WHAT CAN BODY-PSYCHOTHERAPY SKILLS OFFER THE INTERESTED NEUROTHERAPIST?

Introduction

“Embodied Relational Therapy” (ERTh) is a particular body-psychotherapy school. Having completed a one-year training with Nick Totton (see http://www.erthworks.co.uk) I would like to attempt a description of the ERTh paradigm with some reflections on its relevance to neurophysiotherapy. Embodied Relational Therapy is about the relationship aspect of treatment, and it is about how the relationship can inform the recovery process (become embodied). I am suggesting that body-psychotherapy, e.g. ERTh, is important because it enables and requires a shift from seeing the recovery process as just neurophysiology or the plasticity of the central nervous system, to seeing each treatment session from the wider perspective of the scheme of things generally and the meaning of the patient's life in particular.

This material is about listening skills in the broad sense of the term, and bringing more of the relationship aspect into the treatment process. It is about handling the emotional and mental relationship as being inherent in the physical relationship of body to supporting surfaces. It is above all else a way into the perceptual centre of the patient.

This article is concerned with the concept of relationship: ‘being in relation to’, ‘in relationship with’ oneself, the environment, and the patient. This is the use of the word ‘relationship’ as in the use of the word craftsmanship – the practice of, being skilled in relating.

Embodied relational therapy sees relations as an embodied phenomenon. ERTh is earth, it is the relational experienced and felt in the body.

In neurophysiotherapy we are primarily motion oriented: posture and movement is what we work with. We are concerned with control not only in the here an now but particularly in the future, and our skills lie in setting in train those plastic adaptations which as they manifest in the future will be advantageous to the patient in very specific terms of their stability/mobility i.e. their function. Just as the person who has not suffered a neurological catastrophe takes their postural mechanism for granted so we neurotherapists take our motivation for granted. In other words we fail to pay sufficient attention, in my view, to e-motion, as in perception, value, and meaning.

So, it is my intention to broaden my perceptual field so that I can tune in to the motion and its accompanying emotion, in much the same way as neurophysiotherapists generally have become accustomed to holding both the here and now response and trophic code within it.

ERTh

This particular body-psychotherapy uses a four-stage model of the treatment:

- Contact
- Information gathering
- Amplification
- Integration

Before going into this I would like to say something about listening skills. When we touch a person deeply it is because of, and through the communication of having heard that person's difficulties, or experience, empathetically.

It has been said that all therapy is listening, what does this mean? I think it means that being listened to makes the patient more intelligent, more comprehending of their situation, more able to deal with it. It gives the patient more control. So in this way listening is therapeutic. In a sense all therapy is listening. Conversely, “doing” to the patient without listening is abusive, it contravenes the ethical principles of creating and respecting autonomy. The more effectively we listen the more informed we are. My own experience confirms this, as I listen more attentively, more fully, the patient becomes more intelligent and I in turn am better informed. I then experience my work as relevant and appropriate in each moment, I

experience presence. Just as feedback is inherent in the acquisition of motor skills, in the same way it is the conscious awareness of feedback that constitutes real presence. Listening is an active process. It is the elucidation of significance and meaning.

Listening is not just proprioceptive and auricular, it is cortical, experiential, and imaginal/empathetic. It is cross-modal. Each of our senses touches or hears the sense object, the exteroceptors bring the objects of sight sound and smell to our perceptual and conceptual world, and the interoceptors provide us with the "felt-sense" of our experience, for example, we may experience excitement and anxiety as 'butterflies' in the stomach. Listening to our own body felt-senses enables us to listen to the felt-senses of our patients. In this way we empower the patient, bringing them into contact with themselves, with their own innate intelligence. (This is not intellect, but the intelligence of being, the innate healing potential within each of us - and this may be a different model from the one that is widely held, but it does offer certain advantages to a patient centered approach and is for that reason worth considering.)

Daniel Goleman has referred to this as 'EQ' - emotional intelligence or quotient - in contradistinction to 'IQ' intellectual intelligence quotient (Goleman 1996).

Listening skills take time to develop. Such skills require self-awareness, discrimination, and intention (to cultivate a listening approach). The process requires reflection on practice and this can be supported and nurtured through supervision – in the sense of having recourse to one who can support, encourage and guide development and learning, ideally not one who is in a management or other pre-existing relationship to us.

