

*...Bearing thy heart, which I will keep so chary; as tender nurse her babe from
faring ill.*

- William Shakespeare, sonnet XXII

CHAPTER THIRTY-SIX

FORCELESS SPONTANEOUS RELEASE, A FORM OF YIN TUI NA

INTRODUCTION TO THE SECTION ON TECHNIQUE

This chapter will provide instruction in performing Forceless, Spontaneous Release therapy, or FSR. The next chapter will guide you through a very specific practice session in which these techniques are applied to legs, ankles, and feet. The chapter after that will offer an explanation of how FSR works. Several chapters that explain the very still, resting variation of FSR that we use on Parkinson's patients follow these chapters on FSR.

This chapter will start by explaining why we have to learn and use both the standard FSR and the Parkinson's variation.

Comparing the technique of FSR and the Parkinson's variation

The technique of Forceless, Spontaneous Release, FSR, is extremely simple. It consists of holding a body part between two hands in such a supportive way that the patient doesn't really notice that he is being held. Undetectable, even purely mental nudges in one direction or another may be performed, if necessary, to determine whether or not the area being held is capable of reflexively responding to either the support or the minute suggestions of movement. The hands are removed after the body part being held *seems to relax or otherwise responds in some way*.

This technique is different from the FSR variation that will be used in the locations of the more stubborn injuries that are seen in PDers: with certain PD-initiating injuries, no matter what you do, how correct your pressure is or how long you wait, certain injured areas, particularly certain areas in the feet, will not respond for a long, long time: maybe months – certainly not minutes.

Because the injured feet of people with Parkinson's do not respond to touch in the normal manner that is seen in FSR, we need to use a variation of normal FSR technique when we work with Parkinson's patients. This variation, referred to as "resting FSR," consists of assuming the same type of supportive position with the hands that is performed in normal FSR, but then keeping the hands as still as possible, remaining fairly motionless for as long as necessary (usually the length of the session), while actively working to keep one's (the practitioner's) mind uninvolved in whatever the patient's injury might be doing. There is a bit more to it than this, but for now, this description of resting FSR will be enough to differentiate it from the regular, more diagnostic type of ordinary FSR.

Both “normal” FSR and the PD variant are used in treating PD

FSR is a diagnostic tool as well as a treatment tool. We use FSR to determine where the PDer needs the resting variation to be performed and to assess whether or not the area is starting to change. A PD therapist must first learn how to perform FSR, and then the PD variation: resting FSR.

FSR as a diagnostic tool

Normal people have an automatic, reflexive response to being touched or held. The injured areas of PDer's, in stark, clearly perceptible contrast, do not have a normal, automatic response to being held. When, by practicing FSR, a practitioner learns to quickly recognize what the normal range of responses of a healthy person feel like, he will be able to recognize the pathological response that he gets when he homes in on the injured area(s) of a PDer.

Another reason for learning FSR is that, eventually, as the PDer starts to improve, the fairly Yin FSR technique may appropriately supplant the extremely Yin PD variation in order to do the fine-tuning.

Referring to a health technique as both a diagnostic tool and a therapy is somewhat uncommon in the western medical realm. However, when applying assessment methods that indicate whether or not a person can pay attention to a given part of his body, the very process of assessment can be an attention-garnering act. As the body brings its attention or curiosity to an area, it may also bring healing capability to the area: the assessment becomes the therapy.¹

In order to discover which areas of a PDer's legs and feet do not respond with a normal reflexive movement, FSR is first used on the legs and feet of PDer's. When the practitioner comes to an area of the foot or leg (and later on, possibly an arm, hip, shoulder, neck, or cranial bone) that does not respond normally, this non-responsive area is where the practitioner will begin

¹ Years ago, when I was studying Zero Balancing, a very Yin type of body stretching, the teacher kept saying “Gently move the patient's foot (or neck or whatever) in direction X or Y and then assess what happens.” Over the course of two days, I got increasingly antsy with the “assessment” process. I was eager to find out what technique we would do on the areas that had been “assessed” as needing more work.

At the end of the two-day workshop, it suddenly occurred to me that the actual work of Zero Balancing was the moving of the patient: the assessment process was the technique. The verb “assess” had been used, very wisely, by the originator of Zero Balancing to prevent students from thinking that the imposed movements were supposed to do anything to the patient. By asking practitioners to “assess” what happened when moving the patient, the practitioners very carefully tuned in with what was going on in the patient's body, but didn't try to actively do anything. The benefit that was observed by patients was “spontaneous:” it occurred on its own, while the practitioners were very gently moving the patient around, trying to make an assessment.

I realized, several years later, that a major challenge for founders of various schools of light touch movement comes in writing up the instructional material. If the founders use verbs that imply any sense of doing on the part of the practitioner, most of the students will completely misunderstand and use some, and therefore, too much, force. On the other hand, if the writer says “assess” or “apply a few grams of pressure” (a gram being less pressure than most humans can even feel – a gram of pressure is less than the weight that a dime imposes on a tabletop), the student correctly goes about his work of touching in a non-forceful manner. Despite, or because of, the lack of force involved, the patient responds in a beneficial way. Therefore, the assessment and the therapeutic work are very often one and the same.

The best analogy would be that a mother's kiss works best if she first really focuses on the child's little injury, looks at it, clucks her tongue, and then gives the spot a kiss: assessment and gentle treatment. If a mother merely blows a distracted kiss to the crying child from across the room and hollers, “Don't worry; you're still alive! Ha, ha, ha!” a therapeutic benefit will probably not occur. The careful assessment by the mother, drawing the child's own loving and attention to the area, is a crucial part of the healing work.

doing the PD variation on FSR. In comparison to normal FSR, this variation is extremely motionless and intention-free: extremely yin.

Setting standards for diagnostic tools: determining what is normal

One requirement for using a touch technique as a diagnostic tool is familiarity with what constitutes a “healthy” response. In my weekend seminar experiences, I learned from those practitioners who had already been working on PDer, using only text as their FSR learning tool, that most of these practitioners had never bothered to practice first on healthy people. They also were the most baffled as to why their patients were not improving, considering that, according to these practitioners, their patients’ blockages were all gone.

Ignoring the repeated textual admonitions that these techniques should be first practiced on healthy people, these practitioners had assured themselves that the tiny, random, small electrical cellular responses coming from their PDer were “normal” tissue responses. Concluding, based on this wrong, presumed evidence of “movement,” that their patients’ blockages must be gone, the therapists had gone on to prematurely and/or unnecessarily use acupuncture needles or physical therapy on people who still had blocked injuries and backwards-running Qi. These practitioners then wondered why their patient was not getting better. In fact, their patients were *not* yet making normal responses to touch. They still needed Tui Na therapy. But the therapists didn’t know what was a healthy and normal response and what wasn’t.¹

If a person has no training in FSR, he may not realize if a PDer is having a normal response or not. Therefore, I will state as forcefully as possible: the following techniques should be practiced on several healthy people before they are used on PDer. After practicing these techniques on several or dozens of healthy people, a therapist may have enough sense of the normal range of healthy response that, when he comes across a strangely unresponsive area on his PDer, he will know immediately that there is something deeply wrong. He will also know when the injured area is starting to feel healthier, closer to normal.

