



Welcome to your first steps into the world of The Bowen Technique with the The College of Bowen Studies formally the European College of Bowen Studies.

I started teaching The Bowen Technique in 2000 and since then have seen the technique become one of the most popular and sought after therapies in the field of hands on treatments. Building on 25 years dedication and work by Julian Baker we are set to move into the next decade with dynamism and also a calm pragmatic approach for our students and clients alike.

In 2009 my team of professionals opened 3 large health centres in the UK where the Bowen Technique plays a central part of healthcare for their local communities. We are now recognised in Iceland with our Bowen teaching colleagues and building further opportunities in the world as we speak. We embrace traditional methods and important hands on treatments to help people who present as human beings with a wide range of physical and biological situations. Bowen has always played a popular and sought after therapy in these locations helping thousands of people become able to live their lives with less limitation, more opportunity and reduced symptoms. It is the College's aim to train able, motivated and professional therapists across the world to have successful and long careers either in a clinical context or reaching people within their own family and friend circles and to actively increase awareness of this fascinating approach.

Myself and the teaching team are continuously studying and educating ourselves to seek further understanding of the human body and have a working dialogue with traditional approaches and complementary therapies alike. All of this knowledge is shared with you as keen students of the Bowen Technique and it will capture your inspiration.

Please ask your teacher lots of questions, enjoy the process and start to practice as soon as you can.

I look forward to meeting you in the future and in the meantime please feel free to contact me directly with any questions, comments or thoughts you might have.

Best Wishes

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**Tom Bowen
1916-1982**



Any course bearing the name The Bowen Technique would be incomplete without referencing where the technique originated and who gave it its name.

There is plenty of information available regarding the life and times of Tom Bowen in the public domain and this section does not pretend to be about the man himself.

It might be said that the technique as taught today may not even really resemble his own technique, original or otherwise. Many people lay claim to his work and discuss whether their work is more like his, or whether they are being truer to what he was doing. There is no way of telling, as Tom wrote nothing down.

What we do today has evolved and emerged from 30 years of discussion, debate, ideas and hearsay. What is important for Bowen therapists worldwide however, is that we are able to clearly define what Bowen is and what it is not, in relation to what we all do today.

Tom Bowen referred to himself as an osteopath, yet had no training or background to back this title up. He did apply to go onto the osteopathic register in 1981 and was turned down for this very reason. His work was based on intuition, a clear understanding of the true nature of what the client was presenting with, and obvious self-belief in the restricted powers of the human body.

He claimed to be performing up to 13,000 treatments a year, with most of them being first or second treatments. His waiting room was characterised by a number system. With no set appointments, people arriving would take a number from the board and wait to be seen. Everyone was.

It was said that he described his ability as a 'gift from God' but it's likely he picked up hints and tips as he went along, especially from those around him who he was showing his method to.

Similarly he never tried to explain how or why his method worked or what the principles were. Perhaps the level of understanding and vocabulary were not at his command, but perhaps also he was content to simply work with as many people as possible and not question how or why.

It's worth putting his life and work in context, giving some comparisons from today. When he started working, there was no established complementary therapy industry and Tom was not some kind of mystical new age guru. He was a simple Aussie bloke who liked a smoke, a drink, his cricket and sports in general.

Much as some people would like to believe, he had no contact with Aboriginal culture, Asian culture or anything else that would fit our ideas today. He was a religious man who played in the Salvation Army band, ran the Salvation Army boys club, worked as a general hand at the local cement works until demand as a therapist pulled him away and cared for his family.

His healing career if you can call it that, took off due purely and simply to demand. People were in pain and he could help them quickly and easily. Stories abound of the remarkable things that happened in his clinics, but Tom never took personal credit or created an image for himself. He never even called his technique The Bowen Technique, he was just the bloke that fixed people up and his compassion for his fellow man was his sole motivation.

He taught a number of people, all men, over the years, having them come and observe his work for one morning a week. All of these men had varying interpretations of what they saw. Perhaps he showed them different things, or perhaps they understood what they saw differently, according to their own approaches. In any case it is clear that he taught no women and the stories surrounding some of his legacy and how he handed it on, have been little short of fantasy. His family has been constantly amazed and hurt by some of the claims that have been made, and it's interesting to note that the story has changed to suit the telling over the years.

Tom Bowen was undoubtedly a genius and I have an enormous respect for a man who stepped away from a steady income and faced criticism from some in his community as a result, to follow his

personal destiny. He spent his life dedicated to helping others and never refused treatment to anyone who asked. He would be woken in the middle of the night to help people and invariably took no money for the treatments he performed.

His daughters Pam Trigg and Heather Edmonds, have been a great source of encouragement and inspiration to me and they have contributed much to the understanding of the man himself. Heather always said how amazed her father would be at the worldwide acceptance of a technique bearing his name. His humble approach and dedication to making the world a better place is an example to aspire to.

A foundation continues to run in his name, helping disabled children and details of this can be found at www.thebowentechnique.com

However, with a big deferential nod towards his memory, it is time to move on. We need to find a place for Bowen in the world and need evidence and good scientific backup to do this. With this in mind CBS are proud to be connected to and directly working with some of the most interesting and pioneering scientists in the world in relation to fascia in order to help explain and mobilise a more in depth appreciation of the work Tom originally carried out.

Fascia

For the purposes of this discussion, it should be made clear that whilst all fascia is connective tissue, not all connective tissue is fascia. Different types of fascia include, cartilage, tendon, adipose tissue, bone and even blood.

Connective tissue, in the field of conventional medicine be it fascia or any of the others mentioned has had a little in the way of attention. It is considered to be a supporting or filling structure, one that has responsibility for binding and cementing, but with function or purpose otherwise. Yet there is a strong view which holds otherwise. Theophile de Bordeu an 18th century physician recognised that connective tissue carried out regenerative functions for certain organs and acted as circulatory and nervous systems.

It's only the connective tissue that has contact with every part of the body and does exactly what it says on the tin, connects! For this reason it's a system which we should take a great deal of notice of.

In addition there is a function of cleansing and washing that takes place within the functional role of connective tissue. " everything that comes out of the blood takes a somewhat complicated route through the connective tissue to the parenchymal (thin walled cells) and then into the lymph system" (Pischinger 2007)

Skin and Superficial Fascia

I put these two structures together in one title from the perspective of the body worker or therapist rather than from the side of the anatomist. There is plenty of study material available on the skin and even some on the superficial fascia, but it is the relationship of these two materials that is of interest here.

The skin is the largest organ of the body and referred to by Dean Juhan in his incredible book, *Job's Body* as 'The surface of the brain' (Juhan). It quite literally breathes and acts as an organ of waste removal, temperature control and infection protection. It is an emotional layer, a layer that allows us to react to the world around us and to feel good or bad through. Something might make our skin 'crawl' or we might feel mentally and physically more balanced when the sun is on our skin.

It is a continuous structure that moves, distorts, grows and shrinks with us as we grow, and reflects our health, our climate, our age,

our well being and even our emotional state. Have you ever blushed, sweated through fear or gone white with shock?

Attached to the skin in an intimate relationship, is the underlying superficial fascia layer. This layer is often called the adipose or subcutaneous tissue and although contains the two types adipose tissue, white and brown, it is also much more than just a fatty layer.

The superficial layer gives us the springy feel to our body and acts as a huge shock absorber as well as a very important infection fighting layer. It's ability to easily store fat is one of the reasons that we experience obesity but it is also an endocrine organ, secreting hormones such as leptin, (Kershaw and Flier 2004) involved in the regulation of metabolism and appetite, and resistin, increased levels of which are suspected as playing a role in obesity and insulin resistance. In addition cytokines - cells secreted by the immune system- which regulate and control inflammation and emergency responses throughout the body are stored in the adipose. This means that superficial fascia as an adipose layer, has all the equipment it needs, not just to store energy, but to communicate with all the other organs of the body, including the central nervous system.

