Wide Dimensions to Yoga Therapy: Comparative Approaches from Viniyoga, Phoenix Rising Yoga Therapy, and the Feldenkrais Method®

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Abstract

Three well-known but very different mind/body methodologies for working with individuals are presented in a common framework consisting of: definition, methodology, case studies, and credentialing requirements. Chronic lower back pain is the presenting symptom considered by all three. Part of the background for this effort is the growing interest by conventional health care institutions in complementary and alternative therapies and the implications for Yoga therapy as a recognized discipline.

Introduction

A principal goal of the International Association of Yoga Therapists is to "support the development of Yoga therapy into a full-fledged preventive and remedial psychosomatic discipline."[1] Recognition of this discipline, however, is hindered by difficulties in developing a common definition of Yoga therapy, in part due to lack of "clarity about its function or purpose" and "considerable terminological divergence."[2]

To promote understanding of divergent views, we believe it is instructive to present a set of short, complementary case studies that provide a common framework with which to begin to compare and contrast how therapists from different perspectives are actually working today.[3] Feldenkrais® is not Yoga, but from the hazy focus on complementary and alternative therapies by many medical institutions today, it appears to be a similar mind/body intervention, and the teaching methodology itself may offer insight to Yoga teachers working one-on-one with clients. One inspiration for this joint effort was the book *Yoga of Healing* by T. K. V. Desikachar and Dr. Arjun Rajagopal, an instructive book in which physicians and therapists from eight different systems frankly discuss their methodologies, including comparative approaches to treating four common chronic conditions.[4, 5]

Background

Part of the backdrop and rationale for this effort is the widespread growth in the utilization of complementary and alternative medicine (CAM) and the subsequent growing interest by the medical establishment in a wide variety of very different approaches to health care. One of the current manifestations of this interest is the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP). The general charge of this Commission is "to develop legislative and administrative policy recommendations that will maximize the benefits of CAM practices and products for the general public."[6] Among the encouraging interim signals from the commission are a recognition 1) that "many CAM systems of practice place an emphasis on promoting wellness in addition to treating illness and dysfunction" and 2) that "the body has a remarkable capacity for healing that can be facilitated by addressing the underlying causes of illness and suffering; an attention to all aspects of life that can impact health—physical, mental, emotional, environmental and spiritual."[7]

A Common Framework

Each contributor first presents a short practical definition of Yoga therapy (or Feldenkrais Method) suitable for mainstream use (such as in a presentation to the White House Commission or a local health care organization interested in exploring CAM). Each then presents a representative case study for chronic low back pain because that is such a common complaint brought to Yoga teachers. Since Yoga therapy addresses much more than somatic dysfunction, we also gave each practitioner an open-ended opportunity to present another aspect of his or her work. Finally, the contributors briefly summarize the credentialing requirements for their school (or guild).

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Credentials and Training

As discussed in the WHCCAMP Interim Report, "people want to know . . . where they can find professionals qualified to provide these services." Standards for certification of Yoga therapists, however, are conspicuously nonexistent in the United States today. This is an inherent limitation to the recognition of the discipline.

An earlier editor of this journal presented one of the better introductory discussions of the implication of the term therapist:

> I believe the term therapist has certain implications in Western society, which can be observed when applied in other contexts, such as physical therapist, psychotherapist, or even art or dance therapist. It implies a type of relationship between the two involved individuals that differs from that of student and teacher. It also implies an acceptance of responsibility by the therapist for the therapeutic process being conducted and a certain level of education or qualifications. These societal and legal issues deserve serious considerations by all engaged in any aspect of Yoga therapy.[8]

As later predicted by the same writer, "As Yoga becomes more widely recognized as a valid mode of therapy it seems increasingly likely that some institutions, such as medical insurance companies, will want an objective measure of what qualifies a person to be a Yoga teacher or a Yoga therapist."[9] The interests of these various institutions appear to be well discussed (albeit briefly) in the WHCCAMP Interim report, and those interested in these issues for Yoga are urged to read the final report.[10]

We are *not* advocating common standards, licensing, or methods for insurance qualification in this article.[11] Instead, in order to shed more light and less heat on this issue, we simply had each contributor briefly summarize the credentialing requirements for his or her school or guild. Since the Yoga Alliance methodology is well known, we attempt a brief comparison with those published standards for Yoga teacher training.[12]

Viniyoga is known as a methodology for adapting Yoga to individual "needs, capacities and aspirations."[13] Therapy in this classical teaching lineage can be considered one of several different (and sometimes overlapping) orientations to practice: therapy, maintenance, development, and spiritual support. While the teaching is still primarily focused on the mind ("we are first and foremost seeking to change attitudes and actions that inhibit the natural healing process"), Viniyoga is also known for teaching means to directly or indirectly support healing for common aches and pains, chronic disease, and emotional health via individual instruction and a relationship with a teacher.[14]

Therefore, a short working definition I use for Yoga therapy *in a health care setting* is:

> Yoga therapy is instruction in specific Yoga practices and teachings to prevent or alleviate structural, physiological, psychological and/or spiritual pain, suffering or limitations. In a therapeutic context, this is usually taught one on one by appropriately trained Yoga teachers for the specific conditions and goals of the individual student.[15]

Viniyoga Methodology

Viniyoga training emphasizes principles, observation, and ways to adapt practice for individual bodies and purpose in an orderly fashion over time. Each student presents a unique matrix of structural, physiological, emotional, and spiritual conditions as well as an individual background and set of aspirations. The classical five *koshas* ("sheaths") provide one means of systematically considering the many dimensions of an individual and can help develop

an overall strategic focus for practice. There is not a standard methodology for working individually with students and there is much room for creativity once certain principles are well understood. Despite providing training in many classical Yoga tools, the teaching is that the relationship is more important than the technique.[16]

I have a written intake form with two key questions: "What is your purpose for practice?" and "What are your priorities for practice?" I ask the student to think about these answers both initially and over time. I use the answers as a reference and as a means of eliciting additional information about why students are coming. This often initiates a rather long discussion at first. Very "inefficient," I'm sure. Most people know why they go to see a doctor, a physical therapist, a psychotherapist, a minister, a personal trainer, etc., but why would anyone see a Yoga teacher privately? We discuss the scope of Yoga practice and the difference between personal practice and practice at the gym. Most importantly, this discussion provides a means to connect, to begin to know who the student is beyond a set of symptoms, and to improve communication. Usually I see a student for an hour and a half. In my experience, four weekly visits are commonly required for new students to develop a personal practice with which we are both comfortable. The "pressure" of weekly visits is a useful self-motivation tool for practice for most students. The case studies below thus present both the initial "Yoga prescription" and the practice four weeks later.

