EMBODIED BEING

The Philosophical Roots *of* Manual Therapy

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CHAPTER 5

Psychobiological Assessment: The Intertwining of Flesh and Thought

A rational, principle-centered decision-making process depends on a number of factors. Besides the obvious need for understanding the principles of intervention, it also requires a highly developed set of assessment skills designed to give practitioners the ability to identify the order-thwarters that are interfering with the client's integration and well-being. I briefly sketched the five types of assessment and intervention in Chapter Two. In this chapter I want to revisit the question of assessment and illustrate by means of examples the nature of the psychobiological type. The adherence to an unhealthy worldview, physical and emotional trauma, confused thought processes, and the like are all examples that fall under the psychobiological assessment category.

Surprisingly, adherence to an unhealthy worldview can have much the same effect as repressed emotions. Psyche and soma are so intertwined that often unless both are released neither will release independently of the other. Two extremes are possible: a person's worldview can be anchored in distortions of the flesh or somatic dysfunctions can be fused to a problematic worldview.

"Wait a minute!" you may be thinking, "Aren't these mental health issues that are beyond the purview of manual therapy and better handled by trained mental health professionals such as psychiatrists, psychotherapists, and counselors?" Generally speaking, they are beyond the scope of the practice of manual therapy, and manual therapy is not a substitute for psychotherapy. But there are times when manual therapy can be very

supportive and helpful in the psychotherapeutic process. It is especially helpful when psychological issues are anchored in distortions of the flesh. If these somatic fixations are not recognized or handled properly, they can interfere with the progress of therapy.

For example, it is not uncommon for a manual therapist to be working on an area of the client's body that seems particularly defended against change when all of a sudden the client is flooded with feeling and begins to sob. When sobbing subsides, the restricted area in the client's body easily releases. Because repressed feelings and memories are anchored in the body, holistic manual therapy can be very helpful in releasing them. Otherwise, if they are not handled, therapy could bog down and go nowhere.

The reverse is also common. What is often considered merely a structural (bodily) issue (such as a vertebra that is "out of place" or a pelvis that is tipped anteriorly) can be partially maintained by adherence to an unhealthy worldview. If a manual therapist does not recognize or know how to handle these cognitive fixations, they are likely to impede the client's progress.

One of the signs of a healthy integrated person consists in a high degree of freedom from conflicted ways of thinking. In contrast, the embodiment of a conflicted way of thinking involves more than adopting an unhealthy point of view. It is not uncommon for the body to express distorted ways of thinking by distorting the flesh.

In order to illuminate how the assessment type called psychobiological intentionality (or orientation) figures in designing treatment, we will examine a number of examples. But first, three terminological points are in order. Unfortunately, there is no single word in English for the whole human person that does not anticipate or assume some version of metaphysical dualism where the body is considered just another object that is separate from the mind. "Psychobiological" goes somewhat in the opposite direction and seems to adequately blur the distinction between mind and body. As for the concept of intentionality, it will be discussed in Chapter Six. Finally, as I point out in the Introduction and further explicate in Chapter Two and Chapter Ten, I use the word "order-thwarter" instead of

words such as "dysfunctional" or "fixation" because it implies that a pattern of distress lives in relationship, not as an isolated symptom.

With that said, let's return to our discussion of psychobiological assessment. As I've said before, the order in which interventions are made during a session is every bit as important as the interventions. You cannot change the order-thwarters you do not perceive—except by accident. Assessment is a form of highly skilled perception. It takes training and practice to recognize the order-thwarters characteristic of each assessment type and have at your disposal the means to change them.

Example 1: Afraid to Slouch

This example is a straightforward case of how belief in a theory can make you go rigid.

