

*“How beautiful to do nothing, and then rest afterwards.”*

*- Spanish proverb<sup>1</sup>*

## CHAPTER THIRTY-EIGHT

# RESTING FSR

In this chapter I will use quite a few words to explain how to “do nothing.”

Doing nothing, also known as resting FSR, is what you will do in those key stubborn areas where your patient doesn’t respond or seems to want to be held indefinitely. When you find what seems to be the most stuck place on your patient, a spot where no movement occurs in response to any of your overtures, you will set your hands on the patient, support the area by using the correct amount of pressure in both hands, and then leave your hands there indefinitely.

### *More details*

To be more specific, you will settle yourself comfortably in your chair, get your hands settled as nicely as possible into the contours of the patient’s skin so that you can best support this crucial stuck place, and, with your hands giving just the right amount of support (as discussed earlier in chapter thirteen: someone else’s baby), you will just stay right where you are.

When the area under consideration pushes you away or seems to no longer want to be held, then you can remove your hands and go somewhere else.

I suppose there might be something more I need to say about how to perform this technique, but anything I might say would just be more ways of stating the above.

### *How long should I hold*

You will need to hold for as long as feels right: until the area starts to loosen up or until it pushes you away. Of course, if your arrangements call for a one-hour session and the area hasn’t started to respond yet, then, at the end of fifty-five minutes you will need to let go your hands and start wrapping things up. The next week, when you resume treatment, you may wish to do a little bit of assessment work, or not, and then go back to the area on which you were doing resting FSR and settle in for another session. On the other hand, if your intuition tells you that you need to work somewhere else, or if this week the area that you had been working on feels as if it is actively pushing you away before you even get settled in, then of course you will work in a different area.

As for how long it usually takes for the area to start to respond, that question is impossible to answer. Some feet respond in about fifteen minutes. One of my patients had an utterly frozen-rigid right foot, as mentioned earlier in this book, that required three years of patient holding before any of its articulations were able to flex in the slightest.

### *What can I do to accelerate the process?*

Stay out of the way.

We have found that trying to impose love, light, or healing energy onto the patient definitely slows things down. The following case studies may help explain why.

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<sup>1</sup> The saying and the attribution “Spanish proverb” was taken from a postcard printed by the Tushita postcard company, <http://tushita.com/tibetimage>.

## Some PD case studies

### *Father Rickman*

Father Rickman was driven to his first FSR appointment at my office by a member of his congregation. The driver, Ida, was a sweet, round-cheeked woman who was keen to tell me all of the wonderful work that the congregation was doing to the good Father.

“A group of us from the church get together with Father Rickman to do a healing-light ceremony once a week. And once a week we get together and do JoShinDo on him. We do group chanting and affirmations. I do Reiki on him once a week,” she bubbled.

“My gosh,” I replied, looking at Father. “You must be exhausted!”

“Why should he be exhausted?” asked Ida. “We’re simply filling him with energy.”

“No, you’re not.” I replied. “Father Rickman is having to work like a beaver to prevent all of your good intentions and vibrations and healing light from getting into his body. He probably dreads these sessions, but doesn’t have any polite way to tell you so. He would rather suffer silently through these sessions, working as hard as he can to repel everything you are doing, than offend you by telling you he doesn’t want your efforts.”

“That’s ridiculous,” exclaimed Ida. “He loves it!”

I turned to Father Rickman. “Well, Father,” I said, “how do you feel about those sessions?”

Father Rickman looked away from Ida and then turned his gaze on me. Then he stared at the opposite wall for about half a minute. Finally, avoiding Ida’s gaze, he said, “You’re right: I do work to resist it. But I really do appreciate that they want to help me. I don’t mind putting up with their treatments; it makes me feel good to have them feel good. They want to feel they’re doing something helpful, and who knows, maybe it’s working.”

An awkward silence squatted in the air. I tried to break the tension by explaining, “He’s got Parkinson’s, you know. Most people with Parkinson’s typically don’t like being messed with. They are defensive about the injuries that are lurking in their bodies. They don’t want them exposed to all the world. Also, if there is something wrong, they usually don’t trust anyone to fix it; they’d rather do it themselves. But at the same time, they don’t like to make waves, as a rule. They will go along with whatever makes other people happy, even if they suffer inside.

### *A PDers strong dislike of “being messed with” or aided*

While not every PDer is completely antagonistic to being touched, most of them are highly antagonistic to being molded, altered, influenced by factors beyond their control. This chapter is not the place to go into depth about the Parkinson’s personality, but the Father Rickman example is very, very typical. Even those PDers who have taught themselves to enjoy a bit of massage or who have learned to tolerate well-meaning, generalized attempts at “energy work” are still extremely guarded in their injured places with a ferocious protectiveness, a protectiveness that, unbeknownst to the PDer, prevents even himself from being able to mentally visualize the injured area or even imagine *himself* sending healing light into it, let alone anyone else.

### *Imelda*

I had one patient who was very affectionate. I had known her for many years before she became my patient. She loved to hug and kiss all her friends, she snuggled constantly with her

children, she was a big proponent of loving, physical contact as a way of healing the little hurts of everyday life.

