Somatic Psychotherapeutic Fascial-Work

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ABSTRACT

Observed through the lens of the fascial system, a new understanding of body armor and its relevance in body psychotherapy emerges. Body armor is recontextualized as layers of fascial tensions and atrophy patterns elicited from socio-emotional contexts and physical traumas such as surgeries and falls. Fascial work and psychotherapy have remained separate due to ethical considerations, cultural taboos, and the resulting moratorium on research in this area. Whether or not a body psychotherapist wishes to include myofascial release in treatments, it behooves clinicians to familiarize themselves with the fascial system due to its intimate connection to the nervous system. The author applies fascia research familiar to bodyworkers to body psychotherapy. The author shows that indirect myofascial release and body psychotherapies, like Sensorimotor Psychotherapy, are viable frameworks for the integration of fascial work and body psychotherapy by utilizing a composite case example from the author's practice. Body psychotherapists with touch licenses can integrate fascial work to address body armor. The result is that clients simultaneously address fascial tensions and atrophy patterns created by both emotional and physical events while examining conscious and unconscious meaning-making.

Keywords: body armor, body psychotherapy, fascia, myofascial release, adaptive behaviors

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> ***The continuity of the fascial and nervous systems implies that clinicians who value neurobiology for the sake of increasing their therapeutic competency would also acquire similar gains by learning more about the biology of the fascial system.***

Clients have long used bodywork and body psychotherapy together to provide for the changes that they seek in their emotional experience and behavior patterns. Reich (1933) introduced the idea of *body/character armor* and developed a classification system for different types of body/character structures. His approach attempted to address client issues by dissolving armoring through breathing, moving, and hands-on tissue manipulation. While psychotherapeutic value exists in addressing body tension, the classification system proposed by Reich is limited by today's standards. The author proposes a new conceptualization of Reich's aim to integrate bodywork and body psychotherapy within a current understanding of the two disciplines. The author provides an update of Reich's *body armor* as the imprint of procedural learning regarding behavioral adaptations on the fascial system across contexts. It behooves body psychotherapists to gain knowledge of the fascial system. The body psychotherapy field has emphasized the understanding of the brain and nervous system in psychological treatment over the last few decades, and one can hardly distinguish the fascial and the nervous system (Myers, 2011). Therefore, a similar emphasis needs to begin regarding our recognition of this powerful system.

Accessing the fascial system concurrently with the nervous system provides a synergy to change somatic patterns, adaptive behaviors, and repetitive emotional experiences. Often, body psychotherapists regard the body as a lever for the nervous system

(Ogden, Minton, & Pain, 2006; Kain, Terrell, & Levine, 2018). However, clinicians should not focus exclusively on either the tissues or the energy that flows through them. The energy in the body makes up thoughts, movement impulses, perceptions, and emotions; the material of the tissues provides the medium through which the energy flows. The author offers to the field a model that integrates indirect fascial work with holistic body psychotherapy specifically for clinicians with training in both body psychotherapy and indirect myofascial release.

First, the author will review the relationship between body armor and adaptive behaviors in classical and modern body psychotherapy. Next, *body armor* is defined as the tissue-based manifestation of adaptive behaviors (i.e., personality defenses), and explored through the lens of fascial restrictions and atrophy. Then, the author describes the biology of the fascial system, as well as the impact of restrictions and atrophy on the nervous system. The section on somatic patterning offers a take on this classic concept from a primarily fascial point of view. Lastly, the author explores how fascial restrictions, and associated somatic patterns and body armor, are elicited from discrete contexts. The second half of the paper provides a true integration of body psychotherapy and indirect myofascial structural bodywork that the author calls *Somatic Psychotherapeutic Fascial-work (SPF)*. A composite case example using an amalgamation of real clients' presentations and progressions in therapy with the author grounds the model through the arc of treatment from the initial session to termination. The paper finishes with a discussion, limitations of this modality, and ideas for future research.

Somatic Patterns, Body Armor, and the Biology of Fascia

Somatic patterning is persistent unconscious movement habits of a body along with related tension and atrophy patterns in the tissues (Foster, 2007). *Body armor* is the tension and atrophy aspect of somatic patterning. Reich (1993) viewed body armor as the physical expression of the conflict between our natural impulses and the imposed constructs of culture. It befits body psychotherapists to understand what happens biologically on the tissue level, because *bodymind* communication is a two-way street by means of afferent and efferent pathways. That means that movement patterns and fascial topography communicate with the central nervous system as much as the line of communication goes the other way. The emotional landscape of the psyche shapes the soma, and the topography of the soma shapes the psyche (Keleman, 1989).

Somatic Patterning and Body Armor: A Positive Feedback Loop

Somatic patterning creates body armor, and body armor supports the deeper instillation of somatic patterning. Humans observe their various contexts and adapt to situations in order to better socialize with others and get their needs met. Momentary adaptations become somatic patterns that form, particularly in early childhood, and affect the physical structure throughout the lifespan. In the words of Alan Watts (1973), "the problem is this: [one] is a self-conscious and therefore a self-controlling organism…there is a point in which control becomes self-paralysis – as if I want simultaneously to throw a ball and hold it to its course with my hand" (p. 62). Watts highlights the nature of the ongoing physical and energetic tensions humans experience when meeting the demands of various contexts. For example, one may simultaneously want to express anger physically, and also hold it in. The personality, i.e., *adaptive behaviors*, of an individual expresses as body armor (Reich 1933; Kurtz, 2007; Lowen, 1975; Smith, 1985; Barnes, 1990). Persistent emotions or states elicit somatic patterning. Body armor supports repeated expression of past somatic patterning because the persistent need to defend against impulses across contexts transforms conscious muscular contractions into unconscious contractions over time (Hendrickson, 2003; Aposhyan, 2004; Lowen, 1975).