Viniyoga Case Study 1: Chronic Low Back Pain

Sam, in his late forties, has had a virtual lifelong tendency toward lower back problems. After a few recent falls, he was in almost constant nagging pain and underwent occasional week-long episodes of being unable to walk. He had sought help from an M.D., two chiropractors, an acupuncturist, a Rolfer, and a massage therapist. Nothing seemed to help.

[In Viniyoga,] the teaching is that the relationship is more important than the technique.

Sam held a sedentary job and was somewhat overweight, but he also struck me as being very intelligent, strong, and attentive. Through his work, he was relatively knowledgeable about many health care issues, especially back care. One unusual feature was that he moved his head in quick, jerky, almost bird-like movements. I wondered if that was contributing to his back pain.

If Sam had come to me prior to any of the other practitioners with this history, I would first have sent him to a physician or other specialist to rule out serious structural or organic sources for his pain. However, since he had already seen several specialists and gentle exercise was not contraindicated, I was willing to proceed. We proceeded very gently nonetheless, even though he was strong, because of his long history of pain.

First Session[17]

1. *Shavâsana* – with bent knees, hands on stomach, and long slow breathing, with an emphasis on longer exhalation and gently tightening the lower abdominal muscles. Exhalation will gently press his lumbar spine toward the floor. 12–24 breaths.
2. *Apânâsana* – gentle, short, dynamic stretching of the lower back linked with exhalation. 4–6x.
3. *Apânâsana*/*Ûrdhva-prasârita-padâsana* – combination with hands behind the knees. Gentle dynamic stretching and lengthening (axial extension) of the lower back. 4–6x.
4. *Cakravakâsana-krama* – gentle dynamic flexion and extension of the back. Only short, partial movements to gently stretch the lower back muscles and then contract. 4–6x.
5. *Shavâsana* – repeat.
6. *Shitalî-prânâyâma* – in a chair. Long slow breathing coupled with gentle head movements. This is unusual but I wanted to continue to promote relaxation and reduction of anxiety, and to counter the jerky head movements.

Sam practiced every day. He continued to see me once a week, to refine movements, and to gradually develop a stronger practice.

Fourth Session

Two practices were given—one very short and similar to the first session for the morning and a longer one for after work. The stronger practice:

1. *Cakravakâsana* – 4–6x, with more movement than before.
2. *Vajrâsana* – 4–6x, with an emphasis on the uplift and the contraction/strengthening of the back muscles.
3. *Bhujângâsana* – 6–8x. To strengthen the back; sometimes with a bent knee.
4. *Cakravakâsana* – 6–8x. Counter pose.
5. *Adho-mukha-shvanâsana* – stay 4–6 breaths. Slightly dynamic, to lengthen the whole spine and to engage and strengthen the upper back.
6. *Ekapâda-ushtrâsana* adaptation – with arms extended vertically. 2–3x/side, then stay 2–3 breaths. To further strengthen the back and slightly stretch the psoas.
7. *Cakravakâsana* – 6–8x. Counter pose.
8. *Jathara-parivritti* – 3–4x/side. To introduce gentle, partial supine twists, with both knees up (once we were assured twisting did not cause any pain).
9. *Apânâsana* – 6–8x.
10. *Shavâsana* – with bent knees.
11. *Ujjayî-prânâyâma* – 1:2 ratio. To emphasize exhalation and relaxation.

This became Sam's basic routine. He would do a very gentle practice in the early morning and this stronger practice with slight variations in the afternoon. He continued to practice almost every day.

Sam's progress was steady. Over several months, his back pain gradually lessened until he was almost pain free. He purchased a binder to hold the various practices I gave him. (This is always a good sign of a dedicated student.) He also improved his diet and began walking 20–30 miles a week. At the end of four months he had lost 20 pounds. Sam noted a change in his mental attitude, including a growing sense of calmness, an improved ability to handle stress, and increased compassion for other people. For months now, Sam has been coming to regular group classes and is able to participate fully.

Viniyoga Case Study 2: Emotional Strength and Stability

Stephanie is a teacher in her late fifties, tall, slender, and intellectually curious. As I gradually learned, she is quite intuitive, sensitive, and skillful in the use of images. She used to live in California and has had much experience with complementary and alternative therapies. She is tired, however, of having things done "to" her and now much prefers to work on her health and personal growth herself.

In our initial intake, she listed improving breathing, dealing with fear, and improving flexibility as her main priorities. She has a history of allergies and was beginning to increase her medications. She took Yoga in the seventies and still did sun salutations regularly.

I observed her normal breathing and sun salutations. Her inhalation was short and shallow and there was excessive kyphosis in her upper back. Sun salutations were easy for her; she was very flexible in forward bends and in the hips, less so in back bends. Her chest was somewhat compressed and her shoulders a bit rolled in. The physical and psychological profile of the chest and shoulders are key intuitive signs for me.

I told her that her flexibility was fine and suggested that improving her strength and stability might be more beneficial. We talked about how physical strength and stability could be a vehicle for emotional strength and stability, which would help to reduce her fear. Strength and stability became the verbal theme. Upper body strength, structural stability, chest opening, and improved inhalation became practice goals.

First Session

Taught the usual Viniyoga full top-to-bottom breathing to illustrate the connection of breath, body, and the spine and to observe her reaction to deep chest breathing. In my experience, people with rolled-in shoulders and breathing limitations sometimes have an adverse emotional reaction to deep inhalation when in a private setting, so one needs to be careful and especially observant here. But Stephanie loved it.

