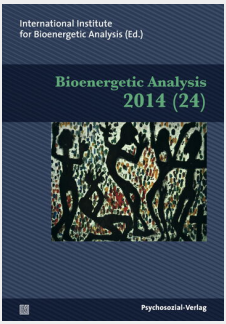
Helen Resneck-Sannes

From Pain and Anxiety to Pleasure



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Helen Resneck-Sannes

Abstracts

English

Two definitions of chronic pain are presented and their effects on sufferers are described. One definition is of pain that is persistent even after the original insult is gone. How this type of pain affects the brain is discussed and its relationship to anxiety, post traumatic stress and other psychiatric disorders is explicated. Factors that modulate the experience of pain are presented as well as a specific somatic exercise for relieving pain.

Key words: definitions of chronic pain, prevalence, neurological processes, anxiety and PTSD, modulating pain, bioenergetic exercise for pain

Von Schmerz und Angst zu Freude (German)

Zwei Definitionen von chronischem Schmerz werden dargestellt und ihre Auswirkungen auf die Leidtragenden. Eine Definition betrifft einen Schmerz, der andauert, selbst wenn die ursprüngliche Verletzung vorbei ist. Wie diese Art Schmerz das Gehirn beeinflusst, wird diskutiert, und ihre Verbindung zu Angst, Posttraumatischem Stress und anderen psychiatrischen Störungen wird erläutert. Faktoren, die das Empfinden von Schmerz verändern, werden aufgezeigt, sowie eine besondere körperliche Übung, um den Schmerz zu lindern.

Questions de douleur (French)

Cet article présente deux formes de douleur chronique et décrit les effets de celles-ci sur les personnes qui en souffrent. L'une d'elle est celle de la douleur qui persiste après une atteinte (trauma, blessure, opération etc ...) d'origine. L'article développe ce que ce type de douleur produit sur le cerveau, et explique les liens de celle-ci avec l'anxiété, les troubles post-traumatiques et d'autres problèmes psychiatriques.

Il présente aussi les facteurs qui peuvent avoir une influence sur l'expérience de la douleur, ainsi que des exercices corporels spécifiques qui peuvent soulager cette douleur.

Dolor (Spanish)

Se presentan dos definiciones del dolor crónico y se describen sus efectos en los pacientes. Una definición del dolor se plantea como persistente incluso después de que el insulto original haya desaparecido. Explica cómo este tipo de dolor afecta al cerebro, así como su relación con la ansiedad, estrés postraumático y otros trastornos psiquiátricos. También se plantean los factores que modulan la experiencia del dolor, así como un ejercicio somático específico para aliviarlo.

Il dolore (Italian)

Sono presentate due definizioni di dolore cronico e descritti i suoi effetti sui malati. Una definizione riguarda il dolore che persiste anche dopo che l'insulto originale è passato. È discusso come questo tipo di dolore colpisca il cervello e viene spiegata la sua relazione con l'ansia, lo stress post traumatico e altri disturbi psichiatrici. Vengono presentati dei fattori che modulano l'esperienza del dolore e un esercizio corporeo specifico per alleviarlo.

Dor (Portuguese)

Duas definições de dor crônica são apresentadas. Uma definição é da dor que persiste mesmo depois que a causa original deixa de existir. Discute-se como este tipo de dor afeta o cérebro, e sua relação com ansiedade, stress pós traumático e outras desordens psiquiátricas é explicada. Fatores que modulam a experiência de dor são apresentados, assim como um exercício somático específico para aliviar a dor.

Chronic Pain: An Epidemic

Serious, chronic pain affects at least 116 million Americans each year, and many of them are inadequately treated by the health-care system, according to a new report by the Institute of Medicine. American Academy of Pain Medicine reports that more than 1.5 billion people worldwide suffer from chronic pain and that approximately 3–4.5% of the global population suffers from neuropathic pain, with incidence rate increasing in complementary to age. (Global Industry Analysts Inc. Report, 2011) Pain affects more Americans than diabetes, heart disease and cancer combined. The chart below depicts the number of chronic pain sufferers compared to other major health conditions.

