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Reaching and Being Reached

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When therapists know how reach patterns emerge and become part of an infant's movement repertoire, they have a broad-based background from which to observe and understand their adult clients. Reach patterns emerge in the infant as a product of several processes: the infant's internal dynamics (anatomical constructions and metabolic processes), the fundamental constraints of the physical field (gravity, earth, space), and the unfolding relations within the social environment (primary caregivers). Each pattern integrates into the developing nervous system and becomes the foundation for the child's, adolescent's, adult's behaviors. The formation of sucking patterns in health and dysfunction and their relationship to adult experience is examined in detail. Three adult case studies illustrate diagnosis and treatment based upon this somatic/developmental perspective.

THROUGH THE RHYTHMS OF LIFE, human experience, or contacting, concerns itself with meeting and being met, influencing and being influenced, reaching and being reached. In the joining of one and another, the individual becomes part of some larger experience *flowing into and with* the greater field. From the *I,* a *we appears.* Separating from the larger, sensing difference once more, the reach completes itself. From the *we,* an *I* emerges. Reaching, we realize our *selves.*

Reaching is a whole body event. The sensorimotor organs of mouth, eyes, ears and limbs measure the distance between one and the other. How far away is what I long for? How near is what has become terrifying? Sometimes the distance feels vast as if meeting is simply impossible. Other times, distance shrinks, offering possibilities to feel part of

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another. Subjective, relational, and perceived, the experienced distance gently expands, abruptly contracts, lightly envelops, or harshly represses.

The observation and experience of reach patterns is a vital method for exploring the relational field for both therapist and client. In the building of relationship, clients extend toward their therapist, carefully measuring the distance between themselves and the other. In the act of reaching, clients discover to what extent, at any given moment, they wish to include the other in experience.

Therapists also measure the distance between the client and themselves and adjust their creative efforts accordingly. They are sensitive to the varied ways their clients reach toward them in the hopes of establishing closeness. They also observe when clients anxiously pull away, fearing that to be close to another is to somehow lose oneself.

Within the course of the psychotherapy session, all movements carry meaning for both client and therapist. And the meaning always arises from the context in which the movement occurs, the client/therapist field. A keen awareness of reaching functions on the part of therapist and client attunes both to the ongoing relationship that builds during the session. The therapist draws the client's attention to his or her gestural pattern, and both become privy to important and necessary psychodynamic information that organizes and emerges within the relational dyad.

When the therapist invites the client to recreate, exaggerate, or attempt the opposite pattern, awareness heightens. The client has little time to calculate his manuevers and thus maintain a vigilant control over his behaviors. The emerging and spontaneous material can be a surprise to the client who has kept it so repressed that it is a secret even to himself.

In health, when the object of interest is perceived as safe, inviting, and within reach, the movement pattern emerges as uninhibited and smooth. Movements are distinct and directed toward the other. The person opens her body, increases her receptivity, and extends toward the other with certainty. In the process of reaching, she feels her eyes, mouth, arms, hands as being *mine*—an integral part of herself. As she senses her body, whatever she grasps becomes part of experience. Including the other encourages her belonging in the world.

When the object of interest is perceived as unwanted and uninviting, the healthy person pulls away with similar conviction and clarity. She is unwilling to become part of the other. Spontaneously she closes her body and exposes much less of herself. Her receptivity diminished; she declares that the "other" does not belong to her experience. It is excluded.

In dysfunction, however, the person *neither* reaches toward the other completely nor pulls away with confidence. The reach becomes routinely "stuck in the middle." The pattern inhibits, disrupts, and demonstrates a position of constant, unresolved compromise. The body loses flexibility and is not fully sensed. For the person who yearns for closeness and is terrified by it, the other often appears frightening, perhaps *too* close for comfort. From this conflicted experience, an ambivalent gestural pattern emerges: for example, the arms may stretch in the direction of the other yet clutch firmly to the sides of the body; fingers curl inward at their tips; the upper torso and neck constrict and pull back; the head faces down and forces the eyes to peer upward. On the other hand, when closeness is experienced as persistently beyond one's grasp, a markedly different gestural pattern may occur: for example, the mouth may open wide; the arms stretch outward, locking at the elbows; the fingers extend with such emphasis they appear to bend backward; the head and upper torso press forward; and the eyes gaze fixedly, without connection to the other.

In these examples, such interruptions in primary systems of support reflect the unique styles by which each individual adjusted to his or her prior environment. Although these fixed patterns were once temporary and creative adjustments within a difficult, earlier field, they have since grown repetitive and, therefore, disturbing to healthy experiencing.