Viniyoga is known as a methodology for adapting Yoga to individual "needs, capacities and aspirations."

Taught a dynamic *tadâsana* on the toes with arm raises linked to inspiration. Like many, Stephanie could not slowly lift her arms in one inhalation. This was very illustrative to her about her limited breath capacity.

Taught a common initial or warm-up series: *cakravakâsana, vajrâsana, bhujângâsana, cakravakâsana*. Emphasized inhalation, uplift, and *bhujângâsana*. Stepanie said she appreciated the emphasis on her upper back and inhalation and that she would use this instead of the sun salutation.

Fourth Session

Stephanie continued to practice almost every day. I could see her get-

ting stronger, her inhalation lengthening, and her chest opening. Each session we made the practice stronger and more demanding on her upper back and inhalation.

1. *Vajrâsana/Cakravakâsana* combination – 4–6x.
2. *Bhujângâsana* – without and then with arms saluting. ~4x; 2–3x/side.
3. *Cakravakâsana* – 6–8x. Counter pose.
4. *Adho-mukha-shvanâsana* – slightly dynamic, staying ~4 breaths.

Sam noted a change in his mental attitude . . . and increased compassion for other people.

Then *adho-mukha-shvanâsana*/*ûrdhva-mukha-shvanâsana* combination ~4x. To develop strength and stability, chest expansion and inhalation.

5. *Uttânâsana* – 6x, with an emphasis on a slow uplift with long inhalation and arms extended.
6. *Vîrabhadrâsana* – variation with arms wide, opening the chest horizontally and flattening the thoracic spine. 2–3x dynamically. Stay 4–5 breaths. A key pose, as it embodies strength and stability and develops inhalation.
7. *Ardha-utkatâsana* – ~4x. A rather strong counter pose, but also to continue the theme of strength and stability.
8. *Cakravakâsana* – 4–6x. Gentle counter pose.
9. *Apanâsana/Ûrdhva-prasârita-padâsana* combination – 4–6x. Transition to *shavâsana*, still emphasizing inhalation.
10. *Shavâsana*.
11. *Prânâyâma – anuloma-krama*. Two-part inhalation.

This practice and similar variations became her daily practice for several months. In her own words:

> Today I am so much better than I was a year ago. Mentally and emotionally I have had the strength to move through crises to new levels of understanding. Calmness and stability are replacing the feelings of fear and fragmentation. Physically, I am becoming strong. Recently I moved furniture that I could not have budged a year ago. Breathing has improved and there are fewer problems with allergies. I am using fewer medications. Digestion has improved. Headaches are less frequent.

As I learned after the first several visits, Stephanie had been involved in some family disputes with her sister. Thus it was interesting to speculate on the linkage between the practice theme of strength and stability and a statement she later made about finally being able to say "no" to her sister.

Stephanie continues to see me approximately once a month. Gradually she has begun to explore other personal issues using different practice themes and different breathing strategies. Once her main daily practice was established, the new practices have become highly intuitive. She continues to practice regularly and does not like to come to group classes. We have a friendly running debate: She calls this therapy; I call it personal growth. She is teaching me a lot.

Viniyoga Therapy Training

Certification as a Viniyoga Therapist from the American Viniyoga Institute (AVI) is a five-to-six–year process integrated with the teacher training program. The teacher training program currently consists of three 15-day and two 10-day retreats sequentially taken over two years, including substantial homework. This program qualifies for Yoga Alliance registration at 500 hours and is a prerequisite for entering the therapist training program. The current therapist program consists of three 9-day sequential retreats over two years with an emphasis on clinical applications and case studies. Anatomy, physiology, pathology, psychology, and Ayurveda are not taught separately; they are integrated into the various modules. Students are expected to acquire sufficient anatomy and physiology foundations independently. The AVI programs continue to evolve and lengthen, with in-depth experience with Viniyoga now required before starting the training. Demonstrated competency is required for certification.

Phoenix Rising Yoga Therapy (Victoria Strohmeyer)

Phoenix Rising Yoga Therapy (PRYT) is a body/mind therapy that combines the benefits of Yoga with contemporary personal growth techniques. It was developed by Michael Lee, M.A.,[18] a recognized educator and therapeutic body worker. It is a complete, fully integrated modality that uses assisted postures (classic Hatha-Yoga *âsana*) and client-centered dialogue in each session.[19] "The practitioner of PRYT uses open-ended, nondirective somatic dialogue techniques and techniques of *prânâyâma* (breath control) to

support the client's exploration of the inner experience."[20] During sessions, clients address all aspects of their lives, including body, mind, and spirit—integrating these aspects of being with daily life. PRYT draws its essence from Kripalu Yoga, but includes inspiration from other yogic traditions.[21] Some clients come to PRYT practitioners with physical concerns such as low back pain or fibromyalgia, but the focus of a session is not on diagnosing or fixing but instead on supporting the client to learn to "read" the body's messages.[22]

Phoenix Rising Yoga Therapy Methodology

Phoenix Rising Yoga Therapy is a vehicle for healing at many levels, with the body and Hatha-Yoga poses used as the port of entry to deeper levels. The initial 75–90-minute client session is begun with a detailed client history including questions about personal support system, health care history, and spiritual orientation and beliefs. The essence of a PRYT session lies not in the structure of certain Hatha-Yoga poses, but in the practitioner's ability to listen to and support the client in what we call a "loving presence." The PRYT practitioner uses nondirective dialogue techniques to deepen the self-reflective process of the session and explains that the work is based on the belief that the body/mind/emotions are unified and the work is not about diagnosing or "fixing." The orientation of PRYT is that growth and transformation occur at the "edge," and the PRYT practitioner invites clients to explore their edge in a variety of Yoga postures. With coaching, each client is invited to dialogue about what s/he is experiencing in regard to body sensations, thoughts, and feelings. Clients are encouraged to seek understanding from within their deep inner knowing—listening without the need to fix anything.[23] There is a final integration process in each session where the client is asked what s/he has discovered, or what stood out in the session. The client is then guided in developing a strategy to take what s/he learned in the session back into her/his life. The client learns to rely upon her/his own resources and inner wisdom rather than on the practitioner.[24] Most sessions use the following techniques:

Phoenix Rising Yoga Therapy (PRYT) is a body/mind therapy that combines the benefits of Yoga with contemporary personal growth techniques.