Robert received his Rolfing session as a model in an advanced Rolfing class I co-taught with William (Bill) Smythe, an Advanced Rolfer and a master of trauma work. Robert arrived for his first session complaining of aches and pain and a great deal of strain and overall tightness. He went on to say how the Rolfing he received years ago had freed him from a long-standing depression. Rolfing had allowed his collapsed body to find a more upright stance. But significantly, he held that stance rigidly, maintaining his body in tension-laden conformity to an unyielding notion of ideal posture. Bill correctly perceived that he maintained this hyper-erect posture because he was afraid that he might collapse back into his depression. Over the years this rigid stance had become all but cemented in place causing him a lot of discomfort. He had sought further sessions of Rolfing for relief, but to no avail. Much of the work he received was forceful and painful. Bill immediately recognized the futility of the forceful method and approached the sessions differently. Realizing that some of Robert's rigidity was rooted in a traumatically induced immobility response, Bill masterfully employed very gentle techniques designed to thaw aspects of Robert's soma, which were immobilized in high sympathetic arousal. The strategy worked well and when coupled with a little philosophical counseling about the

problematic nature of the concept of an "ideal body" and how his adherence to it was creating his discomfort, Robert was able to finally let go of his rigidity and release some deeply held anguish. As a result, his tension began to disappear and his life became easier.

Example 2: Somatically Maintained Worldview

This example dramatically demonstrates how easing patterns of strain and introducing a higher level of organization in the body and its relation to gravity can profoundly alter one's ethics and worldview. This case is a clear demonstration of how a person's worldview can be somatically maintained.

Beth was in her mid-thirties when she sought my services as a Rolfer. She was extremely intelligent and witty. Since she did not trust men, she was wary of me and shared very little of herself during the early stages of our working together. Only after she gained some trust in me did she tell me that her father was horribly abusive. He often referred to her as a "little piece of shit." She was a single mother of a ten-year-old son. After a number of failed relationships and a very difficult marriage and divorce, she gave up trying to have relationships with men and chose a lesbian lifestyle. She lived with her lesbian lover and worked hard as a waitress trying to make ends meet.

Her body was amazingly immature in its appearance. If you covered her face in her before photographs, she looked like a fearful, disheartened, deflated twelve-year-old. After only a few sessions, however, I noticed some rather dramatic changes. Besides the obvious improvements in posture and the increasing ease of movement that are so characteristic of Rolfing, her body began to mature. She became more animated and her body caught up to her chronological age. Almost overnight she began to look like a mature woman. Her change was so dramatic that all her friends commented on it.

After our third session, she told me that she had stopped shoplifting. Until that moment I had no idea that she engaged in this sort of activity. She shared that she had suddenly realized that she had been projecting her anger at her father and the men in her life onto the rich men she imagined

owned these stores. She told me that she only shoplifted at the big department stores. She justified her behavior to herself on the grounds that these men had more money than they needed, that she was owed something for the suffering she had experienced at the hands of all the other rotten men in her life, and that she had a hard time making ends meet.

Three or four sessions after she gave up shoplifting, she told me that she had ended her relationship with her female lover. She acknowledged that she wanted warmth and love in her life just like everybody else. But she also admitted that she had become too frightened to pursue any kind of intimate relationship with men because her experiences with them had been so painful. So she had chosen a lesbian lover instead. Once she realized that she was using homosexual love to satisfy her needs, she realized that she was using her lover in a way that was no longer right for her or fair to her lover.

Before she shared these revelations, Beth and I never talked about shoplifting or her sexuality. She came to these changes in her psychobiological orientation on her own. All I did was work with her body in a respectful way that did not violate her boundaries or contribute to her low self-esteem. If she had asked for my opinion about her shoplifting, I would have discussed the ethics of her behavior as a philosophical counselor. But I also realize in retrospect that any discussion about the ethics of her shoplifting would have been futile. Her shoplifting was fused to her pain and anger at men and bound too severely to her immature and immobile body structure. Even if Beth had brought the topic up for discussion herself, I am convinced that any attempt to address the ethics of her shoplifting would have compelled her to terminate her work with me. I probably would have been perceived as just another self-righteous patriarch telling her what a terrible person she was.