This article focuses on the formation of reaching patterns in the infant and child as mediated by mouth, eyes, and limbs and the relationship of these early structures to adult experience. Just as reach patterns indicate the capacity for spontaneous adjustments within the primary dyad, they also exhibit the capacity for similar spontaneity within the client/therapist relationship. When therapists recognize how reach patterns emerge and become part of an infant's movement repertoire, they have a broad-based background from which to observe and understand their adult clients. Once a more comprehensive, phenomenological diagnosis is made, somatic and developmental experiments can be implemented to heighten awareness of missing sensorimotor supports. More and more of the client's resources are brought to relatedness.

The Developing Dynamics of Reaching

Infants rely on a developing language of body enabling them to reach out and experience the other and, in so doing, experience themselves. Every infant's reaching pattern evolves as a pathway toward solving developmental problems or tasks. Discovering the solution, the reach is made.

Reaching patterns emerge as a product of several processes within the infant/environment field: the infant's internal dynamics (anatomical constructions of bones and joints, metabolic processes), the fundamental constraints of the physical field (gravity, earth, and space), and unfolding relations within the social environment (primary caregivers). The developmental pattern that emerges within this confluence of considerations is, at first, unstable and easily disrupted. Because the pattern has not yet been fully assimilated into the developing organism, there is a great deal of variability in its shape and form. This variability is the substance of creative adjusting.

It takes much practice for the reach to become reliable and fluid—to locate in space what it is the infant desires, to discover the appropriate effort and most efficient pathway leading toward the object of desire, and finally, to incorporate the other into the infant's experience with a final grasping onto. Each emerging pattern *carves* its path through space, relying on the coordination of one part of the body with the other and in relation to the environment. Through a series of reaching experiments, a more efficient and finely coordinated pattern forms, and more of the environment can be integrated into the self.

For the infant whose interactions with his or her primary caregivers are satisfactory often enough throughout development, a balanced rhythm of reaching and being reached emerges. The infant's needs are experienced by the caregiver and met, modulated or exaggerated in ways that serve healthy contacting. In spontaneous and creative adjusting, the infant's reach pattern reveals a harmonic quality as the effort used in shaping the movement comes into balance with the intrinsic energy of the need.

With some infant/caregiving dyads, the infant is neither met nor encouraged sufficiently. In this situation, incomplete or inhibited reach patterns emerge. These inhibited patterns alter the existing need by either exacerbating or diminishing it. For example, a 10-month-old infant in need of attention reaches out to pat his caregiver's face. The caregiver, distracted and lethargic, hardly notices the pat and does not respond. This infant, whose internal energy builds quickly and does not easily dissipate, soon becomes frustrated. His level of energy continues to elevate. A mounting excitement adds to the urgency of the moment and influences the effort underlying the infant's gesture. The pat becomes a hit. Having been hit successively (and successfully), the caregiver *now* notices the infant and attends to him.

If the caregiver is generally distracted and vague in her responses, this infant will frequently implement a forceful and frustrated style of finding attention. A reach pattern evolves for this infant that is sharp, constricted, and intense and one that reinforces, even exaggerates, the

accompanying excitation. A *dyadic, relational rhythm* develops as the infant's reaching pattern conforms to the emerging constraints of field. The movement patterns of the caregiver are also affected by this exchange, and the caregiver's rhythms and quality of pattern shift and adjust with the ongoing dialogue. For instance, with the right amount of prodding from her child, the caregiver's distracted and lethargic style may suddenly burst into sharp and intense explosions, after which she collapses and constricts.

Another infant with a similar distracted caregiver forms a reaching pattern that is wholly different. When this infant needs attention, she too reaches out to the lethargic caregiver and is met with a vague, disinterested response. This child's excitations, in contrast to the first infant, are slow to build and dissipate easily. Rather than an agitated display of concern, this infant signals to the caregiver in a half-hearted manner and soon gives up on her own interests. She collapses, withdraws, and curls her arms and legs inward. While the first infant's reach pattern exaggerated the excitement of his need, this child's languid and flaccid reach serves only to diminish the intensity of her excitement. With a repetition of these kinds of infant/caregiver dialogues, a flaccid and inhibited manner becomes this infant's style of reaching.

In these scenarios, the enormous variety of potential reaching combinations for each infant has been constrained, limited, and directed by the possibilities within the respective infant/caregiver fields. The sequence of kinesthetic interactions within the relational dyad forms the ground from which affective exchanges emerge. These primary, kinesthetic interactions are the foundation for the child's, adolescent's, adult's preferred patterns of relating. They set the affective tone that bonds one to another.

Let us focus in greater detail at the formation of one specific reach pattern: how infants function when receptive to ongoing dialogues within the field and when receptivity is blocked and fluid communicating obstructed.

The Rooting Response: Reaching with the Mouth

One of the earliest developmental patterns to emerge in the infant is the rooting response, or reaching with the mouth. Guided by her nose, the infant reaches with her mouth in search of the nipple, breast or bottle. Once found, she grasps onto it and begins sucking in rhythmic bursts. In the grasping action, the infant takes firm hold of the other for leverage and support.

