The All-New Unified Healing Seminar

Presented by:

Dr Paul J Canali

Jim Fazio, LMT, CSI, UTP

Barbara Lempereur, BS, UTP

July 24th – 25th, 2021

Christ Congregational Church, Kelsey Hall
14920 SW 67th Avenue, Palmetto Bay, FL 33158

Your Name:_____

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The All-New Unified Healing Seminar

Instructors

Dr Paul J Canali:

Dr Paul Canali is a true pioneer in brain body medicine. He is considered to be one of the most experienced Physician Healers alive today. His discovery of the Homeostatic Healing Reflex and a Unified Theory of Healing Therapies has proven to be the most effective tool for healing toxic stress, trauma, and chronic pain.

Jim Fazio, LMT, CSI, UTP:

Jim is a multi-disciplinary Neuromuscular Therapist who has been in private practice for over 25 years. A serious seeker, he represents a rare breed of therapists that addresses the biopsychosocial components of neuromuscular pain, trauma, and anxiety and supports those that are on the spiritual quest.

Jim has a wealth of clinical experience in a variety of medical and fitness settings and brings both personal experience and clinical knowledge to his work as a Unified Therapy™ Practitioner. www.jimfazioib.com

Barbara Lempereur, BS, UTP:

Barbara Lempereur brings over 20 years of healing experience as a Reiki Master, Yuen Energetics practitioner, and Unified Therapy™ Instructor and Practitioner. She graduated Magna Cum Laude from Kaplan University with a Bachelor of Science degree in Psychology.

Barbara is passionate about helping people to heal holistically by identifying the mind-body connection. A devoted student of life, she is always learning new ways to heal, connect, and rebalance. Barbara's Unified Therapy™ practice is located in Beaufort, SC and she can be reached at blempereur@msn.com or 305-401-2914.

Tools to Boost Your Effectiveness

- **Understand how to *recognize* and *trust* the regulatory processes** that promotes safe, fast and efficient ANS and Limbic re-regulation.
- **Learn how to *effectively interact* with** Sensory Processing and Mindfulness in shifting states of anxiety, depression and more.

- **Learn *how to use props* that can help a person to sense & feel in their bodies** in order to enhance their ability to access deep emotions & states.
- **Acquire *new tools to work with* Implicit Memory when it arises.**
- **Learn how to use sensory processing** to return from challenging stimulus (memories, emotions, traumatic experiences) to a safe baseline (homeostasis).
- **Learn to recognize signs of changes in levels of Allostatic Load.**
- **Recognize the signs of shifting from Dysregulation to Re-Regulation to Self-Regulation.**

Unified Therapy™

Accesses regulatory processes that promote safe, fast and efficient ANS & Limbic re-regulation.

Teaches interaction through direct experience with Sensory Processing & Mindfulness (Middle Prefrontal Cortex).

Promotes development of Prefrontal Cortex to gain Conscious control over affect of Limbic Structures by directly interacting with fears that arise during the process.

Treats Comorbid Conditions Concurrently.

Accesses and teaches how to interact with Implicit & Explicit memory in a safe environment.

Re-Creates Conditions (memories, emotions, traumatic experiences) moment-to-moment and returns from this challenging stimulus to a safe baseline (homeostasis).

Decreases acquired Allostatic Load

Supports shift from Dysregulation to Re-Regulation to Self-Regulation.

Highly reproducible and evidence based.

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ACE Score Questionnaire

There are 10 types of childhood trauma measured in the ACE Study. Five are personal and five are related to other family members. Each type of trauma counts as one. So a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

   No _____ If Yes, enter 1 _____

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

   No _____ If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

   No _____ If Yes, enter 1 _____

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

   No _____ If Yes, enter 1 _____

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   No _____ If Yes, enter 1 _____

6. Was a biological parent ever lost to you through divorce, abandonment, or other reason ?

   No _____ If Yes, enter 1 _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   No _____ If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   No _____ If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   No _____ If Yes, enter 1 _____

10. Did a household member go to prison?

    No _____ If Yes, enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

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Trauma History

PATIENT NAME: _____ **DATE:** _____

What are the three most traumatic things you have experienced?

1- _____

2- _____

3- _____

PRENATAL HISTORY

Was your pregnancy planned, were you a wanted child? _____

Were you premature; were you in an incubator for more than two days? _____

Was your birth difficult? _____

Was your mother in poor physical or emotional health, did she experience any losses or dramatic events during her pregnancy with you? _____

Did your parent(s) want a child of the opposite gender? _____

Were you adopted? _____

As an infant, were you separated from your mother at birth? _____

Did you have any medical problems or early hospitalization? _____

Were there other children in your family, Did you feel accepted by them? _____

Did your family have adequate food, shelter and other basic needs met? _____

Did you feel loved? _____

PHYSICAL HISTORY

Have you had any hospitalizations, surgery, or serious illness? _____

Have you had any long-term or difficult medical treatments? _____

Have you had any life-threatening conditions? _____

Have you had any accidents (burns, falls, broken bones, auto accident, etc.)? _____

Have you had any difficult experiences with doctors, nurses or hospitals, how did you respond to the situation? _____

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Have you experienced chronic, unexplained physical ailments? What was going on in your life when symptoms were first apparent?