Condition	Number of Sufferers	Source
Chronic Pain	100 million Americans	Institute of Medicine of The National Academies (2011)
Diabetes	25.8 million Americans (diagnosed and estimated undiagnosed)	American Diabetes Association (2011)
Coronary Heart Disease (heart attack and chestpain) Stroke	16.3 million Americans 7.0 million Americans	American Heart Association (2011)
Cancer	11.9 million Americans	American Cancer Society (2006)

Report from the American Academy of Pain Medicine (2013)

That said, I would like to explain to you my interest in this topic. It was generated after a recent visit to my spinal surgeon. As I checked in, I was greeted with: "It has been a long time since we have seen you." I replied: "It seems much too soon to me." Four years ago I had a one level fusion for a condition called spondylisthesis. This is a genetic condition characterized by having a small area for the spinal cord. As we age, we tend to have bone build up along the spinal canal, which pushes the discs out against the nerves. To make more room for the spinal cord, a portion of the vertebral bone called the laminais removed. However, without the extra support the spine can become unstable and fall against itself blocking the exit for the nerves, spondylisthesis. I am the seventh person in my family on my father's side to have been diagnosed with this condition, and the sixth person to have surgery. Only my younger brother has escaped needing surgery. The difference I have been told is that he doesn't have a job that requires sitting. I waited for three years after the laminectomy, which was

unsuccessful to have a second surgery, which was a fusion. The first one had left me unable to walk and with scar tissue, which tethered my spinal cord at the base of my spine. With a series of spinal epidurals and working with myself, I was able to resume life, although restricted. I had 13 epidurals, many more than is recommended; and after three years had reached the point where I couldn't sit, walk, stand, and lying in bed was producing even more pain. Before the second surgery, I was told I had a 25% chance of being better or worse, but I decided to go ahead and have the second surgery, as I had nothing more to lose. All I wanted was to be able to drive to a restaurant and meet a friend for lunch or dinner. I came out of that surgery with chronic pain but could go on 12 mile hikes up and down mountains, stand, shop, and go out to dinner. Sitting was still iffy and many times I was told I should think about retiring. But I found a good chair for my office, and after two years of healing from the second surgery, I felt pretty good. Then, about six months ago I began to have sharp back pain with walking. Back pain has been a chronic ache, since the first surgery, but most of the pain has been from the spine landing on a nerve and sending pain down my leg. Now, I was not only having trouble with lying down and sitting, but walking was becoming painful again. I had been told that I would probably need more surgery, but I was hoping to avoid it as long as possible.

This time when filling out the pain questionnaire that one always fills out when checking in with a spinal facility, I became aware that I had more pain than many of my chronic pain patients. I began to wonder what causes people to respond to pain differently?

So, I decided to come out of the closet and give a workshop on chronic pain, which has resulted in me writing this paper. "Coming out" is a term borrowed from the sexual orientation movement. I saw myself in a similar place as first I had to admit to myself, the degree and breadth of my pain and how much it was inhibiting my life. I also am aware that by admitting my pain it increases the awareness of my disability, which as we will see later increases the perception of pain. Also, by talking about my pain I am exposing myself as a chronic pain person; and thus am risking receiving hurtful comments from people, which believe me happens a great deal to be people in pain. But, by taking this risk, I am hoping that the information presented here is helpful to both you and your clients dealing with pain.