In addition, the superficial layer not only determines the way that information is transmitted to the brain but the part of the brain that this will go to.

This layer is a loose, aureolar layer of tissue, which when examined has the appearance of bubble wrap. One can push ones fingers in between the loose pockets of fatty, yellow material and gently tease it apart. Yet at the same time as being almost fluffy and flexible, it is incredibly strong and able to absorb large pressures placed upon it.

If for example you were to press hard and quickly onto it, then just like bubble wrap, the layers would close on themselves and protect the underling tissues from penetration or heavy pressure.

It is adhered to the skin in an intimate arrangement that defies manual separation and the only way to examine this layer away from the skin is to use a very sharp blade and forcibly take them apart. Once apart the layer is still incredibly strong, dense and continuous and even prolonged and strenuous pulling will not rip the layer. As well as the ability to contain fat, it is also a layer of connective tissue, which is three dimensional and, like the skin sits in a continuous layer all over the body.



This image is taken from the remarkable Integral Anatomy Series of videos by Gil Hedley, all now available in their entirety for free on YouTube. This picture shows the superficial layer, with no skin, removed from a cadaver in one continuous piece. It's a beautiful layer and one that Gil movingly refers to as this lady's "wedding dress."

It varies in thickness from a couple of millimetres to several centimetres, but is always connected to skin at its outer surface. In much the same way that the skin is the interlocutor between the inside body and the outside world, the superficial layer is also acting on the internal organs. It is heavily supplied with blood and fluids from the rest of the body and is perforated throughout its surface with blood vessels and nerve endings that reach through it to end on the surface of the skin.

It is also a particularly poor conductor of heat, which means that it is very helpful in retaining the heat of the body and keeping us warm. So with all these useful qualities we have to wonder why we have such a poor relationship with it. The fatty layer that is our superficial fascia is often demonised. We are concerned about having less fat in and on our body which to some extent is reasonable. But on the other end of the scale there is the tendency to also go to great lengths to lose weight, burn fat and see it as something to be excised, even going to such extremes as liposuction and plastic surgery.

For the Bowen therapist, this is the layer that we have most in common with and through which we work when trying to reach into other structures of the body. This is the layer which is always present underneath our hands and however much we wish to think

about muscle, bone, deep fascia and so forth, it is this layer which is the translator of our touch to the deeper tissues beneath.

When working around the gluteal area for instance, the depth of tissue is such that we are feeling a distant resonance of gluteus maximus, and whilst we are able to define tension, tone and feeling of the underlying muscle, much of the quality of this palpatory sense will be subject to the sensitivity of how we approach the superficial fascia.

There are many deep tissue approaches in the world of bodywork, many of these sometimes applying great amounts of pressure to delve through the superficial tissues. It must be understood however, that just because Bowen is a light touch, it is not excluded from the world of deep tissue.

From a Bowen perspective you can access any areas of the body you wish to, but the factor that will keep you out is the tension of the practitioner's hands and the way in which the superficial fascia responds to this tension.

If we work through the superficial layer with patience and a light touch, our ability to reach in, palpate and treat deeper tissues without creating pain or being invasive, is perfectly straightforward. My concerns arise from those therapists who think that in order to go deep you have to go in hard. This is, in my view a mistake.

Quite apart from it being unpleasant and pointless, it also raises the real possibility of damaging tissues. It's also very hard work and has ruined the bodies of many a therapist. There is nothing you can achieve with 'deep tissue' work that you cannot achieve with Bowen.

Bowen should never be painful or invasive, and whilst there may be times when you hit a tender spot, anyone creating pain and calling it Bowen is simply a bad therapist!

Muscle

In the world of sports injury, massage and most hands on techniques, the focus on muscles and the movement of them is very large. Much of the understanding of the individual component of the muscle is based upon the study of very trimmed meat, from pictures which bear little resemblance to what the muscles actually look like.

We could say that there are over 800 muscles in the body, each having at least one nerve and a function, which has been defined and documented to the point that there can be no discussion or argument about it. My preference when discussing muscle is to refer not to muscles 'attaching' to this bone or that, but rather to use the word 'reference' instead. The use of the word might appear semantic, yet the word reference implies continuity. It will help us to always understand that any given muscle is on its way somewhere and has come from somewhere else and that these should be considered when appraising muscular function.

It is therefore the connective element of what wraps around the muscles that creates more of an interest than anything else. If asked to put our hand on the abdomen for instance, there is no doubt that we would all place our hand at the front of our body, somewhere around the navel. Yet there is as much, if not more of an abdominal connection at the sacrum and lower back than there is in the small area at the front. It is at the back that all these groups come together to form one thickened and complex band, an understanding that will be explored later on in this book.

So where does Bowen fit in with these myths of the body? Well the beauty of Bowen is that it doesn't tend to, or shouldn't look for sites of pain, but instead treats the body as a whole, hence the remarkable successes that we see, even with chronic, long-standing pain.

7 out of 10 people in the UK will suffer from back pain at some time in their lives and according the Office for National Statistics, the figures are increasing

Over 100 million European citizens suffer from Chronic Musculoskeletal Pain (CMP) though it remains undiagnosed in up to 40 per cent of cases.

Traditional approaches are often quite ineffective and tend to focus on the area of pain for treatment and relying heavily on pharmaceutical remedies. The National Institute for Clinical Excellent (NICE) guidelines on the treatment of back pain run to

over 250 pages, the conclusion being that there isn't much that can be done. We can put a man in space, but we can't sort out your back pain. Long-term non-specific back pain (NSBP) still remains a major cause of absence from work, only exceeded by mild to moderate mental health problems.

I firmly believe that the major reason for this failure is a significant inability to grasp the concept of the body as a connective tissue system. The back hurts because something else is happening to make it hurt. Treatment focussed solely on the specific site of pain will tend to have little effect in these instances.

Because Bowen works upper middle and lower back as part of its basic approach, it takes into account, often by luck rather than judgement, all the other areas that might affect the back.

The connected nature of the deep fascia, that holds and binds the muscular network, is not studied or noted in the teaching of anatomy to doctors. Nor is the concept of how varied movements, postures, functions and habits, help to lay down fascia and connective tissues, which in turn create continued patterns and cycles of pain and lack of effective function.

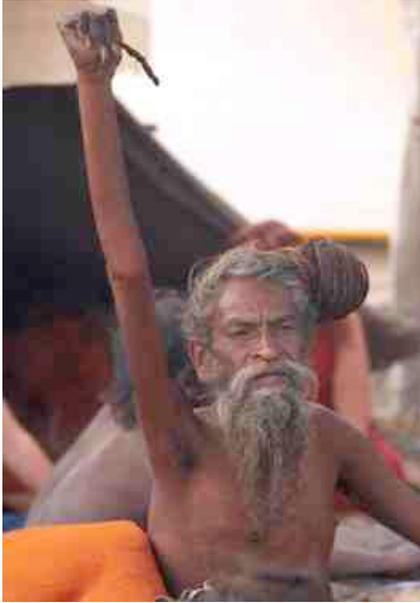
There are many books and internet articles which will help you to learn how fascia is made and created, but I will attempt to give a simple précis of what fascia is, how it is made in our bodies and how it responds to the light touch that is or should be characteristic of The Bowen Technique.

Collagen

The source of what we understand as deep fascia is collagen, exuded into the body by a cell called a fibroblast. There are dozens of types of collagen and it is the most common protein in the body, with around 35% of all protein in the human system being collagen.

