Berit Ianssen (ed),
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Norwegian Psychomotor Physiotherapy

Movements of Life

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Translated by Maren Mørch Lind

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This book is dedicated to the memory of Aadel Bülow-Hansen and Tom Andersen, to whom we are eternally grateful

Following in Physiotherapist Aadel Bülow-Hansen's Footsteps

These words tell us how it felt to be treated by 87-year old Aadel Bülow-Hansen in 1992:

> She demonstrated how she worked with her hands, and how she constantly paid attention to my breathing motion. She listened with her hands, her eyes alert. She was totally present, all the same she always knew when to step aside, so that I could find my own way – and she saw where I went. The nature of her response during therapy enabled me to have faith and courage to make my own decisions. However, she was responsible for the "framework" around me and that made me feel assured and safe.

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Foreword

The original Norwegian version of this book was published in 1997. Our wish primarily is to impart experiences from our own clinical Norwegian psychomotor physiotherapy (NPMP) practice. We have intentionally written this book in everyday language, because we believe that, even if it might seem a paradox, this language is more generous, more wide-ranging than the expert language. Everyday language also makes it possible for us to address the lay-man as well as the professional. The authors give warm thanks to the translator Maren Mørch Lind and to John Wilson who diligently guided her along the tricky road of translation. Their efforts have been invaluable.

Of the seven authors of this book, six of us practice physiotherapy. We gained our post graduate education by what we in Norwegian call a *master-apprentice* model; working independently, but at the same time under close supervision. We attended numerous courses, and we ourselves had to personally undergo the same kind of therapy that we were being educated in. Finally we took our written and clinical exams. During the 1990's NPMP was formalized into a college educational curriculum, situated in Oslo, Trondheim and Tromsø. Quite recently the post-graduate education in Tromsø has been elevated to a Masters Degree level, encompassing a variety of approaches under the umbrella subject of psychomotor physiotherapy.

The founder of NPMP, Aadel Bülow-Hansen, (1906–2001) coached Gudrun Øvreberg from 1961 and the two continued their close cooperation throughout Bülow-Hansen's life. As well as teaching and supervising,

Øvreberg has been working clinically throughout her whole career and she has extended the original concept of NPMP to include movements in groups, treatment of children, ailments during pregnancy, (Ottesen et al, 2010) just to mention but a few. The authors Hanssen, Ianssen, Kvebæk, Ottesen and Rongved represent the generation of psychomotor physiotherapists supervised by and cooperating with Øvreberg; we might say NPMP's 3rd generation.

Psychiatrist and Professor Tom Andersen, who sadly died in 2007, entered into a mutual and, to the field of NPMP significant, cooperation with Gudrun Øvreberg from the 1970's. He studied Bülow-Hansen's and Øvreberg's clinical practice, watching closely how the concept "a change that makes a change" was transformed into practice. As a result of these and later observations, Tom Andersen introduced the expressions *sufficiently unusual* and *appropriately unusual,* and they have been frequently made use of ever since. He also learned how the body showed up as a residence for both impressions and expressions. Being so close to the clinical practices mentioned above most certainly had an influence on his own work within the field of family therapy. The conversation, the dialogue, came to be more than just words; to him they became a whole world of body experience and movements.

Comprehensibility, Manageability and Meaningfulness, are three significant components when it comes to coping with stressors in life. (Antonovsky, 1996). We believe that if we, during therapy, are able to convey an understanding of the human being as a whole, including body, emotions and movements, then the context of body and life just might become more *comprehensible, manageable and meaningful* for our patients.

We cannot anticipate what the patient will get out of NPMP treatment, nor do we know what the reader may learn from reading this book. Our main incentive for writing has been the actual reflection- and writing-process, and our wish to pass on our clinical experiences from NPMP practice.

All professionals working in the field of physical therapy in mental health, share the same responsibility of international networking and

exchanging of knowledge and understanding. Norwegian psychomotor physiotherapy is today a university based, well-founded and documented postgraduate physiotherapy education in Norway.

