A Body/Mind Perspective to Enhancing Movement

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In Touch-Therapy for Mind and Body

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Abstract

This paper focuses on a body/mind perspective of enhancing movement in individuals' physical and psychosocial well-being by exploring the influence of the body and mind on each other. The significance of the initial clinician-client interaction is explored and how this relationship greatly influences successful therapeutic outcome. A composite case study illustration is used to demonstrate a body/mind perspective utilizing the therapeutic approaches of craniosacral therapy, hypnotherapy, and solution focused brief therapy. The authors highlight the significance of the therapist's theoretical lens, the importance of an attentive initial evaluation, and the facilitation of change by tapping into the client's internal resources to assist in wellness of the body and mind.

Introduction

A clinician's facilitation of the client's awareness of the body and mind can enhance movement in individual's physical and psychosocial well-being. Through the therapist's delicate attention to the client's initial complaints followed by the facilitation of consciousness and relational change, movement and balance can be stimulated. This paper focuses on the approaches of craniosacral therapy (CST), hypnotherapy, and solution focused brief therapy (SFBT); and the use of adjunct tools such as exercise, meditation, mindfulness, and attention to nature to improve client health. Many clients with physical and psychosocial difficulties benefit from these approaches, as will be demonstrated through one composite case illustration presented in this paper. This paper is written through the first author's lens of a physical therapist, craniosacral therapist, hypnotherapist, and psychotherapist. The authors' goals are to demonstrate the significance of facilitating movement and enhancing clients' internal resources to assist in wellness, and to explore how the theoretical lens of the practitioner impacts their work with clients. Therapeutic goals can range from improving strength and posture, decreasing pain, increasing physical mobility and wellness, improving relationships; and increasing self-esteem, self-awareness, and joy in stillness, work, and play.

A systems perspective is useful in facilitating a client's process towards wellness, which involves viewing the mind and body in relationship to its ecosystem. Rossi [1] described psychobiology as several subsystems, such as sociology, psychology, and biology, making up one larger system. Areas of the mind, body, personality, family, and society can be seen as a great communicating network working as a system in which there is induction; a change in form of energy and information. This can be an interaction and transition between sensory stimuli of the body and mental perception of the mind. Therefore, memory, learning, and behavior can

influence psychosomatic problems. Rossi stressed that there is no gap between mind, brain, and body and even at a molecular level there is communication between the mind and body. Therapies such as craniosacral therapy, solution focused brief therapy, and hypnotherapy can be beneficial in assisting clients from a body and mind perspective. In addition, including other modalities such as meditation, mindfulness, yoga, exercise, attention to nature, music, and other methods that stimulate physical, emotional, and mental processes can be beneficial in facilitating body and mind healing.

The Body and Mind as a System

The body and mind can be seen as a system living within an ecosystem that influences one another. From this perspective, it is difficult for therapists to view an individual as separate from all their connected parts. Physiological changes often occur in the body in relation to an individual's psychological aspects within a given time [2]. Rossi [1] believed that the major systems of the mind-body connection involve the sympathetic and parasympathetic systems, using the term "neuroendocrinal transduction" to describe how language of the mind is transduced to molecules of the body. This can be described in simple terms of facilitated nerves stimulating hormonal messengers of the hypothalamus and effecting the autonomic, endocrine, and immune systems. Rossi felt that the limbic-hypothalamic system greatly influenced any transduction of information from the mind to the body. Under mental stress the limbic-hypothalamic system in the brain converts neural messages of the mind into neurohormonal messenger molecules of the body. This can affect the endocrine system, which effect steroid hormones reaching the cells of the body. If things are going well the body can take care of itself, but if things are not going well there can be a breakdown. The relaxation response that occurs in meditation, yoga, and prayer stimulates the hypothalamus, thereby decreasing the sympathetic

response. Hindu's system of seven energy chakras correspond to various regions of the body. Interestingly enough, these chakras correspond to the sympathetic and parasympathetic ganglia.

Franz Alexander, a world leader in psychosomatic medicine, showed the relationship between psychoanalysis and physiology of the body noting how stress can over stimulate the thyroid [1]. Stress interacts with the hypothalamus effecting the pituitary and thyroid causing stimulation of the endocrine system. Franz believed that the hypothalamus connect the body and mind and influences consciousness. Consciousness is an interesting term, perhaps representing an awareness of mind and body. Ingham [3] described consciousness as activity in the nervous system that can go from extreme activity to complete inactivity. Consciousness is more than a conscious state, but a state of awareness of internal wisdom that acts as a resource in movement for wellness. Perhaps consciousness can be said to be an accumulation or blending of the conscious and unconscious mind.