Body Armor: Fascial Topography – The Landscape of Tension and Atrophy

Body armor is patterning of fascial tension and atrophy. Researchers discuss the emergence of this patterning as voluntary muscular contractions becoming involuntary over time as well as involuntary fascia (aka plasmatic system) contracts that remain contracted involuntarily. Emotional inhibition has been described as showing up in the body as contractions of the voluntary musculature (Traue, Kessler, & Deighton, 2016; Bischoff *et al.*, 1989). Fascia research suggests that chronic inhibitory patterns in the tissue do not include the voluntary musculature, but rather occur at the fascia level as a plasmatic response to stress (Davis, 1998). Persistent unconscious inhibition of one's natural impulses creates body tension (Traue, Kessler, & Deighton, 2016; Bischoff *et al.*, 1989) as well as tissue atrophy (Hendrickson, 2003). Given enough time under the stress of persistent inhibition, parts of the body will begin to *shut down* feeling receptors on a cellular level (Aposhyan, 2004). When cells and feeling receptors shut down, patterns of atrophy and thickening emerge in the fascial system (Hendrickson, 2003). Tissue areas get *stuck* in contraction patterns, partially due to mechanisms in the nervous system continuing to tell muscles and/or the fascia to contract (Traue, Kessler, & Deighton, 2016; Bischoff *et al.*, 1989; Davis, 1998). The fascial system supports contractions becoming unconscious, automated, and habitual by changing its topography via fascial restrictions made of collagenous crosslinks (Guimberteau, & Armstrong, 2016).

Different layers of body armor exist in an individual because one frequents different contexts regularly in

which they must defend themselves differently. One stops a behavior deemed inappropriate by the surrounding culture through body tension and will inhibit it in different ways in different contexts. Even though inhibition causes stress (Foster, 2007; Traue, Kessler, & Deighton, 2016; Niknamian & Zaminpira, 2018), both self-control and body tightness are adaptive when one acts consciously (Lowen, 1975). Conscious self-control and body tightness became maladaptive somatic defenses when one is too often in an environment that demands one to behave in ways that feel unnatural (Lowen, 1975). Exposure to multiple inhibitory environments makes layers of armoring in the body that therapists can palpate in the fascia (Aston, 2019; Barnes, 1990).

Adaptive Behaviors

As we have seen, unconscious defenses mold the body armor over time, which classical body psychotherapy defines as *character strategies* or personality (Lowen, 1975). In this paper, the term *adaptive behaviors* refers collectively to character strategies, personality, and adaptive strategies. Today's understanding of body armor is less of a fixed personality trait, and more of a flexible adaptation to one's environment. The more unconscious, automated, and inflexible these responses are, the more they resemble a way of being or a *personality trait*. However, at their foundation, they are still adaptive behaviors that result from the dialectics between physical and psychological demands. From infancy to adulthood, adaptive behaviors emerge in order to maintain social connection with others. Different behavioral adaptations present as unique combinations of traits and expressions (Lowen, 1975). Kurtz (2007) and Smith (1985) categorize adaptive behaviors into distinct sets of behaviors and body presentations, yet emphasize that no individual personality maps onto one set of behavioral adaptations. Instead, individuals employ a variety and combination of behaviors across contexts.

The Biology of Fascia

In this paper, the connection between the central nervous system and the fascial system is almost impossible to delineate (Myers, 2011). The field of body psychotherapy has a significant focus on accessing and regulating the nervous system. Therefore, understanding the biology of the fascial system, and its connection with the nervous system, will shed light on future innovations in the field. The following is a brief overview of this complex biological system.[1] At the macro level, fascia is like the clay of the body (Still, 1892). At the microlevel, the fascial system is a three-dimensional web that surrounds all structures in the body down to the cells, and is essential for balance and coordination (Guimberteau, & Armstrong, 2016; Travell & Simmons, 1999). The fascia contains a high concentration of nerve and inflammation cells, while it also protects the body against shock by distributing loads (Inger, 1998). Fascia moves and contracts on its own, independent of muscular contractions (Schleip *et al.*, 2019). Tensional areas become immobile due to adhesions or restrictions that form in response to the inflammation caused by a persistent contraction (Inger 1998; Stecco, & Hammer, 2015).[2] On the one hand, restrictions provide support to compromised tissues; on the other hand, restrictions also generate pain and affect coordination and inflammatory receptors, interfering with movement, which reinforces somatic patterning of the individual (Stecco, & Hammer, 2015; Upledger & Vredevoogd, 1983; Barral & Mercier, 2005; Barnes, 1990; Guimberteau, & Armstrong, 2016).

One's relational context, emotional content, and meaning-making shape one's somatic pattern. Sometimes *a cigar is just a cigar*, and the somatic meaning of a pattern merely reflects repetitive mechanical activities of the body such as sitting, standing, exercising, and working (Travell & Simmons, 1999). Most of the time however, emotional meaning also exists behind one's postures and movement (Aposhyan, 2004; Foster, 2007; Pert, 1997). For example, someone who stands with rounded shoulders and a bent upper back might do so in response to feeling self-conscious about their relative tallness; someone who collapses around their stomach might feel ambivalent about taking in nourishment; someone who locks their knees and tightens their hips might feel resistant to having a grounded life. While these examples illustrate the point to some degree, one should take them as a small corner of innumerable possible meanings behind body movements and postures. Postures and movements have different meanings to different people, and one should not rely on stereotypical descriptions of these postures across all subjects and contexts.

To summarize, as one's somatic patterning presents differently across a multitude of contexts, so does one's presentation of physiology in general, and body tension in particular (Kurtz, 2007). The fascial system lays down collagenous crosslinks (restrictions), or it atrophies and removes collagenous fullness in response to repetitive events in the body (Hendrickson, 2003). Body armor in an individual is not a single pattern, but rather many layers of discrete and blended patterns that show up in

1. For more about the biology of the fascial system, see the works of Robert Schleip *et al.* (2012), Jean-Claude Guimberteau (2016), and Paolo Tozzi (2012; 2014). Guimberteau's (2005) video "Strolling Under the Skin" (ADF Video Productions, 2005) is an excellent visual resource for this information.