Centering – a brief meditation and focusing time. It will include breathing and body awareness as well as reflection on an intention or focus for the session.

Body scan – done in each session in a full or abbreviated way.

Assisted postures and the "edge" – client is physically supported in various Yoga postures and the practitioner checks in with the client to find just the right amount of stretch—the edge. The edge is the place where sensation is felt, not pain. The edge is the right amount of sensation that helps the client to focus in the present moment.

Dialogue – practitioner asks, "What's happening now?" and this is the client's opportunity to notice anything that is happening—physical sensations, thoughts, feelings—and to report what s/he is aware of. At certain times the practitioner will repeat the client's words, and at other times will ask the client to say more about what s/he is aware of.

Focus awareness and breath – client is coached to focus on the breath and given specific breath patterns to imitate.

Integration – near the end of the session there will be specific time allocated to bring what happened in the session into conscious awareness. This fosters empowerment of the client and uses his or her own inner wisdom to guide the next step in the client's journey. It supports making conscious choices in life decisions and puts transformation into action in daily life.

Witness consciousness – there is no "right" experience or "right" way to be in a session and the client is asked to be with his/her self without judgment.[25]

There are many types of Yoga therapy: Some styles are more aligned with specific Yoga *âsana* and *prânâyâma* practices, others are more prescriptive—similar to physical therapy, and still others are more client centered—like Phoenix Rising Yoga Therapy. Those who have become certified in Phoenix Rising Yoga Therapy are not called certified Phoenix Rising Yoga *therapists*, but rather certified Phoenix Rising Yoga Therapy *practitioners*. In clinical psychotherapy, the clinician therapist uses a body of knowledge to assess and diagnose serious mental health issues and develops a plan to address those issues. In PRYT practitioners see psychologically stable clients who have the inner and external resources to integrate what happens in a session into their daily life.[26] To screen prospective clients, practitioners use an extensive intake form and spend as much as 30 minutes interviewing them before a first session. The PRYT training program includes informa-

tion about recognizing "red flags," working in collaboration with a therapist, and honoring professional boundaries. Practitioners are taught that if something emerges in a session that causes concern they should make a referral and suspend sessions until they have the okay from the client's treating physician or therapist. PRYT does not assess, analyze, or interpret, but rather provides a loving presence (or compassionate witness) to whatever is arising in the experience of the client. It is a body-oriented modality as opposed to a mind-oriented modality such as psychotherapy. There is no diagnosis in PRYT, whereas clear, accurate diagnosis of psychopathology is the linchpin of successful treatment in psychotherapy.[27]

Despite this clear distinction between PRYT practitioners and psychotherapists, Phoenix Rising Yoga Therapy falls under the Colorado state definition of "psychotherapy." The Department of Regulatory Agencies in Colorado regulates the practice of both licensed and unlicensed psychotherapists with the following definition of *psychotherapy*: "Psychotherapy means the treatment, diagnosis, testing, assessment, or counseling in a professional relationship to assist individuals or groups to alleviate mental disorders, understand unconscious or conscious motivation, resolve emotional, relationship, or attitudinal conflicts, or modify behaviors which interfere with effective emotional, social or intellectual functioning."[28] Under this legal requirement PRYT practitioners are required to attend an approved jurisprudence workshop and pass a corresponding examination, as well as provide all clients with a mandatory disclosure (informed consent) statement.

Phoenix Rising Yoga Therapy Case Study 1: Chronic Low Back Pain

Since in PRYT we specifically do not diagnose or "fix," it can be challenging to move beyond the client's self-definition of "chronic low back pain," but the following will demonstrate how I worked with a client with this concern. I also bring my entire self to a session. This includes my training as a Yoga instructor, business person, and PRYT practitioner, as well as my intuition and life experience.

Betty was a 61-year-old female, 103 pounds, with chronic low back pain and joint pain. She had recently emerged from a divisive divorce from her husband of 38 years, which involved physical and emotional abuse. She was doing much personal growth work and was active in her church and community as a volunteer. She reported doing some Yoga but "not enough." In response to a question on my PRYT client history form asking if she related to the concept of "Higher Self, God, or Spirit," Betty reported that she feels guided by God and angels and that she is active in a 12-step program.

First Session

In our first session I took a thorough history, did a full body scan, and led Betty through a PRYT "General Session," which is a sequence of specific supported Yoga poses that give the PRYT practitioner an overall understanding of a client's flexibility and body awareness. The "General Session" also helps to develop rapport and create a sense of safety with first-time clients. In the first session I discovered that Betty was hypermobile in her joints and had very little muscle strength. In PRYT work we are aware of a client's structural makeup, but we don't emphasize our structural knowledge in a session. We allow clients to make discoveries through their own awareness. Betty had come to me with concerns of low back pain, which I never addressed specifically in our sessions together. In the first session I used dialogue techniques to ask more about her low back pain. She eventually discovered that the pain was related to not feeling supported in her life. I made a note of that awareness in our first session and used that knowledge to choose the poses for our second meeting together.

PRYT does not assess, analyze, or interpret, but rather provides a loving presence to whatever is arising.