FSR TECHNIQUE

Positioning the hands

The following is directed to the health practitioner who is learning FSR. The word “you” in the following section refers to the FSR student.

Place the palm side of your hand flush against some part of the forearm of your learning partner. Then place your other hand on the opposite side of the forearm. (See fig. 13.1.)

¹ In many training classes, I have had a student or two who had thought his long-time PD patient was responding fabulously because he thought he could detect subtle movement deep inside the skin. In the classroom setting, when these students begin working on healthy fellow students, they are astonished. I remember one exclaiming to the room, “Oh my gosh! Is this what a normal person responds like? My PDer doesn’t feel anything like this!” This same practitioner had been writing to me for months telling me about her FSR progress with her PDer. She had said that her PDer was responding beautifully to her touch, and yet wasn’t seeing a change in her PD symptoms. When this practitioner exclaimed this way, I asked her point blank if she had ever tried these techniques on a healthy person (my previous editions made the point very strongly that one should practice first on several healthy people). She told me, “No, I assumed I didn’t need to. I’m a licensed acupuncturist, and a massage therapist. I had thought I knew what it felt like to touch a person.”

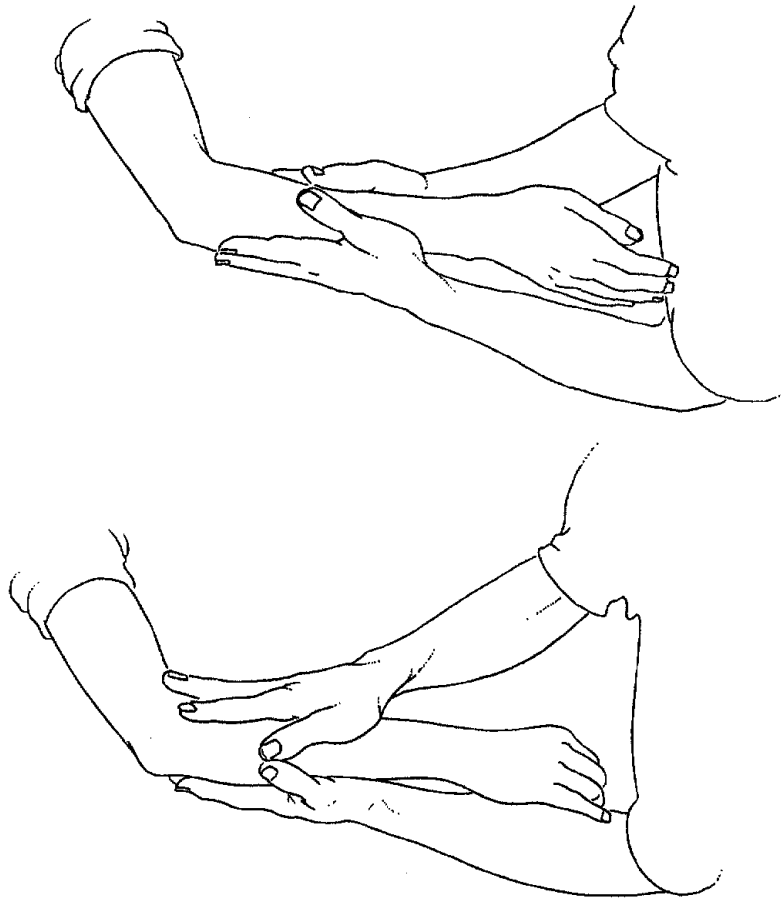


Fig. 36.1

Two examples of placing your hands on opposite sides of a body part. It does not matter exactly in which direction you are holding. The important thing is that your two hands are more or less opposite each other.

Your own physical comfort is an important factor in deciding where your hands and arms need to be, both in relation to the rest of your body and in relation to the contours of the patient's arm. The exact location of your hands during this practice – and whenever you are doing FSR – is not critical. Your ability to be relaxed is much more important than the exact placement of your hands: you may need to sit fairly still for a long time. Slumping back in a soft chair may seem like a comfortable way to sit, but this type of “comfortable” is not easy to maintain for very long. You will be able to work longer and better if you can learn to sit upright, with good posture, while your arms suspend softly from the shoulder, and your hands have no tension at all.¹

¹ This footnote is directed to those people who worked with the 5th edition of this book. In that book, I wrote more details about what the practitioner should do during FSR. We have learned a lot during the last five years. One of the main things we learned was that the level of expertise and attunement with the patients' skin, legs, and bone doesn't matter nearly so much as we thought it did. We also learned that the role of the patient is much greater than we'd thought it was.

Pressure

The amount of pressure that your hands exert on the partner is very important. You should make fairly complete skin-to-skin contact without actually trying to push the partner's skin around. The goal is to hold the patient with such complete support that he cannot feel your hands. Because the completeness of the support is more important than the exact, precise location of where you are holding, it is important that you find a way to nestle your hands into the contours of your partner's forearm, even if such a holding position is not exactly the location of holding that you originally had in mind. When you have gotten your hands nestled into a place that feels comfy, your partner, curiously enough, will often volunteer that you have put your hands in "just the right place."

Now let's back up a bit and look more closely at what you are doing, looking at one hand at a time. Let's assume in the following explanation that you are putting one hand on the upper side of your patient's arm, and your other hand underneath his arm.

Upper hand

If you are sitting in a comfortable position, you will be able to let your upper hand drop gently from your shoulder and come to rest on the patient. The pressure of your upper hand should exactly equal the force that gravity is using to keep your hand resting on the patient. This is a fair amount of force, by the way. If you are using any muscles to prevent your hand from pushing too hard onto your partner, you are holding too lightly. Your hand should be resting like a dead weight, with the full weight of your hand plopped down on your partner.

If you aren't sure what I mean by "dead weight," you might want to abandon your partner for a moment and try this practice exercise: sit in an armless chair. Let your hand flop down onto your thigh. Let your hand just sit there, held in place by gravity. Don't push your hand into your thigh as if you were trying to leave an imprint of your hand: that would be too much pressure. Don't rest your hand gingerly, as if your thighs were sunburned: that would be not enough pressure. Let your shoulders relax and sag down. Let your hand rest heavily on your thigh. That is the exact correct amount of pressure for your top hand. This amount of force could be calculated mathematically as the force of gravity times the mass of your hand. Now, take this hand off your thigh and respectfully allow it to plop back down with the same degree of weight onto your practice partner's arm.

Lower hand

Use the exact same amount of pressure with the lower hand that you use with the upper hand.