Collagen is the building block for our structures and where plants rely on cellulose is to maintain their physical structure and shape, humans are similarly reliant on collagen. A large molecule, one of the largest in the body, collagen forms thick, twisted triple bands of densely packed fibres, which are then laid down all over the body to create fascia as well as a host of other tissues.

The cornea of the eye is collagen based, as are the strong ligaments around the knee. Wherever we see movement we see collagen, which is being produced all the time until the day we die.



Collagen in terms of fascia however has a particular role, and supports our frequent movements and postures. If we were to hold a certain position for any length of time, we would experience a stiffness. This stiff feeling is the beginning of collagen fibres lining up and thickening. Continued lack of movement or stiffness, eventually leads potentially to ossification and atrophy and is characteristic of so many stooped and painful postures that we can see around us.

This Sadhu in India, has had his arm raised for over thirty years and will be unable to lower it even if he wanted to, due to the fixing of the tissues around the should capsule.

Fascia is laid down as a response to need and isn't a judge of good or bad but is merely responding to what the body is asking for. A repetitive action will result in the fascia creating the support around the muscle to fully integrate this action into the movement pattern of the individual.

For instance if you were a golfer trying to perfect a new stroke, you would need to repeat this movement thousands of times in order for your body to undertake this movement naturally and easily, hopefully without having to think about it.

Muscular movement is limited to the line of contraction that it takes to perform its function. A bicep contracts and flexes the arm. That's about the limit of its function and it then needs the triceps to contract in order for the arm to extend.

Yet the arm will flex and extend as part of a combination of thousands of movements every day, in conjunction with a lot of other movements around the body. Yet there is no field of science that looks at these relationships and how they fit together as part of our complex patterns of human functional movement.

If I raise my arm, I can allocate a series of muscles that will be responsible for this function. Yet at the same time, I will need to stabilise my body in order to allow for transference of weight and tension through my frame. The abdominal structures and those

surrounding the hip on the opposite side of the shoulder that is moving, will need to contract and become functional. If they don't then the act of raising my arm will cause me to fall over.

Is it my brain that is directing this stabilising and correcting pattern millions of times a day? It would seem to be something of a wasted resource, if the brain continuously had to adjust the body constantly. Instead, we lay down fascia and supporting tissue to allow us to formulate habitual movement, with these tissues also serving to communicate with each other, forewarning, through tensional behaviours, what is about to happen. A spider's web of tensional information.

It stands to reason therefore, that if this web exists to aid human function and movement. It can also be utilised by the intuitive therapist who can interpret tensions and patterns to assist the body on the road to self-correction.

Perhaps we can even suggest that the connective tissue system is perhaps operating as an independent nervous system. Working alongside the brain, but with some kind of functional autonomy.

Certainly the fascia operates in a way that current scientific thought hasn't yet fully explained, and it is probable that techniques such as Bowen will, in the future be seen as the key to tapping in to this newly discovered area of human function.

Anatomy, New Lamps for Old

The traditional view of anatomy is arrived at simply because the body is divided in the same way that it has been for many hundreds of years. It's just the way it is. One anatomy book is going to be much like another. Each muscle has a name, a function and nerves that innervate it.

That's fine when dealing with structures in isolation, but when it comes to trying to understand how one bit of the body works in reference to another bit, the traditional anatomical view of the body has no answers. If anything it actually denies relationships between far reaching structures.

Modern medical study relies little, on gross anatomy these days, and none at all on the wider relationships of systems to each other. Medical students obviously have to learn the systems of the body, the muscles and the bones, but there is no science that takes them to one side at the end and explains how these things fit together. A medical condition has a symptom, which then has a diagnosis and which then has a treatment. The idea of symptom, diagnosis and treatment is the holy trinity of modern medicine.

The concept of relationship of structures in the process of cause and effect is alien to the allopathic model. How does one problem in the body impact on another area or even create another problem? The diagnosis of a problem in the wrist might result in the treatment being surgery. Yet if the problem has originated from the neck, which in turn has come from a long standing back pain, which originally was prompted by a torn ligament in the knee..... What hope for the wrist problem being solved?

All these answers are in the body and a skilled reader and practitioner will pick these up through a combination of interview and observation. It is a skill that can be taught and learned in much the same way as a surgeon will learn his art.

If the belief is that the knee cannot possibly lead to a wrist problem and that to think this way is to be 'alternative' 'weird' or just 'wrong' then we have little chance that the surgeon of the future will change his view that much.

By understanding the body in terms of an interconnected tensional system however, it becomes easy and logical to grasp the idea that strains, pressures, shortenings or pulls in one area, will have a natural knock on effect in other areas.

Tom Myer's view of the body as a tensional system has led to his very successful Anatomy Trains concept, something for which I have an enormous amount of respect. This system explains a complex series of lines of strain throughout the body and allows the observer to try and pick up on where these strains might impact on the function of the body.

At the same time this also another paradigm, which has the danger of become another person's 'truth'. My view is that the system is only any good if it can be learned and quickly forgotten, leading to a more intuitive and complete understanding of how any individual uses their body to move and create their own version of the function that we all take for granted.

Hold your theory lightly and your practice dearly – Gil Hedley

Modern medical thinking does not have much of an overall view of the body. A surgeon might know intimately the anatomy and structures of the knee or hip that he is operating on, but has probably never taken a full body apart to see how that hip or knee relates to the other hip or knee or indeed the shoulder or diaphragm. Yet these relationships do indeed exist in a very real and vital way and contribute to the overall function, vital to the outcome of any surgery. To ignore them is to end up with small fraction of the full picture.

The integral or holistic view is invariably dismissed however as being 'alternative' or just wrong. My determination has been to demonstrate the actual presence of these tissues and interfaces, in order to be able to state with absolute conviction that there is indeed a correlation between conditions of the face and problems in the lower back.

With the power of this knowledge comes the ability to also demonstrate how these things manifest in posture and movement. With practice we can actually pick out pain from a client and show how this pain has been developed and increased over a period of time.

Tacked on to this approach is also the psycho-social element. If someone is in pain, how does their posture change? If someone is also emotionally or mentally challenged, how is this translated into the way that they carry their body?

As we have discussed, fascia changes and lays down patterns according the task it is given. If the position of our head and neck

is related or caused by the emotional pattern that we have taken on, then we need to consider this as part of our treatment model. It's something that can naturally be experimented with. If we stand slouched forward, arms dropped, head hanging down, the back of the neck rounded and simply say out loud "I feel really, really happy", then we are more likely to laugh. The posture in relation to the words seems ridiculous. If in contrast we stand up straight, push our chests out, lift our heads up and then say "I feel depressed and unhappy", the same sense of contradiction arises.