Latched onto the nipple, the infant's jaw and skull bones move in a coordinated fashion to enable sucking. When the head is well supported,

the sucking action begins at the jaw joints. The upper jaw/skull bone moves away from the lower and backward. With this back and downward motion, the base of the skull levers into the first cervical vertebra and creates a compressive force. The action reverberates down the entire spine. Next, the upper jaw/skull retraces its pathway and moves forward and up. The action closes the mouth, lengthens the upper spine, and completes the action. The entire sequence creates a rocking of upper jaw/skull on the lower jaw. Neck muscles shorten and lengthen alternately. Reaching/sucking actions activate muscles along the back of the body via the spinal column and down the front via the esophagus tube. Reaching and sucking is a whole-body event.

In *healthy, fluid functioning*, the infant is able to adapt relatively smoothly to the nursing task. She experiences the caregiver's support, reaches for the nipple, grasps onto, and includes the other in experience. When sated, she releases the nipple and separates; then she draws her attention inward and distinguishes herself from the other. Within this background of belonging, an experience of individuality emerges.

In situations of *chronically disturbed functioning*, the reaching, grasping, sucking action does not complete itself. Imagine a distracted, detached caregiver who does not carefully support the infant under head and buttocks. The infant struggles to stabilize. He tenses his neck and abdomen. Reaching/sucking is impeded. The upper jawbone/skull is now held in a subtle back and down position and the infant's mouth remains open. He is unable to grasp the nipple effectively. Tension mounts at the base of the neck and abdomen and generates strain in the muscles and soft tissues of the spinal column and digestive tube. Motor coordination is impaired. Sensing is diminished. With repetition of these events, the infant grows uncertain that comfort and nourishment will be forthcoming. Under these conditions, opportunities for a satisfactory affective connection between infant and caregiver are gravely restricted. The infant is left "open-mouthed" and with an ongoing frustration, dissatisfaction, and longing. He must struggle for what he most wants. He braces, helpless in the face of an unaware, unreliable, and neglectful other.

Now imagine a further example of reaching impediment in the infant for whom sucking is automatic. This extreme disturbance might be the product of difficulties in the womb, drugs, alcohol, the mother's extreme mental distress, and/or a cold and indifferent post-natal caregiving environment. To avoid the poverty of her intolerable existence, the sensitive infant abruptly withdraws her energy from the periphery and shuts down. Breathing patterns constrict and tension gathers in the organ systems and the neural core. When breathing is severely restricted, sucking becomes automatic and the mouth is no longer a fluid organ of exploration. The infant does not sense the other

as *belonging* to her, being an integral part of her experience. A deep and unabiding breach of trust forms within the infant/caregiving field—an immeasurable and lasting wound.

Each developmental reach pattern integrates into the nervous system, influencing as well as reflecting the whole of experience. Developmental patterns of mouth, tongue, jaw, from which reaching and sucking eventuate, evolve and serve as a background support for the child's, adolescent's and adult's behaviors.

The Adult Therapy Client

In disturbances of contacting, the client's eyes may appear vacant or stare, lips press furtively together or part involuntarily, hands clutch apprehensively or fold solemnly, fingers grasp in desperation or point aimlessly. The instinctual need underlying the chronic and inhibited gesture is left unsatisfied. The more specific the phenomenological diagnosis, the more precise the prescribed somatic/developmental experiment.

During the experiment, the psychological structures, as the incompleted past experiences, move to the foreground. The elements that have comprised and shaped the pattern, that is: the client's history, biomechanics, neuromuscular, emotional, perceptual, and cognitive features, are no longer secured one to another. During the kind of transitions evoked in therapy experiments, greater variability in movement and an accompanying shift in environmental possibilities emerge. The client, anxious and excited, experiences the edge of new behavior. What was once fixed, unaware and unavailable for use, now moves forward, offering spontaneity, creativity, and choice. Analagous to infant processes, the adult client's more fluid, adaptive pattern will need practice to become accessible and reliable.

In the following case vignettes, both therapist and client experiment with subtle eye, mouth, and limb movements. The experiments bring to the surface each client's existential concern. Embedded in Bob's every reach are questions of his very being: *If you don't welcome me, am I really here*? Cynthia, not wanting to appear as if she cares, reaches and immediately withdraws: *If you don't want me, I don't want you*! Brenda desperately grasps, attempting to secure the other: *If I cannot hold onto you, I've failed.*

Bob: A Description

Bob sits squarely in his hard-backed chair. He is of average height and slightly overweight. His soft, imploring eyes reach toward me while the rest of him remains motionless. He holds his breath as if waiting for

me to do or say something. The distance between us fills with expectation, and I feel suspended.