The unconscious can be described as the deeper, wiser self; an area in which you store things that are not in the conscious mind that can be recalled if needed, and can be thought of as sensory memories [4]. This paper stresses the understanding of the conscious and unconscious mind for both are utilized in the approaches presented. Milton Erickson utilized the unconscious in his hypnotherapy approach and believed that unconscious aspects could be utilized to mobilize physiological functions [5]. The unconscious can have aspects to attend to and when there is limited or no awareness it may show up in physiological and psychological symptoms because the unconscious foci are withdrawn. The interchange between the conscious and unconscious mind has been described as a "splitting" process in which two things are first separated into parts and then unified [4]. From a human language perspective, these experiences are distinctions that must first be brought to awareness in their separateness through the facilitation of the

unconscious mind and then unified by utilizing this awareness in the conscious state. Rossi [6] believed this required an integration of the left and right brain, creatively stimulating the right and left-brain to work in conjunction for movement towards solutions.

Aspects of the unconscious or aspects from an individual's past may at times produce extreme reactions to the body, and somatic symptoms can stem from something blocked and be utilized as armor for survival [7]. Lankton [7] described how individuals put fear, anger, and sadness in their hearts. During distress, for example, our heart pounds, our breath changes, and muscles contract. The immune system can also be compromised affecting a person's hormones. Rossi [1] shared that information of the psychological, physical, and biological levels can be transformed into other more "acceptable" avenues, as aspects are expressed; acceptable in terms of what may be culturally accepted within an individual's social network. Rossi felt that cultural and individual psychological patterns were more significant than the physiological cause of pain.

Erickson [8] described pain as having emotional, psychological, and somatic influence. This can come from a physical or psychological need, and assisting in exploring the client's need is the beginning to moving towards what the client wants, the solution. Pain is complex and can come from physiological or psychological past, present, and anticipated pain. At times the original pain is gone and the client is left with the habit formation of the experience of pain. Pain is a subjective experience with the individual often in full attention to its sensation causing much distress and experienced as having limited or no control. Often with pain there are psychological, physiological, and neurological learnings, associations, and conditionings that have accumulated in the body and mind for some time. As an individual changes their strategy and relationships with pain, often the physical sensation of pain changes [7].

There are several other psychosomatic interrelationships that may present in physical form. In some cases aphasia can be caused by mental distress. Psychogenic infertility can be caused by increased tension during sexual activity affecting pregnancy often with interrelationships of tension, anxiety, and spastic reactions interfering with tubal spasms, which interfere with transport of ovum to uterus [8]. In hypnosis, Erickson worked on relaxing various regions of the body to separate the different parts and gain control of the body when anxious, reeducating the physiological responses of the body. He believed if constipation and retention of urine could be corrected with hypnotherapy, tubal spasms could also be corrected. Difficulties with menstruation either when early, delayed, interrupted, or prolonged can be emotional stress.

Significance of the Assessment Process

Delicate attention to the assessment process is vital when clients enter into a position of seeking help, whether the clinician comes from a physiological or psychological stance. O'Hanlon [9] stated that the assessment process highly affects the problem definition and is influenced by the therapist's attention to the client, the nature of the problem, and the therapeutic approaches the clinician utilizes. Therefore, the clinician's observation lens highly affects the noted data. Exploring the client's problems, as well as the client's needs in a highly attentive and observation state is an integral part of the interview process. Both the therapist and the client influence what is presented and tracked in the interview process. The clinician utilizes what the client brings to therapy and meets the client where they are in the therapy process. What the client expresses must be taken at face value and it is not the clinician's position to decide what is accurate. The client often does not know what the problem is; therefore, the time attending to what the client presents is significant in order to move into any aspect of solutions [10]. In SFBT

and hypnotherapy presented problems are represented through the therapist and client's lens, shaped by their interaction, and co-created [9]. This is also the case in craniosacral therapy.

The clinician must have delicate attention to language, as well as attention to the non-verbal aspects of the client's system to allow for a comprehensive view and understanding of all that influences the client. A person's sensory system is constantly taking in information from the outside world, some that may be conscious and some not [9]. This describes what occurs with the client as well as the clinician. Bringing these sensations into consciousness involves what Erickson [6] called "prescribing a symptom" or "symptom prescription," an aspect of reconstructing what the client presents bringing the symptom to surface so it can be utilized. Erickson emphasized the importance of learning how to observe the client and believed training in hypnosis can assist in this ability. This has been described as a state of fully listening and attending to that brings forth a trance state; a place of fully connecting to the client in which Erickson believed all therapy should originate [11]. Trance is a state of sustained attention that can bring forth an unawareness of time and influence a shift in somatic sensation with the client experiencing bodily sensations from a psychological experience [12]. Erickson [11] felt typical observation came from a more conscious state that may be distorted by extraneous factors, but an attentive state of "listening with the unconscious" brings forth careful observation, an important role for the clinician.