___ Headaches _____

___ Stomach aches _____

___ Colitis _____

___ Irritable bowel syndrome (IBS) _____

___ Autoimmune disorder _____

___ Joint pains _____

___ Skin conditions _____

___ Other _____

FAMILY RELATIONSHIPS

Were you separated from either parent or siblings for a length of time, where and with whom did you live with then? _____

Did any family members have alcohol or drug problems? _____

Did your parents fight-physically, verbally, did you hear or see these fights? _____

How were you punished or disciplined, were you hit, how often, how severely? _____

Did you experience any incest, molestation, ongoing difficulties with siblings? _____

Were your parents married, divorced, remarried? _____

Were there any other relationships coming into the home? _____

How many caregivers did you have while growing up? _____

How many places did you live while growing up? _____

SCHOOL/WORK EXPERIENCES

Did you feel teased, tormented, bullied or threatened? _____

Did you feel excluded, outcast or ostracized? _____

Did you experience prejudices? _____

FRIGHTENING EVENTS

Have you had any direct experience with human-caused assault, kidnapping, mugging, rape, arson etc.?

Have you had any direct experience with nature-based fear, like tornado, earthquake, flood, fire etc.?

Have you witnessed any frightening events? Explain what, and at what age?

Do you have a close connection to someone who experienced a frightening event?

Have you had a frightening spiritual or religious experience?

LOSSES

Have you experienced any deaths of significant others, what circumstances?

Have you experienced the loss of a treasured pet?

Have you experienced the loss of a pregnancy, through what means?

Have you experienced a serious break-up with good friends, boy/girlfriend, spouse or significant other?

Have you experienced a loss of job, what circumstances?

Have you experienced a loss of home, what circumstances?

Other upsetting life events or experiences that you want to communicate.

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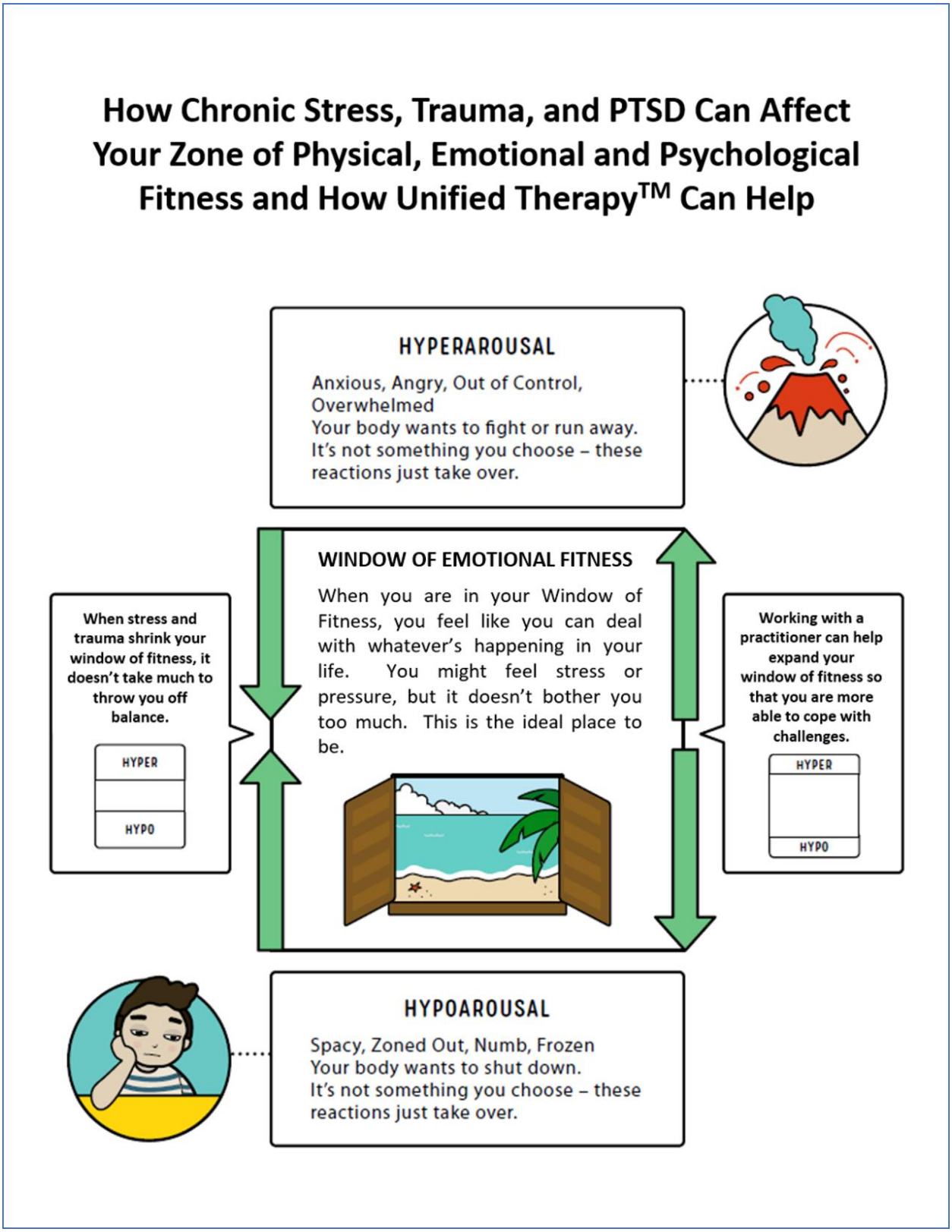
Zone of Physical, Emotional, and Psychological Fitness



