HOW DO COUNSELLORS REFER THEIR CLIENTS TO BODYWORK THERAPISTS?

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Abstract

Current research and writings recognize the therapeutic benefits of attention to the body within a psychological context. Psychological counsellors and therapeutic bodyworkers have each developed systems in which the verbal and kinesthetic realms are joined, to allow clients to experience somatic awareness. To date no research has been done on the relationship between the counsellor and the bodyworker. Little research has been done on referrals among professionals. The purpose of this study was to explore the process and meaning of referral of clients by counsellors to therapeutic bodyworkers. The participants were eight volunteer counsellors who were recruited by word-of-mouth. Participants were interviewed about their predispositions to make referrals to therapeutic bodyworkers, perceptions of the risks and benefits of such referrals, relationships with the bodyworkers to whom they made referrals, and visions for their counselling practices. Results indicated that participants’ personal experience and feedback from others influenced how they brought body awareness into their counselling sessions, and predisposed them toward the application of therapeutic bodywork by referral or within their sessions. Fundamental to the process of referral was the counsellors’ respect for the therapeutic process and consequent deep level of caring about the nature of the referral to the bodywork therapist. This respect and caring was revealed by participants’ descriptions of their relationships to the therapists to whom they referred, their concern for clients’ readiness for referral, and their perceptions of the risks of referral. Respect for the collaborative therapeutic process also emerged in counsellors’ descriptions of their visions. Implications for practice and ideas for further research are also presented.
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Chapter One

Introduction

A perspective has emerged that sees the interconnectedness of all things (Capra, 1983), including the mind and the body (Marrone, 1990). Linkages between emotions and chemicals at the biomolecular level have been established in neuroscientific research (Pert, 1997). Linkages between disease and mental state have been postulated and explored in the area of psychoneuroimmunology (Ader, Felton, & Cohen, 1991; Pert, 1997).

In keeping with this shift toward a unified perspective, psychological counselling has changed from talking about experiences, to having experiences, to studying the organization of experiences. Working with the mind/body interface, counselling assumes that the awareness of connection, within the self and between the self and the world, is healing. The process of therapeutic counselling fosters communication between belief and experience, image and emotion. This awareness helps to organize the parts into the wholes (Kurtz, 1990).

How we feel in our mind affects how we feel in our body and vice versa. The term "bodymind" (Dychtwald, 1977) acknowledges this interrelationship. The bodymind forms a loop of influence between the mind and body with the potential for determining psychological and somatic harmony. The body's patterns of posture, holding, tension, and movement, reflect the mind's feelings. The mind is influenced by the body's holding the memories of what the mind used to feel. This cycle of influence may be interrupted by awareness, via the bodymind, through talk therapies and bodywork therapies that change
the energetic and/or neuromuscular systems.

Yet another viewpoint has argued that with true embodiment, we would need no paradigm at all (Berman, 1989). Somatic anchoring would bring a satisfaction in being rather than doing, a reflexivity that implies an emphasis on how rather than what, on tools rather than world views. This orientation laments the loss of kinesthetic awareness and the deep knowing it provides, the loss of somatic understanding that connects one's body to the flesh of the earth. From the psychological viewpoint the loss in Western culture of a sense of unity with the environment encompasses the biologically-based Self/Other split, which occurs with self awareness and creates a gap that we are constantly trying to fill. Berman has suggested that the loss of the primary satisfaction of wholeness may be less threatening when one is grounded by a sense of being in the body. With this sense of embodiment, one may become aware and acknowledge that no "new paradigm" is needed.

Being in the midst of what is called a paradigm shift, we still use the terms body and mind separately, sometimes struggling for ways to express and integrate new awarenesses while still using concepts and language from the prior paradigm of analyzing the separate parts of things rather than their interrelationships (Kurtz, 1990). Thus therapeutic counselling and bodywork are both vehicles for individual change. In the former, one may describe the primary modality as talking and listening between the counsellor and the therapist, with the possibility of some attention to the body. In the latter, touch is the primary modality, with the possibility of including some dialogue.
Statement of the Problem: Rationale for the Study

In the past, most approaches to psychotherapy have misunderstood attention to the body, or relegated it to the periphery, influenced by the 19th century taboo against touch. The taboo against touch in counselling has been furthered by our litigious sociocultural context, in combination with sexual misconduct by some therapists (Kertay & Reviere, 1998).

Since the 1960’s, the topic of touch in psychotherapy has attracted increasing attention, when experiential psychotherapies began to include some focus on the body. The proposed study is supported by an increasing acknowledgment of the body as an integral aspect of our psychological health. Recent writings have theorized about the importance of touch to psychological well-being, and the relevance of touch for counselling clients with specific issues such as sexual abuse (Lawry, 1998), and have made suggestions about its place within the counselling setting (Smith, 1998). Recent research has looked at characteristics of counsellors who touch (Milakovitch, 1998).

Within the therapeutic bodywork area, numerous writings within the past ten years have focussed on the psychological aspects of bodywork, and devised various bodywork procedures to facilitate well-being, sometimes using the term “body-centered psychotherapy”. (Campbell, 1989; Epstein & Altma, 1994; Hendricks & Hendricks, 1993; Pert, 1997). For example, emotional blocks may be released through gentle contact with the craniosacral system (Upledger, 1990), and systems of energetic or life force flow have been linked to biopsychosocial aspects of human development (Brennan, 1987; Raheem, 1991). Working through the body has been described as a way of accessing
deeper urges and potentials, of coming into contact with the quality of compassion (Heckler, 1993).

Missing from the literature is a description of how the professional counsellor relates to, works with, or refers clients to, the professional bodywork therapist. How does the talk therapist make such a connection with the bodywork therapist?

**Definitions**

**Bodywork**

The definition I use of the construct "bodywork" is multi-faceted and derives from many sources. It does not appear in several dictionaries I consulted, such as The Random House Dictionary of the English Language (1987, 2d Ed.) (except to refer to automobile repair!)

I use the term "bodywork" to refer to a variety of somatic disciplines that use skillful touch with therapeutic intention (Juhan, 1987). "Skillful" includes the use of intuition as well as learned techniques. Included in “touch” is skin-to-skin contact as well as contact with what is called the "etheric" or "subtle" body, which is energy surrounding the physical body (Brennan, 1993). For purposes of clarity, I will specify that a bodywork system is working with this more subtle energy, “off the body,” when I am discussing the use of particular systems such as Therapeutic Touch® and healing touch. Those who do bodywork are known by a variety of names, such as "bodyworkers," "bodywork therapists," or "massage therapists."

Bodywork through skillful touch includes “massage,” defined in The Random
House Dictionary of the English Language (1987, 2d ed.) as "the act or art of treating the body by rubbing, kneading, patting or the like, to stimulate circulation, increase suppleness, relieve tension, etc." The use of hydrotherapy is included in "massage" as defined by The American Massage Therapy Association. In addition, there are named styles of massage such as Swedish, deep tissue, and sports massage. Also included as bodywork are approaches which are not strictly "massage," such as craniosacral therapy, the Feldenkrais Method®, reflexology, Reiki, Rolfing®, shiatsu, Trager® work, and Therapeutic Touch®, to name a few. Brief descriptions of these and other methods of bodywork are available in several recently published books (Claire, 1995; Knaster, 1994).

The application of the word bodywork becomes less precise the more one reads about approaches to therapy and healing from a unified energetic perspective (Brennan, 1987). Although the terms bodywork and counsellor as used herein are defined as coming from separate realms, some current therapeutic approaches combine modalities, and may be called body-oriented psychotherapies (Epstein & Altma, 1994; Kurtz, 1990; Pert, 1997).

As used in my research, the references to touch, massage, and bodywork do not refer explicitly or implicitly to any associations with sexual intent, or with merely "feel-good" sensual recreation. Also not included in the definition of "bodywork" is "physical therapy," also called "physiotherapy," because its medical orientation, training, and discipline set it apart from the approaches named above.

**Counsellor**

I use the terms counsellor, psychotherapist, and talk therapist interchangeably, to
mean a professional therapist who has received at least a Master’s degree in counselling psychology or social work, or has equivalent training with at least five years of counselling experience. In addition, I expect these terms to refer to individuals who abide by the appropriate ethical codes of the professional psychological and counselling associations in North America.

**Referral**

By “referral” from a professional counsellor to a professional bodywork therapist, I mean the recommendation to the client by the counsellor that the client see the bodywork therapist for therapeutic reasons. Through my research I hope to elucidate the process used by talk therapists for these referrals, and the meanings attached to them.

**Controversies**

How touch and counselling are used, together or separately, may call forth issues of boundaries and scope of practice. Whether one has the professional training and credentials to do therapy with the mind or with the body is controversial among practitioners in various jurisdictions in North America. For example, some massage practitioners support the legal regulation of the profession of massage therapy and favor its conformance to a Western medical model of clinical style, with mandatory licensure or certification by exam. Others maintain their right to practice their art without legal oversight, preferring optional standards of accountability. Some bodyworkers consider themselves outside the scope of "massage" requirements because they are practicing another kind of skillful touch.
Bureaucratic rulemaking has artificially separated the mind and the body, which are unavoidably intertwined and integrated (Upledger, 1990). The discussion of the pros and cons of regulation is outside the scope of this research. My expectation was, however, that in my research a participant might bring up the issue of massage certification or licensure as a factor in considering referral to a bodyworker. Thus I mention the existence of the controversy.

In addition, drawing distinctions between erotic and non-erotic contact has been worrisome for both talk therapists (Hetherington, 1998), and bodyworkers. Ethical principles of these therapists' professional organizations consider erotic contact to be an ethical violation (American Massage Therapy Association, 1997; American Psychological Association, 1981; Kertay & Reviere, 1993). In addition, the European Association of Body Psychotherapists has developed standards of practice, a code of ethics, a definition of body psychotherapy, and competency criteria for therapists (European Association of Body Psychotherapists, 1991).

Aside from sexual misconduct, the use of touch may involve issues of power and status, such as male therapists touching female clients. For example, Alyn (1988) noted that higher status individuals commonly touch those of lower status, but the reverse seldom occurs. In connection with the issue of inappropriate touch, one article has noted that touch is not the only way the therapist can be seductive, thus automatic rejection of touch as a psychotherapeutic tool, because of this risk of seduction, is not called for (Kupfermann & Smaldino, 1987).

Except for this brief mention, I do not review the debate over appropriate touch. I
assume for purposes of the research that sexual contact is neither intended nor tolerated, and that therapists are acting with the intent to "do no harm" to the client. For a review of the literature on sexualized touch in psychotherapy, see Kertay & Reviere, 1998.

**Personal Statement**

My interest in the integration of psychological counselling with bodywork comes from my experience, beginning over twenty years ago, of moving through the analytic, intellectual realm of practicing law into the kinesthetic and nonverbal world of therapeutic bodywork. When I initially became a lawyer, I had a love of learning, and a fascination with the workings of the legal system and the people within it. The intellectual challenge, however, was not enough to command the devotion that seemed necessary, or to give me a sense of personal expansion. I jealously guarded my free time, and often felt the stress and anxiety of feeling the work was never finished.

My law practice within a variety of settings was successful. I particularly enjoyed the work with Japanese individuals, who were with the corporate clients that needed assistance in many kinds of negotiations and plans within the context of the computer technology hardware business. Gradually I found myself called upon to comment about the dynamics of peoples’ interactions as well as legal matters. Casual talk of being considered for an executive position within the company’s legal department, however, left me feeling a sense of loss, and a slight panic. I had no interest in such a future. With such lack of interest, and the urge to have more time to indulge my music and artistic past-times, and to simply unwind, I gave four months notice, and hired my replacement.

Thus after being a lawyer for about 12 years, in small and large firms, in
corporations and judicial settings, I decided to leave, without a plan. To not have a plan was, for me, an uncomfortable and unfamiliar situation. To leave the law was preferable, however, after hours of anxious pondering, to remaining in an environment that I did not look forward to being in, in several years’ time.

After two months of “floating,” during which I ruminated, traveled, and felt the strange feeling of not being identified with my work, I began to look into learning how to do massage. I had experienced several, and was impressed with how good I felt and how happy the therapists seemed to be doing their work.

I thought I would just see how it was, and take the intense 100-hour course. My experience within a fantastic school opened my eyes to a more expansive and fulfilling way of being. I completed the 500-hour education and became a teacher and administrator. I studied several kinds of therapeutic bodywork, taking additional training of over 1000 hours, including shiatsu, craniosacral work, and some off-the-body systems, and developed a practice in which I saw clients regularly. The law office where I had worked called within a few years’ after my leaving, to ask if I would be available part-time. I was then able to create for myself the right mix of part-time law, bodywork, and teaching, to maintain flexibility and balance with these different kinds of work and other interests in my life.

Looking back I see myself finding ways to meet my needs for a variety of challenges and to nurture myself. I was able to develop ways of being more aware and focused with my whole self, not just my head, that I had no idea were possible. As a consequence I believe I moved my life forward and expanded with respect to my
relationships with others, and with myself, as well as in the area of career. I have since married, had a child, and developed my music and art abilities. My present study of counselling psychology, and being a counsellor, has brought many of my previous interests, skills, and experiences together. My choices of careers may be viewed as a reflection of my personal evolution toward greater knowledge, understanding, acceptance, and trust of myself and others. To live only “in my head” was not enough. As a result of my life experience, I value trusting one’s intuitive and bodily sense of being, which I believe may be accessed through therapeutic bodywork.
Chapter Two

Literature Review

The movement and evolution toward what appears to be a desired and beneficial therapeutic focus that attends to the interrelationships of mind and body carries with it the history of each of its parts. Thus some counsellors and bodyworkers have been gradually exploring and integrating aspects of each other’s knowledge. On the one hand, ideas about touch within the psychotherapeutic setting have been explored, and on the other hand, views about psychological feelings and thoughts within the kinesthetic setting of therapeutic bodywork have been presented by various practitioners at various times.

In this literature review I begin by summarizing ideas about the significance of touch and touch in psychotherapy. I then mention the historical developments of the use of touch in psychotherapy, describing how the roots of touch in psychotherapy grew from concerns with transference/countertransference issues to a narrow focus on therapists’ use of touch and its effects on clients’ self-disclosure. These early studies suggested conclusions based on artificial applications within inauthentic settings, which may have fostered misconceptions about the use of touch.

Interestingly, more recent work in the counselling area which I summarize has looked at a variety of issues surrounding how and why touch is done within actual counsellor/client settings, and has acknowledged and encouraged its application in appropriate circumstances. From the bodywork side, many theories and techniques of healing through touch have been developed and practiced, with some writings suggesting that psychological benefits are to be gained from bodywork.
Finally, I discuss recent research about referral among a range of professionals to show some of the factors and conditions of such referral, although none of it pertains specifically to referrals among counsellors and bodyworkers. This referral research provides additional background for the area of interest in my study, namely, how counsellors are putting into practice the recent acknowledgments of the therapeutic benefits of touch in psychotherapy, within the "new" paradigm of wholeness, by way of referrals to bodyworkers.

**The Significance of Touch**

Physiological and psychological connections between tactile contact, well-being, and maturation have been established in animal experiments, in particular with the importance of touch in the level of exploration of young monkeys (Harlow, 1958). Extended to humans, the effect of touch deprivation has been explored on infants in orphanages (Spitz, 1945) and in later research with premature infants (Field & Schanberg, 1990). Montagu (1986) noted that the sense of touch is critical to human development and that its importance is frequently overlooked or minimized. He has summarized the theoretical literature and discussed the manner in which tactile experience or the lack of it affects overall development.

Outside the area of talk therapy, studies have found that touch increased compliance behavior (Kleinke, 1977), allowed females to experience more positive affective and evaluative reactions than no touch controls (Fisher, Rytting, & Heslin, 1976), and highlighted the lower status of the recipient (Henley, 1973). In addition, the same touch may be perceived positively by one sex and negatively by another (Nguyen,
Heslin, & Nguyen, 1975). Massage has been shown to be effective with child and adolescent psychiatric patients (Field & Larson, 1990). Massage has also received empirical support for facilitating growth, reducing pain, increasing alertness, diminishing depression, and enhancing immune function (Field, 1998). Nurses have explored the theory and practice of Therapeutic Touch®, an off-the-body therapeutic intervention, developed by a nurse (Krieger, 1979) initially for use with ill and dying patients. It has become more practiced and accepted in Western health care (Heidt, 1981), although it is not without its critics (Clark & Clark, 1984).

Both Western and Eastern philosophical perspectives have theorized about and explored the linkages of somatics, body awareness, and touch with psychological healing (Moyers, 1993). Although the psychodynamic, Gestalt, and existential theoretical frameworks have been the basis of some writings, others come from personal beliefs and experiences.

Various authors have acknowledged the potential benefits to the client of appropriate touch in psychotherapy. Examples of the benefits are: a reassurance that the client is not alone, and is accepted; a dissolution of the client's unhappiness and fears (Montagu, 1986); a release of repressed material; a comforter; a change agent; an emphasis and way of holding or drawing attention; a grounding; a way to silence a disrupter; an agent of control; and a validation of self-worthiness (Older, 1982).

Reasons not to touch from the therapist's perspective have also been acknowledged, such as, when the therapist does not want to, feels it is not appropriate for the client, feels it is not effective therapy, feels manipulated by the client, or that the
therapist may be manipulating the client, or that the client doesn't want to be touched. Guidelines for the use of physical touch have been offered (Mandelbaum, 1998), some of which include suggestions that touching by a talk therapist occur only rarely with individuals, and otherwise in groups or in the presence of a co-therapist (Torraco, 1998).

The issue of touch in psychotherapy is complicated by the many possible definitions of touch. Touch can mean a light contact on the hand or shoulder, or full-body manipulation or massage. In addition, its use can be incidental or intentional. A taxonomy of touch has been suggested by Smith (1998), in which hostile and sexual touch are taboo, and other kinds of touch such as inadvertent, conversational, socially stereotyped, technical, or touch as an expression of the therapeutic relationship, are acceptable or not depending on the circumstances. Other ways of classifying touch are to view it on a continuum, from the more formal ritual or athletic kinds of touch, to the more personal kinds such as punishing, nurturing, intimacy-evoking, or sexual touch (Fagan, 1998).

Ethically, the appropriateness of the touch must consider that the message sent is not necessarily the message received, the meaning of touch is culturally relative, and touch may be more emotionally powerful than verbal communication, and more ambiguous (Smith, 1998).

Even if intent and quality of touch are established by some observable means, the message communicated will not be routinely correlated with it. This uncertainty is suggested by the following observations of psychologists about touching that have been supported by neurophysiology: 1) the same touch can have different meanings for different recipients; 2) the intended message can be modified by the attitude of the recipient; and 3) repetition alters the meaning of touch (Durkin, H.E., Glatzer, H.T.,
Historical Developments

Historically, the taboo against touch in psychotherapy evolved with the development of psychoanalysis (Kertay & Reviere, 1998). Some of Freud's writings (Breuer & Freud, 1955) referred to his initial use of touch, which he then discarded in his development of the psychoanalytic theoretical principles of neutrality or abstinence, and the purely reflective point of view (Mintz, 1969). Psychoanalysis rejected touch because of its interference with transference and its erotic interpretation (Kertay & Reviere, 1993). The issues of transference and countertransference and the place of touch in the counselling session have been vigorously discussed (Durkin, H.E. et al, 1972; Fuchs, L.L., 1975).

In post-Freudian psychotherapy the emergence and growth of the humanistic approach with its experiential theories increasingly incorporated validation of the body (Older, 1982). Positive awareness of the physical body was initially brought into psychotherapy by Wilhelm Reich, sometimes called the posthumous father of the human potential movement (Older, 1982). Reich (1972) was one of the first to develop somatic techniques using breathing and expression to liberate emotion. Alexander Lowen (1971) extended Reich's formulation of character types and the concept of body "armoring." Fritz Perls (1969) as a client of Lowen's was influenced to further expand the interpretation of bodily processes. In Gestalt therapy, Perls saw physical expression and its withholding in relation to their function in the individual's contact with the environment. Also of interest to Perls was the experience of sensation, to have the client
be aware of that embodiment and expression (Kepner, 1987). For an overview of some of the Reichian and neo-Reichian approaches, see Smith, 1985.

The humanistic experiential schools, such as Rogerian, Gestalt, and existential, found the incorporation of touch and body awareness a natural and useful way to increase the client's feeling of trust and safety, and promote a willingness to be authentic and accept her/himself more fully. Self exploration leading to self-awareness has been shown to be a significant factor in successful therapeutic outcome (Rogers, 1961). Individual and group work incorporated touch and physical games designed to increase self-awareness.

Related to the original Gestalt focus, numerous techniques and systems developed and continue to develop, using a hands-on approach as well as verbal interaction, to combine the physical, the psychological, and sometimes the spiritual. For example, Gendlin's (1981) concept of "felt sense" and practice of "focusing," were developed in the context of experiential psychotherapy. The focusing process is intended, through talk and concentration on a deep bodily sense, to access the bodymind, a fusion of intellectual and "gut" knowing.

These evolving perspectives include differing opinions about the role of touch in psychotherapy and counselling settings, and about the attention given to the body in psychotherapy through theories of psychological counselling that have a bodywork component. As previously mentioned, some systems of bodywork have a psychotherapeutic orientation and include verbal dialogue with the client (Epstein & Altma, 1994; Kurtz, 1990). Incidentally, the names of the therapies do not necessarily
indicate whether the therapist's orientation and training are primarily talk focused or body focused or both.

Early research about touch in psychotherapy focused on touch in relation to self-awareness as measured by self-disclosure. As described below, conclusions from these studies seem tenuous, because of the inauthentic aspects of the studies.

**Touch and Self-disclosure**

In an early article in the area of touch and self-exploration, Jourard and Rubin (1968) conducted an investigation to explore the correlations between the amount of self-disclosure to the closest friend of the opposite sex, and the amount of physical contact. The authors assumed that verbal self-disclosure and allowing touch were both means of establishing contact, and expected that measures of each would be correlated. Based on the results of the investigation, the only significant correlation of body contact to self disclosure for men was a slight tendency for men to have physical contact with their male friends in proportion to the amount they disclosed themselves to them. For women, the significant correlation of these two areas was a low tendency to disclose to their male friends in proportion to allowing touch from them. The authors inferred that self-disclosure contributes to touching behavior. Equally plausible, however, is that touching a person may have contributed to a tendency to disclose oneself to that person.

In the Jourard and Rubin study a questionnaire for measuring body contact and a self-disclosure questionnaire were administered to 54 male and 84 female students in the senior author's undergraduate personality development class. The purpose of the study was explained and the option given to not participate. The reliability of the questionnaire
was established. Fifty male and fifty female scores were considered (the same subjects for whom the reliability coefficients were calculated). All subjects were unmarried and aged 19-22 years.