Delicate attention to the client's observable data will allow the therapist to see, hear, and at times feel the client's problems and symptoms at a level that will assist the clinician's ability to facilitate change. The observable data can be seen as the client's problem and all that may be in relation to the problem. The client's reality enters the therapeutic session as observable data and this is where therapeutic intervention begins [13]. Meeting the client where they are in a

given moment is vital and this must be observed with an understanding that every client is a unique individual. It is important to look through a new lens with each client. Clinicians must meet the uniqueness of the individual's needs rather than applying a universal theory of human behavior to all clients.

Symptoms. A significant factor in beginning any therapy or intervention is accessing and reframing symptoms, a process that Erickson called "symptom prescription" [6]. This involves accessing what the client brings to the clinician at face value with little attention to diagnosis. What the client presents in a given moment must be accepted as a legitimate part of their condition and an understanding that this is the reality of the client's symptoms [14]. The therapist must accept the condition presented, just as accepting a broken arm or leg. When there is acceptance, the therapist and client can work with this understanding of reality in present time. Erickson [15] described symptoms as being a way the client communicates with the clinician referring to symptoms as socially adaptive and having a social function. At times, symptoms are expressed in other means that may appear unrelated to the disturbance, and the symptom may not be understood according to how it presents itself. Therefore, it is important to explore the interrelationships and interdependencies of the symptoms and be aware of its potential to be a response that is socially adaptive. Symptoms can be called involuntary requests that show up as communication of problems or complaints either physiologically or psychologically [4].

Perhaps the importance lies not in the symptom, but all the details about it. Over time, ongoing symptoms frequently become habitual patterns; therefore, symptoms can be seen as problems that show themselves in patterns [16]. Presented problems often have aspects of sequences, what triggers the problem and how the problem persists, giving light to opportunities for intervention to occur and perhaps find solutions within the problem itself. These can come in

the form of physical or psychological symptoms and commonly come forward because the client cannot clearly express their difficulties [17]. These symptoms commonly show up physically as headaches, rashes, stomach difficulties, and various chronic pains; and psychologically as depression, isolation, and anxiety, to list a few. This involves an ability to listen attentively and objectively observing all that presents itself.

Diagnosis. A diagnosis is closely linked to client symptoms and observed with a careful eye as addressed above. The clinician generally gives the diagnosis by observing the presenting problems experienced by individuals. A disease can be considered dis-ease of the body and mind. Erickson [16] believed that psychopathology interfered with normal behavior and growth and felt these aspects are a part of living. Perhaps a different paradigm is necessary when observing clients, one that looks at complaints and symptoms rather than a categorical explanation of norms.

Representational system. The observational data is also greatly influenced by an individual's representational system. Lankton [7] described the representational system as the sensory system of sight, smell, taste, audition, and tactile, that influences behavior. This influences how individuals perceive the world, both what they perceive internally and outside of themselves. Individuals operate out of their own sensory representations of the world; therefore reality can be considered subjective. As a therapist observes the client and their representational system, the clinician's own representational system influences their observation of the client as well. For survival, individuals filter much of this information; therefore, much of this information is not in awareness on a conscious level. A person's perceptions and understandings could be a combination of what is conscious and unconscious, and happiness is experienced by their view of what they see.

How people perceive the world is not only affected by their representational system, but also aspects from their past experiences. This can surface in how clients communicate their problems or symptoms. At times the non-verbal, kinesthetic communication surfaces, such as nods, shakes, and bodily movements [15]. Therefore, the clinician's attentive state requires their ability to utilize their unconscious and conscious awareness. It is not the clinician's job to interpret these movements, but to welcome the language and bodily movements as a multi-communication style of communication, all giving input to what the client presents [15].

The Therapeutic Session

It is of great importance to accept and to utilize psychological states, understandings, attitudes, and all that the client brings into the session. Erickson [14] believed that the clinician's attitude towards the client greatly influences the results in the client's progress. This requires delicate and attentive listening. Empathic listening is vital for the therapist to understand the depth of the problem, as well as time spent getting to know the client. Taking one's time is significant in moving forward with a client, attending to their uniqueness, joining with the client; and providing an opportunity for the client to respond according to their understanding, their behavior, and their reaction patterns [14]. This is more than just data, but the time taken in getting the client into a state of therapeutic interaction with the therapist, as well as attempting to bring forth therapeutic intention in experimental exploration.