It is not a matter of developing an intuitive listening skill at the expense of intellectual rigour or reason: both polarities are required for us to be effective in a fully developed way. The cortical event and the bodily felt-sense form a gestalt, a complete picture in the sense that all channels are represented in it. In this way we can translate experience across different channels within ourselves and consequently, and importantly, between our patient's and ourselves.

Listening permeates each stage of the model: contact, information gathering, amplification, and integration. These stages are sequential but not strictly so, and can be used to mark where we are in the process. This marking where we are might be around a single piece of work in a treatment session that consists of several set pieces, or it might be in relation to the treatment session as a whole. It could be in relation to a longer period of treatment or even the whole process from beginning to ending. Thinking in terms of the four stages also helps to keep a larger perspective in mind while we are focused on a particular point, we are then less likely to lose the plot and find that the patient is leaving the session without having sufficiently integrated the work done. The four-stage model helps in structuring and pacing a treatment session.

Contact.

Contact is that finely balanced point between not invading, not separating and not merging. This is a constantly shifting point. I experience it as being touched. This implies a state of awareness, and I think that contact in treatment is arising from a heightened or deepened sense of awareness of the other and their needs. It is not just a physical thing. There is awareness, there is consciousness. So there is the noticing that I am touched, and with it the emotional tone and the quality of the emotional response.

This is the contact boundary - contact is taking place not just on the physical plane but also on the emotional plane in the imagination. To have contact we must negate three dangers: invasion, separation, and merging.

Not invading: contact is not invasion, but what is invasion? Well, it is something that can only be defined with reference to the patient's feelings. The question is not whether the therapist has been intending to invade, of course (s) he would not do so knowingly, but rather whether the patient is feeling invaded. So what is the feeling of invasion? It is a feeling we get when someone is doing something to us that we have not given permission for. It might be only that we have not given our permission, even though the treatment does not in itself feel unpleasant, the fact that we have not been properly asked is disconcerting and undermines trust. And it might be just the feeling that our personal space has been invaded, or feeling embarrassed at being unclothed, or it might be that we don't like the way that we are being handled. Each of these possible scenarios is an invasion

when it has not been agreed to either explicitly or implicitly. If we find the work unpleasant but have agreed and are still in agreement about having it, i.e. we think it is doing us good, then we don't feel invaded, even if it is painful. So not invading actually requires a great deal of sensitivity. It might be helpful to bear in mind that the patient may be in denial about being invaded, that they may have dissociated, i.e. are no longer truly present in their body. It is not enough to have asked, we must also feel that the consent is an adequately integrated response. We need to read the person's autonomic responses, not just their verbal responses. The more I work on this the more I realise that in the past I have unwittingly created resistance (spasticity). The more I reflect on this the more I think of spasticity as a defence against invasion. It is worth mentioning too that if a person has been invaded in the past they may be vulnerable to invasion and feel powerless to prevent it.

Not separating: not separating is not going too far in the opposite direction from invasion. With separation it follows that there is a loss of contact, so when do we lose contact in this way? Well, on the physical plane we lose contact when we start doing something else, it might be getting or adjusting some equipment or furniture, especially if it involves leaving the room. But here we might keep the mental and emotional contact even so. On the other hand we could appear to be in physical contact but be mentally and emotionally absent. Not separating means having concentration, being able to stay with the process from moment to moment with lightness and ease, and maintaining a sense of continuity, contentment and happiness. If we are feeling distracted, traumatised or overwhelmed then to that extent we will not be available. It follows that good contact will be helped by having supportive conditions, being free from having to deal with other things during the treatment session. We might also experience aversion to the patient, for whatever reason, and if this is the case we will need to keep an awareness of our repulsion or revulsion so that it does not lead to us losing contact. It might be helpful to have present or be able to bring to mind an inner witness, some part of ourselves that is able to just observe what the rest of us is doing.

Not merging: At its most extreme form merging is where the therapist can no longer differentiate between what is happening in his/her mind and what is happening for the patient, a complete identification with the patient's process coupled with a loss of awareness of one's own process. The reality check has been switched off if you like. If I become one with the patient in this way the boundary between us that informs the treatment process has been dissolved. Contact is at the contact boundary, that is the organ of contact, so if that is dissolved it is no longer contact but rather union (union is not contact). There is a loss of grounding in merging that goes with the loss of contact. So contact means not merging to become as one with the patient, but keeping sensation at the contact boundary clear.