2. A fascial adhesion or restriction is a maladaptive collagenous bond that forms between two structures in the tissues that should not be bonded (Stecco, & Hammer, 2015; Upledger & Vredevoogd, 1983; Barral & Mercier, 2005; Barnes, 1990). "Scars" are the same thing as adhesions, except scars are at the surface of the body and visible (Barral & Mercier, 2005). Adhesions (i.e., collagenous crosslinks) form when trauma to the tissues (like an impact or surgery), glycation, or inflammation occurs in an area (Guimberteau, 2005).

different contexts with perhaps as much variation as parts of the personality. Reich's *body armor*, therefore, is the manifestation in the tissues of the body of procedurally-learned daily movement patterns and repetitive body responses to different emotions and contexts. Fascial restrictions and atrophy patterns mold the *clay* of the body such that the fascial record of procedural tendencies becomes detectable by sight and sensation.

Accessing the nervous system alone to change fascial patterns and associated emotional expression is not enough. Body psychotherapists should consider the body at the tissue and cellular level. Often clinicians look at the body as a lever for the nervous system when, in reality, neither the material nor the energy that flows through it should be emphasized over the other. Clients get stuck in patterned behaviors that are rigidly held in the belief system and also reinforced through the fascia, and vice versa. That a client can attempt to change the way they think or choose to hold their posture differently, but might soon find themselves back to where they started, can be summarized in the following inquiry. (Remember, personality is a behavior adaptation.)

> Is the skin the outer surface of the brain, or the brain the deepest layer of the skin?...
>
> The body is not just a reflection of the personality; it is the personality....Therefore mind-body awareness are two sides of the same coin, immutable, joined, inseparable, connected, influencing, and communicating constantly. (Barnes, 1990, pp. 27-29)

It is not enough to work on the fascia alone, since the psyche will affect the fascia once the session is over. Nor is it enough to mold the psyche alone, because the fascia, without appropriate bodywork, is slow to adapt to new patterns. Hence, a more accessible model is working simultaneously at the meaning-making *and* the fascial level.

To be clear, this is not an attempt to override resistance in a client (which never "works" anyway). Both the psychotherapeutic and the fascial work process requires change to occur slowly over time. The psychotherapeutic and the fascial work processes are so linked and intertwined that it is more effective and ethical to perform the processes simultaneously: more effective because they are "two sides of the same coin" (Barnes, 1990), and more accessible because the practitioner understands the soma-psychic process at a deeper level. Thus, the client is less likely to have to spend more time and money seeing multiple practitioners. To combine bodywork and psychotherapy in one practitioner increases accessibility. Furthermore, an SPF practitioner is more likely to understand the purpose and nature of resistance in a client, because such a practitioner is able to feel and assess that resistance in *both* the psychic and physical structure.

An Integration of Structural Bodywork and Body Psychotherapy

If clinicians are to help clients change habitual patterns that show up in the belief system, behavior, and the body, it makes sense to address the fascial system and other somatic body patterns while also attending to the associated beliefs and behaviors. Working with the body, beliefs, and behaviors in an integrated way is no news to body psychotherapists. The author's approach differs from current body psychotherapy practices by integrating body psychotherapy with indirect fascial work aimed at balancing tissue structures. The following model genuinely integrates indirect myofascial release (MFR) techniques with experiential body psychotherapy interventions. This model is specifically for clinicians with training in both body psychotherapy and MFR to create an approach that integrates both modalities.

Direct and indirect techniques are the same insofar as they can be applied all over the body. The kind of *touch* used with indirect methods affects larger patterns in the body. Direct techniques rely on the direct application of periodic intense shearing force to the center of a restriction. Indirect techniques rely on the *time element* to slowly and gently release tissues that have lost their mobility (Barnes, 1997). MFR holds take at least a few minutes to effect change in the system. Therapists induce change in the fascia by gently but firmly displacing the fascia on the periphery of the restriction and slowly and gently allowing the tissues to *unwind* (Minasny, 2009). Since fascia is one piece, therapists can displace the targeted fascial area indirectly. For example, the therapist can work the diaphragm by displacing the diaphragm itself (closer to the area), or by gently pulling on the arms (farther from the area). Thus, indirect techniques can be used farther away from the release site if that approach makes the client more comfortable, or if it is safer for the client's condition.

The author chose indirect techniques to integrate with body psychotherapy for three reasons:

1. The clinician can work on different parts of the body without having to touch those parts of the body (e.g., therapists can work on the pelvis from the feet, and avoid performing work that might be too intimate for some clients).
2. Indirect techniques require a relatively light touch compared to the, at times, heavier-pressure touch used with direct techniques, like Rolfing. Direct techniques are very helpful, but are harder to integrate into psychotherapeutic contexts. The use of direct techniques can be discussed and used on a client-by-client basis as they become clinically relevant, or the clinician can refer out to a Rolfer for sessions that include only bodywork.
3. Indirect techniques are also more appropriate for psychotherapeutic context as they allow for the client to be fully clothed, if desired. In a typical myofascial release session, the client wears shorts or

two-piece clothing, which allow for movement while working and for hands-on-skin manipulations. For some clients, this level of vulnerability will be tolerable and welcome, and for other clients, it will be too much exposure. Again, therapists can use indirect techniques to perform releases all over the body without ever having to touch more than the endpoints of the body. Even though having access to only these parts of the body can limit therapists' leverage in the fascial system, much can still be done without violating clients' sense of safety and comfort.

Somatic Psychotherapeutic Fascial-work: Arc of Treatment

In this model, the touch and movement approaches come primarily from the John F. Barnes Myofascial Release technique. The author chose this technique due to its gentleness, emphasis on listening and feeling over following protocols, its ability to work on vulnerable areas of the body by touching less vulnerable places, and its relative ease to learn. Upledger's (1997) craniosacral therapy, Barral's (2005) visceral manipulation, Aston Patterning (2019), and other gentle fascial modalities would also work. Though this article focuses on illuminating the use of indirect myofascial release, modalities such as the Bodynamic and Biodynamic approaches would also provide valuable insight to the MFR and SPF orientations to soma-psychic transformation. Sensorimotor Psychotherapy (Ogden, Minton, & Pain, 2006) informs the talk portion of this model. Somatic Experiencing, Hakomi, and other body psychotherapy approaches would also work. The author chose Sensorimotor Psychotherapy (Ogden, Minton, & Pain, 2006) because it includes approaches to trauma processing as well as developmental wounding, already includes some understanding from bodywork, and has a focus on incorporating knowledge of biology. The author uses both initial myofascial contact and sensorimotor dialogue approaches simultaneously to lead the client and therapist into mindfulness or *theta-wave states*. Theta waves are the brain wave frequencies that occur during light sleep or deep relaxation, as with meditation (Tang, Tang, Rothbart, & Posner, 2019).

