**SomatoEmotional Release is not Psychotherapy**

CranioSacral Therapy and SomatoEmotional Release are forms of bodywork. We follow the tissue and the Inner Physician of the client as accurately as possible, using the Significance Detector as our "insurance policy" against leading the client's process. We do not advise or interpret our clients' experiences. We merely support and facilitate their inherent process of self-healing.

**An Excerpt from Your Inner Physician And You by Dr. John E. Upledger**

**SomatoEmotional Release and the Psyche**

I have asked a doctor of clinical psychology with more than 20

years of experience in both psychotherapy and hypnotherapy

to comment upon the efficacy of SomatoEmotional Release

(SER) by therapists who are not necessarily trained as psychotherapists

or counselors. Russell A. Bourne, Jr., Ph.D., is

that psychologist. He is familiar with the SER process and has

seen it used by many therapists who are trained in CST, SER

and bodywork, yet who have little or no formal training in any

of the psychology-related subjects. He has seen the bodily and

energetic release of emotions with only hands-on work,

accompanied by some commonsense verbal support. His

comments follow. We are also fortunate to have permission

to reprint a short explanation of how SER is not psychotherapy,

written by British osteopath John Page. His essay follows

that of Dr. Bourne.

**Psychology and SomatoEmotional Release by**

**Russell A. Bourne, Jr., Ph.D.**

It is with both pleasure and a bit of trepidation that I respond

to John’s request for a few words regarding the relationship

between psychotherapy and SomatoEmotional Release. As a

clinical psychologist, I am well aware of the debate concerning

which professionals should provide what services in the realm

of counseling and psychotherapy. Indeed, many in the varied

mental health professions, i.e., psychology, psychiatry, social

work and counseling, have spent hundreds of hours and thou-

sands of pages arguing among themselves about the issue of

professional competence and the appropriate limits or scope

of one’s practice. It seems as if many of these folks wish to

equate specific academic degrees or titles with presumed competence.

I would like to explore a different set of questions in the

next few pages; questions that I believe are much less controversial

and fairly easily answered by professionals and

laypeople alike. The first question I’d like you to consider is

whether or not you believe that, in many cases, there is an

emotional component to significant physical injury or disease.

Most people will respond in the affirmative to this question

and that, in turn, leads to a second question: Is the acknowledgment

and expression of this emotional component

important for healing and recovery? Nearly everyone I ask also

responds with a resounding “yes.” It seems quite natural to

people that emotions play a major role in our health and wellbeing.

Now, at the risk of being pedantic, I’d like to pose two additional

questions. These questions, which are also simple and

straightforward, influence the nature of one’s approach to

healthcare. First, is it possible for a person to experience physical

distress as a result of emotional or psychological causes?

And second, can emotions be released through the body?

Again, when I pose these questions to laypeople and professionals,

the overwhelming response is something like, “Why

yes, of course. Who would think otherwise?”

The idea that thoughts and emotions influence our bodies

has been part of our culture and that of our ancestors for hundreds,

if not thousands of years. In today’s media, one can find

countless references to mind/body communication and the

importance of responding to the whole person when addressing

matters of injury, illness or disease.

The influence of our thoughts and emotions on our bodies

is quite easily demonstrated by two simple examples of ordinary

human responsiveness: the act of blushing in an

embarrassing situation, and the act of crying when viewing

an emotional scene at the movies. In each case, an idea or

thought crosses one’s mind and, in a matter of seconds, the

body responds. In the first case, the response is a temporary

condition of localized high blood pressure in the cheeks

and/or throat. In the second case, the response is the production

of tears and/or the characteristic “lump” in the throat.

Each of these reactions is a response to a thought—an

internal process of the mind that then results directly in a

physiological alteration in the body.

Now, let’s return to the discussion of SomatoEmotional

Release and psychotherapy. Mental health counseling and

psychotherapy are respected modalities for assisting those

whose lives have been affected by physical or emotional

trauma, or whose progress in life has been impeded by emotional

or relational conflict. There are, of course, a variety of

approaches and “schools” of psychotherapy. Yet as most of

you know, irrespective of theoretical orientation, counselors

and psychotherapists primarily offer support, insight and

understanding to those with problems. This assistance is

accomplished essentially through the use of words—specific

conversations and dialogue to address particular purposes or

goals.

I believe strongly in the power of language, in our ability

to use words and images to facilitate an alteration in perspective

as well as in consciousness. Indeed, I believe language is

a wonderfully effective therapeutic agent. Thus, as a psychologist

who is intimately familiar with psychotherapy and

SomatoEmotional Release, I wholly support the use of

imagery and dialogue in the therapeutic practice of those who

do CranioSacral Therapy. Since, as we’ve noted, language and

thought influence emotions, and since emotions influence

the body, it makes perfect sense to facilitate a respectful and

permissive expression of that emotion, especially as it relates

to the maintenance or continuation of physical distress or illness.