One way of avoiding these dangers is to negotiate the contact. For example: "Would you be comfortable with that?" "Does this feel OK?" "Would you prefer to work lying down or sitting?" - where the questions are based on an intuitive sense of how the patient is, where the contact edges are, etc. Another is to use contact statements, for instance: "I notice that your eyes are moist, is there a lot of emotion coming up for you?" or " I notice that you look a bit unsure about lying on the plinth, is it that you are afraid of falling off?"

What is my experience of contact as client? (I prefer not to think of myself as a patient, interestingly) - sometimes it is wonderful and sometimes it is difficult. And with my own clients or patients? Part of the difficulty for me has been feeling <u>inadequate</u>, feeling a lack of confidence, and this has separated me from the patient, it has undermined the contact. Wrapped up in this feeling of inadequacy is a need for approval, the desire to please. And this too is very counterproductive because it focuses my attention on whether what I am doing is pleasing the patient, or my peers, students, mentors, audience etc., whether it is meeting their expectations, rather than working with their process. You can see the whole gestalt here - being able to walk is not just a physical process, it encapsulates and enfolds feelings and attitudes about what should be happening or not happening, and these feelings and attitudes may distract from the recovery process and negate potential. <u>Accessing recovery is a skill on both sides</u>. (I like that as an aphorism because it can refer not only to both sides of the contact boundary, but to the both sides of the midline.)

"The native healer will try to come into contact with the part of the self that the person is not aware of, and to elicit it, so that there is some possibility of consciousness and growth leading to a new perspective that might help with the illness." (Moyers B 1995)

Information Gathering

What do we notice? What is our attention drawn to? Being open to information that may seem peripheral or even outside the box, allowing intuition – "I am not sure quite why I am doing this but it feels right" or "it seems like a good idea." Information gathering is the stage at which we define the scope of the patient's process. It might be better to err on the generous side.

There is I think a general idea that assessment is something we all do, as if it is an objective state that is being assessed, but actually the reality is quite different, meaningful assessment is much more subjective, we each of us see in our unique way, and it is important for us and for our patients that we honour that and gather information in a broad sense, noticing what is rather than having preconceived ideas of what it is that we 'should' be noticing. The objectivity arises out of the recording.

Perhaps the most important lesson for me is allowing time for information to surface, especially at the beginning of the session. I like to allow time for a full picture to emerge before putting my hands on the patient. (On rare occasions it has been possible to do the whole session without putting hands on at all, either because the patient needs to talk, or because the treatment is through a process of amplification that doesn't require hands on.)

There can be a ritual process here, giving myself and the patient time to arrive in the session, checking that we are present mentally as well as physically. Allowing time for what is important to emerge. There may need to be a social connection made, some reference to the weather may be, or the journey. For me the information gathering then tends to move to a more visual/(kin)aesthetic mode: seeing the physical relationships between the patient and the environment, and myself, their posture and alignment, the gestalt of it, and the centre of it, what it all seems to move around, and this may be distal as well as proximal, it may be a place outside of the physical body.

I try to be open to intuitive responses, to notice what I feel drawn to, curious about, as well as being logical and rational.

Having gathered information in seeing and listening touch is informed and refined. The informational picture can be filled in in more detail and the broad impressions and guesses verified or otherwise. The hands bring knowledge about where the body is being held and how, and whether that is too much.

Amplification

Amplification is a way of bringing something to the patient's awareness, and sometimes, perhaps even often, becoming aware is enough.

For example "I notice that your hand tightens when you stand up from the chair."

"I notice that you seem frustrated with your hand tightening."

This does not have to be verbal, very often when we notice something, the patient also notices at some level even though they may not be conscious of it.

Amplification is the process of what we choose to pay attention to. And that is going to depend on what we see.

Each of us see things differently and so we are going to amplify different things. If this is indeed the case, and to the extent that it is, any expectation that we are going to amplify the same thing in the same way as each other is deluded. In this respect treatment cannot be taught, it is something that happens in the moment. What can be taught is to be in the moment, with your experience just as it is, and having the confidence to amplify what seems to be important even when it is unusual.

In his book "Psychotherapy – The Erotic Relationship" David Mann (Mann D 1997) distinguishes between common knowledge and transformational knowledge, between the routine and the inspired. He calls these transformational and inspired learning experiences 'the hinterland'. The hinterland is, I think, where significant growth happens for the therapist, and it is where the therapist amplifies or pays attention to what is important for the patient.

What I have needed more than anything else in my career as a neurotherapist is the freedom to perceive the important. And yet, interestingly, I have often struggled with issues around conformity.