An ambiguity in the study relates to the previously mentioned point about intention and its perceived effects. A discrepancy exists between the authors' conclusions about receptivity and the language of the instructions in the questionnaire. Being receptive to touch was not part of the instructions. The instructions asked for certain responses if "the area is never touched meaningfully or purposefully (e.g. to express affection, anger, or to attract attention, etc.)...", if contact occurs "rarely", or "as a regular part of your relationship" (Jourard & Rubin, 1968, pp. 41, 42). Body contact in "anger" or to "attract attention" (to whomever) or "rarely" or "regularly" does not necessarily indicate receptivity by the receiver. Thus the participants were not, according to the instructions, asked to consider only incidents of allowed touch.

The study's conclusions are therefore questionable, about who allowed what from whom, the interchangeability of the touched/being touched patterns, and the predictions stated. For example, the following statement is suspect: "Women show a slightly greater accessibility to physical contact than men, but this is accounted for by their relationship with their fathers" (Jourard & Rubin, 1968, p. 47). Such a conclusion is dubious if some of the women reported instances of touch to which they were not receptive or did not allow.

Also difficult to understand is the authors' statement that touch is equal to sexual intent, either consciously or at a less conscious level, because it was the opposite sex
friend with whom the most widespread (over the body) physical contact was exchanged (Jourard & Rubin, 1968, p.47). This generalization failed to distinguish among the different kinds of touch and their quality. Although some areas of the body are reserved for sexual touching, not all touch has sexual intent.

Additional uncertainty about the authors' conclusions concerning heterosexual patterns comes from the instructions. The subjects were asked to indicate the degree of closeness of the opposite sex friend, whether s/he was someone seen occasionally-less than once a month, frequently-up to once a week, or more frequently-going steady or engaged. First, this degree of seeing variable did not seem to enter into the study's conclusions. Second, if it was a factor, why was it not specified for same sex friend? Does "seeing" someone imply sexual intent? What about the subject's ability to be candid about same sex sexual intent as related to body contact, especially if, in the authors' words, it is less than conscious? What about heterosexual frequency implications, i.e., the women's reporting frequent touch by the fathers, and the men touching same sex friend more? The authors' generalization that touching equals sexual intent among heterosexuals based on the results of this study raises too many questions to be acceptable. The subjects of this study were 19-22 years old and unmarried, and their ways of handling verbal self-disclosure and physical touching were probably influenced by their chronological age and/or developmental stage. The situational variable and cultural background are other unmentioned components (perhaps assumed by the authors to be homogenous).

Also, the context of touching and being touched determines its frequency, where on the body it occurs, and linkages with self-disclosure. For example, touch and/or body accessibility for the subjects and their likelihood to self-disclose might be more or less
likely among the targeted parent persons in situations where parents were geographically close, distant, or separated from each other, where siblings were present, where groups of peers gathered, etc. Finally, the study did not appear to specify a time frame, such as the past year, five years, or their entire lives, for the subjects to have in mind when they responded to the questionnaires. With appropriate revisions based on the above caveats and criticisms, a current study comparing these two modalities of self-disclosure and their interrelatedness would be interesting:

Jourard noted in a later book (1971) that the experimenter is not just a passive recorder of the phenomena studied, but a powerful influence on them (Rosenthal, 1967). He saw a related problem in measuring results of this study: answers to questionnaires are dependent on what the subjects are willing to disclose to researchers about their past disclosures to others. "It could be that thousands of questionnaires are a record of thousands of lies" (Jourard, pp. 1971, pp.102, 103). Also, as a predictor, the self-disclosure questionnaire relied on the assumption that past performance is an indicator of the future. In fact, responses to a questionnaire are no more valid than the willingness and ability of the subjects to be authentic in their efforts to comply with instructions.

The following four quantitative studies (Alagna, F., Whitcher, S., Fisher, J. & Wicas, E., 1979; Hubble, M., Noble, F., & Robinson, S., 1981; Pattison, 1973; Stockwell & Dye, 1981) span twenty years, from the mid-sixties into the mid-eighties. The research designs have focused on client perception measured by questionnaires and audiotapes. They show the artificial application of “touch” as a condition to counselling with pseudopatients or short-term volunteers.
A study often cited in the area of the effects of touch on the therapeutic relationship is Pattison's (1973) investigation. It had three questions: 1) Do clients who are touched engage in more self-exploration than clients who are not touched? 2) Are counsellors perceived differently by clients they touch than by clients they do not touch? and 3) Do counsellors feel differently toward clients the touch than toward clients they do not touch? Rather than using topics of a personal nature to measure self-disclosure as Jourard and Rubin did, this study measured self exploration on a continuum from no personally relevant material volunteered, through voluntary self-disclosure, to self-probing and self discovery.

Subjects were 20 female undergraduate students aged 17-26 who came to the university counsellor training center for personal counselling. One male counsellor age 24 and one female counsellor age 32, both second-year graduate students with education comparable to practicing master's degree counsellors were the counsellors. They used Rogerian concepts of unconditional positive regard, empathy, and congruence and allowed clients to choose content. They were trained in touching clients and practiced the procedure to be used. Four treatment combinations were randomly assigned to five subjects per treatment combination. Three response measures were used: the Depth of Self-Exploration scale used for rating clients' self-exploration by trained judges listening to audiotapes, the Relationship Inventory, completed by both counsellors and clients, and the Relationship Questionnaire, completed by clients.

Significant differences were found between touched and non-touched clients for depth of self-exploration: clients who were touched engaged in more self-exploration than clients who were not touched. No significant differences were found between touch
and no-touch groups on the measures of perception of relationship. Nor were there significant differences between the two counsellors.

The author raised questions about the use of questionnaires. For example, disproportionate weighting on total scores was caused by the clients tending to use the same numerical ratings regardless of the item on the Relationship Inventory. Some clients also said they were reluctant to make the counsellor look bad, and some counsellors felt they should be showing a high degree of therapeutic conditions with all clients. This social desirability factor may have tended to obscure the real differences between treatments (Pattison, 1973, p. 173). Furthermore the author thought that subscale scores rather than total score may have suggested a relationship between touching and the warmth or regard dimension on the Relationship Inventory, and called for further investigation. Rather than a global questionnaire, she favored behavioral measures, direct client report, audio and video observations, and physiological means, to establish the real effects of touch (Pattison, 1973, p. 174).

Results from a study by Stockwell and Dye (1980) contrast with Pattison's (1973) research showing positive effects linked with counsellor touch. This study used a random selection of 56 male and 44 female undergraduate students in an interpersonal communication skills course. Counsellors were 14 male and 11 female graduate counselling students. They were trained and rated in touch/no touch procedures, and each saw a client of each sex in the touch condition and a client of each sex in the no touch condition. Interviews were 50 minutes and centered on interpretation of a vocational interest inventory. A self-report measure of counsellor effectiveness as judged by client ratings and a behavioral measure utilizing audiotapes and three independent raters were
the major dependent measures in this study. Further checks on internal validity showed that experimental procedures were observed closely and clients were not aware of the parameters or the study.

No significant effects on counsellor evaluation resulted from the factors of nonverbal treatment (touch or no touch), or counsellor or client gender. In self-exploration, female clients were more self-exploratory than male clients. Counsellor touch was found to have no significant effect. A difference in this study and that by Pattison (1973) is that undergraduate subjects in the former were enrolled in a class, and in the latter were seeking counselling.

In a study finding positive effects of counsellor touch, by Alagna, Whitcher, Fisher, and Wicas (1979), the undergraduate subjects were volunteer participants in a study of career counselling techniques, rather than being enrolled in class. Perhaps the volunteer aspect of the client seeking counselling created a more natural setting, in which those who were touched evaluated counselling more positively than the non-touched subjects. Stockwell and Dye (1980) also noted that in comparison to the study by Alagna et al. (1979), their study had more internal validity and control of nonverbal behavior such as eye-contact, and also included differences in length of the session, the focus of session, and the method and timing of the touch.

A study by Hubble, Noble, and Robinson (1981) was undertaken to accomplish two purposes: 1) to uncover additional data on the impact of counsellor initiated touch in a counselling session, and 2) to investigate the moderating effect of a personality variable, clients' field dependence-independence, on responses to a counsellor's touch.
Three pertinent criteria were chosen: anxiety, self-disclosure, and perceptions of the counsellor.

Thirty-two females, aged 17-25 years, who were enrolled in an undergraduate education course, were selected for participation in the study by scores on a measure of field dependence (finding target forms embedded within more complex geometric figures). Half were selected based on dependent scores, the other half based on independent scores. As a course requirement, they participated in a counselling session to explore their vocational interest in teaching. Two levels of treatment, touch and no-touch, were used. Each of three male doctoral counselling students, aged 30-32 years, received extensive training in the touch treatment, and saw two field-independent and two field-dependent clients within each of the touch/no touch conditions for 45 minute interviews focused on vocational teaching interest. After the session the client completed the criterion measures, responding to the anxiety scale based on how they felt during the session, completing a self-disclosure questionnaire about the degree of willingness to disclose to the counsellor a wide range of topics, and rating the counsellor for attractiveness, trustworthiness, and expertness. Judges also rated clients' self-disclosure by listening to audiotapes using a rating scale.

Results showed that the clients who were touched by their counsellors perceived the counsellor as more expert than the clients who were not touched. No other significant findings were revealed. The authors called for further investigation of technical issues such as timing, location on the client's body, and manner of touch, as well as the effects of touch over time. They also suggested that unlike this study, naturalistic settings with real clients rather than undergraduate students, may allow a greater depth of self-
exploration, as was found by Pattison (1973). The context of the interaction is a key component. Factors not mentioned by Hubble et al. that might have impacted perceptions of expertness and willingness to self-disclose were gender, age, and culture. Were the younger undergraduate females more or less likely to respond in particular ways to older male counsellors? Do the results of this study, involving undergraduate females and older males, support Jourard and Rubin's earlier study finding that women (undergraduates) report more self-disclosure and more being touched by their fathers (older male)?

Some of the more recent studies reviewed in the next two sections about counsellors’ use of touch and clients’ perceptions of touch have used methods of interviews and questionnaires to attempt to capture the complexity of the relationship of touch in real therapeutic encounters. They have focused on the many interpersonal experiences that make up a therapeutic relationship in counselling. Thus the results of these studies are from less contrived environments than those of the earlier studies, and are perhaps more trustworthy.

**The Use of Touch by Counsellors**

I anticipated that my research about counsellors’ referrals to bodyworkers would need to consider the counsellors’ predispositions and beliefs about touching clients. The intention of the person touching is a factor in the appropriateness and effect of touch. Ideally it incorporates some dimension of intuition and unconditional positive regard, not unlike the attitudes emphasized in Rogerian counselling (Rogers, 1951). Those trained in counselling may or may not be unaware and untrained as to the quality of their touch. Touch has been described as therapeutic when it takes the form of three dimensional
shaping and is supportive, rather than a linear imposition, such as poking (Bartenieff & Lewis, 1980).

In a study of differences between therapists who touch and those who do not (Milakovitch, 1998), both professional and personal experiences with touch appeared to influence a therapist’s beliefs about touching clients. Telephone interviews based on a previously sent questionnaire were conducted with a group of 84 therapists. The group included equal numbers of humanistically and psychodynamically oriented therapists, plus those with “other” orientations.

Responses to the questions showed that if therapists had received permission to touch clients from teachers or supervisors, and if they had received body therapies or body-oriented psychotherapies, they were significantly more likely to use touch with their clients. Therapists who received touch in their own personal therapy and liked it were significantly more likely to touch their clients than those therapists who were never or rarely touched. Interestingly, just as many therapists who disliked the touch they received in their personal therapy touched clients as did not touch clients. Those therapists who reported having been sexually abused were both more likely to subscribe to humanistic theoretical orientations and more likely to touch their clients. Responses also revealed that therapists had differing beliefs about whether touch was beneficial to their clients. The author noted the importance of the therapist’s awareness of personal biases and how these biases might color the choice of interventions for clients.

Another study examined therapists’ self-reports of their decision-making process regarding the use of touch in psychotherapy (Clance & Petras, 1998). Therapists’
responses to questionnaires asking them to explain how they decided to touch or not touch their clients during therapy revealed therapists’ considerations of the following variables: clients’ ego strength, dynamics, body language and cues, needs, history regarding touch, time in therapy, and cultural norms. No norm or rule was apparent in the process, as each therapist appeared to use their own thinking and judgment about clients in the decisions they described.

**Touch as Perceived by Counselling Clients**

From the psychological counselling perspective, a few studies have been undertaken to explore the effects of warm and accepting physical contact by touch, which is nonerotic and appropriate for the client. Clinical observations (Wilson, 1982) have shown that specific types of clients in specific situations, such as schizophrenics, or parents who physically and emotionally neglect and abuse their children, may benefit from physical contact in psychotherapy. In addition, the experience of touch in psychotherapy has been explored from a quasi-experimental perspective in a factor analysis of the relationships between the clients' personalities and their experience of touch (Edwards, 1984). Despite limitations, a strength of this study was the identification of possible themes of the role of touch in personal growth groups.

The clients’ perspective of nonerotic touch in therapy was the subject of a phenomenological study (Geib, 1998). Interviews were done with ten relatively well-functioning Caucasian women who had been in at least ten months of psychodynamically oriented talk therapy with men, and had terminated therapy within two years of the interview. Responses revealed that touch has the power to create both therapeutic and
nontherapeutic outcomes.

Based on these clients’ reports, to be therapeutic, touch cannot be forced and needs to be congruent with the client’s needs and ability to accept it. To be therapeutic, touch cannot be experienced as needed or demanded by the therapist. Ongoing discussion of the limits and boundaries of the experience needs to occur. Touch needs to be congruent with the therapeutic relationship and sensitive to the client’s issues.

Client perceptions were explored further in a study (Horton, 1998) asking patients to evaluate their experiences of touch in non-body-oriented psychotherapies on a Likert scale. Positive evaluations of touch in therapy were explained by the congruence of touch with the client’s issues, the client’s perception of the therapist’s sensitivity to the client’s reaction to touch, and the client’s ability to communicate feelings about the therapist with the therapist.

Responses, which positively evaluated the experience of touch clustered around themes of touch creating a bond of safety and caring, communicating acceptance, and enhancing self-esteem. Patients reporting child sexual and/or physical abuse experienced touch as reparative of self-esteem, power, and trust.

A survey of clients about touch in Gestalt therapy (Imes, S., 1998) used a questionnaire given to selected Gestalt trainee therapists in therapy, individual clients, and group clients, who had been touched extensively, moderately, and minimally in therapy. The intention was to explore similarities and differences in their responses and to discover themes about touch that might emerge.
Responses showed a relationship between clients' desire for and responsiveness to touch and their experiences as children. The clients who received, according to their wishes, extensive use or minimal use of touch had experienced extensive abuse at an early age. Those clients who were moderately touched with beneficial effects had experienced trauma in the adolescent years. Through description and analysis of the study's responses and selected cases, the author emphasized that no one criterion determines the appropriateness of touch in therapy. Useful considerations are the client's childhood history, verbal and nonverbal cues, the developmental level at which the client is working, the client's current personal and professional functioning, the degree of dependence on the therapist, and the availability and use of support systems outside therapy.

**Body-oriented Psychotherapies**

From the bodywork perspective, anecdotal and theoretical accounts attest to the beneficial effects of bodywork or body-centered therapies, and attempt to isolate the therapeutic results of touch in connection with the client's psychological awareness (Conger, 1994; Maitland, 1995). Clients' experience of Reichian bodywork therapy was explored in a qualitative study that found high client satisfaction and suggested further exploration of bodywork psychotherapy (West, 1994).

Within the past ten years many books and experiential descriptive articles, as opposed to studies, have been written about therapeutic bodywork and the ways it can access and involve levels of emotion and the spiritual and human energy fields. A recent encyclopedic work, *The Future of the Body* by Michael Murphy (1992), described the
interconnection and metanormal potential of the mind and the body, and their integration with the transpersonal or spiritual, by summarizing the evolution and practice of many different modalities in those areas.

I anticipated that in my research, counsellors who are predisposed to refer their clients to bodywork would have some knowledge of body-oriented psychotherapies. Although not talk-focused, these therapies may involve verbal guidance and empathy. Some are more or less well-known and established than others. For example, the theories of Reich are often referred to in writings about the history of the body in psychotherapy (Smith, 1998). Reich’s belief that illness results from psychological and emotional trauma contributed to Lowen’s development of Bio-energetics, which works to free trapped energy through a combination of psychotherapy, breathing and releasing bodywork (Conger, 1994). Less well-known is a "bio-existential" therapy formulated by Dublin (1981), a combination of three approaches: the cognitive awareness of Transactional analysis, the "head-down" Gestalt approach, and the "body-up" Bio-energetic principles of Lowen.

The following summaries are a few examples of how the integration of body and mind is being acknowledged and accessed. As noted earlier, whether a somatic therapy is more verbal or more body oriented is not clear from the name and description alone. Its application depends on the training and orientation of the therapist.
These summaries are not intended as complete descriptions, endorsements, or evaluations. Not all the systems described below were mentioned by the participants in this study. Indeed, my participants sometimes named types of bodywork or movement therapies with which I was unfamiliar.

Kurtz (1990) developed the method of Hakomi Integrative Somatics, which views the body as a source about the unconscious mind.

In Hellerwork, a form of structural integration related to Rolfing which is a basic bodywork therapy that aims to free major segments of the body (Rolf, 1989), deep tissue manipulative techniques are combined with movement education and interactive dialogue about issues that may arise during treatment.

Bodynamics (Bernhardt, Bentzen, & Isaacs, 1996), developed by Lisbeth Marcher, is a somatic developmental psychology based on developmental psychomotor patterns that emphasizes working with body awareness as a central tool in strengthening ego functioning.

The Feldenkrais Method® develops awareness of feeling and doing through movement, to enable choice about opportunities for greater well-being in the bodymind.

In craniosacral work, and at a more advanced level, SomatoEmotional release (Upledger, 1990) the bodywork therapist uses gentle somatic work, dialogue, and therapeutic imagery to facilitate the client’s well-being and may guide the release of the emotions held in the client’s body from negative experiences.

Rubenfeld Synergy (Rubenfeld, 1988) integrates light touch with verbal expression to foster change through awareness, using a synergistic combination of techniques from the Alexander technique, the Feldenkrais Method® method, Gestalt practice, and Ericksonian hypnotherapy.

Jin Shin Do Bodymind Acupressure (Teeguarden, 1987), developed by psychotherapist Iona Teeguarden, combines gentle yet deep finger pressure on acupoints with verbal body focusing and emotional processing techniques to help release physical and emotional tension and armoring (Claire, 1995).

Polarity therapy (Stone, 1986), developed by Dr. Randolph Stone, a chiropractor, osteopath, and naturopath, uses gentle touch, counselling on diet, nutrition, and exercise, and psychological counselling, to restore energetic balance to mind and body.
Having reviewed some of the history and literature about touch, psychotherapy, and bodywork, I now turn to writings about the process of referral. Curious about reasons for referral among professionals, I anticipated that the process of referral among counsellors and bodyworkers might share some of the attributes and characteristics reflected in the following studies.

**The Process of Referral**

Ironically, the familiar dualistic notion of treating the mind and the body separately, and the professional wariness of overstepping the bounds of one’s practice, are two factors which support my research exploring the connection between talk therapists and bodywork therapists through the process of referring clients. Referral might be a moot point among practitioners trained and guided to practice with a more holistic perspective that viewed the unity of body/mind/spirit.

Even with professional training, however, which encompasses theories and techniques of skillful touch as well as those of psychological counselling (not to mention spiritual orientations), individual therapists are likely to specialize in accordance with theoretical orientations. For example, within transpersonal psychology, a more holistic perspective is endorsed, but approaches have different theoretical bases (Boorstein, 1996). With that said, and operating within the previous but still existing paradigm which has fostered specialists among the various modalities of talk and touch therapies, I will briefly review some of the literature on referral.

The following description of research literature about referral since 1987 shows
studies among 1) teachers, 2) medical doctors, 3) mental health workers, 4) the clergy, 5) supervisors, and 6) rehabilitation workers. Professionals usually refer individuals to other professionals based on a determination of the individual’s needs. This assessment may be based on standards defined by the profession, such as specific diagnoses or labels in the medical field, and/or be in accordance with the provider’s knowledge, skills, experience, and intuition about the individual’s condition. In addition, and of greater interest from a psychological viewpoint, are variables pertinent to the individual referred, such as ethnicity, gender and age, and characteristics of the person making the referral, such as perception of self-efficacy, or degree of responsibility.

**Teachers.** The influence of age, ethnicity, and gender on a teacher’s decision to refer students to school psychological assessment services were examined in a study of children from four to 18 years old suspected of having developmental or severe behavioral problems (Andrews, Wisniewski, & Mulick, 1997). Younger children were not referred at a disproportionate rate as compared to older children. African-American children were referred at a disproportionate rate for developmental issues, as compared with Caucasian children, and boys were referred more than girls for behavioral issues.

More experienced teachers selected referral more often than less experienced teachers in a study in which fifty-five teachers of 2nd to 4th grade were presented with 12 vignettes describing chronic, persistent classroom behavioral problems (Hughes, Barker, Kemenoff, & Hart, 1993). They were interviewed regarding their perceptions of causes of, control over, self-efficacy for resolving the problem, and choice of intervention. Generally, self-efficacy, perceptions of control, and attributions did not predict teachers’ decisions to seek consultation or to refer the child.
In another study of teacher referrals (Wilton, Cooper, & Glynn, 1987), referring versus nonreferring teachers were more likely to have made previous referrals, had better access to psychologists, were more confident of their ability to identify special needs of children, believed their school to be more encouraging of referrals, were more likely to have made use of special programs, and received more frequent visits from psychologists. Teachers with mildly mentally retarded children in their grade 2-5 classes responded to a study questionnaire about the teachers’ personal and professional characteristics. Of the group of 127 teachers, 53 had referred the children to the school psychological services.

Medical doctors. In a study regarding referral of depressed and anxious patients to mental illness services, 17 general practitioners and 10 psychiatrists from South Wales, U.K., were asked to make decisions based on information in 16 vignettes (Farmer & Griffiths, 1992). The information contained randomly assigned sex, psychiatric label, good or bad psychosocial context, and age, as well as eight different severity ratings of depression and anxiety symptoms. Both GPs and psychiatrists were influenced in their decision making by the severity of the illness, but the GPs alone were also strongly influenced by the presence of male gender and a psychiatric label. Good or bad psychosocial context had no influence on the GPs referral decision, and previous experience in psychiatry or other vocational training had no detectable effect.

A study in Finland examined the relationship between doctors’ willingness to refer patients between 65 and 85 years old for elective surgery, and patients’ age, comorbidity, institutionalization, living habits, and signs of dementia (Ryyanen, Myllykangas, Kinnunen, & Takala, 1997). Doctors who responded to a questionnaire containing 18 vignettes of imaginary patients were asked whether they would refer the
patient for elective surgery, treat the patient conservatively, or choose some other alternative. Responses showed less willingness to refer old patients for elective surgery, but co-morbidity, lifestyle, and institutionalization had a greater effect on referrals than age.