The use of intention is also a tool as the clinician decides the best approach with a particular client. Lankton [7] felt that intention comes from an individual's spirit, bringing aspects from the clinician's internal drive in moving forward with the client. This intention is significant not only for the clinician, but greatly influences the client's ability to work towards a

goal. This can be described as a therapy system in which the clinician and client reconstruct the problems toward solutions [10].

The clinician assists and facilitates in expansion of choices. This facilitates the client to see, feel, think, or act in some way towards some kind of difference. Erickson [10] facilitated this process through a co-creation of utilization. Utilization requires both the therapist and client to be unique, creative, and exploratory [5]. Utilization attends to the unique needs of the client and utilizes indirect techniques to attend to the problem in a subtle manner, facilitating awareness beyond conscious limitations and within and around the client's environment. Erickson [10] often said that the conscious mind is very intelligent but the unconscious mind is smarter. Lankton [7] described this as "mindful visualization." This can be symbolic imagery to facilitate and tap into the emotional and/or visceral experience that is connected to both the problem and the solution. This visualization and intention comes forward through verbal and non-verbal communication in interaction between the clinician and client. The therapist can assist in facilitating the client's awareness, perhaps even an unconscious awareness that can influence automatic change. Erickson [10] thought of the unconscious mind as an aspect that is with individuals at all times, but perhaps is not always in awareness of your conscious mind.

Utilizing words in this manner can also benefit clients that may present as resistive, due to fear, discomfort, or other aspects, which may be difficult for the client. Rossi [6] described aspects in which the client may block or resist sensations which can prevent the clinician and client's access to the problem, thereby interfering in any kind of reframe in moving towards change. The therapist's task is to meet the client where they are at, and bring the therapeutic encounter to a level in which there is no contest [14]. The clinician wants to use what the client brings into the office, not what the therapist thinks should be; utilization of the resistance will

assist in possibility of interchange between therapist and client. The clinician deals with the condition as it is, in understanding and working with what the client presents. The attitude of the clinician will significantly affect the outcome, and therapy is a process of accepting the client, and at the same time facilitating their process to something new [14]. The idea is to assist the client's learnings to where they experience a different reality both in the body and mind. Therapeutic change occurs as a result of new learnings, which assists the client in change [15]. Erickson [15] did not focus on what was behind the problem, but had a view that when the client changes, their environment changes, and the new situation stimulates difference. This requires an availability to offer each individual client a therapeutic approach that they need in the given moment.

Craniosacral Therapy, Solution Focused Brief Therapy, and Hypnotherapy

Craniosacral therapy (CST), solution focused brief therapy (SFBT), and hypnotherapy are widely utilized by professionals in the health care system. These approaches can be used to facilitate wellness with many physical or psychological issues. At times these approaches can be utilized interchangeably, applying additional approaches when needed if suitable training and licensure permits. Craniosacral therapy can benefit, but not limited to: orthopedic disorders such as acute and chronic pain, back/neck pain, headaches, temporal mandibular joint (TMJ) dysfunctions, and torticollis; neurological disorders such as cerebral vascular accident (CVA), traumatic brain injury (TBI) spinal cord injury, cerebral palsy, seizure disorders, and/or peripheral nerve injury or compression; pre-/postnatal care, gastrointestinal disorders, hyperactivity and learning disabilities, sinus problems, dizziness, and tinnitus [18; 19]. Solution focused brief therapy and hypnotherapy [1] can benefit but is not limited to: preventive healthcare, stress management and stress related disorders, depression, sleep and anxiety

disorders, low self-esteem, grief/loss, addiction, and marital and parenting difficulties. Hypnotherapy can benefit a variety of physical and psychological issues, including those addressed above [5; 6].