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Observing dysregulation and re-regulation in the autonomic nervous system DURING A SESSION:

HYPOAROUSAL
(Parasympathetic Arousal)

- Poor heart rate variability
- Shallow breathing
- Muscles flaccid
- Sleepiness, spaciness
- Dissociated from body and emotions.
- Person acts absent, can't concentrate, doesn't hear, nobody home.
- Numb, doesn't feel much.
- Not much energy to work during session.
- Resistant to proactive exercises
- Feeling of resignation
- Flat effect, ie face can look blank
- Slow to respond to questions or no answer at all.
- Stuck patterns of involuntary movements.

Signs of Reregulation During a Session

Increase in ability to surrender.

Curious to experience

Present

Feeling of settling/relaxing

Allowing shaking/trembling to naturally flow through cycles.

Deep peace while still alert

Able to observe/experience involuntary movements and emotions impartially (staying totally present)

Passive movements easy

Digestion back "online" or less pain or restriction.

Less overall perception of pain in the body

Resilient

Therapist can feel body tone shifting more quickly.

Tears in eyes

Reporting experience in a slow and concentrated way.

Ability to sense and track sensations.

Changes in patterns of involuntary movements.

Able to work independently.

HYPERAROUSAL
(Sympathetic Arousal)

- Poor heartrate
- Breaths per minute running high.
- Hypervigilant
- Muscles tense
- Digestion "offline", burning, cramps, nausea.
- Blood drained away from skin – cool/cold skin.
- On alert, startles easily, "jumpy".
- Legs kicking, knees bending.
- Arms grabbing, punching, pushing.
- Excessive energy
- Jaw clenched, grinding, tight.
- Argumentative, confrontational, resistant to the process
- Passive movements difficult
- Dissociated from body and emotions.
- Person overacts to physical stimulus, lower pain threshold.
- Face looks tense, eyebrows furrowed.
- Movements too fast, hard to slow down.
- Too quick to respond to questions.
- Higher anxiety level
- Stuck patterns of involuntary movements.

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what is a direct experience of sensation?

what kinds of questions help access sensation directly?

What words express *thinking about* or *interpreting* sensation?

- *neglected*
- *happy*
- *angry*
- *"wants to move"*
- *"wants to get out"*
- *"wants to...etc."*
- *sad*
- *bored*
- *broken*
- *frustration*
- *indecision*
- *dislike*
- *horrible*
- *stuck*
- *black/red/etc.*
- *overwhelming*
- *heartburn*
- *nausea*
- *crooked*
- *free*
- *wrong*
- *out of place*
- *removed*

EXAMPLES of Invitational Languaging:

what does "neglected" feel like in your body?

how are you experiencing "wanting to move"?

is there a center to your "sad" feeling?

where is the "anger" in your body?

is there an edge to the warm feeling you have?

where does the stretching begin and end?

is it ok to stay with that feeling for a minute?

let's see what happens next.

What words express *directly experiencing* sensation?