Her immobility and immature appearance were tied to the traumas of her life. She was somewhat dissociated, and her body was frozen in a high state of sympathetic arousal. Like every other severely traumatized individual, she had lost much of her ability to defend herself. Her remarkable transformation during the early stages of our work together began

with her being able to trust me and the process of Rolfing. As the Rolfing manipulations eased the patterns of strain in her fascia, she was able to discharge her highly tuned sympathetic state and clarify her self-sensing. As a result, she regained more of the inherent mobility and motility of her body, recovered many of her lost resources, and, as a result, learned to better fend and care for herself. She improved her financial condition by receiving some training and getting a better paying job. As she released her fear and clarified her self-sensing, she learned that she could trust herself and her body to guide her choices toward a more mature future.

This case is particularly interesting because it shows how changes to the organization, motility, and mobility of the soma can profoundly alter a person's worldview. These changes in Beth's psychobiological orientation were the direct result of the myofascial manipulations of Rolfing. Philosophical counseling and any kind of verbal therapy would have been a waste of time. The fact that she experienced Rolfing in a safe therapeutic environment was also a critical factor in her transformation. But it is important to realize that in the early stages of our work together, I did not employ any philosophical or psychotherapeutic techniques.

This case clearly demonstrates the profound hold our flesh can exercise on our ideas and how we live our lives. It also underlines the importance of giving the body its due in any psychotherapeutic and philosophical counseling session. If the flesh does not agree with the logic of a verbal intervention, there may be no significant change in a person's worldview. And, as this case so clearly demonstrates, sometimes all that is required to change a person's outlook on life is a little more order in the flesh and a little more clarity in self-sensing. Of course, it is not always as simple as this case makes it appear, and I am not suggesting that therapists should make it their business to change a person's sexual orientation.

Example Three: Philosophically Maintained Pain

Donna's case is a bit more complicated than Beth's but demonstrates in a fascinating way how a person's tacit worldview can contribute to

maintaining her pain. Donna is a married working woman in her late thirties and the mother of two children. She sought out Rolfing for the relief of pain in her right shoulder, which became more pronounced with movement. She received a number of sessions from me and other therapists in our physical therapy clinic where we practiced a team approach based on integrating the three paradigms of practice. The manual therapy she received gave her little to no relief. After a few weeks of therapy at our clinic she went back to her doctor. He discovered that there was a bone spur on her acromion and recommended surgery. After the surgery Donna returned to our clinic for more manual therapy. She experienced no complications from the surgery, and her pain was well on the way to being alleviated. Unfortunately, fate intervened and involved her in an automobile accident. Her pain came back with a vengeance. She continued to receive intensive manual therapy at our clinic for a number of months following her accident. I worked with her at least once a week. After most sessions she would get some relief. But always her pain returned—sometimes within a few hours, sometimes within a day.

At first I didn't notice the almost obsessive way Donna continually complained and worried about her situation. After all, her pain was real and it was seriously interfering with her busy life. She clearly wanted to get well. She was not an overly controlling person or an obsessive compulsive. Like most people whose pain continues well past normal expectations, she often wondered why this had happened to her and was beginning to fear that her shoulder would never heal. Since shoulder injuries and rotator cuff strains are often very difficult to treat and sometimes never get better, her fears were well grounded.

She engaged me in a lot of talking about her situation. We talked about the metaphysical and spiritual implications of pain. We discussed how she held her body in various activities, how she walked, how she sat, and so forth. We also discussed her sleeping position. She mentioned that she slept on her side with her arm above her head. For obvious reasons, I strongly suggested that she not sleep this way. She took my advice and her pain let up just a bit, but not enough to satisfy her or me. During

every session she talked and worried more and more about her problem, always trying to come up with a new way to adjust or change the way she did things. Donna always shared her latest strategy for recovery and her worried disappointment in its failed results. Slowly I began to realize that her worry and need to do something about her pain was a bit excessive.