Craniosacral Therapy

Craniosacral therapy was first introduced in the osteopathic profession in the early 1900's by William G. Sutherland, E. A. Bunt, and Frederick Becker, all exploring aspects of the craniosacral system and craniosacral rhythm its influence on the body [18]. In time CST became more prevalent and utilized by a variety of medical professionals ranging from physicians to massage therapists. Among others, John Upledger and Jon Vredevoogd greatly influenced its wide spread use. Craniosacral therapy is a manipulation/mobilization technique, to improve musculoskeletal dysfunction, enhance health, improve brain and spinal cord function, reduce accumulated stress, and enhance wellness. It utilizes the craniosacral system (head to bottom of spine, possessing the brain and spinal cord), and includes the fascia (a connective tissue surrounding bone, muscle and organs). Craniosacral therapy influences the musculoskeletal, nervous, vascular, lymphatic, endocrine, and respiratory systems. A significant tool utilized in CST is somatoemotional release (SER), which is the expression of emotions, thoughts, learnings, and internal wisdoms that are contained in the somatic tissue [19]. With SER the therapist's hands continue to be on the client during the CST session, adding a state of attentive and delicate exploration with the therapist and client working collaboratively from a trusting, intuitive state. In CST one views the body as a puzzle, necessitating a comprehensive approach. The individual is evaluated as an integrated totality and the therapist addresses the source of the problem(s), which affect the symptoms.

Solution Focused Brief Therapy

Solution focused brief therapy is a systems theory and a postmodern approach used by psychotherapists. Systems theory observes objects and people in interaction with one another, as opposed to observing them in isolation, including interaction of behaviors within context [19]. Additionally, the systems perspective looks at circularity and dynamic interchange. Solution focused brief therapy strives for an alternative to the medical model for a different experience, with no need to rush [13]. It can be described as brief in terms of its goal of moving from problems to solutions, and it is strategic due to its intervention to facilitate problem resolution. The postmodern aspect brings forth a position of relativity where there is no absolute truth and reality is subjective [20].

Insoo Kim Berg and Steve deShazer were the developers and pioneers of SFBT in 1978. In SFBT it is believed that most problems occur in human interaction, and solutions lie in changing these interactions, assisting the client to do something different even if it is a small change [21]. When one part of the system changes, this affects the whole system. DeShazer [21] described the aim of SFBT is to focus on the solution process rather than on the complaint, utilizing aspects of the client's complaint to facilitate concrete goals for possible future solutions. The therapeutic task is to develop solution building by utilizing the client's present resources and visions to build solutions, rather than the therapist taking the expert role of providing a diagnosis and treatment. This facilitates the client to think and behave in ways that will fulfill the client's expectations [13]. Clients generally need assistance in formulating the answer, and attentive and delicate listening and response assist in the client to explore their own internal resources [22]. This requires a level of creativity, with less emphasis on medicalism and scientism, and aspects that connect to the creativity of the arts [23].

Hypnotherapy

Hypnotherapy allows for creativity and is widely used by psychotherapists. Hypnotherapy is a means of utilizing experimental learnings with the therapist's facilitation and direction to stimulate aspects of client behaviors [14], as well as physiological and perceptual processes [11]. It is a modality of communication that increases internal awareness with less attention to external input. This allows for a decrease of analytic thinking so that new learnings can surface and differences are experienced. Normally, individuals will take an idea and question it in the mind, but in hypnosis the transformation of the idea happens quickly. Typically information comes in quickly and does not allow for any inhibition, but in hypnosis it allows moments for exploration of information and learnings that may be relevant to the client's stated problem.

One of its greatest influences on hypnotherapy has been from Milton H. Erickson, a psychiatrist and psychologist, considered to be the world's leading practitioner of hypnotherapy [15]. Ericksonian hypnotherapy includes Erickson's practice of psychotherapy and hypnosis used in conjunction in the therapy process, and can be described as clinical, scientific, observational, and unique. Erickson felt the therapeutic process was an interactional approach between himself and the client and put emphasis on the relationship rather than the individual [13, 16]. The process of hypnosis occurs in interaction between the clinician and the client, but it is the client that has a variety of experiences. The hypnotic trance is something that occurs within the client; it is an altered state of awareness of memories, learnings, and observational data that the client changes their relationship with [14]. In hypnosis, the client has a different type of reality orientation, by experiencing a larger view of a situation and making different and new connections. It can be thought of as a creative art in which the therapist and client work in collaboration to bring together conscious and unconscious minds in exploration for

transformation towards change. Utilizing creativity in facilitating the therapeutic process allows for exploration and flow in the somatic and cognitive aspects of ourselves. The client is in a place of mindfulness; being with something in the moment, suspending reality in the conscious mind, and bringing forward creative expansion in the unconscious.