I was surprised then, when I started to work on her feet, that she drew her feet away from me and pleaded, “Please, be careful; I am so scared. I’ve never even let Seamus (her husband of fifteen years) touch my feet, not ever. I don’t even like him to *look* at my feet.” This fear or concern of having the feet touched or looked at is not uncommon in PDerS.

### ***“I can’t do this”***

I had one patient who drove all the way up from Los Angeles, a trip of over three hundred miles, to be a demonstration patient at a weekend class that I was teaching. She sat through the first half of the day, but when it came time for her to lie down on the table and let me demonstrate FSR technique by holding her right foot, she started crying.

“I can’t do this,” she whimpered. “No one has ever touched my feet. No one has ever seen my feet. I have to go. I’m so sorry.” She picked up her purse and walked out the door. I never saw her again.

### ***TJ***

I had one patient, a horse trainer, who could smoothly and easily lift you off the floor with her right uppercut if you made a threatening move at her. She was radiantly happy when she was mixing things up with the rowdier sort of cow or cowhand. But when came the time for me to start holding her foot, she found herself reduced, for the first time in her life, to a sobbing marshmallow.

At our first session, as my hands moved in slow motion closer and closer to her left foot, she stopped crying and started screaming hysterically. She alternated between apologizing in a perfectly calm, almost laughing voice or screaming at the top of her lungs, writhing, and pulling on her hair for the duration of the session. (Many is the time I’ve thanked the powers that be that my office is fairly soundproof.)

I never did touch TJ’s feet that first day. The closest I could get to her feet was about nine inches away. It was an unforgettable session: I sat on my stool, my one hand up in the air about nine inches away from the top of her foot, my other hand suspended in the air as well, nine inches away from the bottom of her foot, while she either screamed or apologized for screaming. It took almost eight weeks before I was able to actually place my hands on her feet. Every week I got a little closer, and every week her screaming got slightly more under control. When I finally was able to rest my hands on her feet, she didn’t scream; she sobbed as if her heart would break.

### ***Lynne***

Lynne was a body worker herself. When she took a craniosacral class she was terrified to let the other students in the class practice on her. She finally teamed up with one classmate, an old friend whom she trusted deeply, but even so, she was edgy throughout the class. Considering that most light-touch practitioners consider Upledger’s craniosacral techniques to be the gentlest of the gentle, Lynne’s level of fear and resistance might have been surprising. But since Lynne had PD, I was not surprised at all when she told me about her fear of having someone “do things” to her.

By the end of the weekend class, Lynne was exhausted from resisting, with all her mental strength, the techniques that her friend gently perpetrated on her.

Craniosacral therapists often tell me that I am wrong: “Craniosacral work is so gentle, the patient can’t even feel what’s being done.”

I’m sorry, but I must beg to differ. Many of the PDers I have known have *hated* craniosacral work. The fact that it is so well-meaning and gentle makes it seem somehow even sneakier, ever more insidious and, thus, something to be even more staunchly guarded against. These PDers can physically resist strong, Yang-style therapies such as Rolfing, but they have to engage their mind as well in order to resist the gentler techniques such as craniosacral. This means that craniosacral or other gentle and light-touch work can be even more trying, even more exhausting than the brute force techniques.

These case studies are merely the tip of the iceberg, but I think they make the point that most PDers don’t like other people imposing themselves on their (the PDers’) feet. Most people with PD are tough, indomitable and stoic, or were at the time of their injury – and the injured, terrified person is the one you are treating, not the logical person who is in your office. PDers, for the most part, and certainly in the part of them that is still scared and injured and hiding, really don’t like to be toyed with, helped, loved, supported, healed, or messed with in any way. Their battle cry might as well be: “I’d rather do it myself.”<sup>1</sup>

### ***Irony***

The ironic nub of the situation is that, even though they’ve done so much with their lives, they can’t do their own healing by themselves. It almost seems as if *admitting* that they need, want, and dread the healing presence of another person is a part of the emotional healing process.

Again, keep in mind that the admission that help is needed has to come from the child/young adult who is still lurking in the background with an injury and an injured state of mind, not the thoughtful adult who is telling you that he really does enjoy massage. This dread of the very necessary physical hands-on part of the treatment can contribute to the challenge of recovery.

The mental part of the recovery from Parkinson’s, in which the PDers must retrain their minds to acknowledge their injured body part, is addressed in a later section of this book, but I can say here that their mental resistance to opening up and allowing healing to occur in the area of the long-suppressed injury can be ferocious.

### ***The self-control and self-reliance of Parkinson’s***

Most PDers will be quick to tell you that self-reliance and/or self-control has been a crucial factor in their “success” in the world. When they learn that their extreme level of self-reliance or self-control is a normal part of the Parkinson’s pathology and that their treatment is

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<sup>1</sup> Sometimes there is also anger being held inside, accompanied by subconscious fear that the anger might come out. One patient, telling her sister about our program, was stunned when her sister said, “Nothing is going to help you until you get rid of your anger.” The recently diagnosed PDer was flabbergasted. Never in her life had she spoken an angry word or responded with anger in any situation. She was the most compliant, easy-going person she knew. She was so shocked by her sister’s words that, later that day, she locked herself in her bedroom and said out loud, “If there is any anger in my body, I want to behold it right now.”