Second Session

Betty and I did some gentle warm-up stretches, and she reported hamstring sensations. This, along with her comment the previous week of "not feeling supported" and my awareness of her difficulty with the divorce, led me to choose forward bend (*pashcimottanâsana*) as the first pose of the second session. The forward bend is a posture of letting go of control, of resistance to life, and of imagined obstacles. In this pose the client is supported in welcoming and embracing resistance, which allows the client to accept that part of ourself.[29]

Betty sat on the mat as I drew her arms overhead and forward over

her legs. I had placed a tie at her feet, which she held in each hand after releasing from my assisted extension. I coached her breath. I said, "I embrace my resistance with openness," which is the affirmation/metaphysical element associated with the forward bend in PRYT. I noticed tears falling from her eyes. We held this pose for many minutes with small adjustments, side-to-side micro-movement rocking. I asked, "What's happening now?" And she just shook her head silently and let the tears stream down her cheeks. I told her we were going to transition out of the forward bend and asked her to let go of the tie and let me support her in letting go and leaning back on me. (I sat behind her with a pillow between her back and my chest as I slowly encouraged her to lie back against me as I lowered her to the floor). I asked what was happening and she said, "I hold tight because if I let go no one will support me." I fed that back and gently continued to support her falling back into my arms. Her breathing was labored and she was sobbing. I asked Betty, "What is happening now?" She said, "No one ever supported me in my life—the nonsupport is too big to say." I repeated her statement and asked her to tell me more about the nonsupport. She said, "I've never been supported." I helped her lie back on the floor with bent knees. I then moved into the second pose of the session, which was assisted fish (*matsyâsana*). The focus of the assisted fish is on the fourth *cakra*, the heart center. This pose encourages the release of emotions associated with being vulnerable.[30] I worked my hands under her heart center from the sides and gently lifted her chest. She began sobbing and had great difficulty breathing. I held her for five breaths and asked her to draw her chin toward her chest as I slowly released her down to the floor. I asked her to stay in her internal experience with her eyes closed and assisted her to a seated cross-legged position.

In PRYT work we are aware of a client's structural makeup, but we don't emphasize our structural knowledge in a session.

I asked her to reflect on what she had experienced. She said her whole life she had held on tight because if she let go no one would support her. She continued to sob and I asked, "What is happening now?" Betty said, "My whole life felt like that—not being supported." I asked her to connect with her angels and guides and ask for their support. Betty said, "I know that I am safe." I asked Betty if there was any guidance on how the angels could help her remember: "I, Betty, am safe." I repeated her affirmation, "I, Betty, know I am safe" three times, and each time she repeated it she added another word. It finally became, "I, Betty, am safe, supported, and loved." We repeated this again. I affirmed her willingness to feel her tension and reminded her that she is safe, supported, and loved. She opened her eyes and said how much lighter she felt and how her body was tingling and her head felt clear and open. She wrote down her new affirmation and stated that she would post it on a mirror in her home and repeat it frequently every day. I thanked her for being so courageous and willing to do such deep personal growth work.

I have seen Betty a number of times since this session and she continues to do tremendous personal growth work. She has moved from the state where she and her ex-husband lived for 38 years to a new state where she is freer of associations with her former married life. She has stopped smoking and walks a bit each day outside in nature. Even though she came to me as a "Yoga therapist" for low back pain, I never did directly address her back pain. My questioning about her low back pain did, however, lead to the realization that she lacked support, both in her body and in her life. It is difficult to know whether or not her awareness of the lack of support in her life helped resolve the structural pain that brought her to me, but she reported being free of the low back pain after the second session.

In PRYT sessions we encourage the "homework" to be self-assigned by the client through his or her own inner awareness. If I feel a client needs more structural support I will give them a Yoga pose or two to do as "homework" after a session—similar to the "Yoga prescription" that Viniyoga Therapists prescribe to their clients, but this is adjunctive and not part of the PRYT therapy protocol.

Phoenix Rising Yoga Therapy Case Study 2: Lower Leg and Foot Pain Due to a Car Accident

Laura is a 63-year-old female who regularly practices Yoga and T'ai Chi. She has undergone many forms of bodywork, acupuncture, and acupressure to help relieve the pain she has in her left leg due to a car accident ten years ago. She has had four operations on the lower leg and foot, but it continues to cause her pain. When asked to explain the condition she was working on, she responded, "Sur-

vival." Laura is a Yoga student of mine, and we have known each other for almost ten years.

We did a centering, a short body scan, and some warm-up stretches. When asked for her focus in this session she replied that she wanted to work with her "rotten" leg. After speaking to her about all the standard PRYT preliminaries, I decided to introduce the PRYT "legs to side" pose. Laura was supine and I held her left leg steady with traction and began to draw her left leg toward a vertical position. I asked her what was happening and she said, "The most amazing thing—I am right back at the accident!" She reported a sensation in the arch of her foot and the heel. She was animated and excited as she played back the accident scene in her mind. After a few minutes of holding the stretch and coaching breathing I transitioned her leg from vertical to "leg open" out to the side. She said her hamstring, her calf, and her foot were at the "edge" of her stretch. I held her leg out to the side for a few minutes and asked her what was happening. She said, "It is amazing, but my leg has completely relaxed." As I drew her leg to the floor she reported, "My leg feels three feet longer than before." She asked to work on the other leg to catch up—and I brought her right leg through the same "legs to side" pose. She reported that she felt wonderful, that she could feel energy pulsing throughout her leg and body. She said, "I feel like a 10!"

We spent 30 minutes of our 75-minute session in integration. In integration Laura was asked to recall the most significant part of the session. She replied that going back to the actual scene of the accident was surprising since she had blocked it from her conscious memory. She reported feeling a connection to her leg that she had not experienced since the accident and the multiple surgeries. I led her through a guided meditation and she received the realization that she could thrive, and not simply "survive." She made peace with her leg and spent some time apologizing to her leg for having labeled it as "rotten" since the accident. She made an agreement with her left leg to treat it with respect and give it love and consideration equal to her other leg. I affirmed her for watching herself at the scene of the accident while keeping a dual perspective of having survived the crash. This particular session stood out for me because my mental choice would have been to avoid working with her leg in the first session. But her body and mind wanted to do a pose that involved the leg, so that is where I went with the session. Her self-assigned homework was to give special attention to the left leg through touch, massage, and kind thoughts.

Phoenix Rising Yoga Therapy teaches me . . . to simply hold a space for my client to show up—without attempting to judge or fix her or him.

