapy, 33(1), 119-127.

APPENDIX A

NEWCASTLE PUBLISHING COMPANY INC.

Publishers & Distributors of fine Books

13419 Saticoy Street
North Hollywood, California 91605

(213) 873-3191
P.O. Box 7589
Van Nuys, Calif. 91409

1/31/85

Lesly Derksen
182 McIntosh Ave.
Winnipeg, MAN R2L 0K6
CANADA

Dear Lesly Derksen:

You may have permission to include the material you wish from ENERGY ECSTASY by Bernard Gunther, Ph.D. (note correct spelling of author's name). This permission is without cost to you, but we would ask that you give credit in the following manner:

"The illustrations on (your page number) and (your page number) are reproduced from Energy Ecstasy by Bernard Gunther, Ph.D. with the permission of Newcastle Publishing Co., Inc. and are © copyright 1984 by Bernard Gunther."

Good luck with your thesis!

Sincerely,

Douglas Menville
Editor

APPENDIX B

NEWCASTLE PUBLISHING COMPANY INC.

Publishers & Distributors of fine Books

13419 Saticoy Street
North Hollywood, California 91605

(213) 873-3191
P.O. Box 7589
Van Nuys, Calif. 91409

1/31/85

Lesly Derksen
182 McIntosh Ave.
Winnipeg, MAN R2L 0K6
CANADA

Dear Lesly Derksen:

You may have permission to include the material you wish from ENERGY ECSTASY by Bernard Gunther, Ph.D. (note correct spelling of author's name). This permission is without cost to you, but we would ask that you give credit in the following manner:

"The illustrations on (your page number) and (your page number) are reproduced from Energy Ecstasy by Bernard Gunther, Ph.D. with the permission of Newcastle Publishing Co., Inc. and are © copyright 1984 by Bernard Gunther."

Good luck with your thesis!

Sincerely,

E. P. DUTTON, INC.

2 Park Avenue, New York, N.Y. 10016 212-725-1818 Cable: Yardfar Telex: 12-5836

March 5, 1985

Mr. Lesly Derksen
182 McIntosh Avenue
Winnipeg, Manitoba R2L 0K6
Canada

Ref.: Fig. 7 "Spinal Contacts of Chakras"
VOLUNTARY CONTROLS by Jack Schwarz

Dear Mr. Derksen:

Thank you for sending a copy of the above selection.

We are pleased to grant you permission to include this illustration in your thesis. This permission is for one-time use only, covering the territory of Manitoba, Canada.

We shall require that full credit be given to the source of the material as follows:

"From VOLUNTARY CONTROLS by Jack Schwarz, copyright (c) 1978 by The Alethia Foundation. Reproduced by permission of the publisher, E.P. Dutton, Inc."

In the event that your thesis shall be published by a publisher in the future, a new permission has to be obtained.

Sincerely,