Finally, I suggested that she try an idea. I explained that I had noticed over many years of working with people in pain that the kind of worrying she was engaging in often interfered with healing. I said that excessive reflection on our own suffering was sometimes a serious impediment to recovery. I asked her to imagine a situation in which she was surrounded by all the healing energy she needed to get well and that this healing energy was doing everything it could to get into her body to do its work. "Imagine," I said, "that your excessive dwelling on your suffering is the very thing that is preventing the energy from entering your system, and that what you must do to allow the energy to do its work is to stop worrying." I also asked her to be attentive to how she responded whenever she felt even the slightest twinge of pain, and to notice how easily the appearance of her pain catapulted her once again into dwelling on and worrying about her shoulder. I directed her to set her worrying aside and not to tarry the slightest with her pain when it showed itself.

After two weeks of not dwelling on her shoulder, her pain decreased by ninety percent. She was greatly encouraged by this turn of events. We continued her therapy at the clinic and she continued to improve. Even though she was almost pain free, during a session she began worrying about the small discomfort that she was still feeling in her shoulder. As she talked about the lingering discomfort, her worry escalated and suddenly the severity of her pain increased to the level it had been right after the accident. She was horrified, and I was aghast at how much pain she was experiencing.

I immediately asked her to experience both the fullness of her pain and how it was being held by her in reflection. I asked her to notice how her worrying and reflecting on her situation was sufficient to bring her pain back. I suggested that she cease her worrying. She complied and as

she gave up her reflective worry, her pain dissipated just as quickly as it appeared. We decided that the appearance of her pain at this point in her therapy could be used as a sign of her excessive reflection. From that moment on whenever she felt pain she simply stopped thinking about it and it disappeared.

She continued the team approach at our clinic and was happy with the results. A few weeks later I saw her for another session. Her pain was negligible, and she was confident that her life was back to normal. We chatted easily as I worked with her shoulder. She reported that she was very upset at the news that Linda McCartney, wife of ex-Beatle, Paul McCartney, had died of cancer. I was surprised by this and asked why the death of someone she only read about would be so upsetting to her. She replied that Linda McCartney was a vegetarian, that she practiced yoga, and had worked hard at living a healthy peaceful life. Donna also devoted herself to a similar program and confessed that it was unnerving to learn that someone could die of cancer even after devoting so much of herself toward living a healthy life.

Curious, I asked her if she believed something like the following: there are a set of rules that define how life is to be lived, and that if we do our best to discover and follow them, God or the universe will make sure nothing too awful befalls us. Immediately the intense pain in her shoulder reappeared and her eyes filled with tears. As further investigation and discussion revealed, even though she had never really brought her view into full reflective awareness, she tacitly held a view something like the one I articulated for her. As it turned out, this view was at the heart of her excessive attempts to control and deal with her pain. She believed that if she could only discover how she had strayed from the right way of living and using her body, she could correct her mistakes and be free of her difficulties.

We talked in some detail about her tacit presupposition. I did not try to argue against her view, but only gave her other views against which she could contrast her pre-reflective tacit worldview. I explained how other spiritual traditions left lots of room for the occurrence of random, meaningless events that are capable of derailing one's life. I also mentioned that

some traditions even believed that God was also learning and evolving. Once she brought her tacit worldview into reflective awareness and was able to contrast it with other views, she realized that she really was not committed to her view and abandoned it on the spot. She has been free of shoulder pain ever since.