Prior to being translated into English, the original Norwegian book has undergone a minor revision. This English version is our contribution to making this special field of physiotherapy known to professionals, to patients or to anybody simply interested in understanding a little more of Norwegian psychomotor physiotherapy and movements of life.

The real voyage of discovery
consists not in seeking new landscapes
but in having new eyes

Marcel Proust

Berit Ianssen

Introduction

We have to go back 60 years to track the origin of the tradition of Norwegian Psychomotor Physiotherapy (NPMP/psychomotor physiotherapy).

Physiotherapist Aadel Bülow-Hansen got her education in the beginning of the 20th century. Her career started by giving sleepless women massage in their homes at night. From 1927 she was in the employ of Sophies Minde, Oslo, a hospital specialising in orthopaedics. Her father was a surgeon at this same hospital. Among his patients were children with polio. These children were referred to Sophies Minde for treatment on adverse effects of this disease, and they came from all over Norway. The children came mostly without their parents, feeling very lonely of course. There were many tears shed in these children's wards, and many of the children had complaints of pain, *not* as one might guess, in the operation site, but in fact in their tummies. Aadel Bülow-Hansen asked her father why this could be so. Without hesitation he answered her that fear is embedded in the stomach. He was an orthopaedist, but his answer demonstrates that he certainly was able to reflect beyond the limits of orthopaedics. From now on Aadel Bülow-Hansen's understanding of muscular tension and body pain existed within a wider context.

Later on she started her own private clinic. She believed that there had to be some kind of correlation between muscle tension, respiration and emotions.

In 1946 she gave a lecture to The Norwegian Neurological Association. When she had finished, neurologist and psychiatrist Trygve Braatøy

rose to his feet and proclaimed that this was the first time he had met a physiotherapist who included the issue of respiration to her treatment. This was where it all started.

Trygve Braatøy was so intrigued by Aadel Bulow-Hansen that he invited her to come and work with him at Ullevaal Hospital, Oslo, in the psychiatric ward where he himself was in charge. This was the beginning of their close professional relationship which lasted until Braatøy's untimely death in October 1954, only 49 years of age. This cooperation resulted in what we today call Norwegian psychomotor physiotherapy.

Trygve Braatøy showed great interest in many fields. As a medical student, he studied neurology at Clinique Charcot in Paris, and as a young doctor he studied psychoanalysis with Otto Fenichel in Berlin. At the age of twenty-nine he did his medical PhD on young men with schizophrenia.

He expressed an interest in the concept of muscle tension for the first time in 1937. At that time he was interested in Pavlov's work, especially about the repression of primitive reflexes. Braatøy viewed muscle tension as part of this repressing process, and further claimed that this repression would often coincide with the tensing of a number of muscles, e.g jaw muscles, ”breathing muscles” and abdominal muscles. At the time he met Aadel Bülow-Hansen he was well acquainted with the idea that there could be some connection between impaired respiration and enhanced muscle tension, and that this could be understood as part of a ”nervous” condition.

Gudrun Øvreberg, a renowned teacher in NPMP, met Aadel Bülow-Hansen in the early 1960's. On their first encounter Bülow-Hansen told Gudrun Øvreberg that the only way to learn was to undergo the treatment herself, and experience her own body's reactions, – ”then we will see what kind questions you wish to ask”. In this way, Bülow-Hansen clearly demonstrated that the body is given first priority, the words come in second, and later on there is room for afterthought and reflections. The first weeks she treated Gudrun Øvreberg giving only little verbal information. Gradually she opened up for questions. How was Gudrun to understand all of this? Aadel Bülow-Hansen said:

Use your intuition and your fantasy. Study your anatomy and be aware of what happens in your own body when tension increases, when the brakes on your respiration are put on and you lose your movement flow. How are you to get out of this state? If you are able to experience this yourself, then it will be easier for you to help your patients.

Another important person in the development of NPMP was Professor Tom Andersen, a renowned Norwegian psychiatrist. Tom Andersen worked as a General Practitioner (GP) before specialising in psychiatry. He had many questions he wished to discuss with Gudrun Øvreberg, among them questions about the correlation between mental and body problems. Together, in 1986, they wrote a book based on observations of Aadel Bülow-Hansen's treatment-sessions and their follow-up discussions. Three items were of particular interest; the concepts "appropriately unusual", "body activity" and the phenomenon of "listening to, and expressing oneself".

