Finding the Edge

A hands-off bodywork technique for working with trauma-induced somatic illness

DRAFT version 5.0 :: 10/June/2012

© Andrew Cook MSc RCST

Complementary Health Care Clinic
34 Exchange Street, Norwich NR2 1AX
+44 1603 665173

ALSO see ...

http://www.hummingbird-one.co.uk/workshops/edge.html

Comments welcome via StrixAluco@gmx.com

If you are interested in attending a practical experiential workshop on this material, please send me your email address!

This essay and other essays on bodywork, craniosacral therapy and physiology/anatomy are available from

http://www.hummingbird-one.co.uk/resources2.html

Abstract/Summary

This document describes the development and practical application of a technique for helping the body's defensive alarm states to self-adjust. Functionally, we have an outer "skin" at some distance from the body which contains our safe body space. Its behaviour and normal resting distance beyond the physical skin control a lot of the detail of our daily interactions with people and our relationships. The edge/boundary of this invisible space is also in a reciprocal relationship with much of the physiological state of the body. If the boundary and the space it encloses are over-reactive, it not only can be implicated in relationship/ attachment "issues", but also can be a major contributor to many common "physical" pathologies. A description is presented of *one* way in which how these hyper-alert states can be consciously worked with and helped to self-normalise, and what kind of phenomena are commonly experienced during this process. The intended audience is for bodyworkers, particularly CST practitioners - but psychotherapy (particularly body psychotherapy) practitioners may also find it of interest.

Edited and published using OpenOffice.org Writer and Draw, using Garamond font.
Images : line drawings & diagrams © Andrew Cook

There are moments when the soul takes wings:
what it has to remember, it remembers;
what it loves, it loves still more;
what it longs for, to that it flies.

from William Sharp (writing as Fiona MacLeod)
The Divine Adventure : Iona (1895, first publ. 1910)

...The individual is a totality and cannot be segregated into intellect, motor and social factors.

The correlation of visceral, psychic and peripheral stimuli, underlying muscular response, involves the whole of man. It is the very perception of viscera, nerves and organic life. The whole body, enlivened as it is by muscular memory, becomes a sensitive instrument responding with a wisdom far outrunning that of man's reasoning or conscious control.

from Mabel E Todd (1937) The Thinking Body p. 3

© Andrew Cook June 2012

Table of contents

Overview : Negotiating no contact at all
An article submitted to “The Fulcrum” (the professional journal of the UK Craniosacral Therapy Association), March 2012

... and in more detail ...

1. Introduction

2. Background

3. The *distance work* process – a detailed description

3.1 General procedure
3.2 Variations and experiences
3.3 The positive boundary
3.4 The collapsed boundary
3.5 The suction boundary
3.6 Fear, stored emotions, energy cysts and states of overwhelm
3.6.1 Definition of an Energy Cyst
3.6.2 The Kinetic-Energy EC
3.6.3 Semi-conscious dissociation
3.6.4 Consciousness, emotion and tissue mobility
3.6.5 Therapeutic interventions that heal ECs
3.6.6 Overwhelm states and hyper-collapsed fields
3.6.7 Fear and hyper-collapsed states
3.6.8 Internal and extraneous entities
3.6.9 Summary of hyper-collapsed states : Integrating trauma-psychotherapy and bodywork experiences
3.7 Other variations
3.7.1 The placenta and other embryonic gestures
3.7.2 Chi soup
3.8 Case Study
3.9 General Discussion
3.10 Returning to the body

4. Theoretical material

4.1 Layers of skin and other boundary zones.
4.2 Resourcing.
4.3 Sense – movement/response – feedback.
4.4 Optimisation of energy usage.
4.5 Love as a natural point of stabilisation.

© Andrew Cook June 2012

4.6 Inside the box, outside the box.
4.7 Now and then – the experience of time.
4.8 Window of Tolerance (Sympathetic/Parasympathetic functional ranges)
4.9 Positive stories of S/P activity in survival states.
4.10 The Three Selves

4.11 Temporary expedient autonomy (TEA) : fragmentation as a normal survival adaptation.
4.12 Sensory preferences.
4.13 Energy Cysts
4.14 A Few Basic Dialoguing Rules

5. Summary

Figures

A The trauma response cycle (normal and interrupted versions)
B The Window of Tolerance : normal states
C The Window of Tolerance : incomplete survival responses
D The Three Selves
Table 1 : The attributes of the three selves
E Progression of the freeze-flight response between different postures

Acknowledgements

A few selected sources

© Andrew Cook June 2012

Overview : Negotiating no contact at all

An article submitted to “The Fulcrum” (the professional journal of the UK Craniosacral Therapy Association), March 2012

Background

The spectrum of shock, trauma, PTSD (post-traumatic stress disorder) and DID (dissociative identity disorder) is a very broad subject. For brevity, I will refer to these collectively as trauma spectrum disorders (TSD). The fact that TSDs are apparently a psychological issue is confounded by the even more central fact that they are expressions of both functional and dysfunctional survival responses that operate on a non-conscious and often purely somatic/physiological level. As such, although they can be overriden by conscious control, that ability is quite limited. In fact, the nervous system and neurotransmitter balance associated with these states may often dominate conscious experience of life.

TSDs may be caused not only by obvious traumatic events, but also drip-fed low level stress over several years, or events which are pre-verbal (infant or pre-birth), generational memories, and may even be transferred between people. Vicarious TSDs may be generated simply by being in the approximate vicinity of an event (without even being *directly* affected by it), or even by watching the news or hearing about some event. I experienced such a thing some years ago when I was told about a rather gory atrocity that took place during a recent war – it took some three weeks to purge my system of the visceral response. Resolution of shock usually occurs through normalisation and positive support over the few weeks after an event. If this normalisation and support is unavailable, then the shock may become chronic and then is, by definition, a TSD.

Once even a minor unresolved TSD is in place, the person's normal physiological window narrows. Thus they become more likely to be affected by the next “traumatic” event, and this effect is often cumulative. Estimates of people suffering from PTSD-spectrum pathologies in relatively peaceful western countries such as the USA or the UK suggest that up to 15% of the adult population may be dealing with the side-effects of these conditions on a daily basis, and some 8% have PTSD of a severity that is diagnosable using formal instruments (questionnaires). Furthermore, an estimated 0.5 to 1% of the general population

© Andrew Cook June 2012

are probably suffering from the most severe form of TSD – Dissociative Identity Disorder. These figures are remarkably high, and are, of course, even higher in countries where war and violence is endemic. The psychological effects – including depersonalisation – make further violence more likely in any society where these occur. Without necessarily having an obvious *remembered* trauma to attribute the symptoms to, these conditions usually go undiagnosed; and so it is a very common event for health professionals to be asked to help with somatic symptoms (pain, physiological symptoms, neuropathies, etc) that are actually expressing a TSD.

There are many ways of working with traumatised states, and at the same time, all of those approaches have certain common features, because they have common material – the human being. The works of Peter Levine and Steven Porges are common references. The difference between approaches used by different practitioners is a function of the particular training, viewpoint, inclination, set of skills and experience of the practitioner. It is also partly a function of who is coming for treatment – some techniques simply do not work with some people, and one possible reason for that is because the technique itself is somehow activating.

As Craniosacral Therapy (CST) practitioners our main modality is bodywork, and the main way that we apply that technique is through some form of manual contact, with the patient lying down. In fact, if somebody books in for a bodywork treatment, they usually *expect* to lie down and be touched. Just as somebody who goes for psychotherapy would generally expect to be seated during the session and *not* to be touched. It is unfortunately a fact that many people who have TSD symptoms are activated by both touch and being in a vulnerable position – and a supine position is fundamentally vulnerable. So in *some* cases of TSD, regardless of the skills of the practitioner or the intention of the client, it may be the case that – on a biological level – the implicit therapeutic contract of a normal bodywork session (physical contact by a stranger whilst lying down) is antipathetic to non-conscious survival agendas. In these cases, there will always be an abreaction during or after the treatment, or a compliant "cure" followed some safe time later by a relapse or an abreaction. This is regardless of the fact that someone may have *consciously* chosen to have bodywork, or even specifically CST bodywork to

© Andrew Cook June 2012

address the emotional and/or somatised side effects of a TSD.

There are several issues that (ideally) have to be considered as part of the treatment offered in these circumstances. Given that the therapist recognises that what is presenting *may be* a TSD, questions that arise include :

- Does the person consciously recognise that their somatic symptoms may be a form of TSD?
- Is there a conscious memory of events that may have caused a TSD?
- Would the person be willing to consciously recognise that if they were told? This is particularly an issue is there is no specific memory of a traumatic event. And one of the main guidelines for working with TSDs is that the therapist consciously avoids statements that might be suggestive. The word "trauma" is itself so loaded that this is a very real issue.
- Is the therapist sure enough about this to even mention it as a possibility? And if so, what level of qualification and experience allows the therapist to make statements that may appear to the client to be a "diagnosis"? i.e. how to what extent can the client *consciously* participate, given the professional remit (etc.) of the therapist?
- And following on closely from the previous issue... If the patient were referred on for psychological help to a trauma specialist, would that be beneficial, considering the initial intention was (probably) to come for bodywork to address a somatic "problem"? What on balance is the implication of referring for psychotherapy – given the above questions, some of which it may not be possible to verbalise with the patient, because this might be excessively suggestive or (in your estimate) may just be too far outside their comfort zone?

Although the above questions need to be *somewhere* in a CST practitioners awareness, it is possible to over-egg the pudding. My experience is that the vast majority of people presenting somatised TSD symptoms who have come *of their own volition for bodywork* will respond very positively to techniques designed to deal with TSD from a bodywork approach. Thy have made a decision about who they wish to be treated by and what modality they wish use, and in the vast

majority of cases that consideration overrides any of the above questions.

But, given that the therapist becomes aware of the possibility of the somatic symptoms being expressions of a TSD, there remain issues around touch and vulnerability which should be seriously considered. Again, many of these are often secondary to the fact that CST contact is based on an awareness of the field around someone, and includes and appreciation of emotional states in tissue. I am sure that there are many ways round this particular "problem"; but here I would like to present one particular method that I *personally* find to be useful in many cases. Like all techniques, it is not a universal panacea, and will not suit every practitioner. However, it is worth describing, if only that it has given me an interesting and (literally) expanded perspective on the near-body and embodied fields that we usually work with.

Development

This all started when I was "attempting" to help a migraine case. I became aware of a strong constriction in the midline just anterior to the vertebral bodies. If my attention even contacted it with the faintest of feather touches, it tightened even more and the migraine intensified. If I removed my attention completely., then literally nothing happened – and indeed, nothing happened for quite a few treatment sessions, regardless of what level of awareness and degree of spaciousness I adopted. In order to remove myself sufficiently (i.e. for the migraine not deepen), I was having to imagine myself so far away that my brain felt a bit like Bilbo Baggins' "butter spread too thinly on toast". And that level of no-contact may have been neutral, but it was also of no obvious positive benefit. In the end, I had had enough, the client had had almost enough and I decided that (even if it was just in the interests of self-preservation) I had to do things differently. So I got out of my chair and started to find how far I had to physically move away for the migraine to subside. We mutually located what can only be called a boundary, about 5 feet from the patients body. When I moved only an inch into this space, the migraine came on. When I moved out, away from the table then "other" somatic symptoms/ sensations started to arise, but the migraine disappeared. I found that as I was being told where to stand by the patient, I was

also becoming aware of quite subtle but nevertheless clear sensations in and on my own body that told me where this “edge” was. And I was also aware of internal sensations, emotions etc. that more or less mirrored the sensations being reported to me. To cut a long story short, what eventually revealed itself was a defence zone with a “skin” of its own – some distance from the body - that I was capable of sensing and interacting with.

The method of exploration of these phenomena is open to some degree of choice. Most clients don't (at least initially) have the degree of sensitivity or intensity of somatisation described above. In fact usually they are (at least initially) completely unaware of the location of this boundary. There are two quite distinct aspects to the extra-cutaneous field being described above. The first is a force – almost like air pressure, that allows the location of the fields' boundary to be identified. The second is – lets call it *information* – in the form of an increased ability by the client to identify subtle somatic shifts without being pulled into the content, and an increased awareness of counter-transference by the therapist – with (usually) a greater ease of separation from identity/personal issues. Ideally the therapist is able to engage with the *counter-transference* field such that you literally *feel some reflection of* the responses that are happening in in the clients body *but* are also able to not associate with them and to recognise that they are not your own, and the physical distance assists greatly with this separation. This allows a certain amount of feedback to be given to the client, and most people can be trained with a remarkably small amount of feedback to identify the usually subtle changes happening in their own body that the therapist is detecting. Once both of you have this simultaneous more or less mutual experience, then a meaningful and useful process can comfortably roll out over a period of maybe 20 minutes.

I spent some months in 2011 attempting to document this set of phenomena, and finally after I had written over 80 pages, I realised that I could describe it by direct analogy far more easily, and at the same time convey much more information.

Back to basics

Lets start with a simple CST contact. The first stage of *physical* contact involves a

negotiation, during which the therapist becomes aware of a certain distance from the body that his/her hand is “allowed” to come to. This position is sensed as something almost like an increase in air pressure against the palm of the hand. Its usual response *provided that excess force is not used* is that the zone gradually eases into the body and a physical, albeit (usually) very light contact is then made. It was usual (at least in the training I received, having practised CST for some 17 years now) to consider this negotiation something of a preamble to the treatment rather than being a contact in its own right. That is – unless I was specifically working with an energy phenomenon such as a chakra, in which case the off-body work was considered to be relevant rather than a preamble. On reflection I find that distinction rather curious.

So firstly, what I was being made aware of is that this zone of negotiation *is* actually a contact in its own right of equal (or even greater) importance to skin contacts, regardless of what it might be associated with. And secondly, it is sometimes so far from the persons body that – if you were to sit in a chair talking to them or sit near a treatment table and not even touch them – you would already be *inside* it. The situation here is one which I describe as “all the fuses have blown”. Once inside this zone there is no information for the therapist that they are inside anything, and of course the material that the zone represents is unavailable, because, just as in a universal hologram, all the information is on the periphery rather that in the middle. And once you are “inside the box” you are no longer a relatively neutral observer – you are an active and unwitting part of whatever is occurring. In cases of TSD, the effect of somebody – no matter how well-intentioned - being inside this zone is usually to activate the traumatic material.

For the client, this zone/boundary/bubble appears to be a place where energetic fields meet proprioceptive senses meet hindbrain/RAS[1]/ANS[2] survival responses. As such, anything that penetrates this invisible bubble may (in some circumstances - i.e. when there is a TSD) be perceived *on a non-conscious biological level* as a potential mortal threat. In which case at least some parts of the body then go onto

1 RAS = Reticular Alarm System : a sensory reflex-response function of the hindbrain
2 ANS = Autonomic Nervous System : a branch of the nervous system largely devoted to the adaptive control of physiology (blood flow, etc). The ANS itself comprises two major branches (sympathetic and parasympathetic), which act together, one often being more dominant. Any specific balance between these two may be adopted by the whole body, or diferent parts of the body may be in different ANS balance states.

© Andrew Cook June 2012

red alert and engage in whatever defensive survival mode they are programmed to default to. If they default to Sympathetic, then the fight-flight response is engaged. However, many undiagnosed TSD's default at some level to *last-ditch defensive* Sympathetic (retreat to the core followed by core tightening - hence the migraines! - with the exterior left to cope on its own, often in a nice floppy and comfortably numb parasympathetic state). This can evolve into *deep* Parasympathetic (*last-ditch defensive* Sympathetic followed within less than a second by collapse and dissociation at a core level). This is sometimes described as (and experienced as) "soul loss", and more formally as depersonalisation and dissociation. If this dissociative experience is 24/7, then it will be "normal", and the client will not know that their experience of life is missing anything at all.

Resourcing

For now, it is enough to say that dissociated states are definitely poorly resourced, since they represent a state of loss of connection with a sensation or physical strength or mental function. One of the cardinal principles for treating TSD's is that we need to have as much resource in place as possible, and ideally some conscious engagement of the patients frontal cortex. This is another reason why the supine position is not necessarily the best for working with TSDs. The most fundamental positive survival trait is curiosity and a willingness to explore, and if this is engaged, the patient is a) in conscious control, at least at some level, and b) well resourced, and c) operating primarily from the frontal cortex rather than the amygdala or RAS. Another aspect of resourcing is that the patient experiences themself as being in control, and so I usually have them at least sitting in a chair rather than lying down. Often they will choose to have the chair in a specific part of the room (and me in another part of the room). Sometimes they stand up – this is far more resourced. Some clients are incapable of engaging with this highly resourced state because the TSD they are locked in "believes" that they have to be submissive in order to be safe. These are far harder TSD's to treat, and this kind of response is often associated with DID, and some state has to be found that is both resourced in some way and still safe – i.e. not recognisable externally as being resourced.

© Andrew Cook June 2012

What is out there?

In short, this off-body zone behaves in many different ways depending on the person. Sometimes it is quite specifically a somatic memory of embryonic states, such as the yolk sac or more often the placenta. But the most usual way that it behaves is as a defence zone.

So what is the "technique?" I simply stand at the edge of the boundary and use the sense of the air-pressure boundary and counter-transference in my own body to follow it wherever it goes, maintaining a light but persistent contact *on the edge* of the defence zone. This is *exactly* as I would have moved my hand to negotiate a tissue contact in a more recognisable CST treatment, except that my whole body is responding rather than just a hand. My *interpretation* of the main effect of this technique is that *it provides the clients alarm systems with the correct form and pace of information so that the RAS and other non-conscious biological safety systems have an opportunity to reassess the safety of the environment* ***here and now*** *rather than being stuck in a reaction that relates to some* ***there and then***. Once the body (*non-consciously*) reassess the possible threat/safety of that off-body contact, then (his being a survival reflex) the body will choose the most appropriate state that requires the least amount of energy and imposes the least disturbance to normal physiology. i.e. given half a chance the body chooses to detraumatise itself, simply because a low alert state is more efficient than a high alert state. We just have to give it that chance by providing information in a form that it understands. The RAS is non-verbal and highly connected to the somatic, proprioceptive and spacial senses. These spaces normally respond to danger in less than 0.1 seconds. Once set in a high alert state, they take 5, 10, 15 or more minutes to reset themselves IF they are given a clear and safe boundary contact – wherever that boundary might be.

Exploring the space

The first contact is the hardest because often the boundary is weak and diffuse. You have to be very perceptive to stand on its edge rather than inside it. If you are too far inside at the start, or move too quickly it *may* "collapse". By this, I mean that it rapidly expands, and you will suddenly be left inside the bubble with

absolutely no sense of being in contact with anything. What is left in the space previously occupied by a positive repelling pressure is either neutral or a field of suction, *pulling the front of your body forwards*. If you follow the suction, it will pull you in more and more strongly the closer you approach the client. If either of the above happens ("nothing" to connect with or a sense of suction) , you simply have to move back out to the (new) edge of the bubble – and the system seems to immediately adapt to the fresh contact. Often I start off quite close to the wall on the opposite side of the room to the client, and us a large room approximately 14 feet square. The position of the door is a critical factor in the relative positions you first adopt. If you gauge the distance correctly (and this may be sensitive to as little as a centimetre), then sometime between maybe 2 to 10 minutes (or more) the field will start to strengthen. At this stage it is possible to engage in a little experimentation and to test what happens when you move a few inches towards and away from the client, to see if they also have some sense of response to the movements. If they do have a good sense of a change, this can be affectively used because they can be put more in charge of the experiment, which is more empowering and they are immediately more in control – i.e. more resourced.

Just as in negotiating a hand contact, this edge has to be followed respectfully rather than forced in any particular direction. If you find yourself being pushed away, it is an excellent and hopeful sign that the defence zone is feeling confident enough to strengthen itself, and it is important to physically acknowledge that force by moving with it. After strengthening, the field will start to move back towards the client, and when you are maybe four feet or so away from them you will have arrived at the normal body space, and the field will become much less intense (this is neither a collapse or a weakening, but rather a softening). A second phenomenon (I have so far described the positive, repelling pole) is that sometimes there is an attracting pole that responds when you attempt to move away by a few inches. This pole does not suck in from in front like a vacuum but rather pushes from behind! I interpret this as an attachment deficit response. Clinically it appears to be more important to respond to the repelling pole. Two of the many possible reasons this may be the case are a) normally the defensive pole is unconsciously invaded and "blown" by anyone and everyone who walks past them or approaches to within less than maybe 10 feet of their body, and b) defence-survival is possibly more primary than attachment-survival.

Discussion

One thing this has made me realise is that – when we "make space", we are not necessarily "just" creating a sense of spaciousness – we may also be placing our attention at an invisible external boundary. In fact, when this is explored in detail, it becomes apparent that a sense of spaciousness (e.g. when holding the vault) is rather different from the negotiated space of a contact. The former is simply room to breathe whereas the latter is a non-physical contact which itself may be given more or less spaciousness. When we contact that extra-cutaneous boundary, then we receive information about it and it receives information about us – this is a point of communication. Spaciousness naturally arises because we are no longer *invading* a boundary whose existence we were unaware of. This is 100% analogous to touching skin, but we are touching with our minds "something else" that behaves like a kind of defensive non-physical skin, and other things besides. Another important aspect of being *physically (rather than just intentionally)* on the edge of this bubble or even outside it is that (in my experience) any counter transference becomes more somatically noticeable and at the same time easier to recognise as being counter-transference. So simply physically moving further away from a client until the mental static becomes less personal (for you) and therefore more manageable is also a useful secondary application of this technique.

My current estimate is that about 70% of migraine cases are last-ditch sympathetic core tightening as described above. And using the above approach I think I have more or less reduced the number of treatments I need to make by about 70% for these instances of migraine. A need for orthodontic fixed braces and extractions also appears to correlate with an over-tight core, and I have seen one case where appropriate treatment of that core tightening has substantially helped teeth to become straighter (in association with the use of ALFs[3] -the ALFs were struggling to contain the movement of the incisors until the pre-spinal core softened and normalised). Most peripheral circulatory deficiencies and some peripheral neuropathies also respond at least partially to this approach, as do about half the

3 ALF = "Applied Lightwire Functional" : a lightweight, minimal pressure wire spring orthodontic brace. These light touch devices apply a similar level of pressure as is used in CST intraoral work; and so the level of force they apply does not evoke a resistance reaction from the body. This results in far faster and less painful expansion of the maxilla. The system is in fairly widespread usage in the USA, Canada and Australia, but so far (at time of writing, April 2012) has not been accepted in mainstream orthodontic practice in the UK.

© Andrew Cook June 2012

cases of Menieres and other forms of loss of balance/coordination. Every case of non-DID hyperarousal I have used this method with has renormalised to a substantial degree within a few treatments. Most hypermobility appears to include at least a component of of parasympathetic core collapse, and this is not easy material at all – in fact, parasympathetic TSD states in general are far less easy to work with than sympathetic states using *any* technique.

Of course, there are also a lot of caveats to all this in terms of client management and the non-verbal contract. If I stand 10 feet away from them as they sit in a chair and wave my arms around, shuffling backwards and forwards, towards and away from them a few feet or inches on the floor; there has to be an adequate communication of intent, understanding of purpose, trust, a re-framing of what might constitute a “treatment”, etc. etc. So this is not necessarily something that is easy to integrate into a practice. Nevertheless (with some appropriate structuring and some time – anything between 10 minutes and a full session- spent discussing the principles and describing the defence systems of the body) it works in many cases. A simple half-way house that works with experienced clients is to negotiate your way through the distance between your desk and the treatment couch, giving time for contact. If the client is sufficiently familiar with and accepting of a culture of spaciousness and minimalism, then it may be that no specific explanation is necessary.

Typically, if I find myself being aware this may be a useful approach (and this is the case in maybe 20% of new adult clients who walk into the clinic), I might spend anything from one up to (rarely) 5 or 6 sessions working in this way. After this, even if the TSD is not completely diffused (and a surprising number *do* appear to be completely reintegrated), I find that the body's defences seem to be far more willing to allow me in to do “normal” hands-on CST, the client doesn't dissociate anywhere near as easily during the session, and far more material is accessible in a non-traumatising way than previously. The response of true DID clients is far less predictable.

The above is a very brief description of a very large subject. The following document contains a more detailed experiential view of this subject, along with theoretical material from a wide range of diverse topics that appear relevant.

1. Introduction

This monograph is a description of a specific technique I developed over a period beginning around 2006 to treat “trauma”-related problems. The emphasis here is very much on practical rather than theoretical issues. The technique appears to provide a simple and effective way to assist the Reticular Alarm System (RAS) to re-assess the safety of its here-now environment and then reset *by itself* its state of defence-readiness, its presence in the zone of safety it applies round the body, and the distance which that zone lies beyond the skin.

When I attempted to pin down the theoretical structure behind this process, I found myself in the territory of trauma/body psychotherapy, biology (evolutionary, cellular, and behavioural), “energy” of various kinds, meditation, sensory perception and consciousness, embryology, neurology, linguistics and several other fields. This integrative view of the body-mind has became something of a project in its own right. I have therefore presented the theoretical model I apply – which may not suit everyone – from the practical application. The most important theoretical topics are “resourcing” techniques (typically used in the first stabilisation stage of trauma treatment) and the “Window of Tolerance” - both mainly derived from Sensorimotor Psychotherapy. It should also be fairly obvious that there are a lot of theoretical dots to join up that have not been covered.

Very briefly, the approach described below is one of sensing the outer boundary defence zone, and then actively responding to it in a way that allows it to reset itself - by *physically moving* in the space around the person to contact with the “physical” location of the edge of the defence zone.

Much of the development of this technique has been experiential, so I have avoided being pseudo-academic – and have *not* supplied the usual detailed references. Important sources are acknowledged in a more general way, so any interested reader will still be able to explore these and flesh out some of the detail for themselves in a way that suits their particular interest and curiosity.

The following pages are a summary of my experience *so far*. Although it feels fairly substantial and the model and data are a good match, I can honestly say that every time I have thought that I had a complete catalogue of possibilities, somebody has walked into the treatment room and shown me something completely different. I am very sure that there are states that fall into this system that I have not described here. There may even be things out there that would force me to throw all the theory away and start again – I hope I have enough humility to do that should it become necessary.

Taken as individual pieces, there is very little here that is new. This approach is integrative, and combines trauma theory with bodywork techniques, Hakomi principles, an intelligent application of counter-transference and senses more related to the “Chi” field recognised in martial arts and Qigong. Various major elements that appear to contribute to its positive effect are described, along with the phenomenology of working with space instead of tissue.

It is customary for bodyworkers to *have* to touch, and what I am suggesting, based on my experience using this approach, is that even with the most refined of contacts, for some people,

© Andrew Cook June 2012

some level of biological defence may be over-activated even by being inside a space within a few feet of their body. Once the therapist is inside this zone there is no information available to either therapist or client that a boundary has been overridden. On the other hand, psychotherapists tend to position themselves some distance from their client in a seated position, but then remain in this static position. Again, I am suggesting that sometimes the position adopted may be far too close. Whilst the static nature of the position may be *eventually* accommodated by the body's defence, sometimes it may not be accommodated at all. A more responsive, expansive and dynamic use of space is a far more efficient way of working with these hyper and hypo-aroused states.

2. Background

My main treatment core skill is Craniosacral Therapy (CST). This is primarily a hands-on bodywork treatment modality derived from Cranial Osteopathy and several other strands of complementary medicine.

The aim of all CST treatments is to provide some kind of connection or contact that results in the body reorganising and repairing *itself*. There is a trust that there is an inherent wisdom in the "body" that not only knows *how* to repair itself and in what order this is necessary, but also *will* do so given a minimum of necessary assistance. All of the contacts used in a CST treatment are designed one way or another to be recognisably friendly to the body's various self-defence mechanisms – so that (a) there is no resistance (e.g. through tightening/armouring of superficial muscles) and (b) any responses that are evoked can be helped in a cooperative manner – rather than pursuing a manipulative agenda.

This *can* take the form of a deliberate physical intervention, such as "fascial glide". The connective tissues and muscles are pulled or pushed in such a way that fluid enters between adhered fascial sheets. The use of "pull" and "push" is a relative term, with a typical contact pressure being about the weight of a 20p piece or maybe a £1 coin. In reality the quality of intention and presence when making contact is far more important than the physical pressure applied. The weight/force of contact may be considered to be a secondary external representation of this intention and quality. Despite the fairly small pressure used in most circumstances, fascial glide is *one of the most* physical techniques used in CST. On more subtle levels, there are various rhythmic "fields" (Cranial Rhythms) inside and around the body that appear to be related to the expression of health. So another CST approach is to latch onto, invoke, invite and/or encourage these rhythms so that they enter and mobilise the body, become stronger, more symmetrical, and more universal. Generally speaking, the overall intention of any CST contact is to encourage the expression of health, and so the focus is primarily on health rather than pathology. Although there are a few "fix-it" techniques in the CST tool bag, the main approach is to listen, to allow and encourage health to express itself fully, and to provide a opportunity for the body to do what it does very well itself with the correct amount of of cooperative support.