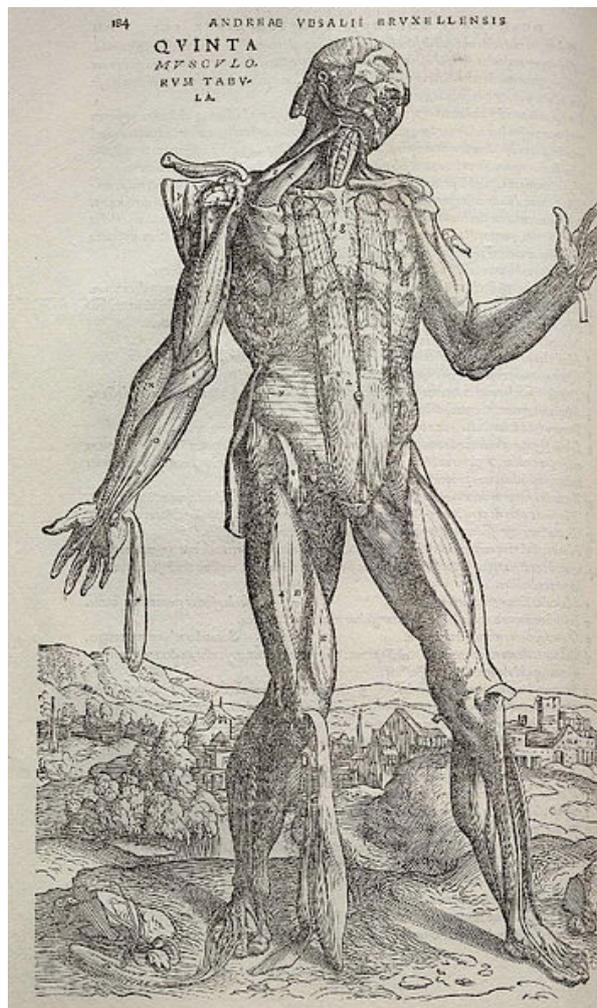
This is a forced scenario, but the principal remains. That we are in a symbiotic relationship with our emotions. We feel first, and react accordingly. Our feelings are enmeshed in our sense of self. We 'squirm' with embarrassment, or 'curl up' with it. We are 'sick' with fear or 'paralysed' by nerves. When we are let down or disappointed we might say we are 'gutted' reflecting the feeling inside.

The concepts of feeling and emotion have tended to be separated into distinct disciplines. We might see a doctor for our heart problem or stomach problem and a counsellor, psychotherapist or even psychiatrist for our mental disorders. Again the separation here is tenuous at best.

It's a subject which increasingly extends itself each time I touch on it, and one which might call for more writing on in the future. But I do encourage all therapists to truly embrace the concept of the holistic and include the nature and emotional position of the client. It's all too easy to 'medicalise' clients, trying to treat the condition rather than the person and it's not a model I feel comfortable with.

Anatomy. More tradition than science.

The study of anatomy has been driven by established approaches for many hundreds of years and had its roots in a man called Galen, a Greek physician born in 129AD, who conducted most of his research and based his theories on human function around the dissection of monkeys and pigs, as human dissection was forbidden under the Roman Empire. In the mid 16th century, a Belgian physician Andre Vesalius led the field into the use of human cadavers to study the workings of the body discovering that there was indeed quite a difference between man and monkey. He published pictures and descriptions of his dissections in *De Humanis Corporis Fabrica*. (Vesalius, O'Malley et al. 1950)



The medical profession of the time was outraged and Vesalius was even tried and condemned to death under the Spanish Inquisition, although this sentence was later commuted. Even then Vesalius stopped short of undermining the findings of Galen in respect of how blood circulates around the body. It was only in 1628 that William Harvey established the circulation of the blood with the

heart as a pump, changing the views held as true for over a thousand years.

The theory of the brain controlling all muscle movement through the cranial and peripheral nervous systems, still held as a central belief today, stemmed from experiments performed by Galen nearly two thousand years ago.

By the Georgian period, private anatomy colleges proliferated in London and men such as John Hunter and his brother William, fought tooth and nail to procure material to perform dissections and experiments, spawning the 'resurrectionists'. These were men who would steal newly deceased bodies from graves in the dead of night, selling them to the anatomists and leading to pitched battles over opened graves.

Inevitably with the demand as high as it was, the prices rose accordingly and it was a natural progression that bodies would start to become available to the dissectors via more sinister methods culminating in the famous Burke and Hare murder trial in 1828.

It was only with the anatomy act of 1832, prompted by this kind of activity that the supply was regulated and the atrocities of stealing the dead and murdering to order was brought under control.

The main body of influence in modern anatomical thinking however was Henry Gray, who in 1858 published the first edition of what would become the seminal anatomical textbook for the next hundred years. Today the 40th edition of Gray's Anatomy which was published in 2010(Drake, Vogl et al. 2010) is an updated version of the original. It is worth noting however that although modern anatomical thinking has changed and developed, it hasn't really become joined up.

Most medical students undertake very little in the way of dissection and even the study of anatomy is limited to working with sections of tissue that have been prepared in a manner which has changed little in the past one hundred years. Medicine is based around a segmented approach and the understanding of the human body follows this thought process almost slavishly.

Hence a newly qualified doctor will have had years of study under her belt, including an extensive knowledge of the various functions, workings and failings of the human body. She will however have little or no understanding as to how the functions are interlinked.

The preparation of tissue for study is carried out along fairly prescriptive lines, and the study is undertaken from texts and methods that haven't changed that much since the time of Vesalius. The human structure relies on its integral nature in order to move and function. Without the dependant relationships that characterise and underpin the human form, we would have no basis for studying the nervous or digestive systems.

This lack of cohesive understanding which could be considered to be a failing or a lack of integration within medicine would be a sad omission were it not for a further tragedy. In the field of manipulative medicine, complementary medicine, physiotherapy, chiropractic and osteopathy, the study of anatomy has tended to follow the same, somewhat incomplete approach.

We study muscles and groups of muscles, learn their actions and the nerves which supply them, but take no consideration of the relationships that make them relevant to the rest of the body. We say that a bicep muscle flexes the arm, or that a deltoid is involved in abduction. Both statements are not untrue, but neither of them are exactly definitive when it comes to understanding function.

In traditional anatomical thinking, I could reduce the lifting of my arm to a group of muscles based around the shoulder girdle, with a few others into the chest and neck for good measure. If there is something paining me or preventing me from performing this function, I will assume that the problem will lie in the area of presenting pain and as a result will tend to treat this area as the problem.

In order for me to be able to lift my arm however, a whole series of factors come into play. I need to be able to stabilise the rest of my body as the act of lifting the arm will shift the weight around my centre of gravity. If the opposite side of my body is for some reason unable to support this shift, then I will need to compensate into another area. The result may well be that I lift or move my arm in a way that creates a conflict with what might be considered 'normal' movement. If there is a weakness associated with the compensating area, this could be the location of the problem, even though the pain or restriction is nowhere near this point.

To most people it sounds pretty straightforward and obvious and in many ways it is, but this element of simple cause and effect movement is neglected and even denied by the conventional surgical, segmented approach.

The myths of conventional anatomy are perpetuated by concepts which we hold true and dear, with an example of the skeleton being the best. We see skeletal images all over the place and when walking into a classroom or anatomy lab we are faced with the rictus grin of the wired skeleton as a ubiquitous presence.

The concept of a skeleton as a framework is an example of the problem we have. This is a created image, a myth, a sculpture and bears no resemblance to anything we might see as truly existing within the human frame. On the skeleton we can see two hundred or so bones joined together. It stands there as if, given some kind of brain and a malicious will, it could come to life and chase us, bony arms outstretched. The point is that the only reason it is standing there in the first place, is because, much like the dead parrot of Monty Python fame, it is nailed there.

If we took away the wires, screws, bolts and bit of plastic that held the structure in place, it would simply fall apart, leaving a collection of bones on the floor. Each bone would have no relationship to any other bone, but would simply lie there as an individual piece of dog food. This relationship or lack of relationship extends to every bone in the body and begs the question of hard tissue adjustment techniques, what is it that they are adjusting exactly? Well it can hardly be bone, which only leaves what is left, the soft tissues. Over to you chiropractors!

The next stage is to add bits to the bones which will allow them to move around and it is here that we start to introduce the muscles, ligaments and tendons which bind the bones in place and give the skeleton mobility. The traditional view adds muscle and soft tissue in layers, creating the idea of there being certain groups that have certain functions. Whilst this is useful in terms of a learning tool, it is however far from definitive when we start to examine interconnected relationships. The learning of traditional anatomical models is useful, if not essential for the aspiring therapist. The problem comes when it is the sole element of studying the body. These models have been handed down from generation to generation of anatomy lecturer, with most lecturers never seeing a dissected human form, but teaching the inadequate knowledge from a book.