Professor Andersen noticed that the physiotherapist occasionally massaged a specific tense muscle in a pain-inducing manner. This was done with the intention of releasing tensions elsewhere. Respiration motion increased in response to this pain stimulus and in turn, this seemed to result in reduced muscle tension. He observed that if this massage caused too little pain, the breathing would not be affected. If it caused too much pain or was held too long, the patient would respond by holding his or her breath. But when massage was given with perfectly appropriate pressure it would in fact induce a change in the breathing and subsequently the tension; too little, too much, and just right. Professor Andersen became aware of how this corresponded with elements in the dialogue in psychotherapy. If what they talked about was either too usual or too unusual, the patients would lose interest. He put these experiences in writing in "Guidelines for psychotherapy", thus influencing the verbal dialogue in psychotherapy towards the "appropriately unusual". He became more sensitive, more aware of the movements in the dialogue and of the client's comfort or discomfort.

Words – a Body Activity

Professor Andersen learnt from Aadel Bülow-Hansen how we express ourselves verbally and emotionally when we exhale. We can put it in this way: when we draw our breath, we accumulate body tension. When we exhale, (as in a sigh) this accumulated tension is released, bringing us “back to basic”, so to speak. So, this means that the act of speaking represents a continuous shift between accumulating and releasing tension. The tongue’s movement, the vocal cords and the flow of air that accompanies the breath are the elements that give our words their full substance. This explains how verbal expression may be understood as body activity, and that the spoken word, emotions and body movements can never be separated from one another.

Listening and Expressing Oneself

When Aadel Bülow-Hansen worked, her tongue spoke and her ears listened, like this is something we all do. But in addition to this she listened and spoke with her hands and her eyes. The working hand, the one that gave the massage, spoke to the patient, whilst her other hand rested elsewhere listening attentively to the patient’s reactions. Her eyes listened to all the subtle signs from the other person, and they spoke by expressing her presence, compassion and warmth.

Perhaps we could understand more, understand other things, if we were more aware of the potential in our own eyes and hands, if we were to grasp more fully what it is to listen and to express something. Perhaps we should let ourselves be even more touched by other people; a touch so subtle that it hardly can be seen, heard or felt, or a touch that passes so silently or so swiftly that it is missed by our conscious awareness. If we were to listen differently, would this make us speak differently?

Professor Tom Andersen taught us a lot about the dialogue. He helped us believe in a natural dialogue, as opposed to a technical dialogue. This gave us “permission” to do what we felt was right there and then in each specific session; meaning we could allow ourselves to speak

with the patient throughout one whole session while we might let another session pass hardly saying a word.

”We Learn From Our Patients”

This was Aadel Bülow-Hansen’s primary doctrine. If we want this to be more than a cliché, our patients’ feelings and experiences must be taken seriously. The therapist needs to try to understand the patient from the patient’s own perspective, rather than from one’s own theories. Our understanding is founded on the total sum of information collected; what we see in the body’s attitude, movements and breath, the information we gather from the patient’s skin and muscles through our hands, and what we hear in the patient’s words.

Dialogues and Movements

In our dialogue with the patient, we do not always need to seek the meaning behind the words expressed. Instead we try to listen accurately to what is being said and first of all try to understand only this. We do not need to have the patient reveal or even understand the whole story of his or her life. The aim of the dialogue is to put into motion whatever has been brought to a stand-still or has become frozen. The person who is coming to us for help brings with him or her the body’s own knowledge, its own information, its own story. We know something about the body and life in general, the patient has knowledge specifically about his or her own life.