I note that Bob's skull presses back and down while his lower jaw remains slack, mouth gaping. Seeming to defy and oppose the downward thrust of his skull, Bob shoves his shoulder bones upward. The force between head and shoulders creates an intense pressure at the base of his neck and tenses the muscles of his upper back. A similar pressure at his low spine generates a severe pelvic arch and pushes his soft belly outward. These constrictions at both ends of his spinal column place stress on his nervous system.

Bob locks his upper arms and elbows close to his torso, as if trying to keep warm. His hands routinely gesture in front of his body and otherwise near to it. Rarely does he fully extend his arms to either side, opening and exposing his heart. Although his tight arm muscles bind his movements, his hands and fingers are unusually flaccid and appear to swim through the air as he motions. When he is excited, Bob separates his index finger from the others and extends it, as if to argue a point. But his movements are indirect and sometimes flail, and his point is generally not well taken. The bound tension of his arms and contrasting looseness of wrists and fingers reveal Bob's difficulty sensing these parts of his body. Lacking a kind of ownership, "This is *my* arm . . . *my* hand," he cannot fully sense what he reaches *for* or grasps *onto* as part of his experience, as *belonging* to him.

Severely dulled in his sensations and constricted in his movements, Bob has only limited ability to contain and express his excitements. Enthusiasm either abruptly converts to delirium or explodes in chaos. Or Bob immobilizes himself and seems to avoid all feeling.

The Therapy: Workshop Seminar

Bob reports that he is angry, and does not feel well treated at his job. He is, in fact, "enraged" and so angry he could "kill *them*" because they are "killing *him*." He says that his killer feelings are either directed toward other people he believes have "wronged" him or are turned toward himself. I ask Bob if he would attend to his body while repeating the words, "I'm angry." Doing so he lifts the toe balls of both feet off the floor, one at a time, while the heels remain. The movement continues creating a rhythmic pattern—one-two, one-two, lift-drop, lift-drop. But it does not release fully into the floor, so each foot is left partially contracted at its ankles.

I ask Bob to change the movement's rhythms from a lift-drop to a lift-stomp, with the emphasis on the stomp, and to complete the act saying, "I'm angry." He experiments with both movement and phrase for about 5 seconds, then abruptly stops. His eyes well with tears and

become even more imploring. A habitual and familiar experience emerges for him, desperate loneliness mingled with an abiding fear. I sense this to be a static experience, a well-traveled road. Closely identified with an earlier image of himself as unwanted infant or child—his mother was cold, deeply depressed, and with more than a dozen children—Bob has formed a rejected and forlorn self as the perennial background to his relationships.

I comment, "First, you were angry. When asked to exaggerate that feeling, you swiftly killed it by filling yourself with a desperate sadness. From what I know of you, you are either raging and wanting to kill someone, beating up on yourself, or falling into a well of grief." Bob agrees, "I don't know anything else."

I take this as my cue and ask Bob if he will return to the experiment. "Let's build support for your angry feelings from the bottom up. Go back to your feet and gently push them into the floor. When you sense they are under you, repeat the phrase, *I'm angry*." For the next several minutes Bob slowly feels his feet on the floor. Spontaneously he begins to stomp, and I add the phrase, "I'm so angry I could . . . fill in the blank, Bob." "I'm so angry I could smash cars," he says. His embodied, emboldened anger is experienced and expressed for brief moments until a recurring helpless grief and incongruous smile or joke interrupts. This occurs with every interruption, and I invite Bob to find his feet under him until he senses his body and the energy of an angry expression.

His anger finished for now, Bob withdraws into himself. I wait with him, sensing my own breathing, and then ask, "What are you feeling now?" "Surprised!" he states. I tell Bob when an infant or child is surprised, he expands his chest, opens his arms, eyes, and mouth and gasps with the anticipation and delight of being met. Once met, the infant sighs with satisfaction. I demonstrate the response, eliciting a smile from him and he soon joins me. He extends his arms, opens his mouth, and inhales deeply. Air is forced into his lungs, and his tight upper ribs expand. A full and deep exhale follows. We do this together several times. His eyes never leave mine. "You mean I'm welcome . . . really?" he laughs.

I turn his words around, "Try the sentence, 'I am really welcome here.'" For the next 10 minutes we work with Bob's capacity to breathe in and out deeply while stating "I am really welcome here" to me and the other group members. With practice, Bob's excitement becomes easier for him to sustain. I up the ante and ask him to continue the experiment while he stands and faces the group. Upright, Bob exposes more of his body to the others and becomes more receptive. He also experiences his feet directly beneath him, which supplies a much needed support for his retracted pelvis.

Bob reiterates the phrase, "I am really welcome here." He jokes, gets tired, repeatedly forgets the sentence, remembers, and persists. Now and again he reminds himself, "I need to feel my feet." With each practice, his expression grows more authentic. The gestures that emerge solidify his experience and embody it further. Now he spontaneously points to himself when he says "*I*," and opens his hands and extends his fingers toward the others when he says, ". . . am really welcome *here*." Once the experiment finishes, he reports that he feels more relaxed in his neck and shoulders. I notice his eyes appear to rest in their sockets. His breathing is deeper, more even, and moves into his upper chest. His neck is lengthened. His gaping mouth is closed.