A month later, when she was telling this to me, she said, “A moment later I could see black clouds of rage billowing out of my body. I don’t know if would have been visible to anyone else, but to me, the black clouds filled the room with horrible, choking smoke. That smoke was full of my rage at my parents, my teachers, my children, my husband, my siblings, my pastor, my relationship with God. I was seething with fury at a thousand suddenly-remembered insults, unfairnesses and hurts. And I swear, until that moment, I didn’t even know that I had any anger at all in my body.”

going to involve learning to climb down from their self-reliance throne and accept physical ministrations to their foot from another human, they usually have one of two responses: they see the irony and perfection of the situation or they become obsessed with a self-pitying litany of all the situations in their lifetime in which life was harsh or they were treated unfairly. In either case, they are still usually resistant to opening up their hearts and minds to their own injured area.

Which brings us back to why this extremely Yin form of Tui Na, resting FSR, is used for treating PDer's. With resting FSR, the injured person and the injured area are being held. That's all. The injured person, in response to this quickly undetectable support that is accompanied by complete emotional detachment on the part of the practitioner, finds himself in the position he has long been looking for: a little time to be by himself in a safe setting so that he can get around to mentally, emotionally or somatically (with cellular feeling) looking into that old injury that he put on the back burner so long ago.

When a person is receiving resting FSR treatment, the part of his body that is being supported is essentially "all alone, but being protected." While receiving this type of supportive holding, there are no demands being placed on the patient's physical body, there are no demands being placed on the mind or the emotions of the patients. The practitioner is performing in the role of Human Poulitice. The long-awaited conditions necessary for healing are being met: respectful treatment is being given, the injured area is not being threatened, the emotions that were used to block the injury are not being threatened; in fact, nothing is being threatened.

As noted in the previous chapter, *a person cannot relax and cannot let go if he is busy defending himself, however silently and invisibly.*

### ***Emotional relaxation***

When a person no longer needs to interact or defend himself, he can relax. If this PDer was at home, ostensibly able to relax, he would not do so. Instead, he would probably feel the need to be doing something, possibly sleeping or making himself helpful around the house. Most PDer's like to stay very busy and productive. It is not unusual in my experience for a PDer to hold down three jobs, at least two of them being full-time jobs. It is not necessarily for the money, but "Because I can" or because "Someone needs to do it and I'm the best person for the job."

It may be that they are trying to stay busy to avoid having to ever look too closely into their past. For many of them, they have been supremely productive as a way of fighting a life-long impossible battle to prove their worth to some humiliating childhood memory. The average PDer does not, cannot relax very deeply for very long. Even if he did relax, the part of his body that is injured would be on guard and wary.

When the PDer is lying on his back in the therapist's office having his foot held, he realizes that there's nothing practical and distracting that he can be doing at that moment. If the therapist is not challenging the injured part of him in a physical, emotional, or mental manner, the PDer may, if he is supported just right, begin to relax the emotional barrier that has long been protecting his injured area.

### ***Physical relaxation***

Many PDer's have asked me if they can't get the same benefit by doing mental Tui Na on themselves. Others want to know if their spouse or friends can't just do the Tui Na mentally, thus avoiding the tedious, hands-on work.

The hands-on aspect of resting FSR is crucial. The physical support being received by the tissues causes them to relax over and over again, getting slightly more relaxed each time, as they try to maintain what they think is their normal level of tension. What the tissues don't realize, if the FSR is done correctly, is that the hands of the practitioner are, over time, subtly supplanting the tensions that are usually in force in the injured area. The net result, after an hour or so of continuous relaxing, is that the tension that's historically been holding the injured area rigid is now being performed by the therapist. Meanwhile, even though the net amount of support and tension in the injured area hasn't changed, the tissues in the foot are completely relaxed: the health practitioner is holding it all together.

When the part of the mind that normally protects the body is relaxed, and the tissues of the injured area are relaxed, the injured person has finally gotten himself into the situation he has long been waiting for: a little quiet time, during which he can mentally/emotionally attend to whatever it was that happened so long ago, that event that was put on the back burner to be "dealt with later." Finally, in the office of the health practitioner, "later" has arrived.

Once this situation is set up, the injured part of the body can, if it wants to, spit on its hands, haul up its slacks, and get to work on healing the problem area in the foot. It may take some time, since the mind can barely even remember that it has a foot. But the warmth of the practitioner's hands, the tiny movements that the practitioner may be unconsciously making (more like gentle sighings than actual movements), these little indications of supportive, non-judgmental human contact draw the patient's attention to the area in a non-threatening manner.

Eventually, over hours or years, the mind will start noticing there is a foot, that there is something wrong with the foot, and from there, the foot healing can commence.

### ***Exceptions to the rule***

Of course, there are a few patients who are not as terrified as the patients described above. Also, some patients learn to lose their fear after a few sessions or a few years of being worked on. Very often, a patient will deny that he is afraid of being held, and yet, after the feet begin to relax, he may start crying and even start reliving some of the emotional events that prevented him from healing. He may suddenly, or over a few weeks, realize that he has, in fact, been living his life with a part of himself stuck on "extreme alert" even if his conscious mind was trying to create an image of his being self-possessed, calm, or complacent.