In illustrating parts of a body, there is a formula which is fairly rigid and which has been adhered to for a long time. However the concept of there being more than one way to skin a cat extends upwards through the food chain. As Gil Hedley has aptly demonstrated there are countless ways to dissect a body and demonstrate the individual nature of the human. (Hedley 2007)

For example there will be many who will be confident in their ability to identify the structure known as the iliotibial band or tract, running down the lateral side of the leg to the tibia and diverging into the quads' at the front and the glutes' at the back. When running dissection courses, it is a particularly pleasure of mine, to ask students to find this tract, its beginning and end. Because of the nature of the fascia that wraps itself around the leg, it quickly becomes evident that this is not a separate structure at all, but simply what is left when the dissector has trimmed away all the stuff that he or she is not interested in.

This is the same with probably the majority of gross anatomical pictures, whether they be dissection pictures or illustrations. The picture is of what is left when everything else around it has been removed. The result is quite a distorted and sectional understanding of the human form and one which has a lot missing. It begs the question that if it is there on the human form on those around us, why is it so dismissed and diminished in the field of anatomical understanding.

From my side, the missing 'stuff' is what I want to focus on. It is the superficial areas of the body that we as hands on therapists need to focus on and understand, as it is these layers that we are predominantly working on. Our study of deeper layers and muscle is of course useful, but the access to these structures is permitted and facilitated by the layers of skin, superficial fascia, deep fascia and connective tissues. If we don't see, feel and understand these layers, then any attempt to affect the deeper tissues is immediately arrested and compromised. It's also probable that if treatments for conditions are devised around anatomy which is wrong, then the treatments themselves might be questionable.

The word superficial tends to conjure up a shallowness and lack of depth, leading to our immediate impulse to dismiss these layers as unimportant or merely worth of noting in passing, on the way to something more interesting deep down.

No physical therapist ever touches muscle, tendon, bone or ligament, but merely feels these as reflections or projected images. If we understand this then we must surely endeavour to understand the material through which we work and through which our deeper understanding is reflected.

The whole of what we are dealing with can be termed connective tissue in the broadest sense of the word some of which is also called fascia.

Does Bowen address bones? Certainly it does, as the act of releasing and unwinding the tensional relationships, creates a potential for bony relationships to move and respond as they need to. There is rarely a need to crack or manipulate and I would suggest that if adjustment cannot be made or achieved through soft tissue release, then it is unlikely to be achieved by manipulation or high velocity thrust movements.

One muscle is connected to another muscle because of its fascial connections. So for example the pectoralis muscle is pretty much the same muscle as the deltoid muscle to in order to separate these muscles you need to take a sharp knife and cut them.

The fascia doesn't just surround the muscle, it surrounds all the spindles and the bundles of the muscle it around the bone in the form of the material that we call periosteum. It is the network that gives the body its integrity and ability to move around.

Muscle is effectively pink, squishy, protein and without fascia has no basis for movement, strength and connectivity. Muscle relies in entirely for its integrity on the fascia that surrounds it.

Traditionally one can assign a function to a group of muscles. For instance abduction or a lifting of the shoulder will be assigned to muscles around that area such as the rotator cuff and so forth.

However there are very few books on the market if any that will suggest or show the relationship between the shoulder and the abdominal muscles on the opposite side. Yet without the stabilization, activation, and functional competence of this grouping it will be impossible for me to lift my shoulder at all.

To be a fully effective therapist, I therefore need to understand the relationships of the structures rather than just the structures themselves. Bowen either by design or default manages to address these relationships very effectively and practically and this course will start to bring to your awareness the existence and importance of these connections and relationships.

The bringing together of these systems has often been referred to as being holistic, a word which is rather used as an unpleasant stick with which to beat complementary therapy. However it seems more like common sense if you address the body as a complete unit and understand these relationships.

As we start to move towards a greater understanding of the new anatomy, we will perhaps develop a wider acceptance of the whole body model. It takes time, research, commitment and conviction and won't happen overnight. As it was once said, "You can't stop a liner with a speedboat turn!"

The ability for the body to change is reflected by the fact that collagen represents something in the region of 40% of all proteins in the body. Collagen is to humans what cellulose is to plants and is the structural building block for movement and function but at the same time is also the building block for restrictions, calcifications and what we call our aging process.

We continue to make collagen every day until the day we die and lay it down in fascial tissues according to our movement, job, sport, injury and so forth. The way that collagen lays down, is in strong spiral units. Each collagen fibril is a triple helix, three strands wound around each other in a tight spiral, banding together with other spirals to form structures, fascia, with the strength of steel wire.

It is these patterns that give us our posture, movement patterns, and even our habits and in turn direct a lot of the way that muscle and in turn our whole body, moves. Spirals are the new model!

Mixing it up! Principles of Bowen and Common Ground

One of the most discussed and in some cases controversial aspect of Bowen is the argument as to whether Bowen mixes with other therapies or not. In addition there is the point to which one can change Bowen around to make it something different.

It is important to start with the understanding that The Bowen Technique is a therapy which has a worldwide following and acceptance and is practiced by many thousands of people. We therefore need, I feel, to define what it is that we call Bowen and to at least determine that we are going to keep some kind of shape to that definition, if there is going to be a separate therapy called Bowen in ten years time.

The definition therefore has to come from what we see as the majority view. What is it that the majority of Bowen therapists are doing and how have these people been taught?

The nature of the argument has little or nothing to do with Tom Bowen. It might be that what we are doing bears little or no resemblance to what Tom was doing thirty years ago, and whilst that would be sad it is however not my understanding. Even if it were, the therapy that thousands of people are now calling Bowen needs to be put into some kind of structure that can be identified, irrespective of what was being done a long time ago by one man.

We can call on what certain knowledge that we do have of Tom's modus operandi, coupled with the training content of the largest schools teaching Bowen around the world and come up with something that most of us will recognise and relate to. More importantly will be Joe Public who, when looking for a Bowen treatment, will be able to be relatively safe in the knowledge that what he has researched on the internet as Bowen, is what he is likely to receive when he turns up at the clinic advertising Bowen treatments. If I order a steak in a restaurant and get a plate of carrots I will be rightly aggrieved, even if the chef calls carrots steak and thinks that carrots are better than steak. You can put a saddle on a pig but it doesn't make it a horse

There are four elements which define Bowen very clearly and these are;

- 1) **The move.** Not a flick or a twang, but a rolling type move designed to disturb the skin and underlying tissues. The move is a relatively light pressure and no deep or prolonged pressure is used. If the move is consistently painful for the client, then the therapist is applying Bowen incorrectly.
- 2) **The Stoppers.** Specific areas which use the potential energy of structure, discussed in detail elsewhere.
- 3) **The Breaks.** Short pauses designed to allow the appropriate response to take place within the body. The key element to Bowen, the breaks should be at least two to three minutes.
- 4) **No other hands on treatments.** A point that Tom Bowen was very specific about. "Don't see anyone else" and a theory that has been tested to death over the years by many therapists and clients.

These four elements clearly define what Bowen is and therefore what Bowen is not. Far from being a restrictive and controlling edict it is in fact very liberating, as much by what it doesn't say as what it does.

The first three of these areas are covered in other sections of this book, but it is number four that seems to provoke the most controversy and resistance amongst the mixers out there.

The therapists, and I have met hundreds of them, who tell me that they do 'Bowen' but do it 'differently' or better, is generally one who has learned several therapies and sees good results with most or all of them. The next step therefore is to create a blend of these treatments that get great results and keep the client happy and the therapist busy and feeling that they are giving good value.