"You are now finding supports for enlivened experience. As the foundation is made solid, your persistent feeling that people are 'killing you' and the reciprocal need to defend yourself by 'killing them' will dissipate. Good riddance to that." Bob laughs. The session ends.

Psychodynamics

Bob's habitual and seriously insufficient style of breathing sharply curtails his expectations and satisfactions. Unable to expand with desire, he anticipates the frustration and despair of not being met. He chronically holds his breath on the inhalation. This pattern creates a bound muscular tension throughout his body—the kind that erupts in unsupported, falling-apart anxiety and its avoidance, rage.

Bob inadvertently cuts himself off from the nourishment of deep breathing and restimulates an earlier pattern of longing. The object of desire is far off and cannot be found. His eyes beseech the other for attention, approval, love. They express unspoken feelings of deprivation and the accompanying violent helplessness of not having what he wants. Intermittently, his eyes flicker with terror. The threat of asking for, maybe *getting*, what he wants can be as great as the crushing disappointment of *not* getting. What if he reaches out and is not met? What if he *is* met, and then loses what he has just received? Bob is stuck in a fiercely ambivalent, compromised position. He reaches toward in desperation and simultaneously holds back in dread. This conflicted pattern reflects in bodily discrepancies and splits: head pressing forward, upper spine and pelvis pulling back, arms held tight and close to his torso, hands flaccid/flailing, legs held rigid, feet askew.

As a child living with ongoing neglect, Bob learned to inhibit his breathing and tighten his body. To hold back from a desolate, indifferent caregiving environment is creatively adaptive and temporarily supportive. Why reach out if there is no one reaching back? Giving up seems preferable to feeling despondency and harsh disappointment. But the chronicity of the pattern continues to suppress his excitements as an

adult and to discourage their energetic expressions. He is filled with the pain of his own inauthenticity. He is also filled with resentment.

To discover support for his angry expression, I encouraged Bob to press his feet into the floor and spontaneously stomp. Doing so allowed him to move away from the muddle of an early and rigidified wound, and from the ensuing character of victimized child. The experiment helped him to identify with his adult self. He felt entitled to his anger and its vital, genuine expression.

The novelty of his experience surprised Bob. I demonstrated for him an infant or child's expression of surprised delight: full inhale; open eyes, mouth, and arms; and extended spine. This was followed by a deep and satisfying exhale. He mirrored the pattern. The incremental, fluid shifts in his breathing and gesture cultivated a *pleasurable* expectation for him. Bob completed the act, and in doing so his earlier script of *never having been met*, for the moment, was rewritten.

Cynthia: A Description

Her well-formed muscles lend Cynthia the appearance of sturdiness, and she appears to be capable of handling whatever comes her way. Her shoulders elevate, rib cage lifts and expands outward, her arms hug resolutely to her sides, and her elbows pull backward. The overall pattern makes her seem taller or bigger than she is and adds to the initial impression of confidence that she gives.

The weight of Cynthia's body rests on the backs of her heels. To prevent herself from falling backward, the muscles along her thighs and legs constrict, and her knees lock. Her muscular tension is exacerbated by the backward and downward press of her head. This creates strain in the base of her neck, jaw, and upper spine. The natural curve of her low back exaggerates and tips her pelvis forward.

Cynthia holds tight, determined to keep herself under control. It is as if she is persistently pulled up, back, and away from some impending catastrophe. The rigidity of her postural pattern limits her full range of movement possibilities, the extent of her excitements, and their expressions. Ungrounded and with so much energy held in her upper body, Cynthia experiences intense pressure generating in her head. She is besieged by an almost continual flood of unwanted thoughts.

As she pulls herself up and away from the possibility of environmental dangers, she also pushes away feelings of hurt, sadness, and disappointment, the *internal* dangers. When feeling threatened, she secures her arms still closer to her torso. Only anger seems permissible for her, and Cynthia often uses her customary belligerence to intimidate. Her pugnacious attitude serves to keep others out, but it leaves

her with an unbearable loneliness and deep feelings of exclusion. Nevertheless, she bolsters herself and remains consistently alert. This behavior keeps her away from not only what she is frightened of, but also what she hopes for.

The Therapy: Clinical Encounter

Cynthia says she feels a constant "struggle" with her mother. "She's always hovering over me . . . telling me what I should be doing. She even tells me what to eat! Our relationship has never changed. She never gives me what I want."