If the therapist is too gung-ho or inclined to *try* to make something happen, this can simply get in the way of what the body is trying to do – or it can be perceived at some biological (or other) level as a threat that has to be resisted. It is this latter category that is less easy to gauge, and for

the purposes of working with boundaries is the more important. Getting out of the way sufficiently to be recognised as not being a threat by the various *biological* defence mechanisms is not always easy. The body defends itself all the time, and its *biological* view of a "friendly" contact may be radically different from the kind of physical contact that we *consciously* allow, tolerate, or even enjoy.

One way to create a "safe" form of touch that has been found to be useful in CST is to *imagine* that the hands are some distance from the body – even though they are touching. This imagined/ *intended* distance generates a sense of spaciousness which the body recognises as being an intent not to harm, and so the tissues will naturally soften rather than engage in an armoured reaction. The suggested sense of space also creates a potential for self-organisational movement. This is followed by a *negotiated contact*, where the CST practitioner senses the body's response to the proximity of their hands, and only approaches as close as the body "allows" - *eventually* coming into physical contact.

It was in the application of this technique that I first decided to *not* touch the body at all. At the time, I was working with a few people who were suffering from migraine, and was aware of a really deep core tightening that accompanied the migraines. It was as if the entire fascial band directly anterior to the vertebral bodies was tightening, and pulling on the base of the skull. Obtaining any kind of positive outcome to treatments was almost impossible. As soon as I became even the tiniest bit aware of this tight vertical line, the migraine symptoms would substantially increase. If I just ignored it by deliberately holding my attention on health (rather than pathology) – then unusually - nothing useful happened. I decided to see how much space I could give the tissues by imagining myself a very very long way away – further than it was immediately obvious that I should intend. This definitely was an improvement, in that I was no longer triggering a migraine, but there was still not really any substantial change in the migraine pattern.

We needed more space. But in order to *not* activate the migraine I was already stretching my mind so far out that my head felt thin on the edges and I was almost getting a headache myself. I decided that this was not good for me – it certainly didn't feel very good – and I started to look for some way of achieving the same effect without having to imagine such a big distance. At the time, having attended one of Jaap van der Waal's embryology workshops, I was thinking about Rudolf Steiner and the expression of polarity. The thought came to me that such a profound tightening and contraction in the core of the body was probably accompanied by an equally large expansion of "something". So – if we can't touch the tightness, how about contacting the "other" end of the polarity - whatever it is? The piece of experiential evidence that I had in front of me is worth stating again – *when <u>my awareness</u> made even the slightest of contacts with this tight core of the body, <u>the client simultaneously experienced</u> a migraine onset and I experienced an increased tightening of the core*. This effect occurred whether I was touching the body or not.

Although we are dealing with the subtleties of awareness and intention here, it didn't take many trials to demonstrate that this was a clearly repeatable response. It behaved like a defence recoil – like a small animal curling up tightly. Rather like someone touching a slug or a hedgehog – no matter how friendly you are, they just curl up even more tightly. So the thing that might be expanding out that I would try to look for might be some kind of zone of safety? It turned out to be a good initial guess, but it took a couple of years to get a clear picture of what was happening. When I *physically positioned myself* various distances away form the client, this had an effect on

their migraine intensity. Attempting to locate the physical position at which a change occurred, I found that I could sense some kind of boundary, and that sensation matched the sensations reported by the client – when I moved we *both* noticed a somatic response at the same time. I asked several therapists who I knew whether they had come across anything like this, and the responses suggested that this was a known phenomenon in body psychotherapy, but not one that had been particularly well explored because of its apparently intangible nature. Asking more questions whilst writing this, I have found that quite a few CST practitioners have started on this journey for various reasons. There also seem to be some parallels with the work of David Boadella and Peter Levine.

For want of a better description I called this method "*distance work*", and that is still to me the most comfortable way of describing it. After rather cautiously experimenting with *distance work* for about 2 years, but not really understanding it, I attended the Module 1 (PTSD) course with the SensoriMotor Psychotherapy Institute. This proved to be really valuable, because I suddenly had a well structured physiological model of PTSD that fitted what I was experiencing. I had also learned a very effective set of tools for resourcing clients (to reduce traumatisation levels). And perhaps most importantly, I had a way of describing what was happening to them in a way that is intelligible, easy to understand and accurate. With this ability to *explain* what they were feeling as I moved backwards and forwards by a few inches, it became much easier to use this method for long enough to have a significant effect.

In practice, *distance work* is a hands-off version of CST, with a large component of Sensorimotor *resourcing* to support what arises from it and provide a teachable and physiologically accurate framework that allows the client to understand and participate in what is happening.

Clinically, I use *distance work* whenever somebody comes for treatment and one or more of the following apply :

- their body reacts to contact (physical, perceptual or intention) in any way that suggests that its defences may be hyper or hypo-arousal (or both)
- they describe symptoms that are suggestive of dissociation
- they suffer from migraines or other somatic symptoms "typical" of dissociative disorders and present some other history or type of response that suggests that may be possible

AND I also will usually be quite cautious and assess how well they might receive this hands-off "bodywork" before I even think of suggesting it.

Some approaches in CST also apply a sense of embryological unfolding as part of a treatment. Or perhaps more accurately, sometimes there is a sense of embryological formative gestures and movements which feel as if they are stuck – and these can be helped to complete their gesture by correct application of contact and awareness. This type of work often has profound effects on all aspects of the adult body, from musculoskeletal alignment to digestive function to psychology/ sense of identity, and to the range of sensory awareness and adaptability of states of consciousness. I have, for various reasons, brought the *distance work* approach back in what is something of a full circle, and also *sometimes* prefer to apply it when working with (e.g.) umbilical and placental issues.

© Andrew Cook June 2012

Clinically, this approach may simply be used as an indication that the CST practitioner is OK take 90% (or even 100%) of the treatment session to fully negotiate a hands-on contact, *and* that this is time usefully spent, *and* that this approach may have to start at the edge of the treatment room.

Whilst writing it I have been very aware that there may be many completely different techniques and approaches that perform essentially the same purpose. So the following descriptions are *not* a statement that this is the *only* way to help reset the RAS or to normalise alarm-state boundaries.

.

3. The *distance work* process : a detailed description

3.1 General procedure

This tool is essentially a way to help the body's defence systems to renormalise. A more or less common pattern that works through in maybe 70% of cases goes like this (there is substantial variability in the exact order) :

(a) Explain the reticular alarm system, the Window of Tolerance (WoT) and the idea of safe body space. A common simile I use is an intelligent fire alarm that goes off when I carry a nice hot cup of tea into the room. The fire alarm is necessary because it makes sure that I am safe from real fire. So I do not want to disable it – but rather help it to recognise real fire and discriminate it from the steam around my tea cup. Three points work in our favour here : *Firstly* high alert states are also high energy expenditure states, and the body wants to be as efficient as possible. *Secondly*, the survival alarms will not allow themselves to be switched off or turned down if they suspect danger. Just like a fireman who thinks there is a fire will insist on you leaving the building and might even start to fight you if you attempt to prevent him doing his job. This latter point may seem like a problem – but actually it preserves integrity in the face of excess force by the therapist. If any attempt is made to disable the survival mechanism or your intention is too much oriented towards an end goal, the mechanism will either turn into a mule, or will go underground. Either way, you will have pretty well lost all opportunity to work with it for some time, and will somehow have to regain its trust. *Thirdly*, an accurate verbalised description of the positive functional strengths and roles of the ANS will itself generate a shift – it is "as if" the body hears this, understands it, and then goes - "*hey – of course – NOW I remember what I'm supposed to do....*". This deep physiological response to *positive* role description is in some ways comparable to the "body talk" / "cell talk" approach adopted by John Upledger in the Therapeutic Imagery and Dialogue technique used during Somato-Emotional Release. A directly elicited dialogue with body parts appears to be often unnecessary given a sufficiently accurate and holistic grasp of physiological function. I am, however, conscious as I describe ANS functions that I am primarily talking to the non-conscious/the body, and am aware of and responsive to (e.g.) subtle shifts in body posture which give feedback as to how this information is being received.

(b) Get the client to find what part of the room feels "best" for them to sit in. If they have no preference or they choose an obviously unsafe position (e.g. with their back to a door) then go more cautiously, but still continue. You might choose to point out this kind of "anomaly" and make it more conscious – I have had some very useful interactions when I have broached these issues. It is sometimes useful to simply provide a blanket for them to wrap themselves in, which provides a sense of containment and safety. They may want to stand instead of sit – there are many possible variations. Although sitting with (e.g.) back to the door is normally a poorly defended position, it may be preferable for someone with a very highly activated alarm system who wishes to *both* be near the door (for a fast escape) *and* simultaneously have a good view of the rest of the room. Most often clients seem to gravitate towards a wall, this being a natural defensive position. Sometimes they will take up a central position that dominates the entire room. Move yourself to the corner of the room furthest from them which is not in between their seat and the door. Leaving a clear

escape route will reduce the pressure on the RAS. Explain that this is an experiment and ask if they are OK with taking part in it. They may need a more clear explanation of the general process before agreeing to start.

(c) Intend to be aware of their body space and slowly work back towards them (see next section for details of this part of the process). The aim is generally to find and then stay *on the edge* of their alarm zone. This is analogous to respectfully touching the skin with an "ideal" mid-level pressure – not too hard that it feels invasive, not so soft that it leaves a sense of uncertainty. This light, positive and respectful contact creates an interaction which does not over-ride the RAS. Follow this edge wherever it goes (but NOT into a void – again, see below for more details) – **the aim is to present a very slow and predictable feedback to the RAS so that it is able to recognise the safety of HERE and NOW (rather than being stuck in a state which reflects THEN and THERE).** Given enough time to make that assessment, it will reset itself to a more efficient level of energy expenditure, balanced against its (non-consciously/biologically) perceived safety priorities. The aim is NOT to get as close to them as possible, but rather to allow the boundary to expand and contract however it wishes and to follow it/respond to it wherever it goes. It will *usually* (eventually) contract to a more stable, stronger and less reactive position (but in *its* own time, and as *it* sees fit).

(d) During this process I usually spend some more time describing how the ANS works and, if I have not already covered it in the preparatory talking period, something about the "Window of Tolerance". This is a useful bit of information for the client, and itself may help the process. However, the main intention is to keep talking in some useful but non-invasive way such that the clients mind is engaged on positive models (of physiology and boundary/relationship) so that the RAS is given time to react to this non-invasive contact. The RAS usually needs at least 5 or 10 minutes to regroup itself when given a positive but non-invasive contact. This time is ideally filled in a way that retains a clear communication between you and the client, encourages the client to be conscious of their state here and now, and particularly engages with the clients frontal lobes. In general *I prefer to talk instead of allowing the client to talk during this particular process*, because this keeps their attention moving on the positive theme I am providing and prevents them falling into their particular story for any substantial length of time, *and* it keeps them informed as to what I am doing. The reason for this distraction is to keep their mind away from re-traumatising story lines. When they are kept temporarily disengaged from these, their system is more resourced and its reactions are more related to your physical position than to any *non-local* alarm triggers (such as memories of past events). If the client interrupts, takes up the dialogue and relates this to their own experience, this is also useful, but the danger of this is that they will talk themselves back into a trauma. Once a memory is too strongly evoked, then you are in a counselling/ psychotherapy session and not in a bodywork session. Sometimes there is no option. Someone who has a desperate desire to be heard by verbally telling their story (and be understood/listened to in a way that they are familiar with) is probably not in a good state to go through this type of process and would be better referred on for formal psychotherapy, or the treatment re-focused onto more familiar hands-on bodywork principles (where talking has a much lower priority than receiving touch). Regardless of how much you natter on during this stage, you ARE listening to them by feeling their alarm state through your own

body. But this type of listening is not necessarily going to be acceptable to or understood by everyone. There is also an issue of the degree of control exercised by the therapist – the level of being in control described above may itself be experienced as being supportive or it may be experienced as being threatening/activating. Similarly, any attempt to ask the patient to describe their internal perceptions *may* be perceived by their non-conscious defence system as a dangerous threat. It is particularly important to be adaptive to these, and sensitive to what is happening as you ask for information or talk in any other way (or apply some form of bodywork!).

(e) If the field does not stabilise easily, or keeps collapsing or thinning out, then some resourcing is necessary even before you start (and that might not be a bad idea anyway in most circumstances). When the field has stabilised for a few minutes (see below) I always will start to ask the client if they are OK if we experiment with me making small movements. If they agree, I will move BOTH towards them and away from them very slowly. "Towards" usually comes first, but the choice is always open. During both of these phases I sense the degree to which movement is "allowable" and ask the client what they are feeling in their body as I make the movements. About 10% of people feel nothing. That is not necessarily an indication of the (lack of) usefulness of this exercise - but it does present a problem in sustaining some level of credibility of this technique in a treatment programme. The fact is that somatic perception is highly variable between individuals. If they do feel a response in themselves, it is almost always possible to feel that as part of the counter-transference. Movements that create a "safe" (i.e. non-collapsing) response are usually of the order of a few centimetres (or less).

At this point we have a direct palpable somatic communication set up between two people in a simple, safe environment, and the client can be fully engaged and participatory in any further exploration. In fact, they *should* be fully participatory when this sensed response is evoked, because that allows them to conduct their own experiments and to some degree manage the session. This is a highly empowering experience, and most people recognise the to-and-fro of the boundary responses from their own life experiences. However, because you are holding the boundary contact at a safe level and all movements are massively slowed down, the experience becomes conscious, manageable and understandable. Clients who have already worked with boundary issues from a psychotherapy viewpoint have usually made really intelligent use of this 2-way feedback, and have been able to use it to gain improved levels of integration very quickly – provided that they feel able to accept this somatic approach (and are also able to recognise that the dialoguing being used is not a form of counselling). The implied loss of distinction between body and mind is not comfortable for everyone. For less experienced clients, it is usually easy to non-forcefully direct them towards a productive use of this period of connection. This is a good time to return to resourcing. If someone is having difficulty with the concept of feeling their body, I often tell them that I'm going to ask a daft question, and then say something like *"if couldn't see your body or move it, how would you know that you have a body right now?"*

3.2 Variations and experiences

Although there are quite recognisable and common patterns in the way that *distance work* plays itself out, there are substantial variations in sequence of events, how the alarm system works, and even what is “out there”. The sensations are more often than not symmetrical and equal at all levels (but...)

First, remember that intention is 90% of everything you do. You can think of a boundary zone as a defensive bubble, as the persons required body space, as an aura, as a memory of being a fertilised cell – there are many possible intentions. However, it is vital to remember that your *exact* intention will make a difference to what you perceive, and *all the descriptions here relate to an initial intention of connecting with the edge of a defence/body space zone.* A second important intention (that is implicit in CST) is that *we are allowing the wisdom of whatever level (body, consciousness, spirit) to play out and make any necessary re-arrangement rather than imposing any particular result.*

You may (of course) choose to experiment with a different intention from this. However, with a clear *initial* intention the same as the one above you at least have a model to compare to your experiences. Having a confused/multiple or different initial intention will mean that the following guidance may not be useful.

All movements should be calm, slow, well considered and there should be a verbal communication of intent before making any movement. Any questions should as far as possible use the basic guidelines for dialoguing (Section 4.14). Sometimes there is an obvious somatic response even when the *thought* of making a movement forms itself in your mind. In this case you are *possibly* working with some level of Dissociative identity Disorder (DID), even if the person has no formal diagnosis of this and has just come to you for treatment for a bad back (or, possibly one of the typical pathologies often arising out of dissociation spectrum states – e.g. headaches, trigeminal neuralgia, tinnitus, dizziness, disturbed sleep, adrenal exhaustion/CFS/thyroid problems, an autoimmune illness or poor peripheral circulation or peripheral neuropathy). Just bear in mind that - telling someone who has come for bodywork for a physical pain or other diagnosed physical illness that they need psychotherapy from a trauma specialist is NOT usually a useful intervention, and may also simply be incorrect. One indicator is not a diagnosis – especially if you are not trained to diagnose. And you will be surprised at how much can be done with bodywork skills without having to step into a formal psychotherapeutic framework, *provided that you remain a conscious observer of – and not an unconscious participator in – the field of counter-transference.*

3.3 The positive boundary

This feels like a distinct “air” pressure against (usually) the hands and upper chest, almost like walking into a slightly over-pressured room. It is often quite sensitive, in that once found, a radial movement of less than a centimetre can cause it to react. Initially it may be quite faint and difficult to detect, almost wispy, diffuse, spread over a radial distance of maybe 300mm or more. If this boundary is very fine, dispersed over a substantial distance and/or hard to feel, then it is also usually far more sensitive, and if you stay inside it at a level that is easier for you to detect it may collapse. It is far better to back off again and then stop at the tiniest hint of it being there.

If you hang out at this first zone of contact, the boundary will regroup and become stronger. I

© Andrew Cook June 2012

have found that a perceived strengthening of this felt sense of pressure to be a very positive sign – and is literally an indication that the boundaries of the person are becoming stronger. The bubble's "air pressure" may increase without the location of its edge changing. If it pushes you further away, go with this, but interestingly, when the boundary starts to strengthen it will often become more tangible and feel more powerful whilst its edge stays in the same place. Once the boundary is of sufficient strength, it will *eventually* reorganise itself at a lesser distance (to conserve energy?) This may happen in one session, or it may take much longer. Whatever, it is important to have an agenda of just contacting the boundary and allowing a process to unfold, because IT has an intelligence and is capable of perceiving your intention; and is also fully capable of running rings round anyone who tries to deliberately make it change.

The physical location of the boundary zone may move in or out during strengthening and regrouping – and it is important to follow that change in distance as quickly and accurately as you are able. It often moves a lot at the beginning, maybe to test your intentions(!) or maybe just because it is unfamiliar with being acknowledged. A strong boundary is usually constrained to a very thin zone (a few millimetres), but nevertheless feels like a strong air pressure on the full front of the body as you approach. If you attempt to walk further into it, it feels like the air inside is increasing its pressure against you as you advance forwards.

Often (when the boundary has strengthened) about 5cm to 15cm movement into it is as much as is possible before there is a sense of not being able to advance any further. This would also almost always result in an easily observed but non-traumatised somatic reaction in both yourself and the client. This is *often* a slight tightening or butterflies in the abdomen/ stomach, but some sensation may also arise anywhere else in the body.

Clearly the initial distance that the boundary is set at is partly affected by the environment. Rooms are usually of a limited size, and I suspect that the boundary mechanism adjusts itself to take account of the size of room (however, see section on Proxemics below). I work in a room that is about 13 feet square (4 metres), and with the client sitting in a chair almost against the wall on one side I often find myself having to start within 2 feet (60cm) of the opposite corner. Occasionally it feels as if I am (at least initially) being pushed against the wall, but usually there is some space to play with. If this expanded boundary remains at such a high level of defensive alert, it will be almost impossible for the person to have a relationship. Sometimes the boundary plays around, alternately pushing out and pulling in – but not collapsing. The client will usually here be familiar with push-me-pull-you relationships. Once the counter-transference field has been engaged with, then following the boundary is a remarkably accurate mirror of the clients life. This accuracy carries a substantial onus of respect and care.

3.4 The collapsed boundary

If you advance too quickly or too strongly, or "miss"/walk through the edge if the first defence zone, then a weak boundary will simply collapse. I interpret this as a rapid shift from moderately (or even highly aroused) fight/flight sympathetic to deep (preparation for death) parasympathetic. This feels first of all like walking into nothing at all. I often find myself describing it as a state where the fuses have blown. Whatever has "collapsed" is no longer available. There is no resistance, no hint of any occupation of body space. If you get within 3 or 4 feet of someone and have felt nothing, then you probably have just walked through their

defences and are already standing inside their etheric viscera. In fact, when the boundary "disappears"/"collapses", it has (as far as I know) always ***expanded***. It is important to recognise the sense of "nothingness" that is experienced when the contact is lost, and to back off to a distance where the boundary can be picked up again. This is a very simple thing to do. If no action is taken or you approach further, then the collapse may deepen.

When this first level of collapse deepens, it eventually evolves further and becomes an active suction – there is a sense of being dragged into a black hole or even a vortex with an obvious swirl, and the closer you get, the greater the pull. You are here experiencing a traumatic boundary collapse (see the description of Hyper-collapsed boundaries in the next section). You may start to feel some form of dizziness, light-headedness, weakness/tiredness or nausea. It is instructive to consider that a simple non-threatening movement into an apparently open space maybe 3 metres from a person is enough to collapse some part of their defences to the point that it implodes. They must experience this regularly even when walking down the street or shopping or sitting in a cinema or visiting friends. So an absent or collapsed state will be a familiar and "normal" experience for them. So much so that even if they did experience something somatic, it will be so familiar that they may not necessarily consider it to be of any noteworthiness. However, they may report increasing symptoms of dissociation and/or an increase/onset of headache or pre-migraine.

As an aside, I now have started to think of (most) migraines as being a response to a "boundary infringement" rather than to "stress". This means that something is in the persons environment that is invading their safe body space, or causing their body to think that it is under attack. This may not necessarily be general stress, but is far more likely to be a result of a particular relational transaction or a specific person who is particularly "pushy" or maybe someone who has a poor sense of body space. It is not particularly helpful to "blame" these people or events, but if they are identified, this can help to set up temporary avoidance strategies. More importantly, it usually offers an insight into the particular relationship "field" that was present when this was originally set up, and also may provide a useful means to identify the pre-migraine onset stages. If we can identify the precursor stages and hold there (so that a full collapse does not occur), then we are in a very useful treatment zone (see Window of Tolerance notes later).

Boundaries can also "collapse" suddenly from an (apparently) moderately strong state, but it is usually possible to track a cause – and that is itself another useful exercise. They will suddenly seem to have disappeared. The therapist has not moved fast enough as the boundary has pushed out, and has been left inside the defence bubble, and all the fuses have blown. Almost always it is a particular thought of either the therapist or the client that has caused this collapse. To recover, you just need to acknowledge it as best seems appropriate, move back to re-engage with the expanded edge, and start again. In fact, this gives a much clearer picture of a boundary that has collapsed but which has not collapsed so far as to become a suction zone. The apparent "collapse" is actually an expansion and thinning out of the safety zone.

Also consider that almost all one-to-one bodywork and talking therapies take place well within the distances described above. My experience with collapsed boundaries is that – provided you back off, keep engaging the client positively and calmly and re-find and actively but gently engage the edge of the boundary zone, the zone will uncollapse itself and strengthen. The therapeutic value of just this is incalculable. It is well worth spending a good 40 minutes waving

your arms and standing like a sore thumb apparently doing nothing. Collapsed boundaries often result in abusive relationships. If the initial defensive boundary is strong but highly expanded, then boundaries in relationships will also be strong – but at a cost, and starting or maintaining a relationship will be difficult. Once a boundary space collapse happens the relationship becomes deeply co-dependent and may feel to be out of control. If the push/ defensive component is weak (and the most immediate response is a tendency to collapse at even the lightest of "contacts"), then the usual pattern I have seen is that abusive/ violent relationships are *almost* to be expected.

The body is always resilient in its response. I have *never* encountered a boundary that has collapsed during the session that could not be re-energised by moving back out to find its new expanded edge. So "*nothing*" collapses are actually a sudden expansion, leaving the witness without any form of recognisable contact. After working with these for some time, I think that I am starting to detect a quality to the inside of the boundary that is "other than" pure *absence*, but have not defined it yet in my sensory catalogue. As the boundary field/ bubble expands, the strength of its edge tends to decrease, and its *practical* usefulness to the person decreases logarithmically. When these off-body boundaries are strong, they are palpable to most people – even people who do not have a conscious awareness of them. When excessively expanded, they become thinner and are no longer so tangible, and so – although they may allow a greater sensitivity to approach, their use (in general) becomes far more sensory, and their repellent properties reduce to near zero.

3.5 The suction boundary

Accompanying some strong defensive boundaries are accompanying suction boundaries. First the defence engages (pushing centrifugally, but then there is a *centripetal* push (which can be as strong or even stronger than the defence) *from behind*. This often feels like being trapped between two opposing and unyielding forces – a butterfly between two glass plates. Defence pushes outwards, desire for contact/connection pushes inwards. Note the qualitative difference between this kind of "suction", *which pushes the therapist from behind*, and the black hole/pulling suction of the hyper-collapsed boundary which draws into itself, and feels more like falling into a hole (see later). If you're unable to distinguish these two, it doesn't really matter as long as you engage with the edge rather than getting drawn in.. Whatever happens, it is important to remain engaged with the *defence* rather than submit to this suction. In everyday life, the centripetal force will dominate relationships, since it degenerates into a collapse/ suction once the centrifugal boundary zone has been infringed. Here we are seeing an attachment conflict, with a defence ("stay away") combined with a "come closer" need for companionship, support, love. The person here will often have experienced themselves ambivalent about relationships, seeing themselves letting people in who they know they shouldn't have – sometimes in astoundingly inappropriate ways - and keeping people out who they actually, in their heart of hearts, want to let in. If you stay with the defence until it normalises, then the defence distance will tend to reduce, the suction will also reduce, and the attachment deficit will be easier to deal with, or may even disappear without any further work.

A relatively uncommon variation on this is when the alarm zone and its detection "nerves"

become more highly activated when you move outside of their range. A very weak suction is followed by a collapse when you move *backwards*! This is rather like playing a dangerous game of cat and mouse. The mouse feels more threatened when it doesn't know where the cat is. When it can sense the cat it knows where the potential threat is coming from, and feels safer. When you have a positive contact with the edge of the zone, this results in a very *relative* sense of safety. In this case, just staying well outside the zone in an attempt to be less invasive/activating will have as negative an effect as approaching too closely.

3.6 Fear, stored emotions, energy cysts and states of overwhelm

This has been the hardest and (for myself) most useful section to write, mainly because I had not previously managed to clarify the differences and common threads between bodywork and trauma psychotherapy. Both bodywork and trauma psychotherapy say that something quite special happens when the patients resources are overwhelmed – i.e. there are insufficient resources available at the time of the “incident” to deal with it. The effects of these overwhelm states are relevant to working with off-body boundaries *in some circumstances,* and my sense of the material being dealt with is that it is a continuous spectrum, which has different manifestations and sometimes requires different treatment approaches depending on the degree to which the overwhelm is affecting the person.

3.6.1 Definition of an Energy Cyst

In bodywork/CST we have the concept of Energy Cysts or Fulcrums. It is more or less agreed that an energy cyst is a specific type of trauma storage. A Fulcrum is something far more general, and may even include somebody's family or work, or important non-traumatic events such as the moment of conception. It may seem strange to classify trauma and fundamental life events together – but from a bodywork perspective these two both create a centre of force around which the body tissue or the personality or maybe even the entire person's life will revolve around. Energy Cysts were first defined by John Upledger [4] when he was attempting to reconcile his clinical experiences with laboratory measurements of human bioelectrical activity; and the following description is largely based on Upledger's work. An Energy Cyst (EC) is a disruptive force that has been encapsulated by the body because the body did not have adequate resources to deal with that force at the time it was experienced. The encapsulation is initially intended to be a temporary measure.

The “force” causing an EC may be one **or several** of :

- an infection;
- a physical impact or incision of any type or cause;
- chemical poisoning (including medication and recreational drugs);
- burns (heat or radioactive);
- a strong emotion;
- a very strong *thought* about the person from someone unaware of the force they are using (or far more rarely a deliberate psychic attack from someone who is aware)

4 JE Upledger. Craniosacral Therapy I,II and Somato-Emotional Release (1983, 1987, 1990)

© Andrew Cook June 2012

- a serious metabolic disturbance which is life-threatening to at least some part of the body (e.g. starvation, dehydration, drowning/insufficient air or oxygen, blood loss).
- some other event that *the body* (and/or the person) considered to be a mortal threat – e.g. surgery, anaesthesia are common instances

As a very general rule, the more violent or life threatening was the event *and* the more negative the emotions *as it happened* (fearful, angry, etc.), the more likely an EC is to form and the stronger it will be. Stephen Porge's research indicates that the critical factor in traumatisation – particularly in collapse into parasympathetic overwhelm states – is related to an inability to move or act or some level of physical restraint/ immobilisation. Note that the body's survival mechanisms are not particularly well conditioned to correctly assess the real threat level in many 21st century situations, *and often will over-react if the conscious mind does not carry out its role and perform a reality check*.

ECs which are not eventually dealt with by the body or by conventional means are usually complex – i.e. they contain *both* some physical effect *and* a strong emotional component. Infective encapsulation is a well recognised medical phenomenon – and there is an interesting ambiguity in which it is not clear how much the infection is keeping the immune system out, and how much the immune system is keeping the infection in. ECs are less mobile than ordinary tissue of the same type and always cause a loss of mobility of the tissue which contains them. ECs slow down or even prevent full healing if they exist in any area that has been damaged.

Upledger, Retzlaff and Karni[5] showed that the presence of just *one* EC increases the level of whole-body electrical activity. They also lose coherence with the surrounding tissue... They obviously remain connected to the nervous system and the blood and lymphatic circulations. My particular view is that - in other ways – probably through inter-cell communication, possibly EMG field frequencies – they stop being a full member of the total organism. “They” (i.e. the tissues/cells containing the EC's) are so busy taking care of whatever they are containing that they become inward-looking, more or less unaware of the body around them, and unaware that whatever threat they are dealing with has finished. They are in effect in a time capsule, and do not recognise that time has moved on. They continue to have the (overwhelmed) resources that they had during the incident, and remain at the same age that the person was when it happened. This type of behaviour implicitly implies/assumes that tissues and cells themselves have some level of awareness, and are to some degree active participants in the field of consciousness. The experience applying bodywork is that this activity occurs *locally*, and the brain simply observes it (and is affected by what it observes).