Now that we've been doing this work for many years, we have learned to not accept at face value a patient's assessment of his own fear levels. No matter whether or not a patient tells us that he is open and unafraid, or terrified and distrustful, we treat all patients with the same caution and respect. We always ask permission before we start. We always assume that the patient should be treated as if he is injured and afraid. Even if we are laughing and joking around, the underlying principle is that the patient's body is sacred and we are mere servants in the temple.

### **How much mental attention to give the patient**

As noted previously, we have found that sending mental images of love, support, and healing has a detrimental effect on the healing process.

Just as the best physical support is the kind of support you give someone else's baby, the best mental attitude for treating PDers is the one in which you mind your own business.

A member of the PD Team said once, “Sometimes I start daydreaming while I’m holding someone’s foot. When I stop daydreaming, I realize that I’m holding his foot more gently than usual, and it feels just right. If I try to change and use more pressure right then, it feels wrong.

He continued, “Sometimes, still working on the same person, when I stop daydreaming the second time, I realize that I’m holding his foot with really powerful pressure, and it feels just right. If I try to relax my hands at all, it feels wrong. The most important thing is to give the patient exactly what he needs at that spot at that moment. I find that I do the best job, the patient seems to get the best releases, when I’m not directing my thoughts directly at the patient.”

### ***The poetry example***

The best way I can explain the degree of emotional detachment that you want to use on your PDer is the poetry example.

When we were running the free PD clinic at the college where I teach, each student would work on the same PD patient for two semesters. The students understood that, while doing resting FSR, they were supposed to be emotionally detached from their patients. The students were not supposed to be giving mental suggestions to the feet as to where, when, or how they should wake up and start moving. The students also understood that they were not supposed to be sending “healing energy” into their patients.

The students usually felt that they were doing a good job of keeping themselves distant from their patients’ emotions during the resting FSR work.

About three months into the semester, I would introduce an experiment, without explaining my purpose to the students. At the beginning of this particular clinic session, I would wait until each student was sitting down quietly, resting his hands on his PDer’s foot. Then I would pass out to each student a sheet of paper with an uplifting but fairly long and somewhat obscure poem – usually something from Shakespeare’s sonnets or the Rubiyat – and tell the students that, while holding their patient’s foot, they needed to memorize the poem. I would tell them that they had twenty minutes to memorize as much of the poem as they could, all the while holding onto their patients’ foot. Then I told them that, at the end of twenty minutes, they, the students, were going to have to stand up and recite their poem in front of their fellow students and all the patients.

After the usual exclamations of resentment or protest, which I would ignore completely, answering only that, “The clock is ticking,” the energy in the room would change. Usually, a peaceful silence prevailed in the large clinic room with seven patient tables placed around the perimeter. When the poetry assignment was given, the energy of the room was more charged, yet even more deeply still than before.

When the twenty minutes were up, I told the students to stop holding the PDers, and stop looking at the poem. Then, instead of having the student recite poetry, I went around the room, asking each patient in turn how this particular treatment felt, compared to the treatments they had been receiving for the last few months.

The students were often insulted by the patients’ responses. For the most part, the patients said things like: “This session was by far the best I’ve ever had,” “I felt a warmth surging through my legs that I’ve never felt before,” or “Something seemed to change inside of me. I almost felt like laughing or crying.”<sup>1</sup>

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<sup>1</sup> The reason that I qualified the reactions in the above sentence, saying “for the most part,” is that, once in a while, a nervous student would have lost all sense of what he was doing to the point where his patient afterwards

The most interesting thing was the student responses. They were usually defensive, and somewhat bitter. After all, the patients were saying that this treatment, during which the students were paying no attention whatsoever to the patients, had been the best treatment yet. It usually took me five or ten minutes to explain to the students why it was that they felt so insulted by the whole thing. They were insulted because, even though they had wanted to imagine that they weren't mentally invested in their patients' responses, in fact, they were invested, and deeply. Even though they were trying to be detached, they were making a point of their detachment. They were still focused, despite their determined lack of intent, on helping the patient.

When the patients stated that they felt and experienced more, had almost miraculous changes, or simply enjoyed the treatment more when the student got out of the way, the students felt miffed. The student response might be summed up as, "You prefer it when I am nothing more to you than a pair of hands? What about how much I care about you? Don't you realize how hard I've been working at not imposing my own ideas on you? How dare you say that you prefer my touch when I act as if you're just a piece of meat!"

And yet, after the students calmed down, they did absorb the point of the lesson. Their previous detachment had not actually been very detached. The students were, despite their desire to be providing unconditional support with no expectations, expecting *something*, however subtle. Even that very subtle degree of emotional involvement had been detrimental to the treatment. This only became obvious when, in panic and fear, the students had been intensely absorbed in something even more important, at that moment, than the patient: the dread of having to recite a poem from memory in front of the class.

### ***Focusing on the blue sky***

The best attitude on the part of the practitioner's hands is one of utter alertness. The hands should be utterly responsive to any change on the part of the patient so that if the patient's foot, ankle or leg moves, the hands can follow the patient perfectly.