Crisis that Inspires Somatic Psychotherapy Treatment

Clients generally start psychotherapy when they have run out of options. Typically, clients come to alternative forms of therapy (i.e., myofascial release, acupuncture, chiropractic, and nutritional interventions) when their symptoms cannot be explained or resolved by modern mainstream medicine (i.e., medication, surgery, and short-term therapy protocols). When modern medicine reaches its limit, clients can experience a particularly vulnerable state due to their disillusionment regarding the efficacy of the medical establishment. Clients find comfort in the idea that medicine has the answers. Thus, clients often arrive with a sense of confusion and loss, unaccounted-for bodymind symptoms, relationship difficulties, ailments, and disease processes that do not register on medical testing. Life transitions are, at times, enough for clients to seek alternative forms of therapy. However, these clients usually already have an appetite for complementary medicine and are on a solid routine of prevention.

Composite Case Example

The presentation of the arc of treatment includes a composite case example that closely resembles the experiences of clients treated by the author. Composite client Linda is a 45-year-old queer female-identified white person. Linda has come to therapy due to some recent losses, including the death of a close friend, choosing to leave a job that was a bad fit, and an amicable break up with her intimate partner of 18 months. Linda presents without organic mental illness. She is an active person who loves outdoor activities and ballroom dancing. However, she began feeling less motivated to pursue her hobbies, both before, but also especially after her recent losses. Her body has begun to feel achy, weak, and collapsed. Linda chose to seek help from a psychotherapist because she noticed that her grief and lack of energy were interfering with her ability to enjoy her activities and feel a connection with others. Tired of grieving alone, but feeling ambivalent about reaching out to friends and family who have come to rely on her being the happy/stable one, Linda begins a course of treatment.

Linda's experience growing up included some predictable developmental wounding through typical episodes of misattunement by caregivers and her socio-cultural environment. Linda came to believe that her needs could not be met by others, that she alone could provide for herself. Linda adapted to this belief by seldom asking for help. Her community unconsciously reinforced this belief, since they frequently praised Linda for her independence and autonomy. Her adaptation was compounded by her coming out as a teenager. Her parents and community were supportive of her self-expression. However, they were not able to understand the challenges of oppression that Linda faced when she was not in her community. Linda also adopted the belief that she needed to present with positive affect the majority of the time, due to unconscious cultural values. Her childhood community values warmth, strength, and autonomy above other feeling states. Her community value system generally fostered healthy behaviors among members. However, members of the community quietly enforced a subtle rigidity regarding messier feelings, like grief and weakness, by attending to affects that they approved and neglecting those they disapproved. Underneath Linda's happy-go-lucky disposition lies a vast range of human emotion that Linda hides, in part, in order to keep those around her *unburdened* by her feelings, and also because Linda does not understand why she feels diverse emotions. As a result of these influences, Linda rarely discusses her less-than-positive feelings.

Linda tries talk therapy first, which helps her begin to name feelings and put words to her limiting beliefs. As Linda's capacity to attune to herself grows, she begins to notice that she understands herself a lot more, but still harbors various stuck and stagnant feelings that she cannot address with words alone. As those feelings linger, Linda also notices that her body continues to feel weak and collapsed, and that she has an uncanny feeling of not being able to connect with others. No pathology shows up on neurological, biochemical, or musculoskeletal testing, and her physicians suggest her symptoms might be related to her emotions. Linda's talk therapist recommends that she see a SPF practitioner to address the unnamable feelings, the collapse that Linda feels in her body, and the emotional distance that persists in her interactions with others. In what follows, the paper will cover the different stages of treatment, starting with assessment and followed by the initial stages of therapy, major growth epochs, tasks a client engages for psychosomatic mastery, and termination – using Linda's example to illustrate the work.

Assessment

Therapy begins with rigorous and varied assessments. The therapist documents visual and palpatory descriptions of body alignment, tissue restriction/atrophy, cranial rhythms, gait, and organ motility. The therapist also takes an inventory of familiar somatic sensations across contexts, as well as of the client's belief system. Furthermore, the therapist records a biopsychosocial history, history of medical symptoms, and a history of emotional and behavioral patterns. Not only does the assessment give the clinician a more precise picture of where this client is beginning treatment, but it also provides a metric by which the therapist and client can confirm progress. Every individual session begins with an assessment of the fascia through visual observation and palpation, along with the usual mood, affect, and content assessment.

Linda presents with subclinical skeletal misalignment due to fascial atrophy/restriction patterns (aka her body armor), as well as disorganized cranial rhythms and sluggish organ motility. Subclinical means symptoms that impact a client but do not register on allopathic testing. Linda's biopsychosocial assessment reveals that Linda tends towards avoidant/dismissing attachment, is more depressed than she realizes, relies on herself to meet her emotional needs, and carries considerable pervasive unconscious anger and sadness. Her emotional landscape presents in her somatic patterning as collapse, weakness, sluggish organ motility, and disorganized cranial rhythms. Linda's medical history includes the removal of her appendix when she was eight, and she has experienced several minor to moderate falls during her outdoor activities, which means that she has fascial restrictions directly related to surgery and falls. In general, restrictions related to physical injury still carry emotional components, like shock and grief, but exist for primarily physical reasons. Restrictions have both a physical and emotional impact, regardless of the origin (Barnes, 1990).