An EC may occur on any level of being – if only a few cells were unable to cope, then the EC will more or less be contained to them. If the whole body was affected (e.g. dehydration or lack of oxygen), then the EC will be present to some degree in the whole body. The impression is that some part of the body tissue or physiology (and implicitly, some part of the field of consciousness of that human being) will take responsibility for dealing with/encapsulating the overwhelming event, leaving the rest of the body to be able to continue more or less “as normal”. However, the presence of an EC decreases the total efficiency of the body, and so imposes a small but nevertheless significant burden on day-to-day metabolism.

5 Upledger, JE; Karni, Z (1979). "Mechano-electric patterns during craniosacral osteopathic diagnosis and treatment". The Journal of the American Osteopathic Association 78 (11): 782–91. PMID 582820

© Andrew Cook June 2012

Generally speaking, the body wishes to be as well as it can be, and continually reviews ECs (and/or the ECs review the body's ability to deal with their contents). This creates cyclic negative emotional patterns – as the EC opens, says "*can anyone out there help me?*" and releases a small part of the contained material. Usually the person reacts to the physical sensations and emotional content by going "*Yuk*" and attempting to distance themselves from it – at which point the EC closes up again. If whatever is contained is not "held", then it returns to where it came from – and so the EC does not decrease in size over time. In fact, it may increase in size if the emotional reaction to a glimpse of its contents are sufficiently strong and sufficiently negative. I recommend that you compare this description of how ECs work with the description of Transient Expedient Autonomy (TEA) in section 4.

ECs that are formed around a sense of mortal threat or a strong emotion may initially be quite small. However, if the situation is repeated, the containment response impact tends to be repeated in the same fragment, and so the EC will tend to increase in size. This places PTSD due to repeated exposure in a rather different light, because – from a bodywork perspective – there is likely to be a low level EC formed even at the first exposure. The effectiveness of positive resourcing that diffuses shock from one event is really determined by the degree to which the EC/TEA really is temporary – and is re-assimilated back into the organism.

3.6.2 The Kinetic-Energy EC

Possibly the easiest *general category* of EC to explain and describe is the one arising from a physical impact. Usually the kinetic energy from a blow will either pass through the body or dissipate in the tissue. There are usually changes in tissue protein alignment around the impact site of an EC – where the proteins arrange themselves radially, somewhat like the head of a dandelion. If the impact is sufficiently strong, or the tissue is rigid (usually due to an emotional response which includes tightening of muscles and/or contraction of organs) the tissue cannot dissipate the impact, and at some point in its travel the body will contain the impact energy. This impact site is not necessarily in a straight line from the impact point on the skin. Not only does the position of the body on impact have an effect, but also the energy diffracts in tissues of differing densities and at interfaces between tissue and fluid. Once contained, the kinetic energy dos not dissipate over time, but remains encapsulated – often for years or decades.

As it releases, the kinetic impact is *often* experienced by the client and/or the therapist as leaving the body along the path that it entered, *or* it may be simply felt to dissipate and be absorbed by the surrounding tissues. During this process there may be sensations of heat, cold, pulsing, vibration. Memories or emotions may be re-experienced, always at a manageable level, or the release may have no memory content whatsoever. Sometimes there is simply a quick memory of a long-forgotten incident, and the tissues then release with no other obvious experiential connection to that memory. Sometimes the body is unsure about releasing the EC. There can be many reasons. A list might include issues of acceptance; the fragment may need to be told how much time has passed and that it is now safe; the body fragment may need to be acknowledged for the work that it has done containing this impact damage; there may be a lesson that has to be learned; the body may need explicit permission to release the material; or there may be other ramifications of a full EC release which need to be addressed. All these can be worked with by asking the client to talk to their body, or by very well contained and controlled unravelling of the

© Andrew Cook June 2012

tissues by the CST practitioner. These co-opted fragments may vary in importance from being just a few fragments of tissue up to being entire organs, limbs or even archetypal essences for an individual's identity – power, love, etc.

Once the EC has been activated and it has started to release, the client will often be very aware of the part of the body that this is happening in, and often have a sense of the size, shape, colour, texture, even personality of the EC that has started to move. When they ask it questions, it answers! Interestingly, although it is better to maintain neutral positive language when dialoguing with ECs, *they usually understand negatives.* This is a remarkable thing – a lot of emphasis is given to positive language constructs in hypnosis/NLP when talking with the non-conscious, but ECs – although being some form of body-based (and therefore apparently non-conscious) memory – will usually understand the meaning of negative language constructs. This is not easy to explain unless the idea of a *higher self* is invoked – a mediator or internal healer/guardian/parent. If this were purely something to do with the normal waking conscious mind, then it would be possible simply to think ourselves better from *anything!* An alternative model here is that the conscious somatic connection also carries a more emotive sense of *meaning,* allowing a communication to occur *also* on in the language of the body/hindbrain. Upledger's Somato-Emotional Release tends to defer to what he called the "Inner Physician" - a phrase that is difficult to translate fully into non-American English, as we have a rather different cultural relationship with our medical professionals and do not usually use the word "physician". Its original context conveys a sense of some internal archetype which has full access to every available resource self-healing, has some oversight to both detail and the bigger picture, has some long-term responsibility for healing the whole person, and apparently requires the activation of a conscious decision... This has many parallels to the Huna *Aumakua*. In my personal belief system it would be something like ...

Every blade of grass

has its angel that bends over it

and whispers "Grow! Grow!" (from the Talmud)

As mentioned previously, when an EC releases, there are measurable changes in body electrical activity. An substantial release and internal reorganisation is usually preceded by anything from a few seconds up to tens of minutes of intense stillness. This stillness is recognised in all CST schools as a period of re-integration. It may be local to just part of the body, occur through the whole body, or even be a stillness that seems to fill the whole room – as if there is some silent vibration. When the stillness and pulsing come to an end, there is also usually very clearly experienced/palpable softening of the area affected, and often other experienced changes, increased body awareness, and a sense of improved body integration, a return of the CRI[6]. The body awareness is often noted by both the client and the therapist – the client says something like "my leg feels more solid", and the therapist is more able to feel *through* that part of the body rather than just hitting a blank zone.

6 CRI : Cranial Rhythmic Impulse : the most physical of the cranial rhythms, having a cycle of about 10seconds

© Andrew Cook June 2012

3.6.3 Semi-conscious dissociation

At this point it is worth mentioning semi-conscious types of dissociation that occur, usually in response to physical pain – and are a major reason that many ECs are not healed by the body. If someone is in pain, they often will attempt to distance themselves from the pain. Now, there are several different ways of doing this – some of which are useful and therapeutic, and some of which are truly dissociative or even self-abusive. I have come across people who (internally) scream at their body until it does what they want – their relationship with it is almost as if their body is some malign beast in which they are locked in some kind of battle, and whoever can scream more violently will win. Another less forceful but similarly relational variation is to try Faustian bargaining. Fortunately these are fairly uncommon. People with NLP skills often attempt to use their NLP in a forceful way to combat pain. This might be a useful first aid tool for emergencies, but when used as a long-term strategy is a total misunderstanding of both how the body works and the lessons that have been learned in NLP about the necessity for "ecological" interventions. Non-ecological interventions often work for a while, and then the body finds a way to avoid them. They will then cease to have any substantial effect, and any subsequent attempt to use these coercive approaches may even increase symptoms. I have seen meditation skills misapplied in a similar way. There seems to be (probably due to the lack of guidance available in common culture and in many westernised spiritual schools) a fairly common confusion between the kind of approach that is perfectly OK as a short term expedient body-override, and techniques that are appropriate for longer-term application. This is partly a confusion between symptoms and pathology. We fight to get rid of symptoms, but *obvious symptoms are often an expression of health*, and attacking them creates a conflict with the body's own self-organising and self-repairing agendas. This kind of misdirection of meditation or other mind-body skills is less easy to cut through, and clinically it is particularly difficult to provide assistance to EC's that have been attacked and manipulated in this way.

Many people attempt to distance themselves from the pain by not wanting to be in that part of the body – they put in place a wall, or disown that part of them ("*I wish someone would cut it off*") or they physically attempt to move away from the pain (they are "*beside themselves*"). The result of this is to not only change awareness and proprioception but to alter the entire alignment and neurological state of the musculoskeletal system. Often some part of the person will literally be outside their body – either the (usually smaller) part that they have evicted or the (usually larger) part that doesn't want to feel the pain. This kind of dissociation is different to, but may sometimes be on a similar spectrum to more commonly recognised forms of traumatic dissociation. Its main difference is that this form of dissociation can often be stopped or substantially reduced by reframing the mind-body relationship so that the conscious mind begins to treat the body with some compassion and as a valued friend rather than as an enemy. This kind of reframing on its own is sometimes capable of releasing non-complex ECs. Non-healing fractures are a particularly straightforward case in point – when the relationship between the mind and the body has been re-framed into one of cooperation and any dissociation in the limb has been resolved, the fracture then heals quickly. Maybe 90% of the people who I have helped with remedial tissue work on old injuries were quite unaware of how much they had distorted their perception of or dissociated from the injured limb until I helped them deepen their awareness of it (and then allow that dissociation to reverse). I can't claim that I would necessarily have done any different given a frightening injury and severe pain before I became

aware of these issues. Most of the problem is a societal/cultural programming which gives most people an extremely unhelpful relationship with their body – and this is remarkably easy to reverse provided that it is taught experientially rather than just as a theory.

Note that all of the above are *not* totally unconscious responses – they include a significant conscious component; though the client is almost always vague or even unaware of the process or the specific choices they have made or of the details of how this is happening or its implications. The fact that someone has chosen (or more usually - accidentally adopted) a manipulative, dissociative, combative or controlling relationship with their body is itself an aspect of the particular emotional issues that they will be (knowingly or not) struggling with. If this conflict of agendas between body and conscious will is strong enough, it can lock up the tissue movement. At this point the CST practitioner doesn't have many options without getting into psychotherapeutic territory. The contradiction/conflict can be held with no judgement or agenda and helped to resolve itself through the tissue. If this is blocked by the (usually unwitting) exercise of will by the client, then they can be called out and asked to consciously interrupt this conflict. This latter approach is something of a last resort, and is rarely received with much enthusiasm.

3.6.4 Consciousness, emotion and tissue mobility

Fairly clearly from the discussion above, my experience is that body tissue *requires* consciousness and a sympathetic and compassionate conscious mind in order to both repair itself fully and to be capable of normal movement and muscle tone. If the stored emotion is an adrenally-based (Sympathetic) emotion (fear, anger), then any muscle or soft tissue organ it is affecting will become harder, less mobile, and therefore (in the longer term) less able to repair itself, due to pressure on small blood vessels. The reduced mobility will also affect locally adjacent tissue (and this immobility may spread over a period of decades) by restricting its movement, and will affect the entire musculoskeletal balance. Fear stored in or associated with part of the body will make conscious access more difficult. Exercises such as Yoga, which require conscious access to relatively immobile areas of the body are – if practised with some depth of perception and cooperation – capable of restoring that conscious connection, and dissipating whatever the cause of its loss was. Overwhelm stored in the body may be encased in an adrenaline/fear zone, in which case that part of the body will still be hard – in fact it will be very immobile – but the hardness will be “empty” (as described in Shiatsu jargon). Overwhelm may sometimes *not* have an adrenal shell, in which case the tissue/muscle tone will be reduced, and instead of inflexibility and stiffness, there will be muscle weakness and joint hypermobility; maybe even with loss of peripheral circulation, loss of proprioceptive awareness control or even loss of sensation.

Experientially, emotions are somewhat akin to the bubbles that rise through a glass of lemonade – they begin in one part of the body, and then rise through the body, until they release through the orifices in the head or transform into something else. The natural state of an emotion is movement and transformation – if you observe a baby, it does not hold onto its emotions, and is capable or shifting from one state to another within a few seconds. Emotions may be stored in the form of an energy cyst, but may also be something rather like trapped bubbles. As they rise, they need to pass through tissue, and will become stuck in domed structures (in exactly the same

way that an oil/gas field is created in domed geological structures) wherever tissue is not freely mobile. So all of the bony joints, the diaphragm, tops of the lungs and heart, zygomatic arches, eye sockets and sinuses of the maxillary and frontal bones are places where these rising bubbles may become stuck. The last thing that should be done with a traumatised client is to deliberately remobilise and open up limb joints – this usually leads to a strong trauma recall either immediately or within the following 24 hours. A lot of traumatised people just don't like bodywork at all, and so this is not an issue for them. Quite a few go for regular spinal manipulation, and their bodies have become used to containing the trauma for short periods despite the open joints – and then always close up the joints again. I suspect that *one* reason that EFT works is that simple physical tapping of these domes will release emotions in them and allow the emotion to continue its lemonade-like journey. This is not a straightforward thing. If the tapping is too strong, then too much emotion is released and the tissue tightens up even more, making the tapping ineffective. However, a small amount of reflective experience allows this simple technique to be practised, and the sense of how hard and how long to tap for is quite easy to acquire. Certain emotions are more likely to become trapped in certain organs (e.g. sadness/grief in the lungs; externally directed anger/frustration in the liver), and I am not sure whether this is a function of the organ itself or more a statement of where the emotion is generated in the body and what pathway it then travels along. I do not know if these emotion "bubbles" are real bubbles or more an *experience of bubbles*, but this bubble phenomenon is experience-able and easy to work with in a way that can be observed and investigated *experientially*. I find that anatomy and physiology are useful, but they do not cater for all experiential phenomena – in fact, attempts to rationalise these phenomena often end up denying their experience.

3.6.5 Therapeutic interventions that heal ECs

An EC is detected by observing body tissue movement patterns – they tend to rotate around any EC instead of passing through the tissue area. This is not necessarily an easy process, and treatment is usually very much a case of peeling layers of an onion. One reason I suggest that ECs are part of a continuity of phenomena is that often a direct skin contact over the EC is not possible, and a small-scale version of *distance work* is necessary – this is usually called *"negotiating a contact"* - and involves feeling whether permission to touch has been given to touch (or not), and what distance the therapist hand has to be from the skin for the body tissue to remain unreactive.

The release (i.e. opening up) of an EC can be achieved therapeutically (i.e. by one person using bodywork skills to help another) by one or more of ...

i. conscious connection
ii. by exactly meeting the pressure (both force and direction) of encapsulation such that the pressure in the tissue is neutralised
iii. helping one of the longer cranial rhythms (mid-tide, or preferably long-tide) to move through that particular volume of the body

All of these allow – in different ways – the tissue to remobilise, and once it is remobilised it will release the EC. Like any other healing, this may also be done by an individual without

© Andrew Cook June 2012

therapeutic intervention, but this is not a process that is easy to describe.

One particularly important pre-requisite is that there are sufficient resources to hold the remembered event. In the case of a purely psycho-emotional EC, that would be conventional trauma resourcing. For most physically-caused ECs the EC will often resolve provided that the psycho-emotional component is supported, suggesting that this is the most common factor that prevents ECs being temporary. The main factor that initiates and completes the healing of an EC is some kind of connection to conscious awareness – either the clients and/or the therapists. This conscious connection *may sometimes* be assisted by the kind of tissue pressure neutralisation described above – but only for ECs that are relatively small.

Neutralising the internal pressure of an EC works also for non-kinetic ECs, and the phenomenology points to the body using the same generic process to store *all* ECs, regardless of their origin or content. Provided that sufficient resources are available, remobilising an EC precipitates *either* an increased coherence with surrounding tissue, followed by a re-assimilation of the fragment back into the body – *or* an awareness by the client of something that could be called an "entity", which responds to verbal contact and conscious contact in a variety of ways. And insufficient resources or forceful remobilisation result in either increased reactivity and tension/pain (sympathetic) or some kind of dissociative response. It is important to understand that this "entity" is only very rarely something not of the client (i.e. something that has entered form outside).

I have seen ECs dissipate in an extraordinarily diverse variety of processes. Many will just re-integrate as soon as a well controlled, light and non-forceful conscious connection is made. ECs are often contained by immune system resources that should be properly employed elsewhere, and part of the EC release process may include a conscious or not-so-conscious reintegration of these containing forces. Sometimes the content will also re-process in a way that is almost imperceptible to the client – they just feel their body reorganising itself, and remain unaware of any traumatic or unpleasant content. Sometimes small memory fragments come up. Sometimes memory plays like a film on fast-forward. Quite often the client is aware of the content far more than the therapist, and is able to describe exactly what is there and what is happening to it. Sometimes the client is blissfully *un*aware of most of what is happening, and the therapist may become aware of anything from no content (i.e. just tissue movement) through to emotional content, through to a fairly detailed "memory" of what the initial cause was. The same release process occurs for all ECs as for Kinetic ECs – temperature changes, pulsing, periods of intense stillness/vibration – followed by softening of the tissue and a sense of lightness, relief and ease both physically and emotionally.

3.6.6 Overwhelm states and hyper-collapsed fields

As I have already said, even small ECs that occupy just a few cells may be overwhelm states. It would not usually be possible for the state of a few cells to have any major effect on an individuals waking experience of life. Larger ECs have a greater effect, and when one gets ECs of order of magnitude about the size of a pea, these can *sometimes* have a substantial disruptive effect on the persons life experience (depending on the emotional content of the EC) – and on their physical health. Aside from the possible self-dissociation that can occur around pain or an EC containing an unpleasant memory or emotion, some ECs contain quite a lot of fear. This

© Andrew Cook June 2012

may be experienced (by the person whose body contains the EC) in several different ways. It may simply be a tendency to feel the body less – or not at all. This may be simply numbing; or it may be an out-of-body dissociation, in which the loss of sensation often begins at the feet/lower legs (the dissociation is usually upwards – in a kind of "*beam me up, Scotty*" attempt to leave the physical world) and there is a sense as if walking on stilts (like the feet are really tiny). If one side of the body contains a particularly strong memory of something, then the dissociation tends to be to the opposite side – people will become "*beside themselves*". This is usually associated with reduced neck mobility to the "danger" side – a familiar phenomenon in SMP. There may also be quite a swirl to this – a kind of rotational field – in particularly strong panic/fear states, which are often confused with physical dizziness and other pathologies of the balance organs of the ear. A large proportion of untreatable dizziness seems to be a dissociative condition, and responds quickly to very basic resourcing.

In the clinic I very rarely use the full technique taught in SMP - of eliciting a body movement and then allowing it to run its course. This is simply because most people I see are not in extreme trauma states. Instead, a very simple change in their focus of attention (*"which part of your body feels warm and alive and perfectly healthy"*) and asking them to wiggle their fingers and toes now and again – is all that is necessary to keep them resourced. When these approaches lead to parasympathetic responses, I simply notch up the resourcing until we have a level of detail that is sufficient to provide sufficient resource. This may include a rewind, where we move from supine conventional bodywork treatment back to sitting or standing, and (usually) something like *distance work*.

I have already mentioned anaesthetics in relation to dizziness/sleepiness These and other chemicals (e.g. nicotine, alcohol, drugs of various kinds) may be a greater or lesser part of the dissociation field. If you have a medical background, you might find the idea of e.g. anaesthetics remaining in the body and causing dissociative effects for decades a bit odd. I can give three examples that may help you to understand this viewpoint. I provided palliative care for cancer patients for a while, and it was quite noticeable that their bodies recognised the chemotherapy being injected in to them as being deadly. Their veins often disappeared as soon as they entered the cancer treatment ward, and they experienced severe pain and cording in their arms at the site of the chemotherapy injections – their arm literally attempted to stop the chemotherapy entering the rest of their body by tightening muscles and restricting its blood flow. When I physically released the tight tissues and chording round the injection sites, a smell of chemotherapy chemicals would often appear *in the room*, and the patient would experience the same coldness and shock symptoms that they had felt when receiving their chemotherapy drip. Patients who received chemotherapy several years previously show the same effects – indicating that chemicals may be stored in tissue for some years. Neil Armstrong – a particularly healthy individual – was given extensive medical checks during the space programme and his digestive system was found to *still* be carrying traces of pharmaceuticals that he had been prescribed during childhood. My own personal experience receiving therapy for dissociation symptoms was that I went through a phase of releasing nicotine and alcohol into my blood stream as I accessed memories of being in the womb (both my parents smoked at least 20 Players Navy Cut per day and went out partying every weekend in the Manchester club scene of the 1950's and 60's). When those chemical releases stopped, the dissociational dizziness also stopped, and the somatised pre-birth memories also ceased to occur during treatment sessions.

3.6.7 Fear and hyper-collapsed states

If fear of annihilation is totally overwhelming, then although the primary reaction is sympathetic, there is a rapid collapse into the deepest of parasympathetic states. Although the parasympathetic is really an intelligent and systematic preparation for death, these hyper-collapsed states are sometimes more like death itself. They have a certain suction to them, they may have a rotational field around them which feels like entering a space of dizziness, but they are utterly black holes with no bottom. There is a common fallacy in personal development circles that at the bottom of all trauma – if one can only go deep enough – is a core of health/ light which can reverse the trauma. That is not my experience. Hyper-collapsed fragments may be located more or less inside the physical body or may be any distance from a few inches to many many miles away. These states cannot be directly worked with without a lot of preparation, and any attempt to go directly into them will most likely be counter-productive. If you find one, first acknowledge it and then for the moment ignore it, and re-focus on the health. This must be done without fear, (i) because the person has walked into your room under their own steam despite the presence of this void inside them, and (provided you do not attempt to force a change i.e. inter-fear) will walk out again equally functional; and (ii) these holes are there because of fear, and contain fear. It is really important that – to the best of your ability - your system resonates with something other than this fear. When there are sufficient resources available, these imploded lost fragments will start to become retrievable again. The more that they represent/ contain/ hold/ *are* a significant fraction of the original whole person/ identity, the less easy it will be to find sufficient resource. In these cases, the client is dependent far more on the therapists resources than they otherwise would be, and the therapist is more dependent on spiritual assistance – sometimes just to maintain their own presence in the proximity of this nothingness.

Getting back to *distance work* and detecting off-body boundaries... There are quite a few phenomena that may be called dissociation, but have different causes. Similarly, there are many different sizes and strengths of EC or fragment that contain that fear. If the fragment is small, then regardless of its contents, it is relatively easy to work with, contain, support and release, and may often be addressed by using conventional hands-on bodywork techniques. And in this case, the off-body boundaries will be more or less as described above.

If there is a substantial degree of fear and overwhelm, then there may not be a detectable boundary – instead there is a field that collapses – almost as if walking into a black hole. As you approach, a suction becomes obvious, and as you approach closer, maybe pulled in by the suction, the suction increases. This would also be obvious if you walked through a boundary without stopping at the edge. In fact, to experience a hyper-collapsed state, you must have walked through a boundary – *but* the boundary may have been so sparse, weak and distant that it is really quite difficult to find any kind of edge to it. Practising any kind of therapy in this situation from a position inside the boundary will result in absolutely no indication that the boundary has been infringed – except that the counter-transference field will be particularly strong, and may even overwhelm or incapacitate the therapist. Alternatively, the client may simply be unable to remain resourced, and fall into a physically collapsed and mentally exhausted/overwhelmed state.

If you remember how all this started – I was looking at migraines – in which an internal collapse was balanced by an external expansion of the defence zone... this gives something of a clue as to

what is being dealt with here. An expansion is always accompanied by a contraction *(and vice-versa)* - the movement is polar. I wonder if the "suction" that is being felt is actually a connection to the internal collapsing pole. Since centripetal collapses are usually accompanied by feelings of dissociation, the suggestion is that "something" that is collapsing has been released form the body and entered the non-physical space, and that *something* is actually the contracting/centripetal end of the pole. This suggests that dissociation, tightening and other emergency responses are sometimes within body tissue, and sometimes in something that is usually body-centred (and is usually bound to body tissue), *but which is not necessarily contained within the body.* This rather strange phenomenon is one that is very familiar from CST bodywork. The best description I have been able to come up with on this field is that it is the mental field - the zone of consciousness. It also more or less correlates with the middle layer of Chi (as in Jing-Chi-Shen) as experienced in Qigong.

The distinction being used here of "fear" is somewhat artificial. In reality, each non-heartful emotion has a basis of fear. As fear becomes stronger, more overwhelming and all-encompassing it strays into the end of the emotional spectrum that contains blind terror and panic. This is the zone in which hyper-collapse is more likely to occur, and there is no fixed boundary at which collapse occurs – and sometimes it does not occur. Fear transforms into Awe in Daoist alchemy. The way that I understand this is embodied in the story of survivors of the Dresden firestorms during WWII. When exposed to a force that was so utterly incomprehensible, most people fell into overwhelm. A few fell into Awe, and instead of terror they experienced their own mortality and smallness in contrast to the vast energies and distances of the universe. Instead of closing in fear, their hearts opened in the presence of something beyond their comprehension that they were powerless to change, and in their own improbable survival.

The pleasing thing about bodywork is that fear is stored largely as a physical signal, consisting of tissue tension (or lack of), cross-membrane ionic balance, electrical potentials, electronic activity and biochemical changes. Much of the fear in any EC is capable of dissipating through physical change of its physical state rather than as a memory that has to be re-lived. This is particularly the case where the person has made some effort to come to some kind of mental equilibrium with the event or some level of acceptance or decision to move on in life. When released in a resourced environment the fear dissipates with largely physical signs instead of mental distress.

3.6.8 Internal and extraneous entities

Another comment that may or may not be useful to you. A significant proportion of hyper-collapsed states seem to be at least partially composed of a bubble/ memory of fear that has been somehow passed on from someone/somewhere else. This may be an unwitting parent, often the mother during pregnancy or birth (or people around her), or the grandmother (or people around her)... sometimes going back a many generations as you care to imagine. It may be also be a case of more or less deliberate psychic attack – something that has been forced on them or that they have been tricked into giving permission for it to be there. These latter can often be dissipated quite easily by the client revoking the permission, and are in any case a rare phenomenon – I've come across maybe 10 cases of this in the past 15 years, and they seem to

have come through the door only after I had found the resources that enabled me to deal with them.

This process is in essence quite simple once a body-oriented state of perception is achieved (this may have to be trained first). I find that it clears a lot of ground quite quickly when we are dealing with most early life traumas and some traumatic accidents. I would apply it where the patient has already identified fear as an emotion contained in their body, and there is some suspicion that some of it may have been "picked up" rather than originating purely within them. The clues to this may be quite subtle. If we are looking at fragments maybe no bigger than a large grapefruit in size, often the sense of the fear is *experienced by the client* as something black (occasionally acid yellow), often with a well defined shape. It is usually actively uncooperative when any dialoguing is attempted, and the client instinctively feels that this is something not of them (though that feeling is sometimes more to do with their fear of what they have perceived inside their own body). Bigger fear fragments tend to dominate consciousness rather than be amenable to it and would not be perceivable in that way. In either case, the client simply talks to the whole of their body. This may be done out loud or silently. It is possibly more effective when spoken out loud (because a sense of vibration is carried through the tissues) but it seems to work just as well for most people if they just "imagine" talking to their body. First they just say "*Hello*" generally inside – if there is an *immediate* sense of a response, then we have a good quality of mind-body communication and so can continue with this dialoguing approach. We first explore the EC a little more, maybe getting a sense of when it arrived, etc. When fear and overwhelm is the main content, the body will protect the client by refusing to answer "difficult" questions – so some care is needed – if the question is too close to a dangerous topic or too direct, the conversation will be terminated and the clients internal perception of the EC will vanish. When we have prepared the ground, we might say something like *"Do you have a sense of what proportion of this ... did not originate in {Joe Bloggs}...?"*. If the client clearly senses that some did not, we can go on to check particularly important sources (e.g. mother/father/other family) or maybe just go on to ... "*If any of this/however much of this (i.e. whatever they can sense) did not originate inside [their full name] then it no longer has permission to stay, and if it was given permission at the time it entered, that permission is now revoked*". If the "guess" has been correct, there is usually an immediate sense of lightness, and sometimes also a sense of something leaving the body. It's not always that simple, but most times this works pretty well.

When the fear is from the mother/ grandmother or other family members, this is sometimes more complex, because it may have been absorbed by the baby/ foetus in an attempt to protect the adults. Or occasionally the foetus may not have a sufficient grasp of the distinction between itself and the mother. I must admit that I am surprised (considering all the other things that can happen with mother-foetus interactions) how often the foetus *does* understand the distinction. My guess is that probably the adult-now understanding supports the foetus-then fragment; and cases where this does not happen are because the foetal fragment is relatively large. Terminated foetuses can also remain as fear fragments that then accumulate other fears within a subsequent or sibling foetus. Obviously, these have to be dealt with in a very different way, and with a lot more compassion when compared to (say) a blob of fear that happened to be passing at the time of a road traffic accident and found a new home. There are far too many possibilities and variations to make general statements on this topic anything other than potentially misleading.

Another more common variation on this is for fear that the client has generated themselves.