The mind should also be utterly alert. However, the mind of the practitioner should be alert and working on *something that is personally important to the practitioner*. Hopefully, anyone who is doing much healing work has some background in meditation, silent chanting, visually focusing on some inspirational image, or some other regular experience with uplifting subject matter such that he always has something that he can be focusing on with all his power of concentration. You may recall the story of Shinzo Fujimaki, the shiatsu teacher in chapter xxx, who focused on the blue sky.

The expression "mind your own business" applies. The business of the practitioner is not always to be mentally focused on the patient. The business of the practitioner, the business of all people, is to always work at becoming a better person. For a practitioner, doing resting FSR is a wonderful opportunity to focus hard on self-improvement. This is much, much harder than it sounds. I remind students of this when they tell me that they feel uneasy charging money for "doing nothing."

### ***Getting paid for "doing nothing"***

Many practitioners, especially after taking a weekend class, ask me how they can possibly justify charging money for doing nothing. I have to point out to them that they have just

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would say, "My student had such a painful death grip on my foot I thought it would turn blue and fall off!" These patients did *not* prefer the poetry experience.

spent two full days realizing that their preconceived idea of doing nothing was not correct, and that when they were, to the very best of their abilities, “doing nothing” to their patient, it required enormous mental focus and restraint.

Most beginning practitioners have a very difficult time “doing nothing” for an hour at a time. If the mind is not accustomed to this level of discipline, the practitioner finds that his mind refuses to stay away from the patient. Also, a person who has not disciplined his body somewhat may not be able to hold still for more than a few minutes at a time. While the essence of this work is not difficult, the application requires discipline. As with any discipline, the student improves with practice.

### ***Singing***

Continuing on with the poetry/mental detachment aspect, I have tried other experiments; once, as an experiment, I had the students mentally (silently) sing songs while holding a PDer’s foot, to see if that would be a positive experience for the patients. After that one experiment, the patients reported nothing especially good, and several reported that they felt agitated by the unconscious rocking that their students were doing. I have not repeated that experiment.

### ***Talking during treatments***

For my part, I often engage the patient in conversation, especially during the first few treatments. I find that, by diverting the patient’s conscious mind away from the feet by chattering, while simultaneously keeping, to the greatest extent possible, the silent part of my own mind focused on my morning’s inspirational reading, I am able to provide a maximum level of security for the injured area.

The injured area, assuming that I am busy conversing with the head office, is less likely to perceive me as a threat. Meanwhile, as long as the patient’s conscious mind is busy answering my questions, it is not contributing its usual internal dialogue of negativity about how it doesn’t like the foot to be held, or whatever the case may be.

As I sit there nattering away, and the patient is explaining whatever he needs to explain, the injured foot is experiencing the sensation of being held in just the very way that it always thought it should have been held, so long ago, when it was hurt. The injured area is not having any attention paid to it. It is just being held. My hands are at peace, they are resting on the injured area, and they are giving it so much support that the foot may feel safe enough to relax, just a tiny bit, for possibly the first time in decades.

And yet, though my mind is minding its own business, my hands are able to notice if anything changes. Just as a really good fisherman, sleeping on the banks of the lake, knows instantly when a fish has bitten his bait, my hands know exactly how to respond if the patient’s foot makes a move. Just as a busy and preoccupied parent does not miss a stride while he expertly moves his hands to accommodate a shifting child that is sleeping on his shoulder, my hands, resting on the patient, move on their own, without my mind getting in the way. It just takes practice.

Many a patient has been surprised when, in mid-sentence, I will suddenly say, “Aha!” Or “There now, did you feel that?” Very often, the patient, and sometimes my conscious mind, was completely unaware that things were shaking it up down in the foot. But my awareness in my hands conveys to me, when it needs to, that something has shifted. At this point, I might stop my chatter and reassess the situation using the more dynamic type of FSR described in chapter xxx.

Then, within a moment or two, I might go back to “doing nothing” again – with or without some level of small talk.

It takes a tremendous amount of concentration to keep the hands thoughtlessly, but responsively, doing their job, while also keeping one’s thoughts on a strong internal focus, all the while answering questions from a patient.

Returning to the issue of the practitioner who asks how he can possibly charge money for doing nothing, I might reply, “You are attempting to do work that is extremely difficult, work that few people can do, and work that few people want to learn to do. It can take time and mental focus to even begin to master this work. You are providing a singular service. It is reasonable to charge money for this work.”

### *Finding a practitioner*

This brings me to the subject of finding a practitioner. While this subject might not seem appropriate for a chapter on technique, you shall see that it is not unconnected. As I explain what I have seen of the patient-practitioner relationship, it may become apparent that the subjects of “how to do this work” and “who should do this work” are actually closely related.

PDers, when first seeking a practitioner, usually want to find someone who is highly experienced in FSR. However, this type of bodywork is not yet common in the western countries, and only beginning to come out of hiding in the east. Therefore, a lot of information is posted on the PD Recovery website on the subject of finding a practitioner. But I would like to add a little something to the practical suggestions that are posted.

Most of the PDers that have visited my program from afar have brought with them the person whom they recruited to learn and perform FSR. These practitioners are very often new to the entire field of light touch therapy. These practitioners have been, almost without exception, very capable and deeply inspired people. They do understand what FSR is all about. Most of them tell me that they have read between the lines of my text and that what they have read resonates with something they had already known.