- *tingling*
- *stretching*
- *hard*
- *soft*
- *immobile*
- *gooey*
- *sticky*
- *stringy*
- *warm*
- *cool*
- *cold*
- *metallic*
- *muddy*
- *sharp*
- *fuzzy*
- *burning*
- *itching*
- *lightness*
- *buzzing*
- *constricted*
- *relaxing*
- *tight*
- *pulsing*
- *shaking*
- *trembling*
- *expanding*
- *contracting*
- *bubbling*
- *stabbing*
- *etc...*

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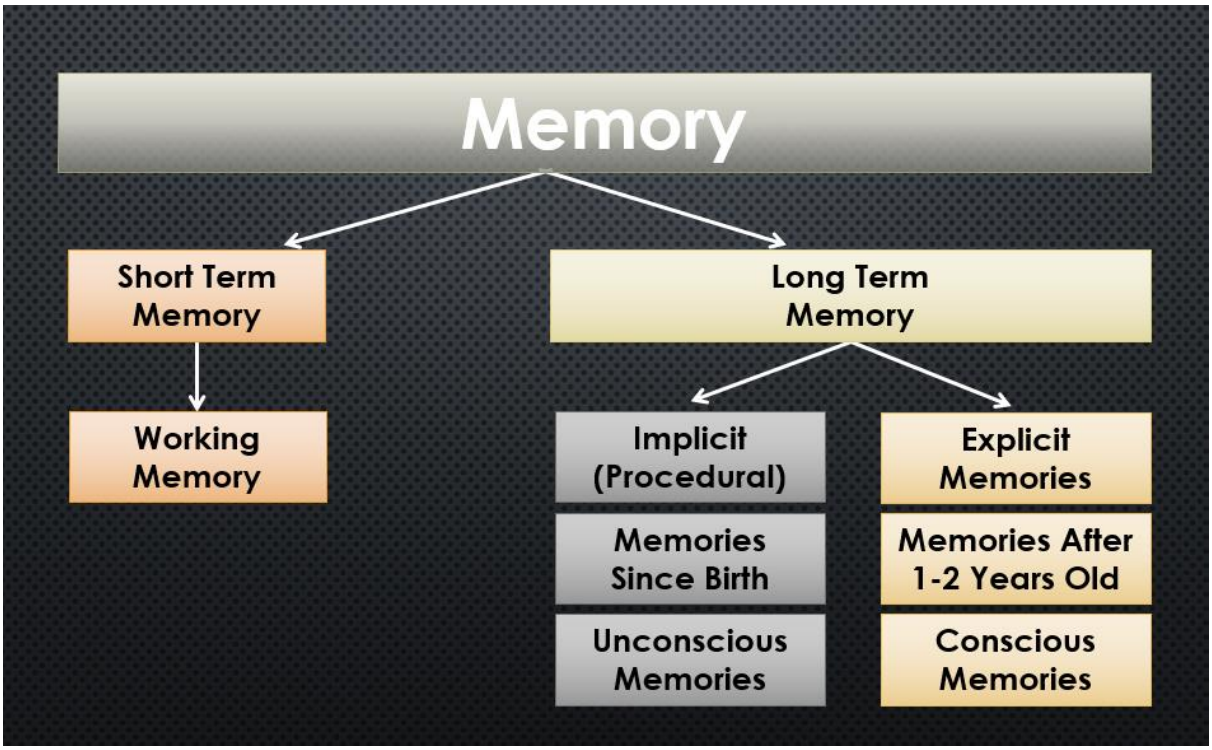
How can different types of MEMORY show in a session?



How can IMPLICIT MEMORY (procedural) express itself DURING A SESSION?

Often is as real as the first time we experienced it.

No autobiographical memory or explanation.

A feeling that is difficult to verbalize.

Vague and elusive emotions or sensations.

Bodily sensations can be the beginning of access to implicit memory.

Perception of chaotic expression of memory.

Spontaneously arises during process of therapy with no frame of reference.

Feeling of lack of control

Unaware that is it coming from the past.

How can EXPLICIT MEMORY (declarative) express itself DURING A SESSION?

Conscious memory that you can make sense out of.

Sense of recollection in timeline of life.

Logical series of events.

Concrete places or events recalled, context dependent.

Partial retrieval of memories is possible.

Emotions can be explained/rationalized.

Memories of events can play over and over in the mind.

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active diagnosis

what does the term "active diagnosis" mean?

Practicing *Active Diagnosis* means that you are constantly observing and re-assessing what is going on with the patient. During any given session, symptoms/affect/physical sensations/movements can shift and change their nature within minutes or even seconds. It is important to stay present and adjust your strategy at any moment depending upon what you observe.