The time required for treatment was a distinctive factor in the referrals by general practitioners who returned questionnaires in a study regarding referral of patients with anxiety disorders and sexual dysfunction (Brown & Kent, 1992). Perceived responsibility for treatment was also a factor. Seventy percent of the variance in referral decisions for sexual dysfunction, but only 26 percent of the variance for anxiety disorders was accounted for by the variables of perceived expertise, time required for treatment, and confidence in agencies.

Mental health workers. The decisions of mental health clinicians in hospital psychiatric emergency settings to refer patients to inpatient care versus less restrictive alternative care was examined in a study of variables thought to predict disposition to alternative care (Segal, Watson, & Akutsu, 1996). Patients’ need for a controlled hospital setting, as indicated by the severity of their condition, was most important in determining the use of hospital alternatives. Quality of care, especially the clinician’s ability to engage patients in treatment at a level appropriate to their functioning, was also a significant predictor of whether alternative care was considered or used.

A study of social work clinicians at two urban psychiatric emergency services found that decisions to refer patients for hospitalization were influenced by the opinions of patients’ family and friends, suicidal ideation, and lack of social supports (Gillig,
Hilliard, Deddens, & Bell, 1990). Decisions to refer were not related to cognitive reactions and self-reported feelings, such as negative affect toward patients.

Clergy. Willingness to make mental health referrals, and the degree of confidence in handling issues of marital and family life, life adjustment, spiritual, moral, emotional, sexual problems, drug and alcohol abuse, and severe mental illness, were examined in a study of 115 Caucasian and 40 African-American clergy, aged 21-66+ years, from six denominations (Mannon & Crawford, 1996). By their responses to questionnaires, these clergy showed the most confidence in handling marital, family, life adjustment, emotional, spiritual, and moral issues, and least confident in handling severe mental illness. The African-American clergy reported significantly more confidence in counseling on all mental health issues except adjustment, spiritual, and moral issues. Clergy from larger congregations were more likely to refer than those from smaller congregations, and the conservative clergy, as defined by the study, were less likely to refer than liberal.

Supervisors. Referral of subordinates to an employee assistance program by students acting as hypothetical supervisors depended on the severity of the problem, in a study looking at substance abuse, AIDS, HIV, and job impairments (Gerstein & Duffey, 1992). The person with job impairments was referred less frequently than the person with substance abuse, HIV, or AIDS.

Rehabilitation workers. A study compared the impact of categorical labels versus functional limitations on rehabilitation professionals' referrals of clients for supported employment (Langford, Boas, Garner, & Stromer, 1994). Clients with a categorical label
such as mental retardation or traumatic brain injury were more likely to be referred than those diagnosed with epilepsy, hearing impairment, or no diagnosis.

Summary. Taken together, these studies about referral show that it may be examined from several perspectives: the characteristics of the person making the referral, and the condition and characteristics of the person referred. None of the studies I reviewed mentioned the relationship between the professionals, or the context of their communication before, during, and after the referral. Of interest in my research are the intra- and inter-personal characteristics of the counsellors who are predisposed to refer their clients to therapeutic bodyworkers, and the process by and context through which those referrals are made.
Chapter Three

Research Focus

My research focus was to discover from counsellors their process and experience of referring their clients to therapeutic bodyworkers, who use skillful touch to allow positive change to happen for clients. I was interested in exploring how they acquired their predisposition to make referrals, the issues, indications, and contraindications which led them to consider referrals of clients, the factors they attended to in the process of referral, how they selected the bodywork therapist to whom they made the referral, and their experience of the consequences of making the referral. The question assumed that each of these therapists, the counsellor and the bodyworker, was predisposed to acknowledge the validity of the other’s work, perhaps even considering each other’s work to be a necessary adjunct to their own. The question also anticipated that responses would include criteria for referral, perhaps describing client readiness or appropriate issues.

Methodology

This semi-structured interview study was open-ended with some focused questions. The qualitative paradigm was best suited for my question about the discovery, description, meaning and experience (Osborne, 1990a) for talk therapists of their referral process to bodywork therapists. The choice of methodology within the qualitative framework was guided by consideration of the basic research question being asked (Lock, Spirdieso, & Silverman, 1993), about counsellors’ experience of the characteristics of the referral process. Thus I have chosen to use the replicated case study
design as my methodology to explore the meanings and interpretations of the process as experienced by eight individuals.

I have written, below, about aspects of case study research and phenomenological research, because both are relevant to my research. Each therapist's story about how they refer clients to therapeutic bodywork is like a case study, and the process of referral may be seen as the phenomenon. My inquiry, however, is about the comparative contexts of the process of referral. It is not a single story, or case, and it is not a discrete event, or phenomenon. Thus, I see the multiple case design as a way to compare stories about process, combining aspects of case study research and phenomenological research.

The case study is an effective means of investigating phenomenon within its real-life context (Yin, 1994). Case study allows “an investigation to retain the holistic and meaningful characteristics of real-life events” (Yin, 1994, p. 3). “[A] case study becomes the opportunity to discover knowledge about how it is both specific and representative of a larger phenomenon. Its originality does not keep us from making comparisons, and its representativeness does not refer to a metasocial law, but to analytical categories” (Wieviorka, 1992, p. 170).

The multiple case design is a variation of the case study and is like multiple case experiments. With replication, similar results from multiple experiments or case studies are considered more compelling and robust than findings from a single experiment or case study (Yin, 1994).

According to Yin (1994), five important components of a case study research design are: 1) the study's questions; 2) its propositions, if any; 3) its unit of analysis; 4)
the logic linking the data to the propositions; and 5) the criteria for interpreting the findings. These components applied to this research in the following ways.

1) The question that guided this research sought to understand the talk therapist’s experience of the process of referral to bodywork therapists.

2) No formalized research propositions were used in this exploration. I am sensitized to the experience of referral, however, by my review of the literature, theories, and concepts, and my personal experience as a counsellor and bodyworker. Theories, models, and concepts are used “as sensitizing devices, rather than translating them into formalized propositions that are tested” (Vaughn, 1992, p. 196). These sensitizing instruments are “guides for looking that do not overwhelm the situational particularity of the circumstances, settings, or groups under study” (Harper, 1992, p. 141).

3) The primary units of analysis were the interviews. The intent of these individual interviews was to elicit interpretations, understandings, and meanings associated by talk therapists with this process of referral. Written transcriptions of the interviews were the database.

4) Without research propositions, the component of linking data to propositions does not pertain to this study.

5) Criteria for interpreting a case study’s findings are the least developed part of case study research (Yin, 1994). The primary purpose of this study was to explore the talk therapists’ experience of referral of clients to therapeutic
bodyworkers, and to explore the degree of commonality within this referral process. This study relied upon identification of themes among the interviews, their relation to existing research and writings, the impact of findings on the referral process, and implications for counselling and the integration of bodywork within the therapeutic process.

As noted earlier, by seeking to understand experience through the methodology of replicated case study, I was also within the realm of phenomenological methodology. Phenomenology, an exploratory method of inquiry (Osborne, 1990a), allows one to explore and gain a richer understanding of the phenomenon in question as experienced by the individual in the everyday world (Van Manen, 1994). Phenomenological research also requires that the investigator have the personality characteristics and skills used by counsellors (Osborne, 1990b), which I utilized in my research.

The application of touch within the counselling setting, although not wholeheartedly endorsed, has been acknowledged as beneficial and therapeutic. Likewise, some bodyworkers have acknowledged, witnessed, and fostered through various systems of application as described above, the potential for psychological healing that occurs through skillful touch, on or off the body. Yet the interface between the two professions has not received much attention. When little is known about a phenomenon, when gaps or omissions occur about what is known, or when aspects of a phenomenon are not easily quantified, the phenomenological approach is appropriate (Giorgi, 1985; Osborne, 1990b).

Change through talk and change through touch are two different therapeutic
modalities of psychological healing that are combined for the client who is referred by the counsellor to the bodyworker, and I sought to illuminate aspects of that process of referral. Thus, the research lent itself to exploration through the replicated case study method, to compare accounts of those therapists who are predisposed to refer their clients to therapeutic bodywork.

**Recruitment**

Participants were recruited through word-of-mouth. I described my criteria for participation to colleagues and talk therapists in the Vancouver community, and asked them for names counsellors who refer their clients to bodywork therapists. I contacted these potential participants, introduced myself, and described my intended study (Appendix A). I also discussed issues of confidentiality, explained the time commitment, offered to answer any questions they might have about the study, and decided if they were appropriate for the study. If the counsellor agreed to participate as my co-researcher, we set up a time for the first interview.

**Participants**

Participants in this study are referred to sometimes as co-researchers, because they were volunteers who had a personal interest in exploring the phenomenon in question (Osborne, 1990a). I interviewed eight co-researchers who had a desire to understand and explore their experience (Gall, Borg, & Gall, 1996), and were able to articulate it (Colaizzi, 1978). I stopped interviewing after the eighth counsellor because the themes that were emerging were similar.
Selection of the co-researchers was based on whether they fit the purpose of the study, a method known as purposeful sampling (Patton, 1990). Criteria for participation were that the participant have: 1) at least a Master’s degree in counselling, social work, or equivalent training and experience; 2) the predisposition to make referrals of clients to therapeutic bodyworkers; and, 3) the experience of having made at least one such referral within the past two years.

The requirement of a Master’s degree, or equivalent training and experience, allowed me to establish some sense of baseline education and qualification in counselling, recognizing that substantial differences exist within that baseline. The predisposition to refer was a criterion because I was interested in the process of making connections through referrals between these therapies for change. I did not include in my research those counsellors who were opposed to, or who had no idea about, therapeutic bodywork. The time of two years was selected as a way to allow the counsellor’s recollections and descriptions of their experience of referral to be fresh in their minds, and to allow for the possibility that over this time period they had processed the meaning of the experience.

I interviewed seven women and one man. The names of co-researchers used herein are pseudonyms, with the exception of Carol who wanted her name used. Alice was a colleague; Mary was an acquaintance of a colleague; Carol was a therapist for a friend; Sally was a facilitator for a group I was in; and, the other four participants, Joan, Laura, Sarah, and John, were suggested by a counsellor in response to my request for suggestions of therapists who met my criteria. The relevant backgrounds of my co-researchers are as follows.
Alice has a graduate degree in social work, has co-authored a book for therapists working with survivors of sexual abuse, practices healing touch, and has been counselling for over fifteen years. Carol and Sally have counselling psychology graduate degrees with extensive training and personal experience in systems of counselling which pay attention to the body, as well as massage, and have been counselling for over 20 years.

The four remaining women interviewed have a medical background, one in physiotherapy and three in nursing. Laura was a physiotherapist for over 15 years practices biofeedback, and has been counselling for over five years with a graduate degree in counselling psychology. Joan, one of the former nurses, has a counselling psychology graduate degree, practices Therapeutic Touch®, and has been counselling clients for over 15 years. Mary, another former nurse, who has been counselling clients for over ten years, has had extensive training in cognitive therapy and treatment of depression, and knows some massage therapy. Sarah, the third counsellor with a nursing background has had extensive social work training, experience with the Feldenkrais Method® system of bodywork, and has been counselling clients for over thirty years.

John has also been counselling clients for over thirty years. He has an eclectic background in many systems of counselling, a graduate degree, and training in different kinds of somatic experiential work. He is a trainer for Bodynamics.

**The Interview**

Through personal interviews I intended to identify the characteristics of the counselling therapist's referral to the bodywork therapist, to gather as much breadth and depth of detail as participants were capable of offering (Mishler, 1986). The interviews ranged in length from one to two hours, and took place either in the therapist’s office or
Participants read and signed an ethical consent form (Appendix B), and retained a copy. I reminded them that their participation was voluntary and that they could withdraw at any time. After the co-researcher had the opportunity to ask any questions about the study, I described its purpose. I reviewed with them my orientation, and expressed my excitement about and enthusiasm for learning about the integration of therapeutic bodywork and counselling through the process of referral. I established “empathic rapport” with each participant (Osborne, 1990a), and facilitated dialogue by telling my story, as related in the Personal Statement, above. Throughout the interview process I used attending, listening, paraphrasing, and empathy skills, as appropriate.

Rather than have a set of prepared inquiries, I invited co-researchers to respond to a general question about how they refer. I used additional questions as prompts and probes (Appendix C), knowing that I wanted to explore and hear about certain aspects of the referral process from my co-researchers. I wanted to know about the origin of their predisposition, their approach to and style of counselling, the kinds of clients and issues they consider referring to bodywork therapy, the kinds of bodywork to which they refer, their source of and relationship to people to whom they refer, and their perceived outcomes of the referrals. Further questions were useful to elicit additional information or to encourage a participant who had “run out of steam” (Osborne, 1990b, p. 81).

I found the interviews with the participants to be fascinating. I was intrigued by their stories of how they acquired the predisposition to attend to the bodymind. Their examples of cases in which clients were referred to therapeutic bodywork were
illuminating. Their descriptions of how they developed relationships with the bodywork therapists and their interface with them were instructive. Finally, although their philosophies of the therapeutic process contained similar views, each co-researcher had a unique way of expressing her or him self that gave a fresh perspective to the research. In addition, as a counsellor, I appreciated learning not only about my topic of study but about styles of counselling, ways of being in a therapeutic practice, and case formulation.

Early on in the course of doing the interviews, I learned from the co-researchers about two areas relevant to their process of referral not mentioned above. One was the degree of body awareness they brought to their clients within the counselling sessions, and the other was their vision about how they saw their counselling evolving into a more integrated practice with other kinds of therapies, including therapeutic bodywork. Thus I included these areas of inquiry, about body awareness in counselling and the vision of the future, in my research interviews.

One challenge for me during the interviews was to resist the temptation to engage in discussion about topics raised on which I had knowledge to add or to explain. To do so would distract from the intent of the interview which was to discuss the counsellor’s process of referral. For example, when a co-researcher voiced an opinion about the effectiveness of a certain bodywork system in which I have training, I resisted the urge to voice my opinion.

Another challenge was to know when to follow the co-researcher’s story, when to probe more deeply, and when to guide into a new area. I was attuned to the meanings the participants attached to their experience and the clients they described. Thus when I
wanted to hear more about something I would probe. Yet when the probing felt forced or seemed to muddy the waters for the participant, I let go of that particular issue, and followed the stream of narrative. Occasionally a co-researcher described in vague terms an experience that I nevertheless intuitively understood, despite the imprecision of language. Many times I realized I had to accept the description on those terms and not disrupt the flow of the co-researcher’s story, despite my curiosity to know more.

**Data Analysis**

I audiotaped the interviews and then transcribed the tapes verbatim. I kept process notes describing participants’ non-verbal responses, and salient thoughts that occurred to me during the course of the interview. Patton (1990) has indicated that while there are no universally accepted rules about how to conduct analyses of qualitative data, there are guidelines. A central concern is that the analysis reflects the experience. Several times I read each transcribed interview, referred to as a protocol, and listened to each tape, to get an overall sense of the participant’s experience.

I also wrote a brief commentary outlining my recollection of the process and meaning of referral within the context of each interview. This strengthened my grasp of individual accounts, shifted me to a level of abstraction, and facilitated the later comparative analysis.

I then summarized each interview, intending to include all material relevant to the process of referral and the counsellor’s predisposition to integrate body awareness within the therapeutic process. The summaries are included as Appendix D.
Reading the transcripts, listening to the tapes, and writing the summaries allowed me to familiarize myself with the content of the various responses. I formulated the meaning of significant statements and attempted to retain as much of the participant’s language as possible to allow the “data to speak for itself” (Colaizzi, 1978, p. 59). In this step the research is required to “leap from what {the} subjects say to what they mean” (Colaizzi, 1978, p. 59).

When I compared these statements, events, experiences, and meanings from each interview, themes emerged. To organize my thoughts in this cross-study analysis, I created matrices and meta-matrices of conditions supporting referral, as well as the obstacles and risks of referral, to become aware of the inter-relationships of these themes (Miles & Huberman, 1984). I also compared similar ingredients from each interview for similarity of impact on the referral process.

Through this process I identified commonalities in the process and meaning of referral. My purpose was to ascertain whether a common pattern or patterns of experience would be found across all or some of the co-researcher’s accounts. Throughout this process of analysis, I referred to the original protocols for validation.

Quantitative research, as opposed to qualitative research, depends on the scientific method and the idea of an objective reality. It is evaluated by examining reliability, the extent to which research results are replicated, and validity, the extent to which research is measuring what it is intended to measure. In qualitative research, which does not depend on an objective reality, these measures are irrelevant. “{H}ow we gain access to cultural knowledge and justify our trust in its truthfulness...are in different terms, the
issues of reliability and validity” (Harper, 1992, p. 147).

To be successful in illuminating the phenomenon it is necessary to abandon the desire for control and to tolerate some level of ambiguity (Colaizzi, 1978). Weber wrote that “in the social sciences we are concerned with psychological and intellectual phenomena the empathic understanding of which is naturally a problem of a specific type different type than from those which the schemes of the exact natural sciences in general can {solve} or seek to solve” (Shils & Finch, 1949, p. 74).

Reliability in qualitative phenomenological research such as this study depends upon whether the meanings generated from the experiences yield a sameness (Wertz, 1986) to which other counsellors who make such referrals can relate. Consistency depends on “trackable variability” (Krefting, 1990, p. 216), as detailed by the researcher.

Likewise, rather than judge the validity of the research by whether it is measuring what it intended to measure, I checked whether my analysis of the data adequately rendered the phenomena (Osborne, 1990b) by testing any existing hypotheses or assumptions against emergent themes and patterns. In a case study, “data gathering and analysis are simultaneous and we tend to develop hypotheses during all stages of our work” (Vaughn, 1992, p. 199). Thus, to increase trustworthiness when generating data from interviews required challenging my explanations of the data, and acknowledging the disconfirmatory information.

To check my interpretations I met with each participant for a validation interview, which lasted about an hour. I asked them to compare the summary of the transcript with their own experience to assure that my summary was trustworthy and comprehensive. I
also shared with them the common themes and some of the dissimilarities that had emerged in the interviews. Additional data or changes were incorporated into the final analysis.

For additional validation that my results were a faithful representation of the interviews, a colleague with a Master’s of Education degree in Counselling Psychology read my results and the interview summaries. I asked her to compare these writings and discuss with me her perceptions of whether the themes discussed in the results accurately reflected the substance of the interviews as described in the summaries. She confirmed that they did.

**Personal Assumptions**

My values and interpretations motivated my research and also colored my perspective of my findings. By making my values and assumptions explicit (Van Manen, 1994), I attempted to “bracket” them, to set them aside and see the phenomenon, in this case the process, as it is (Osborne, 1990a), rather than a projection of my personal views. To explicitly state the following assumptions has allowed me to understand that they are implicit throughout all aspects of the research (Colaizzi, 1978).

I believe self awareness is an ongoing process that leads to therapeutic change through greater choice about how to be in the world. Based on my experience as a therapeutic bodyworker, my transitions through various careers as described above in the Personal Statement, and my studies concerning the power of touch, I believe awareness of the self on potentially many levels occurs through the kinesthetic experience of touching and being touched. In my experience, awareness of the body gives access to
stored emotions, leads to a feeling of centeredness, and assists in making sense of one's thoughts, feelings, and actions. My assumptions are that self awareness is desirable and that bodywork and psychological counselling are ways to enhance awareness and promote therapeutic change.

My experience and knowledge about bodywork and counselling, and my personal belief about the interconnectedness of all things, led me to choose to talk with therapists who were predisposed to make referrals which aim to promote therapeutic change by enhancing the client's sense of self-efficacy and wholeness. I was interested in finding out more about these attitudinal predispositions, exploring the counselor's process of referral, discovering the meanings attached to it, and learning the types of presenting problems that occur.

I acknowledged that my interaction would affect the data. Furthermore, by engaging in qualitative research, I assumed that "objective reality" is not consistent, but is rather a social reality that is situational, transitory, and subjective, constructed by interpretations of individuals (Gall, Borg, & Gall, 1996). In addition, while continually monitoring my beliefs and biases regarding my research topic, I anticipated my lived experience would benefit this study in that “the knower had some fit with thing to be known,” sensitizing me to the therapists' accounts of their process of referral (Sandelowski, Davis, & Harris, 1989, p. 78).

**Limitations**

My biases were a limitation in this study. Although I attempted to be aware of my values, beliefs, and assumptions, they have been reflected in every aspect of how this
research is conducted, from the selection of the research focus and questions, to the categorizing of the data into themes.

The confidence I had in using the interview strategy depended upon the process of the results of the actual interviews, and the data analysis. In the interviews I remained open to the counsellors’ feedback about their understanding of my inquiry and whether the language of my questions conveyed my intention to elicit the information I needed, to discover patterns and themes about referral.

When aspects of the relationship between emotions and the somatic experience of kinesthetically based work are described, our language seems imprecise, and at times inadequate. We are attempting to connect and access the more nonverbal environment of the body with the mind’s articulation of feelings. I was confident that I grasped the counsellors’ sometimes subtle perceptions of the influence between mind and body (Dychtwald, 1977), because we shared respect for and experience of the power of therapeutic bodywork.

The predispositions of my co-researchers were likewise a limitation of this research. Participants were those who volunteered, met my criteria, were within a certain geographic location, and were contacted through my recruitment methods. I interviewed only as many as I felt were necessary to give sufficient breadth and depth to the process of referral. When I felt saturated with information that began to echo similar patterns, themes, and events, I ceased recruiting and interviewing.

Thus the results of my research cannot be generalized, because the participants, my co-researchers, were neither randomly selected nor of a large enough “sample size” to
be representative of the general population. Generalizability as defined in quantitative studies, however, does not apply in a phenomenological study (Heppner, Kivilighan, & Wampold, 1992), which emphasizes the uniqueness of experience that has been integrated (Krefting, 1990). Furthermore, understanding the therapists’ unique experiences of making referrals is not necessarily furthered by the tendency to generalize (Van Manen, 1994).
Chapter Four

Results

I learned from these eight counsellors that their predisposition to integrate body awareness with counselling, and to make referrals to bodywork therapists, developed from significant personal experience and feedback from others. I also learned that from these influences, my co-researchers developed a sense of respect for the power to heal within each individual. They thus encouraged clients to take more responsibility for caring for themselves, by paying attention to their bodymind.

Each of my co-researchers described how they integrate body awareness in counselling. Knowing the potential for psychological well-being afforded by therapeutic bodywork, some counsellors with whom I spoke with voiced a desire to learn to apply a system of therapeutic bodywork themselves. Each participant also described how they knew who to refer to, their relationship with the bodywork therapists to whom they referred, and some of the risks and concerns about such referral. They discussed the readiness of clients to benefit from such referral. Finally, my co-researchers shared with me their visions of their counselling practices.
Based on the foregoing salient aspects of the interviews, the description of results is divided into the following themes:

1) Influences of personal experience and feedback from others on the integration of body awareness with counselling; 2) Perceptions about clients’ readiness to be referred and issues appropriate for referral; 3) Relationships with the person to whom the client is referred; 4) Risks of making referrals to therapeutic bodywork; 5) Obstacles to receiving therapeutic bodywork; and, 6) Visions of integration of the therapeutic process.