If you want, you can abandon your partner again for a moment and practice holding your thigh again, but this time you will use both hands. Let your first hand flop down onto one side of your thigh, and place your other hand on the opposite side of your thigh. Imagine that your thigh is a mound of bread dough. Use as much pressure between the hands as you would need to use to keep the lifeless bread dough from dropping to the ground. Do not hold the limp "bread dough" gingerly; it will slip through your fingers. Spread your fingers apart so that the "bread dough"

If you first learned FSR from the old book, you will notice that this edition spends a lot more time on FSR technique, but has also eliminated some of the old material. This does not mean that the instruction is less complete. It means that we've figured out the critical elements and spent more time on those, and left out the things that turned out to be not important.

doesn't sag. Have a firm grip on the two sides of the "bread dough" of your thigh, but don't be leaving imprints of your fingers in your flesh.

Either one of your hands acting alone could not hold up the soft bread dough from the side. But the two hands, one on each side, can firmly (but gently, without squishing the dough) support the lump of dough if both hands press towards each other with just the force of gravity.

Try placing both hands on your partner's forearm again, using the same amount of support that you used to support your thigh.

More about how much pressure to use

Again, how much force should be coming from your two hands? You should use as much force as you need to make the patient feel perfectly supported. If you are holding with approximately the force of gravity, the patient will be able to stop fighting the force of gravity in that particular body part. This unconscious work of combating gravity (on the part of the patient) can cease. The patient can relax.

However, the actual body position of the patient will not have changed, and if your hands are merely supplanting a force that was already there, the net change in applied forces will be zero; the patient's body soon will be unable to tell that anything like force is being applied by your hands. The patient will feel as if, for all intents and purposes, your hands are not even there.

Again, do not hold gently; nothing can be more annoying. Get a nice, solid, supportive hand position on the area that you are going to work on. Place your other hand opposite the first one and have the two hands together hold the body part with such support that even if the table on which your partner is resting was to be pulled away, your holding would prevent any falling down of that part of the patient that you happen to be holding.

Don't be trying to physically *or mentally* manipulate the limb you are holding. At this stage, when you are practicing how to hold without undue physical or mental pressure, consider that any intention on your part for the good of the patient is a form of psychological pressure. So don't be imagining any particular outcome as a result of your support. Have no intention in mind for how the practice partner should respond.

Pressure without intention: the harried mother example

I frequently use the following example to demonstrate what I mean by solid support without intention.

Picture the scene: a harried mother is trying to cook dinner. She is standing at the stove, stirring food in two pots. One pot has almost come to a boil and needs to be watched closely. The other pot is bubbling away and needs frequent stirring. Just out of arm's reach, her four-year old child is pestering her two-year old child. The younger child is just starting to scream in frustration. The mother cannot reach them because she is stirring the dinner, plus she is talking to her friend on the phone; the phone is the old fashioned kind, attached by a cord to the wall. She is not using her hand to hold the phone, the phone is cradled between her ear and her raised shoulder. She is alternating between telling the youngsters to stop fighting and trying to arrange a babysitting swap with her friend for tomorrow. Meanwhile, she is also holding a baby on her hip; it is not her own baby; Mother is, at this moment, babysitting for the other neighbor, who should be home shortly. Until that neighbor gets home, the mother has the neighbor's baby wedged up against her left hip and she has her left arm wrapped around the baby. Baby is stuck between the firm left hip and the snug left arm. Baby is in solid. Baby is going nowhere.

With her other arm, mother is now alternating between adding some spice to the dinner and stirring it. Mother is still on the phone, on hold, and is now pleading with her young children to stop fighting over the stuffed weasel that they are trying to tear in two.

Here is my question: who is the most contented person in the room?

If you guessed the neighbor's baby, you are absolutely right. The baby is looking around, taking it all in, reveling in the fact that he doesn't have any social interactions going on. Baby is being held so closely that he doesn't even notice that he is being held. Baby has such complete trust in that firm support coming from the hip and the embracing arm that baby does not notice the pressure from the mother's hip and arm. Also, the mother is not paying any attention to the baby with her eyes or words. The baby is physically relaxed and comfortable.

Of course, when the baby's mother returns, baby will probably go into his regular routine of crying or cooing at his own mother, doing all the things it has already learned to do to fulfill his mother's expectations. But while the baby is being held tightly on the neighbor-mother's hip with no one looking at him, no one cooing at him, no one expecting anything of him, he is able to take it all in with wide-eyed wonder, amusement or contentment, and his body will be physically at peace.

The way that the above mother is holding the baby, that's the way you hold a person with Parkinson's disease.

As a member of the PD Team often says, "The biggest mistake therapists make is that they hold the PDer as if he was *their* baby. You should hold the PDer as if he was *someone else's* baby."

Comfort for the practitioner

In the example above, the mother is doing whatever she needs to do to be comfortable. No doubt she has one hip swung way out to the side to support the baby. But the hip is not putting undue pressure on the baby. The pressure that exists in the baby-hip contact is the pressure from gravity acting on the baby. The hip is not trying to force itself onto the child to support the child. The hip is just there. What with gravity and the additional lateral support provided by the left arm, the baby is nice and snug. The amount of force that occurs in the hip-baby contact is the amount of force that your hands should be using on your partner/patient.

This amount of pressure should be comfortable for you. If you find that you are getting tired arms or sore hands, possibly you are using way too much pressure or your chair is not at the right height. If you are not relaxed, it will be hard to give perfect support to your patient.

Now you have mastered two parts of FSR. First, you know that the hands are opposite each other, supporting the body part in between. Secondly, you know to use just as much pressure as you would need to counteract gravity: enough pressure to provide support.

Practicing position and support

Practice the above positioning of the hands (one hand opposite the other) and applying just the right amount of force on a practice partner. Place your hands on your partner's forearm and experiment with positioning your hands until you find a pose that is very comfortable for you. Have your partner tell you if your hands feel too pushy, too light, or if they feel just right. Have your partner then try the same on you. Take turns seeing how it feels to hold someone's forearm. If you think you are comfortable with the forearm, try holding the upper arm. Try holding the partner's thigh or lower leg. Play with this. See what it feels like to hold supportively but without expectation, and how it feels to be held.

As you get more familiar with this type of holding, try pretending that your confidence level has increased to the point that, as soon as you set your hands on your practice partner, you are instantly applying just the right amount of pressure. In other words, you don't want to spend five minutes figuring out exactly how much pressure to be using. Practice resting your hands firmly and opposite to each other until you get to the point that you know, even before you set your hands on your partner, just how much pressure you will be wanting to use. From the moment you start to place your hands on your partner, do it confidently, with the correct amount of pressure.

Movement occurring in your partner in response to your holding

When you practice holding your practice partner's forearm, you will notice, eventually, that at the moment when you place your hands on your partner using exactly the correct amount of support and pressure, an immediate and perceptible change occurs in the position of those muscles in your partner which are immediately under your point of contact. This comes from the immediate, localized relaxation of the patient's body part in response to your touch. The change may even be visually perceptible to you (and your partner) because your hands, making firm contact, will perceptibly move even as your partner's forearm relaxes.