Pain and Sleep

Patients suffering from chronic pain often find that their problems are compounded by the additional difficulties that come with insomnia and sleeping disorders. Of

those who report experiencing chronic pain (about 15% of the general U.S. population and 50% of the elderly), approximately 65% report having sleep disorders, such as disrupted or non-restorative sleep. (Lavigne and Choiniere, 2007)

In a recent study, it was found that approximately two-thirds of patients with chronic back pain suffered from sleep disorders. Research has demonstrated that disrupted sleep will, in turn, exacerbate the chronic back pain problem. Thus, a vicious cycle develops in which the back pain disrupts one's sleep, and difficulty sleeping makes the pain worse, which in turn makes sleeping more difficult. (Deardorff, 2006)

One continual comment I hear from people is that I need to sit down and rest. However, the most common condition which will cause me to what I term as hitting the wall" with my pain and need to start taking drugs are the following: I am sitting too long because I am enjoying the social time and don't want to have to stop the dinner party and the good time by leaving. Then, at night when I lie down, the nerve that has been compromised by sitting is further exacerbated by lying in a position that irritates it, which for me may be as simple as lying on my side. My calf muscle seizes, waking me from sleep. I need to get up and begin walking. If it is after 5:00 am, I go to the gym and get on an elliptical trainer and can get myself out of pain. Sometimes, I walk the halls, waiting to see if it will subside. But there are times, when the pain has been disturbing my sleep for several days, and I am so tired that I just want to lie down and rest, but lying down or sitting triggers more pain. Finally, I give in and take drugs and rest. Then, after lying around all day, I am gratefully nudged by husband to get up, get out of my pajamas and start moving again. As the acute pain subsides, I am filled with relief and gratitude that I can resume my life. So, as you can see although rest is needed, lying down and sitting can exacerbate the condition.

And pain is the imperious third party who dictates the terms of our relationships. I have lost three close friends and often find myself isolated. I can't sit, so it is at a cost for me to go out to a lengthy dinner, or a long play, or a movie, or to drive to visit a friend 21/2 hours away. In successful marital relationships most issues have to be able to be negotiated. I really didn't have many demands on my partner about how or where we spent our leisure time. Now, my back issues dictate how much we do physically and how we are able to travel. I have worked with many clients and the healthy partner accuses the one who is suffering from pain of being too controlling and self-centered. I have been able from my own experience to explain how controlled the partner herself feels by her own physical limitations. She too misses the spontaneous physical and easy connections and is grieving the loss. One of my clients was lamenting that he could no longer go off hiking or on lengthy raft trips. He knows that I was an avid athlete, back packer, and traveled to distant and primitive regions of the world. I answered that I too miss those things especially being way back in the

heights of the Sierra mountains, but I'm glad I did all I could when I could. If I had waited, I never would have had those experiences.

Definitions of Chronic Pain

One definition of chronic pain is that it is pain that lingers even after the original assault is no longer present. Another definition of chronic pain is that it is pain that is ongoing. It's nature is to wax and wane, so that sometimes it is so intense that it interferes with and even prevents activities of daily living: sleeping, sitting, preparing food, and walking. Other times it is a low hum, like a steady ache that can be tuned out especially with an interesting distraction; and with much gratitude, there are times when it is not present at all.

In trying to understand the first definition of pain, that it is pain that lingers even after the original assault is no longer present, scientists have found that the perception of pain involves far more than mere sensation. The affective and evaluative components of pain are often as important as the production and transmission of the pain signal. Brain scan studies show for the first time how chronic pain emerges as a result of an emotional response to an injury.

Apakarian (2013) says: "The injury itself is not enough to explain the ongoing pain. It has to do with the injury combined with the state of the brain." The emotional state of the brain can explain why different individuals do not respond the same way to similar injuries. Some recover fully while others remain in constant pain. Emotions may determine why some people are more likely to suffer chronic pain than others.