I was surprised by how quickly and easily Donna's pain disappeared upon giving up her excessive reflection and worry. I was even more surprised by how suddenly it returned when she re-engaged her excessive worry. But it wasn't until she shared her upset over Linda McCartney's death that I realized that her excessive worry was rooted in a tacit philosophical view of how the world worked, a view that unreflectively spurred her to continually interrogate her pain and experiment with ways to manage it. She was an intelligent woman who had her life in good order. She was not driven by a neurotic need to control her world, and she was not an obsessive compulsive. But her unexamined worldview, which may have been influenced by her Catholic upbringing, drove her to take too much responsibility for healing herself and compelled her to think excessively about her problem and how to solve it. You might say she had a bad case of philosophically maintained pain. Clearly, if I had pursued manual therapy in a purely structural/functional way and had never uncovered her tacit worldview, Donna would still be in pain today.

These three examples are meant to illustrate how the psychobiological intentionality assessment type comes into play. Placing this kind of emphasis upon the psychobiological intentionality assessment type should not imply that the other assessment types are not relevant. Further assessment would show that all three of the clients needed varying degrees of structural and functional work. Since an order-thwarter in one assessment type usually shows up more or less as an order-thwarter in all, you should come to expect that you almost always work with a number of assessment types and their ways of intervening at one and the same time. Our fourth example is an actual assessment designed to demonstrate how all the assessment types can be relevant to designing a session.

Example 4: Immaculate Perception

This last example is based on a simplified version of an actual assessment. Its purpose is to demonstrate the depth and kind of perception that is really possible and available to us. But you will not learn how to perform this uncanny way of perceiving until we get to Chapter Seven where I present the simple three-step method I created to train practitioners. For now, simply appreciate the way this example displays how a complex pattern of order-thwarters reveals itself in relation to the whole across all the categories of assessment to an experienced practitioner. It demonstrates the process a practitioner might go through in order to perceive at this level of sophistication.

Imagine that you are about to begin assessing a client with back pain. If you are a Rolfer, you might begin your session with a visual inspection of your client in order to evaluate how well she appropriates gravity. Your training and years of experience in geometric, structural, functional, energetic, and psychobiological assessment have given you the perceptual skills necessary to make this kind of assessment. You notice that she has many of the key characteristics of the structural type Jan Sultan called "externally rotated": high stiff arches, externally rotated femurs, posteriorly tipped pelvis, diminished A-P spinal curvature, a relatively flat occiput, etc. As you continue your assessment, you notice that she doesn't have clear centerline, her pelvis is right rotated, her sacrum is bilaterally fixed posteriorly, and there is strain in the left, abdominal region. As you assess her psychobiological orientation, you sense that she is grounded, and that she comports herself with confidence and ease. At the same time, you feel a sense of withdrawal and sadness in her chest. Then you notice that she is tired at the same time you feel that her cranium is in trouble.

In order to bring the information gleaned from your assessment to a more full-bodied perception of her living form, you shift your orientation from actively looking at patterns to getting out of the way and letting your client's body show you its problems. As she lies supine on your table, you gently place your hands on her head using your favorite vault hold and

just wait. Your job, at this point, is not to have a job. You wait and do nothing. You are no longer actively trying to assess your client's structure, function, energy, or psychobiological intentionality. You don't even think about trying to change her for the better. Instead, you shift your orientation from trying to accomplish results and evaluating structure to an orientation of allowing what is to show itself. You simply get out of the way by expanding your perceptual field, dropping your self, and opening a loving space.

The clarity and safety of this clearing makes it possible for the being of your client to wordlessly reveal her troubles to you. As you continue to create this loving space, you often close your eyes as a way to see more clearly and to encourage more and more aspects of your client's problems to show themselves to you. In order to further expand and deepen your perception, you take your hands off your client's head and feel-perceive her whole body and energy field with your whole body and energy field. After a time, a perspective begins to come into focus and you finally get your first glimpse of a unified pattern of distortion and its relation to the whole: you perceive a cranial shutdown, the lack of a clear center line, a bulging out of the energy field around the lower left region of the abdomen coupled with feelings of sadness and anger saturating an intensely held strain in the peritoneal sac around the descending colon; you more clearly perceive her posterior sacrum and the rotation of her entire pelvis to the right. As often happens, when your eyes are closed, your mind starts to drift as if you were in the first stages of sleep. Suddenly, a compelling image of your client being traumatized appears and with the image comes the conviction that she was ten years old when the incident occurred.