Stage One: Initial Stages of Therapy

The initial stages of therapy involve helping the client gain access to experiencing the body and the psychic structure, as well as understanding the relationship and interdependence between the two. Clients often come in with a presentation of somatoform and psychoform dissociation, whether at clinical or subclinical levels. Therefore, the first part of treatment focuses on soma-psychoeducation, followed by increasing the client's capacity to read internal states. This is offered in coordination with teaching the client how to *soften and let go* at the tissue level, which is an MFR technique that resembles progressive relaxation and requires client participation. Clients are also instructed on re-toning atrophied fascia areas using gentle isometric exercises (i.e., yoga or other somatic movement and stretching practices). Both client and therapist work together to establish goals for this particular soma-psyche, while holding the principle of *letting go of the outcome* in mind. Letting go of the outcome allows the clinician and the client to reevaluate and change goals as more information comes to light. Clients also learn to tolerate a wider variety of emotions at varying intensities while they simultaneously begin increasing their capacity for self-observation.

After assessment, Linda's therapist begins treatment by having Linda report her inner somatic sensations while the therapist performs myofascial leg pulls. For leg pulls, the client lies face up or face down on a massage table. The therapist holds the heels or the tops of the feet of the client and provides gentle traction that displaces the fascia in a telescopic manner. Any myofascial *hold* displaces the entire system. The fascia is one piece from the top of the head to the tip of the fingers and toes. When the whole fascia is displaced, the therapist can use proprioception to determine where restrictions reside in the body. To clarify, imagine a piece of gauze on a table. The gauze represents the fascia. Now, place objects on this gauze. These objects represent restrictions in the tissues. Pinch a corner of the gauze and pull the gauze with the objects gently across the table. The gauze puller can feel the location of those objects on the gauze without looking at the gauze. Similarly, the therapist can feel the restrictions in the fascial systems just by adding drag. Leg pulls are particularly non-intrusive for most clients and help with the palpatory assessment. Therefore, leg pulls are a great place to start for most clients.

Linda responds by becoming increasingly aware of how her bones line up, and where her tension patterns lie. Linda begins to notice waves of sensations akin to fear and anger that move through her torso. Memories from the past, including her early 20s, teenage years, and early childhood accompany these waves. The leg pulls reveal that Linda's spine lacks appropriate mobility in the thoracic region, and that Linda perceives

that she stores unmet grief in this area, as evidenced by her becoming tearful when the leg pulls begin to affect her thoracic spine area. Linda and her therapist explore what exercises might help her begin to open, strengthen, and move the thoracic spine area. From yoga, they select cat-cow pose to mobilize, and downward-dog pose to strengthen, because these poses feel good to Linda and she already enjoys yoga. Linda commits to doing these poses for five minutes each morning, along with lying face down on a soft and malleable ball in her diaphragm for another three to five minutes. The ball in the diaphragm serves to free the dorsal thoracic area, because it is often easier to access back tension through the soft tissues in the front body. Opening through the front of the body allows Linda to stand up straight with ease (which is one of her personal goals), rather than feeling forced into a collapse. Releasing and toning these areas allows Linda to breathe more deeply and process grief, both verbally and somatically. Balancing Linda's body in this way supports Linda to better stay with her own experience, rather than compulsively rescuing others from her natural feelings – which in turn allows her to take the risks she needs to feel more connected with others.

Growth Epochs: Upper Limits and Growth Crisis

As clients receive all the new and familiar information about themselves during the assessment phase and begin developing their soma-psychic skills, they often experience an initial decrease in symptoms, empowerment, and more possibility in their lives. Linda begins to feel more lightness and freedom in her body after four weeks of treatment. She begins to enjoy her activities again, and reports that "it is such a hard feeling to describe, but it seems like the world is colorful again." She feels more connected to others and has a new friend from her dance class. Still, all change is stressful, including positive change. The upper limit is the maximum amount of growth and progress one's nervous system can take over a segment of time (Hendricks, 2010). Once one reaches the upper limit, there is often a painful, yet essential, crisis that follows.

Initially, clients can feel so empowered by their new skills and insight. Then, however, grief and fear can set in. Clients often have to grieve not having known the many simple interventions clinicians offer that could have prevented the initial crisis that brought them to therapy. They begin to feel sad about the many years where they were limited, and the lost opportunities they can never get back. Clients become fearful because, as they let go of their limiting beliefs, they face the expanse of their potential. They may feel anxiety at the edge of the unknown, or they can feel worried that they will grow too far too fast, beyond their comfort zones or beyond the capacity of their loved ones to accept them. Also, clients can feel frustrated that the interventions, though helpful, do not cause transformation overnight. This complex mix of feelings often accompanies a flare-up in bodymind symptoms. Linda soon begins to feel *wobbly* again. Linda can hear her limiting beliefs loud and clear now. Linda begins to realize that she internalized the belief that both her full range of feelings and her identifying as queer are unacceptable to others. Now that she is feeling the inner movement of her feelings during her daily activities, she is becoming fearful that her true self might be revealed and rejected. Her anxiety that she might show emotion and self-expression that she does not know how to navigate accompanies her feeling collapsed and sluggish.

Stage 2: Radical Soma-Psychic Acceptance and Theta-State Processing

During the *growth crisis*, clients get to re-experience the original crisis that brought them to therapy and are often available for exploring deeper wounds from earlier in their development. Clients begin a new phase of treatment that is characterized by continuing repatterning movement practice and radical acceptance. In this second phase, clients radically accept the subjective and objective human condition, and master the cyclical nature of personal growth. Clients accept limitations that are already known or that emerged over the course of treatment.

Clients also dedicate themselves to practice despite these limitations. Clients learn to let go of the outcome of any particular limitation, which is *letting go of "quick fixes" and establishing an intuitive self-care approach*. Clients learn to feel their soma-psychic rhythms, and can give themselves what they need, rather than by a rote schedule. Clients, therefore, embody the *ability to have goals, but to let go of outcomes and develop self-compassion*. Many of their limitations might resolve along the way, but clients and therapists cannot know which limitations will resolve, nor can resolution happen without practice. Soma-psychic practice, much like a meditation practice, must be undertaken not to better oneself but for the pleasure of the practice. Accepting limitations and taking their health into their own hands allows clients to meet themselves where they are, have reasonable expectations for life, and be better able to get their needs met emotionally and socially.