It also seems that the patient-practitioner relationships that I have seen have, very quickly, developed into a significant, beneficial relationship for both parties. Even when the practitioner is the spouse, a new dimension in their relationship develops.<sup>1</sup> Without wanting to sound too mystical, it almost seems as if the practitioner-patient relationships we’ve seen were relationships that were, for some reason, meant to be.

They have come about in this way: the patient usually had to give up on the idea of finding someone who already knew FSR. He had to fall back on making inquiries of local physical therapists or friends who knew someone who knew someone who was interested in massage or acupuncture. After some amount of work on the part of the patient, he connected with someone who was interested.

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<sup>1</sup> I am not advocating one way or the other for the spouse to be the practitioner. It has occurred that some spouses are keen to do the FSR. Others sense that they can or should do a little bit, but that they should probably not be the primary FSR provider.

In general, it is very, very difficult for a spouse to attain the necessary degree of emotional detachment. Even some of my colleagues, very experienced FSR providers, find that they cannot work as effectively as they would like on close friends or family members; they realize, while trying to do FSR on these loved ones, that they cannot let go of their emotional involvement. They can sense that their treatments on family and friends do not have the same detached ease that they attain with their other clients.

So that I do not paint the patient-practitioner relationship as being more one-on-one, exclusive, than it is, I will also point out that, very often, the practitioners are fascinated enough by the work that they go on to seek out more PDerS.

For example, I know one FSR practitioner with a supreme sense of detached touch and a sixth sense of what area needs to be worked on. He is rapidly becoming an effective FSR practitioner. He only started learning this work because it was a source of extra income. Within six months of practicing FSR on several patients with good success, he is considering becoming an acupuncturist and full-time health practitioner. He told me, “The almost miraculous changes that I see in these patients make me think that maybe I have a talent for this. And while I’m pretty sure that the last thing I really want to do with my life is spend my years holding people’s feet, I’m also starting to realize that, if I can do so much good in the world by sitting still and holding, then maybe I have some sort of higher obligation to make this my life’s work.”

The above is actually nothing more than a long aside, but it may serve to explain, better than my other attempts, that performing resting FSR sometimes seems almost like a calling. Certainly, doing this work changes both the patient *and* the practitioner. In light of that, it may be not so important that a patient find an experienced practitioner. It may be more important that the patient find the *right* practitioner. And so far, from what we have seen, patients have, almost invariably, found the right one.<sup>1</sup>

## HOW NOT TO WORK ON A PDER

### Some rules for FSR practitioners

These next two pages include some important admonitions for budding health practitioners. These pages address the very common problem of people starting to imagine that they have healing powers in their hands. The techniques that you are going to be mastering are so seemingly mysterious that they were banned in China in the 20<sup>th</sup> century for being too charismatic. Don’t forget: in centuries past, people were burned alive if they were able to evoke powerful responses in sick people simply by using their hands: they were in the employ of the devil.

The problem is, when one sits still, trying to be detached from the patient, the temptation is always there to mentally try to look around inside the patient, to move things around using mental energy, perform psychic surgery or any number of other highly invasive, energetic techniques.

Just as these techniques can be very impressive to some observers or patients and terrifying to most PDerS, they can be dangerously ego-boosting to the practitioner.

I find myself in a difficult position. By teaching these techniques of very Yin Tui Na in a book for the general public, I am keenly aware that I cannot be certain that the usual teacher-student admonitions are being conveyed. These admonitions would be warnings to never participate in any of the types of therapy in which the health practitioner uses his own energy to try to fix the problem of the patient. Familiarity with very Yin Tui Na techniques can sometimes

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<sup>1</sup> We do hear from people who say that they suspect that their FSR practitioner is not the right one: the therapist is not following the protocol, he is not going slowly, or carefully, or it just seems like something isn’t right. We need to point out to the patient, in cases like these, that evidently this particular therapist is not the right one. We like to point out at the same time that the patient knew, via his own intuition, that the practitioner was not the right one. Reminding the patient that his knowing is an indication that he does know, on some level, the right practitioner from the wrong one, we then suggest that he continue his search for the right one.

give a person the realization that he can, especially with a weak-willed patient, use his hands to perform healing. From realizing that he *can* do this, sometimes it is only the merest of steps before the practitioner thinks that he *should* do this.

Patients who are manipulated via the energy of others do not thrive in the long run. Practitioners who imagine that they are receiving instructions from the heavens to invade the privacy of a patient's skin are usually greatly mistaken.

Historically, techniques such as the ones I am writing about were only taught to health practitioners who had studied alongside a teacher for many years. That teacher usually gave students injunctions as to when they should and when they shouldn't use certain techniques. Since I am sharing this material with the general public, the warnings and admonitions must be included here.

While it may seem as if these warnings are on behalf of the patient, that is only superficially the case. The real danger of these simple yet powerful techniques is to the ego of the health practitioner.

### ***Looking under the skin***

Sometimes, if we are holding a patient just right, we can feel what is going on under the skin, as if our hands were X-ray machines. I used to teach that this was a reasonable thing to observe. I no longer think that it is, especially in a course for the general public.