Because of your commitment to supportive contact on your partner's skin, when his skin/underlying muscles move, your hands must move along with him. Your hands may find themselves resting in a slightly different position than they were when they were very first placed on the partner's arm.

You might ask, "What if my partner is already relaxed? If so, he will not relax in response to being held." Don't worry. If your partner is fighting gravity, he is doing work and, therefore, is not perfectly relaxed. One can safely assume that all conscious patients/partners are not in a state of perfect relaxation and will relax somewhat in response to being supported.

When your hands are applied to his forearm (or any body part), your hands will supplant some of the patient's inherent tension; the touched area will relax its share of internal muscular grip accordingly. This small release of muscle tension will create a movement in the skin and underlying muscles, such that the practitioner's hands will find themselves resting on the patient in a slightly different position than when they began. This change might not be perceptible to the partner/patient if he has his eyes closed. Because he felt no vector of force being applied, the partner will most likely think that nothing has happened except that he briefly felt the contact from your hands. If the partner sees that your hands have moved in the first moment after you placed your hands on him, he will most likely assume that *you* have initiated some movement that caused your hands to move.

However, if your partner's eyes are closed during the time of contact and subsequent movement, he will probably not detect that anything has happened at all other than the fact that you are supporting his arm. However, you may have noticed, especially if the angles of your wrists and arms had to move in order to follow the movement of your hands, that your partner's skin, by relaxing, has carried your hands to a different position from your starting position.

Although you will have done nothing but support, something will have changed in the partner/patient. Sometimes enough relaxation can be inspired just through this type of brief holding that a significant release of tension or repositioning of displaced bone or tissue will occur. Sometimes – and this is the point – healing can begin to occur in an area that previously, due to tension, was resistant to healing.

This simple holding and the immediately subsequent following of the response with your hands are the basic events of FSR. Practice it on someone else. Practice it a lot.

Delicate touch, heavy touch

Though I risk redundancy, I repeat that touching, if done too lightly, is an irritant. Oppositely, when touching is done with too much pressure, it generates a pulling back response. The type of touching used in FSR is the confident, firm gentleness with which a mother holds someone else's sleeping child. FSR requires a supportive, a full hand touch which does not impose, but which conveys confidence and assurance.

More practice exercises for understanding position and pressure

Very possibly you understand exactly what I am talking about and are ready to move on to the next chapter. However, the most common requests I get are for more information about how much pressure to use or where to put the hands. The following is a rehash of the above. It may prove helpful.

“Forceless” touch

Most often, the beginner is far too delicate, employing an irritating, “gentle” touch. The problem is that he is trying to be “forceless.” Therefore, I repeat myself: the word “forceless” applies to the perception of the patient, not to the amount of pressure used by the practitioner.

We are surrounded by forces. We are unaware of most of them. Air is pushing against our skin at all times. Gravity is always exerting a force. Our skin is holding in the contents of our insides. Blood vessels are putting pressure on the blood. There are many acts of pressure and force at work on our bodies at all times. We cannot perceive these forces because we have become used to them. We can even become used to unnatural forces; when we wear clothes and shoes to which we have become accustomed, we don't actually feel them. Within a few moments of putting on a snug pair of old shoes, we have no awareness of the shoes pressing against our feet. This level of force, a force comparable to the perfect snugness of favorite shoes, is the level of force that you should use when supporting your patient.¹

Again, gentle touch is annoying. Full support, in which the patient feels completely safe and supported, is just the opposite of annoying; such support quickly becomes imperceptible to the patient. Again, the word “forceless” in the name of this technique does not describe the amount of pressure used by the practitioner. “Forceless” describes the amount of pressure that is perceived by the patient. The art is in learning to make contact that is firm but which is soon imperceptible to the patient's consciousness.

¹ One excellent FSR practitioner that I know says that, when he sits for an hour not moving, with his hands cradling a PDer's wounded foot, he feels like a human cast. Actually, that is a very good analogy. A plaster of paris or (more modern) plastic cast gives solid support, but it is rigid, cold and cannot conform perfectly to the changing contours of a live human. A cast made of human hands gives an even better level of support: it is warm and conforms more perfectly to the skin of the patient. I like the idea of a human cast. You may have noticed just now that I am suddenly talking about a practitioner sitting without moving for an hour, holding a person's foot as if he was a human cast. Consider this example to be foreshadowing of the variation on FSR technique that we use on the site of a PDer's injury. For now, talking about basic, diagnostic-type FSR, we are not sitting motionless for an hour with our hands in one position.

Skin contact: the pranam

This exercise might help you spend a little time playing with your hands and observing the forces at play.

Press your two hands softly together, palms touching, fingers touching, as in the "prayer" position, or Indian "pranam." Notice how much force you require to hold your hands together. Each hand is comfortably aware that the other hand is there, mutually supporting. Close your eyes and imagine that one of your hands is the skin surface of your patient, and the other hand is your hand, practicing FSR. Can you tell which is which? Did the pressure change as one hand took over the role of "practitioner"? Hopefully, the answer is "no." Notice how little energy is required for your hands to stay still, touching each other, making contact, but not exerting any force on each other?

Now, let one hand rotate a little bit so that your hands are in the "keep your hands folded in your lap" position. In this position, the thumbs cross each other and the distal ends of the fingers of each hand drape gently towards the back of the opposite hands. In this position, the palms of the hands can make even closer contact than they did in the pranam.

Hold your hands like this for a moment and notice that, even though your hands are now pressing on each other with a little more firmness and contact, they still don't really seem to you to be putting force on each other – even though they are. Again, it's hard to say which hand is pressing on which. The two hands are both doing the same to each other, making equal contact with each other. This firm equal-to-both-parties contact should be used while supporting and evaluating your patient.

The force of gravity

Let your hand and arm drop onto the table top or desk top. Do not hold your arm and hand up with your shoulder muscles. Let the full weight of your hand and arm collapse onto the supportive surface. Let your arm go limp from the shoulder. Feel how much dead weight your body is applying to the desk top or table top. This dead weight force is how much force you can have pushing down on your patient with your hand. You were not pushing on the desk top, were you? No. You were being passive. Passive can have a lot of force to it.

Combine contact and gravity. Rest your elbows on the table about a foot and a half apart. Let your hands press against each other again, other making firm contact, contact in which neither hand is pushing harder than the other. Now, let the two hands apply the same weight, the same force, onto each other that they put on to the desk top. With your elbows propping up your hands, your hands will hold themselves up against the weight of gravity. This should create a very nice, somewhat firm but very comfortable position. Your hands are not being gentle, they are being strong and firm. They are applying force, but it is just the natural force of gravity. Neither hand is pushing on the other. They are both resting on the other. This is the way your hands should settle on your patient.

More practicing with a partner

One hand

Remember to be comfortable. Both you and your practice partner should be seated on chairs. The partner rests a forearm on a nearby table. Set your hand down on his forearm. Do not press down. Just let gravity settle your hand snugly down onto his forearm. Use your full hand. Do not try to be "gentle."