Phoenix Rising Yoga Therapy teaches me as a practitioner to get out of my own way—to simply hold a space for my client to show up—without attempting to judge or fix her or him. This can be extremely hard to do, and that is why so much of the PRYT training is focused on the personal growth work of the practitioner. So often in a session my mind imagines what is "wrong" with the client and how I would like to intervene to help them fix what is wrong. But the specific format of PRYT demands that we simply witness the client and his or her experience. "Companioning is about going to the wilderness of the soul with another human being; it is not about thinking you are responsible for finding the way out."[31]

Training and Certification in Phoenix Rising Yoga Therapy

To become certified in Phoenix Rising Yoga Therapy, completion of three levels of training is required. The first two levels are residential, the first a four-day and the second a six-day intensive. Students learn assisted postures (*âsana*), proper body mechanics, the metaphysical aspects of body psychology, dialogue techniques, breathing techniques, integration techniques, elements of professional practice, and contraindications and variations for working with specific clients. Level 3 is a six-month supervised practicum that includes two week-long residential trainings. Students are assigned mentors who give feedback, guide studies and personal growth, and help students refine techniques. "We believe that the yoga therapy practitioner's *presence* is a key factor in how a client will benefit from a session, and we therefore focus on the personal as well as the professional development of the student during the training program."[32] The Phoenix Rising Yoga Therapy training program is accredited by the National Board for Certified Counselors.

The Feldenkrais Method® (Staffan Elgelid)

Dr. Moshe Feldenkrais (1904–1984) developed the Feldenkrais

Method in response to a knee injury he had sustained. To heal his knee, Dr. Feldenkrais started studying anatomy, kinesiology, and physiology and combined these fields with his knowledge in mechanics, physics, electrical engineering, and martial arts. After the knee healed he took up the study of human function, development, and learning. All these fields combined to form what we today call the Feldenkrais Method.[33]

In the Standards of Practice it is stated: "The Feldenkrais Method is not a medical, massage, bodywork or therapeutic technique. The method is a learning process."[34] The Standards of Practice also state that the body is the primary vehicle for learning, and that the Feldenkrais Method is an approach that expands people's repertoire of movements, enhances awareness, improves function, and enables people to express themselves more fully. The Standards of Practice for the Feldenkrais Method were written with the understanding that the Feldenkrais Method is an evolving method and that "any attempt to write a definition of the Feldenkrais Method might be seen as producing a somewhat static description of a highly fluid and dynamic method." In some respects the Feldenkrais Method might be similar to Yoga therapy in that it is difficult to exactly define an evolving profession.

Feldenkrais Case Study for Low Back Pain

The client was a 45-year-old male with a 20-year history of low back pain. The initial injury happened when the client bent down to lift up a box and twisted to the right at the same time he was lifting. He immediately saw an M.D. who ordered bed rest for two weeks. After one month of no improvement the client started physical therapy. He was instructed in correct body mechanics for lifting and was told to avoid bending forward and twisting his torso. The client was aware of the importance of keeping his lumbar spine in extension at all times. By the time he arrived at my office, he reported a continuous ache and stiffness in his low back. He felt he could do less and less activity without pain and that his recreational life and social life were being limited. The client denied any radiating pain down either leg and walked with minimal involvement of the spine.

First Lesson

A Feldenkrais teacher can take many approaches with a student.[35] A teacher's approach may vary depending on his or her style of teaching, experience, and training outside the Feldenkrais Method. In this particular case I chose to first have the client exaggerate the pattern he used. The strategy behind exaggerating is that unless a student first recognizes the overall pattern he uses, he cannot change it. The student was asked to walk around the room and to pay attention to how he used his back when standing and walking. By focusing his attention on how he is standing and walking before a lesson he has something with which to compare his state following a lesson.

The student was then asked to lie down on a table, and he positioned himself in the supine position. I did not tell the student what position to take, since I assumed he would choose what was most comfortable, and I wanted to observe his choice. The student was asked to feel the space between his low back and the table. Initially he wanted to put his hand between his low back and the table to measure the space with his hand. This is common but very much the opposite of what the Feldenkrais Method is trying to teach the student. One of our main goals is to raise awareness of students through movement of the body[36] and by helping them learn to trust the body's internal feelings. Instead of measuring the space between his low back and the table with his hand, the student was advised to feel how much of the lumbar spine was touching the table. Was the space between the lumbar spine and the table different than the space between the cervical spine and the table? By noticing and comparing differences the student became aware of different parts of his body. He noticed that a fair amount of his lumbar spine did not touch the table. This was expected since his physical therapist had told him to hold his low back in extension. If the low back muscles are allowed to release when a student is in supine position, most of the lumbar spine will touch the table. The therapist probably did not mean for the student to hold his back in extension at all times, but frequently one habit will be present through all our movement patterns.

Even though the student is in a supine position the Feldenkrais teacher is still thinking about functions such as standing and walking.

After the student had scanned his body for the space between his lumbar spine and the table, he was advised to bend his knees so that the soles of his feet were on the table and to start arching his low back. He was advised to pay attention not only to

how he arched his back, but also to what happened in his feet and neck when he did so. He was next asked to arch his back while having his feet in different positions and while pressing different parts of his feet into the table. All these variations of arching the low back were performed to give the student an idea of how the position of the feet influences the ability to arch. Furthermore, by arching his back with his feet contacting the table he was being prepared for sitting, standing, and any other activity where the feet contact the floor. Even though the student is in a supine position the Feldenkrais teacher is still thinking about functions such as standing and walking.

After practicing arching his back, the student started "flattening his back" into the table. Arching the back is commonly called anterior pelvic tilt, and flattening the back is commonly called posterior pelvic tilt. A flattening of the back in supine position translates to a flexion of the back in standing and sitting. The first movement, arching/extending the low back, is something that the student knew how to do very well. The movement of flattening/flexing the back was more difficult for him, since he had been told to keep his back in extension. While flattening his back he was directed to still pay attention to movements and pressure changes in his feet and neck. After exploring the second movement he combined the arching and flattening movements through the whole available range of movement in the lumbar spine. At the end of the movement exploration he was advised to pay attention to how much of his low back was touching the table and compare it to before the movement exploration. He felt that a much larger portion of his low back rested on the table and that his back felt heavier. He was then helped up to a seated position. The reason for helping the student was to minimize the chance that he would revert back to his habitual pattern of immediately extending the back.