I can honestly say that I have absolutely no problem with this. A bit of reflexology, some massage, a few Bowen moves and a chiropractic adjustment. If it works, bring it on and pay the choir.

My simple point however is that it is **not** Bowen. It does not fall within the remit of Bowen, is not recognisable as what thousands of people all over the world are calling Bowen and would not be what a client who had researched the technique, would be expecting when they booked a treatment.

I would never for a moment suggest that someone cannot or should not mix Bowen with whatever they please, but simply that when they do so, they should respect the therapy, the other people using the therapy and the client who is paying for the treatment, by being

clear about what it is that they are really doing. Otherwise it's both misleading and a little dishonest.

Bowen mixed with anything other physical therapy, however effective, useful or inspired is just not Bowen. It doesn't make it any less valid, simply that it steps away from the definition of what is very widely accepted as The Bowen Technique.

That said there are many theories, applications and approaches that encompass the understanding of the technique and create an ability to be incredibly varied and creative in one's application.

For instance I might have studied acupuncture, kiniesiology and Bowen. I muscle test for an imbalance in a meridian, then find a specific acupuncture point and apply a Bowen move in the area to release this. Am I mixing and stepping outside the definition of Bowen? Well if we check the rules, I have applied a move after the stoppers, put a break in and not done any other physical therapy, so the answer is no, it's still Bowen, just with some diagnostic and assessment elements.

THE BOWEN MOVE

The Bowen move is what defines the technique and is made up of three parts.

- 1) Skin Slack
- 2) Pressure
- 3) The rolling type move

Skin Slack

The skin slack is what we use in order to make the move itself and in this respect it works for us. The spare skin covering the tissue that we are trying to move, can also work against us as well, as it can create a barrier to the completion of the move. In order to get at the muscle, we need to pull (or push) the skin in the opposite direction to the move, before effectively 'riding' it over the tendon ligament or muscle which is the target of our move.

When we make the move we must ensure that we don't slide over the surface of the skin. If we imagine that our fingers are glued to the skin then we can imagine that when we get to the limit of the skin, we are stopped, before any sliding can occur.

The pressure that we need in order to move the skin around is very slight, much less than the pressure used to make the move. The other factor to remember about skin slack is the variability factor of skin availability. In addition the tissues that are adhered to the underside of the skin, referred to as 'superficial fascia' or adipose, will vary greatly in thickness and texture. Whenever we move the skin, we also move this underlying tissue as well.

In some people and in certain areas of the body, there will be lots of skin available to move around, possibly even too much! The average amount will be what can be found on the back of the hand and yet with some clients the amount of skin available will be that which can be found on the palm.

This variability will inevitably affect the quality and content of the move, but it is important that the pressure is not increased simply due to lack of skin slack.

Skin slack also has implications for observation, as the skin is the largest organ of the body and is the end point for all the other

organs of the body. In the case of the kidneys it is the regulation co-ordinator for temperature and general conditions outside. It responds to the Autonomic nervous system and can be measured to test the function and effectiveness of a huge number of systems of the body. In addition it is intimately connected to a major endocrine organ, the adipose layer or superficial fascia.

We can make good use of observations regarding the condition of the skin, its temperature, colour, and elasticity. Does it have blemishes or textures that are noticeable? When we have made the moves, it is often the skin which gives us our first indication of what the response is. Redness or erythema, which is coming from the capillaries in the deeper layers of the skin, can be a sign that significant changes are taking place and that a response might be required.

The skin is a constantly changing structure that begs close observation during treatment and which if we are paying attention will give us great rewards.



Here the skin slack is drawn in the opposite direction to the intended move. Only at the point of the move will the eyeball pressure be applied.

Pressure

The variable pressures used in Bowen have been the subject of much discussion and debate. The idea about what Tom Bowen did or did not do, has had to give way to the weight of clinical application from thousands of Bowen therapists all over the world.

These days Bowen is described and widely accepted as a 'light touch therapy'. Whilst there has been much debate over the years

as to what constitutes light touch, I am going to go out on a limb and say that for the sake of argument, touch refers to a physical touch of the therapist onto the client. At the same time I recognise and freely defer to the energetic field of the human form and accept that the influence of the therapist is more than just stemming from a physical touch. So please, no letters!

The pressure used when making a Bowen move is one which could best be described as confident, without being hard.

The phrase 'eyeball' pressure is sometimes used to describe this pressure, yet if you press onto your eye and then feel the average Bowen move, you will see that generally there is much more pressure used, than that which could be applied to an eye.

Yet the term is a useful one, as it can be used to describe a type of pressure. If you press your eyeball then it will become quickly apparent that any excessive pressure will be painful and damaging. Yet there is a point as you are pressing, at which the pressure is acceptable. The finger pressing and the eye being pressed, communicate that there is a comfortable level that has been reached and that the pressing should now stop. At this level the finger could probably be easily moved around on the skin covering the eye without discomfort.

We can also see that there is much less pressure needed for us simply to take the skin slack and so it emerges that there are two types of pressure required when making a Bowen move. One type of pressure to take the skin slack and another to make the move. It might sound obvious, but it's a difference that is easily missed.

An experience therapist will be constantly aware of the pressure differentiation and be sure not to apply such pressure as to accidentally flick a muscle whilst taking the skin slack.

The pressure used will naturally vary from person to person and from body type to body type. A rugby player's hamstrings and would probably need the application of more pressure than a ballerina. That said, if the rugby player was injured and in a lot of pain, then I would need to reduce the level of pressure so as not to hurt him. Indeed I might even back off to the extent that it would be a feather light touch.

Bowen is ideal for use in very acute conditions specifically because very little pressure is needed for the move to be effective and for the process of repair to be started.

If in doubt about the amount of pressure needed, then follow the principal that applies to virtually everything in Bowen, Less is More.

As well as the actual pressure applied by the fingers or thumbs, heaviness in a move can also come from tension in the hands, arms or shoulders and it's important when performing the moves to ensure that these areas are relaxed. Tension will translate into the hands very easily, resulting in a heavy or hard move.

The concept of pressure is becoming more and more important as we understand the layers of the skin and superficial fascia and their role in a whole body treatment. The superficial fascia, or adipose layer, acts as a protection for the deeper layers and needs to be acknowledged by the therapist if he is to access the deeper structures.

Pressing too hard and too fast, results in this fluffy layer acting as a crash mat, stopping the progression of the force into the body. Some forms of body work and even some 'developed' or 'later' forms of Bowen mistakenly apply much more pressure than is needed or even useful. The result is likely to be painful and potentially damaging, especially in the hands of unskilled and thoughtless practitioners.

It is surprising how much depth one can go to if one is patient, acknowledges each layer and effectively asks permission before going any deeper, stopping and working wherever you happen to be if permission is not granted. It is this intelligence of touch that determines an advanced practitioner, rather than the number of procedures learned or workshops attended. Whilst Bowen is described as a light touch, it would be a mistake to think that depth is not possible. Thinking and listening through the fingers is what is called for in order to detect changes and tensions in the layers we are working through.

The Rolling Type Move

The idea of the actual move is to create a disturbance of the muscle, about which the brain will probably need to take action. The disturbance creates questions that need answers and it is this questioning and response, which happens during the breaks in treatment. The actual response and the way that information is shared throughout the various systems, particularly the influence of deep fascia, is under some consideration right now. New understanding of this deep layer give rise to suggestions that perhaps it is the deeper fascia which is responsible for a lot of muscular communication to the brain and back. Certainly this material is there for a reason. However with a lack of definitive research at this time, we will stay with the muscle brain model. Check back in a few years!