In facilitating trance the therapist maintains positive intent preparing the client, taking identity aspects and weaving them into the trance state, taking new experimental learnings and integrating into the system, and transferring these new learnings into action in the client's life. Erickson [14] thought of this as a correction of the client's orientation. The clinician's goal in hypnosis is to facilitate understandings that exist within them both at a psychological and physiological level. Hypnosis allows for exploration of the physical and psychological aspects of individuals, examining how a client behaves or reacts from all levels [8]. It can elicit the experimental learnings that were unrealized, and explores potential levels of functioning both psychologically and physiologically. The client draws from their own resources of life experiences and previous learnings [5]. Rossi [6] suggested that this process might be effective because it appeals to the right hemisphere of the brain, which processes visuospatial, kinesthetic, imagistic, emotional, and body image.

Hypnosis can affect both physiological and perceptual processes, thereby influencing all aspects of an individual [2]. These changes do not occur as an isolated entity within the individual, but in total psychological/physiological context. As one area changes, associated areas change even occurring across the psychological/physiological aspect of the client. The client has increased awareness of their internal experiences from their unconscious perspective and less on their external realities, and this is utilized to affect their external present conditions [2]. This does not create new abilities, but opens an avenue of using the client's abilities, their

hidden potentials, in different ways. The client learns from the unconscious and then shared with the conscious to be utilized towards active change. The clinician adapts the technique in session to the individual needs of the client [8].

Clients may have needs that address pain and stress issues, two of the greatest problems in medicine [8]. Experience of pain can be influenced by a correction or change in orientation. Sometimes the client will substitute the state of pain with a different memory because pain is frequently associated with an unpleasant memory. The client can be directed away from their pain and connect towards a new learning of pleasant memory within the unconscious mind [14]. Experience of the pain, noticing it and being with it, is a vital aspect to diminishing the sensation. This is similar to states of anxiety where resistance against the feeling of anxiety actually increases the sensation. The unconscious learnings are repeatedly experienced and reinforced by additional life experiences and this can contribute to the client's experience of pain. Hypnotherapy can assist in breaking this cycle and intentionally making new corrections without resorting to drugs [8]. It is known that hypnosis has been assistive in alteration of sensory-perceptual functioning thereby reducing the client's experience of pain [5].

At times pain is described as psychosomatic and hypnosis has been useful for reducing the psychosomatic pain [17]. It assists in communication of ideas and understandings to explore the client's psychological and physiological aspects of self that may influence bodily complaints. It is known that many non-physical contributing factors become evident in hypnosis for pain control [24]. Common pain control interventions used with hypnosis involve acceptance, division of pain into parts from past memories or future expectations, dissociation of a painful part, transformation or a dilution of the pain, diminishing the pain, and resolution allowing investigation to see parts that are normally hidden [24].

Adjunct Tools

In addition to the clinical approaches described, I have found adjunct therapies can be helpful in the therapeutic process with individuals with physical or psychosocial difficulties. Exercise provides movement to enhance circulation, flexibility, strength, cardiovascular conditioning, energy, and overall function and well-being. This can be demonstrated in the therapy session if a client presents with physical complaints and it can be recommended for individuals with psychosocial difficulties to enhance some aspect of movement, stimulating the mind and body. Meditation and mindfulness can be demonstrated and practiced in the therapeutic session utilizing a variety of tools that facilitate centering, quieting of the mind, and to bring attention to the present moment. Utilizing breath is simple yet very powerful in assisting clients to increase awareness and movement of breath throughout the body and mind. Attention to nature can facilitate release by connecting nature to breath and internal resources. Music can also facilitate aspects of release and enhance connection to internal resources. There are several other adjunct tools, but for simplicity these may be presented in other studies.

Case Illustration

One composite case illustration will be used to represent aspects of several client cases of the first author, a physical therapist, craniosacral therapist, hypnotherapist, and psychotherapist. The case illustration is presented from the perspective of the first author using a biopsychosocial perspective. Mary is a 12-year-old girl diagnosed with Reflex Sympathetic Dystrophy (RSD) and post casting of right ankle. She plays soccer on a travel team as an offensive player, and her team ranks number two in the country for her age group. Mary had an important match in five days at the time of the first therapy session. Her right ankle was casted prior to the initial visit due to complaint of pain in her right ankle, with the x-ray showing possible growth plate pain in ankle.

Her ankle was casted for 2 weeks for rest, and following removal of the cast the client was released to play after 1 week of physical therapy to maintain normal strength and range of motion. The follow up x-ray of her ankle showed negative findings. At the initial session Mary complained of severe pain when putting weight on her right foot, she was non-weight bearing, and walking with crutches. No atrophy and edema were noted, and it was not possible to evaluate strength and range of motion at initial contact due to her fear to move her leg She was in extreme distress crying on and off and breathing heavy at times. Her father stated that she sometimes needed to be carried and had missed 3 days of school.