© Andrew Cook June 2012

These fear “bubbles” are not usually so big as to cause a hyper-collapse, but are on the same spectrum as the bigger versions. Often the body - i.e. the Amygdala - will want to keep part of that as a lesson to prevent this danger happening again. However, there is sometimes room for negotiation, and a very simple dialogue can achieve a similar partial sense of lightening... “*What proportion of this [whatever it is] can be released now such that you body will still be safe, and also will not have to carry so much?*” The answer may be anywhere from “none” to “all of it” - but is usually more likely to fall around the range 70%-90%. You then remind the body that it is perfectly capable of letting go of this in a way such that the person dos not have to experience its content, and then get them to ask their body to release whatever it feels able to. The effects of this simple approach are often quite substantial. The usual caveats apply – in that the therapist does not simply wade in with this technique, but rather introduces it only when appropriate with some sensitivity to the belief systems of the client.

In all the above, the client should also be tracking replies from their body, and not from their cognitive self. It is usually possible to tell which is which by the degree of surprise that they have in receiving an answer at all. If you suspect this is becoming cognitive, then some checking is necessary. I find that most “fresh” clients are able to “get it” and are easy to keep in body-awareness rather than cognitive mode. It is more often clients who have experience of being in analysis who think they know what is being asked of them who are more likely to get stuck in cognitive processing, what ifs, past states (rather than present experience), imaginative constructions and theorising.

Also, I should point out that this only works if the therapist is not frightened by what is being dealt with, or by the above process. Check your heart rate, tone of voice, breath. Stay on ground (i.e. technique) that allows you to remain well resourced.

3.6.9 Summary of hyper-collapsed states : Integrating trauma-psychotherapy and bodywork experiences

I have been aware when writing the above section of the huge divide between conventional scientific medicine and the experiential aspect of bodywork – and to a lesser, but more frustrating extent, the divide between trauma-psychotherapeutic models and the models used by CST practitioners. I have found that the Sensorimotor Psychotherapy (SMP) resourcing techniques help all kinds of bodywork, whether the client is apparently traumatised or not. This is simply a matter of understanding how to work with the autonomic nervous system (ANS) and central nervous system (CNS) on its own terms. In bodywork we have not just the ANS and CNS to deal with, but also the fascia, lymphatic and immune systems, musculoskeletal system and the soft tissue organs. And we have the body *as a whole.* What I can say is that the strange phenomena described above is very much what arises when working with the body *as a whole.* There is a distinct sense of working with something that is not just a nervous system or a brain, but which has a hierarchy of intelligent systems with some kind of over-seeing intelligence that is amenable to consciousness, but is not consciousness as we commonly understand it.

The model most consistent with my clinical experience (so far) is that *every* overwhelming event creates an Energy Cyst (EC). Usually that EC is capable of dispersing *provided that* the person is able to consciously resource themselves and work with their body in such a way that the body can process the EC somatically. If not, the EC *may* remain unresolved in the body, and if a

similar event occurs or the person reacts very negatively to the EC itself, then additional emotional load gets added and the EC increases in size. The EC may have a physical or physiological effect even if it is only as small as a few cells. At some point, where the EC occupies more than (very approximately) 1% of the persons body in one way or another, the content of the EC starts to have a significant effect on their mental-emotional responses to everyday events. At some greater volume, maybe when 2 or 3% of their body is having to contain the EC (or several ECs), dissociative symptoms start to arise, because the EC starts to make substantial parts of the body less available to conscious attention, or may even displace the proprioceptive sense relative to the actual location of the physical body. You may think of this simply being the mid/hindbrain restricting sensory information to the conscious mind in an attempt to keep certain things out of consciousness, and/or you can think of it as a literal displacement between two systems that are usually coherent and fully aligned. My experience is that *both* of these processes are occurring. Important points for treatment include the optimistic thought that - since an accumulated multi-event EC consists of a series of individual ECs, there is no need to process all of the EC at once, and in fact, each event may (theoretically) be separable from the others. Certainly, this is how it seems to play out in treatments which include a significant resourcing input. If no resourcing is applied, it is quite difficult to keep different issues separate, and when one thing moves they all move. When the conscious mind is dominantly focussing on any particular EC or part of an EC, then the whole physiology tends to be drawn into the particular physiological state embodied by that EC. Otherwise, if attention is not held strongly by any particular EC, the physiology will be different in different ECs and in the body volume not holding ECs.

Basically, my experience in practising CST is that the more extreme Dissociative disorders are not a special case, but rather a good working model for how the body deals with *any* trauma. It's just that the *degree* of fragmentation determines how disruptive that fragmentation is in normal everyday life. All of these effects are largely somatic *survival responses.* Therefore, if they are treated as important functions of the body (rather than things that have to be excised or pathologies), they are far more amenable to being helped, and will very willingly reorganise themselves – at whatever level they are occurring at – once they are presented with an opportunity to re-evaluate their environment fully. That is – provided there is a majority core that everything else can organise itself around. For most people, there is a core identity – a fulcrum of health - around which ECs can reorganise and into which they can reintegrate. Where there is not a dominant core, and everything is a fragment (DID), then the situation is somewhat different.

The fact that reintegration is strongly dependent on the conscious mind providing some kind of guidance and reality check is both a help and a hindrance. There are very few (if any) positive instructions provided in our society for using consciousness in a way that is body-friendly. People therefore fall on a particular mind-body relationship by a series of random accidents. Some people naturally do exactly the “right thing” - because that is what they have always accidentally done – and even if traumatised they will rapidly de-traumatise themselves. Other people – simply because of the way that they have accidentally learned to relate to their body – are capable of making a highly disabling trauma out of quite a small event. An incomplete list of mind-body relationships that *do* provide a high quality resourced and self-healing mind-body connection are listed in the “Resourcing” section.

© Andrew Cook June 2012

3.7 Other variations

It is not uncommon to find that these centrifugal/ centripetal forces are uneven. Often there is a suction undertow (or different type of outward pressure) at ankle level accompanying a weak defence at chest level. Sometimes there is a lobsidedness to the boundary, with it being weaker/smaller on one side than the other, or even pushing in a direction that is not in a radial line between the two body centres (i.e. of the client and therapist). You might feel holes like Swiss cheese (or one analogy that came to mind recently was a castle with its walls full of cannon ball holes). If these asymmetries are verbally and physically (positionally) acknowledged, accommodated and followed, allowing defence to build strength first, then in my experience they often have at least partially normalised themselves given 10 or 20 minutes. The edge can also be quite active. Usually it is relatively static, but it may expand and contract (apparently) randomly quite quickly and markedly. "*Is this OK? yes – no – maybe – oo-err – well, that's OK – oh – maybe that's too close...*"

As a general principle, the SMP rules for working with the window of tolerance are an excellent guide. Anything that encourages moderately high sympathetic arousal is a good start. Anything that results in a slide into parasympathetic dominance is (at least initially) best avoided. Sympathetic states that are especially useful include an element of "freeze" (deer in the headlights). I particularly enjoy the way that it is possible to imagine the ears perking up when evoking the elongated neck that comes when the major senses are outwardly focussed in a freeze state.

3.7.1 The Placenta (and other embryonic gestures)

It is important to retain an awareness of the *quality* of the boundary that is being connected with. Occasionally I have experienced a field that at first appeared to be a "normal" boundary, but then on closer attention turned out to feel more like a remnant embryonic shape/ field. There are several possible candidates for such a field that I have come across so far. In chronological order, a list might include :

- "past life" or ancestral/ family tree patterns. I always prefer to start with *this* life, but occasionally what is arising is so blatantly not of this life that there is little option but to proceed down this rather unbounded road. (I am sometimes left with an open question as to whether we have worked with the clients material or somebody else's material or even something more universal, in its nature).
- the bed of the ovary (pre-conception). This often feels soft, cosy and rather like a sofa in a warm conservatory that you are reluctant to leave.
- the unfertilised and/or fertilised egg cell wall
- the *zona pellucida*
- the placenta (see below)
- the womb/amniotic sac

Experientially, for myself, the most common of these to arise are the placenta and the egg cell wall/*zona pellucida*. My experience of the placenta is that it is a graceful, wonderfully peaceful and almost divine presence, smiling benevolently on everything it contains.   This collection of cells that forms the interface between the mother and baby is for several weeks

© Andrew Cook June 2012

the biggest aggregate of cells that arise from the fertilised egg. It is odd to think that a being with such *presence* forms itself and then sacrifices itself to allow the smaller smear of cells it surrounds to develop and metamorphose into something more complex and adaptable than a sphere. There is something about the way that the egg ⇒ blastocyst ⇒ invertebrate ⇒ vertebrate/fish ⇒ reptile ⇒ mammal ⇒ human development arises that reflects and mimics the evolutionary history of life on Earth. This principle is so deep that it takes years to explore it and develop a working understanding, My preferred way of learning is through my own somatic experience - the workshops of Linda Hartley (and books by Bonnie Bainbridge-Cohen), and the Birth Process technique devised by Ray Castellino are wonderful ways to explore this world. Jaap van der Waal's embryology lectures are also a hugely useful introduction. I also have often wondered if our sense of a *higher self/ Aumakua* is in part a remnant connection to or memory of some aspect of the placenta. The egg and *zona* have quite a different feel to them, and (in my experience so far) are less "alive" in an emotional/ spiritual sense, but more so in the animated sense of *an organism being alive*.

Embryonic remnant patterns are often asymmetric in one way or another, and are usually frozen in time due to the presence of some kind of pathological element. There appear to be many possible reasons why the adult body should retain internal and external shape-fields that reflect distortions of the embryonic field, and this is a vast subject in its own right. Non-viable twins (or more specifically, *partially* reabsorbed twins), the yolk sac, a sticky membrane, adhesions in the womb, chemical or other environmental pollutants in the mothers bloodstream - the list is long. And susceptibility to these is hugely variable - what may have affected one person may not affect another. Clinically, the response that works is very similar to that used for boundaries. If you encounter these fields and are not used to working with them, then it will have to suffice that you make contact, retain a light spacious awareness, and allow movement to unfold itself. That simple approach will be more or less effective in many instances. The (same) principle of working with the expanded side of this asymmetry (rather than the dense contracted side) is also usually useful.

3.7.2 Chi soup

Another interesting question is – what is *inside* this boundary? The experience of it working is that there are at least two components. First there is some kind of force that is capable of keeping people at a distance if it is strong enough! I have seen this kind of thing being demonstrated by Taiji, Aikido and Qigong Masters – they can emanate a presence that is so strong that it becomes literally impossible to enter it. I once was given a small lesson with one of these, and, although standing some 15 feet away from the person, I was physically, mentally and emotionally unable to do anything except to turn round and flee. We also often feel a lesser version of this when there is a strongly charged emotion in a room – and say that "*the tension/anger (etc.) was tangible or palpable*". There is also something here to do with charisma. David Bowie is not a physically large person, but he somehow can completely dominate the pyramid stage at Glastonbury. I once came across somebody who had responded to bullying by becoming *extremely* violent. His defence was to fill the space all around him with a palpable threat of violence (which was also backed up by the real thing). Looking back in hindsight - this happened before I had started to really understand these

extra-body safety zones - he actually *told me* that his safety zone was far bigger than the room we were in. He had constructed – for reasons I do not know - a safety zone that would inevitably be infringed.

The second thing that this space contains is some kind of sensory arrangement. It is definitely easier to work with these boundaries with eyes open - suggesting that there are some kind of visual clues that are transformed into counter-transference sensations through mirror neurons. However, it is also possible to do this with eyes closed. So what is providing the information? However strange this might sound, the *experiential* answer is that there are some kind of invisible nerve fibres out there. When we talk about people being aroused and activated by their environment, we talk about "eyes on stalks", and "having all our aerials out". When the boundary expands, these invisible nerves also stretch out to fill it and find out information from . The penalty is that the further out they stretch, the more energy is used, and if the person is less strong than (say) a Taiji master, then their field/bodyspace becomes less easily noticeable to *everyone.*

Looking at the safety zone from this non-physical perspective, it starts to take on the appearance of the zona pellucida, or even the outer part of the cell (with the nucleus being the physical body). As Steiner pointed out, the gesture and form of various levels of our development are repeated in many levels of life. In fact, there are many analogies that can be used, and the cellular/evolutionary analogies match the reality of these other expressions very well indeed... The problem is that the analogy only makes sense – in that there has to be some kind of linking causal mechanism (?) – if I assume that there is something in this space other than just air. Plasma, electromagnetic resonances, whatever – the tangibility of this invisible zone is quite unmistakable once we give ourselves permission to be aware of it. I find it is important to throw out attempts to pin down some causative factor when working with embodied senses – things happen, things *are.* It is important to have a working model of *how* it behaves, but the *what* will have to wait. Applying the catch-all word "energy" is often unhelpful, because it encourages a lack of clarity. If you see a tree when driving down the road and your thoughts say "tree", there is usually a remarkable lack of interest in what kind of tree it is!

I find it particularly interesting that there is a tangibility about what looks to be empty space – OK, we know that there is air in this space, but the experience is that there exists *something* in addition to normal air. And simple changes in mental and emotional intention and awareness have distinctly palpable effects when two people are in a "relational field". This and other phenomena that are mentioned here suggest to me that consciousness (or at least, some aspect of consciousness) is a "field" in its own right, usually more or less contained within the body capable of spreading into the zone outside the body, or breaking off from this dependence on a physical core, and moving around more or less under its own steam.

Moving on from the client being a passive receiver of the therapists movements, this can also be developed into something more mutual. This is particularly the case (in the sense of what is being conveyed here) if the client experiences the somatic connection well enough to consciously work with it. Most people seem to be able to sense this – though sometimes it takes a lot of verbal and conceptual acrobatics along with some skilful prompts to help recall of common experiences – before the semantics and oddness of the experience stop getting in the way of a more experiential level of communication.

3.8 Case study

I've been a patient of Andrew's over the past four years, at times seeing him for CST session more than others. It was about four years ago I participated in a particular technique which sought to help me remove issues I had with boundaries/relationships.

I can not recall the details of the techniques but know at that time of my life I was single and found it difficult to form a meaningful relation ship. Mentally I felt ready to have a boyfriend/ long term partner but I was conscious that there were certain unconscious things holding me back.

In my sessions with Andrew using his particular technique I was able to mentally and physically recall certain memories in my childhood that I had not processed. I did not have a good relationship with my father and as a child that left me with certain vulnerabilities and unfortunately certain hallmarks of my character have been shaped by those emotional experiences like not being able to form a significant relationship.

During the sessions I was ready and willing to do what ever I needed to release old emotional issues and really move forward with my life. I recall while in sessions with Andrew having very clear recollection of events in my childhood. I was able to go through those particular events and let them go, some events were harder to let go of than others. Andrew paced me and would ask me what I was thinking and feeling at particular times while doing the technique, on the whole not a lot of talking but enough for the healing process.

Now a few years later I can say the technique really worked, I have been with my husband for about 4 years, married for about 3 and have a delightful one year old girl. I have a good set of friends and am close to my family. Also over this time I have really found a strong foundation of inner strength and true confidence and intuitiveness.

The above was written by the first person I applied distance work with in the form described above (Section 3). S came for a total of 7 treatment sessions. The first four consisted of CST bodywork, during which I worked with embryological patterns. The time frame that important body memories seemed to be stored shifted to post-birth. At that stage I decided to try out some *distance work*, and this was the main technique applied during the final three sessions. As S points out, she was determined to change some long-term life patterns, and had decided that CST/bodywork was the most appropriate way to achieve this. Following the initial phase of teaching her the WoT model, the amount of conversation during the sessions was minimal, with just enough dialogue between us to make sure that we were tuned into the same field, and to ensure that she was not getting stuck in any particular memory or reactive state. S went through several fairly strong emotions during two of the distance work sessions. Instead of requesting details, I simply maintained contact with the boundary/edge and occasionally – where this felt to be appropriate - prompted her to re-focus on her resources rather than the memory. This is an example of the usefulness of relinquishing control to the client in certain circumstances. Without having to be asked, S chose to stand rather than sit or lie down, and selected her own place in the room. This level of self-determination is fairly unusual, and it is more normal to have to offer the choice explicitly. It is also fairly unusual for such intense processing to take place so quickly, and emotions are usually much less obvious. Given sufficient resource, the body processes most of the material with very little need to know the content.

3.9 General Discussion

This approach works spectacularly well in some instances but it is, alas, not a universal panacea. Although *most* people who come to my clinic are coming because they have a *physical* condition – usually pain of some kind or other. I also have a steady trickle of high-functioning people interested in personal development through bodywork, and also a small number who have various mental health diagnoses, including depression, bipolar, schizophrenia and Dissociative Identity Disorder (DID). All of these “mental health” cases are not only self-referred (as are almost all of my clients), but also the treatment I provide is seen as being peripheral and supplemental to any other treatment they are receiving, and largely palliative.

It's well worth remembering when working with trauma that physical position has a strong impact on resourcefulness. If somebody is lying down, they are passive and vulnerable. So conventional bodywork for anyone who is traumatised is not necessarily going to be the best thing. For some people the safe and structured physical contact is exactly what they need, and feels supportive and nourishing. For others it is too activating – and results in them zoning out and having considerable difficulty in coming back to full consciousness at the end of the session. The belly (and front of the whole body) is particularly vulnerable, and covering them with a blanket is useful. I would also be very cautious (i.e. I am particularly careful at sensing the body's response) before I make any hand contact on the soft abdomen.

Maintaining verbal contact by helping them to become aware of resourced areas of the body or resourced memories may help some people, and with others may make the situation worse if the questions are perceived *unconsciously* as being potentially invasive. The sitting position is less vulnerable (especially when a blanket is provided), and the standing position is the most empowered. When applying *distance work* I usually stand (so that I can move easily) and the client sits – this sometimes is obviously not working, and I have to sit as low as I can on my wheelie chair and scuttle round on it, so that they are not loomed over. A typical very clear indication that something is being pushed too quickly or that the setup is in some way de-resourcing would be an observable slippage from freeze into parasympathetic lassitude. In some cases, the slightly confrontational position adopted – more or less face-to-face, to sense the safety zone – is too much, and there is much less activation when sitting closer but not facing the client. This is not work that can be turned into a simple protocol; because every stage of every treatment demands from the therapist a high level of adaptation, responsiveness, and sensitivity to the appropriateness of every move, word and nuance.

Interestingly, clients who have no immediately obvious symptoms of PTSD – in that their lives appear to be “normal” and there is no obvious history that would lead to an expectation of embedded shock – respond remarkably well to techniques designed to dissipate traumatic shock. So it is a rather broad spectrum of people who show substantial change after only one session. As I have used this technique over the past five years, the number of cases that it has helped substantially appears to be over 90% of people who have been willing to “give it a go”. At the very least, a session of *distance work* has usually substantially increased the volume of their body open to being perceived during a normal CST session, and therefore it almost always has a useful clinical outcome.

For the people who it has helped, *distance work* has been almost revelatory in some instances. A few people simply not respond at all, despite all the “signs” being present that this may be a

useful exercise, and it is worthwhile just reviewing possible reasons for this. Every time I have thought that I have a fairly definitive picture of this system, someone has walked in the door and presented an entirely different pattern to the ones I have become familiar with. The number of individual variations are probably endless, but so far I would say that is *doesn't* work when at least one of the following are happening :

i. this is too direct an approach – it has hit the nail too squarely on the thumb e.g. the client is presenting DID, and their defence alter(s) is/are too threatened by this

ii. the primary pathology is not a boundary issue

iii. the transference/counter-transference field is not being fully recognised (and so it is being unconsciously acted out in some way)

So far my experience working with the most severely traumatised clients (DID) is that they can make extremely rapid progress or can also (quite obviously within the first minute) view it with a breathtaking degree of hostility, verging on violence. As well as providing valuable mutual visible feedback, the use of this technique has its problems. The alarm/defence states that it identifies may consider themselves to be invisible and derive some comfort from that fact, and if this part is a substantial personality fragment (Alter) it may take exception to being outed. The way that boundary movements can become immediately reflected back is not necessarily a comfortable one, and where there is a defence alter which relies on being invisible, some negative reaction may occur. The response to being found may be anything from palpable hostility through to panic and fear. *Formally diagnosed* DID clients sometimes choose to carry on with this, and in this case they have always had positive and useful results. Most have preferred to self-refer themselves back to a specialist trauma psychotherapist to deal with the issues that it has raised, because that feels safer to them. I keep a list of suitable local people so that this preference can be supported if necessary.

There is also a vital point of ensuring that an increased awareness of the workings of non-conscious and alter(ed) states do not become a cause or justification for self-attack. I always take substantial time at the outset to outline the difference between brain areas that are conscious and ones that are not - and emphasise the fact that the system being observed is a biological one that has common elements with even earthworms or single celled organisms. Recognising that it is *not* a conscious brain state that controls it is important. At the same time, on its own this message would be highly disempowering or lead to a loss of sense of responsibility or control. *The fact is that as conscious humans* ***we can consciously choose to place out attention in a way that helps this biological system*** *to re-adjust and reset itself to a more normalised state. In this way, conscious input and participation by the client is empowering and helpful.*

And this combines well with CST bodywork, in that

(a) if at least one or two distance/boundary sessions are used prior to any hands-on work, the alarm states learn to recognise that the therapist is friendly - and so is allowed to access parts that would otherwise be invisible. The invisibility may be an active hide-and-seek game (which would otherwise manifest as a set of symptoms that move around, rather like chasing a phantom) or more often there is a retreat to parasympathetic overload in some part of the system, which I liken to fuses blowing. The circuit is switched off, has gone deep into a suspended

animation. It considers any contact to be potentially life-threatening and burrows even deeper (or drifts and disparates further out into space) on the slightest of perceptive contacts. Whichever of these happens, it becomes invisible and an inaccessible but really vital piece of the jigsaw. You could almost say that it has died, and some experiences working with these collapsed states have had the overtones of "soul retrieval".

(b) since CST accesses the body-mind by proxy, once contact is allowed it is possible to help the client to access states of resource that s/he would find difficult to discover by themselves. Physiological states can be evoked which the body-mind itself recognises and then makes use of or integrates as it sees fit. The process is one of re-membering and making access available, NOT deliberately changing anything. The changes are made by a deeply biological agenda to minimise energy expenditure and optimise adaptability. Alarm states are either high energy usage or have a poor adaptation capacity, and the body (as a living organism) always prefers not to be in them if this is at all possible.

That figure of >90% above should also be taken with some caution. I believe – rightly or wrongly - that I have become fairly good at identifying people who have the combination of (i) being open minded and up for trying a different approach, and (ii) presenting a set of symptoms that are diagnostic of some level of PTSD or other boundary infringement that is amenable to this method. There is an intrinsic boundary issue in that each therapy that people attend has implicit assumptions as to what is expected and what is not. You would not expect a normal psychotherapist to touch you, and you would not expect a body therapist to *not* touch you! So branching out into this middle ground requires some tact and a careful appraisal of the possible benefits, the likely speed of reaction vs any possible negative response that might occur due to the treatment format stepping outside the zone of expectation/ comfort.

The very fact that this approach works on so many people who come for bodywork treatment of aches and pains is a curious thing in itself. My sense is that - (looking at the responses of the majority of "ordinary people" who are helped by this and who come through the door of my clinic) - *as a society* we have endemic traumatisation in a substantial % of the population, which underlies many apparently physical illnesses, pathologies and disabilities. Epidemiological studies have shown that about 8% of the population of the USA have *diagnosable* levels of PTSD, rising to *at least* 30% of the population of countries with ongoing conflicts such as Algeria, Libya or Palestine/Israel. At this higher end, a substantial portion – maybe over 5% - also show diagnosable dissociative spectrum disorders (DID, etc.), making it not surprising that conflict continues to flare up one generation after another. An ongoing study (ACE, Felitti and Anda)[7] is finding that many common pathologies are far more likely to occur if someone has suffered severe trauma or neglect as a child. My clinical experience is that these emotionally-induced pathologies have a high probability of just vanishing if the associated trauma is released fully *from the body* – obviously this comes with lots of caveats. Mental-level processing alone is usually insufficient – these memories are *somatic*.

Also, although *distance work* can sometimes be sufficient input in its own right to have a positive effect, more usually I would use it as just part of a more typical CST "treatment

7 http://www.acestudy.org/

programme". When used in a bodywork practice, the usual pattern of application would be at least one or two "normal" treatments, during which I find an overall pattern which (a) is not easy to access through the usual CST approaches, and (b) appears to fit the "traumatisation" model. I would then apply *distance work* for only one or two sessions, which would then usually be sufficient to reset the patients survival defence/alarm system such that I was no longer excluded by (part of?) their defence system – and so more of the usual bodywork would be possible. Sometimes several phases are necessary, repeating the above cycle. It goes almost without saying that – if the survival/defence system is to be worked with in this way, it must be respected – otherwise it will simply refuse to cooperate.

Although I wouldn't start to talk about this to a client, this collapsed suction can be very dangerous. The field of counter-transference in this state (i.e. your own somatic responses and the thoughts that come into your mind) will usually strengthen and may include sexualised content, or violence, or a reduced ability to remain focussed on the task in hand. Chemical effects which are particularly difficult to handle at close range include anaesthesia – where the therapist will have to exercise substantial will in order not to drop off or become stupefied, and oxytocin – usually when there are issues arising from the late gestation to perinatal period. This latter may produce a sense of almost unresistable love. It is important to (i) *physically* get back out of this zone quickly and calmly, explaining that you have come too far and have to start again, and (ii) not allow yourself to mentally or emotionally engage with or take part in the mental field you have encountered. If you do get outside of this zone and find *and engage with* the real edge of their boundary, the counter transference will decrease to a manageable level and the boundary will strengthen.

If you are only using hands-on/bodywork techniques (and do not feel comfortable with hands-off), then the only option you have is (ii), which demands a far greater level of emotional and relational robustness. It *is* possible to engage this field from inside it by *either* making yourself totally impervious to outside influences *or* by exorcising every single bit of it from your own system as an act of Tonglen/compassion. Both of these are more or less determined by an ability to remain heart-centred. The former is an exercise of will, and the second is an exercise in transformation. The exercise of will/choice to look at resources is definitely a useful option in any treatment. That focus could include the long tide, some timeframe prior to any trauma, or some part of the clients body that is present in the now and fully resourced, and selecting one of these will be enough to cut through the counter-transference in cases of mild trauma. Stronger trauma fields may be far more difficult to cut through. The second option (Tonglen) is interesting. It is another way that CST works on quite low-intensity material during the course of a normal treatment. If the starting mindset is compassion, then that can often cut through even strong chemical effects. If that compassion isn't strong enough to centre the therapist, or the counter-transference field is particularly strong, then it gets into the therapists body quite quickly, and then separating from it can require a substantial effort.

I have achieved this second possibility fully in a powerful counter-transference field only *once* during over 15 years of practice, when I experienced a strong sense of disgust. I couldn't believe that I had such a sense of disgust of the person I was seeing, so it was relatively easy to recognise this as the clients self-disgust being felt as a counter-transference field and disentangle myself from it. Nevertheless, it took a full 40 minutes of vipassana-style introspection to chunk through my whole body checking every corner to confirm absolutely that this emotion did not

arise in me. When every place had been inspected, I no longer felt it, and the client didn't either.

It would be nice to be able to work like this all the time, but the level of clarity required is something of a lifetimes work. Bodywork provides a space to do this level of personal internal processing because I don't *have* to talk – I can just feel and perceive, and so it is theoretically possible to eventually reach a totally compassionate state which dissolves anything else. I've never achieved this level of processing with a fear counter-transference, because I simply haven't yet become fearless myself. It was relatively easy with the emotion of disgust because that's not an emotion I “do” in normal circumstances, and so feeling it at all was a surprise. So – for now - simply moving physically outside it to reduce and clarify resonant amplification of transference/ counter-transference is the easiest way forwards. Another aspect of counter-transference is that is can be very “sticky”. It would be nice to think that this is simply a resonance with the therapist's “issues” and mirror neurons.

A lesser but perfectly adequate (and more readily achievable) alternative to full-blown Tonglen is simple recognition of the Counter-Transference as exactly what it is. A positive, clear, free-from-fear internal acknowledgement that this is “yours” and *choice* to then let go of this by the therapist a) will prevent the therapist being affected, and b) will help it to move within the client. This is essentially the same process as the dialoguing described above (3.6.7, 3.6.8), but the therapist does it for themselves, silently.

For anyone wishing to apply *distance work*, please remember that it should be viewed as a tool in the toolkit rather than a job description. I would strongly recommend that you take *at least an equivalent of* the first level Sensorimotor Psychotherapy training – which is intended for people working with PTSD. A practical grasp of NVC and/or Rogerian counselling and/or neutral language patterns (as applied in NLP and other hypnosis/dialoguing techniques) is also useful. Receiving a significant amount of treatment from experienced practitioners of body psychotherapy *and* something similar to CST is also (in my opinion) important. Unless you have experienced it from the receiving end, you won't necessarily understand what is happening for the client.

You will also need to develop fluency in reading counter-transference *in your own body* and robust enough not to be pulled into acting out the patterns you are resonating with. That is something of a life's journey, and mistakes happen. Fortunately, you do not have to be perfect – just compassionate with both yourself and others and reflective enough to notice when something has not been quite right. One useful marker is that – if I find that I have an urge to tell someone about what I have experienced in the clinic, then there is something that I have not noticed or fully dealt with. Cultivated psychic robustness and self-awareness is particularly important in relation to the “suction” described earlier. This undertow can be very strong.