The Atmosphere

However, there is more to a session than what has been described until now, something not easily put in words. Might we call it the session’s atmosphere? What is it then, that may characterize this atmosphere? Professor Tom Andersen once wrote about this in a letter to me:

I believe that it has something to do with the patient feeling that he or she is being seen, listened to and touched. I have reflected upon how you psychomotor physiotherapists “use” yourselves: your ears are receiving, your tongue and all that is attached to it, breath included, is purely giving, while your eyes and your hands are both giving and receiving. I think the patient perceives all of this; he or she experiences the physiotherapist’s genuine attempt to understand.

Perhaps the most important element during the session was your ability to create the kind of atmosphere I have mentioned here. Through your hands, your eyes and your ears, something was initiated from the ”outside”, then this “something” moved on inwards giving the patient access to his or her own spontaneous thoughts and feelings. An atmosphere like this enables one to finish off problems of the past, to participate fully in the present, and be prepared for whatever (one believes) lies in one’s path in the future. To me, words and their corresponding feelings, breath and movements is what this is all about.

Is it ”Physical, ”Psychological” or ”Psychosomatic”?

How are we to understand the concepts of “body and soul”, “holistic treatment”, “psychosomatic illness”, “psychological problems manifested in the body”? What is the human body, what is the soul, and what kind of connection is there between the one and the other?

The philosopher René Descartes believed that body and soul *co-exist* in a human being, the one having no influence on the other. He believed the soul to be superior and immortal, the body merely functioning as a residence for the soul.

The Greek philosopher Aristotle had a completely different view on the matter. According to him the soul represents a human being’s abilities, his nature, his vitality. The human body is all organs: mouth, stomach, intestines, eyes, ears, skin, muscles and so forth. It’s only by way of thought that we are able to separate the soul from body. We may reflect

on this in the following way: the eye with its eye-lens represents the body, eye-sight the soul. Likewise we may consider the muscles as body, and its movements as soul. Thus, eye-sight and movements are elements in the human-being's soul. This is an organic perception of the soul – the function and the skill of living, being attached to the human organs. So one may continue to understand the concept of soul in Aristotle's manner of thinking: the intestines belong to body, digestion to soul; the lungs belong to body, breathing to soul. The brain belongs to body, the brain's function to soul.

Aristotle wondered if the act of thinking or imagery was possible by use of other than the body's organs. In other words, is it possible to think without using our senses? His answer to this is no, meaning we are completely dependent on our senses to be able to perform the act of thinking. We perceive through our senses, this turns into memories, and gradually become our experiences. Ultimately our intelligence, reasoning and intuition enter the arena.

Breathing and Life Itself

We should mostly use verbs when speaking about life. Nouns are stationary, while verbs move; move, as does the living human being, as does our breathing. We inhale and exhale, or using Aadel Bülow-Hansen's own words: We let air in, we let air out. The crucial component in breathing, or even in life in general, seems to be contained in the word "let". Let in and let out, or let go. A vital element in Norwegian psychomotor physiotherapy is supporting the patients in their process of being able to let in, let out or let go, and imparting the importance of opening up to give their respiration its necessary space. When air is let out, or let go, the body's increased state of tension may also drop to a more relaxed state. This explains why we say that breathing can liberate tension.

Stretching, opening up and setting free what has been tied up, may be hard work, it may also be frightening. This process requires slow progression, giving the person the time he or she needs to readjust and to

get accustomed to a new way of breathing, a new way of moving. When the body starts moving, lost or repressed expression is revitalized in movements, emotions and words. Further one may become aware of the fact that new ways of moving correspondingly influence a new way of talking.

If the patient is suffering from heavy emotional problems, it might be necessary to involve a psychologist or psychiatrist. The combination of NPMP and psychotherapy is often fruitful.

Life is in constant change, we experience difficult events, mental strains, problems, grief and anxiety; nobody can avoid the strains of life. Mental and body pains are often intertwined, so what can we psychomotor physiotherapists do to help our patients? We have to search for what has stopped, what is being repressed; is it the patient's movements, reactions, words or breath? We try to facilitate a different way of moving; we try to help the patient rediscover his or her repressed breath, movements and expressions. Perhaps then words and thoughts will change a little. This change may in turn trigger new responses not only from the person him- or herself but often from the person's environment as well.