"What is it that you want from her?" I ask. "I want her to leave me alone," she quickly replies. With further investigation, Cynthia clarifies her statement, saying she wants her mother to acknowledge and respect her. "What would respect feel like?" I ask. She contemplates my question. Her eyes fill with tears, "I think I want her to love me," she says with a look and sound of incredulity, as if wanting a mother's love were a novel notion.

I ask Cynthia to stand up and imagine her mother. *How* she organizes her experience is clearly revealed by her standing posture. Visualizing her mother, Cynthia says, "She's holding back from me," but when I probe further she cannot describe how she knows this. "It's just something I feel," she says. I ask Cynthia to notice her body. As she turns her attention inward, she senses intense tension developing at the back of her neck and shoulders. She has sought treatment for these chronic neck/shoulder pains through massage and chiropractic and has found only temporary relief. I ask Cynthia to exaggerate the tension in these areas. To recreate and magnify the pattern, she notices that she must tense her neck and pull back her head, an action that jams the base of her skull into her spinal column. Simultaneously, she lifts her shoulders up and slightly backward. She also notices that her arms hug to the sides of her torso, her elbows are pulled backward, and her fingers are tensely grasped. I ask her to exaggerate this posture and again to visualize her mother. Immediately she exclaims, "I'm holding back too! I never realized that. I feel sad for both of us," she sighs.

The Following Week

Excited, Cynthia talks about her "profound" experience of the prior session. "I'm always so tense. Mostly around my mother, but even when I'm not with her I do the same thing. I'm not sure why, but I'm anxious a lot," she confides. We continue to experiment with her habitual and braced postural pattern. She tenses and pulls back her neck, lifts and tightens her shoulders, pulls her elbows backward, and simultaneously

hugs her arms to her sides. Her fingers grasp. She looks like a boxer waiting for an opening. Cynthia holds this position for some time, feeling the inherent struggle in the pose.

Silently, I entertain two possible interventions. In one, Cynthia curls her hands into fists, pulls back her arms further, and finishes the restrained action with several jabbing movements. I feel uncomfortable as I imagine this experiment. It is too early in our relationship for Cynthia to safely reveal her anger so completely. Not enough supports are in place. Instead I invite Cynthia to unwind her tensed, grasped fingers and then to follow the natural, sequential, unfurling action of the pattern until she is fully extended. This will unravel her compromised position, I surmise.

At my request, Cynthia relaxes her hands and slowly and deliberately reaches out. The movement initiates a dynamic and energetic release through her arms, shoulders, chest, and head. At the end of the movement's sequence, her stance is more relaxed and both her arms fully extend. Only her head and eyes are cast downward, interrupting the flow of action. "Will you look directly at me?" I ask. She lifts her head and eyes to meet mine. Then she startles, suddenly retreats, and pulls back and in. She notices this immediately. "I just got scared and pulled away from you," she says with surprise. "I'm afraid to reach out. I'm not sure why."

Cynthia explores her anxiety further in a series of reaching experiments. I realize there is little movement in her mid-back as she extends her arms. The physical blockage results, in large part, from lifting her rib cage up and pulling it back. A lack of motoric flexibility just behind her heart indicates insufficient support for her reach.

Now we experiment with Cynthia lying face down over a large oval-shaped, 85-cm ball. As she yields into the ball, she audibly exhales. The ball lends support to her ribs and pelvis. I further support her upper spine by gently tapping the area between her shoulder blades. She breathes deeply. Between tapping motions, I rest my hand lightly on her back. Once I sense that she is more relaxed and open in her spine, I ask her to stand and reach both arms directly overhead. Then I kneel in front of her, placing my hands on her feet. The downward pressure of my hands enlivens the underlying supports (her feet) for her upward reach.

When Cynthia fully attends to the reach of her hands and press of her feel, I change my position. Standing behind her, I place my left hand on her right shoulder blade and press lightly downward and toward her ribs. At the same time, I gently grasp her right arm with my right hand, and slowly pull it up, creating a subtle sensation of traction. The shoulder blade *slides* down, inhibiting tension, her arm *stretches* up,

facilitating a greater range of motion. I recreate this hands-on technique with the other shoulder/arm.

After my adjustments, Cynthia rests her arms by her sides. "My back and shoulders feel so much looser and my arms are heavy. And I still feel my feet." I ask Cynthia to continue feeling her feet and to reach toward me. She experiences, and I observe, the backward pull of her upper spine as she reaches out. Cynthia's conflict is clearly visable as she exaggerates her position. "I want to reach out to you, but I'm not sure what you want. . . . I mean if you want me to." I ask her to repeat the sentence, but with a slight variation, "I want you, but I don't know if you want me." At hearing these words, Cynthia crys, then sobs. When her tears pass, she says, "My neck feels so much better. I can't remember the last time I felt pain free. I feel good."