Notice how all the information you gleaned finally congealed into a unified perception of her structural, functional, energetic, and psychobiological way of being. In the beginning of your assessment you were actively engaged in the process of evaluation. Much of the information you gathered about your client was the direct result of actively engaging and searching for patterns and structural imbalance. Recall how you saw

that your client was an external type, for example. Before you learned the internal/external typology, you probably would have noticed how the pelvis was too posterior, how the lumbar and thoracic spines were too flat, how the legs were valgus, and so on. But you wouldn't have grasped the significance of what you saw for the whole structure. You probably would have seen these aspects as individual structural curiosities. You wouldn't have understood that what you were seeing was an expression of the morphological type known as the external type. But now when you look at your client, you immediately and clearly see that she is an external type. As a result, you understand the complicated array of strain patterns with which she struggles in relation to her morphological imperative.

You also began to perceive aspects of her psychobiological intentionality by means of feeling. You felt and saw the confidence in her comportment, while at the same time, sensing her withdrawal, sadness, anger, tiredness, as well as the effect of these aspects on her cranium. This kind of *feeling* in which you perceive the emotional meaning of a person's bearing and structure requires not just the integration of the sensory and the cognitive but also the integration of your feeling-nature. When you can feel aspects as well as see them, your ability to read your client's emotional and psychobiological orientation is much more accurate than when you deduce them from visual patterns displayed by your client's body.

As you continue, you rely less on your senses and more on your feeling-nature to perceive what was going on with your client. Much of the same information appeared, but more of it came to you through your feelings. There is no question, much of what you perceive as a holistic practitioner comes from your senses—but not all. Notice that you can see without your eyes and feel without your hands. You often closed your eyes in order to perceive more clearly, for example. Since you felt what is happening in the lower abdomen and pelvis while your hands were on your client's cranium, you were not feeling with your hands alone. Add to these considerations that you can feel more by not touching your client, and it is clear that you are not perceiving with your senses only—you

are also perceiving with your feeling-nature. When you perceive your client's structural problems and her comportment as sad and angry, you are see-feeling by means of the integration of your cognitive, sensory, and feeling-nature.

Let's look more closely at what we actually experience when we perceive with our feeling-nature. Whether you touch your client or remove your hands from her body, when you allow what is to show itself, you often feel in your own body where the problems are in your client's body. Where your client has a problem in her body, typically, you feel a kind of pressure or fullness in the same place in your body. As you continue to attend to what is showing itself to you, the vague sense of pressure begins to come into focus and you begin to see-feel it as an emotional, energetic, and structural distortion in the descending colon that affects the pelvis and right knee. If you close your eyes, you may also notice that you also see in your mind's eye the same pattern of distortion.

The more anatomy and physiology you know, the more you perceive in your client, especially if you keep an open heart. The better you know anatomy and the freer you are of emotional fixations and conflicts, the better you are able to perceive the details of what is being shown to you. In this example, if you didn't know the anatomy of the organs, the vague sense of pressure would remain a vague sense of pressure indicating a problem somewhere in the left lower region of the abdomen. But since you do know the anatomy of this region of the body, you see-feel the detail that indicates an organ.

It is as if your energy field and your feeling-nature overlap. You not only feel with your whole body, you also feel with your energy field. You feel in your own energy field the place where your client's energy is distorted. The more familiar you become with the energy patterns that are part of your clients' problems, the more clearly you feel them.

There is an important difference between perceiving with your eyes and perceiving with your feeling-nature. When you perceived your client as an external morphological type, you perceived her as other than yourself and "over there." When you felt your client's structural, energetic, and emotional

difficulties, you felt all of these aspects as "over here" and in yourself. There was next to no distance between you and these aspects of your client. You felt them as if they were your own, because your way of knowing them is by feeling them in yourself and because feeling-perception is non-dualistic, participatory, and not based on reflective thinking.