**Influences of Personal Experience and Feedback from Others on the Integration of Body Awareness with Counselling**

**Personal experience.** Each therapist I interviewed expressed the opinion that emotions are stored in the body. For example, Alice said, “what’s going on for {clients} shows up in their bodies.” Carol commented “we hold in the body and we remember in the body.” Joan said that the body holds memories and “can be an incredibly efficient access point for healing.” Phrased another way, Laura said “the body is wise and can reveal what’s going on emotionally.”

The counsellors I interviewed came to this opinion and appreciated the power of paying attention to the body because of personally experiencing some kind of therapeutic bodywork. They not only valued, but considered essential, their ability to bring this personal experience to their clients in the therapeutic process. In addition, as noted below, several therapists stated their belief that with attention to the body, one is able to take more responsibility for his or her healing on emotional, spiritual, and physical levels.
Alice, who now does yoga, works out, and receives massage, stated that she brings to her clients the experience of her evolving trust with receiving bodywork. For four years she recovered from a whiplash injury with the help of craniosacral work, acupuncture, physical therapy, and massage, and learned to listen to and trust the feelings in her body. Personal experience of the work as a way to build the therapeutic relationship, by sharing its power with the client, was also cited by Mary, who had benefited during depression from therapeutic bodywork. Likewise, Carol credited her own process of deep experiential work with grounding her in her body and allowing her to be comfortable with her client’s processes. She advocated therapists being willing to experience any of the kinds of work they do with clients, including bodywork.

John said his early training in massage therapy left him feeling his body for the first time. He was amazed at the power in his hands. He said his later experience of deep wounding that occurred within a system of mind-body therapy affected his counselling greatly. It gave him respect for the power of bodywork, and sensitivity to assessing clients’ resources. John felt destabilized for many years, because of this deep body-centered work that grounded him but left him unprepared for the emotional connection. John said he is good at “putting people back together again who have been regressed for a long time” because of this intense personal experience, through which he became sick for about ten years and lost his spiritual and emotional connection.

Sally said she has personally experienced for her own growth the kinds of work she does with her clients, which include attention to the body. She described her ability to listen to clients from a very still and deep place within her body, an awareness she believes she learned from her mother’s listening to her. When her self-observation about
being grounded in this way is voiced to her clients, she said she becomes a model of how one may be aware of being connected to body, mind, and spirit. Thus, she teaches clients how it feels in the body to be centered, grounded, and taking responsibility for enhanced awareness.

Laura advised that personal experience has allowed her to trust the connection to the body and what it can reveal. She described receiving the diagnosis of a serious illness as a “wake-up” call. She said she then disregarded the medical opinion that she could do nothing about it. She paid attention to her body, which told her she was going in the wrong direction career-wise by getting sick. She took care of herself, received bodywork, revised her career plans, and recovered. That experience has helped her guide clients to find ways to access what’s going on for them. For Laura, the meaning of her work is to “get people to feel more in charge of their own health, and their own body, and understand that the psychological help and the physical help are inter-related... {Clients} have a lot to do with healing themselves.”

Joan stated that personal experience of bodywork has allowed her to trust in her sense of the bodyworker’s style, sense of intuition, and degree of gentleness, which has been important information for future referrals. Joan noted that she believes that the energy of the person who is the therapist impacts on how they apply whatever kind of work they do, including bodywork, that clients heal when they are ready, and that “there is a wisdom to healing.”

In her personal experience, Sarah said she has healed four back injuries over the years, with the benefit of craniosacral work and muscle energy techniques. She said she found disturbing the lack of attention to feelings in the medical world when she was a
nurse. She sensed the whole person needed to be attended to, and looked to social work and counselling as a more satisfying way to address her concerns. She said she is aware of her own process of aging and the importance of taking responsibility for her body and keeping fit. Thus, part of Sarah’s philosophy is to empower clients to take responsibility for their health and well-being. She has in her community therapists who do many kinds of bodywork that deal with more than just physical symptoms, and recommends them when she feels they would be responsive to a client’s needs.

Feedback from others. As described above, my co-researchers learned to pay attention to the interdependency of their feelings and their bodies from their personal experiences and the influence of therapeutic bodywork. According to the participants in this study, feedback from clients and other therapists has also guided them toward attention to the body in the therapeutic process, without which something was missing. For this reason, several participants have been motivated to train in some system of therapeutic bodywork. Others gravitated toward learning body-oriented psychotherapies, such as Bodydynamics.

For example, Alice reflected that initially she felt there was something empty in the work she did with survivors of trauma, but she couldn’t identify what was missing. In writing a book about healing the trauma of sexual abuse, Alice found she could not work with survivors in isolation with only talk therapy. She learned from colleagues about the healing touch therapy, an off-the-body, nurturing, focused scan of the client’s body, intended to energetically assess and clear blocked energies.

Alice noted specifically that feedback from clients in her group program for survivors allowed her to realize the importance of healing touch bodywork. Alice said she
ran the group and the women in it received healing touch from her co-facilitator. These women would relate their experience to the group. Alice said she could see “how differently they sat in their bodies, how much more body aware they were, and when they spoke, it wasn’t an intellectualization. It was really from the heart, from the soul, from the spirit.” She said that survivors of trauma require the body awareness component as well as the talk component since what’s going on for them shows up in their bodies.

Alice said having the bodywork component with the survivors’ group work speeded up the recovery process. She said the women were empowering themselves, getting off social assistance, getting trained in various skills, going on to get great jobs. Alice then felt compelled to get the healing touch training.

As a student nurse, Joan was influenced by a man who was dying of leukemia. He talked her through his dying process. She said she became fascinated with the psychology of illness in the body and the spiritual, mental, and emotional dimensions of healing. Her interest in the emotional impact of illness, the dying process, the grieving process, the pain, suffering, and anxiety, led Joan to study the energy-based practice of Therapeutic Touch®, an off-the-body modality that works with the client’s energy.

Sally has studied and applied Bodynamics in her practice, because using only talk therapy had a “ceiling effect’ and was incomplete. She said “the issues were happening in the body.” She realized the importance of involving the body in therapy when she first worked in the early 70’s with mothers from off the street, teaching them about life skills and parenting. Sally told the story of how she took some donated sewing machines, set them up on tables arranged in a circle, and taught these women how to sew little shorts, pants, and T-shirts for their children. Many of the women had never been near a sewing
machine before. While sewing, they would talk about different things, like parenting, relationships, poverty, and birth control. Sally said she realized how the activity of doing something while talking melted their defenses and allowed them to open up. They lost their sense of being defeated. Together, they created something and empowered each other.

Sally said she then became a child care worker with children from infancy through adolescence. She encountered issues of sexual abuse. She worked with play therapy, and again made use of the body. The clients, in their play, re-enacted the traumas repetitively until their minds and bodies were able to release them.

Laura related that meeting a psychiatrist who became her mentor when she was a physiotherapist expanded her awareness of how the mind and body influence each other. She worked in his multi-disciplinary clinic as a physiotherapist and they ran groups together until he retired in the mid-80’s.

When she was involved with movement and hands-on physiotherapy work, Laura found that clients would readily talk to her about issues such as trauma and abuse. Knowing that she wanted to learn how to handle that valuable information, which she knew was an important part of her clients’ healing, Laura was drawn to study counselling.

Integration of attention to the body within counselling. Each of the therapists I interviewed described how they integrate attention to the body in their counselling practice. They were careful to state that the degree of this integration depended on client readiness, which is discussed later in more detail. Their interventions have ranged from
talking about body sensations, to linking body and mind via body-oriented psychotherapy such as Bodydynamics, to actually applying a system of therapeutic bodywork.

As noted earlier, Alice, Joan, and Sally voiced a feeling of frustration in doing only “talk” therapy. They were motivated to acquire some training in bodywork or body-oriented psychotherapies. They wanted to provide that missing link for clients, to bring attention to the body into counselling and allow clients the maximum opportunity to recover and move on with their lives. John also uses therapeutic bodywork in his counselling. The ways these four therapists integrate their counselling and attention to the body are described below.

Alice, who works with women survivors of sexual abuse as well as other clientele, has now trained in and practices healing touch with some of her clients. She also asks clients to notice where in their bodies they are feeling, and to describe those feelings.

Joan said that she brings three approaches to her counselling practice, which is basically humanistic, integrative, and focused on people living with illness, or their family members. She does the talk therapy, works with imagery and the unconscious, and brings the Therapeutic Touch® into her sessions when appropriate.

For Sally, Bodydynamics has given her an awareness of how each muscle is related to a psychological developmental stage. Some muscles have either given up and become hypotonic, or have defended and become hypertonic, depending on how one’s early needs were met. As a counsellor who works with the body in her therapy, Sally said she works with getting those muscles to a healthy place psychologically, by letting go of defenses and/or strengthening the ego.
Sally said her office has a feeling of allowing attention to the body because of the presence of the mat she uses. Sally said she uses the mat to have the client work on regression issues or issues around shock or trauma. To incorporate the use of the body in therapy with families, Sally said she used sculpting and guided imagery. These were wonderful ways “to tap into the inside... to sense the body, {to be} able to stay with it and watch what happens and see how it turns, and stay connected.”

John is a trainer for Bodynamics, which he has used with clients. He also draws upon his eclectic background, which includes experience with craniosacral and Reichian work, EMDR, attention to the breath, and working with developmental trauma issues, family systems, and the client’s somatic experience.

The other four co-researchers, Carol, Laura, Mary, and Sarah, each have some experience with doing hands-on work, but do not incorporate it into their practice. They bring attention to the body in their counselling in the following ways.

In her work Carol has focused on being in the body, grounding, and feeling the connection to the earth in the body. She has brought attention to the body by doing guided visualization sensing awareness in each part of the body. She described that she works with the client to enhance body awareness. She asks the client to notice what’s going on, where in the body is that happening, and “could you put your hand there and just breathe into it, just close your eyes so you can go inside yourself.” Carol added that if a client has a difficulty with breathing, perhaps by always breathing shallowly, she will consider referring them to therapeutic bodywork because of its emphasis on breathing.

Carol has also worked with people in very physical ways, dong anger work on a mat, or moving with whatever feeling was happening Her work varies depending on the
client. She started with Gendlin’s (1981) “felt sense,” then moved into the Gestalt training and outlook, and has now evolved her own style. Carol said she is studying a system of body-integrated psychotherapy. Although she has trained in massage, she does not practice it with clients.

Like Carol, Laura said she asks her clients to notice what their body is feeling, what that may have to do with whatever else is going on, and what could it be trying to say. For mind-body relaxation she has taught them relaxation, referred them to tapes, and treated some clients with biofeedback. Another way Laura has found to combine the two, counselling and attention to the body, is in working with teenagers. To be active and do something with them is a way to access their feelings. For example, Laura told of seeing one teenage girl in her foster home. After refusing to talk in other environments, this client's feelings “poured out” after Laura got up on the trampoline with her.

Within the chronic pain clinic where Laura works, clients may benefit from the mind-body connections offered by an interdisciplinary team composed of a counsellor, a physiotherapist, a kinesiologist, and a physician, as part of a program sponsored by insurance companies. Laura described working with an anorexic client to help allow her to see her power and “get into her body.” This client will also have the benefit of the multi-disciplinary team at the clinic.

In ways similar to the other co-researchers, Mary described how she incorporates the body in her work. She said she encourages clients who only talk about their dissociation to sense that their bodies may have some of the answers they are searching for, and that their bodies remember even if they have no intellectual memory. She brings attention to the body through having the clients experience pressure points, art therapy,
and drawings of their bodies, and to notice where in their bodies their feelings are located.

Especially with her clients she intuitively perceives as blocked, as not at all “in their bodies,” Mary said she works with their body awareness, even though they struggle to protect themselves by asking for explanations and staying on an intellectual level. She said she finds she “talks about it more, far more than it’s ever followed through with” because most clients are overwhelmed with their healing on an intellectual level already. At times Mary has thought of doing the bodywork herself but is not sure whether that would be taking on too much to be able to properly integrate the two together.

Sarah pays attention to how people are in their bodies. “{S}ome people are just at home in their bodies. Other people are held in their bodies. It’s like they’re wearing a shirt that doesn’t quite fit and it holds them in a place.” “{I}f there’s something physical going on, I talk to those people quite directly about it, because if you can put it out, if they can literally see it then they can imagine that something could shift.” To begin with, she looks at the basics with clients, like whether they are getting enough sleep, exercise, and proper food, and having fun. She said she notices whether people are holding their issues superficially and how integrated they are in their bodies. Being superficial means wanting their needs met now, wanting to be fixed now. Sarah said she has trained in the Feldenkrais Method®, but does not apply it in her counselling.

Counsellors’ Perceptions about Clients’ Readiness to be Referred and Issues Appropriate for Referral

The counsellors I interviewed voiced their opinions about who benefits from receiving therapeutic bodywork, and how they know when to refer clients to it. They also
described the kinds of issues for which referral to and application of therapeutic bodywork is appropriate. The following summary of their views begins with the idea that everyone may benefit from bodywork, proceeds to explore the usefulness of bodywork when counsellors feel stuck, then discusses client readiness, and finally, relates the co-researchers' perceptions of client issues that are responsive to therapeutic bodywork.

**Everyone needs, but may not be ready for, therapeutic bodywork as part of the therapeutic process.** Laura said she believes that “touch is the thing that loosens people up.” Carol and Sally expressed their belief that everyone needs therapeutic bodywork of some sort, although they may not be ready to receive it. Carol said she feels all her clients may benefit from therapeutic bodywork, because “it’s so useful at times to have touch that can aid the letting go process.” Carol said she is interested in connections among the body, the mind, and the spirit, and described her work as body focused psychotherapy. She said her spiritual beliefs include a physical spirituality, about how we learn through our physical bodies and our connection to the earth. For Carol, the bodywork is about staying in the body, being present, and staying in contact with another person. She said she considers referring clients who are far along in their process of awareness to bodywork right away, because she knows they are open to it. She will respect a client’s decision to forego bodywork, but she may bring it up again and challenge the client if she feels the client is ready to benefit.

Sally said she has a basic belief that we all need bodywork in its broadest, most holistic sense. She noted that our culture has relegated and sanctioned the care of the body to the medical professionals. Sally said non-medical ways of attending to the body, such as the releasing and preventive aspects of craniosacral therapy, are often thought to
be peculiar things needed for only certain people. According to Sally, attention to the body not only helps work through specific issues such as trauma, but is essential for us all, because we all have basic developmental woundings to some degree. Sally’s belief about bodywork is not “who needs it” but “who is ready for it.”

Several therapists addressed whether men or women were more or less open to receiving bodywork. As described by the following comments from Mary, Alice, and Joan, client gender has not determined such openness, although it has affected one therapist’s comfort level in doing the therapeutic bodywork.

Mary doesn’t work with men, and said she could not generalize about their openness to touch. She concluded, however, that trusting oneself as a therapist and trusting the client are key factors to assessing someone’s openness to experiencing therapeutic bodywork. Alice recognized that she is less comfortable doing the healing touch with male clients, and is more inclined to refer them out for therapeutic bodywork or healing touch. Joan noted that among her clients, she found women no more or less willing than men to consider bodywork. No matter what their gender, they have all been through illness or the trauma of grief, which she sees as being catalysts for being quite open. Joan noted that her clients are dealing with death, illness, and tragedy. They may experience an urgency, and thus a willingness to experience bodywork, because their healing process has to speed up.

Referral when the counsellor feels the therapeutic process is “stuck.” Several counsellors described knowing that referral to some system of therapeutic bodywork was appropriate when they or the client seemed to be “stuck” in the therapeutic process. Feeling stuck meant being unable to move through feelings, when the counsellor’s usual
approaches were not enough to address and have the client explore the feelings associated with particular issues, such as abuse, trauma, or loss.

For example, Mary said referring a client to a bodyworker is appropriate when the client is aware of but can’t move into her feelings. Likewise, Laura noted that she makes referrals to bodyworkers when she’s blocked or stuck in working with a client, when she “can’t move them through” an issue because it is too painful to talk about, and perhaps related to abuse. She said she feels she would otherwise “need to use my hands to move them through,” but she does not do bodywork in her sessions.

Alice said when she referred clients out, she would do so when she felt stuck, and when the client was stuck, on an intellectual cerebral plane, without a connection to be able to process the trauma on a bodily level. Currently Alice doesn’t refer clients out for healing touch work, because she feels confident about doing it herself.

Like Alice, Joan said she considers referring the client to a hands-on therapeutic bodywork when she feels stuck in her work with the client. For example, she saw a client’s body react in a “very physical obvious way” as the counselling got close to some trauma locked up in the client’s body that was difficult to talk about. When she sensed that talk therapy was at a standstill, Joan referred this client to a bodyworker whose work Joan had experienced. At the same time she sensed that the client was fearful of bodywork, and might not allow herself to trust the process. Thus Joan questioned whether the client would follow through on the referral to bodywork. Indeed, this particular client did not follow through.

As a counsellor who does a lot of “mind-body work” John said he gets clients who have “done a lot of therapy and haven’t gotten where they want to go.” John
described these kinds of clients, who are often therapists of some sort themselves, as “already seekers,” and thus open to therapeutic bodywork of some sort. Other clients John sees within his body-mind-spirit counselling practice feel like they are stuck, although they are functioning very well. They want to do spiritual or meditative work, which may involve work with the body and breath. John acknowledged that he has seen clients move “to places he couldn’t seem to move [them] to” by working with other therapists in bodywork, such as craniosacral.

**Readiness to receive therapeutic bodywork.** Although a client may need bodywork, he or she may not be ready to even consider receiving therapeutic bodywork, let alone benefit from it. In general, my co-researchers felt that client readiness to follow through with referrals may increase and be encouraged as the therapeutic relationship develops over time with the counsellor who encourages body awareness.

Readiness includes the ability to handle the impact of the work. Although touch is extremely helpful with trauma or developmental deficits, John voiced concern that it can be risky if the client lacks “good adult resources.” Good adult resources to John means that the person can function in the world, has solid opinions, can make up their mind about things, and doesn’t regress or collapse for a long time if they get upset. In addition, while everyone has some childhood issues, according to John, those clients who also lack adult resources may feel abandoned easily. Thus he voiced caution about referring them out to too many places.

Likewise, Sally said that making the decision to refer a client to bodywork, like any intervention, depends her assessment of the client’s openness and readiness to hear it. She said, “I really see the referral as threaded into the therapy, because if it isn’t, you can
cause the client to withdraw.” Sally said she first assesses a client’s support system, then the client’s awareness of ways to self-care. “When you’re working with a client you may see an issue but you can’t go there unless you know the client has the resources and is open to it. So that’s the same with the body, any kind of body.”

Sally told some stories about clients’ readiness for considering other resources such as bodywork. One man from a family of medical doctors came to see Sally about anxiety. Sally said after she learned about his lifestyle, she asked if he had ever considered seeing an alternative health care provider. When he replied that he sees the doctor and that’s all he needs, she let it go, noting to him that if he ever became interested, she was aware of how other people with anxiety had benefited from consultation about their diet. After doing more work with Sally, this client had a flashback of some early trauma and she assisted him in working through it with some bodywork. When she then wondered aloud to him whether he suffered from allergies, and how allergies to foods can impact the body and the mind, he asked for a referral and she told him about a homeopath and a naturopath. Thus he was more open to hearing her referrals after gaining some trust and sense of safety with her.

Sally told about another client who followed Sally’s referral to see a craniosacral therapist, then stopped after a few times saying she got nothing out of it. This same client then went to a chiropractor to whom Sally had referred her. The chiropractor said to the client “I don’t think you want to be here.” When the client confirmed that she didn’t want to be there, the chiropractor said, “Well then, I can’t work with you.” The client then found another chiropractor on her own, and eventually went back to the craniosacral therapist, telling Sally that both were quite helpful. Thus, the seed was planted by Sally’s
suggestion at a time she perceived the client would be ready to benefit from the experience. The client, however, had her own timing, and the need to have a sense of control and responsibility, to be able to receive and appreciate the work.

Sarah described how she talks to those who are open about ways they could be touched. She described her way of being with clients as sitting with them and supporting them with whatever they’re doing, not being judgmental. She sits and listens. She said she believes we all have intuition. Some of us can speak from it and some of us can’t. She acknowledged that some people are not capable of being touched and are more suited to movement, such as walking, dance, or Tai Chi. Sarah said that she sees what the client is ready for, supports them to explore that, then lets them move at their pace.

Sarah recognized that if the client is not open to what the therapist is saying, they are not going to be open to her recommendations. With such clients, Sarah said, it takes a long time for them “to soften” and to be open. Unless they think it’s a good idea, they won’t follow through.” “I can’t be imposed from the outside...it can’t just be that their friend recommended them.” “You can spend hours and hours and hours asking people to do different things, whether it’s stretches or writing exercises or contemplation exercises...they just don’t do it unless they’re ready.”

When referring, Alice described how she would say to the client that working with a bodywork specialist might allow the client to be less intellectual and more connected to the traumatic experience. That connection might result in the client’s body becoming a less threatening place to be. In Alice’s experience with survivors of trauma, “the body is a very threatening place to be...and intellectualization is a very safe way to escape.” On the other hand, Alice perceived that some clients are ready from the very
first session, such as those who have been referred to her for healing touch. Alice said that, in addition, some clients seek out bodywork on their own and bring their experience of it into the sessions with her.

Laura noted that some bodywork systems, like Pilates, a gentle guided stretching, may be perceived as "a bit flaky." Thus the clients have to be quite open before she considers referring them to it. For clients who are less receptive to being touched, Laura recommends physiotherapy because it is more mainstream, therefore perhaps less threatening than other kinds of bodywork.

Mary described her approach as pragmatic and multi-disciplinary, taking cognitive therapy one step further. She helps the client to function better not only by changing their thinking, but by looking at core beliefs that are perpetuating the thoughts, to incorporate healing work at a deep level. She lets the client self-direct, either choosing "ten or 20 sessions to just feel better, or...do some of the process kind of work." She noted that most clients opt for the process work, what she called the healing part of the therapy. The process work for Mary is where referring to a therapeutic bodyworker fits, because the healing process may involve letting go of trauma, or other pain, and grieving, for which bodywork is appropriate.

The client's readiness for bodywork, according to Mary, relates to the time she spends in therapy. This readiness depends not only on a foundation of trust with Mary in the therapeutic relationship, but on having the experience of being in therapy for over one to two years, not simply for the "superficial" ten to 20 sessions. They would be in therapy "for quite awhile or have had a lot of raised consciousness about their own issues" before
they’d be open to the bodywork. Mary said, clients “who are more...self-actualized or at a higher level of consciousness...tend to be more open to the bodywork.”

**Issues that benefit from therapeutic bodywork.** My co-researchers had stories of particular issues that benefited from therapeutic bodywork, some of which have been alluded to, above. Those issues included abuse, trauma, lack of boundaries, need for receiving nurturing, chronic illness, pain, and grief. The following summary relates some additional examples of the counselors’ experiences.