Many clients are not comfortable being touched where they have been injured.

Once he was comfortable in sitting on the table he was advised to gently arch/extend and flatten/flex his low back in sitting. The flexion and extension of the back was more difficult in sitting, since he could not get feedback from the table. (In this circumstance students must pay attention to the internal sensation they experience while doing the same movements performed supine.) He was advised to pay attention to his ischial tuberosities, feet, and head/neck. When performing flexion and extension of the lumbar spine in sitting there is an accompanying rocking movement in the ischial tuberosities that can be identified by the student. There is also a pressure change in the feet with lumbar movement, something that he experienced in the supine position and that he now also could experience in sitting.

After performing the flexion and extension in sitting, he was guided up to the standing position where the same kind of movement explorations took place. In standing, the degree of feedback is even smaller than in sitting, since the only external feedback received is from pressure changes in the feet. He had gone from flexion and extension of the lumbar spine in supine position (maximal external feedback) to standing position (minimal external feedback). If the lesson ends at the table the student does not get to incorporate the movement into functioning, and thus the lesson is not integrated into the student's life. After the student had performed the flexion extension movements in standing he walked around paying attention to any changes in his walking compared to before the lesson. He reported that he was more aware of the pelvic movements with walking and standing.

Second Lesson

The second lesson took place one week after the first. The first had focused on anterior and posterior pelvic tilts as a way for the student to start having the option of a fuller range of movements in his lumbar spine. He also had been advised not to rotate his spine, and he therefore needed to regain this ability. With rotation there is always a coupled movement of opposite-side bending occurring in the lumbar spine.[37] Thus the second lesson for the student was to focus on the side-bending component of rotation.

He was observed while walking and was then advised to lie on his right side with his hips and knees at a 90/90 angle. From this position I started moving his left shoulder toward his left hip and then away from his hip. Very small movements were performed so that he was comfortable with the action of side bending. Even though the shoulder movement did not introduce a direct side-bending movement of the lumbar spine, it introduced the idea of side bending in a nonthreatening way. After a few minutes of this gentle rocking I put his hand on his left clavicle and started introducing the same kind of rocking movement—but through the clavicle and

therefore through the spine. I then put one hand on his hip and one hand on his shoulder and started moving his hip and shoulder toward and away from each other. During this movement the student was advised to pay attention to pressure changes in his ribs that rested on the table. He was aware that the pressure on his ribs and waist increased as his shoulder and hip moved toward each other and that the pressure decreased when the hip and shoulder moved away from each other. As soon as he was comfortable with this movement, he actively started moving his hip and shoulder toward and away from each other.

After he understood the movements he was advised to roll over and rest on his back paying attention to the differences between the right and left sides of his body. He reported that his left side rested more comfortably on the table. This is an indication that the muscles on the left side of his body had started to relax and did not have to protect him anymore. He then sat up and did a similar movement exploration while sitting with his right ischial tuberosity resting on a chair and with his left ischial tuberosity off the chair. In this position he had to rely more on the internal feedback coming from his hip, shoulder, and ribs. He then stood up and walked around the room paying attention to how he moved. He reported that his left foot reached toward the floor more easily and that the reach seemed to involve his whole left side.

Two aspects of the second lesson should be noted. First, the student only performed the movements on his left side. This was done to magnify the differences between the two sides. If the movements had been performed on both sides, he could easily have missed the changes that occurred during the lesson. Second, I never touched the lumbar spine with my hands. Instead the student worked with approximations of the location of his left hip and shoulder. Many clients are not comfortable being touched where they have been injured. By staying away from the injured area clients may be less tense and defensive.

The Feldenkrais Method does not look at improvement of physical functioning as an end in itself.

Third Lesson

The third and final lesson focused on spinal rotation. The student started in the supine position and I rotated his head to the right and left. This rotational movement was done to introduce rotation through the spine. He was then asked to rest on his right side with his hips and knees in a 90/90 position. I once again put one hand on his left hip and one on his left shoulder. This time I started introducing movements in an anterior/posterior direction. Initially the shoulder and hip moved in the same direction. No rotation was introduced—the student was just feeling the connection between the hip and the shoulder. After he was comfortable with this idea, the shoulder was gently stabilized and the hip was moved anterior/posterior, followed by stabilization of the hip and movement of the shoulder. This introduced a minimal amount of rotation through the spine. The shoulder and hip were then moved in opposite directions—that is, the shoulder moved anterior when the hip moved posterior and vice versa. This put much more demand on the spine's ability to rotate. After all these movements had been performed passively the student performed them actively, both in supine position and while sitting, standing, and walking.

To integrate the three lessons the student was advised to first walk with an exaggerated flexion/extension movement of the spine, then with an exaggerated side-bending movement of the spine, and finally with an exaggerated rotation of the spine. He was not told when to use which one of the three movements. In an intelligent body, the right movement will be used at the appropriate time. He was advised to keep his exaggerated lumbar extension when lifting and also not to rotate his spine while lifting.

In addition, he was advised to call if he needed more lessons. He called three weeks later and reported that he was moving without the sensation of stiffness and aching in his back that he had had prior to the lessons, and that he had returned to work and recreational activities. He reported that he continued to explore the different movement options that were available in the spine in different activities.

This case shows how a Feldenkrais teacher might work with a student who has a chronic back injury. Many people limit themselves unnecessarily. While it is true that there is a need to limit the painful motion while the tissue heals, to proscribe that movement indefinitely is seldom necessary and leads to decreased options in life. The Feldenkrais Method does not look at improvement of physical functioning as an end in itself. The movement improvement is considered one way to enhance general awareness so that individuals can live more fully and more interactively with each other and their environment.

Certification Requirements

To become a certified Feldenkrais practitioner a student must attend a 4-year, 800-contact-hour, guild-certified Feldenkrais training. During the training, students gain an understanding and awareness of their own movements and of how movements are formed and organized, as well as the ability to observe movement in others.[38]

Endnotes

1. Feuerstein, G. Editorial. *International Journal of Yoga Therapy*, 2000, no. 10, p. 3.

2. Feuerstein, G. Yoga therapy: Further ruminations. *International Journal of Yoga Therapy*, 2001, no. 11, p. 5.

3. The term *therapist* can be a term of art, a legally defined term, and/or a term carefully avoided by some disciplines for either philosophical or regulatory reasons. Here we are using the term in a very general sense for working with individuals. See the individual discussions and cautions discussed in the text.