Initial Interview and Observational Data

Mary entered the office on crutches, together with both parents. At the time of initial introduction she was not crying. Brief introduction and attention to her complaints began in the waiting room. In initial observation, she stated she could not move her right leg or ankle and while sitting in the chair, she was holding her right knee in extension. Her parents explained the above history. Mary stated that after removal of the cast she had extreme pain and could not walk on her right leg or play soccer. As she described her pain, she began to cry, stating her pain is in her right ankle and foot. She did not allow me to touch her while in the waiting area. After listening fully to her description of problem, observation of her movement was noted as she moved to the back treatment room. She walked independently very slowly with crutches, and was non-weight bearing on her right leg.

Method of Intervention

The client was asked to walk with crutches into the back room where treatment began on a treatment table. She was asked to lie down, but chose to primarily sit while lying down occasionally and bringing her right leg off the table at times. I asked if I could touch her leg and

where it would be okay to do so. She allowed hand placement at her right knee and I began CST to the right knee, eventually moving to other areas of the musculoskeletal regions of the right leg (e.g., thigh, knee, shin, calf, ankle, foot). This was coupled with beginning conversation that incorporated somatoemotional release (SER), hypnotherapy, aspects of SFBT, and breath work. As CST began, the conversation initiated on Mary's sport interest of soccer, in time adding aspects of SER and hypnotherapy moving into her role on her team, her teammates (most were a few years older than her), her coach, her parents' perspective, her goals for herself, her body's condition, school, her love for the sport, her upcoming game in 4 days, stress related aspects to her upcoming match, expectations from others, her motivation to continue with soccer, and other relational aspects. Mary went from talking to crying on and off, and needed redirection often when crying increased in continued conversation. This was coupled with SER and aspects of hypnosis in interchange between the client and myself utilizing what Mary presented to facilitate further exploration.

Aspects of SFBT were provided while attending to present complaints and utilizing these in exploration of possible solutions, emphasizing what Mary would like to see. Conversation resembled a type of trance exploring relational aspects to her position and her sport. Mary often asked if she was done, but with facilitated conversation she would continue on. As the session progressed, the client allowed more areas of her leg to be touched and slightly moved and in time I was able to touch all areas of the right leg as I provided CST. As CST continued and movement increased with both volitional and assistive movement, I noted full range of motion and strength to be within normal limits. The therapeutic session was 90 minutes with the first author functioning as a physical therapist using an added psychotherapy perspective. The psychotherapy perspective involved aspects of SER, and aspects of SFBT facilitating the client towards what

she wanted in solutions. When the session was finished, she was not crying, and asked her father to carry her to the car.

Philosophy of Method

Regardless of the diagnosis or description of the problem, what the client presented was utilized as problems in the given moment. Description of the interview, observational data, and exploration of the client's representational system was attended to. Aspects of what the client presented was viewed from a stance of curiosity in the collaborative exploration of influencing factors to Mary's pain. I remained open and sensitive to any physical and psychosocial origins. Therapeutic interventions were prescribed by the complaints offered in the observational and representational data, following the client, yet in facilitation of her process. Although Mary often asked if the session was over, she would continue as I facilitated conversation.

Therapeutic Intervention and Results

I explored and facilitated the therapy session by utilizing Mary's language, paying delicate attention to her verbal and non-verbal communication, attending to her physical movement, and facilitating influential factors of the body and mind. This assisted Mary in the exploration of her internal wisdom/awareness, as well as her thinking processes and any influencing factors. Craniosacral therapy with a SER component, aspects of hypnotherapy, and aspects of SFBT facilitated this process as she moved from her present state to a place of difference. This conversation was different from day to day conversation, utilizing the client's language to facilitate something new. Although Mary was not in trance as with hypnosis, it is possible to be in a trance type state that facilitates stimulation of that which is not fully in our conscious awareness. After the session, Mary walked to the bathroom with crutches, non-weight bearing on her right leg, but asked her father to carry her to the car. She had little to no comment

after the session. Mary's mother reported absence of pain by the evening, and Mary was able to walk on both legs without crutches. Mary's mother later reported the client was able to play in her soccer match 4 days later without difficulties.

No explanation of the session or the outcome was needed for the client and her parents. However, I believe that the facilitation process that occurred in the therapy session allowed exploration beyond the client's conscious awareness, significantly influencing successful client outcome. Perhaps there were underlying issues that contributed to Mary's initial distress (e.g. fear and anxiety of performance, fear of pain to resurface during the game, peer pressure, expectations from her parents and peers), but the question of why is not important. The significance lies in the exploration that facilitates an awareness that influences change.