With the integration of healing touch with counselling, Alice said she has seen trauma survivors “doing their recovery so much more quickly, and integrating it so much more, intellectualizing less, being able to work through the unfreezing of the trauma and making it liquid, moving it up and out through their heads, finding ways to... pull it to the outer corners of their bodies, so maybe the trauma occupies ...a fingertip or a small corner of the shoulder, instead of ...in the center of their bodies.”

Other needs for hands-on work are physical symptoms Laura senses may be related to abuse, such as headaches, abdominal pain, digestive problems, anxiety, or great distress. She said she knows when she has reached her limit, and “they need to go to something more nonverbal, more supportive, and gentle, and just work with that.” Laura refers clients for strength conditioning to Pilates, particularly if physiotherapy hasn’t worked. When there are physical symptoms from an accident, where the client is distrustful of the medical system, or fearful of moving, Laura said she refers clients to Pilates, craniosacral therapy, or massage. For gentle bodywork Laura makes referrals to Rosen work, which she said she has benefited from.
With women clients who were sexual abuse survivors, Carol said she has found the results of bodywork to be dramatic. Carol said she refers her clients for bodywork to various therapeutic bodyworkers, including her partner, who is a male therapeutic bodyworker. She said that to go to a male bodyworker is significant for many of her clients in their healing. For example, even survivors who had never experienced safe touch from a male, readily go to Carol’s partner, because they trust Carol deeply, and he is connected to her. Carol described the value of bodywork as “the healing into knowing that I own my body.” She said she will also recommend massage therapy as a basic physical intervention for someone with tight shoulders, if she feels it will be useful to the therapeutic process.

Carol described how one client worked with Carol’s partner on boundary issues. “{F}or a long time the work that he did with her consisted of her telling him where he could work and it would be her feet or her shoulders, and her saying ‘no’ after just a few minutes, ‘stop’, or ‘no’, and him stopping, and her breathing and deciding when she wanted the work to begin again...the message being that this is {her} body” and that she could pay attention to what was going on for her. According to Carol, the bodywork may also benefit clients who have issues around allowing themselves to be nurtured, to be taken care of, and to receive.

For some of Joan’s clients “to actually start to touch into the feeling realm” was an essential step “especially for people...who have shut down tightly for a long period of time...it feels like they’re so wound up.” Touch has been the doorway making it safe to “go and have a look in there and feel what’s happening.”
When Joan senses a client needs “incredible nurturing in a very quiet peaceful place” she may refer them to craniosacral work, a gentle soothing type of light touch that works with the cerebral-spinal fluid. For clients who want a cognitive understanding of the body, who may have a chronic physical condition that is impacting their psychological state, Joan said she refers to a physiotherapist who does acupuncture and craniosacral therapy, and is very good at explaining things.

Another example of a client Joan considered referring to therapeutic bodywork is a woman in her 70’s who has had two children die over the past 40 years. Her feelings are not readily accessed and Joan said she has become isolated in her body over the years. Joan described how “grief can solidify the body if it’s not worked through,” how the body gets very tight and very tense. She said this particular client wanted “a quick fix” but talking it out would probably take a long time. So Joan has done some relaxation work with her and assessed how she is with being touched by doing some touching and holding of her feet. Joan observed that with this light touch she “could see everything settling” in this client and “had a sense with her that it could be a route to her grief.”

Joan’s work also occurs with children, in children’s hospices, and with teens. Since Joan doesn’t know bodyworkers who work with children, other than a colleague who works does craniosacral work with infants, she doesn’t think to refer children to bodywork therapists. She speculated that kids would benefit from therapeutic bodywork because they are so body-oriented. She reflected on the readiness of teens to experience grieving through touch, as an access to emotions. She has noticed that teens who have someone die shut down emotionally for two or three years after the death. She described how she sees them as clients at the point where after having shut down, their life is totally
falling apart, they’ve got no direction, they don’t know what they’re doing and they don’t connect it to the death.

Joan described teens’ interest in imagery and relaxation, their longing for touch, and how touch was the grounding one teen needed. She said she hasn’t referred teens to bodywork because she feels she doesn’t have them for long. She doesn’t want to lose them. She feels teens aren’t into a long therapeutic process, so she just goes with what’s happening in the moment.

The Reiki method of bodywork is one that Mary has experienced and recommends to clients who need nurturing, because of its flow of love and a maternal kind of caring. She gave the example of a client whose mother was devouring rather than nurturing as someone she believed could benefit from Reiki.

Sally described how a client who had difficulty receiving from others and making connections went to a massage therapist on Sally’s recommendation. Sally saw that the client, who had borderline characteristics, was using the contact in the massage inappropriately. She would allow herself to feel connected only when she was there, she sexualized the contact, and she voiced that she was otherwise unlovable. Sally told the client that Sally could not work with her unless she stopped the massage therapy. The client became very angry, but reached out to her family and brought them into session with Sally. Thus the process of referral led to the therapeutic step of having the client make contact with her family. Sally noted that this experience showed that she needs to continually assess whether, and how, aspects of the work she does and the work done by referral are integrating therapeutically.
Sally told about a client who went into spiritual worlds quite easily as a defense. Consequently in the counselling they worked together on the client’s ability to focus on the day-to-day practical priorities. For this kind of client, Sally said she would recommend very physical bodywork, like a chiropractor, to have the client be able to feel her flesh and bones. Sally said she would not refer this kind of client to craniosacral therapy because that would take her into less-boundaried worlds.

**Summary.** Based on the foregoing description, the activity of referral to therapeutic bodyworkers, for these counsellors, entails an ongoing assessment of client readiness as well as an attunement to how the therapeutic process is proceeding. Interwoven with these perceptions are the participants’ knowledge about and experience with the issues that clients are addressing. Another consideration for the counsellor in making a referral is the relationship with the person to whom the client is referred, which is next discussed.

**Relationships with the Person to Whom the Client is Referred**

The counsellors I interviewed described the ways they knew therapists to whom they made referrals for bodywork, and the kinds of relationships they have had with those people. The following summarizes those descriptions.

Alice said when she first began to make referrals, she was not very active in the process. She would give her clients a name and let them follow up. Alice related that as time went on, she became more involved. She described how she would get a release from her client, then contact the bodywork specialist to describe some of the client’s challenges, and become more of an advocate for the client, to help them get what they needed. Referring to about ten years ago when she initially considered making a referral
for bodywork, Alice didn’t know the right questions to ask. She said that “in those days, there wasn’t a lot of separating out the various kinds of bodywork.”

Alice said that she would refer to people she heard about from colleagues. After taking the level two healing touch course, she began to make more contact with people doing therapeutic bodywork. As she became more involved in doing the healing touch bodywork, she became more discerning about what was being presented to her and might or might not be appropriate for her client. Alice added that now she is more aware, has worked and trained with, and knows people who do kinds of bodywork that have the psychological component. Several of these are healing touch therapists who are also counsellors, one is a bodyworker, and another is the nurse who facilitated the level two training.

Carol said she gets names from colleagues, and sometimes from clients, of bodyworkers who are comfortable with emotion being expressed, because if the bodywork therapist becomes distressed as well as the client, the work is ineffectual and the client may even feel shame. She is confident that her partner is an appropriate bodywork therapist for many of her clients.

Carol noted that at times she is present in the room with her partner doing the bodywork. Carol may do some hands-on to give a sense of grounding or holding energy, or voice some verbal reminders to the client. Carol related that she will often consult with her partner as well, with the client’s permission. She gave the example of a client she worked with for years, who learned to work through her body and with breath, and who now works more with Carol’s partner. She comes back to Carol “when something big is going on.”
Other than her partner, Carol mentioned making referrals to a Rosen worker, a person who does breath work, and a yoga teacher who gives each person specialized attention. Carol refers clients to therapists whom she knows to be sensitive to the emotional and spiritual aspects.

Carol said the contact she makes with bodyworkers on behalf of the client varies, depending on the client's needs. Sometimes she just suggests that the client call the bodyworker. Other times she asks if the client would like Carol to call first. She said, “I don’t take on what I don’t have to take on for someone but in some cases…it can be a bridge and a comfort to someone and help them make that step.”

The people to whom John makes referral for body-centered psychotherapy are trained in counselling, with added skills in Bodynamics. Within his extensive network of colleagues, John may refer to people he has trained in Bodynamics or other somatic education. Whenever he refers, John said he makes a judgment about not only the client’s needs, but what the bodywork therapist has to offer. He usually knows that therapist from being their supervisor or counsellor.

John said when he is not accepting new clients, people consult him about whom to go to, either because they want to see him as clients, or they are therapists who want to refer their clients to him. When referring someone who wants to be a client, he said he considers what the client says is needed and tries to find a match with a body-centered therapist, in terms of appropriate style, age, gender, and personality. In advising a therapist about a referral for a client, he described finding out what the therapist thinks might be beneficial for the client, and often re-shaping her or his thinking about what might be needed.
When he makes a referral to another therapist, John said he usually has the client call directly. Later John will ask the client what happened. He will talk to the other therapist if anything unusual comes up. On the other hand, if the client does not have a lot of awareness about their body, other than athletic training, John will get their permission and call the person to whom he has made the referral. He will establish a relationship with them to find out their perception of what is going on with the client, because the client’s perspective may be that “nothing happened.”

John noted the different ways some people combine the work with the mind and the body. Someone who might seem to work primarily with the body, such as an osteopath, chiropractor, physiotherapist, massage therapist, or a person doing the Feldenkrais Method®, Rolfing®, Aston patterning®, or Alexander work, may actually focus more on the psyche than the body. Thus, one who refers would be wise to know the emphasis of the person’s work to whom they refer, and not rely only on a name.

John said he does psycho-spiritual work within different philosophies and spiritual disciplines. John said the relationships among his clients and him may be multi-layered because of his involvement with supervision and administration of Bodynamics training. For example, one of John’s clients may have been referred to John by a therapist who is also John’s client; or John may refer one of his clients to a therapist who is also John’s client. Thus John’s waiting room may be filled with people in dual relationships. To handle these dual relationships, according to John, “people have to have a reasonably mature sense of their ego function boundaries.”

John voiced concern about the dilemma of perceiving issues for a person, that the person may not be aware of or ready to hear, when he is not able to take them as clients
for a period of time long enough to do the work he sees is needed. He wondered what to say, and how much his referral needs to take into account those perceptions.

Laura described the bodywork therapists she refers to as people she knows well, whose work she has experienced. She described how she tells the client that she has benefited from seeing a bodyworker and wonders whether the client would also find it beneficial.

Clients will go off and see the bodyworker without coming back to see Laura, or see them both concurrently. Laura also said the bodyworker will send clients to her as well. Usually the client is responsible for "bridging" the two therapies, because Laura doesn't usually talk back and forth with the bodyworker. If they do such a consultation, Laura gets the client's permission.

The bodywork therapists to whom Mary refers are, she said, thrilled to have the recognition and support of other therapists as evidence by those referrals. They appreciate being acknowledged and incorporated in the therapeutic process.

Mary described as ideal the situation where the client is seeing Mary and the bodywork therapist in parallel, because the client can talk about her issues and also have the experience of feeling in her body. She mentioned that this ideal is, however, potentially financially impossible for clients. Usually Mary does not talk to or consult with the bodywork therapist; she lets the client be the bridge.

In Joan's experience, she considers whether the bodywork therapy for the client will be an adjunct, in parallel with the counselling she does, or be a shift or switch from Joan to the bodyworker. Joan said she has also built up her knowledge by hearing feedback from her clients. A name may keep coming up in relation to a certain kind of
bodywork and its results. A craniosacral therapist to whom Joan makes referrals is part of a team with whom Joan runs retreats for people with cancer. The team helps provide emotional, physical, and spiritual support. Ideally, she would like to expand these retreats to families, and to include more integration of the emotional and spiritual with the physical.

When making a referral Joan said she calls the person to whom she has referred and, with the client’s permission, describes the context and discusses whether the bodyworker is interested in working with this client. Joan said making that contact, that bridge, is important to her. She doesn’t see it happening much in the community, among different kinds of therapists. Joan said “We have to be...gatekeepers...do some of the research...When you’re really vulnerable you need help to sort it out, to see who’s ok and who isn’t.” She added “I think we do have a job to...talk to each other more and find out who’s out there and who fits with my philosophy as a therapist so then I feel confident to say to my client, I really think this person will be able to help you...If I can give confidence to that process I think {we’re} off to a good start.”

Joan described from among the broad range of styles of bodywork how scary it is for her to think of referring clients who she has prepared for the “the next step,” to someone “out of the phonebook” with whom she has no personal relationship or experience. Without such personal contact, Joan finds it difficult to know the bodyworker’s background, theoretical framework, and how they actually work with a client. Joan usually goes to a bodywork therapist to check it out:” so she knows “what I’m referring to.”
Also, Joan said one finds that not many bodyworkers are comfortable working with the very ill, and that she sees a need for that. She described the bodyworkers to whom she refers as those "who really have an understanding of gentle work" for clients who need the simple "soothing comfort of having someone touch {their} body...that's full of disease, that's maybe got parts missing...or {that} they just feel awful about." For some clients who are chronically ill, the traditional massage practitioner offers too much energy and is too intense. In her network of people Joan has found some registered massage therapists who have "a certain way of being that I trust" even though massage therapy is usually very physical and more medically oriented than the gentle Rosen method.

Having been in the community for 30 years, Sarah said she has a lot of people in her friendship circle and in her collegial circle, with whom she can consult, find support, and question about her perceptions of clients' needs and her referrals for them. Sarah said she finds that her colleagues are glad to answer and to respond to questions. She said that after making the referral she doesn't talk to or consult with the person to whom she refers the client. With any referral, Sarah said she knows what's out there and what works for her, but needs to know what's going to work for the client, to meet the client's needs. Sarah said she keeps lists of people in her network but never refers to the lists. She trusts that she knows what she needs to know at any particular moment. "I don't ever forget anything that I need to remember right now."

To find out about other caregivers, including bodyworkers, Sally said she has a wide network of friends and colleagues. She has studied what their strengths are, and asked them what resources work for them. For example, Sally asked a friend what she
had been doing because she appeared to have been transformed. The friend then
described Pilates work to her, and Sally said she took careful note. She does the same
interested inquiry with clients who show a transformation in their personal growth
through therapeutic work they have experienced, in addition to the counselling with Sally.

Sally’s consultation with the bodywork therapist to whom she refers depends on
whether the client needs that to be a part of the process. She may make suggestions for
craniosacral therapy, pressure point work, or massage therapy from therapists who are
familiar with releasing the tension rather than massaging it back into the body. She also
refers clients to Pilates, neuromuscular therapy, or physiotherapists, as well as
naturopaths and homeopaths.

**Risks of Making Referrals to Therapeutic Bodywork**

*Competency of the person to whom one refers.* None of my co-researchers
mentioned specifically the risk of sexual misconduct or the qualification of licensure or
certification in discussing referrals to therapeutic bodyworkers. Yet they did express
concern with certain characteristics of the therapeutic bodyworker, such as humility vs.
dominant ego, mutual respect vs. dishonoring, and skill and ability vs. inadequate training
and inability. The following descriptions address these concerns, which in general are
about the competency of the person to whom one refers, as well as the respect one has for
the process.

Joan said she wants to refer to bodyworkers who have a similar philosophy about
healing. She said she hesitates to refer to people who think they are healing other people,
because their egos get in the way. She described her view by saying, “I trust that you can heal and that makes me a healer but you’re the one that does the healing.” She said she finds it scary that there isn’t more care and respect for the individual’s healing process. She doesn’t relate to those in the psychological community or the bodywork community whose egos dominate their work.

Sally emphasized that not only is it important for her to know about the person and the work to whom she is referring, but she also must be sure that her work is honored and respected by those to whom she refers. Sally related the experience of her work not being honored. She said she referred a client to a well-regarded homeopath. The client returned to Sally upset, saying the homeopath had told her to stop seeing the therapist, i.e., Sally. Sally cautioned that an earlier wounding may be re-opened for the client, because of the possible triangulation among the client, Sally, and the other therapist. For example, the client may become like the child, in the middle of the two therapists who are like the two parents against each other.

Thus, Sally said when she hears a client speak about one of their other caregivers, she is careful to honor that relationship. For example, if the client says that the chiropractor didn’t see what Sally said she saw in the client’s body, Sally will say to the client, “Oh, now you were given two opinions. Here’s an opportunity for you to really be the center and get a real sense of which one fits, or do they both fit, or do neither of them fit.” According to Sally, addressing the apparently different opinions becomes part of the client’s therapeutic process.

Despite hearing from her colleagues ten years ago that her clients would benefit from bodywork, Alice felt resistant to training in any system herself because she thought
it was a "flaky, on the edge way of working." As noted earlier, Alice perceived a lack of
distinction among different kinds bodywork, and she said she didn’t know the right
questions to ask. With her experience in healing touch she has become more discerning
and knows more people who do kinds of bodywork that have the psychological
component. She believes some bodywork systems, such as healing touch, have become
more refined and their training more rigorous in the past few years. Thus she is less
hesitant about considering their appropriateness for her clients.

John noted that some bodywork systems struggle with legitimacy and may be
perceived as flaky. He said the practitioners are not necessarily flaky but may be
uninformed and not know what they are doing. He voiced excitement about the creation
of standards, safety, theory, and legitimacy that is starting to manifest in some systems,
like Bodynamics. John said he chose to study the Bodynamics system because he felt it
was the one bodywork system tied most closely to existing theory. He also noted the
recent groundswell of interest in body-oriented psychotherapy. He voiced apprehension
about the lack of clear protocols in some systems. He said the work is so powerful, the
possibility for people to be hurt exists unless the practitioners know what they are doing.

The risk of a therapeutic setback because of the existence of a gap between the
psychological work and the bodywork. Alice related feeling a wonderful sense of release
with receiving massage therapy. She was aware, however, that the practitioner was only
beginning her training in the psychological perspective of bodywork. Therefore, Alice
said she hesitated to disclose her feelings during the massage. Alice has recognized that
this gap, between having the bodywork available but not the psychological therapeutic
component, also exists for clients, and may cause a therapeutic setback.
Alice related that clients expressed dissatisfaction because of the gap— the 
bodywork therapist could help the client identify the trauma but not necessarily work it 
through. "They had part of what the client needed and I had part of what the client 
needed but there was still that gap in between those two parts... that bridge piece was 
missing, so I really knew when they were coming back and they weren’t completely 
satisfied with the intervention." Alice added, "they might have even experienced perhaps 
some further trauma around being touched and not feeling... quite ready to be touched in 
terms of how that massage therapist or how that bodywork specialist might have touched 
them."

Alice described her disappointment when she first started to refer. She would tell 
the client that "you might be ready for that body component now... we’re at a point where 
we can’t go any further until you explore how you’re holding the trauma in your body.” 
Then the bodyworker would lack the sensitivity or awareness of how trauma survivors 
respond to touch. Alice said that for some of her clients, the experience was like a re-
victimization.

Joan also voiced concern that the referral would result in a setback for the client 
because of the possibility that the necessary trust and rapport may not have a chance to 
develop with the person to whom the client is referred. For example, with one client Joan 
has sensed a readiness for the bodywork but wonders whether the switch to another 
therapist, in this case a bodywork therapist, would be like starting over. Joan noticed the 
risk of creating a gap in the therapeutic process by a referral, even to someone with 
whom Joan has a personal relationship, and who Joan felt was “the right person.” She 
questioned whether it was feasible to expect a client who had a relationship of trust with
Joan to make the switch to another practitioner, even when that practitioner was trusted by Joan. To avoid that gap in the therapeutic process Joan mentioned that sometimes she wondered if she “needs to go and get those skills” in bodywork.

**Obstacles to Receiving Bodywork**

My discussions with my co-researchers revealed that clients may not follow through on the referrals to therapeutic bodywork for a variety of reasons, some of which relate to readiness, addressed earlier. As an obstacle, their lack of readiness, which keeps them from receiving the work, may show up as an inability to make the time for it, or to accept that it is worthwhile. They may not trust that the therapy to which they are referred is credible. They may not be comfortable with touch or off-the-body techniques. They may not have the financial resources, or be unwilling to pay for therapeutic bodywork even if they are able to afford it. Their counselling may be funded by a third-party, and therefore limited in time and content. The following summary describes the counsellors views about some of these obstacles that keep clients from going ahead with the referrals to therapeutic bodywork.

Alice said that in her experience although money may be an obstacle to accessing the therapeutic bodywork, people will find creative ways to do it if the motivation is there. Alice noted that other obstacles to receiving the bodywork are apprehension about being touched, or a perception that the bodyworker is flaky or not credible. Alice said in the last few years, because of her healing touch training and seeing clients achieve successful results, she has sensed that therapeutic bodywork has acquired greater credibility.
Since John doesn't do any insurance work, his clients are generally financially resourceful and able to afford to pay for other therapists. Even when a client could afford other therapies, however, he was unable to follow through because of family pressure. For this client John had used a lot of his own resources and skills. He wanted this client to go out and experience work from other therapists, however, for a new perspective as well as added benefit, and to lessen the client's tendency to become fixated on coming to John for everything. This particular client, however, faced pressure from his family, to spend less time going out for different therapies. Thus the challenge John described is one where he wanted to refer the client out to “people who could help in some of the areas {the client} needs to be helped more than I can. However I can't get him to go without throwing the balance out of the system.”

Mary said she finds many of her clients stay on an intellectual level. Their resistance to bodywork may come from the work being too subtle. They are perfectionists even in their healing and want results immediately. They ask when will they notice the effects of the bodywork. Through education and coaching she encourages clients to realize that bodywork doesn't work that way, that the work takes time and that their bodies will respond when they are ready.

For Laura, clients who are resistant to bodywork often need to be educated about how they deserve to spend time and money on themselves. In her private practice, clients have to be able to afford to follow through on her referrals to therapeutic bodywork. Therefore they may have to choose to do one or the other and may shift back and forth from one week to the next. Laura has found that because of the cost, her private clients see her about six sessions, although they may come back at some later time.
Laura noted that for one to go on one’s own to the clinic would be almost impossible financially, particularly if they’d been out of work for awhile. Not only are there financial limitations for clients who pay with their own resources, but there are also constraints around the number of sessions provided by an insurance plan. Laura voiced the sense that this restriction of time makes her reluctant to expand her counselling into areas other than talk, such as movement, touch, or experiential modalities.

In the future Laura wants to apply hands-on therapeutic bodywork in the context of psychological counselling, but she feels uncertain about how to make it congruent with the counselling. She said “if I started doing physio under the guise of being a counsellor, I think it would be too threatening.” It would be unexpected and therefore not feel safe to the client. According to Laura, physiotherapy itself is directive and non-threatening and clients feel safe in talking to physiotherapists more than counsellors, because their verbal defenses are less engaged when they are being touched within the context of the physiotherapist’s directive and expertise. In addition, if their pain is somehow too psychologically linked, the clients who have been sent by a third party for treatment are at risk for not receiving benefits, or and feeling like they are crazy because their pain is not physically “real.” Thus, the context within which the client is receiving counselling may inhibit the application and beneficial effects of therapeutic bodywork.