Notice how it feels to be making relaxed, even contact with absolutely no pressure other than the weight of gravity. Continue to rest. You will notice that the amount of pressure you need to apply to keep your hand in place is exactly equal to the amount of upward pressure of your partner's arm resisting you.

Notice that when you set your hand on your partner's arm, your hand does not sink into his – it doesn't float through his arm and come out the other side! There is resistance coming from his arm that supports your hand. So you can relax your hand completely.

If you press down at all, using willful force, your partner's muscles will begin to exert a matching force back outward onto your hand. You don't want that to happen. Your partner's arm should be able to stay just as relaxed as if you weren't there. It won't be able to, of course. For your partner to actually stay relaxed, you are going to have to use your other hand to provide the support, support, support that was described in the last chapter. But we aren't quite there yet.

Ordinarily, air is pressing at all times on all sides of our bodies. Also, the skin of the arm is holding the insides of the arm together, exerting a slight force on the insides of the arm. In this exercise, your hand is taking the place of the air that ordinarily would be pressing down on your partner's forearm right at that spot, and becoming like a second skin. By becoming a second skin, your hand is also taking the place of some of the pressure that the partner's skin is exerting to hold all the arm contents inside the skin. Your hand should make nice, firm contact with their arm, just as air does. Air pushes firmly and equally against all surfaces of our bodies at all times, but we cannot notice it. We don't notice air pressure because we are used to it. We also don't notice the air pressing in on us because it is intention-neutral.

Another baby example

Have you ever tried to move a sleeping baby? Most often, if your movements are self-confident and direct, the baby can and will sleep right through almost anything. However, if you try to be oh-so-gentle, and whisper, and act as if the baby is the most fragile construct in the world, the baby is sure to wake up.

Your patient's injured body parts will respond favorably to confident and direct interaction because, if you are confident enough, he can't actually tell what your hands are doing. However, the patient's injured body part will know that it is able to relax more than it has in a long time. Oppositely, uncertainty or insufficient support will be detected at once, and spurned.

Two hands

Next, place both hands on opposite sides of your partner's forearm. (Review fig. 13.1.) Use the same amount of contact that you used with one hand, and apply it with both hands. Just rest there for a moment.

It does not matter exactly in which direction you are holding, whether side-to-side or top and bottom. The important thing is that your two hands are more or less opposite each other so that the partner can feel completely supported.

The second hand, just like the first hand, doesn't need to do anything. If the first hand is on the top of the partner's forearm and the other hand is under the forearm, holding the forearm so that it can't get away, that is just right. The second hand can be thought of as a passive receptacle for the weight of the first arm. By the same token, the first hand might feel like a passive receptacle for the force that the second hand is using. That is just right, too.

The patient's arm should be able to feel completely held up, supported by the lower arm and the upper arm. This doesn't mean that either hand is doing anything aggressive or overt.

They are not. The hands are simply preventing the patient's arm from giving in to gravity. The hands should provide as complete a support as possible, giving a nice base of support, while conveying the idea that they are not doing anything at all and they don't intend to do anything at all. Your hands are just there, and they are solidly there.

Letting Go

Now that you know how to hold on to your partner, you need to learn when to let go. The rule is: let go when the patient's skin tells you to let go.

Your patient's skin in the area where you are holding will do a microelectric shift when your support is no longer wanted. If you keep holding, the patient's entire body and soon his mind will also start sending you a message that it wants you to let go. However, if you are not used to observing these small but definite signals, you may want to practice the steps below.

Practice this exercise in knowing when to let go. Start by doing the holding exercise above one more time: place your hands on either side of your partner's arm.

This time, after following with your hands the movement of the partner's skin as he relaxes, notice that there is a tiny, momentary sensation of connectedness between your hands and the skin of the partner. It might feel to you as if your skin is being magnetically bonded to your partner's skin. Oppositely, your skin may, a moment or two later, sense that your partner's skin is pushing you away.

Holding skin is different from holding a book. There is a feeling, a slight feeling of something alive. (Do not practice this on a PDer. Much of a PDer's body might be lacking this feeling. You must learn to recognize these feelings on a healthy person.)

This tiny tingling has been compared to static electricity. One student hypothesized: "It's like when I made contact and the arm relaxed in response, the relaxation released not just tension, it also released the Qi that was holding onto the tension, and that Qi scattered all through the area and made static between everything."

This sensation of a static connection has been compared to the feeling that exists between two socks that have been tumble dried together and have become charged with static. They can be pulled apart, but the pulling will require a small amount of force: there is a perceptible attraction between the two socks. A similar, or smaller, level of attraction may be palpable between your hands and the skin of the partner if there has been a recent relaxation movement in response to your supportive touch.

Do not let go of your partner as long as you can feel that static, or tingling.

If you try to remove your hand before that Qi has dispersed, it will feel as if you are using a bit of force, as if you are wrenching your hand up off of the partner. It will feel somehow wrong. If you wait until the static has dispersed, your hand will come up easily off of your partner. If the static disperses and the skin actually reverses its charge, your hand may almost feel as if it is being subtly repelled away from the partner. If you feel as if your hand is being pushed away, then do not impose your hand a moment longer.

When should you let go? Do not let go as long as the feeling of electric attraction is ongoing. Do not let go if you feel as if your hands are being pulled in to the partner's skin. Do not let go if, when you try to remove your hands, you feel as if you are having to use force to extricate your hands. Do let go if the static or feeling of attraction has dispersed and you feel that you no longer need to leave your hands on your partner's skin. Do let go if you feel an electric sense like that of two positive ends of a magnet being pushed at each other, repulsing each other. Do let go if you feel uneasy in any way. Such a feeling of uneasiness may be coming from some

energetic turmoil that has been stirred up in your patient, and, if you don't want to be a party to it, that's perfectly reasonable. Of course, do let go if your partner verbally asks you to do so.

Electric resistance to being touched

Sometimes, a PDer will have such strong resistance to being touched, particularly in the vicinity of an injured area, that when you first begin working with him, you cannot actually rest your hands on him for the first few minutes of the treatment. Sometimes this palpable resistance to being touched can last for an hour, or even for weeks.

(When I have a patient with this level of fear around being touched, I just rest my hands in the air space several inches immediately above his injured body part. I support my hands with the muscles of my arms and shoulders, as if my hands were resting, nonchalantly, up against the electric field of his injured area that is emitting the "go away!" signal. Usually within a few minutes or a few weeks, the area is less afraid and allows me to set my hands down on the skin.)

When you are practicing holding, try to feel the sensation between your hands and the partner's skin. You will soon learn when it feels "right" and when it feels "wrong" to rest your hands on his skin and when it feels right to let go.

Sometimes it will seem a bit awkward at first if you are working on a patient and a full minute goes by before you get the signal to let go. More often, the static feeling will disperse quickly.