Premises for Practicing UT™:

1. **There is an innate intelligence that you can trust.** If you learn how to support and encourage this innate system, it will always engage.
2. **Higher consciousness/awareness/perception is the goal.** *Your level of consciousness dictates how your body and mind react to the world. Make sure the client is at all times focused on the present moment (engaging Prefrontal activity), not distracted, dissociated, or "spacing out". It is absolutely necessary to have the conscious attention of the client, otherwise everything you do together will be less effective.*
3. **Keen observation and presence on the part of the Therapist is KEY.** *You must always be tracking the client's Autonomic Responses like: breathing (patterns and sounds), affect (verbal and physical expression of emotions), movements (are they involuntary or voluntary? What is moving?), temperature changes (sweating? cold?), Mirroring in your own body (are you feeling something empathetically?), Monitor stimulation and sedation pendulation (when do you need to change direction?). Use the pulse oximeter to measure heart rate variability and oxygen levels.*
4. **Know the difference between leading and invitational languaging.** Ask what they are noticing, sensing, experiencing, feeling as opposed to telling them what you feel or see.
5. **Support, encourage, call out the moment when you see the client engage**–the moment when their body lets go–when a spontaneous movement/trembling/softening/shift happens.
6. **Integration time is important-pause-take your hands off-stop talking**. *Allow for time when the client can work on their own as you watch carefully-this allows time to integrate the input they have just received.*
7. **Remember you are reading a different language: Everything You Need to Know is in Front of You-Just Observe**. Maintain your confidence that what needs to happen today will happen, and no matter how fast or slow the process goes, it is right and perfect. You can trust the body.

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To see is
to forget
the name
of
the thing
one sees.

-Paul Valéry

"Being mindfully aware, attending to the richness of our here-and-now experiences, creates scientifically recognized enhancements in our physiology, our mental functions, and our interpersonal relationships. Being fully present in our awareness opens our lives to new possibilities of well-being."

-Daniel J. Seigel, MD
The Mindful Brain, 2007

Try to be AWARE AT ALL TIMES of, for example:

- Letting go of any preconceptions you have, or any need to "figure it out" just be present, observe, wait.
- Whether the client is present, dissociating, distracting themselves, trying to distract you.
- When the client is stuck in a pattern (physical, emotional, thought)
- When the client gets stuck in hypoarousal or hyperarousal-notice quality of breathing, repeated movements, no movement, no affect.
- Whether the client is able to stay with what they are sensing or not.
- Any involuntary movements or trembling.
- Changing Emotional States (Affect).
- What is dissociative talking and what is productive dialogue.
- Your own fears or anxieties coming up.
- Your own dissociating.
- Your own bodily sensations.
- The state of the client's breath.
- When to slow the client down, when to speed them up (sedation and stimulation)
- When to leave the client alone for a while (integration)
- Sensing when the client has done enough for one session: closing.

sensory processing

Unified Therapy™ Exercise 1

Following Sensation/Sensory Processing

Objectives:

- Learn how to teach your client to perceive the vast number of available sensations in the body.
- Learn how to draw your patient's attention into the areas they are sensing by using compression, holding, slow movement, for the purpose of following when the sensations change.
- Learn to recognize signs of effective attention and signs of ineffective concentration.

Lesson Steps:

a. Ask Client to lie on their back on the table. Make sure they are comfortable. (a pillow under their knees, a blanket, and a pillow under head if necessary.)

b. Before doing anything, have the patient scan their body-find spots that attract their attention-and describe the sensations they have. One of these sensations can be feeling numb all over, or in parts of the body. Give them time to really feel what is going on in their body. If they do not seem to be concentrating, they may need more guidance, like asking them to check their feet, their legs, etc. This gives you and the client a baseline to refer back to later and also gives you a chance to test somatic awareness to see what level you are working with.

c. After you have determined the spots where they are feeling the most, go to one of them and put pressure there, or move the joint slowly. Encourage them to concentrate on feeling and explore the sensations and how they may change. Explain that the sensations may intensify, or move to another location, or change in character right where they are. There are infinite possibilities, they just have to stay present to see what happens next.

d. Keep your intense attention on the entire body as you look for signs that they are responding and connecting. This can take the form of a deep breath, shaking or trembling, emotional release, softening of the tissue, a change in mobility, among other responses.

e. When the changes or responses subside, have the client check the area again to see what is there now. Feel if you can sense a change yourself.

f. Ask them to scan the body again, and then find the next spot and repeat the steps of sensory processing.

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enteric brain

Unified Therapy™ Exercise 2

The Enteric Brain Technique™: Working with the Abdomen

> "*The Enteric Brain is a built-in biological system to keep us on the path to health and higher consciousness or awareness. It is controlled by an innate network that tells us whether or not it is safe to become fully human and free from fear, or to stay living in fear, survival, and separation.*"
>
> ***-Dr. Paul Canali, 2006***

> *"The brain in the gut plays a major role in human happiness and misery."*
>
> ***– Dr. Michael Gershon,***
> *Professor of Anatomy and Cell Biology at*
> *Columbia-Presbyterian Medical Center in New York.*

The Enteric Brain Technique™, originated and developed by Dr. Paul Canali, has allowed doctors, therapists, and patients to directly affect and balance the Autonomic Nervous System, or ANS, including the Enteric Brain for the first time by way of somatic or body centered therapy. The Enteric Brain Technique™ is a method of somatic sensory input using specific touch and biofeedback in conjunction with focused concentration. This type of mindful attention increases brain-body and brain-Enteric Brain bidirectional communication and feedback.