In this stage of treatment, another important goal is to understand and *deeply experience the soma-psyche* in a way that is appropriate and not overwhelming for the client. In other words, clients experience the affective core of the self (Alcaro, Carta, & Panksepp, 2017) as well as gain access to their landscape of primary emotions. Through phenomenological reports, MFR therapists know that fascial work on its own can produce this state, which is also a goal of body psychotherapy. One of the main inspirations for integrating these modalities emerged from clients' reports that fascial work on its own, without talking, produces the affective core of the self. *Body psychotherapy and fascial work can produce the same results in very different ways*. For a client to ex-

perience this state, a shift of consciousness must occur, which the author refers to as the theta-wave state. This deeper relaxation state allows for a client's maximal tissue response and facilitates the therapist in accessing therapeutic intuition. This state is called *mindfulness* in Hakomi and Sensorimotor Psychotherapy (Ogden, Minton, Pain, 2006; Kurtz, 2007). The author hypothesizes that the brain exhibits theta waves in this state due to the increased ability of the client and therapist to experience abstract images and sensations often related to memory (Coglin, 2013). Within that state, a soma-to-psychic dialogue can emerge with specific content.

The content of each particular session can vary wildly from one to the next. However, the author classifies sessions into three different types:

1. The therapist and client address content regarding the client's family of origin to challenge distorted beliefs at the soma-psyche level.
2. The therapist and client address content emerging from abstract and metaphorical body sensations that can feel unusual, nonsensical, and almost dreamlike. The therapist focuses the SPF on supporting the unfoldment of the abstract sensations along with the meaning-making processes.
3. The therapist and client address content focused on nervous system regulation and pain management in the present moment more than on meaning-making. This kind of session might look the most like a typical myofascial release session, but still has a psychotherapeutic focus through the clinician connecting the client's physical experience to the emotions and beliefs.

Each session begins with an assessment and theme selection for that day. Just as ordinary conversation begins to drop client and therapist into the theta-wave state, assessment often slides into treatment and acts as the treatment in and of itself (Finn, 2007; Barnes, 1990). The phase of a session that really *looks like* treatment can commence with the client either sitting, standing, or lying in a variety of positions on the floor, couch, or bodywork table. The therapist and client *drop in* to observation mode, accessing mindful theta-wave states. Here, a somatic conversation unfolds; this is a process facilitated by proprioception and mirror neurons that allows the client and therapist to attune, so that new insight can emerge (Kain, Terrell, & Levine, 2018). The therapist monitors the depth of consciousness in the dyad. Excessive ordinary consciousness or excessive theta-wave consciousness can interfere with the flow of the transformative portion of treatment. The balance of alertness and relaxation provides the therapist and client with dual awareness, i.e., the observing part studies the wounded part, and witnesses transformation. The dyad must keep the observing part online because the observing part always resides in the present moment. All who engage in somatic dialogue encounter the mystery of the process, including the therapist, who needs to remain profoundly humble and open. Though a preliminary explanation exists for the underlying mechanism of the somatic dialogue, the experience of it leaves more questions than we may ever answer. A humble therapist makes way for the centering of the client's process. The more the client joins in the interventions and meaning-making of the session, the deeper the layers of change in somatic, emotional, and cognitive patterns.

Linda begins a session and reports feeling stronger where she felt collapsed before, and shares that connecting to herself and others felt easy before this particular session. Linda reports feeling more collapsed that day, and can feel a belief running inside that "it is not okay to feel my natural feelings. I am a bad person for wanting more support from others." Linda reports feeling grief because she knows that this belief is not true or helpful, and she feels frustrated that she can know this intellectually, but her body still feels the weight of this belief.

The therapist uses verbal reflections that help Linda elaborate and deepen into her experience. She describes the collapse in her body: "It feels like a thick rubber band is connected to my chin and my belly button. I can pull up against the weight and make myself stand taller, but it takes a great deal of effort to do it, and I just snap back down into this collapse. It's so tiring, I just let myself surrender to the collapse and the loneliness. When I'm like that, I forget to drink enough water, and my visual focus becomes very narrow."

The therapist notices that Linda has an anterior tilt in the right side of her pelvis, forward head, a shortened, collapsed and inward pulling through her sternum, atrophy through her posterior thoracic region and hamstrings, and restrictions throughout her respiratory diaphragm and psoas areas. The therapist has Linda lie face up on a massage table for a palpatory assessment. The therapist cups and lifts Linda's heels. The therapist waits for her hands to sink into Linda's fascial system, and then leans back gently to create drag in the fascia. The therapist confirms that Linda is restricted in her diaphragm and psoas, and also feels restrictions in Linda's upper calves and upper trapezius areas – all of which are similar to Linda's initial presentation.

Both Linda and the therapist decide to focus on that restriction and begin entering into a theta-wave meditative state of consciousness. The dyad's sense of time and space distorts as the world begins to feel more dreamlike. The therapist has Linda sit on the edge of the table, and performs a seated transverse diaphragmatic release (Linda is sitting on the table, and the therapist's hands are on either side of her diaphragm, one hand on the back and one hand on the solar plexus).[3] As the release progresses, Linda begins to have a series of sensations related to the release:

T: Allow yourself to feel my hands on your back.
[Pause.]

T: What do you notice?

L: I feel an aching in my upper shoulder and neck area, a lump in my throat, tears coming to my eyes, and a deep quivering in my belly near my spine, as if I were cold. But I know I'm not cold. I can feel the heat in the room on my skin.

T: Stay with those sensations and allow that quiver to happen.