More advanced students notice that they are sometimes aware of a feeling of relaxation in their own hands, or even in their arms or torso, which occurs at the same instant that the static cling feeling goes away. As you become adept at this work, you may even begin to notice that your own body perceptibly relaxes at the same time as the partner's. Sometimes it is as if you were unintentionally holding your breath, and at the moment when the partner relaxes, you find yourself exhaling, or relaxing your abdomen.

So there are actually many cues: the static sensation, the attractive (holding) force, the repellent (letting go) force, the partner's relaxation, and even a feeling of relaxation somewhere deep within your own body. These are all signals telling you to either hang on or let go. You may notice one or several of them. When you feel anything that is telling you to let go, let go.

To be redundant, when the skin of the partner's arm is no longer clinging to your skin, it is time to let go. If you feel as if your hand is being sucked into the partner's skin, this means that the partner's skin wants you to keep holding on.

Working through clothes

By the way, this technique can be practiced on a partner's clothed limbs. At the very beginning, it may be easier for you to imagine that you feel the static release when working with bare skin, but, in fact, electromagnetic fields are not diminished with clothing. The force of these fields does decrease over distance. But thin clothing does not make a huge difference in the distance between your hands and the skin of your patient.

Within a day or two of practicing, a person should be able to feel these things right through thin clothing. If you doubt this, answer this question: can you feel when someone has hugged you for a little too long, even if you are both clothed? Of course you can. The same "go away" signal that you unconsciously (or consciously!) send to a person who hugs for too long is the same kind of signal that a partner's skin will send you when your FSR work is done.

The hug that lasts too long: an example

Hopefully, most of us who are planning to do this type of work already know, via our intuition, exactly how long to keep hugging someone and when to let go. Is there anyone among us who has not experienced an uncomfortable feeling when he is hugged for a bit too long, to the point where he suddenly feels discomfort in being hugged? Oppositely, haven't we all wanted, at some point in a harried or stressful day, to just be held tightly until we feel that we've had a chance to collect ourselves?

When holding small children, it is always obvious when they want to be held more tightly. They snuggle in and almost burrow into your chest. And yet, the moment that they've decided that they don't need a hug anymore, they are impossible to restrain; they squirm and fidget, making it obvious that the time for holding is over.

No one should need to be taught how to recognize when someone needs a hug, or when someone wants the hug to end. However, in our untouching culture, when it comes to therapeutic touch, we actually have to study and practice in order to be able to perform these basic, human functions correctly.¹

So start practicing holding and supporting a partner's arm, leg, foot, neck, or whatever wants holding. Note carefully if there is a quick, fleeting relaxation response to the touch, and also note when the static in the skin stops pulling you in like a magnet and starts pushing you away.

Children are very quick at learning this technique. Adults sometimes take more time.

YOU ARE READY TO PRACTICE FSR

You now know the basic technique of FSR. It consists of hold, notice if anything happens or not, and let go.

Hold with the correct amount of pressure, follow the person's skin with your hands if the skin or underlying tissues move in such a way that you need to move, and then, when the partner wants you to let go, let go. That's it.

I could probably get away with writing several chapters describing over and over the technique of FSR. Instead, I have put it all down in about fourteen pages, and I think I have said what I started out to say.

The reason for the brevity of text describing the techniques is this: there is not very much about these techniques that can be taught in words. The techniques are very simple. The trick to mastering these techniques does not lie in intellectual understanding. The best way to become proficient is to jump right in and practice these seemingly simple techniques. It is the practice, not the intellectual understanding, that will make you skilled.

Response to FSR: the diagnostic portion of your work

As you have seen by practicing the above sections on position and pressure, your partner's forearm will usually perform some quick and tiny movement, a relaxation response, when you hold his arm with just the right amount of support. You used just enough support to take the place of the energy that he was using to resist gravity. He experienced a release of tension in some part of his forearm. Diagnostically speaking, if your patient had a relaxation

¹ Some people do have trouble recognizing these signals. Autistic people and those with Asperger's syndrome may not be able to recognize when their touch and/or their presence are not wanted or needed. Also, I have noticed that people taking certain drugs, notably the antidepressant, the anti-anxiety, and most of the Parkinson's drugs, are not able to ascertain when they are receiving a "go away" signal.

response, then the area being held is healthy enough, for our purposes: you don't need to work any longer in this particular area. If your partner had a response, you can make a mental note of the fact that this particular body location is able to respond, and you can move on to the next body location, a few inches away.

Watching for movement

Practice supportive holding on your partner's forearm and notice whether or not any response occurs. This may seem redundant at this point, but though the material is similar, notice that the focus has now changed. We have moved away from "how much pressure" and "when to let go" to "how much of a response was there?"

So even though you have practiced touch, try it again, but this time stay focused on whether or not your patient responds. Whether your practice partner does respond or not, when you get a "go away" signal, lift your hands off the skin and move them to a new location a few inches away. See if this new location responds. After you are done at the new location, lift your hands off the skin and move your hands yet again, to yet another location a few inches farther down the arm.

You may have already noticed this movement that we are looking for when you did the "two hands" exercise a few pages ago. A tiny movement of the skin is all that you will notice, but it is very significant. This is the *immediate* relaxation that often occurs from supportive human touch. This is the movement that we look for when doing FSR. This movement, or the lack of it, allows us to evaluate where the patient is having normal responses or not.

When you are working with a healthy patient (defined here as a patient who does *not* have an unhealed injury in the area), you will notice that the moment you place your two hands on the patient in an opposites (supportive) position, there is usually a tiny, automatic, reflexive movement coming from the patient, as if in response to your support.

One of the PD Team members refers to this immediate, unthought response to being touched as "The Dance." As she sometimes says, "It looks like my partner's skin dances with my hands."

Responsive movements can be small and quick, large, or slow

The movement may be very quick, a small, instantaneous movement, over in a blink, or it may be a languorous, undulating move. The movement, if small, may not be visible to the eye, but if you watch your hands, you might see that your hands moved a bit: your hands were carried by the partner's response.

Notice carefully the exact angle of your hands, their exact position relative to the floor and ceiling, as you go to put your hands on your partner. Within a split moment of putting your two hands on your partner, you may see that your hands are no longer in the exact angle, relative to the ceiling and floor, as they were when you started to place your hands on the partner's skin. Sometimes the partner's skin and muscles will relax just a tiny bit, so that you end up with your hands a few degrees off from where you intended them to be. Other times, a partner might relax so deeply that your hands will end up 180 degrees from where you started.

Even if your hands are not carried away to a new position, you may feel something, a sense of life or a brief acknowledgement of your hands, in the body part that you are touching.

Even though the partner might not consciously feel the movement that his skin and underlying tissue is making, this movement or alive feeling is certainly palpable to the experienced FSR practitioner's hands. The skin of the partner is not particularly moving away or

toward the FSR hands; it feels more as if the skin and its underlying tissues are relaxing just a tiny bit into a different, more comfortable position.