The practical application is hands-on stimulation and sedation of the abdomen (Enteric Brain) by the therapist, as well as self-imposed work using the weighted exercise balls, along with guided breathing, and mindful interaction with somatic sensations. This method of biofeedback entrains the Autonomic Nervous System, particularly enhancing Vagal nerve function, to respond to conscious or mindful control.

This in turn empowers the client to develop a proactive dialogue to somatic or body sensations without becoming overly fearful, aroused, or somatically dissociated.

Objectives:

- Learn how to guide your patient's attention into the abdomen and train them to use mindful observation and recognize different types of responses.
- Learn how to work with stimulating and sedating the ANS through working with the Enteric Brain.
- Learn how to teach your client to let the body express itself (trembling, movement, affect) without fear and somatic dissociation.

Lesson Steps:

a. Ask Client to lie on their back on the table. Make sure they are comfortable. (a pillow under their knees, a blanket, and a pillow under head if necessary.)

b. There is no particular rule, but a good spot to start is in the area of the diaphragm. While watching the client's face carefully, put an even pressure using your fingers. The pressure will depend upon the person's sensitivity.

   Ask them to breath in, and then to breath out. Have them concentrate on their breath with all of their attention. As they breath in you lift up your fingers, and then push down as they breath out. Guide them to see what they are feeling. Give enough time for them to respond and try to tell by the way they are talking if they are really feeling with mindfulness, or sound like they are just reporting.

   With experience you will be able to tell if they are present or dissociated. Feel for the heartbeat and ask them if they feel it too. You will notice if it is strong or weak and ask them for feedback too to see if they are feeling the same thing.

   This can be a good time to put a weighted ball on their abdomen and have them practice concentrating on their breath and the rhythm of their heart by themselves for a while. This strengthens their ability to keep their minds focused, and also see that they can work independently to build their ability to be somatically mindful.

c. Next, let them know you are going to move around the abdominal area, and tell them about the Enteric Brain if you have not already. It helps to know why we are working in this area since sometimes it is not so comfortable for people.

d. Move around to various spots on the abdomen and press in-always looking at the face of your client. You are looking for a spot which brings a response-emotional, physical, movement, trembling.

e. In class we will demonstrate this technique-we use many ways of activating-startle response, myofascial, compression, light touch etc.

> "Provided that the Vagus nerve is intact, a steady stream of messages flow back and forth between the brain and the gut. We all experience situations in which our brains cause our bowels to go into overdrive. But in fact, messages departing the gut outnumber the opposing traffic on the order of about nine to one."
>
> ***–Dr. Michael Gershon, MD***

> "The Vagus nerve, … has been termed the most important nerve in the body because it controls heart rate, digestion, and other fundamental body functions, [and] also controls the immune system."
>
> ***–Kevin M. Tracey, MD***

using props

Unified Therapy™ Exercise 3

Working with Props

Props are any tools you use to help you work with the client during the session, such as bands, weighted balls, rollers, inflated balls, etc. Props are used to help the client work with **sensory processing**. They are also a good way for health professionals who do not have a hands-on therapy license to help the patient work with their body's sensations. Another important use of props is that the client can use them at home to work on their own.

Objectives:

- Learn how and when to use various props.
- Learn how to leave a client alone using props and why you do it.
- Be creative – always remember the purpose of the props – there are many tools to be discovered.

Example uses of Props:

Rollers:

- Under the Upper Back
- Under the hips
- As a way to stretch the arms when the patient is supine
- Under the neck

Weighted balls:

- One in each hand-1 lb or 2lb-patient supine-exercise
- On the abdomen or chest-or anywhere else-3lb, 4lb. 6lb
- One in both hands-patient supine-moving in different angles
- Under the body

Bands:

- Wrap around wrists-patient supine-exercises.
- Wrap around wrists-prone-exercise-forward and back.
- Wrap around ankles-patient prone-exercise.

Inflated balls:

- Between knees-patient supine
- Between hands-patient supine

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To Touch or Not to Touch

Clinical Update

By Zur Institute

http://www.zurinstitute.com/touch_clinicalupdate.html

http://www.zurinstitute.com/touchintherapy.html

A woman patient of mine lost her first and only infant son in a drunk driving accident. At the time of this tragedy, the pain of her loss was, of course immense; she could not stop crying and was contemplating suicide. At the insistence of her family, she agreed to an emergency appointment with a psychotherapist expert in loss. In this grief-stricken state, barely able to stand, she entered the office and sobbed uncontrollably. In her desperation and isolation, she begged him to hold her. True to his most recent Ethics and Risk Management continuing education workshops, he explained to her that therapy is about talking, not touching and citing something about professional boundaries. At the end of the session, he suggested that she get a prescription for Valium from her GP and set an appointment for a couple of days later. Eight years later, addicted to Valium and alcohol, divorced and with two failed rehab programs behind her, she began therapy with me. After an intense and tearful few months of therapy and long conversations we went to her son's grave. It was the first time she had ever visited the grave. There we stood, holding each other, and both weeping. We stood there for a long time as she cried and I cried. She had finally begun facing her baby's death and mourning for him and grieving for the years lost in drugged denial. That therapist followed risk management guidelines to perfection. He took the "safe" path that forbids touch. However, by practicing risk management, adhering to the "no touch" dogma, he inflicted needless additional suffering on this woman. He sacrificed his humanity and the core of his professional being, to the demands of a heartless, paranoid, and destructive protocol.

We have been told by ethics experts, attorneys, continuing education instructors and supervisors never to touch our clients. Touch has been increasingly perceived as a risk management issue to be avoided rather than as one of the most powerful tool of healing. Non-sexual touch, we have been told, is very likely to lead to sexual touch. In spite of the almost half century of knowledge of the emotional, physiological, and behavioral benefits of touch, most therapists still shy away from appropriate non-sexual touch due to fear of boards, attorneys, and lack of training. **This Clinical Update summarizes the significant, ethical, and clinical utility consideration of non-sexual touch in psychotherapy.**

The General Significance of Touch

- Touch is one of the most essential elements of human development: a form of communication, critical for healthy development and one of the most significant healing forces.
- In his seminal work, *Touching: The Human Significance of the Skin*, Ashley Montagu (1971) brought together a great array of studies demonstrating the significant role of physical touch in human development.
- The effects of touch deficiencies can have lifelong serious negative ramifications.

- Bowlby and Harlow, among many others, concluded that touch, rather than feeding, bonds infant to caregiver.
- Touch has a high degree of cultural relativity. People of Anglo-Saxon origin place low on a continuum of touch while those of Latin, Mediterranean and third world ancestry place on the high end.
- The general western culture and its emphasis on autonomy, independence, separateness, and privacy have resulted in restricting interpersonal physical touch to a minimum. America is a "low-touch culture."
- In Western society, sex, love, power, and dominance are dangerously confused.
- Americans tend to sexualize or infantilize the meaning of touch and as a result tend to avoid touch. Watson, parenting expert of the early 1900's, cautioned mothers not to sexualize their infants by kissing or hugging them affectionately.

Touch And Healing

- The medicinal aspect of touch has been known and utilized since earliest recorded medical history, 25 centuries ago.
- Touch unleashes a stream of healing chemical responses including a decrease in stress hormones and an increase in serotonin and dopamine levels.
- Touch increases the immune system's cytotoxic capacity thereby helping our body maintain its defenses.
- Massage has been shown to decrease anxiety, depression, hyperactivity, inattention, stress hormones and cortisol levels.
- Massaged babies are more sociable and more easily soothed than babies who have not been massaged.

Types Of Touch in Psychotherapy (See articles for details)

- Ritualistic or socially accepted gestures
- Conversational Marker
- Consoling or reassuring
- Playful touch
- Grounding or reorienting
- Task-Oriented
- Corrective experience
- Instructional or modeling
- Celebratory or congratulatory
- Experiential
- Referential
- Inadvertent
- Preventing someone from hurting self or others
- Self-defense
- Therapeutic intervention - A body-therapy medical technique
- Inappropriate, unethical, and mostly illegal forms of touch include sexual, hostile-violent and punishing touch.

Sources Of the Prohibition of Touch in Therapy

- The general western culture and its emphasis on autonomy, independence, separateness, and privacy.
- The cultural tendency in the USA to sexualize most forms of touch.
- The traditional dualistic Western mind-body or mental-physical split.
- Homophobia.
- Some fundamentalist religious denominations that have a highly restrictive view of all forms of touch.
- The litigious culture and the resulting risk management and defensive medicine practices.
- Psychoanalysis and its emphasis on neutrality, distance, and rigid boundaries.
- Those feminist scholars who assert that most touch by male therapists of female patients is disempowering and injuring to the women.
- The fear-based, illogical slippery slope idea that non-sexual touch inevitably leads to sexual exploitation.
- The more recent crisis in the clergy and the not-too-distant day-care hysteria in regard to sexual exploitation.