And other researchers, Hansen and Streltzer (2005) have found, emotional aspects are most prominent in chronic pain patients. It is no surprise then that insecure attachment leads to a higher level of anxiety and therefore a greater response to pain signals. (Meredith, Ownsworth and Strong, 2007) Overall, some psychiatric morbidity is present in up to 67% of chronic pain patients. (Scarry, 1985) Personality disorders have been found in 31% to 59% of chronic pain patients. (Charmaz, 1983)

Apakarian views pain as merely a signal in the body until it reaches the emotional brain, where brain scan studies have shown for the first time how chronic pain emerges as a result of an emotional response to an injury. Pain is registered in the body mind and handled in the same way as emotion, both of which result in elevated activity in the insula, a structure found deep inside the brain. The limbic system, where emotions are processed, modulates the amount of pain experienced for a given noxious stimulus. The emotional response to pain involves two areas of the brain within the limbic system anterior cingulate gyrus and the right ventral prefrontal cortex. These two areas respond

to both to social rejection and physical pain. (Eisenberg and Lieberman, 2004) Once a pain signal is received in these two areas of brain, two other regions of the brain begin to interact: the insula and the nucleus accumbens. If the insula, a structure deep within in the brain is emotionally reactive, then the pain signal is transmitted throughout the brain. The nucleus accumbens teaches the rest of the brain how to evaluate and react to the outside world. It evaluates the signal and registers it as pain. As Apakarian says: "it may use the initial pain signal to teach other parts of the brain to develop chronic pain".

Apkarian and colleagues recruited 39 people with clinically diagnosed subacute or moderate back pain that was persistent and had begun 1 to 4 months earlier. None had a previous history of back pain. The participants underwent assessment at the start of the study and at three more visits over the following year. During these assessments the researchers took fMRI scans of their brains and asked them to rate the level of their pain. By the end of the 12 months, 20 of the participants had recovered, and 19 continued to experience pain, thus meeting the definition of chronic pain. Apkarian and colleagues said there was a much higher level of cross-talk between the insula and the nucleus accumbens brain regions in the participants whose back pain persisted compared to those whose pain subsided. And they could see that this increased communication between the two brain regions was present right at the start of the study. When they did the analysis, they found these early scans had an 85% accuracy in predicting which participants would still be in pain by the end of the 12 months. They suggest that the more emotionally the brain reacts to the initial injury, the greater the chance of the pain becoming chronic.

The nucleus accumbens helps teach the rest of the brain how to evaluate and react to the outside world, said Apkarian, so it could be that it uses the pain signal to teach the rest of the brain to develop chronic pain.

Apakarian has tracked the effects of chronic pain and it's long term effect on the emotional and cognitive processing of the brain, and he sees it as a neurodegenerative disease. He and his colleagues also observed that the brains of the participants who went on to develop chronic pain lost gray matter density, which indicates loss of parts of the brain that are important for communication between brain cells, such as synapses that link brain cells, brain cells themselves and glial cells, that support brain cells. In other words, chronic pain degenerates the brain. So, even though the original pain-causing event is no longer present, the brain is reacting as if it is still there.

The areas of the brain reacting to chronic pain are the same areas activated in PTSD. Like sufferers of trauma, the original fear inducing event is gone but the body/mind is responding as if it is still present. The set point of arousal for people suffering from chronic pain and PTSD is very sensitive. Pain sufferers and people suffering from anxiety disorders are reactive to slight variations in emotional arousing events.

Researchers, Chialvo, Baliki, Geha, and Apkarian (2008) have found that in a healthy brain all the regions exist in a state of equilibrium. When one region is active, the others quiet down. But in people with chronic pain, a front region of the cortex mostly associated with emotion never shuts up. The areas that are affected fail to deactivate when they should. They are stuck on full throttle, wearing out neurons and altering their connections to each other.

He also found brain disturbances in chronic pain patients not directly related to the sensation of pain. Chialvo and colleagues used functional magnetic resonance imaging (fMRI) to scan the brains of people with chronic low back pain and a group of pain-free volunteers while both groups were tracking a moving bar on a computer screen. The study showed the pain sufferers performed the task well but at the expense of using their brain differently than the pain-free group. Chialvo (2008) says: When certain parts of the cortex are activated in the pain-free group, some others are deactivated, maintaining a cooperative equilibrium between the regions. This equilibrium also is known as the resting state network of the brain. In the chronic pain group, however, one of the nodes of this network did not quiet down as it did in the pain-free subjects.