The therapist and Linda work together to track the unfolding of Linda's experience throughout this seven-minute release. (Myofascial release holds require several minutes to obtain a single release). Without prompting, Linda begins to describe a memory symbolic of many experiences she had as a child. She is playing outside with a group of children when she is nine years old. They are riding bikes around the neighborhood. One of her younger friends loses control of the bike, hits a curb, and launches over the front wheel, smacking his face on the pavement. Linda feels her body become numb as she rushes over to tend to her friend. She puts her friend on the back of her bike and rides him home to his parents. His parents take him to an urgent care clinic, and Linda goes back to her friends playing outside. Even though she feels shaken inside, she continues to comfort her friends, who are in shock. Linda's community praises her ability to handle stressful situations like this. Linda feels haunted for the next few weeks by the amount of blood and the screaming that came from her friend. However, Linda does not tell anyone about her pain because she feels proud of how the adults praised her competence in an emergency. This memory represents Linda's repeated experiences of competence and loneliness in emergencies, and it serves as a metaphor for other instances like this one. Linda repeatedly presented as the *strong one* when other members of her family and community were having physical and emotional difficulties, while hiding the impact this role had on her system. Linda repeatedly was put in the role of being a sturdy support person who could deny her needs on command.

After Linda discusses this crucial memory, the therapist changes the structural hold. The therapist has Linda lie face up again and cradles her occiput. The therapist waits for the tissues to begin to release. The tissues expand in a distal-proximal fashion, and the therapist follows the tissues, release after release. The therapist's task here is to help the client work simultaneously with the fascial and the belief systems.

L: I just feel like if I show my weakness to others, I will be ignored. It feels so painful. I can be there for others, but I believe that others don't want to be there for me.

T: Is it okay if we try an experiment? I say a sentence, and we see how it feels to you?

L: Sure.

T: Notice what happens in your body when I say the words... "*When you feel weak, I am here for you.*"

L: I notice that tightness in my throat more, and I can feel the releases happening around my sternum. I feel like I don't believe you, and that you're just saying that because that's the polite thing to do.

T: Okay. Stay with those sensations. I'm going to say that sentence again...Notice what happens in your body when I say the words... *"When you feel weak, I am here for you."*

L: "The tightness in my throat is lessening, and now I feel more tearful. I believe you a little bit more, but now I feel scared."

T: Stay with that fear... What do you notice as you stay with it?

L: I feel a burning in my belly like churning lava.

T: If that churning lava could speak, what would it say?

L: *(after quite a long pause) "You're going to use my weakness against me."* Huh, how odd. I don't remember anyone ever doing that to me. I remember being praised for my resilience but never really taken advantage of...

T: It's okay if this doesn't make sense. The body stores memories and beliefs in ways that can feel strange to the intellect.

In this session example, Linda studies her soma-psyche in the here and now. As the therapist leverages the results of displacement of the fascial system, Linda can narrate her direct experience of her affective core of self. Linda demonstrates her budding openness to the unknown within her, as evidenced by her ability to let content that does not make sense emerge from her somatic experience. As Linda grows in her ability to tolerate the unknown, she can surrender into the process, letting go of the outcome of the session. Here, Linda practices using her observing ego to track her unfolding experience and to develop self-compassion. Each of these skills translates to Linda's development of a helpful mindset, namely one that tolerates her limitations, and that can stay regulated as the unknown of her life unfolds. She can now get curious about her range of feelings, rather than numbing when she feels feelings that were unsupported by her community.

This session continues to unfold around Linda's belief that she will be taken advantage of if she shows her weakness. The therapist continues to apply different indirect myofascial holds as feel appropriate in the tissues. At the end of the session, Linda reports feeling markedly calm, yet upright and sturdy, in addition to feeling a slight sense of confusion. Clients commonly report this sense of confusion at the end of sessions, and this can signal that space has been made for new beliefs and structures to come into the body. Linda continues to feel waves of grief, fear, and body aches over the next

3. For clients who would not tolerate a direct diaphragmatic release, the therapist can substitute arm or leg pulls.

48 hours after the session, along with an increased desire to drink water. Her system settles down on the third day. She notices that standing upright has become more comfortable and more natural, as has feeling trust in the people to whom she feels closest.

Stage 3: Termination

Termination in SPF is a whole phase of treatment that can last a few sessions to several sessions. These final sessions are to review the arc of treatment and help the client plan for how they will continue to incorporate what they have learned in therapy going forward in their daily lives. When termination happens appropriately, the soma-psychic wisdom continues to grow in the client outside of therapy, or with minimal therapeutic encounters. Clients, especially ones who have experienced a great deal of trauma, re-establish fun, pleasurable, productive, and creative scenarios and activities. One of the ways a clinician can know that their client is beginning to become available for the termination process is when the client begins to work, play, and have fun again without prompting. The dyad determines when the client has reached their goals, or when goal progress has ceased. Often clients end regular weekly or biweekly visits and begin receiving treatment as needed. Clients may also return for future stints of weekly treatment.

Linda and her therapist know she is ready to terminate around her 50th session. Linda no longer feels stuck in collapse, feels a decrease in her depressive symptoms, and feels enough satisfaction in her relationships and with her self-expression. Linda continues to experience dips in her mood and periods of discomfort around her intimate relationships. She still has the main restriction in her respiratory diaphragm/psoas area, and some of her scars from falls and surgeries will never go away. However, Linda's established self-care routine and self-knowledge enable her to address these episodes, remaining restrictions, and ongoing scar care, thereby minimizing disruption in her daily life. Linda and her therapist spend five sessions co-creating and discovering together the self-care practice that is sustainable and suitable for Linda, and that supports ongoing myofascial balancing with somatic resourcing. For low mood, Linda uses yoga and myofascial unwinding (Minasny, 2009). She uses self-myofascial release, namely lying on a ball, for restrictions in her respiratory diaphragm/psoas area. Linda addresses her permanent scars using manual soft-tissue mobilization techniques learned from her therapist. She applies shorter and longer versions of her self-care routine at different frequencies, depending on her needs. She finds this routine relatively easy to maintain, although she must work to find motivation at times. Linda continues to receive sessions with her therapist as needed – sometimes a few times a year, sometimes more frequently, depending on the evolution of her needs.