Ethical Consideration of Non-Sexual Touch in Therapy

- Touch in therapy is not inherently unethical.
- None of the professional organizations code of ethics (i.e., APA, ApA, ACA, NASW, CAMFT) view touch as unethical.
- Touch should be employed in therapy when it is likely to have positive therapeutic effect.
- Practicing risk management by rigidly avoiding touch is unethical. Therapists are not paid to protect themselves, they are hired to help, heal, support, etc.
- Avoiding touch in therapy on account of fear of boards or attorneys is unethical.
- Rigidly withholding touch from children and other clients who can benefit from it, such as those who are anxious, dissociative, grieving or terminally ill can be harming and therefore unethical.
- Sexual, erotic, or violent touch in therapy is always unethical.
- Stopping therapy in order to engage in sexual touch or sexual relationships is unethical and often illegal.
- Ethical touch is the touch that is employed with consideration to the context of the therapeutic relationship and with sensitivity to clients' variables, such as gender, culture, history, diagnosis, etc.
- Seeking ethical consultation is important in complex and sensitive cases.
- Ethical therapists should thoroughly process their feelings, attitudes, and thoughts regarding touch in general and the often, unavoidable attraction to particular clients.
- Critical thinking and thorough ethical-decision making are most important processes preceding the ethical use of touch in therapy.
- Documentation of type, frequency and rationale of extensive touch is an important aspect of ethical practice.

Clinical Considerations for Touch in Psychotherapy

- The meaning of touch can only be understood within the context of who the patient is, the therapeutic relationship, the therapist, and the therapeutic setting.

- Touch, like any other therapists' behavior and interventions should be employed if they are likely to help clients.
- Touch increases therapeutic alliance, the factor found to be the best predictor of therapeutic outcome.
- Touch can help therapists to provide real or symbolic contact and nurturance, to facilitate access to, exploration of, and resolution of emotional experiences, to provide containment, and to restore significant and healthy dimensions in relationships.
- Clinically appropriate touch must be employed with sensitivity to clients' variables, such as history, gender, culture, diagnosis, etc.
- Sensitive, attuned touch gets etched into our developing neural pathways enabling us to feel of value, and to connect emotionally with others. As such, touch can be a powerful method of healing.
- Language never completely supersedes the more primitive form of communication, physical touch. As such it can have a significant therapeutic value.
- The unduly restrictive analytic, risk management or defensive medicine emphasis on rigid and inflexible boundaries and the mandate to avoid touch interferes with human relatedness and sound clinical judgment.
- Due to the absence of attention to touch in most training programs, clinical supervision, research and testing, the majority of therapists tend not to incorporate the use of touch in therapy.
- Fear, misguided beliefs, and lack of training often lead to therapists employing an approach of "touch but don't talk."
- Touch that is inappropriate, sexual, cold, or abusive can be harmful.
- Traumatic memories are encoded in our sensorimotor system as kinesthetic sensations and images, while the linguistic encoding of memory is suppressed. Therefore, appropriate touch can have a significant therapeutic value.
- Disturbances in non-verbal communication are more severe and often longer lasting than disturbances in verbal language. Using touch in therapy may be the only way to heal some of these disturbances.
- To disregard all physical contact between therapist and client may deter or limit psychological growth.

Guidelines For Clinically Appropriate and Ethical Touch in Therapy

- Touch should be employed in therapy if it is likely to be helpful and clinically effective.
- Avoiding touch due to fear of boards and attorneys is unethical and a betrayal of our clinical commitment to aid clients.
- Touch in therapy must always be employed with full consideration to the context of therapy and clients' factors, such as presenting problems and symptoms, personal touch and sexual history, ability to differentiate types of touch, the client's level of ability to assertively identify and protect his or her boundaries as well as the gender, and cultural influences of both the client and the therapist.
- Touch should be used according to the therapists training and competence.
- Extensive touch should be incorporated into the written treatment planning.
- The decision to touch should include a thorough deliberation of the clients' potential perception and interpretation of touch.
- Therapists must be particularly careful to structure a foundation of client safety and empowerment before using touch.

- Factors that are associated with congruence are; clarity regarding boundaries, patients' perception of being in control of the physical contact, the patient's perception that the touch **is for his/her benefit rather than the therapists.**
- The therapist should state clearly that there will be no sexual contact and to be clear about the process and type of touch that will be used.
- Extensive use of touch, as utilized in some forms of body psychotherapy, is likely to require a written consent.
- Touch is usually contraindicated for clients who are highly paranoid, actively hostile, or aggressive, highly sexualized or who inappropriately, implicitly, or explicitly demand touch.
- Special care should be taken in the use of touch with people who have experienced assault, neglect, attachment difficulties, rape, molestation, sexual addictions, eating disorders, and intimacy issues.
- Therapists should not avoid touch out of fear of boards, attorneys, or dread of litigation. Therapists are paid to provide the best care for their clients not to practice risk management.
- Consultation is recommended in complex cases.
- Therapists have a responsibility to explore their personal issues regarding touch and to seek education and consultation regarding the appropriate use of touch in psychotherapy.

Workshop Slides will be on the websites at:

http://www.ehmiami.com/Education.html

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