Now, I teach something else: when I teach a workshop, I have the students do the following while partnered with a fellow student. I ask them to put their hands on the sides of their partner's arm. Then I ask them to imagine that the atoms of their hands are so far apart that their hands can slip down inside the partner, in between the molecules of the patient's arm. Once inside, I ask them to imagine that they can discern the various muscles, bone articulation, and anything else that they fancy. I ask the partners to notice whether or not they can feel these invisible hands.

If I guide the students through this exercise slowly, and explain to them that all they are doing is adjusting their mental attunement to the vibratory rates of different tissues, all the students are able to do it.

I put them through their paces. I ask them to mentally imagine that they are placing their hands on their partner's radius (arm bone), and then gripping the ulna (another arm bone) with their invisible hands. The partners can feel the sensations inside the arm as the practitioners do these exercises.

Then comes the important part of the class.

I ask the students if they were able to do it. They are usually all looking very pleased with themselves, because they have done something pretty unexpected. I ask for a show of hands of the people who were able to do this. All the hands go up.

At that point, I look around and nod my head a few times, for effect. I really want them to hear what I am going to say.

"You were all able to do this exercise. That proves that the ability to do this is not a special gift. You are not special because you can do this. Just the opposite; you are normal. However, as you know, in normal society, in our culture, we do not do this. To do this is considered rude and invasive.

"Many people, when they discover that they can do this, start to imagine that they must be very special indeed, that they have a mission in life as a psychic healer. Nothing could be

further from the truth. Everyone can do this, as you have just demonstrated. But as a culture we agree that we do not do this.

“The skin is the organ that is designed as a barrier. When you mentally probe inside the skin, the person being probed has no defenses. You are invading his body, and his body has no defense against your mental probe. This type of work is invasive and dehumanizing.

“It is not your job to get under someone’s skin and fix things. That person’s own body can fix things. Our job as health practitioners is to inspire our patients’ own innate healing force to rise to the job. We can do that with acupuncture needles, herbs, western medicine, surgery, whatever the patient thinks it will take for him to be rid of whatever is blocking him from calling in his own healing ability.

“Never intrude into a patient’s private spaces under the skin. Thank you.”

### ***The yoga sutras of Patanjali***

The great sage Patanjali of India, at about the same era as Socrates in Greece, wrote a brief book outlining the various stages of spiritual progress. He wrote about the various abilities and matter-conquering attributes that mark these stages. He wrote that in one advanced stage of spiritual development, a person will be capable of healing others. *But* that wise person will choose not to do so. Unless commanded by God, usually for some obscure reason known only to the heavens, the saint will not perform such a feat.

The saints and sages know that when you perform a healing on someone, you have not done that person a favor. Instead, you have weakened his will power. The patient will still have the wrong thinking that allowed his illness to thrive in the first place.

When these patients are cured via a miracle, they have not learned to do the work of battling their own weakness; they have instead started or reinforced a habit of relying on others to do their work for them.

Most saints and sages of every faith are familiar with this principle. Once in a great while, a very humble saint will be instructed by God to perform miraculous healings. This is not necessarily for the health benefit of the person healed, but for the benefit of certain people who are lacking in faith. After, all the bodies healed by great masters still must someday feed the flames of cremations. The lasting miracles are in the spiritual growth inspired by the great ones.

Sorry to be going on about this, but as a teacher in an acupuncture school, and as a lecturer for practitioners of alternative medicine, I run into a steady stream of would-be miracle workers.

I like to remind them that, when they are truly saints, and God is telling them whom to heal and whom not to heal, they will no longer be attached to the fruits of their actions. As long as they *want* to be a healer, they are ego-bound and their actions will be prone to error. As long as they think that they are the doer of a healing miracle, they are doing it wrongly.

Again, going back to the beginning of this section, everyone in the classroom is able to do the various “psychic” tricks. Therefore, these abilities are *not* special. What is truly special, what is very rare, is learning to mind your own business.

And what is your business? Your business is not healing patients. That is the patients’ business. Your business is knowing your own soul, being a master of your own consciousness. If you become such a master, then by proximity your patients will feel a sense of deep peace and love such that they may be able to summon up their own healing powers. Heal yourself, that’s your business.

As for the rest, if you are training to be a doctor, do what you learned in school, and do it to the best of your abilities. Don't go showboating. By just doing what you were taught in school, without trying to add your own variations, you will learn humility. Humility is the first step in becoming a master of your own soul. Don't worry about whether or not the patient gets well. You do your work to the best of your ability, and in this way you may inspire your patient to do the same for himself. When the patient begins to physically, mentally, and spiritually take charge of his own health, then lasting healing will begin.

### *A summary of the don't's*

Never impose your own healing "vibe" on a patient.

Never imagine that you put your Qi into a patient.

Never imagine that you are a healer.

Never imagine that you have been divinely ordained to do healing work. Don't worry about letting God down; if God is determined that a patient shall get better, that patient shall recover no matter what you do.

### *A summary of the do's*

When working with PDers, your job is holding their feet. You need to keep your hands alert to the various sensations that are received by your hands, and letting go at the right time. Your other job is minding your own business. Any moving, healing, or changing that occurs in the patient is the responsibility and choice of the patient.