This constant firing of neurons in these regions of the brain could cause permanent damage. Chialvo hypothesizes that when neurons fire too much they may change their connections with other neurons and or even die because they can't sustain high activity for so long. If you are a chronic pain patient, you have pain 24 hours a day, seven days a week, every minute of your life. That permanent perception of pain in your brain makes these areas in your brain continuously active. This continuous dysfunction in the equilibrium of the brain can change the wiring forever and could hurt the brain.

Chialvo speculates the subsequent changes in wiring may make it harder for you to make a decision or be in a good mood to get up in the morning. It could be that pain produces depression and the other reported abnormalities because it disturbs the balance of the brain as a whole. It is essential to study new approaches to treat patients not just to control their pain but also to evaluate and prevent the dysfunction that may be generated in the brain by the chronic pain.

Ways to Modulate Pain

So, what about people like myself who do suffer from ongoing chronic pain, have a known physical cause, but don't identify themselves as pain sufferers. It has been told to me several times by surgeons who have read my MRI that the degree of my disability doesn't predict my capacity to function so well in daily life. And after both surgeries my stay in the hospital was half the expected time and I was told that I re-

quired much less pain medication. So, I became interested in what I was doing that was different. By examining the literature and reviewing my own techniques I am hoping that what I have found might be helpful to others.

However, and this is very important: I do not want to minimize the amount of pain my chronic pain patients experience. Also, when my clients have a documented psychiatric history of anxiety and depression, their medical providers have sometimes either denied or minimized that their pain may be due to an underlying medical issue. Until I had my own experience with nerve pain, I too may have not really heard them and discounted the degree of their suffering and the truth of their medical concerns. Also, the comments by other people in response to people living with ongoing pain are often so insensitive that they border on the inane; and at other times are outright cruel.

One client, who manages pain everyday suffers from severe scoliosis. She has a traumatic history and I know by looking at her back, she must experience a great deal of chronic pain. She rarely complains about it other than not being able to lie on her back for long times and needing to turn on her side. I have a friend with lupus who during her flares has quite a bit of joint pain. She mentions it but rarely complains. I decide to ask myself what do we all have in common that differs from my chronic pain patients. The most obvious answer is that we are very much involved in life, and distraction is one of the best ways to handle chronic pain. Focusing one's attention on pain makes the pain worse. (Eccleston, 1995) Patients who have somatic preoccupation or hypochondriasis are overvigilant about bodily sensations. It has been found that by attending to these sensations, they amplify them to the point of feeling painful. (McCracken, 1997)

Conversely, distracting patients is highly effective in reducing their pain. Cognitive distraction where attention is directed from the right brain (pain) to the left brain also helps modulate pain. Burn patients undergoing treatments or physical therapy experience excruciating pain, even after they have been given opioids. It has been shown that these patients report only a fraction of this pain if they are distracted with a virtual-reality type of video game during the procedure. (Hoffman, Patterson and Carrougher, 2000) I wonder if using the left brain for distraction would be as effective for people suffering from head pain, as It is very difficult to focus on anything when pain emanates from the head.

The response to pain also results in guarding and immobility. This learned response to chronic pain increases muscular tension and prevents healing from occurring to the injured areas. Robert Scaer is an orthopedist and was also a student of Peter Levine. He has documented that ongoing pain after a trauma, with no physical findings is a result of the way trauma has been stored in the body. (Scaer, 2001) The body stays in a holding pattern as a result of the trauma. Releasing the holding patterns, cannot only relieve chronic physical pain, but often can remove it completely.