You will probably have noticed by now that I tend to think of fear and thought forms in general as if they are *potentially* capable of having a life of their own and/or being capable of existing and moving independently of the physical body. This is definitely my experience, both personally and in helping people to release fear. I'm not strictly subscribing to an “entity” model here, but rather recognising that thought – particularly when it has a strong emotional basis – is a

© Andrew Cook June 2012

force in its own right that is capable of existing either in the conscious awareness or literally hiding in the non-conscious body. I have seen quite a few instances of fear having literally entered people's bodies from outside during road traffic accident injuries. Of course, this may be some kind of perceptual distortion or coping mechanism in which the fear is dis-identified, but if so it is a common one. And in these circumstances, helping the client to "own" the fear is rarely a useful therapeutic intervention – even if it disappears, it has clearly not gone, and there is no sense of relief or lightness. However, the process I described above – revoking permission – does work, and it works very quickly. For whatever reason.

I have not yet talked about the more or less subtle variations available to a therapist – eye contact, facial expression, body language, voice modulation and tone. There are quite distinct changes in how eye contact is received – sometimes it is avoided, and sometimes it is the missing ingredient that increases boundary zone strength. Simply being aware of what is happening with eye contact is a useful part of therapeutic presence. Facial expression, vocal modulation and body language are to a great extent out of the conscious control of the therapist. You have primarily to remain congruent, and a lack of congruity will be detected immediately. It is possible to deliberately alter body position to mirror the client, but that clunky conscious mirroring is a non-congruent action. It is far better to relax enough in (what is after all, *your* space), so that the mirroring happens on its own. If you smile, you are indicating that you are relaxed and feel safe. This *may* help. Mid-range, rich vocal modulation is resourcing, and low frequency sounds and vibrations tend to be activating – because predator growls and heavy footfalls are low frequency.

One other point that may be useful. The "finding the correct distance" technique used when first engaging in a CST bodywork session is not only constrained to 3 dimensions, but also applies to the dimension of time. I find it particularly useful when applying bodywork to track to a timeframe when all necessary resources were in place. This may be a few years or some time pre-birth, or several lifetimes ago – I think once or twice it has required a move forwards in time rather than backwards. There is no logic to this, merely a sense that when awareness has gone to a certain point in time, things feel OK. There is more space, more light, and the clients body often palpably relaxes when your attention reaches this point/time of resourcedness. However - when applying *distance work*, I personally find that it is really important to remain in *now.* The resources that are being invoked are *now,* and the therapists engagement with now helps the client to also be engaged with *now.* Sometimes it is even useful to say something like "*can the Joe Bloggs who is 48 years old....*" when asking the client to be aware of or dialogue with something in their body. This engages far more strongly with the client *now* and the resources that they have brought to the room and their own particular life experience – and may even be a necessary adjunct to *any* resourcing if the traumatised fragment is fairly large.

After leaving the treatment room, I leave much of this behind. Firstly, it would be too much to be tuned into this level of information in the busyness of the society we inhabit. It works best in a simple, controlled environment, and even there it took me some years to become sufficiently resourced (I use the word "robust") to be able to remain distinct from the fields that are being explored. Secondly, there is an issue of permission and respect..

© Andrew Cook June 2012

Biodynamics

Putting this into a biodynamic context[8], several phrases resonated strongly with my experience of the above material... "entering witness consciousness in present time", "not getting lost", "being-to-being fields", "first step is relational has to settle and basic trust established before anything else can possibly happen"...

I think that "The Edge" is one way to accelerate that relational settling process, or even facilitate it where it might never have happened at all given only the option of physical contact.There is also an element of it that requires one to be congruent to subtle internal shifts that otherwise would not be acknowledged - this is a relational field, and it is being tracked with a finesse that is not usually provided; and the way it is set up, the patient is involved - they have visual contact, and some more control of their own environment, and if the experimentation stage gives them a personal contact of the relational field, then they participate in whatever is shifting.

At the end of the interview Franklyn Sills also describes how the shadow is not always easy to hold, and again - one aspect of Edge work is that it becomes easier to identify counter-transference and therefore not get caught up in it if it coincides with personal material. So I don't consider the description of Biodynamic CST in that interview to be very different from the process I describe - this is just another way into the same territory.

8 Interview with Franklyn Sills – see http://www.youtube.com/watch?v=ISx4OCzUiFg

© Andrew Cook June 2012

3.10 Returning to the Body

The principle of working with Babbitt's Atom/solitons/ECs as described in preceding sections is in some ways familiar to any CST practitioner. We have the basic concept of negotiating contact.

The treatment session starts with a diagnostic contact, during which (after some time to allow the body to decide what it wishes to present) we perceive a centre of rotation or other Fulcrum that demands attention. We then go to that place and offer a hand contact. During this negotiation, we start with the hand at some distance from the body, as if touching something – not at an imagined distance, but rather at a distance at which there is literally a sense of the body responding and a sense that something palpable has been connected with in this apparently empty space. In my experience, this is always something that is associated with an EC. When this off-body edge is gently connected with and allowed to respond, it reorganises itself. Then there is usually some response in the tissue in the body, and the armouring in the body reduces, eventually (again, usually) allowing physical contact with the physical tissues of the body to commence. There is no essential difference from this familiar technique and the *distance work* technique that I have described, except that the *distance work* approach is used when the EC and its associated centripetal field is particularly large. When it is particularly large, one has to engage it further from the body. And one would naturally expect that a larger EC would require some additional technique to support whatever it contains. The techniques I apply are based on mainly on Sensorimotor Psychotherapy principles and a smattering of Upledger's SomatoEmotional Release/Therapeutic Imagery & Dialog.

Another thought that seems to be correct is that the principle in CST of “giving space” is actually a mental intention that gets the therapist outside the box – i.e. outside the EC that is being dealt with so that it is able to reorganise. Given this understanding, one has the *choice* of being well outside the box, or being in direct contact with its edge.

When one considers this in more depth, again there is a direct continuity of spectrum between the small, familiar ECs and the larger whole-body ECs described in section 3. It is perfectly possible to ignore the repulsive field around a small EC and to directly engage with body tissue, but the body tissue will then be armoured, largely unresponsive, and any response likely to be a defensive one rather than a therapeutic one. All of this either results in no therapeutic result at all or requires much greater force to be applied such as a straightforward manipulation. Also, once the hand has passed through the outer defensive zone of the EC, there is no information that this zone exists, and often there is even a centripetal pull into the tissue, as if this type of contact is being “demanded” by the body. This applies in exactly the same way to the larger, whole-body EC. The difference being that the entire therapist (instead of just the hand) is inside the defence zone.

Here we also come across an interesting set of ambiguities. Tissue will “demand” a certain level of contact in order to neutralise the contained forces – the skill in a successful CST treatment lies in being able to distinguish the pull of a force required to neutralise a tissue pattern vs the pull that arises when an EC collapses. This has been a topic of much controversy, argument, and fear amongst practitioners and between CST schools for some years. One answer I have to this mulligatawny is that – unless there is an almost paranoid level of care taken in all circumstances, there will always be particular situations, clients, layers of material that result in an armoured

© Andrew Cook June 2012 http://www.hummingbird-one.co.uk

response or collapse instead of a true tissue balance/resolution. Personally I don't *completely* agree with that level of pussyfooting around. My reasons, based on my clinical experience (comments and conversations about this from CST practitioners by email are very welcome) include :

i. Most people, most injuries, many pathologies don't need to be treated with such caution. The body wants to be helped, and is usually acting more or less in line with the conscious agenda. Also, most interventions carried out in a CST treatment will not take the clients system into a situation which it is unable to reverse.

ii. As the layers of "pathology" become more related to mental/emotional or even spiritual (rather than physical) issues, there is a gradually diminishing mechanistic interaction between the EC/soliton and the physical tissue. It is therefore (obviously) possible to engage with the body on a physical level and to ignore the more diffuse fields around mental/emotional issues. And sometimes when physical healing takes place, the mental/emotional body also reorganises itself around the increased health.

iii. The clinical technique necessary to deal with a dissociative element or deep parasympathetic EC/trauma is quite different from the techniques that would be effective with more energised centres, and needs a much slower, more paced approach.

However, I would also say that there is a step-down effect from spiritual to mental to physical, with effect largely moving in that direction. So as a very general principle (i.e. in maybe 70% of cases), it may be useful to default to a higher level. An important and rarely mentioned aspect of all CST work is that the diagnostic process, approach and contact that precedes and forms the early stages of every treatment is the most important part, and may occupy almost all of the "treatment" session. The final process of applying a technique which results in some kind of lasting systemic change may only last a few minutes, but without that preparation period it would not have happened at all.

The pattern that emerges from all this is one where energy and tissue more or less interact, but are nevertheless only loosely linked. The energetic component is a 3-D soliton-like field which contains information and has a certain level of energization.

When the energetic pattern becomes more active/energized, its centrifugal component expands and becomes thinner, and may expand outside the confines of the body. At the same time its centripetal component becomes denser and stronger, and the tissue which it is on contact with will respond by also becoming denser and tighter.

When the energetic pattern is contacted on its periphery (the place at which centrifugal forces reach their nadir and become centripetal) and given sufficient contact "pressure" (of whatever kind is necessary) to enable it to be contained; then the centripetal and centrifugal forces begin to balance themselves and to neutralise each other. The other pole at which this may happen – the eye of the storm, usually preferred by many therapists – is much less stable, far more reactive, and one has to fully enter into (and therefore potentially activate) the eye to reach its quiet core – a far more difficult task for the therapist. The centripetal core is capable of contracting so far that it essentially becomes invisible. At the same time it has also necessarily

© Andrew Cook June 2012

have to be far more energised, and so will be far stronger when it re-emerges.

All this also (simultaneously) plays out in the dominant ANS balance. There is definitely a therapeutic advantage in helping someone's system to go deeply into parasympathetic balance so that they completely relax or even fall asleep. However, that is only(?usually?) therapeutically useful if the ANS balance has remained within the Window of Tolerance (WoT). If sleepiness is caused by a parasympathetic collapse (i.e. outside and below the WoT), then it is less likely to have been useful, the client may have difficulty re-awakening, and/or they will feel like they have been "run over by a bus" for the next week. I was on the receiving end of this kind of approach for a few years, and eventually realised that it was getting me nowhere – most of the apparent shifts all disappeared again, and whatever changes did occur were relatively peripheral. This is again a point of some let's say disagreement between CST schools. My take on it is that it is impossible to be perfect, and an attempt to totally avoid all possible instances of this kind of abreaction is as bad as socially trying to prevent all accidents. The fallout from a determination to achieve total safety and perfection imposed through fear is far worse than the benefits being sought. Some compromise is necessary. Instead, one should ideally be aware of when an abreaction has occurred and then adjust the treatment style and degree of resourcing provided to suit. Sometimes it takes several stages to drop down to an appropriately deep level. Sometimes there is no bottoming out because the treatment parameters are not conducive to the EC being contained – e.g. clients physical position, acknowledgement of counter transference, environmental noise, etc etc etc. In the case of CST, it is important to remember that the level of intervention being applied is so small that we can afford to make mistakes. If we were practicing surgery or very physical manipulations or working with people who had some severe level of mental instability my opinion would be rather different.

This brings us to the treatment of people suffering from severe PTSD and/or people who are on dissociative disorder spectrum (DID or Dissociative Identity Disorder). Here several factors make their treatment very different. When treating Dissociative Disorders, it is absolutely vital to understand that integrity and stability of the core personality has only been preserved by fragmentation. Fragmentation in these cases is a fundamental resource. Thus, attempting to deliberately induce integration (thorough e.g. deliberate choice of long tide phenomena) is literally dangerous and may create severe abreactions. In this example, if the long tide *arises* without being sought – then that *may* be different. Even that may not be so good. Many people who have learned to manage their Dissociative symptoms see integration as a pipe dream that may be some ideal end point of treatment - but also one that is also so fraught with danger as to be deeply undesirable.

In any case, fragmentation should be considered to be a resource for as long as the body considers it to be necessary. The intention of treatment in these cases must be very clean. In non-PTSD cases it is quite easy to side-step this and tacitly drop into the habit of assuming that integration is, in the words of Pooh bear, a Good Thing. This is definitely mistaken for severe trauma, and I would suggest that it is also not necessarily the best assumption to make in other situations. If integration is going to occur, it will happen on its own, and it does. When the body decides to reintegrate, tides come in their own time of their own accord.

© Andrew Cook June 2012

4. Theoretical Background

The following topics are the nuts and bolts of my personal conceptual framework. And so, being a *personal* world view/ working model may not be relevant to every reader. As written, they represent middle ground where experience, theory of varying degrees of solidity and speculation – meet. I originally was not going to include any theory, but realised that there were far too many hanging question marks without it. And far too many important details (e.g. the Window of Tolerance, Resourcing) that are in my opinion absolutely necessary components of any successful application of the technique described in section 3. The basic day-to-day premise I work with is that *uninterpreted* experience is reliable data, whereas working (theoretical) models and the interpretations that arise from them are rather more ephemeral.

4.1 Proxemics : Layers of skin and other boundary zones.

Layers and boundaries inside and around the human body vary from the purely physical – such as a cell membrane – and its analogy, the skin – through to safety zones and the Aura. A boundary is a division between two functional units, and of necessity creates a sense of self and other, and an inherent relationship between whatever is inside and whatever may be outside, focussed within the thickness of that interface zone/ boundary layer. The inside of each boundary has its own functional homoeostasis and normal range of activity – and this will change dependent on the external environment and whatever is there to be in relationship *with*. So not only do boundaries divide, they also connect, because – unless the boundary is totally impermeable, some information is transferred at least one way, and so a responsive relationship emerges.

For a single cell, there is a limit to the number of possible responses to changes in the internal and external environment. These are summarised by changes to the biochemical signalling molecules and to the gross balance of major ions, and to the properties of the boundary/membrane. This total chemical/ electrical/ tensegrity response to the sum of internal and external states is encoded by the organism's physiology – the organism *becomes* this response, and its homoeostatic balance shifts to this response state.

As human organisms, we have very few options for response in addition to those of a single cell, and Emotions are our way of describing this change in neurotransmitter/ peptide balance, membrane electrical/ osmotic/ ionic potential and global muscle and connective tissue tension. Each emotion has a particular function in terms of our physiological response. Anger is an externally directed surge of energy, associated with preparation for fight (by increased tension of structures around the mouth, hands, arms, shoulders, belly and legs/feet), and is associated with Sympathetic arousal of the ANS. Sadness is an internally directed retreat from the external environment, with a corresponding swing of the ANS towards the Parasympathetic.

If a boundary is broken/ infringed, then there is an automatic defence response. With the skin, we would expect a defensive armoured tensing of superficial muscles as a threat of penetration is detected, with some flinching or even major movement initiated at the spinal reflexes. This is followed by an immune response (the immune system is our body's active sense of identity, self and other) should that penetration happen.

© Andrew Cook June 2012

There are three obvious immobile versions of the so-called "fight/flight" sympathetic state. The "deer in headlights" freeze is a high alert state where all of the senses are engaged, and the head (i.e. the limb containing the external senses) is elevated as high as possible and is oriented towards the suspected direction of threat. This relates to threats that are a substantial distance away, and would be more likely to precipitate a flight response. The crouched freeze is a fight/attack posture for more nearby threats which may also evolve into a flight response. But if it does convert to a flight response this always requires the head and then the body to be turned. The spine is curved forwards in an armoured fashion to protect the soft belly, the fingers and toes held in claw or fist shapes, the teeth bared or clenched, the head down but eyes directed towards the threat. Porges makes the point that changes in jaw position tend to reduce the ears sensitivity to low frequency (i.e. predator) noises, so a growl/snarl/bared teeth pose is one that would only be adopted by an animal that generally expects to be able to fight its way out of a corner and/or one that has already detected its foe. The third sympathetic response is just an armoured state – the body is curled in a tight ball to protect vulnerable parts, muscles are contracted and the head is averted from danger. Some animals go into this automatically (e.g. hedgehogs), and for others (including humans) it is a last-ditch adrenaline survival posture.

If the sympathetic states are overwhelmed, this is followed by submission and a swing into to a parasympathetic state either before the boundary is infringed (if we *expect* to be overwhelmed), or after the infringement (when our body "realises" that its fight/ flight strategies have not been successful). The outside of the body becomes soft and pliant, but there *may* also be a simultaneous internal tightening in front of the spine that seeks to protect the core of our body – regardless of what happens to the outer layers and limbs. I suspect that this retreat-to-core causes many cases of peripheral neuropathies and loss of circulation (e.g. Raynaud's) and hypermobility, as well as migraines/headaches. The parasympathetic state is also a dissociative one, and hypo-aroused states may be responsible for various sensory/ balance/ limb coordination dysfunctions as well as difficulty concentrating or thinking.

The zone outside the body has been approximately charted by the study of Proxemics. Here, it is recognised that there are quite distinct spaces around the body that have specific meaning, shown in Figure 4.1.1 below. These zones are strongly adaptive to environmental conditions and to cultural and social factors, and so this is a much bigger topic than can be covered here. So the following is restricted to factors relevant to this discussion.

Note that the distance at which this technique is applied (i.e. at which it works out in practice) is very nicely defined by the "social space" zone. So an over-reactive defence response enlarges personal space into the zone usually considered to be social space (and maybe even beyond). This is in some ways a reminder that these responses are driven by the RAS – a hindbrain function. And the reptilian hindbrain is primarily interested in sex, food and *territory.*

The spaces are adaptive (with regard to bodywork) in that they are usually capable of being overridden for functional purposes – medical help, physical assistance, etc. So there is an alteration of the alarm response if there is a good cause for allowing unfamiliar people into the personal or intimate zones. This is very poorly defined in the literature, probably because – beyond an experiential account, it is very difficult to pin down how this system adapts and changes.

And of course, they are partially overridden when we stand and sit in crowded public spaces like

© Andrew Cook June 2012

elevators or buses/trains and waiting rooms. Here is some clue to the workings of these overrides, in that we do not make eye contact. in fact, the degree of eye contact and the orientation of the body and head relative to another person not only signals something to them, but also signals something to our RAS body space alert system.

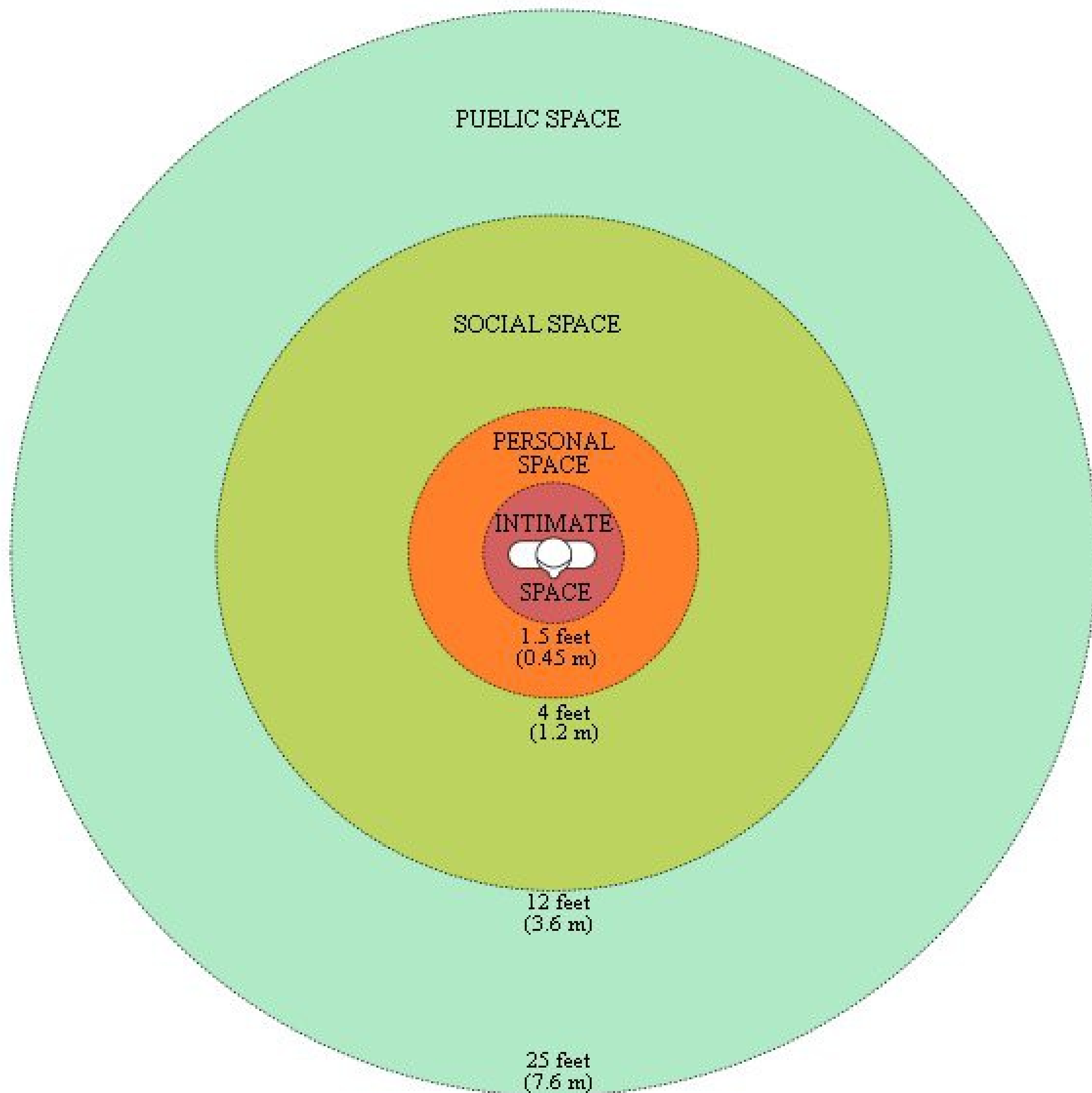


Figure 4.1.1 Proxemics body zones (from wikipedia under the GNU and Creative Commons licences)

So normally, a client will have decided to place a certain level of trust in a therapist, and on that basis they lie on the table. The preliminary period of case history taking is only maybe 20% about gathering information, and is mainly about allowing the client a chance to develop a sufficient sense of trust – such that their system will not be on red alert when the treatment takes place. It will still be watchful, because that is it's job – but it will be watchful in the background rather than going straight into a defence reaction. One way of thinking about this would be to say that the RAS also might work through *an equivalent of* the pre-motor cortex, so there is no need to act out a specific response – there is some level of ability to (semi-)consciously self-regulate even low level physiological responses relevant to the external environment.

The *Intimate space* is a zone up to about 1½ feet from the body, about the distance that two people would be separated if they were holding hands in an intimate way. As bodywork practitioners we are always inside this space. It is an intimate distance, and nevertheless, anyone seeking some kind of help is either desperate enough to be prepared to allow that kind of contact for a while, or in need of contact, or is relatively numb to their body's reactions to proximity, or is supremely self-confident and trusting. More likely a combination of them all.

The *Personal space* (between 1½ and 4 feet from the body) is about the distance that would be covered by two people shaking hands with outstretched arms. From a survival perspective, it is the distance within which combat takes place – anyone (unarmed) inside this space is capable of launching an attack very quickly, and so this is a natural zone of defence – we would wish people to be friendly who enter this space. From this point of view, the *Social space* is an interesting distance, because it is pretty well exactly the sphere of influence of hand weapons such as swords. It is the zone within which we would normally hear any conversation, and tends to be the distance at which people naturally become (semi- to sub-)consciously aware that someone has entered their space, even if they have not seen that happen. The extent of the *Public space* is, I suspect, something of a guess compared to the more inner spaces, and I would personally say that the normal variation and responsiveness to the environment in these spaces increases as we go outwards.

On a day-to-day basis we communicate our willingness to communicate with others, and what terms we are doing so, by our use of the space around us. We also receive information about how people around us are in that regard by observing *their* use of space. The nuances are so subtle and full of meaning that an entire conversation can be had by simply moving relative to someone else. The eyes play a particularly important role in this dance. It is a biological fact that we use the same type of body expression for both threat and socialisation – the socialisation requires that the dangerous connections are played out in safe ways – this is particularly visible in childhood games of tag. Full eye contact is a predator-prey or a fighting contact, but is also a sign of trust (i.e. trust that this is *not* a fight or a predator-prey relationship). So although socially we expect to have eye contact as a sign of mutual trust – and mutual trust is a requirement for allowing a relative stranger into our intimate/personal body space – eye contact in the treatment room is rarely full. Consciously tracking both the clients eye contact and the therapists (counter-transference-driven) automatic eye movements is a useful part of observing the nuances of relationship as the treatment progresses. Similarly, body movements are very telling. Feet attempt to hide behind each other. The spine reaches up or curls over or collapses. Arms lie listlessly or have a sense of energy. It's particularly interesting how, with practice, it's possible to see the difference between a relaxed limb, one that is in freeze and one that is floppy-parasympathetic and playing dead.

I was particularly moved recently by an observation my partner made in her work. She teaches movement and exercise to disabled people, and she had seen one particularly institutionalised young woman attempting to draw all of her extremities into her clothes when she was obviously not being given enough space. Of course, clothes, rooms, houses, professional labels - are all another form of skin. Withdrawing the hands into the sleeves, with other parallel gestures, is a clear sign that there is nowhere else to retreat to.

© Andrew Cook June 2012

There is also a direct archetypal connection between these defence zones and boundaries and the embryological shells that we inhabit in our metamorphosis from egg to human. In particular, the placenta is a fundamental archetypal presence. The images of Shiva's Dance of Creation (*image left is copyright-free, courtesy of Los Angeles County Museum of Art*) are one possible visual representation of the space formed by the embryonic placenta. It is a peculiar thing - that is hardly mentioned in any description of human gestation – that the placenta is a part of the embryo itself. In fact, for some weeks, the placenta is the largest part of the embryo, and initially forms a protective enclosure around the small smear of cells that will eventually become human. Moving the arms and hands to acknowledge and connect with this space is a very powerful gesture that can also connect us up to early issues with boundary and the relationship between self and other. This movement is used not only in body psychotherapy, but is also integral to the calming and collecting of the Chi back to the navel (umbilicus) and the cultivation of Shen (spirit) in Qigong practices.

4.2 Resourcing.

It is a basic spiritual principle that whatever we focus on – we get more of. The neurological explanation for this is the activity of pre-motor Mirror Neurons playing out internally *as if we had actually done it ourselves ...*

- anything we see other people doing
- anything we think about or imagine doing
- anything we remember
- anything we talk about, read in a book or newspaper or see in a film, or on the news

So the problem with remembering (or even thinking about thinking about) a past traumatic event is that we are immediately thrown into it as if it were happening again. Furthermore, the brain is programmable, and one of its fundamental functions is to give the conscious mind more of whatever we put our attention on. So if we deliberately look for disturbing memories or images, or painful sensations, the volume of these and our ability to connect with them will gradually be ramped up, and up. This is clearly not a good idea.

This apparently troublesome response can be turned to good use by deliberately choosing to focus and pay attention only to whatever makes us feel stronger, more capable, more integrated, more energised, more alive, more comfortable in our skin, more confident, more empowered, more able to deal with whatever comes our way. These states are identified not so much by mental attitude or thoughts, but far more by some kind of change *in the sensations in body (e.g. feeling strong, supported, centred, in control, supple etc) and/or changes in state of awareness (e.g. alert, calm, internal/external balance of awareness, etc)*. The higher level mental state that we usually inhabit is essentially interpretative, and *arises out of* the physical/ physiological state (though more generic mental states are part of the physical response). All this happens below the level of thought – it occurs on the level of *experience*.

So "Resourcing" is a base-level set of body-awareness skills that provide the foundation for any work with traumatic memories. Once we have charted a path to an internally resourced state, and remembered it by carefully unpicking the body sensations that come with it, then

a) we consciously can find it again simply by remembering the sensations or by remembering any kind of anchor that causes them to be recreated. This is just like you have moved to a new house and have to remember landmarks along the way so that you can find your way back to your house from the nearest post box. Once we have charted a route even only once, our body remembers how to do that again.

b) we automatically know when we are feeling OK, because we recognise that state of OK'ness through experience

c) our use of attention has also told the body *that we are interested in* that resourced state of being, and so it will start to give us more of it. In fact, the body much prefers these states itself, so it is surprisingly easy and quick to train it to orient towards empowered, resourced states.

And once we have practised connecting to this state of being resourced, then we can consciously and actively start to use it in various ways to dissipate embodied states of shock, trauma and overwhelm.

Whatever we focus on, we get more of ...

This is the most important choice that we can ever exercise

One analogy I often use is the idea of a hole in slippery muddy ground. Some part of us is lost in the hole, and so far, every time we have visited it to try to help, we have slipped on the clay and found ourselves in the hole. Once in the hole, we can no longer help (see Section 4.6). Every time we have revisited the hole in the past, we have just increased the size of the muddy slides that make the edge so treacherous. Instead, we now carefully start to lay some flagstones round the edge of the hole. When we have firm ground to stand on, we can remain outside the hole, and, kneeling down, reach out a hand....