Sarah said she often works together with the client to help them create whatever they need in terms of other kinds of therapies, such as bodywork. Sarah said many of the resources that have a bodywork component are not necessarily financially impossible, and available in community centers. She named various psychophysical movement and exercise methods, such as yoga, Tai Chi, Aikido, and the Feldenkrais Method®. She
observed that other clients have their own programs. Some are very resourceful and
ecclectic on their own after seeing Sarah for a long time, and only come back to her in
moments of crisis.

**Visions for Integration of the Therapeutic Process**

Some counsellors voiced a desire for a more integrated therapeutic practice, either
within their own counselling sessions, or with a team. As noted above, several
participants are currently practicing within a multi-disciplinary setting. The following
describes the visions that were expressed by some of the co-researchers.

Alice said her vision is to be able to facilitate groups and provide the therapeutic
bodywork component. In addition she would like to integrate her own approach more and
take additional training in healing touch or other therapeutic bodywork.

Mary voiced her philosophy that she trusts that women have a lot to offer each
other. She has a vision of building that trust with other women, like “in the old village
days, when kids would be with grandma, auntie.”

As noted above, Joan is currently involved with a multidisciplinary team of
professionals that design and implement retreats for cancer patients and their families,
She mentioned wanting to expand that and make it more accessible to clients with other
issues.

Carol noted that she and her partner are studying Integrative Body Psychotherapy,
an eclectic therapy that comes out of object relations and Gestalt therapy. Breath and
grounding are seen as the basic resources for the core self to expand. Carol also described
being involved as a therapist with a team of practitioners, including two medical doctors,
a naturopath, an acupuncturist and Chinese herbal doctor, a bodyworker, a yoga teacher,
and a hypnotherapist, set up to take clients through a week-long program. The focus has been cancer patients and their families, but eventually the resource will be open to anyone. The vision includes prevention of disease as well, on emotional, spiritual, and physical levels. According to Carol, the team shares the belief that the power of healing includes attention to nature and to the body.

Laura’s vision, given unlimited financial resources, is to work in an environment that allows her to integrate the talk and the hands-on, with a garden, music, art, animals, bodywork therapists, and space for movement. Similarly, Sally said her vision is to join with other professionals in a clinic “in a place in nature.” The group would include a chiropractor, a physiotherapist, a naturopath, a bodywork therapist, and others who are specialists in developmental issues. These practitioners would support each other and work in a holistic way, appreciating their uniqueness, their common philosophy, and the ways in which their resources can be complementary.

Overall, the results of my research gave my co-researchers insight into their own referral process. The results also provide a frame of reference for counsellors about how to refer clients to bodyworkers, and are an indirect resource for clients interested in their own process of change and growth.
Chapter Five

Discussion

Based on the foregoing results, the interviews with my co-researchers confirmed the research literature’s endorsement of the significance of appropriate touch to psychological well-being (Montagu, 1986; Older, 1982). Since this study was not about therapists’ use of touch or its effect on clients, the results do not directly relate to the issues raised in the literature around casual touch and self-disclosure. They lend support, however, to the general concept that touch may bypass some of the client’s “usual” defenses (Kepner, 1987), and allow more powerful reactions (Macnaughton, Bentzen & Jarlnaes, 1997). Significant, also, was each participant’s appreciation of the power of body awareness to access stored emotion (Kurtz, 1990; Maitland, 1995) and to experience sensations in the present (Perls, 1969).

The Role of Personal Experience in the Predisposition to Refer

The interviews showed that the predisposition to refer clients to therapeutic bodywork is connected to the desire to bring body awareness into the therapeutic process. This desire, in turn, comes from the counsellors’ experience in receiving skillful touch or witnessing its powerful effects on others. The impact of receiving or witnessing the effects of skillful touch is tangentially related to the study by Milakovitch (1998), where counsellors who have received body therapy or body-oriented psychotherapy used casual touch more in their practice than those who did not have such experience.

Thus, personal experience of the counsellors was the foundation for the value they placed on body awareness and their consequent interest in therapeutic bodywork. They expressed the belief that body awareness needs to be part of the therapeutic process,
whether through talk in counselling, application of systems of therapeutic bodywork in
counselling, or referral to therapeutic bodywork.

**The Integration of Therapeutic Bodywork and its Relationship to Referral**

To bring somatic experience into counselling, by work with the body that is
intentional and skillful, requires a clear sense of boundaries and preferably some training
in application and supervision (Macnaughton, Bentzen, & Jarlnaes, 1997). This
perception is in keeping with the previously noted study by Geib (1998), emphasizing
that from the client’s perspective, even casual touch needs to be congruent with the
therapeutic relationship and sensitive to the client’s issues. As anticipated, some co-
researchers had knowledge of, and applied, body-oriented psychotherapies (Conger,
1994; Epstein & Altma, 1994), such as Bodydynamics, within their counselling sessions.

One participant, Laura, who was a physiotherapist wondered how she might
combine physical bodywork, such as physiotherapy, massage, or some other skillful
hands-on touch, in a counselling setting, and have it feel appropriate and non-threatening.
Another participant, Mary, said she thought of doing the bodywork herself, but wondered
whether she would be taking on too much to properly integrate it with counselling. The
basic concern voiced by these co-researchers was that if the client’s trust was lost because
the use of therapeutic bodywork within counselling did not feel safe, the opportunity to
facilitate healing was also lost.

Without a clear protocol and confident understanding of how to make the work
feel safe for the client, even counsellors who bring to their clients the invitation to
become more aware of their bodymind, and who facilitate body awareness for
psychological well-being, may feel reluctant to apply actual hands-on bodywork. None of
my co-researchers, except for one who used craniosacral work in his sessions, reported doing very physical hands-on therapeutic bodywork within the same session as counselling. The one exception, John, expressed a sensitivity to the power of the hands-on work, and has over thirty years experience in the fields of somatic education, several systems of therapeutic bodywork, and counselling.

Another co-researcher, Carol, whose partner is a therapeutic bodyworker, has training in massage but does not use it in her counselling sessions. She has not brought the actual hands-on work into her sessions because of the close working relationship she has with her partner. As noted, she mentioned that at times, she has been with her partner in the session, with the client receiving therapeutic bodywork from him and counselling from her.

Two participants, Alice and Joan, have applied, within their counselling sessions, systems of very gentle bodywork, namely, Therapeutic Touch® and healing touch. Notably, however, these two systems involve subtle work, and address energetic flow. In the counselling sessions the Therapeutic Touch® and healing touch were reportedly applied primarily "off-the-body," with perhaps some gentle holding, at the feet for example, depending on the client's readiness.

Thus, Alice and Joan had neither the training for more physical hands-on bodywork, nor the close relationship with a bodyworker that would allow them to integrate themselves into the process. By learning to apply therapeutic work off-the-body, they came one step closer to the integration of both talk and bodywork in the counselling setting in ways that felt safe and appropriate. Referral out has remained necessary for the therapeutic work that one cannot, and ethically should not, do.
Counsellors’ Respect for the Collaborative Therapeutic Process

Fundamental to the process of referral was the counsellors’ respect for the therapeutic process and consequent deep level of caring about the nature of the referral of the client to another therapist, in this case, a bodywork therapist. The foregoing discussion about the appropriateness of bringing bodywork into the counselling session reflects aspects of this respect and caring. Further support for the co-researchers’ respect and caring emerged particularly within the three themes of: 1) the relationship with the person to whom the client is referred; 2) client readiness; and 3) risks of referral.

These three aspects of referral are not specifically reflected in the literature I reviewed about referral among professionals. To me this suggests that my co-researchers displayed a unique regard for the integrity of the therapeutic process for their clients, and a desire to allow that process to be as seamless as possible. The following discussion elaborates on these three aspects of referral, and suggests that they are key criteria for consideration in referral to therapeutic bodywork within the psychological process.

The relationship with the person to whom the client is referred. As noted, my co-researchers recommended that one know the bodyworker to whom they refer, to be able to trust in the bodyworker’s abilities, and therefore entrust him or her with the client. Some mentioned considerations of age, gender, personality, and style of work. “Knowing” for most of these counsellors meant experiencing the work themselves, or at least having a clear understanding of the ability of the bodyworker to stay grounded and centered with the expression of emotion.

Another important factor for some of my co-researchers was to know intuitively, or by experience, that the bodyworker was gentle, and respectful of the client and the
counsellor. As a criterion for referral to a bodywork therapist, therefore, the counsellor who honors and desires to promote the client's therapeutic process needs to know that the bodywork therapist's work will be congruent with that process.

My co-researchers had different opinions about how much of an advocate or liaison they needed to be on behalf of the client, vis-a-vis the bodywork therapist. In general, they suggested that the amount of contact between themselves and the therapists to whom they referred their clients would depend on the clients' needs and abilities.

Client readiness. Client readiness for referral was another important factor that emerged in this research. For my co-researchers, considering readiness showed respect for the client's process, assumed that the client could take responsibility for him or her self, and reflected the desire to intervene in collaboration with other therapists and the client on the level that was appropriate for the client's well-being.

Readiness, according to my co-researchers, depended upon the client's inner and outer resources, dependency on the therapist, the time spent in therapy, age, as well as the counsellor's formulation of the case according to his or her theories of psychological counselling. Similar considerations, such as ego strength, dependency on the therapist, time in therapy, and history regarding touch, were noted in the study by Imes (1998), which examined client responses to casual touch in Gestalt therapy, and by Clance and Petras (1998), in their study of counsellors' self-reports about the use of casual touch in therapy.

Somewhat related are several variables in two of the studies related to referral, mentioned in the literature review. Time required for treatment and perceived responsibility for treatment were distinctive factors in the referral by general practitioners
in a study regarding referral of patients with anxiety disorders and sexual dysfunction (Brown & Kent, 1992). These two factors can be seen as operative in the counsellors’ assessments of clients’ readiness to receive therapeutic bodywork. As noted, several co-researchers spoke about the factors of time and responsibility in the following ways. They mentioned not wanting to lose clients who were there for only a short time, fearing a gap in the process, and wanting to assure that the therapy was not going to re-traumatize the client. Likewise, the variables of quality of care and consideration of the patient’s level of functioning in another of the referral studies reviewed (Segal, Watson, & Akutsu, 1996), were factors reflected in the co-researchers’ considerations of client readiness.

If the client is not ready to receive the therapeutic bodywork, the referral is inappropriate. Although the interviews were not designed to address the formulation of cases or application of theory, my co-researchers’ stories, noted in the results, were descriptive enough for me to conclude that they each had a desire to further the client’s process according to the client’s needs and abilities, viewing the client as the expert, rather than imposing a prescriptive agenda. Perhaps the psychotherapeutic process is unique among the professions that serve the well-being of individuals, because it allows room, depending on the orientation of the therapist, for client self-direction and choice among therapeutic interventions.

At its heart, the process of referral for my co-researchers was driven by a very person-centered (Rogers, 1951) philosophical orientation. This orientation included respecting the client’s self-direction and choices, developing a relationship of trust and safety, and having a positive regard for the client.
As part of the person-centered therapeutic process, the act of referral can be seen as a reframing activity. Like reframing, the referral to therapeutic bodywork is a vehicle to becoming unstuck. Reframing is a way to transform perspective, to gain insight, or overcome blind spots, and its effectiveness is enhanced by the development of the person-centered relationship between counsellor and client (Egan, 1994). The participants discussed the process of referral as a counselling activity. They revealed a desire to maintain continuity and track the therapeutic process, while allowing the client through referral to therapeutic bodywork to get support and to explore aspects of themselves on another level, perhaps deeper and more profound.

Risks of referral. The intimacy which evolves within this person-centered counselling relationship evoked for the participants a desire to nurture and to protect clients from threats to their well-being within the therapeutic process. Thus, co-researchers expressed concern for clients' vulnerability to the risks of therapeutic bodywork, and respect for the fragility of clients in the process of exploring challenging issues and aspects of themselves.

Even with a good relationship among therapists and a careful assessment of client readiness, some participants perceived that a client might not follow through with the referral, or might not experience what the counsellor had anticipated. The concern of several co-researchers about the consequent gap in the therapeutic process as a risk of referral was notable, because it was unlike any aspect of the referral process in the literature reviewed about referral among professionals.

For two counsellors, as noted, doing the off-the-body work was one step in the direction of maintaining the cohesiveness of the therapeutic process. As noted above,
bringing into the counselling sessions the actual physical hands-on bodywork may be the next step, as counsellors evolve their skills, abilities, and sense of appropriate boundaries, to bring to their clients the body awareness through therapeutic hands-on work as well as the psychological counselling. Alternatively, as therapists with different skills and abilities learn more about each other’s work, more collaborative relationships may evolve, thus resulting in that more seamless process of psychological healing that incorporates the bodymind.

Indeed, the vision of several co-researchers was expressed as a desire to work in collaboration with other professionals, on behalf of the client’s well-being. As noted, several counsellors have already embarked on creating that vision of a team. This idea of a center of resources for clients impacts on the basic idea of referral, since it provides a foundation for the development of trust and respect among therapists deemed necessary by my co-researchers.

**Implications for Practice and Suggestions for Further Research**

Counsellors interested in the integration of body awareness within the therapeutic process may choose to consider referring their clients to therapeutic bodywork. Ideally, the counsellor interested in incorporating the bodymind within counselling needs to bring body awareness into the counselling sessions. Based on the interviews with these co-researchers, bringing body awareness into the counselling sessions helped prepare clients to be ready to receive therapeutic bodywork.

To make a referral, the counsellor would be well-advised, based on the voices of the participants in this study, to experience the work themselves. In addition, to lessen the risk of a gap in the therapeutic process, and the consequent potential setback for the
client, the counsellor needs to know as much as possible about how the work of the bodywork therapist will be congruent with the counsellor's formulation of the case, philosophy of healing, and style of working.

In addition, according to some co-researchers, a collaborative relationship with the person to whom the client is referred helps maintain the integrity of the therapeutic process. Furthermore, counsellors may find themselves needing or desiring to train in body-oriented psychotherapy or therapeutic bodywork, as some participants did, to understand the somatic experience in theory and practice.

A counsellor needs the ability and confidence to assess client readiness, and to identify appropriate issues for and obstacles to the application of therapeutic bodywork. Experience of the work and consulting with colleagues will facilitate these qualities, according to the experience of the co-researchers reflected in these interviews.

Future research in the area of counsellors' referrals to bodywork therapists would be interesting from the perspectives of the bodywork therapists and the clients. Their viewpoints would add to the picture of how the collaboration among professionals works for themselves and for their clients. Another idea for research is to continue to explore the kinds of bodywork, both hands-on and off-the-body, that counsellors do within their counselling practice, a topic that showed up in this research unexpectedly. Finally, to focus additional research on any of the issues that co-researchers said were responsive to therapeutic bodywork would more deeply elucidate the specific benefits, and how they are accessed and developed.
References


causal attributions, and self-efficacy as predictors of teachers' referral decisions. 


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Appendix A

Introductory Information

The following information will be communicated by the researcher to the potential participant during the initial contact.

In partial requirement of an M.A. degree in Counselling Psychology from UBC, I am conducting research into the phenomenon of the referral of counselling clients by their counsellors to therapeutic bodyworkers. I am interested in learning about your experience of that process of referral.

Criteria for your participation are that you have: 1) at least a master’s degree in counselling or social work, or equivalent training and experience; 2) the predisposition to make referrals of clients to therapeutic bodyworkers; and, 3) the experience of having made at least one such referral within the past two years.

I will be asking you to describe your experience. I am interested in exploring the issues, indications, and contraindications which lead you to consider referrals of clients, the factors you attend to in the process of referral, how you select the bodywork therapist to whom you make the referral, and your experience of the consequences of making the referral.

The main question I will be asking you is:

What is your experience of making a referral of a counselling client to a bodywork therapist?

There will be two audiotaped interviews. From transcripts of the first interview, about two hours in length, I will create a summary of your experience. In the second interview, about an hour in length, you will have the opportunity to make changes to make sure that my analysis is not inconsistent with your experience.

During the interview I may ask you more about something you have said, for additional information, or for clarification, to be certain that I have understood your experience. You are not obligated to answer or discuss anything with which you are not comfortable, and there is no “correct” answer. You may even withdraw from the study at any time. In addition, your confidentiality will be maintained and once the research is concluded the audiotapes will be destroyed.
Appendix C

Interview Questions

General question:

What is your experience of making a referral of a counselling client to a bodyworker for therapy?

Aspects of referral for prompts and probes:

What is the role of body awareness in your counselling sessions?

What factors do you pay attention to in the process of referral (readiness, issues)?

What are the indications/contraindications/risks/obstacles for referral?

How do you choose the person to refer to; what is your relationship?

What are the consequences and follow-up of the referral?

What is your vision?
Appendix D

Summaries of Interviews with Eight Co-researchers

Each summary is based on the verbatim transcript of each co-researcher’s interview. The numbers that appear in parentheses after statements in each interview summary, for example, (54-70), refer to line numbers appearing in the margin of the transcript for that interview.

Presented alphabetically by pseudonym:

1. Alice
2. Carol
3. Joan
4. John
5. Laura
6. Mary
7. Sally
8. Sarah
Interview with Alice

As a result of our conversation, Alice said she became aware of the evolution of her awareness of attention to the body in therapy, which grew along with the proliferation of new and more refined systems of bodywork. After she first recognized the need for bodywork she began to make referrals, then received her healing touch training and integrated it into her practice. She has continued to refine her knowledge of the increasing variety of bodywork resources available to her clients (931-935).

Alice reflected that initially she felt there was something empty in the work she did with survivors of trauma, but she couldn’t identify what was missing (77-81). She became aware by talking to colleagues, learning about the healing touch therapy, and writing a book about healing the trauma of sexual abuse, that she could not work with survivors in isolation with only talk therapy. She questioned whether she was providing what was needed by her clients, for them to recover and move on with their lives, because she was missing the training in bodywork (77-101).

Alice said when she first began to refer clients to bodywork, some would come back from a referral and not be happy. She felt a tremendous frustration, like her “hands were tied” (803) because she couldn’t provide that missing link for them, she couldn’t bridge the gap (800-806). Alice admitted that despite this frustration she felt resistant to training in bodywork years ago. She said when her colleagues would talk about it she would think to herself, “oh I would never do that...lean on this sort of flaky, on the edge way of working” (807-830).

Alice said when she first began to make referrals, she was not very active in the process. She would give her clients a name and let them follow up (354-357). Alice related that as time went on, she became more involved. She described how she would get a release from her client, then contact the bodywork specialist to describe some of the client’s challenges, and become more of an advocate for the client, to help them get what they needed (358-367).

Alice described her disappointment when she first started to refer. She would tell the client that "you might be ready for that body component now...we’re at a point where we can’t go any further
until you explore how you’re holding the trauma in your body” (405-410). Then the bodyworker would lack the sensitivity or awareness of how trauma survivors respond to touch (414-415). Alice said that for some of her clients, the experience was like a re-victimization (433-436).

Alice expressed her awareness that client dissatisfaction existed because of the gap -- the bodywork therapist could help the client identify the trauma but not necessarily work it through (374-382). Alice voiced how her concern about that gap led her to think “I owed it to my clients to get myself up to speed on that aspect of the training, that I could offer them that whole integrated way of working with the trauma instead of just one aspect of it” (425-429).

“[T]hey had part of what the client needed and I had part of what the client needed but there was still that gap in between those two parts...that bridge piece was missing, so I really knew when they were coming back and they weren’t completely satisfied with the intervention” (390-397). Alice added, “they might have even experienced perhaps some further trauma around being touched and not feeling...quite ready to be touched in terms of how that massage therapist or how that bodywork specialist might have touched them” (398-402). With her awareness of this gap for her clients, Alice started to think “I really need, as a therapist, to acquire this component” (60-62).

“In those days there wasn’t a lot of separating out the various kinds of bodywork” (455-458). At that time, when she initially considered making a referral for bodywork, she didn’t know the right questions to ask (637-638). She noted how she has a better sense of how to assist clients in interpreting the work by asking “how do you hold that in your body, what’s going on with your body” (643-644).

Alice said what allowed her to realize the importance of healing touch bodywork was feedback from clients in her program for survivors. Alice said she ran the group and the women in it received healing touch from her co-facilitator. These women would relate their experience to the group. Alice said she could see “how differently they sat in their bodies, how much more body aware they were, and when they spoke, it wasn’t an intellectualization, It was really from the heart, from the soul, from the
spirit” (851-857). She said that survivors of trauma require the body awareness component as well as the talk component (46-47) since what’s going on for them shows up in their bodies (49-50).

Alice said having the bodywork component with the group work speeded up the recovery process. She said the women were empowering themselves, getting off social assistance, getting trained in various skills, going on to get great jobs (864-868). She then felt compelled to get the healing touch training (880-881).

Alice voiced her recognition of a gap, between having the bodywork available but not the psychological therapeutic component (118-146), in her own experience of receiving massage. Alice related feeling a wonderful release with massage therapy. She was aware, however, that the practitioner was only beginning her training in the Bodynamics psychological perspective. Therefore Alice said she hesitated to disclose her feelings during the massage.

Alice said she brings to her clients in therapy her own evolving trust with experiencing various bodywork interventions (1134-1139). Alice said she does yoga and works out. She would like to receive massage more often. After a whiplash injury from a car accident in 1992, she was involved for about four years with receiving craniosacral therapy, acupuncture, physiotherapy, and massage therapy (968-976).

When she used to refer clients out, she would do so when she felt stuck, and when the client was stuck, on an intellectual cerebral plane, without a connection to be able to process the trauma on a bodily level (261-267). When referring, Alice described how she would say to the client that working with a bodywork specialist might allow the client to be less intellectual and more connected to the traumatic experience. That connection might result in the client’s body becoming a less threatening place to be. In Alice’s experience with survivors of trauma, “the body is a very threatening place to be…and intellectualization is a very safe way to escape” (291-302).

Alice said that in 1993 she took level one of the healing touch course, which is an off-the-body nurturing focused scan of the client’s body, working energetically to assess and clear blocked energies.
Alice reflected that this initial course, with mostly nurses, concerned the body more than the psychological and emotional aspects (156-163).

Without that psychological piece, Alice said that she felt unable to integrate the healing touch work with the counselling she was doing with clients. Thus she continued to refer clients out for the bodywork therapy. About a year after her training, however, she started synthesizing the information she had learned in level one. She said she attempted to integrate it by doing very simple healing touch in her counselling sessions (169-186).

In 1998 Alice took the level two healing touch course. She described how the teachers, a holistic nurse and a therapist, were able to show how to integrate the mind and the body, to bridge the gap between the bodywork and the psychologically counselling (187-191). Currently Alice doesn’t refer clients out for healing touch work, because she feels confident about doing it herself. Alice also recognized that she is less comfortable doing the healing touch with male clients and is more inclined to refer them out for therapeutic bodywork or healing touch. (596-616). Alice said she knows clients are ready to receive the healing touch when she feels stuck (236-243) When they have been referred to her for healing touch, they may be ready almost from the first session (247-251). She said that in addition, some clients seek out bodywork on their own and bring their experience of it into the sessions with her (505-515).