I was working with a client once and when she was grounding, I noticed a twist in her upper body. She didn't present as a schizoid character, so the twist didn't match her history. I questioned her regarding any accidents. At first she denied any and then remembered a ski accident she incurred four years, previously. Her shoulder had been injured and she had been using massage, chiropractic adjustments, and acupuncture, which would relieve the pain only to have it return again. After three sessions working with the holding pattern her shoulder was pain free.

Also the same structures in the brain that evaluate whether the input from the outside world is safe are the same structures that are activated in changing our set point for trauma. People with PTSD and generalized anxiety disorders are very much like clients predisposed to chronic pain. Their system is reactive to slight nuances and the goal of good trauma therapy is to calm the system down. Techniques that work with regulating trauma should therefore also be good for modulating chronic pain. My client and my friend have all worked with me in learning bioenergetics and the somatic regulation of trauma, somatic experiencing.

And, another factor that my client, my friend, and I all have in common is that we are attentive to our body and it's signals, not just the signals from pain. So, the pain is a signal that at time requires our attention but the rest of our body/mind can be engaged in more interesting activities, like writing this paper and being with good friends.

As an aside, when I told the other my client and my friend about this topic and how I saw their ability to manage pain as different from some others, they both spontaneously mentioned a friend who was constantly reacting to every nuance of pain signal in their body with alarm. I asked how their friends reacted to other aspects of their life. The answer was that they were also blown down by every slight challenge. They reacted emotionally the same way they react to pain. I have an 82-year-old client who admits any little glitch in her life causes her to be anxious and depressed. When she began having back pain and difficulty sleeping, she admitted to me that she does not have much tolerance for pain. However, I encouraged her to get an MRI and she does have significant osteoarthritis in her back and epidurals have helped eliminate her pain, at least for a time.

Now, I would like to discuss techniques of working with the body to manage pain. For me I found several things to be very helpful, and when researching this topic, I found out that my experience did agree with the science.

Most helpful, I found was an awareness of my body, both where I could find the limitations of movement and where I could return to find pleasure. When in pain, one may try to first avoid tuning in to their body at all. And left brain distraction techniques like video games do help people reduce their pain. Also, it has been found that people who listened to music for an hour every day for a week reported improved

physical and psychological symptoms compared to a control group. (Knox, Beveridge, Mitchell, and MacDonald, 2011) The participants, who had an average age of 50 were recruited from pain and chiropractic clinics and had been suffering from a range of painful conditions, including osteoarthritis, disc problems and rheumatoid arthritis for an average of six and a half years. Their ratings on pain scales were rarely under six and their worst pain exceeded nine out of ten. The music groups reported that their pain had fallen by between 12 and 21 per cent, when measured by two different pain measurement scales. The control group reported that pain increased by between one and two per cent.

- People in the music groups reported 19 to 25 per cent less depression than the control group.
- The music groups reported feeling nine to 18 per cent less disabled than those who hadn't listened to music and said they had between five and eight per cent more power over their pain than the control group.

> "Our results show that listening to music had a statistically significant effect on the two experimental groups, reducing pain, depression and disability and increasing feelings of power." (Knox et al., 2011)

Siedecki and Good (2006) state that because the experience of pain is partially subjective, altering a person's perception of their pain can change their experience of that pain. Music may disrupt the brain's "pain – stress – pain" feedback loop and in doing so alter an individual's sensitivity to pain. How might this work? We know that music effects evolutionarily old subcortical areas of the brain, thereby influencing many different psychological and physiological states. Music modulates the brain's limbic system, triggering numerous accompanying neurochemical effects. The result of these changes in the brain may be to help distract listeners from negative feelings and modify the influence of past memories associated with pain. As a further result, music may promote relaxation by inhibiting the release of stress hormones and weakening arousal of the pituitary-adrenal stress axis. The brain's opioid system may also play a role. (Renn and Dorsey, 2005). Music that listeners find emotionally engaging seems to affect the brain's opioid system, and opioids control both physical pain and the pain of social loss. (Bicknell, Bernatzk, Presch, Anderson, & Panksepp, 2011)