Summary

It is important never to press forth fundamental change in our patients. Tension is our way of protecting ourselves. When the patient is suffering from extensive pain and tension, then we need to search for the possibilities of inducing a subtle change, a change; a change that makes an *appropriate difference*, meaning a manageable change for the patient.
Over time, what really counts is the total of all the small, subtle changes; a slight reduction in the flexor-muscles' tension, a small increase in the hip-extension, loosening the tension in the thorax just a little bit, relying a little more on one's skeletal construction, surrendering to gravity slightly more than before, a small reflection before speaking. All of these are subtle changes that may in time relieve pain. They may also adjust the body's tension appropriately, changes enabling one to meet the challenges of every-day life.

In NPMP we do not start by simply reducing the patient's state of tension. First of all we often have to work on the feet and legs, do movements, help the patient become aware of his or her tension. At the same time we work on the postural muscles in positions like standing, walking, sitting or lying down. Aadel Bülow-Hansen said "When patients let go of any excessive tension, they have to fill something in to compensate for this loss". This might lead to more stretching, more need for stabilising, perhaps one is given access to new movements. When flexor muscles relax, this will naturally activate the corresponding extensors; these extensors will be strengthened simply through our daily activities. In turn this may lead to a way of moving and breathing that in time may relieve both pain and tension.

NPMP is about exploring our own reactions and learning to value and appreciate them, it's about arousing our awareness of our own limits by listening to what the body tells us; a person may gradually feel more secure and competent, with enhanced self-respect and self-esteem as a desired consequence.

About the Chapters

We have placed the chapters in this book in an intentional order. All the same, each chapter has been attempted written so that they may be read in the order of the reader's own choice.

The first chapter is written by Alette Ottesen. This is an account of one Norwegian psychomotor treatment session, an observation of a colleague at work. She writes about what she sees and hears, about her thoughts on the way and her reflections. The patient is a young man suffering from knee-pain.

In the next chapter, written by Berit Ianssen, we accompany her and her patient through a year and a half of NPMP. We meet this patient again, shortly after the therapy had come to an end. The patient is a woman referred for NPMP because of stomach ache.

Ingeborg Hanssen lets the reader in on her sessions with a female

patient, who was taciturn and in such a lot of pain. Gradually the pain subsided, and the woman became more communicative.

Ingar Kvebæk gives his account from a series of NPMP treatments dealing with a school boy who had reading- and writing-problems. As the therapy proceeds, change happens, and with change, the boy begins to recall significant events from earlier in life.

Eli Rongved tells us about a therapy-relationship that did not work out and was cut short. We are let in on Eli's personal experience and reflections on what happened, and why. And finally we learn about her new reflections and understanding in retrospect, as a result of on-going discussions about the course of events with the co-authors of this book.

Gudrun Øvreberg's two chapters complete the section containing case stories. In the first chapter we meet Mai. Mai has many complaints, and suffers extensive pain. We get a close-up of Mai, during therapy and afterwards. Øvreberg also gives us some general reflections on NPMP. Tom Andersen writes a follow-up account of the authors' meeting with Mai some time later. Gudrun Øvreberg's second chapter is about the NPMP approach when children become patients.

The second part is written by Tom Andersen, based on conversations and discussions within the group in the process of the making of this book, but also from countless meetings over the years. He reflects on the on-going process in NPMP, what is it that influences change, why does change not always happen, and the reader is introduced to the phrase "appropriately unusual". He also brings up significant elements regarding the body's movement, and he philosophizes about human being, and being together, historically and in clinical practice.

Ingeborg Hanssen has written the lyric poem – *Rings in Water*:

Rings in water
a sigh beneath the hand
opens a barrier
sets free
eases breathing
breath spreads into new spaces
like rings in water

Alette Ottesen

A Treatment Session

Norwegian psychomotor physiotherapy (NPMP) normally takes place in a plainly furnished room. A treatment table, a stool, some cushions, towels, a floor mat and wall bars, this is all we need. Many patients are surprised when they see that we have neither electric apparatus nor a studio with a lot of training equipment. Our agenda is to restore free and natural movements in bodies generally lacking subtleness and free flexibility. When the body is already working hard to manage its own weight, then additional weight-training certainly seems a bit out of place. The aim is to let the patient establish or reestablish their own free and easy way of moving, before exposing their bodies to this kind of strain.