This is a lecture that I give to all my students, not just my FSR students. This lecture is even more important for people who are going to work with PDers. PDers, more than most anyone, are wary. They really would rather be healing themselves. They don't really like the idea that some friend or stranger is going to be working on them in a manner that will unlock doors that they can't consciously unlock. PDers are so extremely guarded.<sup>1</sup>

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<sup>1</sup> A patient from across the country came to visit me again after having been to an acupuncturist who lived in his area. The local acupuncturist had assured him that he was going to perform Tui Na and nothing more. However, when the therapist started working on the PDer's shoulder, he exclaimed that there was a psychic tear in the shoulder that needed to be "sewn up." He proceeded to take it upon himself to do the sewing.

When I saw the PDer, I asked him why his arm was so tense; the last time I had seen him he had been doing so well; at that time, his legs and feet were already healed and all that remained was some tremor in one arm. Now his right arm was strangely rigid, he wasn't using it at all, and he even told me that it was OK if he never used the arm, that he could get by with one arm from now on. When I asked him what the heck was going on, he sheepishly told me about the psychic sewing job.

I asked him if he had wanted this work done. He replied that he hadn't, but that he didn't know how to say no. Now he was ashamed of himself, and he felt so bad about his shoulder that he didn't care if he never used that arm again. I was both furious and deeply pained; this was the same person who had needed three years of work before his foot had finally loosened up. It had taken three years of confidence building before he had allowed his foot to respond to me, and now, here he was, admitting to being scared and ashamed after having been shamefully invaded.

We had a talk about whether or not I should go into the shoulder and remove the psychic stitches. While that might help, it might also be perceived as yet another invasion. It was a difficult situation. I greatly resented the unprofessional, disrespectful behavior on the part of the distant Tui Na practitioner. This sort of abusive practice is the very reason that most PDers do not like to be messed with.

We ended up deciding that I would support his shoulder using Yin Tui Na and he could, if he wanted, remove the stitches himself. He felt very unsure as to whether or not he was successfully doing this. After this, he never again showed any interest in recovering the use of that arm.

When you work with PDers, you will only get results if the PDer can be certain that you are not going to do anything to him. Only when you have shown yourself to be a complete respecter of his person will he be able to relax enough to let you do your supportive work.

### **Talking to the feet**

Now that I have drummed into you the idea that you should not get involved in any way with your patient's wounded self, I am going to contradict myself.

Sometimes, we find that the body part will respond in a favorable manner if it is addressed respectfully, honestly, and briefly.

For example, I sometimes will talk directly to the injured foot when I first start working. After having asked the patient out loud for permission to work on the feet, I then introduce myself, either silently or out loud, to the foot or body part in question. Sometimes I also add that I am going to be holding the foot (or wherever) for as long as it wants me to. I sometimes add that I have received permission from (the name of the person) to be doing this. I may add that the person (I refer to the person by name) wants me to be doing this work, and wants the body part in question to be able to relax and/or heal itself. Sometimes, I then tell the body part that I am going to leave it alone while I hold it, and I tell it to "do whatever you want to do while I'm holding you. If you get scared, I'll be right here. If you don't want to do anything, you don't have to, but if you do want to try moving around or taking advantage of my holding, you only have so much time (however many minutes are left in the session)."

After that, I stop talking to the feet and leave them alone.

You will notice that this conversation with the feet is not coercive in any way. There is no statement as to what should happen. Just the opposite. I am saying that my reason for being there is that the person in charge of the body wants me to be there; it's not *my* desire that I be there. I am obeying the person in charge of the body (the patient's conscious choice). The most important thing is that I keep it very short. It is not a dialogue. No response is expected. I am stating who I am, why I am there, and for how long. After that, I mind my own business.

Many Tui Na practitioners find that everyone feels more comfortable if this type of verbal communication, whether silent or out loud, is performed in the very beginning of the session. I often do this at the beginning of every session. Sometimes I vary it a bit, adding remarks such as, "I worked with you last week. I'm going to do it again this week," but I try not to get too fancy, and I never suggest that I am wanting a response. After I have laid my cards on the table, so to speak, I mentally detach myself from any result, and go about my own business.

## **CHAPTER SUMMARY**

Resting FSR using the same amount of support as the assessment type of FSR. The difference is that resting FSR goes on for an extended period of time.

While sitting for an extended period of time doing nothing in particular, the temptation to start looking for signs of progress can be compelling. However, the best results will be obtained if the practitioner minds his own business. When the injured area does decide to move, it will be

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At this point in his recovery, he had resumed playing tennis, golf, and going for long walks. However, his rejection of that right arm was so extreme that when I asked him to use his right arm in any fashion, such as carrying a key in that hand or using that arm to carry a sack, he was barely able to walk, could not figure out how to negotiate stairs, nor could he figure out how to get into his car. It was as if the motor function of his brain slammed shut if he was forced to use the arm that had now become hateful to him.

apparent. Until then, the practitioner should remain fairly still for as long as seems appropriate. If it seems as if the foot no longer wants support, or wants it somewhere else, even if no relaxation has occurred, then the practitioner should move to the new position.

The best way to learn this work is by doing it. After a few dozen hours, the hands of the practitioner, if his thoughts are minding their own business, will become attuned to the needs and wants of the injury site. After that, it is just a question of letting the injury heal itself at its own pace.