Nancy Kline in her book "Time to Think (Listening to Ignite the Human Mind)" (Kline N 1999) speaks of this in terms of co-dependence. She says: (p49) "co-dependence is an addiction to pleasing people" and "Co-dependence is rampant in any structure requiring obedience or conformity." So, being free to amplify what interests you is not a simple and straightforward matter. It requires a certain level of self-awareness and an awareness of others.

Closely related to co-dependence is what she terms 'infantilisation'. "Infantilisation is subtle. Some people explain it as being, in transactional analysis terms, the 'nurturing parent' alternating with the 'critical parent'. You infantilise when you want the well being of another person intensely but you also intensely want to be seen as expert, indispensable and brilliant. Infantilising others is actually an act of profound insecurity. It looks big and confident, but it is a cover for feeling small and doubting deeply." Co-dependence and infantilisation are tendencies in my character that have the deep root of profound insecurity. I have been able to see this more clearly as I have become more willing to see my own vulnerability and weakness, and the body-psychotherapy course has certainly helped me in this respect. Incidentally, this is an example of amplifying something in my own process.

Integration

This is the integration of a change by the whole (the whole body, the body-mind, the personality or character) this requires time, and moral strength - the strength to resist the pressures for immediate results. I suspect that sometimes the lack of carryover that neurotherapists speak of is actually a failure to integrate the changes that the patient has experienced in the session.

As I learn about the value of allowing time for what has happened in a session to be integrated I

allow more time for it. In my own practice I consider it ideal to spend a reasonable amount of time tuning in before doing some work, and then allowing a good deal of time for the integration. So what is integration? It is allowing the work done to be heard and assimilated in the rest of the body to achieve coherence in the field. You can take the field to mean the patient's overall posture, i.e. how they are relating to the world; but you could also use that term to include their space, their personal space, and even the relational field of patient and therapist. The integration process often includes gaining a sense of what the theme of the treatment has been, what the thread running through it has been.

Character

Character is the structure of our patterns of relating. Most of us have a sense of strong and weak characters. In common usage we describe character in terms of opposites: difficult-easy, resistant-yielding, solid-fluid, friendly-unfriendly, nasty-nice, uptight-laid back, stubborn-willing, sweet-bitter, resentful-grateful, upright-deceitful, cunning-naïve etc.

In this setting character is way of thinking about a person's structure or position in relation to the world, i.e. how we relate to the world around us. This idea originated with Freud and his description of three basic character types. Since Freud the ideas about character have been considerably developed. Particularly important for the view of character that ERTh takes was Reich. Reich's views did not sit well with the psychoanalysis establishment at the time and they discredited and expelled him. As a result Reich started the psychotherapy movement, and in particular body psychotherapy, and it is from Reich's work and some of his followers that ERTh draws much of its material.

An underlying idea in character work is growth and development.

ERTh sees character as a way of being in the world that allows us to protect ourselves on the one hand and to express ourselves on the other. This is going on for us and at the same time it is going on for our patients. So there is a need to manage both. In this model we can see that personal growth comes from working on ourselves, our own continuing professional development. We, the therapist and the patient, do the best that we can, and we will develop more effective ways of managing ourselves as we become more self-aware.

Our level of self-awareness, its richness, depth and content, allows/enables (and limits) our ability to work with the patient. Having a model of character structure is like providing ourselves with a mirror into which we can look to see how we would like to be different. Looking in the mirror we can make adjustments. With our knowledge and experience of working with people (embodied relational beings) who have had strokes or other

neurological catastrophes, we can reflect how they are, and model a way of being that embodies creativity and change.

To think of the CNS modulation of tonus as being a purely mechanical thing to do with gravity and locomotion, that can be treated without reference to our emotional and characterological being will be experienced as a lack of contact and undermine our purpose.

Conclusion

Body-psychotherapy emphasises the relationship side of physical work. Physiotherapy emphasises the physical side of the relationship. I have tended to overvalue the physical techniques side in my work, as if it is the most important part of the job of being a therapist, or at least a neurotherapist. Reflecting on this now I can see that the idea that you can do something to the patient is in itself flawed, abusive even. For therapy sessions to be truly therapeutic the patient's needs must come before the therapist's. Given that most of my needs are still below the threshold of consciousness this requires a disciplined approach to practice that sees the relationship side. Here in a nutshell is why I am so interested in body-psychotherapy, because it allows healing to take place on a deeper level, and importantly, it helps to prevent me from doing things that impede the return to balance and health.

References

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