The quality of the move is determined by two elements, speed and pressure. If the move is made too fast and with too much pressure, the result will be a flick or a twang. Try it on your self and see the difference. If we flick the muscle, the chances of causing pain are very high and the body will take action appropriate to the circumstances. Instead of creating a space for asking questions to determine an action, the response will be one closing or defending against the pain and the aim of the Bowen move will be lost.

Again we must remember that the move is only made within the limits of the skin available and sliding must not happen during the move. Defining slide is quite easy. If your thumbs or fingers travel from the point of application, and end in a different place, then you have made a sliding move. The fingers need to be fixed at all times, as if stuck to the surface of the skin.

The skin slack





The move, although gentle, is still very dynamic. It's not really enough for the thumbs to push over the underlying tissue, the hands need to move as well. The whole of the surface of the thumb or finger is making the move and controlling it at the same time.

The action of the move creates an equal and opposite reaction in the muscle. So as we move medially for instance, the muscle which has been challenged, rolls laterally away from the pressure and direction of the move.

The move should be made ideally on the exhalation of the client (and possibly the therapist if there is tension present) and should take around two full seconds to perform, from the beginning of the move to the end of the move.

When the move is completed a slight pause before either moving on to the next move or away from the body is recommended, giving the therapist a moment to take in what has just happened and if needs be to stop.

The move is a little like a swing in tennis or golf, where once the actual hitting has been accomplished the emphasis is on timing the stroke for maximum effect. The Bowen move is an art form in itself and a good move is a pleasure to receive and to perform.

The quality of the move will always be very variable, with the feeling changing from person to person and from different parts of the body. Where we have a client who has a lot of adipose tissue in a certain area, the muscle that we are trying to disturb will naturally be well covered and it won't always be possible to feel much, if anything at all.

In this instance it is important not to try and apply a greater pressure to effect the move, but to work within the confines of what is available, keeping to the gentle pressure and trying to affect a move which will create some degree of disturbance. It can admittedly be very frustrating, but nevertheless is still highly effective, as the body still needs to investigate what is going on in the body. Patience is required here. The superficial fluffy tissues will give way if gently persuaded, but will close up like a clam at high tide if pushed on too hard.

The key to an effective move is practice. It does look very simple, but getting the perfect move can take a long time and timing is crucial.

Direction of Move

It is often asked as to whether the direction of the move being made makes a difference. With the exception of the moves along the erector spinae on page two, I would have to say probably not.

The direction of most of the moves are determined simply by it being the easiest way to go or where it is possible to move.

Similarly the order of some moves are little short of arbitrary and it makes very little difference as to whether I move medially or laterally on a knee as the first move. However as a note to those starting out on learning Bowen, there are points at which it is important to work in a certain sequence and direction so it's as well to learn the work in the order taught before deciding to mess too much with the sequences.

It is said that Bowen moves are generally 'cross fibre' in direction. If we are going to refer solely to muscles, then it is true that a Bowen move rarely moves in the direction of muscular contraction. However the nature of fascia is that it covers muscular structures and travels in every way possible. Hence it is somewhat difficult to limit the movement to being perpendicular to a given muscle.

The Bowen Technique is a difficult creature to pin down, and when one starts to look for consistencies in order to find some definition,

it goes off on a tangent and starts to provide exceptions to any rule directed at it.

Size Matters

It is likely that in this day and age we are going to come across clients who are, if not obese, then at least quite large. Carrying big amounts of adipose tissue, these clients present challenges in terms of how much pressure we should apply.

The analogy I give is that of trying to make a move on the palm of the hand. There is little or no movement and the whole process is frustrating and unsatisfactory. Yet the alternative, applying lots of pressure to try and 'get in' and feel underlying tissues is counter productive. We are more likely to make these clients feel unwell, achy and nauseous by the application of heavy pressure.

Whilst I acknowledge that the treatment may feel less than satisfactory, it's important that the temptation to apply more pressure and go deeper, is resisted. I have discussed the implications of deep pressure in the section relating to superficial fascia, but its a point worth repeating.

A light touch does not exclude depth. By gently dropping through and acknowledging the layers of the body as we go down, we create an explicit permission. At each stage we ask the body if it's okay to keep going, thereby establishing co-operation and unity.

Bowen is considered a light touch therapy and indeed it is. I would however challenge any therapist who considers themselves to have better access to the body because they are a 'deep tissue' therapist to think again.

Simply put, pressing hard does not get you in further. The opposite is more accurate. The harder you press, the more you stay on the surface, thanks mainly to the incredible resilience of the adipose or superficial layer. This light fluffy layer doesn't seem like much, yet has the ability to both store and absorb energy in the form of pressure. If you slip over on the ice and land on your bum, you can thank the superficial fascia for not having a smashed pelvis.

If it can withstand the pressure of many kilograms landing on it, a heavy handed therapist trying to grind their way through it is child's play.

The breaks

There are two types of break in Bowen that we need to address. Firstly is the break which is most noticeable, that of the therapist leaving the room in between sets of moves, for which Bowen is famed.

It has been suggested, somewhat cynically in my opinion, that Tom Bowen only did this in order to be able to treat from two or three rooms. Whilst the ability to conduct multiple treatments is a bonus stemming from the breaks, it is by no means the only one.

There are several theories regarding the reason for the breaks and this book seems the ideal forum in which to explore these.

In the chapter of traditional anatomy, we mentioned the Galenic belief, still held today, that structural movement is mediated by the brain. There are therefore many leaps that we make alongside this belief, one of them being that if sensation is a function of central nervous system and cranial function, then all things related to it must be as well.

So the idea for the breaks is that we are in some way communicating with the brain on a more subconscious level. The breaks give the body the time to communicate with the brain using what I have termed A.R.M., the Appropriate Response Mechanism.

You Need Arms

Indeed we rely on ARMs on a moment-to-moment basis throughout the day and use them to feel and appear normal. If you are walking down the street and someone in a car toots their horn at you and waves, your immediate (and appropriate) response is to wave back, maybe even smiling. You may even do this without having a clue as to who the person was in the car such is the conditioned response.

You are at an event or a function, and someone walks up to you with his or her hand outstretched, you shake it. Appropriate response. If however I walked up to you without ever having met you before, my arms open for a big hug, your appropriate response would probably be to avoid that hug at all costs and protect yourself. An appropriate response to an inappropriate action.

We do this kind of judging all the time, questioning the information that arrives into the brain and working out how it should be responded to. The older we get and the more experience we have, the more these situations are easily recognizable and dealt with.

When we were four, we may well have hugged the other four year old we didn't know, simply because we hugged everyone. As we get older sadly this approach has its drawbacks and we learn to moderate our behaviour.

Over time we build up a memory bank of what is appropriate and when, modifying it as required. Slowly the hot headed youth, impatient for change, learns to adapt what they consider to be appropriate.

In a Bowen situation something similar happens. A series of moves are followed by a break, during which time the practitioner leaves the room. This break should be in the region of two minutes as a minimum, longer in other situations.

It is this break, which seems to actually create the effectiveness of the work and allow such a limited amount of work to be effective. Once the hands are off the body and the therapist out of the room, the brain and body can begin a dialogue.

Brain; "what was that?"

Body: Not sure, never experienced anything like that.

Brain: OK let's check this out. Was it a stroke sort of feeling? Body: No

Brain: A massage?

Body: Definitely not.

Brain: Did it tickle?

Body: Of course not, I'd have told you if it did.

Brain: OK don't snap. Did it hurt?

Body: No not really, in fact not at all

Brain: Right answer. So err was it erotic?

Body: No! So embarrassing.

Brain: OK I'm stuck here as to how to respond.

Body: Well do you have to respond at all?

Brain: Are you mad? Of course I have to respond. *Something* has happened. Someone put their hands on you and DONE something. I can hardly let that go now can I?