And that, my friends, is what SomatoEmotional Release

and Therapeutic Imagery and Dialogue do so well within the

CranioSacral Therapy process.

Perhaps an example or two will help demonstrate the

utility and individualistic quality of the SER process as practiced

by Upledger-trained CranioSacral Therapists. The first

case involves a woman in her late 40s who learned of The

Upledger Institute, Inc., HealthPlex Clinical Services and

CranioSacral Therapy while attending a support-group meeting

for those with Multiple Chemical Sensitivities (MCS).

This particular patient’s symptoms were diffuse and irregular.

Unlike the allergy patients for whom there frequently are

identifiable antagonists, either in the environment such as

with mold or ragweed, or within particular food groups such

as dairy or wheat products, many MCS patients are so highly

reactive to their environments that it is quite difficult to identify,

let alone isolate, the offending substances.

Such was the case with this patient, whose symptoms had

gotten progressively worse over the prior three years. In fact,

she had gotten to the point where it was necessary for her to

greatly limit her daily activity, rarely leaving home, changing

her clothes three or four times daily to reduce exposure and, in

general, living a very narrow, isolated life. Her health was

becoming increasingly compromised due to her highly restrictive

diet, and the level of depression and frustration she

experienced made her miserable.

After six CranioSacral Therapy treatments, she began to

venture out from the house more often and found that her

energy level had improved. Yet she continued to experience

feelings of depression and was very anxious about engaging

in any new behavior that might cause her to have a “reaction,”

which was her term for the physical and emotional distress

and cognitive disorientation that she experienced as a result of

her MCS. Never able to predict these reactions, she became

vigilant in her alertness to her environment and the potential

threat that it held for her. This was contributing to a nearconstant

state of arousal, which was counterproductive to the

goal of reducing her sensitivity.

It was during her 10th treatment session that an SER

regarding this chronic state of physiological arousal and psychological

tension occurred. It seemed to her that the

maintenance of this hypervigilant state was necessary for her

health, to keep her ever ready to protect herself from potential

harm. But during the session she stated that she both

needed and resented the presence of this chronic arousal.

When asked to consider how she might enhance the healthfulness

of this hyperaroused state while minimizing its

negative influence, she was able to imagine her apprehension

and tension changing to a healing energy that she could then

move from her chest, face and throat areas (where she typically

felt the tension) to those areas of her body that could

benefit from the presence of extra support and healing. She

was able to direct this healing energy to her lungs, eyes, hands

and stomach over the next several weeks.

By directing the healing energy to those areas in her body

that typically responded during one of her reactions, she was

able to significantly reduce the frequency of reactions as well

as their intensity. While she continues to be watchful of her

surroundings and has yet to eliminate all chemical sensitivi-

ties, the acknowledgment of the emotional conflict she felt

over her state of arousal, and the increased sense of control

and interpersonal power she experienced by involving her

physiology in new ways to contribute to her overall health,

have contributed significantly to improving her physical wellbeing

and quality of life.

The second case involves a woman in her late 20s who was

employed as a registered nurse and had been accepted to medical

school when she suffered a closed-head traumatic brain

injury as a result of being hit by an automobile while riding

her bike. She had completed the usual in-patient rehabilitation

program at her hometown hospital before coming to the

UI HealthPlex nine months after her accident.

When first seen, she was experiencing fatigue, memory

loss, speech stammering, and feelings of depression and

apathy—all rather typical of the myriad of post-trauma

symptoms that can be experienced by patients with closedhead

injuries. She had received counseling to assist her in

adjusting to the reduction in her daily activity, and with the

continued speech problems. By all indications, she had been

a motivated and conscientious rehab patient who was working

hard to regain her past abilities.

It was during her fourth CranioSacral Therapy session that

a gentle inquiry was made regarding the process of her adjustment

and her hopes and expectations for the future. She

began to sob and expressed anger and sadness that she was not

her old self, her real self. She felt betrayed by her body and

did not feel that she was ever going to be the person she once

was.

Of course, these feelings are quite natural for those who

have experienced this level of physical trauma and loss of abilities.

Yet before this session, she had not been able to actively

state her feelings of loss, disappointment and frustration.

Indeed, she had not permitted herself to grieve for the loss of

her “whole self,” and the emotional energy spent containing

these feelings of grief and sadness had been significant. It

seemed that she had maintained an extreme state of physical

tension in her effort to control the expression of these emotions.