Discussion and Conclusion

Talk, change-oriented touch, and movement applied together offer a new horizon to contemporary psychotherapy. Though body psychotherapists are familiar with this trifecta, the time has come to boldly integrate structural bodywork with psychotherapy, rather than continue to keep these powerful tools separated. This integration differs from Reichian bodywork in that catharsis is not a goal. Clients will, at times, have strong emotions in this process that the dyad can leverage for the ultimate goal: the ability to feel a full range of emotions while remaining regulated, and to simultaneously restore as much motion and function as possible to the client's body. These goals together give clients more choice regarding their behavior. Reactivity that results from psychological or physiological limitations decreases.

Indirect myofascial release encourages clients and therapists alike never to lead and never to force the system (Barnes, 1990). MFR therapists know that too much effort and guidance applied to the fascial system will never overpower the 2,000 pounds-per-square-inch of force that fascia can exert on the body (Guimberteau, & Armstrong, 2016; Travell & Simmons, 1999). Instead, therapists are taught to listen and feel their way through the releases (Barnes, 1990). In the same way, the structure and approach of SPF organically arose from hundreds of experiences of intersubjective bodywork and psychotherapy. There is room for body psychotherapy and bodywork to integrate, such that structural goals get addressed simultaneously with psychological goals. Fascial goals and psychological goals are, after all, often the same goals. This model provides one way for this integration to occur.

This research of current literature and phenomenological experience supports the notion that "body armor" is a combination of somatic patterning elicited from life contexts and fascial topography. This understanding of body armor implies that using fascia-focused movement and structural bodywork could support clients as they pursue their psychological goals. In turn, body psychotherapy supports clients as they pursue their fascial goals as well. SPF aims to disrupt the positive feedback loop of somatic patterning and body armor creation such that clients can experience the affective core of the self. Clients get to know their expression across contexts, and gain access to the affective core of self by working with the fascial topography and with adaptive behaviors expressed through each layer of body armor.

To understand the impact of SPF, one must experience it firsthand. Barring direct experience, an examination of the underlying biology of this approach can at least provide an intellectual rationale for why one might address the bodymind in this way. One cannot draw a line between the nervous system and the fascial system. They conduct energy in the body in different but complementary ways. The continuity of the fascial and nervous

systems implies that clinicians who value neurobiology for the sake of increasing their therapeutic competency would also acquire similar gains by learning more about the biology of the fascial system.

The integration of fascial work and body psychotherapy can appear in many different ways. That fascial work happens at the same time as psychotherapeutic dialogue is the primary way integration occurs. Fascial work can show up in a session like a Gestalt experiment and occupy the main focus of the session while the client processes psychological material, or anything in between. The composite case of Linda offers an example of a client who wishes to address adaptive behaviors from childhood that no longer support her goals and lifestyle. As was demonstrated, SPF allowed Linda to achieve a number of her goals. Linda spontaneously arrived at new insights in treatment. Her ability to embody the insights she gained in traditional psychotherapy increased. She began to shift the way she feels, both emotionally and somatically, as she moves through her life and connects with others. Linda now has an intuitive approach to self-care, and an arsenal of holistic self-care approaches from which to choose. SPF is not for everyone. For clients and therapists who resonate with this work, however, SPF provides a missing link in holistic treatment that is nothing short of life-changing.

Limitations and Further Research

The main limitation of this integration is the scope of practice. Most states in the U.S. require that a practitioner have at least a massage license to perform myofascial release, and at least a master's degree to perform anything that could be considered psychotherapy. The author proposes the creation of a touch license for psychotherapists. This license would enable psychotherapists to include specific bodywork modalities under their scope of practice. Furthermore, it is still taboo to touch psychotherapy clients, or to provide psychotherapy to bodywork clients.

Ideally, clients would wear MFR treatment clothes. However, the reality is that clients can usually go deeper emotionally while wearing loose-fitting clothing that still gives the therapist access to areas that require work. That said, the therapist must consider the amount of clothing a client wears during treatment. A client will never be nude in this model as with traditional massage, because nudity would limit more in-depth psychological work for the majority of clients. The author's background began with traditional massage, so she has a high degree of comfort doing bodywork on people with minimal clothing or no clothing and a drape (the sheets used in a traditional massage). Clients who come for massage are generally comfortable disrobing to nudity or near-nudity and having non-erogenous areas touched for treatment. MFR differs from traditional massage in that MFR is best performed with, at minimum, clothing covering genitalia and secondary sexual features, and, at most, loose clothing that therapists can move with consent for access to release areas. The client and therapist determine the clothes a client wears for treatment by considering the comfort of the therapist and client alike.

Furthermore, the comfort of both the therapist and client determines the use of this model at all. Not all clients will be able to tolerate touch, movement, or talk, or a combination of these. Therapists should not employ this modality with people experiencing active states of psychosis, nor with certain complex trauma cases when touch and movement cause excessive dysregulation. Furthermore, therapists should avoid the touch and movement portions of this modality if a client has had recent surgery and has not been cleared by a doctor to resume all regular activity, unless the practitioner has training in perisurgical bodywork.

That said, for therapists and clients who resonate with this approach, the dyads can perform powerful work that addresses bodymind issues in a holistic and positively life-altering way. The stigma of bringing bodywork together with psychotherapy needs to end. Most therapists are ethical professionals who can navigate the necessary consent and ethical demands of these therapies. Integrating the two should not require more than the normal levels of ethical rigor for therapists already accustomed to using both bodywork and psychotherapy. Detailed research on the ethics of such a practice should be explored.

The composite case study reflects an amalgamation of actual client experiences. Further research should include documentation of client experience and progress in a series of individual case studies. Next, a grounded theory study of physical and massage therapists that addresses psychological changes they witness in clients from doing bodywork would be helpful. On the other hand, a compatible grounded theory study targeting body psychotherapists and the physical changes that they have seen in clients would also be helpful. Finally, empirical research should be conducted using *SPF* on conditions that do not improve with surgery or pain medication, and that have a significant psychological component – such as fibromyalgia, functional neurological disorders, and certain treatment-resistant spine disorders.

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