If you continue to allow what is to show itself, the whole pattern of distortion and its relationship to the whole comes into clearer focus and you see-visualize-feel it as a unified gestalt. Since your client has emotional issues, you feel her anger or sadness in yourself and it will saturate your perception of and be a part of the unified gestalt. The unified gestalt that constitutes your perception of your client is the result of integrating cognition with your senses and feeling-nature. At one and the same time, you are one with her condition because you feel it and separate from her condition because she is not you. Simultaneously, you feel your client's distortions in yourself and see them in her body. Your perception of your client's condition is not a matter of having two different perceptions, one in yourself and one of her "over there." Rather, your perception is one integrated unified gestalt in which you are both one with your client and separate from your client.

So far we have only scratched the surface of our feeling-nature, and we still don't know what part of our anatomy or mind is responsible for this kind of perception. We perceive a rose with our eyes, hear a sound with our ears, smell an odor with our nose, relish an apple with our sense of taste, and feel a rough edge with our sense of touch. But with what sense or senses do we perceive a client's energy and emotional patterns, thwarts to wholeness, or that something is amiss? Whatever this perceptual system is, it consists of the integration of our senses, cognition, feeling-nature, and energetic field. While it is clear that it must involve the brain and nervous system (the senses) as well as what we call mind, it is also clear that it surpasses these systems. Unlike our eyes and ears, it has no specific location. We are driven to the conclusion that this perceptual system is none other than our body-mind and the field around it. For want of a better term, we can call it the *somatic field*.

Conclusion: Where Is the Human Sensorium?

If asked where the seat of perception is or which system is responsible for perception, without much hesitation most people would probably answer that the sensorium is the brain and nervous system. For humans and other vertebrates, this answer seems like a reasonable one. But our excursion into feeling led us to the startling conclusion that our perceptual abilities are greater and more expansive than we suspected. They encompass not only our feeling-nature and whole body, including the brain and nervous system, but also extend into the field around our bodies. If this observation is correct, we must also conclude that the human sensorium is the somatic field.

Our feeling-nature is not only deeply intertwined with and embedded in all our states of awareness; it is also what we share with all living creatures. It is how other forms of life, especially those without a brain or nervous system, perceive their world. Furthermore, what we recognize in ourselves as consciousness is a highly evolved elaboration of the same feeling-nature that all life shares.

Our feeling-nature is a non-dualistic, participatory way of knowing that is not founded in reflective thinking. It permeates every dimension of our being and every level of awareness and is fully integrated with our sensory and cognitive nature. Even though we regularly take no notice of it because our consciousness is dominated by our reflective "I-am-self," it is always there bringing us into unity with our surroundings and revealing the greater ocean of sentience of which we are a part.

Two extremes emerged from our discussion and we saw how a person's worldview can be rooted in her soma in one case, and, in the other, how a person's worldview can contribute to maintaining her pain. The first you could say is an example of a somatically maintained worldview and the second an illustration of philosophically maintained pain. The example of being afraid to slouch is a more straightforward example. It illustrates how adherence to a theory motivated by fear can over time all but cement in place a rigid way of being. I picked these four examples to

illustrate the relevance and workings of the assessment types with special emphasis on the psychobiological. Since the usual way we assess clients would not emphasize just one type, the fourth example shows how a creative and experienced holistic somatic practitioner might work with all of the assessment types. But I also wanted all of these examples to suggest the intertwining of psyche and soma, and how difficult in practice it is to separate our nature into two separate and distinct categories of mind and body. At this point in our investigation these comments are only meant to be suggestive. I am just sowing the seeds for deconstructing metaphysical dualism in Chapter Eight. We will return to the nature of perception and its philosophical underpinnings in Chapter Six and present the three-step method for training perception in Chapter Seven.