The idea that resourcing is a fundamental life skill has been put forwards by Glenn Schiraldi, who runs a trauma-proofing (*"Stress Inoculation"*) programme – initially designed for combat troops, but now used for a wide variety of people from all walks of life. It is a truism that the self-resourcing skills to recover from trauma are best learned when in a non-traumatised state, and one of the difficulties that arises in any trauma treatment is to re-focus the patient in a positive way in the direction of what is healthy. **If as a society we focussed on and got to know in a more conscious way the somatic experiences that come with healthy emotions, healthy states of mind, healthy body – we would, simply, be less easily traumatised, less likely to be left in trauma, and generally – healthier.**

The single most effective resourcing may be a discriminatory body-awareness, but this is not the only form of resourcing that is available. Once a body awareness skill has been fostered and strengthened, then the next most valuable self-resourcing skill is heart coherence (see Section 4.5). There are several SMP techniques for resourcing that I use regularly which I simply haven't described here because of all the issues and variations that arise in them.

Community. friends and family may (or may not) all be potential resources, and just a simple sense of their *presence* may be useful. A large proportion of people who experience traumatic events recover fully – and that is far more likely to be the case where there are supportive community structures and an ability to re-normalise inside those structures. The normality of

© Andrew Cook June 2012

turning up to a regular job or meeting friends in the usual places at the usual times is particularly useful. This is partly related to a sense of continuity – which is *not only* a function of our *present* life circumstances. I have perhaps talked too much here about the difficulties that arise when trauma is passed from one generation to the next. Fortunately, this is not the only thing that is passed on. Our ancestors wish us well. If what they gave us was at the time imperfect, they would not have wished it to be like that. I was particularly struck by one scene in the film Amistad. The Hollywood scriptwriters have the main character say something like "*I now call on my ancestors to be with me, because as I stand here in this moment, I am the only reason they ever existed*".

Clothing is another resource – it is our second physical skin. Its extension – our bedroom/house and car are all external devices that *should* provide protection and a sense of being contained, held, supported. The use of a blanket to increase a sense of security in the treatment room is such an easy tool to use, and most people have a strong sense of the difference it makes. Please let them remove it themselves at the end of the session – rather than *you* removing it.

Nature in all its forms is resourcing. A round pebble in the pocket to hold, or a photograph of a flower or trees, or landscape – again I have some of these in the clinic room, and they definitely make the place feel more nourishing. Natural light is also very good.

Predictability is another resource. The fact that CST is so adaptive in its nature is both an advantage and a drawback. Usually this is not so much of an issue, and the client is more concerned about predictability/ control in their life outside the treatment room. If someone is very reactive, then I will agree the rough structure of the next session with them. Another way that predictability can be increased is to wear more or less the same style of clothing, and to have them book several sessions in advance so that they know what is going to happen over the next few weeks.

The relationship between the mind and body is a particularly important factor for self-resourcing, but sometimes not so obvious. We can only find out about it by very careful questioning – and our language is not usually used to define these rather subtle variations in how conscious awareness is wielded. Positive and resourced mind-body relationships include :

- A willingness to recognise that we are not our body, but rather our body is our companion in life, and is a willing servant. This point is somewhat subtle, because I am not proposing a dissociative relationship – but rather one more like a professional horseman, who recognises the things that the horse is good at (and allows the horse to do that in its own way), and at the same time tells the horse what he wants it to do. Horses need car, attention, water, food, love. Maybe a Centaur is a useful analogy for a human being, or maybe for some people the separateness of horse and rider might be more useful.
- Compassion for the body – recognising that if it is in pain, the pain is being felt by the organism as well as by our conscious awareness, and it is doing its best.
- Taking an adult role – being consciously in the now by orienting to the external environment and to "resourced" (i.e. totally healthy, comfortable parts of the body that feel to be alive). This brings the attention to the person who is now – who has a lifetimes of experience to draw on, and tends to reduce or remove the dominance of

ECs stuck in a there/then state or poor resource.

- Recognising that the body's job is to repair itself, and one way that plays out is on non-consciously directed movements. These movements may be quite small or even micro-movements, or they may be quite large. The conscious mind should get used to being able to switch off the censorship override, and allow these to play out. If they are strong enough to be potentially disrupting and feel like they are getting out of control, then often some dialoguing and negotiation with the body will ensure that it only does them at certain times or in certain environments.
- Talking to the body, with a genuine feeling of gratitude for the job it is doing. This should at first be evenly spread between all parts of the body, with no undue attention to either comfortable/working bits and painful/non-functional bits. This can be done in a very general way in just a few seconds. A more detailed and lengthy process of acknowledgement is often useful as a technique to open up body-mind communication – it would be quite easy to spend an hour chunking through the different parts of anatomy and physiology, acknowledging them, heartfully thanking them and taking a few seconds to feel any somatic response.
- Cultivating an ability to remain aware of the body to at least some degree all of the time, and to be able to come back into body awareness easily.
- Cultivating an ability to focus on the quiet noises of health instead of allowing the conscious attention to be drawn towards the ghetto blaster of pain.
- Cultivating heart-coherence (see section 4.5).
- Being confident in the self-regenerative and self-healing capacity of the body, and that whatever is being experienced is a temporary phenomenon in a continuously unfolding process of moving towards health. This is diametrically opposite to the attitude that is suggested to us by all the “health” information available in mainstream society.
- *Not* getting into a battle with symptoms or considering them to be a permanent feature. This is particularly difficult for anyone who has had any condition for a substantial length of time. The positive or negative identification with a particular symptom (as opposed to the *dis*-identification described above) is one thing that prevents it healing. This is a complex issue, and really it should be thought of as underlining the limits of this kind of “advice” rather than being another *should and ought* to carry. As Swami Beyondananda says - “Oughtism is a result of an over-expanded onus”.

4.3 Sense – movement/response – feedback.

One theory that has arisen out of research into neurology and developmental and behavioural biology is that much of the central nervous system is focussed on translating sensory information into muscular response; and translating muscular movement (through proprioceptors) into a storyline that tells the body how well we have survived a particular incident.

This principle has some remarkable implications that tie in very well with certain types of tissue memory models – e.g. the Incomplete Biological Process (IBP). An IBP occurs when a natural biological process is interrupted. This results in a frozen time-frame, in which a fragment of the person – be that a cell, a group of cells, a part of their identity, an organ, a physiological layer, a muscle or a limb (to name just a few possibilities) – becomes stuck in a continuous loop, in which "it" does not understand that time is passing, and "it" remains trapped in the incomplete stage of that process. The story continues to play a never-ending loop until it is somehow permitted to play all the way to the end, at which point it reintegrates with the rest of the body. The body only knows that the tape has played to the end through feedback (e.g. from the proprioceptors on the muscles that have to work in order to complete the process).

Trauma itself is an incomplete *survival response*. The cycle of detection of threat ⇒ activation/ arousal ⇒ response ⇒ return to homoeostasis (Figure A) has for one reason or another failed to close. It only comes to a final rest when some functional part has operated in such a way that provides an understandable signal to the body that it has, one way or another, survived. These might be the fight muscles or the flight ones, or maybe a combination of the two – for each situation the body has a particular pattern that it expects to observe. This is a specific example of a much more general type of incomplete process. Other IBP's might include examples such as :

- The mother - in some cases of caesarian section or termination. The (e.g.) pelvic floor muscles or hormonal system may subsequently need to express birth as if birth had happened naturally through the birth canal.
- Ditto the baby – hormonal changes, first breath and twisting/ squeezing through the birth canal
- Any aspect of the baby-mother bonding process – for baby or mother or both
- Recovery from an illness – where the immune system has been blocked by drugs, and was unable to go through a response cycle to an infection
- People unable to complete a grieving cycle because there is no body
- A baby left for adoption when still expecting its mother to return
- An unexpressed infant developmental movement – e.g. stretching, crawling, rolling

Some of the above might seem slightly OTT and neurotic – however, the main IBP that recurs is *trauma*, and usually the trauma cycle is incomplete because the survival responses were overwhelmed before they could complete. It is also obvious that most of the examples are from early periods in life, and an IBP is both far easier to set up and a greater fragment of the whole at these earlier stages. Once an IBP exists in the body, it sets up the seeds for the next IBP, and so some rather less obvious IBP's may be set up. Or *(re-)*traumatisation itself becomes more likely

– particularly when it has a similar theme to one of its predecessors. The more IBP's are stored, the more easily the next one occurs. There is no final point in this cascade of fragmentation – for each IBP requires that a fragment of the identity/ physiology is assigned to guard and live out that IBP and protect the rest of the organism from whatever it was. A *Trauma IBP is set up when there are insufficient resources to hold/ contain/ respond adequately without placing the body in a situation in which at least part of it thinks that it will not survive.* ***Survivability is not assessed consciously, but rather - by the body***. The most extreme versions of DID (where the person *still* remains more or less functional as a human being) may have a hundred or more fragments locked into different ages and stages of development – usually called "Alters". An alter may form at any age, including the entire period of gestation, and a tendency to fragmentation of the identity may also sometimes be passed on from one generation to the next. As may (in some circumstances) alters themselves.

An IBP will often be stored in what John Upledger called an Energy Cyst – probably as a soliton, or standing wave - which results in a small but noticeable reduction in communication between that area of the body and the rest, and which also usually creates a zone of decreased tissue mobility.

The ubiquity of these phenomena suggests that, after two world wars and all the rest of the madness of the 20th century, it is only by Grace that we are anything like coherent beings. It is also a testament to the adaptability and spare capacity available in the human body that – whilst many people in the UK may be walking round with *at least* 2 or 3 of these IBP's of various sizes and shapes, we still function remarkably well in the vast majority of circumstances. The body *wishes* to be well, whole, and complete in space and time. It has an unerring desire to reunite itself, or, as Babette Rothschild says – to ***re-member*** itself.

4.4 Optimisation of energy usage.

One of the main driving principles behind evolutionary development and specialisation is that the organism becomes more efficient over as wide a "business as usual" range of environmental demands as possible, *and* to have a large spare capacity for use in emergency situations. This evolutionary search for efficiency and spare capacity is expressed in many ways. One particularly interesting aspect is the ability of living organisms to process chemical reactions using catalysts that speed up those reactions up to hundreds of millions of times. Quantum tunnelling effects and dissipative processes transfer energy instantaneously, or in ways that are 100% efficient. These were feats beyond the dreams of the cleverest of physicists until just a few years ago. And each higher physiological process may have several parallel functions. Nerve synapses not only communicate by means of neurotransmitter diffusion – at a rate of maybe 2000 Hz, but *also* have an electronically functional structure analogous to a LCD pixel in a flat screen TV – and can communicate electronically at about 250,000 Hz *at the same time* as the slower chemical transfer is taking place! Even today, a protein in the eye of a robin can detect changes in magnetic field intensity many times more sensitively than the entire world of human ingenuity can achieve. Whatever is discovered in future, life is definitely Extraordinary. I thoroughly recommend you check the internet for the simulation *Cellular Visions: The Inner Life of a Cell*, and also find and explore *Cell Intelligence* by cell biologist Guenter Albrecht-

© Andrew Cook June 2012

Buehler [9]

The principle of *minimisation of energy expenditure* as part of the homoeostatic mechanism is also visible in the workings of the ANS. Wherever possible, the ANS will return as closely as it can to a middle ground between Sympathetic and Parasympathetic dominance. At this middle ground it doesn't just sit in idle neutrality, but rather “hunts” between the two, ready at a moments notice to respond to environmental demands – this balanced state occurs when we are in a very specific emotional state – one of *heart coherence.* Even if heart coherence is not the cause of this balance, the resultant state of consciousness is one of calmness, quiet alertness and clarity – a very efficient basis for any activity. Permanently stressed or traumatised states, and IBP's are, for different reasons, inefficient. An IBP reduces the coherence of different parts of the body's physiology, and also usually creates zones of increased tissue density / decreased tissue mobility. Coherence - different “parts” (sic) of the physiology resonating with each other such that each facilitates the tasks of the other - is one important evolutionary energy optimisation strategy. Any loss of resonance/ coherence reduces that efficiency.

One example of this is the elastic response of the major arteries to a cardiac pulse. If the heart beat is tuned to the elasticity of the arteries (and vice versa), then a resonant “valveless pumping” action occurs which reduces the load on the heart by up to 15%[10]. The negative effect of reduced tissue mobility is far more obvious – every single movement of the body, from the heartbeat to breathing to walking to peristalsis of the digestive organs requires that the entire connective tissue matrix allows that movement with minimum resistance. Harder tissue of any kind forces the body to work harder to perform any and all of these movements. *Some* cases of ME/ Chronic Fatigue I have come across have simply been exhaustion in the face of a body full of zones of reduced connective tissue mobility and relatively minor internal adhesions.

When body intelligence comes into play, *the body* will *always* make *what it feels to be* the optimum survival compromise in any given situation. These are not always necessarily the best possible decisions, because this decision can be taken by virtually any level or part of the non-conscious/body, and the smaller the part taking the decision, the more myopic its view and less likely that its solution is a universally optimum response. Nevertheless, *it is the body's job* to make these compromises, decisions, adjustments as part of its moment-to-moment functioning. A balance imposed *from above* by the conscious mind – if this is even possible in the first place - is less likely to be ecological and more likely to be imbalanced in some way than even the most myopic decision by the most isolated organelle of a cell. There is another, higher, more universal source of organisation/ reorganisation that can be invoked, but again, that arises *through the body.*

Absolute survival is balanced against the lesser evil of reduced operating efficiency. A compromise is reached, and usually the choice is to sacrifice a small fraction of efficiency. It doesn't take many of these “decisions” (e.g. in the face of an IBP or elevated levels of background stress/threat) to start to compromise important parts of the physiology. And *given half a chance without sacrificing what it sees as important survival alarms,* the body will reverse this choice and reorganise *itself* to reduce its total energy expenditure. All that is necessary is to help the body *become aware of* information that allows it to *choose to* downgrade

9 http://www.basic.northwestern.edu/g-buehler/ FRAME.HTM
10 http://www.ornl.gov/~webworks/cpr/pres/105984.pdf or a simpler version at http://www.ornl.gov/info/ornlreview/v35_1_02/cpr.shtml

© Andrew Cook June 2012

its emergency survival status to a lower state of alertness/threat and higher sense of the actual relative safety of its environment.

In normal, everyday, waking life in 21st century Europe, serious threats to survival are (most of the time) memories or mental projections of "then" or "there" or "if", and safety is in the here and now. The *responsibility* of the conscious mind is to orient itself to bring that sense of here-and-now safety into focus in such a way that provides the information that the non-conscious body can understand. That means choosing to focus on whatever creates positive, alively relaxed, empowered sensations in the body. The mind becomes the link between reality and the sensory system, and the body pays attention to whatever information is being conveyed by the sensations the mind is focussing on. This is the proper relationship between conscious mind and body tissue.

4.5 Love as a natural point of stabilisation : heart coherence

Much has been written about love - it is one of the great recurring themes in human life. However, in 21st century Western culture we seem to have ended up with a single word that describes everything from lust and sex through miserable longing and sadness and self-annihilation through to something like falling into a fuzzy world of sweet pink marshmallow to a state so blissful and all-consuming that it is indescribable and *ergo* untouchable. There is a Love that is none of these things, that is experienced by all of us for at least a few moments every day of our lives. It is so immensely valuable that its importance cannot be over-stated. And – if we are not used to being with it – it is so quiet compared to the noise of other emotional and mental activity that we usually don't even take much notice as it comes and goes. There is not a cultural image or easily graspable simple word for this "thing", so, wanting a definition, it is largely unseen – we bask in it for moments and then, unaware of its significance – we move on to other noisier, apparently more important sensations.

The Institute of HeartMath (IHM) have explored this theme (which they call *"**heart coherence**"*) both from a physiological point of view and in terms of its practical application, and I was lucky enough to chance on this almost 10 years ago whilst attempting to discover a biological basis for the rhythms we work with in CST. Love is simply another emotion, and as pointed out in section 3.1, we *become* the particular response that we feel, through the physio-chemical changes that the emotion is expressing. We have names for the various flavours and colours of love – Appreciation, Acceptance, Gratitude, Forgiveness, Compassion, Awe (that's a slightly louder one), and are also able to recognise untinged benevolence, peace, oneness with the landscape that we are in, and a sense of wishing only the best for everyone and everything.

The easiest, simplest and most familiar of all of these is **Appreciation**. The *body-felt* sense of appreciation (as opposed to its mental half-brother) is actually a sense of love. We feel it regularly through the day as we become aware of something that just makes us feel good. A tree, a flower, the open sky – nature (and life) is particularly good at invoking this sense inside us, and this has one way or another been explored by artists, musicians and poets from the time of the first ancestor.. In its half-glimpsed and then ignored form it just provides a small bit of light relief. If you take the care and the tiny bit of time and effort necessary to chunk back down past the interpretative levels of language, back to the *specific sensations and perceptual states in specific parts of the body and conscious awareness* – then you will have discovered a path to the

© Andrew Cook June 2012

pot of gold at the end of the rainbow. Once you focus on this emotion in the detail described above, your body realises that you're interested in it.(section 3.2). Your body will rejoice, and quickly will start to give you more - because when you are in a state of Love/Appreciation, your body physiology is optimised. The ANS naturally and automatically falls into an optimum middle ground between Sympathetic and Parasympathetic – it is in its most efficient and most dynamically responsive state. The mind tends to become quieter, the other louder emotions tend to become less quarrelsome.

Clinically, there are also benefits for the people whom you have contact with. *Their* bodies also experience counter-transference, and they will start to resonate with this optimal state to whatever extent they can. You cannot force this, because if you *try* to be appreciative (e.g. to deliberately affect others around you), that is simply an expression of a fear that you can't do it or that they are not perfect the way they are. Instead, trust the sensations in your body. Listen to the quieter "sounds" that it makes. And wherever there is love *and a trust in that love*, fear cannot enter. Begin with simple Appreciation, and the rest will follow.

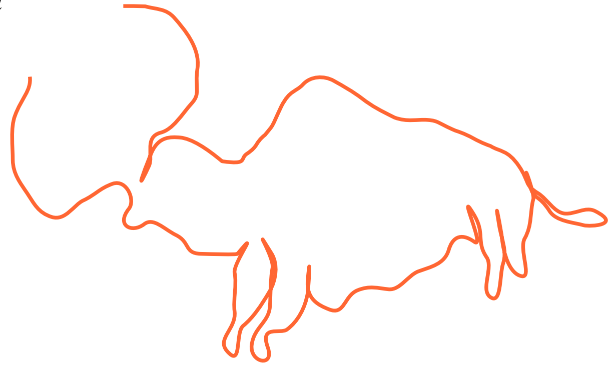
The IHM have applied the principle of heart coherence in many different places – they have a corporate training programme that has been used by most large organisations in the USA (including the armed forces!), because conscious cultivation of this emotional/physiological state causes an improvement in the quality of inter-personal communication. They have also introduced it to schools, and have found that it reduces disruptive behaviour and improves the ability to take in and remember information. My own experience practising it was that a conscious cultivation for just a minute, twice a day for about a month was enough for my body to get the idea and to begin to enter his state of its own accord (i.e. without me having to try) for greater and greater periods of time. Just *simply, genuinely, uncomplicatedly appreciating* a small stand of birch trees for this short time as I passed through them on my way between work and home improved my business, changed my personal life and made me far more confident at public speaking over a period of about 6 months. I find that result impressive. Another interesting spin-off was that I had previously found affirmations to be completely useless – until I started to *feel* them (and my body's response to them) instead of just saying the words. And when I felt a spontaneous heartful response, this was a pretty good sign that they had produced an effect.

4.6 Inside the box, outside the box.

Imagine finding yourself lost inside a cave, without a light. It is actually the cave of Lascaux, but you do not know that. Your feet or knees will feel the roughness and hard textures of the ground, sometimes dry, sometimes wet. Your arms thrash around in a formless void that could extend just a few inches more or a thousand feet. Or they catch glimpses of walls that have no discernible common pattern or shape. Sometimes that contact is easy, gentle. Sometimes more violent as you stumble onto a rough surface and bruise or tear the skin. Your forehead remembers heavy blows that have left you unconscious for – seconds, minutes, days – there is no way of knowing. So as time goes on you move around in more and more of a half-bent shuffle, testing the space ahead as best you are able. The ground is also uncertain – there are flatnesses and there are holes that may go as little or as far as the lack of ceiling above you. There is no way out. You are very definitely inside the box. There is also no sense of the eternal beauty of

the paintings on the walls, or of its history. No easy sense of how one chamber connects to another or their pattern or sequence.

Maybe there is a presence around the paintings that arises partly from the wild imagination of the painter, partly from the spirit of the animal and partly from the 50,000 years that have gone by with this image waiting on the wall to come back to life. You feel it as you shuffle past, and pause, but do not know what it is you feel. In the distance, drips and echoes of drips, and maybe echoes of other things glance off each other and ring out in the silence. Sometimes there is only darkness and silence and your own breath and heartbeat.



One day, you realise that you have other, quieter senses that you so far had been unaware of. There are small changes in moisture, air movement, temperature – so tiny that you had, for what felt like many lifetimes, not even realised they existed. You begin to be curious, and start to follow these new senses, wondering what they might reveal. A sense of direction emerges, and after following this for some time, you begin to sense that the air has a feeling of being more alive in one direction, and almost able to leave you in a never-ending sleep if you follow it the other way. The sleep could be so easy, but instead, you choose life - it feels good in places inside you that you hardly knew were there. And as you follow this source of life, you find you are dreaming the shape of the passageways that you are moving in. It takes a while to realise that this is not an inner imagination, but for the first time, your eyeballs are letting you see pictures of the rocks that surround you. And this has an ever-brightening centre, leading you into a light that – for a time seems to penetrate through to the centre of your body – it is unbearable, everywhere, a vastness of whiteness and the redness of blood. In time – not so long a time - the brightness becomes bearable, and you find yourself in a world of shapes and colours that you don't understand. Like the untouchable heights and depths of darkness, these shapes and colour textures are beyond your grasp. Indescribable. When you sit down on the ground to take in this new experience, you find a strange thing – a tube which sends out a light – almost like a lesser version of the one that is flooding you from all directions. For now, the familiarity of the cave seems more bearable, and, holding the torch, you descend again. Ahead, a vast cavern filled with dew-sparking stalactites opens, its depths disappearing into a pool of darkness. And a great ochre Aurochs rises out of the shadows of a wall. The carbon handprints of its maker seem somehow familiar, and are open in greeting.

Kurt Gödel was a friend of Albert Einstein and also slightly mad. He eventually starved himself to death because he thought his food was being poisoned. Perhaps surprisingly (based on this little anecdote) he was the greatest *ever* mathematical logician. *Gödel's incompleteness theorem* is a mathematical statement of the above story – if you're inside the box, it is impossible to have a complete sense of how the contents of the box can make sense. In fact, things *usually* look as if they don't make sense. Inconsistencies and incongruities are normal. Things only make sense if you can stand outside them, looking as if from a higher level, or bring in resources from that higher domain back into the box. This is why we go to other people for help with various aspects of our life. They are outside our personal box, and so can see clearly what we

have been unable to grasp. If they are wise, they will help us to learn to climb out of the box ourselves, so that we can have a more expansive view (from inside the next box, of course). Or they might just look in and give us a few directions on how to get from A to B. Lets hope that they are understandable and trustworthy directions.

Sensory perception also has its boxes. We can direct our attention inwards or outwards, or be in some middle ground. A totally *INternalised* sensory orientation is almost equivalent to catatonia. Although it *is* able to sense the body's responses to external and internal environments, there is no ability to take any conscious action in response. A totally *EXternalised* sensory orientation is unable to tap into a single jot of body wisdom – we only have external frames of reference and the usual jangle of ideas. And similarly, movements may or may not be coordinated.

So we *all* live in the sensory world box that we have *accidentally* chanced on (or even constructed out of necessity), with its particular internal ⇔ external balance and cardboard walls. And that sensory box is further constrained by expectation/fear. Boxes are not limited to whole organisms, and every Alter/IBP lives in its' own particular box. As does every component of the body. Individual cells and organelles are masters of their own universe and in that contact immensely powerful and knowledgeable – but their universe is rather small compared to the whole body. Although chunking down to a dialog with a small part of the body may be possible, my preference is to invoke something with more of a sense of the big picture.

4.7 Now and then – the experience of time.

Time is a particularly malleable dimension when dealing with trauma and body tissue. Although the body has a sense of rhythm and process, it does not seem to have a sense of elapsed time. Its rhythmicity can be seen in the way that anniversaries often bring memories or emotions or just plain uncomfortableness and agitation flooding back even if we have not consciously recognised that a particular date is looming. The heart and the breath are two of the shorter rhythms – one beat or breath having very little to do with the previous, but being more a response to present and perceived possible (short-term) future demand.

On a non-conscious level, time has little meaning. One could say that a human being is the animal that tells stories. We make up stories about what has happened to us, what is happening, and what will happen. We make up soap operas, fairy tales, entire mythologies and the Tale of the Three Billy Goats Gruff. Every history book is a story with a slightly different twist. I once worked in Namibia during the UN resolution 435 transition from South African rule to independence. One particularly grisly incident during that time was reported in the three national newspapers – each with a different story. I worked in the same area, and talked with people from the same village, from the SA Army, from the two main factions of SWAPO and from the Namibian government, and each reporter, person, eyewitness and local observer had a totally different story.

I was shocked – not so much at the incident itself, but at the idea that all of history could actually be like this - and never again could think that what I read or heard was anything other than one person's story. History and experience only have the meaning that we care to give them. And the search for *meaning* is one of the functions of those pesky mirror neurons that

© Andrew Cook June 2012

keep popping up all over the place in *this* particular story.

Each IBP/EC and *Alter* is stuck in the time frame that it was created in, and often does not even realise that time has moved on. The big difference between an IBP and a fully fledged *Alter* is that an IBP is *temporarily* stuck in a “then”, and will reorganise itself when it discovers that time has moved on and that it is now safe. On the other hand, an alter lives a parallel life to the dominant “apparently normal” personality (ANP), and just like Peter Pan doesn't get any older, but *does* recognise *to some variable extent* the passage of time. The difference between these (IBP/ Alter) is not clear cut, but rather comes in many shades of grey.

Another duty of the conscious mind is to maintain a strong link to here and now – which then allows IBP's (and also Alters, to some extent) to recognise a certain degree of safety that allows them to complete their process and reintegrate back into the body as if nothing had ever happened. They will do this when there are sufficient resources in the *here and now* to hold and support whatever it was that happened *there and then*, <u>and</u> that information is being linked back to them in a form that they understand by means of conscious awareness - which may be the therapist's and/or the client's.

The *continuity* of experienced time is something of an illusion. The human consciousness interfaces with the world at a rate of about 10 Hz. There is an upper limit to the absorption of *consciously* memorised information – of about 10 bits per second[11] The mid and hindbrain work somewhat faster – between 2 and 10x as fast as the cortex (based neurotransmitter-driven synapse speeds), and maybe up to another 1000x faster based on electromagnetic data[12]. These more “primitive” parts of the brain carry out a lot of sensory filtering before the conscious brain gets a look-in, based on past sensory preferences expressed by the conscious mind. Unfortunately these preferences are almost always set accidentally because we have no model in our culture to describe how this happens and how best to use it (section 3.10).

The RAS largely depends on feedback from muscles and connective tissue to know what is happening in our environment. If muscles clench and armour, then the RAS interprets this as being indicative of an attack. Similarly if the jaw joint clenches in a particular way, then the RAS assumes this is a snarl reflex. The face and head is particularly well connected to the RAS. One RAS feedback loop well recognised in CST is the way a strained jaw joint capsule can set off a anxiety/alert state with no need for any specific traumatic event. The bones of the face are particularly thin and can literally change shape when the facial muscles are worked. The otic ganglion, found behind the palatine bone, is another point at which the RAS may become overactive through a relatively minor accident (or tooth extraction) rather than a truly traumatic event.

So the Reticular Alarm System (RAS) – being located in the hindbrain – is particularly fast in detecting any kind of potential danger. It is our internal security guard. If it has not been set up by a trauma IBP to be on high alert all the time, it is a typical part of the body, in that it prefers to tick away in the background taking up as little energy as possible. Once triggered, it will remain on high alert until it recognises that the coast is clear. Typically for a traumatic memory, the RAS will want to be *very very very* sure that everything is OK before it drops back down to a “business as usual” state – so although it can be triggered on in maybe 1/100th of a second, it

11 see http://www.humanbottleneck.co.uk

12 see Valerie Hunt's research into EMG fields and the Aura

can take several minutes to tens of minutes – or longer *whilst being given clear information in a form that it understands* to decide that everything is OK. If you consider that the RAS evolved with the main threat being attack by a wild animal, this strategy is quite understandable. So one has to be very patient when dealing with this system. Even if the correct messages are being provided, the RAS will remain on high alert unless it is given *whatever time it needs* to come to a different assessment based on here-and-now. We must have patience, and encourage simplicity.

4.8 The Window of Tolerance (Sympathetic/Parasympathetic functional ranges)

4.8.1 General principles

The Window of Tolerance (WoT, Figures B, C) is a particularly useful concept – both as a working model and as a simple means to describe to people exhibiting PTSD or shock/trauma how their body is functioning. Anyone who has been anywhere on the bipolar spectrum will recognise every detail of it, and often will remark that they wished they had seen it before.