Alice said that she would refer to people she heard about from colleagues (316-319). After taking the level two healing touch course, she began to make more contact with people doing therapeutic bodywork. As she became more involved in doing the healing touch bodywork, she became more discerning about what was being presented to her and might or might not be appropriate for her client (320-344). Alice added that now she is more aware, has worked and trained with and knows people who do kinds of bodywork that have the psychological component (666-675). Several of these are healing touch therapists who are also counsellors, one is a bodyworker, and another is the nurse who facilitated the level two training (679-710).
With the integration of healing touch with counselling, Alice said she has seen trauma survivors "doing their recovery so much more quickly, and integrating it so much more, intellectualizing less, being able to work through the unfreezing of the trauma and making it liquid, moving it up and out through their heads, finding ways to... pull it to the outer corners of their bodies, so maybe the trauma occupies... a fingertip or a small corner of the shoulder, instead of... in the center of their bodies (223-234).

Alice said that in her experience although money may be an obstacle to accessing the therapeutic bodywork, people will find creative ways to do it if the motivation is there (721-735). Alice noted that other obstacles to receiving the bodywork are apprehensiveness about being touched, or a perception that the bodyworker is flaky or not credible (746-760). Alice said in the last few years, because of her healing touch training and seeing clients achieve successful results, she has sensed that therapeutic bodywork has acquired greater credibility (770-794).

Alice said her vision is to be able to facilitate groups and provide the therapeutic bodywork component. In addition she would like to integrate her own approach more and take additional training in healing touch or other therapeutic bodywork (930-935).
Interview with Carol

In her personal evolution, Carol came out of teaching in the public school system in the Northwest Territories and began as a client to work with a variety of therapists doing counselling, breath work, bodywork, yoga, and group work (326-331). She credited going through her own process of deep experiential work with grounding her and allowing her to be comfortable with her clients’ processes (1274-1281). Carol said that although she’s taken some massage therapy classes, she does the massage only with family and friends (301-303). Carol said she feels strongly that as therapists, she and others should have had or be willing to experience “any of the work that we practice” (380-385).

Carol said she is interested in connections among the body, the mind, and the spirit, and described her work as body focused psychotherapy (220-227). She said her spiritual beliefs include a physical spirituality, about how we learn through our physical bodies and our connection to the earth (886-890). For Carol, the bodywork is about staying in the body, being present, and staying in contact with another person (677-678; 688-690). She said she sees herself now as focused on awareness, having started with Gendlin’s “felt sense,” moving into the Gestalt training and outlook, and evolving her own style (244-269). She said her work varies depending on the client. Carol said she has worked with people in very physical ways, doing anger work on a mat, or moving with whatever feeling was happening (283-286). She said in the past she’s worked with survivors of physical and sexual abuse (290-291). Her practice now is more eclectic. Her clients bring many issues, she has less survivors, and more men (485-492).

Carol said she believes “we hold in the body and we remember in the body” (362-363). She focuses on being in the body, grounding and feeling the connection to the earth in the body (296-299). She said she brings attention to the body by doing guided visualization sensing awareness in each part of the body (986-1077; 1117-1118). She described how she works with the client to enhance body awareness, by asking the client to notice what’s going on, where in the body is that happening, and “could you put your hand there and just breathe into it, just close your eyes so you can go inside
Carol added that if a client has a difficulty with breathing, perhaps by always breathing shallowly, she will consider referring them to therapeutic bodywork because of its emphasis on breathing.

With women clients who were sexual abuse survivors, Carol said she has found the results of bodywork to be dramatic. Carol said she refers her clients for bodywork to various therapeutic bodyworkers, including her partner, who is a male therapeutic bodyworker. She said that to go to a male bodyworker is significant for many of her clients in their healing. For example, even survivors who had never experienced safe touch from a male, readily go to Carol’s partner, because they trust Carol deeply, and he is connected to her. Carol described the value of bodywork as “the healing into knowing that I own my body.”

Carol described how one client worked with Carol’s partner on boundary issues. “For a long time the work that he did with her consisted of her telling him where he could work and it would be her feet or her shoulders, and her saying ‘no’ after just a few minutes, ‘stop’, or ‘no’, and him stopping, and her breathing and deciding when she wanted the work to begin again...the message being that this is [her] body” and that she could pay attention to what was going on for her. According to Carol, the bodywork may also benefit clients who have issues around allowing themselves to be nurtured, to be taken care of, and to receive.

Carol said “it’s so useful at times to have touch that can aid the letting go process.” She said she feels all her clients may benefit from therapeutic bodywork. She said she considers referring clients to bodywork right away, when she knows they are open to it from being far along in their process of awareness. She will respect a client’s decision to not do bodywork, but she may bring it up again and challenge the client about it if she feels the client will really benefit from it.

Other than her partner Carol refers clients to therapists whom she knows to be sensitive to the emotional and spiritual aspects. She said she will also recommend massage therapy as a basic physical...
intervention for someone with tight shoulders if she feels it will be useful (946-960). She said she gets names of bodyworkers who are comfortable with emotion being expressed, because if the bodywork therapist becomes distressed as well as the client, the work is ineffectual and the client may even feel shame (959-972). Kinds of bodyworkers to whom Carol mentioned making referrals include a Rosen worker, a person who does holotropic breath work, and a yoga teacher.

Carol said the contact she makes with bodyworkers on behalf of the client varies, depending on the client’s needs. Sometimes she just suggests that the client call the bodyworker. Other times she asks if the client would like Carol to call first. She said, “I don’t take on what I don’t have to take on for someone but in some cases...it can be a bridge and a comfort to someone and help them make that step” (1453-1457).

Carol noted that at times she is present in the room with her partner doing the bodywork. Carol may do some hands-on to give a sense of grounding or holding energy, or voice some verbal reminders to the client (711-718). Carol related that she will often consult with her partner as well, with the client’s permission (738-739). She gave the example of a client she worked with for years, who learned to work through her body and with breath, and who now works more with Carol’s partner. She comes back to Carol “when something big is going on” (741-751).

Carol noted that she and her partner are studying Integrative Body Psychotherapy, an eclectic therapy that comes out of object relations and Gestalt therapy. Breath and grounding are seen as the basic resources for the core self to expand (814-826). Carol also described being involved as a therapist with a team of practitioners, including two medical doctors, a naturopath, an acupuncturist and Chinese herbal doctor, a bodyworker, a yoga teacher, and a hypnotherapist, set up to take clients through a week-long program. The focus has been cancer patients and their families, but eventually the resource will be open to anyone. The vision includes prevention of disease as well, on emotional, spiritual, and physical levels (1144-1146; 1231-1245). According to Carol the team shares the belief that the power of healing includes attention to nature and to the body (1155-1158).
Interview with Joan

Joan has been in Vancouver since 1984. She is originally from Scotland, where she got her master’s degrees in both nursing and psychology. As a student nurse in Scotland, Joan met a man who was dying of leukemia and he talked her through his dying process. She said she became fascinated with that and the psychology of illness (1144-1157).

She described herself as a clinical nurse specialist (10), with a counselling practice for about four years now which focuses on people living with illness, or their family members (15-22). While working in the health care field about ten years ago, Joan’s interest in the emotional impact of illness, the dying process, the grieving process, the pain, suffering, and anxiety, led her to study the energy-based practice of therapeutic touch (50-58). Therapeutic touch is an off-the-body modality that works with the client’s energy.

Joan said that she brings three approaches to her counselling practice, which is basically humanistic and integrative. She does the talk therapy, works with imagery and the unconscious, and brings the therapeutic touch into her sessions (78-88). Joan noted that she believes that the energy of the person who is the therapist impacts on how they apply whatever kind of work they do, including bodywork (336-342; 873-874), that clients heal when they are ready (174-175), and that “there is a wisdom to healing” (588). Joan said she believes the body holds memories and “can be an incredibly efficient access point” for healing (820).

Joan said she wants to refer to bodyworkers who have a similar philosophy about healing (1616-1618). She said she hesitates to refer to people who think they are healing other people, because their egos get in the way (1626-1632). She described her view by saying, “I trust that you can heal and that makes me a healer but you’re the one that does the healing” (1663-1665). She said she finds it scary that there isn’t more care and respect for the individual’s healing process (1675-1676). She doesn’t relate to those in the psychological community or the bodywork community whose egos dominate their work (1737-1738).
The kind of bodywork Joan has in mind for her clients varies depending on her perception of the client’s needs. Through personally experiencing the bodywork (251), Joan said she is able to trust in her sense of the bodyworker’s style, sense of intuition, and degree of gentleness. For example, she has experienced, and makes referrals to, the work of a therapist who does the Rosen method (279), a very gentle, intuitive process that focuses on breath and emotions in the body.

Joan described from among the broad range of styles of bodywork how scary it is for her to think of referring clients who she has prepared for the “the next step” (293; 311-312) to someone “out of the phonebook” (316) with whom she has no personal relationship or experience. Without such personal contact, Joan finds it difficult to know the bodyworker’s background, theoretical framework, and how they actually work with a client (306-310). Joan usually goes to a bodywork therapist to “check it out:” so she knows “what I’m referring to” (944-946). Also, Joan said one finds that not many bodyworkers are comfortable working with the very ill, and that she sees a need for that (927-930). She described the bodyworkers to whom she refers as those “who really have an understanding of gentle work” (867-868) for clients who need the simple “soothing comfort of having someone touch {their} body...that’s full of disease, that’s maybe got parts missing...or {that} they just feel awful about” (849-863).

When making a referral Joan said she calls the person to whom she has referred and, with the client’s permission, describes the context and discusses whether the bodyworker is interested in working with this client (635-638). Joan said making that contact, that bridge, is important to her. She doesn’t see it happening much in the community, among different kinds of therapists (640-709). Joan said “We have to be...gatekeepers...do some of the research...When you’re really vulnerable you need help to sort it out, to see who’s ok and who isn’t” (1702-1710). She added “I think we do have a job to...talk to each other more and find out who’s out there and who fits with my philosophy as a therapist so then I feel confident to say to my client, I really think this person will be able to help you...If I can give confidence to that process I think {we’re} off to a good start (1719-1721).
Joan said she likes the idea of a partnership or network with other kinds of therapists because certain people have more of an aptitude than others do in different areas (215-222). One concern Joan has, however, is whether the referral will result in a setback for the client (210-211) because of the possibility that the necessary trust and rapport may not have a chance to develop with the person to whom the client is referred. To avoid that gap in the therapeutic process Joan mentioned that sometimes she wonders if she “needs to go and get those skills” in bodywork (2112-214; 361-364). She questioned whether it was feasible to expect a client who had a relationship of trust with Joan to make the switch to another practitioner, even when that practitioner was trusted by Joan (347-357).

Joan said she considers referring the client to a therapeutic bodywork that is “hands-on” when she feels stuck in her work with the client. For example, she saw a client’s body react in a “very physical obvious way” (138) as the counselling got close to some trauma locked up in the client’s body that was difficult to talk about. When she sensed that talk therapy was at a standstill, Joan referred this client to a bodyworker whose work Joan had experienced because she sensed. At the same time she sensed that the client was fearful of bodywork, and might not allow herself to trust the process. Thus Joan questioned whether the client would follow through on the referral to bodywork. Indeed, this particular client did not follow through.

Another example of a client Joan considered referring to therapeutic bodywork is a woman in her 70’s who has had two children die over the past 40 years. Her feelings are not readily accessed and Joan said she has become isolated in her body (486) over the years. Joan described how grief can solidify the body if it’s not worked through” (475-476), how the body gets very tight and very tense ((479). She said this particular client wanted “a quick fix” (495) but talking it out would probably take a long time. So Joan has done some relaxation work with her and assessed how she is with being touched by doing some touching and holding of her feet (517-519; 523-525; 529-531). Joan observed that with this light she “could see everything settling” in this client and “had a sense with her that it could be a route to her grief” (535-539).
With this client Joan has sensed a readiness for the bodywork but wonders whether the switch to another therapist, in this case a bodywork therapist, would be like starting over (580-583). Again Joan noticed the risk of creating a gap in the therapeutic process by a referral, even to someone with whom Joan has a personal relationship, and who Joan felt was “the right person” (587-592).

In Joan’s experience, she considers whether the bodywork therapy for the client will be an adjunct, in parallel with the counselling she does, or be a shift or switch from Joan to the bodyworker (1010-1032).

For some of Joan’s clients “to actually start to touch into the feeling realm” (1302-1303) was an essential step “especially for people...who have shut down tightly for a long period of time...it feels like they’re so wound up” (1315-1319). Touch has been the doorway making it safe to “go and have a look in there and feel what’s happening” (1325-1326).

When Joan senses a client needs “incredible nurturing in a very quiet peaceful place” she may refer them to craniosacral work (876-887), a gentle soothing type of light touch that works with the cerebral-spinal fluid. For clients who want a cognitive understanding of the body, who may have a chronic physical condition that is impacting their psychological state, Joan said she refers to a physiotherapist who does acupuncture and cranial sacral therapy, and is very good at explaining things (1036-1053).

For some clients who are chronically ill, the traditional massage practitioner offers too much energy and is too intense (8997-905). In her network of people Joan has found some registered massage therapists who have “a certain way of being that I trust” (938-939), even though massage therapy is usually very physical and more medically oriented than the gentle Rosen method (302-304).

Joan said she has also built up her knowledge by hearing feedback from her clients. A name may keep coming up in relation to a certain kind of bodywork and its results (950-955). A cranial sacral therapist to whom Joan makes referrals is part of a team with whom Joan runs retreats for people with cancer. The team helps provide emotional, physical, and spiritual support. Ideally, she would like
to expand these retreats to families, and to include more integration of the emotional and spiritual with the physical (1472-1474).

Joan noted that among her clients she found women no more or less willing than men to consider bodywork. No matter what their gender, they have all been through illness or the trauma of grief, which she sees as being catalysts for being quite open (747-748). In addition, Joan’s clients are dealing with death, illness, and tragedy, and may experience an urgency, because their healing process has to speed up (836-837).

Joan’s work also occurs with children, in children’s hospices, and with teens. Since Joan doesn’t know bodyworkers who work with children, other than a colleague who works does cranial sacral work with infants, she doesn’t think to refer children to bodywork therapists (1386-1392). She speculated that kids would benefit from therapeutic bodywork because they are so body-oriented (1416-1420). She reflected on the readiness of teens to experience grieving through touch, as an access to emotions. She has noticed that teens who have someone die shut down emotionally for two or three years after the death. She described how she sees them as clients at the point where after having shut down, their life is totally falling apart, they’ve got no direction, they don’t know what they’re doing (1269-1270) and they don’t connect it to the death (1285).

Joan described teens’ interest in imagery and relaxation, their longing for touch (1340), and how touch was the grounding one teen needed (1298). She said she hasn’t referred teens to bodywork because she feels she doesn’t have them for long. She doesn’t want to lose them. She feels teens aren’t into a long therapeutic process, so she just goes with what’s happening in the moment (1355-1381).
Interview with John

John has trained in a variety of therapeutic bodywork systems, as well as body-oriented psychotherapies. He is also a trainer for Bodynamics (133-134; 178-179; 269). John’s early background included Gestalt psychotherapy and massage training (2068-2075). In doing massage therapy he said he was amazed at the power in his hands, and related that he felt his body for the first time (2207-2212).

John noted that the professional rules and cultural bias around touch are there to protect the professionals as well as the public (1761-1764). He also commented about how the recent groundswell of interest in body-oriented psychotherapy makes him a bit nervous, because not all systems have a clear protocol and the work with the body is so powerful, the possibility for people to be hurt exists (1793-1823). The power of the work can go crashing “through [their] defense system” (1158-1159).

John noted that some bodywork systems struggle with legitimacy and may be perceived as flaky. He said the practitioners are not necessarily flaky but they may be uninformed and not know what they are doing. He voiced excitement about the creation of standards, theory, safety, and legitimacy that is starting to manifest in some systems, like Bodynamics (2697-2711).

John said he chose to study the Bodynamics system because he felt it was the one bodywork system tied most closely to existing theory (1691-1693). In his own experience of therapy John felt destabilized for many years, because of deep body-centered work that grounded him but left him unprepared for the emotional connection (1953-1961). John said he is good at “putting people back together again who have been regressed for a long time” because of this intense personal experience, through which he became sick for about ten years and lost his spiritual and emotional connection (2160-2164).

John said that by going through your own therapy, working on where you get stuck, you are better able to work with your clients because you’ve worked through yourself (2316-2325). He said his “own deep wounding really affected me greatly in how I do my work” (2516-2518).
In the work he does with clients he draws upon this eclectic background, which includes experience with craniosacral and Reichian work, EMDR, attention to the breath, and working with developmental trauma issues, family systems, and the client’s somatic experience (273-277; 414-417). Since John doesn’t do any insurance work, his clients are generally financially resourceful and able to afford to pay for other therapists (1460-1469).

As a counsellor who does a lot of “mind-body work” John said he gets clients who have “done a lot of therapy and haven’t gotten where they want to go” (556-560). John described these kinds of clients, who are often therapists of some sort themselves, as “already seekers” (563-592). John also has clients who are functioning very well but want to do spiritual or meditative work, feeling like they’re stuck. He said he does psycho-spiritual work within different philosophies and spiritual disciplines (795-809).

John said the relationships among his clients and him may be multi-layered because of his involvement with Bodynamics supervision and administration. For example, one of John’s clients may have been referred to John by a therapist who is also John’s client; or John may refer one of his clients to a therapist who is also John’s client. Thus John’s waiting room may be filled with people in dual relationships (618-653). To handle these dual relationships, according to John, “people have to have a reasonably mature sense of their ego function boundaries “ (667-668).

According to John, bodywork is appropriate when cognitive therapy and family systems work cannot address early trauma or developmental deficits (676-689). Although touch is extremely helpful in those situations, John voiced concern that it can be risky if the client lacks “good adult resources” (714-728). Good adult resources to John means that the person can function in the world, has solid opinions, can make up their mind about things, and doesn’t regress or collapse for a long time if they get upset (741-751). While everyone has some childhood issues, according to John, those clients who also lack adult resources may feel abandoned easily. Thus he voiced caution about referring them out to too many places (815-833).
John spoke about a client situation where John used a lot of his own resources and skills. He wanted this client to go out and experience work from other therapists, however, for a new perspective as well as added benefit, and to lessen the client's tendency to become fixated on coming to John for everything (475-511). This particular client, however, faced pressure from his family, to spend less time going out for different therapies (512-518). Thus the challenge John described is one where he wanted to refer the client out to “people who could help in some of the areas [the client] needs to be helped more than I can. However I can’t get him to go without throwing the balance out of the system (524-527).

John said when he is not accepting new clients, people consult him about whom to go to, either because they want to see him as clients, or they are therapists who want to refer their clients to him (16-19). When referring someone who wants to be a client, he said he considers what the client says is needed and tries to find a match with a body-centered therapist, in terms of appropriate style, age, gender, and personality (139-143). In advising a therapist about a referral for a client, he described finding out what the therapist thinks might be beneficial for the client, and often reshaping her or his thinking about what might be needed (21-31).

John voiced concern about the dilemma of perceiving issues for a person, that the person may not be aware of or ready to hear, when he is not able to take them as clients for a period of time long enough to do the work he sees is needed. He wondered what to say, and how much his referral needs to take into account those perceptions (1030-1052).

The people to whom John makes referral for body-centered psychotherapy are trained in counselling or psychotherapy, with added skills in some form of therapeutic bodywork, such as Bodynamics, or Core Energetics (56-143). Within his extensive network of colleagues, John may refer to people he has trained in Bodynamics or somatic experiencing (132-138). John has seen clients move “to places he couldn’t seem to move [them] to” by working with other therapists in bodywork, such as craniosacral (1430-1458).
John noted the different ways some people combine the work with the mind and the body. Someone who might seem to work primarily with the body, such as an osteopath, chiropractor, physiotherapist, massage therapist, or a person doing Feldenkrais®, Rolfing, Aston patterning, or Alexander work, may actually focus more on the psyche than the body (159-174).

Whenever he refers, John said he makes a judgment about not only the client's needs, but what the bodywork therapist has to offer. He usually knows that therapist from being their supervisor or counsellor (1584-1623). When he makes a referral to another therapist, John said he usually has the client call directly. Later John will ask the client what happened. He will talk to the other therapist if anything unusual comes up (287-293). On the other hand, if the client does not have a lot of awareness about their body, other than athletic training, John will get their permission and call the person to whom he has made the referral. He will establish a relationship with them to find out their perception of what is going on with the client, because the client's perspective may be that “nothing happened” (301-319).
Interview with Laura

Originally from Scotland, Laura worked as a physiotherapist here in Vancouver since 1978, mostly involved with clients in acute care, such as thoracic and cardiac surgery, the burn unit, and the intensive care unit. She took an administrative job in 1980 even though she felt more comfortable being a clinician (321-338). She described knowing that the administrative job was not right for her because she got sick and “my body tells me that I’m going in the wrong direction, so I got quite a serious illness which made me stop and think for awhile” (343-346).

Laura described the diagnosis of m.s. (1979) as a “wake-up call” for her (1990). A neurologist told her there was nothing she could do about it. A refusal to accept that set her off to exploring what she could do (1997-2008) realizing her body was giving her a message (2043). She felt empowered, knowing there was something wrong with the statement that there was nothing she could do (2070-2077). That experience helps her guide her clients to find a way to access what’s going on for them (2182-2187). She said she believes the body is wise and can reveal what’s going on emotionally (2463-2474).

Laura related that meeting a psychiatrist who became her mentor expanded her awareness of how the mind and body influence each other. She worked in his multi-disciplinary clinic and they ran groups together until he retired in the mid-80’s (337-400).

As a physiotherapist involved with movement and hands-on work Laura found that clients would readily talk to her about issues such as trauma and abuse, and she didn’t know what to do with that information (406-425). Knowing that she wanted to learn how to handle that valuable information, which she knew, was an important part of her clients’ healing, Laura said she was drawn to study counselling (429-458). She got her Master’s degree in 1995 (680).

Within the chronic pain clinic, clients see an interdisciplinary team composed of a counsellor, a physiotherapist, a kinesiologist, and a physician, as part of a program sponsored by insurance companies (1007-1037). Laura described working with an anorexic client to help allow her to see her
power and "get into her body" (2644-2677). Laura noted this client will have the benefit of the multidisciplinary team at the clinic.

Laura noted that for one to go on one's own to the clinic would be almost impossible financially, particularly if they'd been out of work for awhile (1047-1049). In her private practice, clients have to be able to afford to follow through on her referrals to therapeutic bodywork (1188). Therefore they may have to choose to do one or the other (1231-1233) and may shift back and forth from one week to the next (1245-1247). Laura said she has found that because of the cost, her private clients see her about six sessions, although they may come back at some later time (1490-1514).