Sometimes, when people see me demonstrate this technique, they want to protest that the partner was not relaxing. They accuse me: “You were shoving their arm around!” I have to insist that I was doing nothing of the kind. Other students take the opposite stand: “Nothing happened in response to your hands, the partner just relaxed a little.” Well, of course. That is the whole point: the partner will relax when supportive hands are placed on his skin. This relaxation is extremely fast and it usually seems like nothing significant has actually happened.

Because the response is so unexpected, so hard to feel on the part of the partner and so surprising to the new practitioner, it is possible that both the practitioner and the partner may want to insist that the other person must have been intentionally “moving the forearm around.”

However, whether the movement is large, small, quick or slow, all that matters to us, for our purposes, is whether or not this particular body part was capable of being held and capable of responding in any way, shape, or form. If it was, then the diagnostic answer is “yes, healthy enough for our purposes right now,” and we can move on to another area on the body.

Holding on: maintaining the support during movement

Holding on, keeping the hands in supportive contact even while the patient responds or moves around, is a critical part of the support. When you hold a person with supportive touch, you are rather implying that you are there for him, holding him for as long as need be. This means that, if your patient’s arm (or whatever body part) does move in response to being held, you have an obligation to continue to follow the movement wherever it goes, providing support until you receive a “let go” signal. Sometimes this means that a practitioner’s hands may end up in a very different position than where he started. But wherever the patient goes, there you, the practitioner, must follow.

Letting go temporarily, moving to a more comfortable position

If, in response to your support, the patient’s arm (or body part) moves in such a direction that you can no longer hold on comfortably or keep your balance, then, of course, you should let go and quickly reposition your hands in a way that will allow you to be comfortable while continuing to provide support. The patient will not go to pieces if you let go for a quick moment. Sometimes, if you sense that the patient’s body truly does not want you to let go, but you simply must move to a more comfortable position, then rotate your arms around or move your torso in such a way as to accommodate to the new holding position without actually lifting your hands off the skin, if possible.

Use your common sense with this; there is no value in having the practitioner get a crick in his neck. Picture a worried child wanting to be held tightly by a parent: the parent can move as much as he needs to get himself in a comfortable position and the child will not fall apart while the parent does so. However, once the parent gets to a position of maximum comfort and stops fidgeting, the child also settles down more deeply.

Sudden jerks

The practitioner must be prepared for those rare response movements that are large or jerky. If your hands are committed to supporting the patient and the patient’s arm (or whatever) suddenly twists or bounces, you need to hang on even though you may feel, for a split second, as if you are being carried somewhere unexpected.

As you become more experienced with this technique, you may, once in a while, notice that a faint electrical discharge that feels sort of like static energy moving through your own hands often precedes a major jerk or twist. If you are in tune with this sort of thing, you can use these static discharges as a warning to brace your feet on the floor or loosen up your elbows in preparation for a sudden lurch or lunge.

Problems that might arise when starting to practice this technique

This section is based on questions or problems that often arise in class.

Problem #1: The practice partner's forearm simply refuses to respond.

It is possible that the partner you are working on actually does have an injury in his forearm. If this is the case, his arm may not respond whatsoever to your touch. When students in my class find, while working on one particular fellow student, that no movement ever occurs no matter who is holding this student's forearm, it often comes out, upon questioning, that this particular student-partner has had a memorable injury in the forearm. The injury is usually a broken arm bone, at the very site being practiced on.

While students tend to feel like failures when their partners don't make a response, the students should always be aware that this technique can reveal areas of non-responsiveness. If your practice partner has an injury in the vicinity of the area you are practicing on, he may not respond. His injury is the reason that there is no response.

So if you do not get the results you expect, do not immediately blame yourself or the technique. Consider that the partner may have areas that need a spot of work. And merely choose another part of the arm, or use the opposite arm. Or practice on someone else.

Work with the above technique of holding until you find that you can place your hands on someone's arm, and then, in most cases, observe an immediate, visible, very slight accommodating movement of the skin or underlying muscle.

Problem #2: Not using enough support. Most students, after having worked on their own with this text, are amazed when they get into a FSR class or workshop situation and receive an actual demonstration of the touch from the class teacher. They may say, "You (the teacher) are using much stronger pressure than I had expected." or "You're using way more pressure than I imagined from the reading."

After awhile, as they keep working with the teacher, they realize that the teacher isn't actually using a lot of pressure. The teacher is being practically passive, but his hands are merely matching the inherent outward force of the partner's body with a matching, inward, supportive force. However, the person on whom the teacher is working may perceive both that the teacher is being firm, or solid, and that the teacher's touch rapidly becomes undetectable.

Again, what students usually were doing wrong was trying to be gentle. What they needed to be was "unnoticeable." To be unnoticed, the touch must be confident, firm, and use no apparent force upon the patient other than the force from the dead weight of the practitioner's hand – a weight supported by the practitioner's other hand – a force that turns out to be strong enough to convey support, support, support to the patient.

A so-called "gentle" touch is very, very noticeable. A complete, full hand contact can be almost invisible. Think again about how the mother was holding her neighbor's baby. Her contact was utterly firm and confident, but no pressure, no intention was being exerted on the baby.

One student described it as "the way you hug a friend who's had a hard day. You hold on with enough strength to show that you're there, but you're not trying to be pushy."

Once, while I was demonstrating the technique in class, a student asked the demonstration patient to describe for the class just how much pressure I was exerting with my hands at that moment. My hands were *firmly* holding both sides of the patient's foot as I lectured. The demonstration patient opened her eyes and looked around, slightly surprised at the question. "Is she touching me? I can't feel her hands at all."

Practice, practice, practice

Practice will teach you more than any more words can ever teach you on this subject. Do not practice this on a PDer. A PDer will not make a normal response. You may be able to force a response, or he may be able to force himself to create a response, but, in general, many parts of a PDer's body, not just the center of the foot, will fail to have a normal response to being touched.

Have you ever rested your arm or hand against the arm or hand of a friend and leaned it there for a long time without moving, such as can occur while watching a movie together? You may recall that, when you returned your sense awareness to your hand or arm, you realized that you could not tell (without looking) where your own arm ended and the arm of your friend began. That is the level of support you are learning to attain, only you want to learn how to attain it quickly, instantaneously, without first having to watch a whole movie.

ADVANCED FSR TECHNIQUES

Holding combined with a bit of a nudge

If the person's body does not respond immediately to correct, supportive contact, it is possible that some tension is lurking therein, and the area under contact will not budge until something disrupts the tension pattern. It is very possible that the area under consideration will be able to move and respond if it is given a little bit of a nudge. Sometimes, a slight nudge of movement from the practitioner is all that is required for the body part in question to wake up to the fact that it is being supported. Once it is awake, the recalcitrant body part may respond nicely. It will usually move in the opposite direction of the nudge, as if it is resisting the intrusion of the therapist. However, once it does move, it may be loosened up enough that, a moment or two later, it will respond to the simple holding technique of FSR in the normal, reflexive relaxation manner of healthy tissue.