There are many, many possible variations to Figure A – but the basic picture remains the same. Once a survival alarm goes up, the body has a particular sequence of events that it expects to see in order to know that it has really survives and is safe once again. The alarms are triggered through the ANS, so are encoded in the endocrine/ neurotransmitter and nervous systems. However, the "safe" signals come through use of specific muscles, - the use of which demonstrates to the body what the outcome is. If (e.g.) the legs do not run or the arms fight or teeth bite, then the body does not know that the fight/ flight response has finished or been successful; so it remains trapped in an IBP loop. If it encouraged to take up these movements wherever they left off, it will work its way back through the necessary sequence and then settle down to here and now. The IBP loop can occur anywhere on the survival response curve, and *usually* that curve also has to be followed from wherever it was interrupted until it reaches completion. Note that the immune system response is also activated to deal with wounds and wound infections (direct to blood/flesh) rather than infection pathways dominantly through the external orifices.

If overwhelmed, the response takes a different route. The body goes into parasympathetic dominance. It is possible for the entire body to be in sympathetic or parasympathetic, but trauma usually leaves us with different body *parts* in different states. The legs might be in parasympathetic whilst the head and neck remain in freeze. The side of the body that bore the brunt of the impact/threat may be dissociated and difficult to sense (often interpreted as a neurological problem), whilst the other side attempts to keep things going and look after it – here we may notice that the other foot curls over and strokes or covers the affected foot as if to say "it's OK". Or the neck is physically unable to turn to look directly at the direction that the (e.g.) impact came from – as if the body is unwilling to look directly at the danger.

Normally we have a wide range of possible ANS activity, with an approximate 10 second variation from a true S/P balance as the heart rate goes through a cycle of varying rhythm (the Traube-Meyer-Hering cycle). The homoeostatic range of normal states allows us to relax or sleep, digest food, be peacefully alert, run for the bus or face a stressful interview and *still*

remain in the normal functioning range of the body. This is called the *Window of Tolerance (WoT).* If a trauma has created an IBP or Alter, that is activated once the ANS range approaches the range that *it* operates in. This effectively narrows the normal range of the WoT, so that it becomes far less easy to remain in a "normal" state. Once we are functioning outside the WoT, we are in survival response, and also connected to any memories of trauma (because the physiological state of trauma has been entered). This may be the cause of both bipolar disorder and schizophrenia. Recent research has found substantial non-inherited genetic changes in schizophrenia. Interpreting through the lens of trauma treatment, it is possible that our genes are not only passed on in a Mendelian way - but are also rather more malleable and responsive to environmental pressures (i.e. Lamarckian) than presently considered.

Working with trauma in a useful way requires that we begin with R*esourcing* – so that we can bring the here-and-now ANS state back within the (substantially reduced) range of the WoT. Once the physiology re-enters the WoT for only a second or two, it begins to remember what "safe" means, because the traumatised parts (stuck in a "then and there") have just made contact with parts of the body that know we are safe – because they are still "here and now".

In fact, this more or less describes the process of working with the WoT. We first find or encourage the development of awareness of a part of the body or a state of consciousness that is *well resourced*. Once we have this as an anchor, we begin to reconnect non-resourced states back to this resourced state. This is best done in small chunks. If the chunk is too big, the traumatised state will overwhelm the resourced state. On the other hand, if a small fragment of the trauma is re-stabilised by connecting it to resources, then that will recover a much bigger fragment. The ideal place we aim at in the WoT is maybe 50-75% up within Sympathetic dominance. This provides plenty of energy to work with, whilst still remaining resourced. Also, perhaps more importantly, if they slip out of the WoT, the most likely immediate direction is into sympathetic (instead of parasympathetic overwhelm).

Parasympathetic areas outside the WoT are waiting for death, and often bring on dissociated states of consciousness that are difficult to work with. Speaking for my own treatment - when I understood this model I was able to actively assist the therapist to keep me in resourced states. If I started to feel woozy or sleepy, indicating that something was taking me into deep parasympathetic, I was then able to control the treatment sessions and intervene – just saying - "that's not a useful place to go right now". Although some people do not need this model, and sometimes healing takes place in other ways, it is a good general statement to make that - *once a client understands the WoT and what Sympathetic vs Parasympathetic states feel like, they can participate very usefully in the session* <u>*and*</u> *are often much more able to regulate themselves at home.*

This is worth re-stating, because this is such a simple but rather extraordinary principle. Resourcing to bring people back within the WoT requires simply that their *conscious* attention is brought clearly and firmly to *parts of their body or awareness or memory* that are well resourced. Neurologically, this *safe-here-now* attention engages with the frontal cortex. The language of the <u>non</u>-conscious is the sensory system. If the conscious attention is engaged with anything, that also brings the attention of the non-conscious to bear on that area. Direct awareness of somatic sensation essentially brings the conscious mind down to a level at which its activity could be thought of as being in direct communication with the non-conscious. For this kind of resourcing to work, clients are more or less helped to chunk back down to the detail

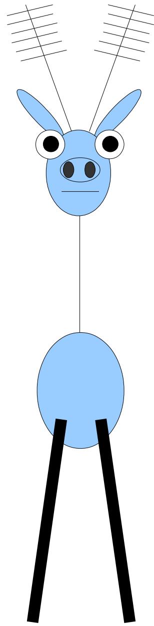
of somatic sensation in a resourced part of their body – going *below the interpretative levels* to a level of sensation. This resourcing then will then, with more or less assistance, spread from there back into the non-resourced states/ body zones. We are providing the body with resources *NOW* that were not available *THEN. The body does not have a sense of history – only process, and so will use the resourced states to retrieve itself from any traumatised state. The body knows how to do this – it just needs a little encouragement to help it stay for long enough inside the WoT. Given this time within the WoT when the conscious awareness is held in a well resourced state and focussed on a well resourced part of the body/physiology, it will link itself back up and complete the trauma IBP.*

A non-exhaustive selection of words that describe different somatic sensations and levels of awareness include :

> *heavy, solid, rubbery, large, small [size and/or age may be sensed as being different to what they know it to be], [sense of limb location – again not necessarily what might be expected!], [sense of muscle texture], alive, buzzy, tingly, micro-movements [motion described in more or less detail], pins and needles, fuzzy, fizzy, pulsing, throbbing, full, cotton wool, expansive, banging, jumping, gurgle, shiver, still, silent, peaceful, numb, blank, absent, nothing, withered, black [or any other colour], woody, metallic, warm, hot, burning, dry/damp heat, cold, cool (breeze), freezing, sleepy, dizzy, drifting off, darkness or light [in the awareness/mind], strong, firm, confident, energised, tired, weak, floppy, stiff, elongated, contracted, full of blood, pumped up, senses all "out there", alert, awake (etc.).*

4.8.2 Animal models

A simplified description of the more primitive survival responses, taken from Sensorimotor Psychotherapy are given below. I have excluded the socialisation reflexes and parasympathetic (including submission), and instead focussed mainly on the three most common adrenaline/sympathetic (i.e. resourced) response postures. Also, for simplicity I have not included the active fight response. You can learn some interesting stuff by role playing the physical positions and muscular tension states of the animals and noticing subtle shifts in sensory perception that arise with each muscle position.

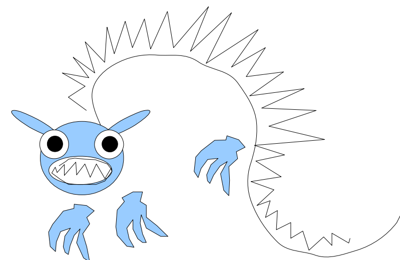


The first animal is the **deer**. The deer is in startle/freeze with its legs stiff, and is pointing its head in the direction of perceived danger. This allows it to receive as much information as possible with its eyes, its ears, its nose and its aerials. Freeze is a useful state to be in if you want to sense as much as possible whilst being as invisible as possible Movement is far more visible, and most animals are coloured so that they are difficult to spot in their normal environment when they are in freeze. Deer have lots of aerials. Its ears are pricked up and pointed forwards. Its eyes are wide, its nostrils flared and mobile, and the deer's neck is elongated so that it can see as far as possible over the long grass. If you lengthen your neck, you will feel your eyes become more energised and the ears becoming more sensitive. The deer's face is in a neutral expression. This removes any compression from the middle ear, allowing the best reception of low frequency sounds. Predators tend to have heavy feet and deep growls, so low frequencies are particularly “interesting” to a startled deer. The deer's eyes are focussed on long distance, because

a) if the threat is closer than that the deer would run instead of just stand there, and

b) its primary survival strategy is to detect predators while it still has a chance to run.

When a deer decides to run, it has first to come out of freeze, and then turn to one side or another and look for an escape route. When a deer is cornered it will attempt to lash out with its hooves and horns, and so will, if possible, temporarily shift through the next position....



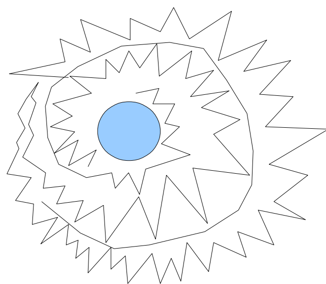
The second animal is a **cat** – or, at least something similar to a cat. This particular cat has realised that it may be close to a predator of some kind, and so it has adopted a defensive position that will allow it the most options for that situation. It has curled up its spine to protect its soft underbelly. The eyes are wide open and alert, but are focussed more on the short to mid distance, as that is where the threat is coming from. We have two possibilities here :

a) the cat has sensed a predator nearby, but has not yet been seen, and
b) the enemy has been engaged with and there is eyeball contact

For both of these the cat is in freeze with its head down near the ground and teeth bared and claws ready. This position protects the throat, gives the cat a chance to attack the underside and throat of its attacker and reduces its likelihood of being seen. The crouched position is a good starting point for an attack, or may be converted into a run. The bared teeth are in warning and are ready to be used. There is no need to retain sensitivity to deep noises, because the cat already knows where its enemy is – its ears are more interested in top end noises that tell it something about the movement of the predator – so clenching the teeth or baring them in threat is more useful than keeping the jaw relaxed. When the cat is still hiding, its ear openings are pointed forwards to listen. Although the rats head is immobile, the eyes dart from side to side, looking for movements and for escape routes. The ears are laid backwards so that they are less vulnerable when a fight is imminent, and the eyes are fixed on its adversary. There is also some change in the load bearing angle of the rear legs to allow a more easy transition from freeze into movement.

Most humans tend to clench their teeth rather than bare them, because we don't normally use our teeth as fighting implements any more – and in this case the teeth that clench tend to be the molars rather than the incisors, creating an interesting set of facial and subcranial muscle tensions. Similarly, we have a choice between clenched fists and claws – these are both adopted, and result again in quite different muscular usage of the hands, forearms, shoulders and diaphragm, and less noticeable differences in tension in the pelvis and legs.

When a cat decides to run, it has first to come out of freeze, and then turn to one side or another. If the cat runs and is caught, if it has any opportunity it will first turn back to face the predator, revert to this defence position, and then may develop its position into....



The third animal is the hedgehog, or alternatively the armadillo. Its soft underbelly and sensitive face are curled up inside a well protected shell. Its muscles are in freeze, because that makes it far more difficult for any predator to uncurl it. When it is most strongly curled up its senses are internalised, so it is less able to feel itself being pushed or hear the growls. A slight loosening of the curl reflex opens the senses more to the external environment. Moving requires first a slight loosening, then a complete unravelling, and then movement returns to normal.

The progression of this restricted set of positions/responses is shown in Figure E. I have specifically demonstrated the most common sympathetic survival response/postures because these drive many of the most common non-conscious resourced body movements that are visible in anyone who is even slightly stressed. When our body feels the need to be safer, it will make involuntary movements that enter these survival response positions and which play out survival movements. Jaw clenching and fist making are quite commonly seen. Claws may be made with either fingers or toes. When there is some state of overwhelm, the body progresses onto self-comforting movements. e.g. Toes may curl up softly. One foot or hand may stroke the other as if to say “it's all right”. And so on. Most of these are quite low key, and not particularly visible. Most are also suppressed as soon as we realise that we are making them. However, these non-conscious movements can be made conscious and then constructively used to give the physical body a far greater *embodied* sense of being in control. Once there is an embodied feeling of being in control, we are some way to creating a resourced state that will constructively support

the release of traumatic memories in a way that is controlled and feels safe. Also, if there is an embodied traumatic memory, some of the above described postures, movements, states of awareness and sensory use patterns will be held in the body as part of that memory. A working knowledge of these helps to identify them and work with them during a treatment – they are all expressions of positive resources.

4.9 Positive stories of S/P activity in survival states.

These short anecdotes give a picture of what the body is capable of when faced with an extreme survival emergency...

"I heard a shout. Starting and looking half around, I saw the lion just in the act of springing upon me. I was on a little height; he caught my shoulder as he sprang and we both came to the ground below together. Growling horribly close to my ear, he shook me as a terrier does a rat. The shock produced a stupor similar to that which seems to be felt by a mouse after the first shake by a cat. It caused a sort of dreaminess in which there was no sense of pain or feeling of terror, though quite conscious of all that was happening. It was like what patients partially under the influence of chloroform describe, who see all the operation but feel not the knife. This singular condition was not the result of any mental process. The shake annihilated fear, and allowed no sense of horror in looking around at the beast. The peculiar state is probably produced in all animals killed by carnivora; and if so, is a merciful provision by our benevolent Creator for lessening the pain of death." David Livingstone (1872) Adventures and Discoveries in the Interior of Africa.

On a slightly different tack, a retrospective study of Crimean medical records suggests that many soldiers in that late 19th Century war suffered massive organ failure – and then recovered and survived without the need for modern intensive care. A more recent example of this is ....

"*On the second day, the sun was out, I was in a field, and I felt very comfortable. That's my last memory ... I must have fallen asleep after that*."

The above quotation is from Mitsutaka Uchikoshii, whose body went into hibernation when he broke a leg on a freezing mountain – and allowed him to survive for over three weeks without food or water. His organs and brain switched off (whilst retaining enough blood supply to keep the cells alive), and then revived when he was found and taken to hospital.

In his book "*Between a rock and a hard place*" (2004), Aron Ralston describes the euphoria that flooded through him when he realised that deliberately breaking and amputating his trapped and crushed lower arm (using a blunt penknife) would give him a chance of survival when otherwise there would be no chance at all.

And another story of the Adrenal system kicking in :   In the Daily Mail[13], 2009 : *Two mothers [and a grandfather] have been dubbed 'Superwomen' after saving a schoolboy's life by lifting a 1.1 ton car off his body. Donna McNamee and Abigail Sicolo sprang into action when the eight-year-old boy was run over outside their homes. ... Both women were surprised at managing to summon up the strength to lift the car. ... "We had to physically lift the car off the ground high enough for others to pull him clear...."*

13 http://www.dailymail.co.uk/news/article-1190759/

© Andrew Cook June 2012

The high adrenaline/sympathetic state is understandable for survival – but what about the parasympathetic? I usually think of it as a preparation for death, or a "play dead and then see if we can survive". The body makes sure that we will not feel pain when we are eaten. It also puts us "in the freezer" just in case we can survive. An antelope taken down by a lion will go into floppy parasympathetic dominance, making the lion think that it is dead, whilst still pumping *more* adrenaline into its system. If the lion is distracted by hyenas and the antelope is still healthy enough to run, then the antelope will leap up and run again – and often escape.

The extreme vagal states tend towards hibernation and therefore coma. An interview with the violinist Paul Robertson was recently transmitted on BBC Radio 4[14]

> *This is violinist Professor Paul Robertson's remarkable story of the Indian ragas he heard from within a coma, and the healing effect that Sir John Tavener's music had on him in his recovery.*
>
> *When Paul and John met at a conference in 2007 they discovered that they had a shared interest in near death experiences. During the course of their conversation, John stated that he wanted to write a piece for Paul involving four string quartets to be called "Towards Silence". John duly wrote the piece and Paul started to make arrangements for its premiere. At this point, John suffered a heart attack and was taken into intensive care in Switzerland. Within weeks, Paul's aorta gave way and he found himself in a London hospital. During his six week coma, Paul had a series of horrific visions, but was occasionally comforted by the sound of a woman singing Indian ragas. Only when he came out of the coma did he realise for the first time, that the music John had written for him: "Towards Silence", was based on an Indian raga. Paul then used the practising of this piece to rehabilitate himself after the paralysing strokes he'd suffered during his coma.*

A few quotations from the programme are quite startling in their implications. Although Paul was in a coma, he was also aware in a symbolic sense of what was happening around him throghout the coma and re-emerged with a memory of those experiences.

"The pain was unimaginable" – and injection of morphine produced a - "delicious darkness - no need to hold onto life any more".

Operation - 3% chance of survival. After the operation he was in a coma for 6 weeks, during which he had a series of visions.

He was one of several entities circulating round Indian Goddess as a beautiful voice sang Ragas. At intervals in this visionary sequence, devils came who were masculine and smelt of aftershave (he was shaved in the hospital once every day) and he described the experience as being defacated!!! Heronymous Bosch-ish. Next were a sequence of experiences of being submerged in deep water with people who were already dead (but didnt realise they were). Occasional explosions would happen in the water in which some of the floating bodies were killed. He would occasionally float upwards towards the light and then stop himself and return back to the depths out of fear.

Physically he was non-responsive : Doctors thought he was never going to come round and at 5

14 Hearing Ragas: BBC Radio, Friday 7th September 2012. http://www.bbc.co.uk/programmes/b01mf7nd

weeks wanted to switch life support machine off. His wife refused and arrahged that a Mozart CD should be played – his breathing rapidly synchronised to music.

As the underwater visions progressd, there was an internal discussion as to whether he wanted to live or die... living was hard option - pain, fear, horror – Paul would occasionally surface from deep water (ship of dead people) - people dead and didnt know they were. He didn't know how much alive he was himself.... He "saw" doctors leaning over him saying he had been desperately ill and had been nearly dead – he preferred to be submerged... "I would not have come up if it has been up to me". This was a grotesque netherworld - "Valley of shadow of death". Even in coma- knew that he was in great pain and could not move - his preference was coma - because was frightened of the pain and paralysis he knew that had to face if he awoke/returned to life. *"Then eventually at some deep level I sort of made an agreement that allowed me to come back to life again - but it was not from my will."*

4.10 The Three Selves

see http://www.hummingbird-one.co.uk/pdf/3Selves.pdf

4.11 *Temporary expedient autonomy* (TEA) : fragmentation as a normal survival adaptation.

see http://www.hummingbird-one.co.uk/pdf/ChapA_TEAs.pdf

4.12 Sensory preferences

An interesting side-issue of working with people in a somatic way is the realisation that there are many different ways to inhabit the senses. It is a noticeable fact that some people will use certain sensory channels almost exclusively, ignoring others, almost to the point that one wonders how we (as individuals, as a culture and as a species) communicate at all – or have any kind of sense of common reality. The fact is that you could have two people in the same room who use the same words to describe an experience, and their consciously sensed-perceived worlds will be radically different.

I have attempted to catalogue these sensory preferences, and briefly discuss three of the major types below...

The first, most obvious variation is the commonly recognised major sensory preference VKA[OG] (Visual-Kinaesthetic-Auditory-Olfactory-Gustatory). The latter two are much rarer as a dominant sensory preference. So, for instance, *in normal circumstances* I am roughly equal Visual/Kinaesthetic (meaning that I feel through my body *and* use my eyes roughly equally), and have a relatively poor connection to Auditory senses (i.e. hearing language). In fact, up to the age of about 35 if I was very busy with my VK senses I was unable to tell what somebody has just said to me – at the best I just knew that a noise had come from somewhere, and it *might* have been speech. One girlfriend used to take the piss when I had to stop walking in order to be able to talk. When travelling abroad, that shifted, my olfactory senses became stronger and I also became far more aware of the space around me – a sense that is not included in the usual

list, except that it includes proprioception – one of the many Kinaesthetic senses. It takes a conscious effort to focus on sounds, and I have to be interested in it enough to make that effort – music or birdsong. And some sounds and vibrations feel highly unpleasant or invasive. The "K" senses were primarily visceral rather than musculoskeletal, and it was difficult to comprehend how people used their bodies in sports – again this has shifted, after some very good quality martial arts and yoga instruction over a period of some 15 years. The fact that these senses dominate perception of reality to the point that it impossible to imagine a different way of perceiving the world – and yet – can be trained to work in a different balance – is really interesting. It suggests that the "hard wiring" due to developmental preferences is relatively minor, and actually the senses are *always* available. All that is required is that somehow the conscious attention is trained to catch hold of something that it has no idea of the location of! Well, actually that statement is incorrect – all that is required is that the conscious mind has the *intention* of perceiving things using those senses, and over a period of time this trains the non-conscious to provide the information.

A second sensory preference type is the internal-external spectrum that is described earlier. The Kinaesthetic sense is the most obvious internal-external sense, in that we have applied a single word "feel" to describe everything from knowing where a limb is, to being aware of open space around us, to skin contact, texture, infra red and pressure to internal sensations of warmth, muscle, pain and emotion. This linguistic nexus is highly confusing for any rational conversation about individual sensory perception.

The "what" we are aware of is highly trained. An interesting conversation with an artist about 20 years ago made me realise that she had trained her perception to be far more aware of colour, texture, light and shadow – and I became very aware that although I could understand her point of view by thinking about paintings, I definitely was not sharing her experience of the landscape. My awareness was at the time (as a geologist) was far more attuned to the interplay of human and natural features, gradients, soil types, subtle ripples and shifts in the land surface that indicated something deeper and far more significant.

All of the VKAOG senses can potentially be used internally as well as externally, in the sense that we can *imagine* things using these senses. In my experience, most imagination also plays out in the visual/kinaesthetic range, so I can "see" myself making a movement, and "feel" that movement – even though I am not performing it. But many of you may have a different experience. I would guess that a typical dog dreams in smells.

A third major preference type is based on the embryological germ layers. It is again well known that people's body shape falls into three major categories – endodermal (pear shaped), mesodermal (athletic, broad shoulders) and ectodermal (tall, thin). These three categories also have their sensory aspects which are *more likely* to be found in their corresponding body type than in another body type (i.e. this is not a hard and fast rule, but more of a loose trend). Endoderms are more focussed on visceral and emotional senses, and as such also tend to be more internally focussed than the other two types. Mesoderms are more aware of their musculoskeletal system (and so tend to be more aware of their body moving - usually), and ectoderms are focussed on skin and any other sense that tells them something about the external environment. I have started to suspect that the physical adult body shape may arise from the sensory preference being expressed.

Some senses are culturally preferred – e.g. the magnetic sense (!) that is used in geographic languages. Here, the speakers of these languages have an innate and continuous sense of the cardinal directions – they would, out of cultural habit, say “there is an ant East of your foot” rather than “there is an ant to the left of your foot”, and the listener would know which direction East is, and look in that direction – which in this example happens to be to the left. There is so far no suggestion that this geographic/ magnetic sense is genetically limited to certain small ethnic populations, so the conclusion must be that we all have this sense, but we have simply forgotten how to access and use it. It will still be available to the non-conscious, so the mid and hind brains will still be aware of absolute direction. All that is required are a small number of neural connections to be made – for this sense to be recoverable and consciously accessible.

If you are working with somatic experiences, it is useful to have at least an awareness of the range of possible preferences - so that you can find ways of communicating verbally that help people to access their somatic experiences easily. As various memories play out in the body, the balance between senses and their overall volume changes – see Figure E and section 4.8.2.

I have come across quite a few people who *do* have a rich somatic life, but who cannot *conceptualise* that using the words commonly used to describe kinaesthetic experiences. They will therefore tend to “think” about their body or just say that they don't feel their body – this perceptual preference must be distinguished from true somatic dissociation – it is more of a cognitive-level conceptual dissociation.

4.13 Energy Cysts

Another topic that I intended to avoid, but which seems unavoidable in this context. Energy Cysts (ECs) are probably solitons – they certainly behave in a *similar* manner to solitons - and a soliton is a self-organising and self-propagating waveform[15]. We see solitons every time we go to the seaside. Every wave is independent, and can travel through its neighbour and re-appear the other side in its original form. It does not contain the same molecules of water, but it does contain the same energetic information.

In the physical body, an EC is created whenever there is an event that our body doe not have sufficient resources to deal with at the time – one way or another it has been *overwhelmed*. The generic process that the body uses to contain that event is the same regardless of the content of the event. It may be a kinetic impact during a road traffic accident, or a strong emotion, or chemical or radioactive poisoning, burning, drowning, loss of oxygen for any substantial period – there are many possibilities. The effect of more physical or chemical impacts is amplified by the presence of emotional responses. An EC will release when sufficient resources are made available to contain and deal with whatever the situation was : such that it is no longer overwhelming *and* the tissue that contains the EC is allowed to begin to return to a physiological movement that is more connected to the movement of the tissue around it (i.e. it begins to reintegrate with the body rather than remaining as a partially walled off zone). This partial connection is well recognised medically in the case of an infective EC – i.e. an encapsulation.

Again, this is not a phenomenon that necessarily makes sense in an everyday scientific way.

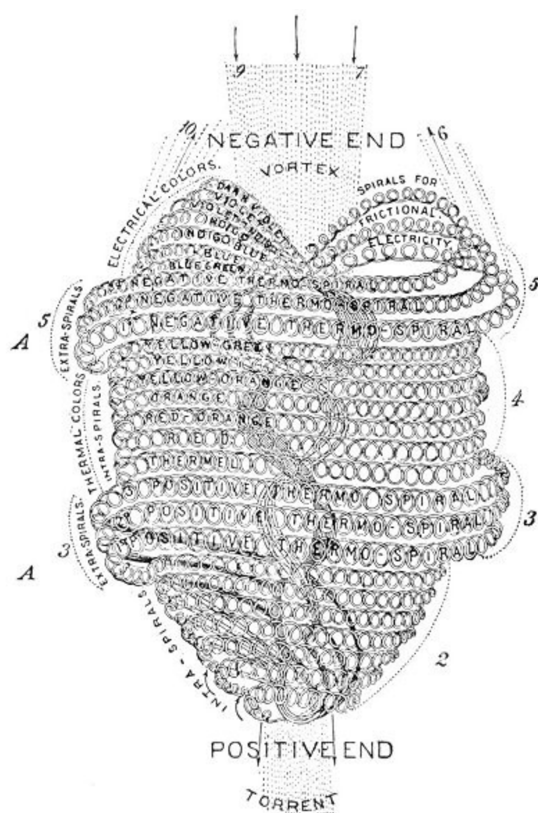
15 http://en.wikipedia.org/wiki/Soliton **and** http://www.ma.hw.ac.uk/solitons/

© Andrew Cook June 2012

However, I can give one example that might convey something of the flavour of ECs. A child fell off a fairground water ride and ended up about 4 metres underwater, and so disoriented that she could not find her way back to the surface. She wasn't particularly scared of dying, but was instead – curious! She was found and pulled out some 2 or 3 minutes later by her father, who dived in to find her. To cut a long story short, this resulted in partial deafness in one ear. On treatment 15 years later, when the EC was released, *there was a sense of being deep underwater in the entire room – felt simultaneously by the therapist and the client.* The emotion that came with this underwater/pressure sensation was - curiosity. As this faded away, hearing returned to the ear. Release of this required that sufficient resources were available to contain the memory (or at least the content that re-played as it released), and that the tissue containing the EC was mobilised in such a way that it began to reintegrate back with the tissue around it. If the stored emotion had been some kind of overwhelm, this would (probably) not have been such a fast or easy process.

ECs may be quite small, up to taking up an entire physiological system or layer of consciousness/ identity, or even the whole person. They are fairly easy to spot when small, as they are usually at the centre of a rotational motion of body tissue. When large, they tend to lead to hyper-collapsed states – i.e. overwhelm – but do not have any apparent centre or focus, so may be invisible except for a few dissociative symptoms and some core tightness.

The internal centripetal vortex of **Babbit's Atom** is a good analogy for the tightened core, and the outer centrifugal vortex is similarly an analogy for the invisible outer boundary that I have described. We usually only take notice of the core of solitons because they are far more obvious – but actually, the periphery is equally important – though far less noticeable.



Just a few peculiar things to consider.. The physical form of a soliton is the same as “Babbit's Atom” (see below) – the shape that was psychically determined during a seance (whilst trying to find the shape of “the most fundamental particle in the universe”) at the end of the 19th century. At the time Rutherford was starting to define the atom, and the psychic group associated with Annie Besant decided to pip him to the post by using psychic viewing rather than physical experiment. The internal structure of Babbit's Atom contains the spiral of Caduceus. Solitons are also related to the formation of a Bose-Einstein Condensate : one physical process that was proposed as a possible basis for consciousness by Danah Zohar.