4. Desichar, T. K. V., and Arjun Rajagopalan. *The Yoga of Healing*. Chennai, India: EastWest Books, 1999.

5. Another inspiration was the excellent survey article "Aspects of Contemporary Yoga Therapy" by Ellen Serber, *International Journal of Yoga Therapy*, 1998, no. 8, pp. 19–25.

6. White House Commission on Complementary and Alternative Medicine Policy, *Interim Progress Report*, September 18, 2001. URL: *http://www.whccamp.hhs.gov*. The final report of the Commission was not available at the time of this writing but should be available by the time of publication.

7. Ibid., p. 2.

8. Kleinman, Steve. Greetings from the editor and reflections on Yoga therapy. *International Journal of Yoga Therapy*, 1997, no. 7, p. iv.

9. Kleinman, Steve. Editorial comments. *International Journal of Yoga Therapy*, 1998, no. 8, p. 6.

10. See A. Weil, *Health and Healing* (Boston: Houghton Mifflin, 1995) for a broad discussion of the evolution and politics of health care in the United States.

11. Indeed, one of the authors has presented a set of insurance cautions for Yoga. See S. Elgelid, "Insurance Reimbursement: What It Might Mean for the Profession of Yoga Therapy," *International Journal of Yoga Therapy*, 2001, no. 11, pp. 99–102.

12. Despite the published Yoga Alliance methodology, it is still very difficult to compare training requirements across programs. Different programs value things differently, e.g., homework requirements vs. teaching experience.

13. Desikachar, T. K. V. *The Heart of Yoga.* Rochester, Vt.: Inner Traditions International, 1995, p. xiii.

14. Kraftsow, G. *Yoga for Wellness*. New York: Penguin, 1999, p. 130. Note the many sections on illustrative practices for individuals with a wide variety of adverse health conditions. For more on Yoga therapy in this teaching lineage, see also A. G. Mohan, *Yoga for Body, Breath and Mind* (Portland, Ore.: Rudra Press, 1996).

15. See J. Kepner, "Yoga Therapy and the Tax Code," *International Journal of Yoga Therapy*, 2001, no. 11, pp. 104–105, for an earlier version of, and rationale for, this definition written with an eye on the tax and economic environment of health care in the United States.

16. Some of the tools are *âsana*, breathwork within *âsana*, *prânâyâma*, meditation, self-inquiry, chanting, sound, personal ritual, and prayer. Recommended study, consideration of personal and social ethics, and lifestyle counseling could be considered tools, or at least part of the teaching in some situations. A broader classical perspective might also consider Ayurveda and Jyotish (Vedic astrology).

17. In Viniyoga we have a methodology for drawing illustrative stick figures and carefully outlining a sequence for practice (the Yoga prescription). *Âsanas* in Viniyoga are often practiced dynamically, with repetition, and carefully integrated with breathing. Without experience, it can be hard to grasp this from a book, but see *Yoga for Wellness* by Gary Kraftsow and *Yoga for Your Life* by Margaret and Martin Pierce for their many fine photographs and careful discussions.

18. Lee, Michael. *Phoenix Rising Yoga Therapy: A Bridge from Body to Soul*. Deerfield Beach, Fl.: Health Communications, 1997.

19. See Phoenix Rising Yoga Therapy web site *www.pryt.com/cmp/faq_yoga.html*, Frequently Asked Questions, no. 1.

20. Hamadock, Susan. Personal correspondence explaining Phoenix Rising Yoga Therapy, Oct 2000.

21. Phoenix Rising Yoga Therapy web site, op cit.

22. Sale, Mary Quinn. Personal correspondence clarifying the distinction between Phoenix Rising Yoga Therapy and psychotherapy, Oct 2000.

23. Phoenix Rising Yoga Therapy staff. Preliminaries. In Phoenix Rising Yoga Therapy staff, *Phoenix Rising Yoga Therapy Certification Training Manual*. West Stockbridge, Mass.: Phoenix Rising Yoga Therapy, 1999.

24. Sale, op cit.

25. *Phoenix Rising Yoga Therapy Certification Training Manual*, op cit.

26. Lee, Michael. *Journey into Healing—Phoenix Rising Yoga Therapy (Parts 1 and 2)* videotape. Burlington, Vt.: Body, Mind, Spirit Productions on behalf of the Wisdom Channel, 1998.

27. See Phoenix Rising Yoga Therapy web site *www.pryt.com/cmp/faq_yoga.html*, Frequently Asked Questions, no. 10.

28. Colorado Mental Health Statute: C.R.S. 12-43-201(9) (1998).

29. *Phoenix Rising Yoga Therapy Certification Training Manual*, op cit., "Forward Bend."

30. *Phoenix Rising Yoga Therapy Certification Training Manual*, op cit., "Assisted and Supported Fish."

31. Wolfelt, Alan D. Quoted from *Hospice of NW Colorado Newsletter*, Fall 2001.

32. *Phoenix Rising Yoga Therapy Certification Training Manual*, op cit., "Certification Training Overview: Training Format."

33. Wildman, F., J. Stephens, and L. Aum. The Feldenkrais Method. In D. Novey, ed., *Clinician's Complete Reference to Complimentary and Alternative Medicine*. St Louis, Mo.: Mosby, 2000.

34. The Feldenkrais Guild. *Standards of Practice for the Feldenkrais Method*. Albany, Ore.: The Feldenkrais Guild, 1992.

35. Joly, Y. 33 strategies for FI (course handout). Montreal, Quebec: 2000.

36. Feldenkrais, M. *Awareness Through Movement.* New York: Harper Collins, 1972.

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38. The Feldenkrais Guild. *Frequently Asked Questions about the Feldenkrais Method*. Albany, Ore.: The Feldenkrais Guild, 1996.

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