Psychodynamics

In the smooth and uninhibited standing and reaching pattern, our feet must subtly press into the floor to give the movement its underlying support.[1] The reaching capacity of the upper extremities is influenced by the underlying *pushing support* of the lower. Reaching moves from the fingers through lower and upper arm bones into the shoulders, rib cage, and spine. The sequence is an energetic flow from periphery to center that then circles back out from center to periphery. At the end of a fully committed reach, fingers grasp onto the object, the longed for assistance and support.

Earlier reaching patterns of past experience have fixed, one into another, shaping and forming the present character of Cynthia's postural configuration. Fixations of postural pattern are an amalgam of arrested developmental movements, distorted yet protecting against the incomplete and avoided aggressive expression of the full pattern. Embedded within these arrested patterns, the structure of unfinished experiences and their accompanying affect endure.

As she imagined her mother, Cynthia felt Mom hold back from her. When I asked her to draw inward and sense her body, Cynthia became enlightened: it was *she* who held back! To heighten awareness of her pattern, I invited her to exaggerate her stance. Cynthia became aware of how she positions herself in relation to her mother. Her initial dilemma of *what she (Mom) does to me* was now experienced as *what I do to myself*.

To be accepted by the significant and primary figures of her early life, Cynthia had to hold down her excitements by pulling back, in and

[1] In sitting this happens through the base of the pelvis, the ischium tuberosity, often referred to as "sit bones."

away from another, a creative adaptation. Holding down, holding back, and holding in express a compromise of conflicts. *I neither reach out to you with all of myself, nor do I completely hold back*. The persistent struggle expresses itself in the present moment of the session and in the presence of the therapist. The appropriate background anxiety of an unclaimed and repressed excitement surfaces. Anxiety, if unsupported, leads to feelings of exclusion and isolation. Once Cynthia's sadness emerged, anxiety dissipated. She was present.

At our next meeting, Cynthia and I turned our attention to Cynthia's postural pattern, a composite of psychological functions. Cynthia exaggerated her retracted pattern and, in the process, released excess tension. Her release coupled with the reaching of her arms, hands, and eyes created a more vulnerable stance. Cynthia startled; she was afraid to reach toward me and did not know why. She tightened around her spine, abruptly withdrew her arms, and flexed her fingers. Her reach interrupted.

I used a large oval ball to construct a support for Cynthia's lower ribs and pelvis. As she lay over it, I began tapping her upper spine to enhance sensations and, thereby, faciliate movement. Between taps, I rested my hand on her upper spine. Both actions helped to reduce her hypertonicity and created flexibility in the smaller muscles of her spinal column.

As Cynthia stood and reached her arms overhead, I used my own hands both to inhibit the chronic spasticity surrounding her shoulder/upper spine (pressing the blade in and down) and to facilitate the improvement of muscle tone (pulling the arm away from the shoulder). The traction created much needed space around the arm/shoulder joint. She developed additional support for her standing posture: a looser spine, relaxed shoulders, arms, and the sensation of her feet on the earth. Cynthia felt relieved. Now that she was more related to her body and the immediate surroundings, formerly unfelt and unavailable psychological material could emerge. When Cynthia reached toward me again she recognized the ambivalence of her uncoordinated movement pattern: her arms reach forward—yes! but her upper spine tenses and pulls back—no! Each force locks in a battle to dominate the other. The psychological function set within the inhibited, ambivalent reach is discovered, "I want you, but I don't know if you want me." The pattern disorganizes, as previously fused components of sensing, feeling, perceiving, and thinking loosen. In transition, Cynthia teetered at the edge of new behaviors. Sobbing, she then committed fully to her present experience.

When the psycho-physical structure of the pattern revealed itself, was experienced and expressed, Cynthia's routinely strained neck freed.

Today, tension in her neck, a symptom of her inhibited reach and the accompanying repressed emotional expression, continues to be an important signal for her both in and out of session.

Brenda: Workshop Seminar

The following experiment occurred during a week-long training seminar attended by psychotherapists. It serves as a poignant example of a mis-matched dyad. Participants were paired together. Person A was invited to lie supine on the floor while person B sat at his partner's head. Partner B held a soft, cloth toy in front of A and slowly moved it from one side to the other. Partner A was invited to track the ball with eyes and head.

What follows describes the experience of one experimenting dyad: Brenda lay on the floor, arms extended at a 45-degree angle from her body and legs separated about 12 inches apart. Her head was placed on a cotton blanket folded several times to create support and lengthen her habitually constricted neck.

Henry, her partner, appeared both eager and anxious. An unfelt muscular tension informed all his actions. His gestures burst forth abrupt and sharp, only to be almost simultaneously held back. In contrast, Brenda's gestures were so languid that, at times, they bordered on collapse. Her eyes, glaring and exposing their whites, maintained a high degree of intensity, as if all energy were localized there.