Even without the presence of an unhealed injury, a partner/patient may have some little bit of hesitancy or tension, some snag that prevents relaxation. If a patient's body does not seem to respond in any way to being supported, the following nudge and/or imagined movement techniques may be enough to suggest to the patient that he let go of the snag. Once the hesitancy is gone, he may respond normally to simple touch. If he does respond, then the area will be treated just like the other others that do respond to FSR. It will be held, the fact that there was a response will be noted, and the practitioner will move along to an area of the body a few inches away. The practitioner is hunting for areas that do not respond. As soon as an area responds, the hunter can move along.

A tiny nudge

What is meant by a tiny nudge? Let's say that you, the practitioner, find yourself supporting your partner's forearm with your hands in what we shall call "position A." From this

position, with your hands opposite each other, you may bring your hands together ever-so-slightly and then immediately let the hands bounce back to position A. The tiny movement is not really a push, it is more like a tiny bounce, or pulsing motion in which the practitioner's hands move momentarily closer together and then move back apart again. Note that I never use the words "push or shove on the patient with your hands." Instead, my language is that the hands of the practitioner come closer to each other and then bounce back apart to their starting position. The practitioner is focusing on his hands, not on what he is doing to the patient. If this move is done correctly, the patient will not perceive the force of the nudge. The nudge will not be felt because both of your hands are opposite each other, taking up the nudge pressure from each other. Since the patient is supported, he doesn't need to do any work to resist the change in pressure. Therefore, he won't really notice what you are doing.

Very often, if a slight tension in the patient/practice partner is preventing the normal type of response that most people have to supportive holding, this tiny, invisible- to-the-naked-eye nudging movement will dislodge the tension. Once the tension is dislodged, the area being held may well move a bit in one direction or another. The area may take advantage of the support being provided to relax to a more comfortable position. When this occurs, when the area starts to move, the practitioner's hands must follow the movement, continuing to provide support, as described in the section on holding on, until such time as it is appropriate to let go.

If nothing happens: change hand positions

If there is no response to the little pulsing movement, move the hands a little bit. Maybe move them a little more anteriorly/posteriorly, or maybe a little bit laterally/medially. If the practice partner immediately relaxes with the hands in this new position, then try going back to the previous position and see if now you can also get a response in the previously unresponsive position. If there is no immediate response in the new location, try moving your hands closer together and apart again in the quick, pulsing, nudging manner described above, to see if the patient will respond. Remember, as soon as you get a reaction – any reaction – in response to your touch, you are finished in this area, and can move on.

Looking for problems

Don't lose sight of the idea that you are doing diagnostics. You are not actually trying to release tension in your patient: the relaxation just happens as a side effect of the testing. What you are doing is looking for areas that truly are not responsive. You will be using this technique to try to locate those strangely rigid areas on a PDer's body that do not, no matter what you do, respond in a normal, healthy manner.

At this point in your study, you are practicing FSR to learn what a "normal, healthy manner" is. There is a pretty wide range of normal, and, after working with just two patients, you may think that there is a huge difference between the two. But if you work with half a dozen or more healthy people and then hold the foot of a PDer, you will be able to detect immediately that there is something deeply, unnaturally wrong going on in the injured areas of your PD patients: their bodies will present an obvious, possibly alarming lack of normal response. If you have used the simple holding technique of FSR with enough people, when you go to work on the feet of a PDer, you may almost feel, as one student described it, "as if you are holding a corpse that's been covered up with living skin."

If nothing happens: do more

If there is no response even after you try doing a gentle, two-handed nudge, and there is no response after you have tried shifting your hand position a little bit, try using a slightly more forceful nudge.

If nothing happens: do less

If no response occurs after you've tried giving a pulsing movement and then an even firmer nudge, try using a smaller nudge. How small? This small: do not actually move your hands. Instead, remain right where you are with your hands not moving, and mentally, with your imagination, picture that you are moving your hands towards each other and then mentally imagine that your hands spring back apart. Do not actually try to move your hands.

Despite your best intentions not to move, and even though your physical hands do not move, the mere thought of moving on your part will stimulate an electromagnetic manifestation of the thought of movement. This electromagnetic suggestion of movement coming from you may resonate with your partner and suggest movement. This extremely subtle type of "movement" (imaginary) is very often the most effective type of stimulation for stubborn tensions. Very often, imagining that you are moving your hands is the best way to wake up an area in your partner that is alive and healthy, but stubbornly stuck.

Notice that you are *not* imagining that the patient is going to move. This would be an imposition on the patient. As always, this technique allows the patient to do whatever he wants. If you are going to impose your thoughts on anyone, impose them on yourself. Your patient will respond best if he is in control. Like the contented baby who is being ignored, your patient will be most comfortable if he doesn't have to deal with your expectations. Again, "forceless" refers to the mental exchange between patient and practitioner, as well as the physical perception.

Do not try to stare down your patient's unblinking foot

Your attention is on your own hands, by the way, and not particularly focused on the patient. The fact that you can notice whether or not the patient makes a response is to be attributed to the obviousness of the patient's response and the disinterested quality of your observation. Don't be scrutinizing the patient too severely. A watched pot never boils and a sensitive person or silverback gorilla does not like to be stared at. You can learn to be aware of whether or not a patient has responded without conveying to the patient that his every move is being assessed. Be somewhat detached, like the sailor that shifts and sways ever so slightly in response to the movement of the ocean, even though he is not paying conscious attention to the ocean. There will be more on this subject later.

If nothing happens after this: move on

If a particular area, a particular body part, does not show a reflexive response to simple supportive touch, nor does it respond to slight nudges or thoughts of nudges, make a mental or written note of the location of the stuck area, and move on to the next area. Very possibly, after the surrounding areas have relaxed, the stubborn area will be able to respond.

If the stubborn bit simply does not respond no matter what, but instead sits impassively, as if it isn't really quite alive, it is very likely that an injury, subconscious tension, or tissue displacement has happened in this area. If this is the case, as noted above, you will want to make a written or mental note of the area, and then move on.

How can this recalcitrant area be helped? The variant of FSR that we use on Parkinson's injuries can be used on areas that do not respond. This will be discussed in an upcoming chapter.

The next chapter will have some specific training drills that will move your focus towards holding the leg. Although PDers often have neck, shoulder, hip, arm, cranial and spinal injuries, in addition to their foot injuries, they *all* have foot injuries. Not only that, their foot injuries are responsible for setting in motion those physical alterations that are most closely associated with classic Parkinson's. Sometimes the other injuries help to mentally and emotionally cement the foot injury in place and to create the unique variation of PD that each PDer brings to the syndrome (no two PDers have the exact same presentation of symptoms), but, for the most part, the foot injury is the one that needs to be addressed first. Therefore, the next chapter will focus on performing on the leg and foot the holding and diagnostic techniques explained in this chapter.