Not only are there financial limitations for clients who pay with their own resources, but there are also constraints around the number of sessions provided by an insurance plan. Laura voiced the sense that this restriction of time makes her reluctant to expand her counselling into areas other than talk, such as movement, touch, or experiential modalities (1353-1472).

For Laura, the meaning of her work is to "get people to feel more in charge of their own health, and their own body, and understand that the psychological help and the physical help are interrelated...They have a lot to do with healing themselves" (2567-2572). Laura said she asks her clients to notice what their bodies are feeling, what that may have to do with whatever else us going on (2475-2477), and what could it be trying to say (2558-2559). She has taught them relaxation and referred them to tapes (2536-2538). One "mind-body" connection she does in her practice is treating some clients with biofeedback (1557-1566).

Working in the clinic now as a counsellor, Laura has found that the clients still talk to the physiotherapists more than they talk to the counsellors (580-581). She said she believes that "touch is the thing that loosens people up" (590-591). She said she believes clients talk to the physiotherapists more than the counsellors for the following reasons. If their pain is somehow too psychologically linked, the clients who have been sent by a third party for treatment are at risk for not receiving benefits, or /and feeling like they are crazy because their pain is not physically "real" (637-668).
According to Laura, physiotherapy is directive and non-threatening (1283-1284) and clients feel safe (1290). Laura said, “if I started doing physio under the guise of being a counsellor, I think it would be too threatening” (1231-1233). Laura said she might combine the hands-on and the bodywork in her practice sometime down the road (840-841). She said she wants to explore how to do both without it being threatening (1347-1348). Laura’s vision, given unlimited financial resources, is to work in an environment that allows her to integrate the talk and the hands-on, with a garden, music, art, animals, bodywork therapists, and space for movement (2502-2512; 2766-2785).

One way Laura has found to combine the two, counselling and attention to the body, is working with teenagers. To be active and do something with them is a way to access their feelings. For example, Laura told of seeing one teenage girl at her foster home. After refusing to talk in other environments, this client’s feelings ‘poured out” after Laura got up on the trampoline with her (1390-1404).

Laura described the bodywork therapists she refers to as people she knows well, whose work she has experienced. She described how she tells the client that she has benefited from seeing a bodyworker and wonders whether the client would also find it beneficial (803-814). She noted that she makes referrals to bodyworkers when she’s blocked or stuck in working with a client, when she “can’t move them through” an issue because it is too painful to talk about, and perhaps related to abuse (730-734). She said she feels she would otherwise “need to use my hands to move them through” (835-836). Clients will go off and see the bodyworker without coming back to see Laura (825-826), or see them both concurrently (887-890). Laura also said the bodyworker will send clients to her as well (855; 873-875). Usually the client is responsible for “bridging” the two therapies, because Laura doesn’t usually talk back and forth with the bodyworker. If they do such a consultation, Laura gets the client’s permission (904-921).

Laura said she refers clients for strength conditioning to Pilates, a kind of gentle stretching and strengthening bodywork (927-938), particularly if physiotherapy hasn’t worked. Laura noted that since
Pilates seems “a bit flaky” to some people, the clients have to be open to it (1770-1783). For clients who are less receptive to being touched Laura recommends physiotherapy because it is more mainstream and perhaps less threatening than other kinds of bodywork (1747-1762). Other needs for hands-on work are physical symptoms Laura senses may be related to abuse, such as headaches, abdominal pain, digestive problems, anxiety, or great distress (1634-1639). She said she knows when she has reached her limit, and “they need to go to something more nonverbal, more supportive, and gentle, and just work with that” (1663-1667). When there are physical symptoms from an accident, where the client is distrustful of the medical system, or fearful of moving, Laura said she refers clients to Pilates, cranial-sacral therapy, or massage (1694-1701). Rosen work is another kind of gentle bodywork she is familiar with and makes referrals to (2197). For Laura, clients who are resistant to bodywork often need to be educated about how they deserve to spend time and money on themselves (2909-2924).

Laura said that “counsellors are always interested in mind-body connection and have no idea how to find it or understand it” (2325-2327), and that different kinds of therapists learning about each other’s work is “a tremendous area for growth and change” (2332). Laura has done workshops for counsellors on how to work with clients with chronic pain. She said she feels the need for counsellor education around paying attention to the client’s physical being, the breath, posture and symptoms they bring with them (2406-2419). Even more crucial for the therapist’s recommendation to the client, according to Laura, are the therapist’s experience of the work, and trust of their own connection to their body and what it can tell them (2965-2990).
Interview with Mary

Mary specialized in geriatrics in her nursing education and was drawn to the psychosocial aspects, dealing with families, caregivers, and counselling (137-151). When she felt burned out from the hard work of geriatrics, she moved into administration and education, doing staff development, education programs, and conflict management and resolution (152-164). Mary also went into sales. She sold the anti-depressant Prozac to the medical community that prescribed it to their patients. She described herself as a person who wants to fix things, so she learned all she could about depression, the medications, and their effects. She felt her eyes were opened to how common depression is, and that she herself had experienced a clinical depression at one time. Mary’s philosophy includes the belief that if people are not able to function, antidepressant medication is useful so they can fully participate in therapy, and then get off the medication (230-238).

Through her work and courses at the Justice institute, Mary became aware of the power of teaching people skills to communicate, to become more effective and to feel empowered (168-170). She described her study as self-guided, seeing a need and finding the resources for herself (174-178). Drawn to study cognitive behavioral therapy, because it helped her with some of her issues (244), she has developed a specialty in working with women clients with issues of depression, anxiety, and panic disorder (319-320). She has studied with cognitive behavioral experts such as Judith and Aaron Beck, and David Burns (245-255). She acknowledged that she has learned a lot through just doing the process of counselling clients (268-275).

Mary heard from the medical community that they felt a need for counselling resources, not just medication. (180-196). With encouragement from the medical community, she left sales, set up a practice, and also got a part-time job to provide some stability (280-298). In her part-time practice out of her home, Mary’s clients are women within an age range of 14 to 65 years old (962), referred from the medical doctors or by word of mouth (302).
Describing her conceptualization, Mary said she has clients work through the context and origins of their beliefs, their patterns, how they hold themselves in their bodies, and how they communicate with their bodies (1091-1165). In Mary’s experience, until the client has experienced herself and her feelings, where she is at this moment, the client cannot move through and past those particular feelings. The client needs to give herself permission to grieve, within her context, so she can then let go of her pain (554-568).

Mary described her approach as pragmatic and multi-disciplinary (1000-1050), taking cognitive therapy one step further. She helps the client to function better not only by changing their thinking, but by looking at core beliefs that are perpetuating the thoughts, to incorporate healing work at a deep level. She lets the client self-direct (352-360), either choosing “ten or 20 sessions to just feel better, or...do some of the process kind of work” (364-366). She noted that most clients opt for the process work, what she called the healing part of the therapy (370-373). The process work for Mary is where referring to a therapeutic bodyworker fits, because the healing process may involve letting go of trauma, or other pain, and grieving (377-380), for which bodywork is appropriate.

Mary recommended that therapists experience the bodywork, to allow them to know its power and to share that with their clients, to build the therapeutic relationship (817-827). Mary said she explains to client how bodywork has been successful for her and for other clients (390-392). Mary said referring a client to a bodyworker is appropriate when the client is aware of but can’t move into her feelings (1163-1165). In addition, the client’s readiness for bodywork, according to Mary, relates to the time she spends in therapy. This readiness depends not only on a foundation of trust with Mary in the therapeutic relationship, but on having the experience of being in therapy for over one to two years, not simply for the “superficial” ten to 20 sessions (500-514). They would be in therapy “for quite awhile or have had a lot of raised consciousness about their own issues” (401-403) before they’d be open to the bodywork. Mary said, clients “who are more...self-actualized or at a higher level of consciousness...tend to be more open to the bodywork “ (105-108).
Mary doesn't work with men and could not generalize about their openness to touch. She concluded, however, that trusting oneself as a therapist and trusting the client are key factors (930-934) to assessing someone's openness to experiencing therapeutic bodywork.

Mary described how she incorporates the body in her work. She said she encourages clients who only talk about their dissociation that their bodies may have some of the answers they are searching for, and that their bodies remember even if they have no intellectual memory (418-431). She brings attention to the body through having the clients experience pressure points, art therapy, and drawings of their bodies, and to notice where in their bodies their feelings are located (440-448). Especially with her clients she intuitively perceives as blocked, as not at all “in their bodies,” Mary said she works with their body awareness, even though they struggle to protect themselves by asking for explanations and staying on an intellectual level (473-476). She said she finds she “talks about it more, far more than it’s ever followed through with” (404-405) because most clients are overwhelmed with their healing on an intellectual level already.

Indeed, Mary said she finds many of her clients stay on that intellectual level. Their resistance to bodywork may come from the work being too subtle (1258). They are perfectionists even in their healing and want results immediately. They ask when will they notice the effects of the bodywork. Through education and coaching she encourages clients to realize that bodywork doesn't work that way, that the work takes time and that their bodies will respond when they are ready (691-694; 698-704).

Mary described as ideal the situation where the client is seeing Mary and the bodywork therapist in parallel, because the client can talk about her issues and also have the experience of feeling in her body (733-739). She mentioned that this ideal is, however, potentially financially impossible for clients (765). Usually Mary does not talk to or consult with the bodywork therapist; she lets the client be the bridge (741-747). At times Mary has thought of doing the bodywork herself but is not sure whether that would be taking on too much to be able to properly integrate the two together (757-762).
The Reiki method of bodywork is one that Mary has experienced and recommends to clients who need nurturing, because of its flow of love and a maternal kind of caring (592-604). She gave the example of a client whose mother was devouring rather than nurturing as someone she believed could benefit from Reiki (595-599).

The bodywork therapists to whom Mary refers are, she said, thrilled to have the recognition and support of other therapists as evidence by those referrals. They appreciate being acknowledged and incorporated in the therapeutic process (630-636). Mary voiced her philosophy that she trusts that women have a lot to offer each other. She has a vision of building that trust with other women, like “in the old village days, when kids would be with grandma, auntie” (1452-1453; 1475).
Interview with Sally

Since 1970, Sally has been working with people “in a very intense way,” and has also received therapy and training herself. She has a Master’s in counselling psychology (205-212). Sally said she trained in family systems, then Bodynamics. The latter gave her an awareness of how each muscle is related to a psychological developmental stage. Some muscles have either given up and become hypotonic, or have defended and become hypertonic, depending on how one’s early needs were met. As a counsellor who works with the body in her therapy, Sally said she works with getting those muscles to a healthy place psychologically, by letting go of defenses and/or strengthening the ego (157-175). In addition Sally said she has an interest in yoga and breath work (177-178). Sally said she has personally experienced for her own growth the kinds of work she does with her clients (192-194).

Sally first worked in Winnipeg in the early 70’s with mothers from off the street, teaching them about life skills and parenting (50-57). Sally told the story of how she took some donated sewing machines, set them up on tables arranged in a circle, and taught these women how to sew little shorts, pants, and T-shirts for their children. Many of the women had never been near a sewing machine before. While sewing, they would talk about different things, like parenting, relationships, poverty, and birth control. Sally said she realized how the activity of doing something while talking melted their defenses and allowed them to open up. They lost their sense of being defeated and were together, creating something and empowering each other (63-90). For Sally, this experience exemplified for the first time the importance of involving the body in therapy (92-97).

Sally said she then became a child care worker with children from infancy through adolescence. She encountered issues of sexual abuse. She worked with play therapy, and again made use of the body. The clients, in their play, re-enacted the traumas repetitively until their minds and bodies were able to release them (98-111).

Sally said she subsequently went to work more with families. She realized that using only talk in therapy had a “ceiling effect,” and was incomplete because the issues were happening in the body
(116-125). To incorporate the use of the body in therapy with families, she used sculpting and guided imagery. These were wonderful ways “to tap into the inside...to sense the body, {to be} able to stay with it and watch what happens and see how it turns, and stay connected” (130-154).

Sally said her office has a feeling of allowing attention to the body because of the presence of the mat she uses (517-524). Sally said she uses the mat to have the client work on regression issues or issues around shock or trauma (603-669). She said attention to the body not only helps work through these issues, but is essential for us all, because she believes we all have basic developmental woundings to some degree (731-744).

Sally said she has a basic philosophical belief that we all need bodywork in its broadest, most holistic sense. She noted that our culture has relegated and sanctioned the care of the body to the medical professionals. Sally said other non-medical ways of attending to the body, such as the releasing and preventive aspects of craniosacral therapy, are often thought to be peculiar things needed for only certain people (743-767). Sally’s belief about bodywork is not “who needs it” but “who is ready” for it (783-785).

Sally said she first assesses a client’s support system, then the client’s awareness of ways to self-care. “When you’re working with a client you may see an issue but you can’t go there unless you know the client has the resources and is open to it. So that’s the same with the body, any kind of body” (785-789). She may make suggestions for craniosacral therapy, pressure point work, or massage therapy from therapists who are familiar with releasing the tension rather than massaging it back into the body. She also refers clients to Pilates, neuromuscular therapy, or physiotherapists, as well as naturopaths and homeopaths (232-253). Sally said that making the decision to refer a client to bodywork, like any intervention, depends her assessment of the client’s openness and readiness to hear it (209-275). She said, “I really see the referral as threaded into the therapy, because if it isn’t, you can cause the client to withdraw” (283-285). Her consultation with the bodywork therapist to whom she refers depends on whether the client needs that to be a part of the process.
To find out about other caregivers, including bodyworkers, Sally said she has a wide network of friends and colleagues. She has studied what their strengths are, and asked them what resources work for them (357-365). For example, Sally asked a friend what she had been doing because she appeared to have been transformed. The friend then described Pilates work to her, and Sally said she took careful note (369-375). She does the same interested inquiry with clients who show a transformation in their personal growth through therapeutic work they have experienced in addition to the counselling with Sally (387-390).

Sally emphasized that not only is it important for her to know about the person and the work to whom she is referring, but she also must be sure that her work is honored and respected by those to whom she refers. Sally related the experience of her work not being honored. She said she referred a client to a well-regarded homeopath. The client returned to Sally upset, saying the homeopath had told her to stop seeing the therapist, i.e., Sally (327-377). Sally cautioned that an earlier wounding may be re-opened for the client, because of the possible triangulation among the client, Sally, and the other therapist. For example, the client may become like the child, in the middle of the two therapists who are like the two parents against each other (297-311).

Thus, Sally said when she hears a client speak about one of their other caregivers, she is careful to honor that relationship. For example, if the client says that the chiropractor didn’t see what Sally said she saw in the client’s body, Sally will say to the client, “Oh, now you were given two opinions. Here’s an opportunity for you to really be the center and get a real sense of which one fits, or do they both fit, or do neither of them fit.” According to Sally, addressing the apparently different opinions becomes part of the client’s therapeutic process (319-324).

Sally told some stories about clients’ readiness for considering other resources such as bodywork. One man from a family of medical doctors came to see Sally about anxiety. Sally said after she learned about his lifestyle, she asked if he had ever considered seeing an alternative health care provider. When he replied that he sees the doctor and that’s all he needs, she let it go, noting to him.
that if he ever became interested, she was aware of how other people with anxiety had benefited from consultation about their diet. After doing more work with Sally, this client had a flashback of some early trauma and she assisted him in working through it with some bodywork. When she then wondered aloud to him whether he suffered from allergies, and how allergies to foods can impact the body and the mind, he asked for a referral and she told him about a homeopath and a naturopath (403-466). Thus he was more open to hearing her referrals after gaining some trust and sense of safety with her.

Sally told about another client who followed Sally’s referral to see a craniosacral therapist, then stopped after a few times saying she got nothing out of it. This same client then went to a chiropractor to whom Sally had referred her. The chiropractor said to the client “I don’t think you want to be here.” When the client confirmed that she didn’t want to be there, the chiropractor said, “Well then, I can’t work with you.” The client then found another chiropractor on her own, and eventually went back to the craniosacral therapist, telling Sally that both were quite helpful. Thus, the seed was planted by Sally’s suggestion at a time she perceived the client would be ready to benefit from the experience. The client, however, had her own timing, and the need to have a sense of control and responsibility, to be able to receive and appreciate the work (483-516).

Sally told about a client who went into spiritual worlds quite easily as a defense. Consequently in the counselling they worked together on the client’s ability to focus on the day-to-day practical priorities. For this kind of client, Sally said she would recommend very physical bodywork, like a chiropractor, to have the client be able to feel her flesh and bones. Sally said she would not refer this kind of client to craniosacral therapy because that would take her into less-boundaried worlds (994-1029).

Sally described how a client who had difficulty receiving from others and making connections went to a massage therapist on Sally’s recommendation. Sally saw that the client, who had borderline characteristics, was using the contact in the massage inappropriately. She would allow herself to feel
connected only when she was there, she sexualized the contact, and she voiced that she was otherwise unlovable. Sally told the client that Sally could not work with her unless she stopped the massage therapy. The client became very angry, but reached out to her family and brought them into session with Sally. Thus the process of referral led to the therapeutic step of having the client make contact with her family. Sally noted that this experience showed that she needs to continually assess whether, and how, aspects of the work she does and the work done by referral are integrating therapeutically (1055-1227).

Sally described how she comes from deep inside herself, “a very still place” (1241) “to get a real reading of what is happening out there “ (1239-1246). Sally said she believes she developed this ability to listen deeply from being with her mother. She said she remembers growing up with other kids around and being in the kitchen with her mother, doing chores. Her mother “had an endless amount of time to hear all of my stories and had a tremendous ability to show me that my stories were all interesting…I learned from her body how to be in my body…it was a very safe home” (1250-1272). Sally said, “that is how I can make quite courageous decisions about no nonsense, that I’m on your side” (1287). She said she is aware of her ability “to go to places where I’m not afraid” and to make statements that she feels are grounded, because she has an internal confidence about her sense of “reality testing.” When she does feel a doubt about her perceptions, Sally said that she will take time out in front of the client to stop and say that “I need to get centered, get boundaried, and then I can move on with you.” Thus she allows the client to be aware of the process of being connected to one’s body, mind, and spirit, by modeling the self-observation. (tel.con. 4/23/99).

Sally said her vision is to join with other professional in a clinic “in a place in nature.” The group would include a chiropractor, a physiotherapist, a naturopath, a bodywork therapist, and others who are specialists in developmental issues. These practitioners would support each other and work in a holistic way, appreciating their uniqueness and the ways in which their work overlapped. (tel.con. 4/23/99).
Interview with Sarah

Sarah has been counselling for 30 years. She was trained as a nurse, then worked as a social worker in the human resources system. After ten years of nursing, Sarah experienced a back injury. She took some time off and started a family. Sarah said she found disturbing the lack of attention to feelings in the medical world. She sensed the whole person needed to be attended to (108-141), and looked to social work as a more satisfying way to address her concerns (150-155). Sarah related that she always knew she had a talent for counselling so it came as no surprise to her, or to others, that after six months of volunteering in a social work agency, she was employed. She worked with adolescents and families (75-81). She has since worked with families, children, women’s groups, sexual abuse groups, support groups, and groups for spiritual inspiration (19-40).

In Sarah’s experience, the clients who are open and ready to self-explore are mostly women between 30 and 60 years old (1027-1029). Her counselling practice now is part-time, working mostly with women, couples, and occasionally children with a family that is splitting up (21-26). Clients come to Sarah by word of mouth. Currently she has been working more with therapists as clients, which she characterizes as “influencing” what gets done rather than “doing” what gets done (1153-1183). In the past five years she has intensively studied and practiced Buddhism (841-842). Sarah voiced her sense of feeling ready in her career to no longer gather but to give and share what she knows (750-776).

Sarah described her personal experience with bodywork. She has trained in the Feldenkrais Method® (445-457). She is aware of her own and others’ aging processes, and the importance of keeping fit (470-473). She has healed from four back injuries through a variety of different bodywork therapies. She has benefited from craniosacral work and muscle energy techniques (478-501), and recommends them when she feels they will be responsive to a client’s needs (663-665). In her community are massage therapists, Shamanic therapists, Bodynamics, muscle energy, and craniosacral therapists.
Having been in the community for 30 years, Sarah said she has a lot of people in her friendship circle and in her collegial circle, with whom she can consult, find support, and question about her perceptions of clients' needs and her referrals for them (710-746). She said she finds that her colleagues are glad to answer and to respond to questions (750-776). She said that after making the referral she doesn’t talk to or consult with the person to whom she refers the client (1579-1580).

Part of Sarah’s philosophy is to teach people to take responsibility (174-175). The client has the responsibility (1602) and she empowers them to take it (1602). To begin with, she looks at the basics with clients, like whether they are getting enough sleep, exercise, and proper food, and having fun (905-908). She said she notices whether people are holding their issues superficially and how integrated they are in their bodies. Being superficial means wanting their needs met now, wanting to be fixed now (261-262).

If the client is not open to what the therapist is saying, they are not going to be open to her recommendations (265-267). With such clients, Sarah said, it takes a long time for them “to soften” (267-268) and to be open. Unless they think it’s a good idea, they won’t follow through” (295-296). “[I]t can’t be imposed from the outside...it can’t just be that their friend recommended them” (284-286). “You can spend hours and hours and hours asking people to do different things, whether it’s stretches or writing exercises or contemplation exercises...they just don’t do it unless they’re ready” (300-305).

She described how she talks to those who are open about ways they could be touched (209-210). She acknowledged that some people are not capable of being touched and are more suited to movement, such as walking, dance, or Tai Chi (213-226). Sarah said that she sees what the client is ready for and supports them to explore that (314-315) then lets them move at their pace (319-320). She described her way of being with clients as sitting with them and supporting them with whatever they’re doing, not being judgmental (1386-1396). She sits and listens (1448). She said she believes we all have intuition. Some of us can speak from it and some of us can’t (1497-1499).
Sarah said she often works together with the client to help them create whatever they need in terms of other kinds of therapies, such as bodywork. Sarah said many of the resources that have a bodywork component are not necessarily financially impossible, and available in community centers. She named various psychophysical movement and exercise methods, such as yoga, Tai Chi, Aikido, and the Feldenkrais Method® (952-1000). Other clients have their own programs. Some are very resourceful and eclectic on their own after seeing Sarah for a long time, and only come back to her in moments of crisis (888-899).

With any referral, Sarah said she knows what’s out there and what works for her, but needs to know what’s going to work for the client, to meet the client’s needs (669-680). Sarah said she keeps lists of people in her network but never refers to the lists (1253-1263). She trusts that she knows what she needs to know at any particular moment. “I don’t ever forget anything that I need to remember right now” (1267-1268).

She pays attention to how people are in their bodies. “[S]ome people are just at home in their bodies. Other people are held in their bodies. It’s like they’re wearing a shirt that doesn’t quite fit and it holds them in a place” (394-401). “[I]f there’s something physical going on, I talk to those people quite directly about it, because if you can put it out, if they can literally see it then they can imagine that something could shift” (406-411).