Discussion

A body/mind perspective may not be necessary with all clients, but for more involved cases it is often very successful. Reflex Sympathetic Dystrophy is thought to stem from physiological causes, but often it can also stem from psychological influences adding to the complexity of the illness with the exact cause unknown. In this case illustration, the first author utilized treatment modalities that addressed the physical and psychological aspects of the client's complaint, with an emphasis on the psychosomatic component. Minimum musculoskeletal mobilization was required although the therapist's hands were on the client throughout. Greater emphasis was placed on exploring the connection of what was occurring in the present moment to possibilities of what can be in the future. The unconscious experience can allow a change of cognitive-belief systems. In this case, pain was treated as pain. The therapist used a stance of curiosity in an indirect fashion of exploring, not in a linear fashion of searching for the cause.

This was done through delicate attention to what the client presented throughout, and utilizing this in movement forward in circular exploration.

Although there appeared to be no physical explanations of the pain, the therapist took it at face value, accepting the client's complaint of pain. The clinician did not take an expert role viewing the client as the expert, and the therapist and client worked together in interchange with the intention of moving presented problems towards future solutions. This required attending to the client's verbal and non-verbal communication, and utilizing both in the clinician's attention to the next set of questions for exploration. What clients present are physically and psychologically part of a complex system. The clinician needs to take into account the client's feelings, thinking processes, and emotions connected to their body at the given moment [14]. This delicate process attends to what the client presents and facilitates movement towards something new. This is similar to Erickson's hypnotherapy perspective that the clinician must recognize and accept the client's reality and willingness to participate in therapy. The clinician utilizes the client's reality to move towards the client's solution in a collaborative process of co-creation towards what can be [11]. This brings forth a both/and perspective in which the client was able to move towards an improvement in attitude, absence of pain, increase in movement, and the ability to play soccer for the following game.

Conclusion

Regardless of the diagnosis or presented problem and regardless of the utilization tool, the therapeutic approach presented in this paper follows the same intention of listening and utilizing what the client presents. Erickson [5] viewed experimental learning as all that individuals absorb throughout their lifetime. Individuals utilize this learning in process of their body and mind. This philosophy of method can be applied with several other diagnoses and

presented problems, and treatment can be utilized in a similar fashion. A body/mind perspective addresses problems from a systemic framework of mutual influences of physical and psychological parts of the whole person. Clinicians function as a facilitator to the client's process trusting the client's ability to utilize internal resources and wisdom to move towards well-being. In addition, adjunct therapies, such as those that facilitate centering, can bring the mind and body together and positively affect the client's system by experiencing stability, calm alertness, non-judgment, connection to life force, connection to a creative unconscious, providing a safe place for vulnerable experiences, and enhancing integration of cognitive and new experimental learnings. Centering is an experience of mind-body integration.

There is a tendency to separate disease into physic or somatic complaints [6]. Rossi [6] stressed the importance of a new formulation of a connection between the mind and body. Perhaps health care goes in waves of moving in and out of this perspective. Perhaps our westernized, rapid lifestyle forces individuals to search for a quick solution rather than a deliberate exploration and facilitation of movement that comes from a person's internal wisdom. Therefore, it is imperative that the therapist as well as the client enhances their "interpersonal sensitivity" [14] in observation and exploration in the therapy process. Erickson [14] believed a person's interpersonal interactions within their external world could be enhanced by an attentive state to their inner world. This heightened sensitivity can also benefit our awareness to self and the outside world, as the individual explores self within their ecosystem.

Ericksonian hypnotherapy, SFBT, and aspects of CST have a premise that change occurs within clients [11, 13], and therapists facilitate change by utilizing the client's "attitudes, interests, emotions, language, and behavior" [11], providing opportunities for clients to do something different. Any shift in psychological experience can have a shift in somatic

experience. If the client resists against sensations in the therapy session the sensation (i.e., pain or anxiety) will actually increase. Therefore, a collaborative and trusting therapeutic relationship is vital, so when these sensations occur, the therapist and client can move through them together. Utilizing a body/mind perspective can be beneficial in physical or psychosocial movement for children and adults enhancing quality of life. Attentive observational skills and delicate listening skills in the initial evaluation greatly influence the follow-through of treatment and successful therapeutic outcome. Facilitated consciousness and experience of relational change in the mind and body is useful in increasing inner experimental learning, awareness, shifts, and new connections, which is vital in enhancing clients' possibilities towards change.

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