Recently, I attended an event where numerous dancers spoke about their experiences of teaching dance in Santa Cruz over the years. As they spoke, I remember that when in emotional distress, I would say: "When the going gets rough, I take a dance class." So, it comes as no surprise that I would find a way to heal myself through music

and movement. After the first surgery, my ability to move without pain was limited, so I couldn't enroll in a class and follow someone else's steps. Dance classes are great, because like video games, they occupy the part of the mind that also processes pain. But I am talking about something more, about finding the place in the body that isn't in pain and being with it. After that first surgery that made even walking difficult, I would lie down in the grounded position, flat on my back and knees bent, watching the pain dissipate. As I found myself sinking into a state of relaxation, I then could find ways to move, to slowly rise up from the floor, to putting one leg slowly forward to the point of the limitation of where the pain would begin again.

I began playing music ... different kinds of music. There was music that would take me into deep emotional experiences of the heart and then there was music that came into my pelvis, and beckoned me to the joy of movement through dance. From dancing, where all movement extends from a stable core, I could begin to extend my leg to a walking position. Walking was limited and painful, but I could dance. When I speak of dance, I'm not talking about learning a series of pre-ordained steps. I'm talking about finding the dance from what emerges in you as the right movement. When injured and in pain, it is very important that the movement arises from one's internal sense of how to extend and engage. Without my training from bioenergetics, I would not have known that pleasure in the body comes from doing little but breathing and gently exploring movement. Many of us live to dance, but I learned that it is possible to also dance to live.

Exercise

Lie down on the floor on your back, legs bent, feet flat on the floor. You may find yourself listening to the music or not. You may go to sleep. That is fine. If an emotion arises, let yourself have as complete an experience of it as you are comfortable with. Holding back feeling creates tension. The goal is to let go of muscle tightness. Also, when you are deep in feeling, the parts of the brain that manage pain are processing other material and you can find relief from your pain. That said, let your body become heavy and sink into the floor. Inhale and then let go of a long slow exhale. Now, let a sound come with exhale, like a soft sigh, but don't push the out breath. Again, with each inhale and exhale cycle, let your body sink more deeply into the floor. Let all your thoughts of what happened before this minute and what will follow slowly recede.

Briefly perform a body scan, but with a curious compassionate mind. Be interested in what you find, but without judgment. We all have areas of tension and relaxation,

so just notice yours. You are where you are and that is all you can be right now. Notice the areas of tightness and tension and direct your focus to only one area. Then slowly redirect your attention to your breath and with each out breath gently press your feet into the floor. (Do this several times.)

Next perform a body scan noticing places that feel the most relaxed and the most comfortable. Let the music get your attention, and as you exhale let go of judgment worry or the need to know.

With each outbreath feel yourself sinking into the floor. Direct your attention again to one area, which is the most relaxed or the least tense and allow your full attention to be there.

Now go back to the area of tension. If it is still there find a sensation word: hot, cold, sharp. Find an image: like a tight fist, a knot.

Go back to the area of relaxation and find a sensation word to describe it, i. e. "soft", "warm" ...

Next, if you can find an image for the relaxed part, i. e. "butter", "water", "bubble", whatever.

Direct your attention again to the tense or painful area. Allow it to slowly move to the music, but just a tiny bit, just to the edge of tension or pain. Repeat the process with slow movements just to the edge. Keep extending your movement. Other parts of the body may want to become involved, your lower back, your arms, your feet your legs, your head. Move the part that calls to you but just a little bit, only to the edge of the tension or pain and then back off. For some of you, the music may be a distraction or irritating. What is most important is to: Find the part of you that is called to move and listening to the body and not pushing beyond pain and discomfort. Each time, you should find that your capacity to move will be slightly increased. If you find yourself in a state of pain or contraction, go back to the resting position and find a place that is more comfortable in you body.

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