The principle of superposition is an important aspect of solitons, and deserves a small discussion regarding its clinical implications. Consider a series of waves in the ocean. If you have three waves travelling in the same direction at slightly different speeds, there may come a time when they are all coincident – they happen to have ended up on top of each other. As mentioned elsewhere, the information contained by each wave is

© Andrew Cook June 2012

preserved, but the externally observable form of the wave becomes the sum of all superposed waves. So the three little waves can (apparently – to the transient observer) become one big wave. In the middle of the ocean these superposed waves sometimes create a *superwave* which may be over 30m high. Similarly in living organisms, the soliton that represents the core psychoemotional personality (the *primary soliton*) may be enlarged by any number of smaller solitons that enter it through traumatic events or other means. Normally the core centripetal component of the primary soliton is aligned and coincident with the spine, and so the person feels aligned and energised. If the core of the primary soliton becomes displaced, then the person may feel displaced from their body. This may be expressed in terms of varying degrees of physical dyspraxia or by a loss of balance, and increasing levels of dizziness, disorientation and loss of the ability to both sense the physical body and to think clearly. The main reason (maybe the only reason?) that the primary soliton may become displaced is if one or more other solitons displace it. In this case, simply forcing the aura back into alignment will not have any lasting useful effect. It is necessary to identify and neutralise any solitons that are superposing on the primary pattern. If these are offset from midline, the task is relatively easy. If they lie on the midline or even have a core that is centred on the primary core, the task is much less easy. Here we rely on the higher self to carry out much of the work. One way that the body resets itself is by deliberately displacing its own primary core away from the physical core and then bringing the two back into a new and more integrated alignment. This appears to happen without the CST therapist having to do anything other than just observe. Nice. While this is happening I find that the use of SMP resourcing helps the clients conscious mind to usefully participate. This participation then helps the exposed invading EC to dissipate. See resourcing section on “useful attitudes and states of mind”.

A well known physical manifestation of a 3-D soliton is a hurricane. A hurricane could be accurately thought of as an energy cyst in the body of the Earths atmosphere. Excess heat and moisture create a convection cell in which the warm, moist air is substantially less dense than its surrounding cool dry air, and so it rises. When this air rises, it pulls in air from all around it, and begins to rotate. If the air that it pulls in is also warm and moist, the strength of the hurricane increases. Wind speeds at the core may reach over 200 miles per hour. The geometric shape of the hurricane is one of the spiral vortices/eggs found in projective geometry, as nature creates a perfect balance of pressure, velocity, volume and minimises the loss of energy inside its own moving form. The hurricane dissipates when it dumps moisture in the form of rain, and the contained warmth is reduced by incoming cooler air. As the lift dissipates, the strength of the core also reduces, the eye loses its form, the core centripetal pole enlarges and the outer centrifugal pole contracts. Finally the two poles converge and neutralise each other. The contained energy/information and the behaviour of the centripetal and centrifugal poles are a totally integrated and mutually responsive entity. A few people have lived to see the eye of a tornado, usually when they have been hiding safely in their cellars, and mistaken the quietitude of the eye for a sign that the storm has passed. Their descriptions are extraordinary. A pair of writhing snakes coil up inside the containing funnel of the eye, disappearing into darkness. Lightning discharges between them and the wall of the eye. The contrast between their apparent aliveness and the vast forces they contain – and the stillness of the air around them – is almost unnatural – beyond anything that the observers ever imagined that they could even imagine. The double helix form in the eye of the hurricane is a direct equivalent of the double helix/Caduceus at the core of Babbitt's Atom.

© Andrew Cook June 2012

In esoteric anatomy. the soliton/Babbit's Atom is the physical forms taken by the **Air** and **Water** elements. Air is the elemental energy that is associated with the parasympathetic system and the "mind", and which organises itself around the axis of the notochord. Water is the medium of life energy and the source of physical form.[16]

4.15 A Few Basic Dialoguing Rules

The structure of language can be altered to

- increase or reduce the degree of suggestion,
- increase or decrease the choice that people have in any answer they may give to a question
- alter the type of awareness that someone is directed towards

Ideally, for any therapeutic usage, there is minimal suggestion, and more choice. The patients awareness is ideally led to being more present in the now, and to a state where the senses dominate mental activity. The sensory preference that is cultivated ideally leads people as far into kinaesthetic (body) awareness as they can go whilst still remaining well resourced.

A few basic structures that help the patient arrive to that more resourced and empowered state include :

Avoid questions that elicit a Y/N answer.

"To what extent....?"

"How much...?"

"on a scale of 0-10....?"

Keep questions in the NOW

What do you notice right now? (Visual)

If you listen to your body, what is it telling you right now? (Auditory)

Where, if anywhere in your body do you notice a change in sensation when .....? (Kinaesthetic)

" ... in this moment ..."

How does 38 year old Joe Bloggs sitting here in this room feel about ...?" (also brings the client back to an awareness of their resourced self rather than some memory of an unresourced state of being sometime in the past – this question is particularly useful for people who have become a little too immersed in unresourced childhood or embryonic states)

Encourage focus on the body rather than on ideas and memories

"How do you experience that right now...?"

16 *see* Esoteric Anatomy by Bruce Burger, books by Ranolph Stone, and The Polarity Process by Franklyn Sills

© Andrew Cook June 2012

“What sensations are you aware of that tell you you are feeling XXXX, and where in your body are they?”

“what are you aware of in your body?”

“Right in this moment, how do you know you have a body? / which parts of your body are you aware of, and what are the sensations that let you know that you are aware of them?

“To what extent does your body react/respond to ....?”

Avoid instructions and invite curiosity as far as possible

“How would it feel if we ....?”

“How would you like to do a small experiment...?”

“To what extent do you sense your body is OK with ... ?”

(checking an answer was actually from the body and not a mental construct) “To what extent does your body agree with that statement...? (and what change in sensation did you sense that gave you that answer?)

5. Summary

My personal list of major points raised here include :

1. According to *Alcoholics Anonymous*, “Alcohol isn't the problem – it's the solution”. Similarly, many symptoms that are considered to be pathologies are actually intelligent and adaptive responses to more fundamental issues. As such, attempts to forcefully remove them may also attack what can be a delicate adaptive balance and cause more problems.
2. The body always wants to be healthy, and will reorganise itself into a more optimum state as soon as it realises that it can do so without compromising its safety.
3. Energy cysts (ECs) /solitons are a useful analogy for how *any* kind of trauma or overwhelm is processed by the body; how it accumulates; how the body adapts to it over the longer term; how the body releases it; and how the body reintegrates after the release of the trauma. They are also a reminder that emotional “memories” (i.e. emotions without a storyline content) may have been picked up from external sources.
4. Although it has a “clock” to measure passage of units of time, the body does not have a sense of time – only of rhythm and process. When an EC is formed - whatever is contained by the EC does not realise that time has moved on, does not realise the traumatic event is over, and has only has access to the insufficient resources that were available at the time.
5. The contents of an energy cyst are (i) a special case of the more fundamental *Interrupted Biological Process*, and (ii) a result of the body's evolutionary inheritance – in which *Temporary Expedient Autonomy* (TEA) (i.e. fragmentation) remains a common feature of both normal and emergency responses. Dissociation is one manifestation of TEA/ adaptive fragmentation.
6. An EC has a tightly contained core – in which the tissues are more dense (and are fairly easily detected because they are less mobile) and therefore all of normal life and physiological motion tends to rotate around them. An EC *also* has an external shell which often extends outside the body, which may be detected by a therapist using senses that *may* include counter-transference. These two components (external shell/centrifugal and internal core/centripetal) form a mutually interactive polarity; and there is always a *choice* as to which of these to engage with during a treatment.
7. The body itself (when in a state of health) has an “energetic” structure which

is essentially the same as an EC, and which is dynamically responsive to the external environment – the *primary soliton*. This relates to the **Air** element.

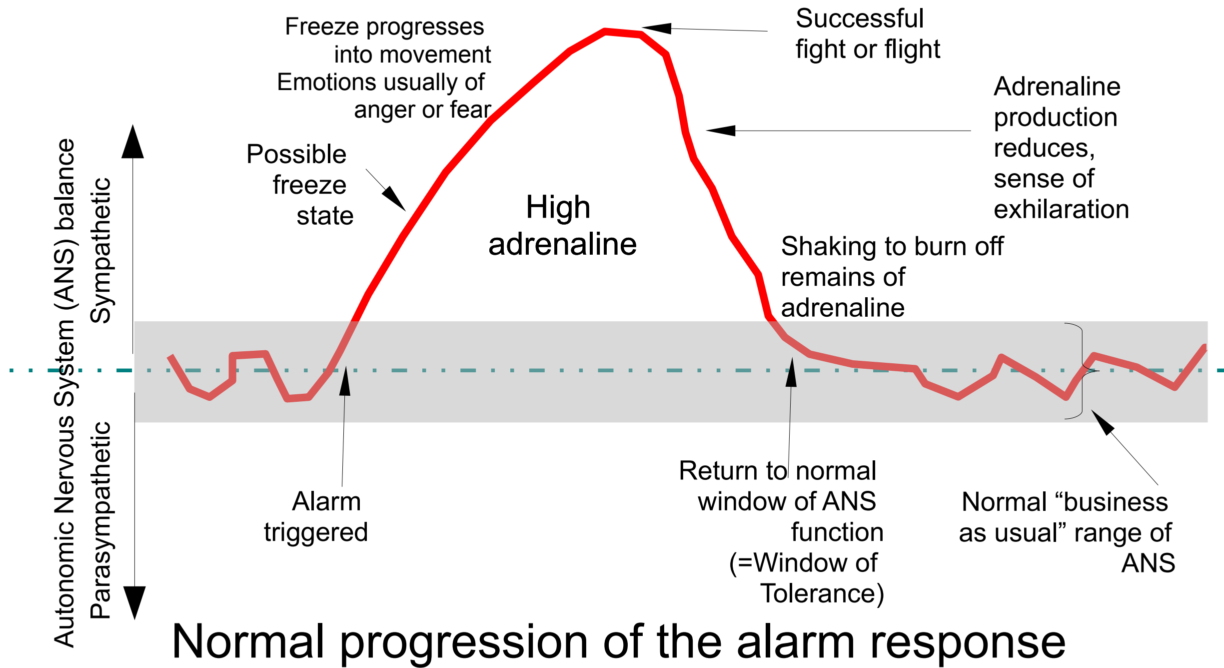
8. Core elements of ECs are strongly defended, tend to be strongly reactive and direct contact with them often simply elicits any overwhelm that they contain. On the other hand, the periphery of ECs is less reactive, and may be engaged more safely.

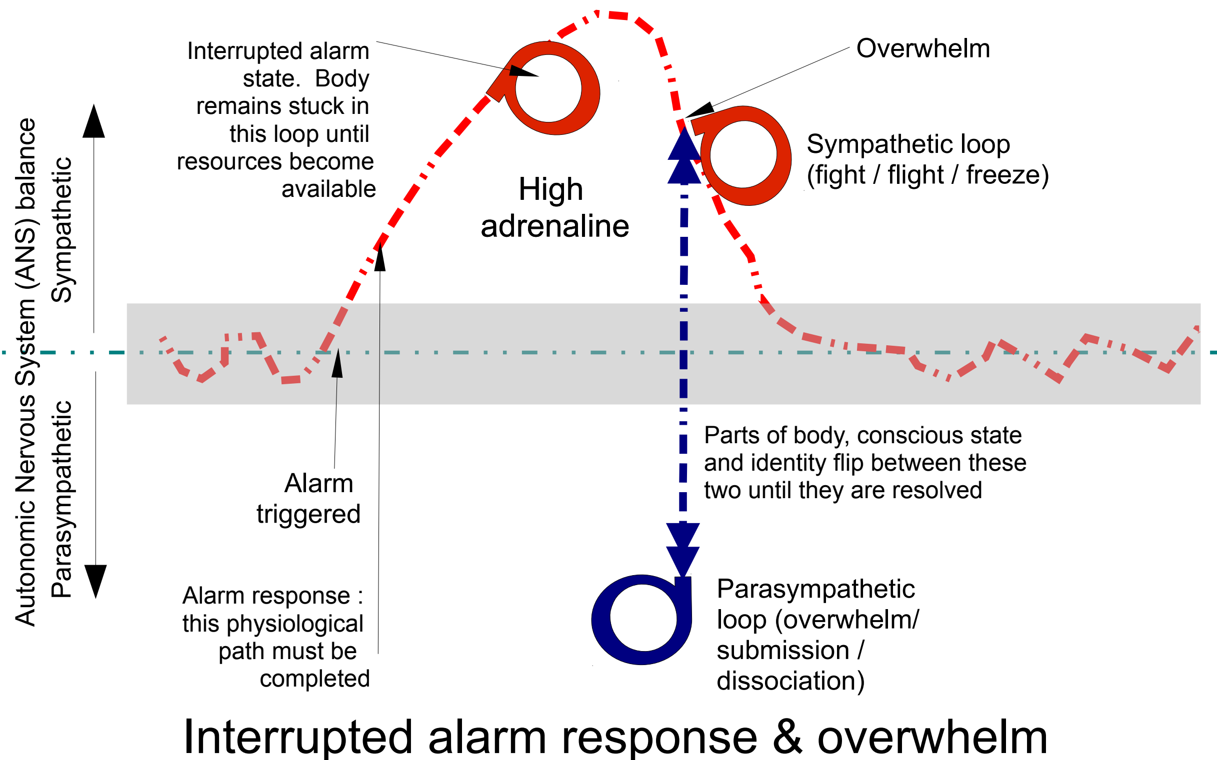
9. The peripheral centrifugal components of the *primary* soliton of the body are equivalent to the defensive/safety zone recognised by the RAS. The core centripetal component is ideally aligned with the core of the torso and head.

10. When the *external* shell of an EC is given an opportunity to reorganise itself by being strongly connected to a safe **here** and **now**, it takes a period of the order of tens of minutes to check out that safety. When it is satisfied that it is safe, the outer shell will reorganise itself, become stronger and will usually contract to a position closer to the body. The core will simultaneously reorganise itself, becoming less contracted. When these changes take place, this has a positive effect on both physiology and interpersonal relationships.

11. If any kind of encroachment is made into the middle of an EC, both the therapist and client are far more likely to be limited to the resources that the (poorly resourced) EC contains. If the therapist stays outside the EC/ "*outside the box*" then more resources are available to the client and the therapist is less likely to be negatively affected by counter-transference.

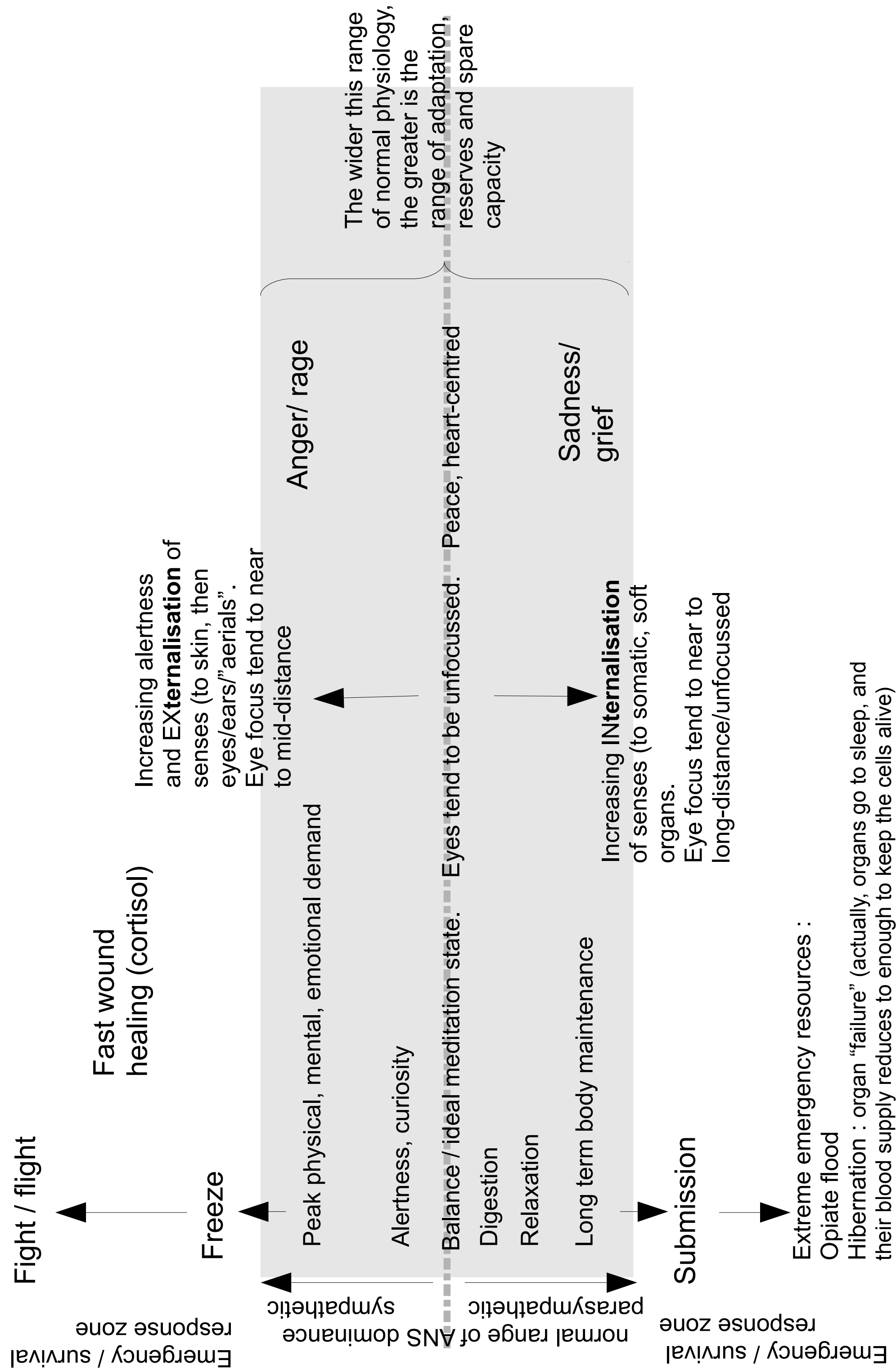
Figure A : The trauma response cycle (normal and interrupted versions)





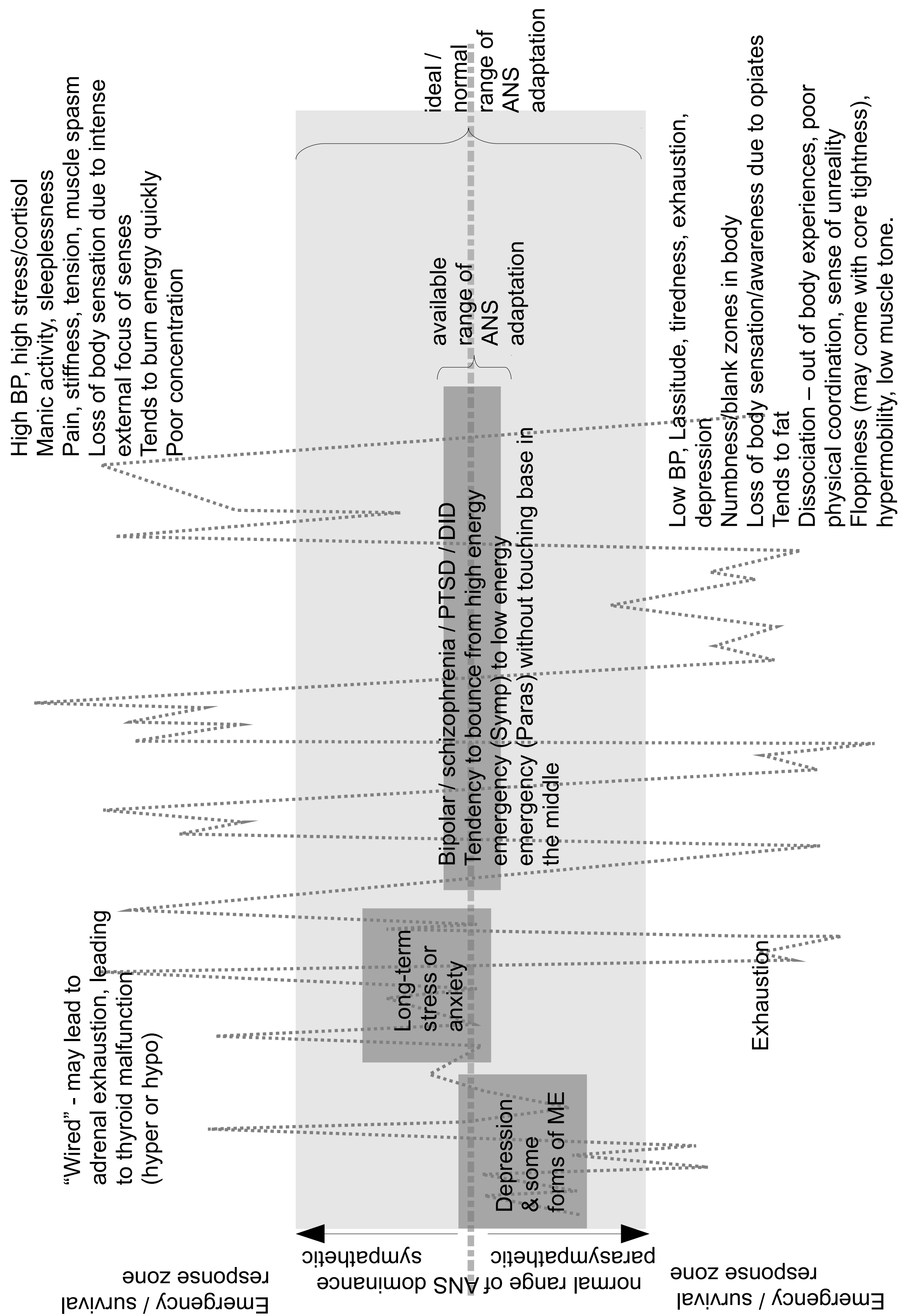
© Andrew Cook June 2012

Figure B : The window of Tolerance : normal states



© Andrew Cook June 2012

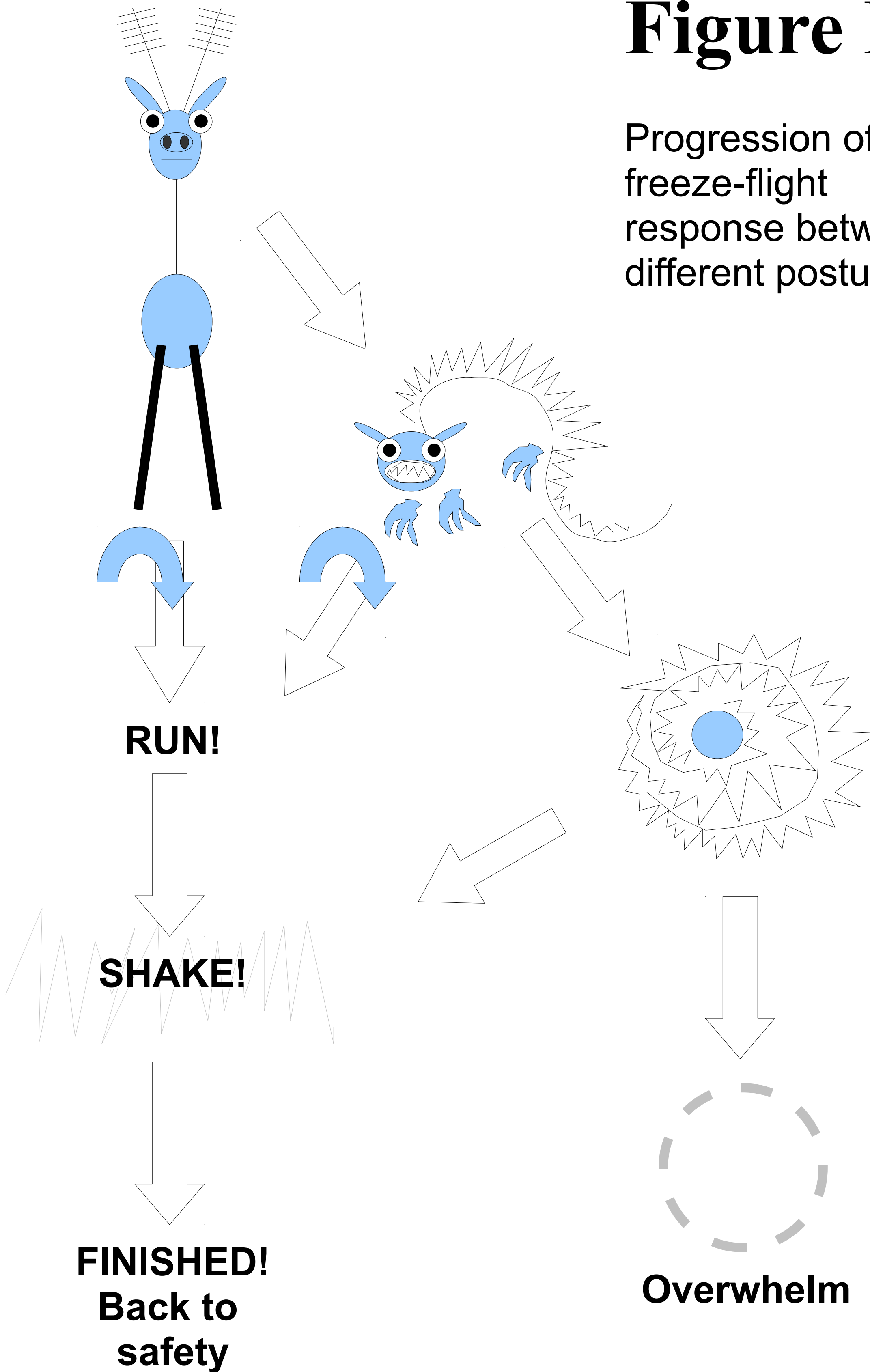
Figure C : The Window of Tolerance : incomplete survival responses



© Andrew Cook June 2012

Figure E

Progression of the freeze-flight response between different postures



© Andrew Cook June 2012

Acknowledgements

The following trainers, training institutions, psychotherapists, bodyworkers and others have, at one time or another, in one way or another, contributed substantially to the development of this approach... The HeartMath Institute; Joy Hicklin-Bailey/Secret Garden; The Sensorimotor Psychotherapy Institute (particularly Janina Fisher); The Upledger Institute; Thomas Attlee; Michael Kern. Jaap van der Waal, Deirdre Youngs (Ray Castellino/Birth Process Work) and Linda Hartley (IBMT) have been particularly influential.

Bee Springwood and Lynne Hunter were members of an IPN peer support group which I was a member of for several years, and were very generous in the way the helped me to bring principles of psychotherapy and bodywork into a more integrated whole. I'd also like to acknowledge my friends in the Ramas and Tenemos discussion groups; and the various anonymous discussers, debaters, experts, arguers, criticisers and trolls on the Gruinard internet talkboards – all of whom (in their own particular ways) helped me to clarify many of the ideas presented here.

I would particularly like to acknowledge the contribution of Zhixing Wang and Zhendi Wu and their senior students, and the teachings of Bruno Groening – both have helped me to have a far better understanding of the more important practical and positive aspects of what it is to be a human being.

© Andrew Cook June 2012

A few selected sources

Body Psychotherapy

The SensoriMotor Psychotherapy Institute (Pat Ogden); Hakomi (Ron Kurtz); Peter Levine

European Society for Trauma and Dissociation; FirstPersonPlural; The Pottergate Centre for Dissociation; and research by (e.g.) Allan Schore, Eli Somer, Ellert Nijenhuis, Bessel van der Kolk

Linda Hartley and the Institute for Bodywork and Movement Therapies (IBMT)

Pierre Janet; David Boadella; Wilhelm Reich; Moshe Feldenkreis

NICABM Trauma Teleseminar series July 2011 – interviews with Peter Levine, Matthew Friedman, Allan Schore, Pat Ogden, Mary Jo Barrett, Stephen Porges, Glenn Schiraldi, Carol Look, Christine Courtois, Robert Scaer, Diane Poole Heller

Spiritual and energetic models

Huna (Serge Kahili King; Tad James; Joy Hicklin-Bailey secretgarden.eu.com)

Bruno Groening Circle of Friends / Grete Häusler Verlag GmbH

Dao Hua Qigong / Chinese Heritage

Valerie Hunt; James Fulton/neuronresearch.net; HeartMath

Biological Models

Web video – Cellular Visions: The Inner Life of a Cell

Jaap van der Waal / embryo.nl; Rudolf Steiner; Cell Intelligence (Guenter Albrecht-Buehler)

Craniosacral Therapy

Authors *including* John Upledger; Hugh Milne; Michael Kern; Franklyn Sills

Energy Cysts

Lawrence Edwards (Vortex of Life) & Steiner (projective geometry); Viktor Schauberger

Google :: soliton, Babbit's Atom

Upledger CST 1&2, SER 1&2

Franklyn Sills : Biodynamic CST Vols 1&2, Polarity Process; Ranolph Stone : Polarity Therapy

DID/PTSD

ESTD : http://www.estd.org/; http://www.firstpersonplural.org.uk/

(see **NICABM** above)

Resourcing and positive body awareness

Pat Ogden : Sensorimotor Psychotherapy

Focussing; Mindfulness (vipassana); Heart Coherence / HeartMath; Focussing

Lynda Hartley; Bonnie Bainbridge Cohen

Serge Kahili King (the Aloha Principle)

Window of Tolerance

Pat Ogden : Sensorimotor Psychotherapy

© Andrew Cook June 2012