Body: 'Spose not.

Brain: Right, you stay there, I'll send out some other signals, find out what's related and what else has been done and get back to you. I'll whack down some nerve ending blood while we're waiting, just to see if anything more informative comes back. You are very trying did you know that?

Body: OK sorreee, jeez.

Well that's how it happens in my mind. Clients then tend to fall asleep, which isn't really sleep or deep sleep, but is a shutting down

of the primary motor cortex in order for other information to be exchanged.

Common responses will be an increase in blood to the skin, erythema, but also interestingly enough, other untreated areas can also 'pink up'. Invariably the client will start to relax deeply and may well fall into what appears to be quite a sound sleep.

In fact this is more likely to be a parasympathetic nervous system response with the client able to respond readily if needs be. It takes some time to drop into deep sleep, with the body carrying out a series of checks to ensure it is safe to do so. Am I warm enough or safe enough? Am I hungry or needing to go to the toilet? It's like when we fall asleep on the train or on a bus. Although the sleep is there, we can readily respond when it's time to get off, or if someone talks to us.

Short periods of this napping type of sleep are very refreshing and creative and the 'power nap' as it has become known, is one of the better things you can do for yourself during the day. (Hayashi, Motoyoshi et al. 2005)

This sleep is also more possible if the therapist leaves the room, allowing the system to really take stock and work out what has just happened when the tissues were disturbed by the rolling type Bowen move.

I therefore find that two things are useful. Firstly that the break immediately after the first moves is slightly longer than the proscribed two minutes and that secondly I ensure the client has their eyes loosely closed.

It is very hard for the body to move towards a parasympathetic state if the eyes are open. There is a good reason why meditation is done with the eyes closed or mostly closed. The client who sits up on their arms, eyes open and looking around the room, is likely to have less of a response than the more relaxed one. A lot of this is about conditions and the right environment in which to treat, but I would suggest that even in the most chaotic situations, a client with their eyes closed has a very good chance of dropping off with the application of the first moves.

The breaks, as well as starting the brain-body dialogue, also has an effect on the tension of the connective tissue, in particular the fascia. Fascia is made up of a triple helix type structure, wound into tension and held all over the body. A spiral, crossing over and under other spiraling structures. The more tension that is present,

either through injury or other stressors, emotional included, the more energy is present in these tightly wound, spring like structures.

Like a jack in the box, little pressure or movement is required to release this, although the case of the spiral fascia, the release is generally a little less dramatic although not always so. The unwinding of this fascia can happen very slowly, over a period of days or even weeks. In some instances it can happen as the client lies on the couch and spontaneous twisting and involuntary movement of limbs have been recorded.

Research into the effects of The Bowen Technique on hamstring flexibility, showed both an immediate increase in flexibility straight after the treatment. (Marr, Baker et al. 2011) This change in flexibility not only held in all the treated cases, but in some, the increase continued over seven days. This is a very unique result for a passive treatment, and suggests that a continuing change is prompted by the Bowen move. Another good reason to leave well alone and not mix in other treatments during the break between treatments.

Five to ten days seems to be the optimum time between treatments. In some instances, clients will benefit from breaks of three weeks, often changing dramatically in that time without even noticing the changes! I am often telling students that the most common response from a client will be "Well I don't think it's anything to do with what you did, but I do feel so much better". The insignificance of what little work the therapist did, compared to the degree of changes experience to the client, just don't add up.

In many instances the client will have forgotten what the original problem was or the severity of it. This is a good reason to take structured notes and records, something we will deal with in another chapter.

When we first start learning Bowen, the breaks are given and written down as to where and when. However as we start to progress and develop an intuitive feel for the people we are working on, we can start to put breaks in the treatment in wherever it feels right. If you find yourself asking the question, "what shall I do next?", then the answer is probably, "do nothing, get your hands off and get out of the room"

Learning to take your hands off and put a break when you find yourself over working, is probably one of the greatest skills you can learn and in my opinion defines you as an advanced Bowen

therapist much more than any extra moves you might have learned on a course.

Treatment Spaces

It is generally accepted by those who have been practicing Bowen for any length of time, that the client and therapist will see some degree of changes within the space of three or four treatments on average.

This is however a claim which needs to be qualified and built on. And will still is not unusual in acute situations to find that there is a rapid response to treatment, there are certain circumstances where extended treatment is going to be needed.

If a client is presenting with back pains that have been present for many years, it is going to be fairly evident that a change in their functional behaviour has taken place. Whilst Bowen is going to be a very effective tool in addressing pain levels, we need to bear in mind that other factors such as changing muscle tone, ability to move normally, and strength, or needs to be addressed. It is possible that other professionals might need to be consulted if the individual bard therapist does not have the required skills in these departments.

I have always maintained that skilled referral, the ability for any individual to realise and accept their own limitations, and to find and surround themselves with those that are qualified and equipped, is a skill as well as a demonstration of humility.

Patience is a required skill when looking for changes. Pain is only one indicator and we need to be skillful in our observation and our ability to read the body. It once again effective and detailed note taking is required, as often the only way we can demonstrate change is to refer to notes taken from previous sessions.

Asking clients to return for treatment is also something that is of potential great benefit. A client who has had relief from aches and pains, can hardly be expected to stay the same for weeks and weeks, once their normal routine has been resumed.

I therefore advise clients to return every 6 to 8 weeks for pop-up treatments topped up treatments top up treatments, which helped them to both maintain their improvements, but also prevent the return of any injuries. This is particularly useful when dealing with sports people, who are prone to injury and loss of training time.

I believe firmly that Bowen is a particularly effective treatment for long-term sports injury prevention. Athletes being treated with Bowen report remarkable responses in terms of not being injured, as well as speedy recovery when any minor injuries occur.

Other areas where more frequent treatment might be indicated or useful, is in palliative care. The main concern in these instances is to keep the client comfortable, as well as attempts to manage pain and reduce reliance on medication where possible.

Pregnancy is another situation where more frequent treatment is possible and also very useful. A woman experiencing back pain particularly in the final trimester of pregnancy, can return for simple sake from treatments on a daily basis if needs be.

Beware the List

Something I have shied away from over the years, and to this day still do, is the making of lists of procedures to address certain problems.

I accept that this approach might at some stage seem useful, but to my mind it completely misses the point of what we are trying to achieve. The law of natural cure states that the body be treated as a whole without referral to named disease. Whilst specific issue or problems might be a starting point from which to investigate, no two people are going to be the same.

A list of procedures for specific problems creates the same reductionist approach which has plagued medicine since time immemorial. It's the reason why we have people with back pain, who get treated over and over again for back pain and nothing else. Logic should tell us to back away and find out what else is going on, but the blinkered idea that pain comes from the place that it is being experienced limits this thinking. Why then would we want to approach a holistic system of treatment from the same skewed perspective?

The four rules of all complementary therapy should be;

- We do not diagnose
- We do not treat specific conditions
- We do not alter or prescribe medications unless qualified to do so
- We do not make claims regarding the, benefit, efficacy or outcomes of our treatment unless scientifically proven.

Someone presenting with whiplash will have whole history of other issues and a life that has brought them to this point. It might be that we will use a reasonably standard set of approaches, but it's easy to miss things.

Someone recently told me of someone they treated with an ankle procedure. Their weekly migraines of over fifteen years vanished. Could this be explained anatomically? Absolutely, although I'm not going to try and start here.

Does this mean that an ankle procedure is something that we should do for migraines? Possibly is the answer. A list is a dangerous thing when it comes to treating people rather than conditions and should be run away from wherever possible.

The temptation to use the list and become prescriptive is there. Instead, start to think outside the box and look for what's not obvious, especially when things aren't changing the way you think they usually do.