Consequently, this physical tension had interrupted

her normal speech pattern. Additionally, her preoccupation

with her “old self ” and the near obsessive orientation to the

past had served to fuel her depression and interrupt her movement

toward recovery.

As she was allowed to release the grief of her lost self, she

released the physical tension throughout her mouth, jaw,

throat and thoracic inlet. At the end of the session, she and

her companion were equally surprised by the degree of immediate

improvement in her speech. She stammered less

frequently and her thoughts flowed more freely. Throughout

the next several sessions she continued to improve in both

speech, cognition and mood.

At the conclusion of her visit, she stated that she had found

a way to say good-bye to her old self and was encouraged by

the process of beginning to get to know her new self. Her

gains from CranioSacral Therapy and SomatoEmotional

Release were clearly physical and psychological. With the

absence of the barriers that were inherent in her earlier state of

repressed grief and sadness, she had progressed to a place of

greater physical well-being and renewed optimism.

In both of these cases, there were physical and emotional

restrictions. When released, these interferences manifested as

detectable physical energy. The rationale of a physical energetic

presence before and after physical trauma follows a

commonsense logic. A bit more surprising was the realization

of a physical energy response to the emotional aspects of

illness and injury. Yet, as I mentioned at the beginning of these

remarks, the manner in which emotions may influence our

bodies is profound. Since the body’s response system is essentially

energetic (i.e., biochemical, electromagnetic and

vibrational), it makes perfect sense that an emotional release

may be accompanied by a significant release of felt energy.

In the first case, the perception of this energy was combined

with a perceptible rise in body temperature over a localized

area in the patient’s chest. Heat seemed to emanate from just

above her sternum for approximately 60 seconds, and was

followed by a very deep and prolonged vocal sigh. It was as if

she had released a tremendous burdensome energy held

tightly within her upper body.

In the second case, a spasm-like vibration within the

patient’s neck and shoulders occurred simultaneously with the

felt sense of a magnetic force pushing the therapist’s hands off

the patient’s body. This palpable energy phenomenon lasted

for 20 to 30 seconds and, as in the case of the first patient, also

resulted in an audible and deeply resonant sigh of release.

As John has written elsewhere, the release of these Energy

Cysts seems to permit a reorganization within the body/

mind/spirit complex of each patient. The personal resources

once needed to contain these respective cysts of energy are

no longer needed to preserve a dysfunctional status quo. Thus,

the patient’s healing can now move forward in more appropriate

ways.

The benefits of combining SomatoEmotional Release and

Therapeutic Imagery and Dialogue with the therapeutic techniques

of CranioSacral Therapy are without question. The

body, mind and spirit are one when it comes to promoting

the realization of the full potential of each of us and, quite

obviously, the health of any one of these dimensions

influences the health of the others.

As my doctoral chairman at the University of Virginia, Dr.

Paul Walter, taught me years ago, “What we are to be, we are

always becoming.” This respect for our individual developmental

process is characteristic of the principles of

CranioSacral Therapy and SomatoEmotional Release. Furthermore,

John Upledger’s recognition of the developmental

process of ideas and shifting paradigms, as well as the innovations

they suggest, sets him apart from most in our

professions. Indeed, it benefits all of us when individuals such

as Dr. Upledger continue to investigate approaches to healthcare

designed to assist each of us in our personal journey

toward health and well-being, toward realizing our full potential

and becoming all that we can be in this lifetime.

**How is SER Not Psychotherapy? by John Page, D.O.**

SER involves physical contact, physical process. It is essentially

a physical therapy involving the thought processes, the

awareness. Psychology requires no physical contact or process.

Psychotherapy applies itself to a previously identified task

using pre-ordained tools. SER is a shared adventure, ideally

not pre-arranged, that thrives on the unexpected. SER

requires the flexible use of many tools, and continues to invent

new ones, presenting them as gifts to the aware and flexible

facilitator. Psychotherapy is directed by a knowledgeable

expert. SER is helped by a facilitator, part of whose skill is

not to need to know what’s there.

Psychotherapy has systems, traditions, approaches and specialties.

Thus we have Rebirthers, Past Life therapists, etc.

The patient is a person-in-need, disempowered, who is seeking

help from an outside expert. There can be temptation for

the patient to perform, to fit in with the psychotherapist by

supporting his or her belief system. SER has no system as

such. Psychotherapy can be used symptomatically, like a

Band-Aid®. SER aims at releasing causes.

Psychotherapy is done by one person to another, in much

the same way that physiotherapy is applied. SER is done by

the person, for themselves with the help of others.

SER can happen spontaneously.