As the experiment began, Henry waved a small cloth doll in front of Brenda, keeping it about 16 inches away from her face and moving it erratically from side to side. As soon as Brenda settled her eyes upon the doll, Henry jerked it away. To keep it in view, Brenda had to keep up with Henry's tensional rhythmic pattern. She moved her eyes and head to a beat that was clearly not comfortable for her.

After a few moments, Brenda shut her eyes. When she reopened them, Henry swiftly yanked the doll side to side, and up and down. She strained to follow his movements, but her valiant effort was short-lived. Again she closed her eyes and sank into the floor. Her hands opened in a subtle gesture of abdication. The position of resignation reverberated in her breathing pattern, which was significantly reduced and held on her exhalation. Henry, genuinely enjoying his experiment, did not seem to notice that his partner had dropped out.

As Brenda had grown listless and withdrawn, I asked Henry if I might try a different intervention. With Brenda's permission, I took a soft brush and stimulated the palms of her hands. She watched attentively, "I like that feeling, she said." Then I took a small, hard rubber ball and dropped it into her palm repeating the movement in a steady, even rhythm. "The predictablility [of the movement] feels soothing to me," she offered.

I took another ball and repeated the steady, rhythmic tempo in Brenda's other palm. Slowly her hands began to grasp the balls. To exaggerate the emerging grasp pattern, I held each of her hands with mine, pressed her fingers firmly around each ball, and pressed the balls into her palms. I took several deeper breaths, and so did she.

Now Brenda slowly rolled to her side, sat up, and eagerly told the group of her "significant" experience. At the beginning of the experiment and as Henry waved the doll from one place to another, "I had to work hard to keep up," she said. The dyadic experiment reminded her of earlier, familial experiences when she was asked to do more than she was capable of doing. At such times Brenda said, she pushed herself in an effort to meet her parents' (in particular, her father's) expectations. "I was always such an overachiever. I *had* to get approval for doing well, and I *had* to do well or I was a failure. That's still true."

As the experiment with Henry proceeded, Brenda became frustrated at the "unpredictability" of the toy's placement. "I really wanted to gaze at it . . . have it come to me . . . have it be easy. I didn't want to work so hard. And then I just gave up. I felt myself going numb." Brenda recognized the familiar pattern, the desperate attempts to overachieve, to be "more than I really am," ending in resignation and despair.

Abruptly Brenda stopped her story, "Do I *look* different?" she wondered.

"What feels different?" I ask.

"My eyes," she answered, "I can't say exactly how."

"Yes," I agree, "Your eyes are softer and they appear receded in their sockets. How do *I* look to *you*?"

Taking her time Brenda answers, "I don't feel my eyes pushing, and it's easier to look at you. I'm not working so hard." Now slowly looking at the group members, "I feel more comfortable with all of you."

Psychodynamics

The difficulty within the dyad emerged immediately as Henry kept the toy much farther away than was comfortable for Brenda and seemingly beyond her reach. Likewise, his gestural rhythm appeared out of sync with hers. Involved in his own enjoyment, Henry neither noticed Brenda's discomfort nor her efforts to shut him out. The mismatch of the dyad brought her routinely inhibited visual pattern into sharp awareness.

Seeing is a balance between our reaching toward the object and allowing the object to come toward us. It is a combination of resist and yield, an aspect of all contacting episodes. Brenda's eyes, *pushed* forward in their sockets, and appeared rigid and stuck. In this style of reaching, a fixed stare, much of peripheral vision is restricted and this drains supports from both organism and environment. Under these

strained conditions, the object of such intense focus looms so large that bodily experience diminishes. Dyadic tension between one and the other do not easily equilibrate. Meeting is fraught with pressure.

The interruption in contacting was clearly visible—Brenda's anxious and piercing wish to reach out and grasp onto the much desired, but elusive object. Working with *direct* touch, I stroked Brenda's palms with a brush to stimulate sensation. To build supports incrementally, I rhythmically dropped balls into one and then the other palm. The weight of the balls gave her the sense of holding onto something. Soothed, she gradually clasped her fingers around the balls, gently *receiving* them into her hands, a natural conclusion to a grasping experience. I wrapped my fingers around Brenda's and pressed the balls deeper into the cup of Brenda's hands. Awareness heightened.

When she was seated, the experience in one sense modality, touching, translated to another, seeing. Brenda released the perpetual searching pattern of her eyes. Looking around, she felt "easier" and "more comfortable" with both the therapist and the group—an experience of inclusion.

Conclusion

In the preceding scenarios, the shape of each person's reach pattern expressed his or her individual style of approaching and withdrawing in sequences that were fluid or restrained. In each case, I observed that the person needed to reach out for assistance and connection but was too anxious to do so. In reaching toward what he or she most longed for was the fear of not being met and the attending discomfort, disappointment, disillusionment, and shame. The ambivalence was displayed in the person's whole body. The prescribed somatic/developmental experiments addressed subtle reaching disruptions and engaged the core of each person's existential/psychological conflict.

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