A Norwegian psychomotor physiotherapy-session lasts for sixty minutes. When patients come for their first session, they normally tell the story about why they are here, about earlier complaints, present complaints, how they move, about their muscular state and their breathing function. The duration of this preliminary conversation varies. Every so often, conversation fills the first meeting. We meet the patient's need for telling his or her story. Body examination includes the whole body, it is never purely limited to the areas containing the patient's symptoms. This assessment may often be extended into the second or third session. We let it take the time it takes.

We normally begin each session by asking how the patient has been after the previous session. We wish to increase their awareness of what is going on, during the treatment, immediately afterwards and above all between one session and the next. Not only does this prove important to

the patient, but also to us because this information guides us in respect to what approach we should choose for the coming session.

This dialogue is a most significant element in the cooperation between the patient and physiotherapist. Whatever the patient expresses to us about experiences between sessions influences what choices we make for the continuation of therapy. In this respect, the patient's own words being of such importance, the patient is given more responsibility for his or her own process, and this will often contribute to an enrichment of the relationship between therapist and patient.

So, each treatment session contains elements of conversation, movements and various massage-techniques. We choose our approach according to what signals the patient's body sends us, *here and now.* What happens in the present is given our full attention. With respect to the conditions pain and stiffness, or inflexibility, and the correlation between the life you live and the body you live in, the reader will hopefully learn to understand our way of thinking about these matters by reading this book.

At the end of each session, the patients are normally allowed to rest on the treatment table with a blanket wrapped closely around them. The physiotherapist leaves the room for a couple of minutes, allowing the patient complete peace and quiet. After this rest, the patient gets up on his feet. Together they may now see and feel whether or not today's therapy has made a difference. How does the patient feel at the end of the session? Is there any change with respect to pain, flexibility, balance and poise?

Readjustment regarding musculature and breathing pattern, takes time. And we must be constantly aware of this time-factor. The patients must be allowed to take their time for change to happen. It is certainly *not* a fact that more frequent therapy will lead to better results. This is no quick fix, but a process that takes time. So, maximum session frequency is one hour a week. Later on the intervals between sessions is prolonged, to two or more weeks or we may even speak of months.

There are no rules as to how many treatment sessions a patient

needs. In some cases 1-3 sessions is sufficient for initiating a process that can be continued by the patient himself. Sessions may be about advice on exercises or movements or positions that are pain-relieving, or re-adjusting overworked movements; or they may be about clarifying the problem and perhaps wanting the patient to be referred to other consultants. Sometimes we may come to a conclusion that the patient's pain does not originate from tense musculature, or the time may not be right for initiating a process with the NPMP approach. Regarding the latter, reasons for this are numerable; their life-situation may be so difficult that body change is not possible at present, they may be so run-down that they are not ready for a change-inducing process, or they may simply not be motivated for this kind of therapy. Then the question is, who's idea was coming for NPMP in the first place?

On the other end of the line, we have patients who are given a follow-up over many years. This may relate to the time-span needed for change to happen, or it may be about needing just a reminder now and then, to "keep on the track" so to speak.

Observing a Treatment Session

In the following I alternate between describing the session in present time and giving my professional assessment of it. My observations during the session will be used to reflect more generally around Norwegian Psychomotor Physiotherapy. I will also present some simple exercises/ movements.

I had no information about the patient previous to this session. Shortly afterwards I had a short conversation with the physiotherapist, and then I wrote down my own observations. Later on I contacted the physiotherapist, wishing to hear his reflections after this session.

Ten O'clock, One Tuesday in April

A young man enters the room. We shake hands. I sit on a stool in the corner furthest away from the treatment-table. The physiotherapist asks how he's been since the last session. The patient tells the physiotherapist that afterwards he had been tired and had felt delightfully sluggish. His breathing had felt better and this improvement had lasted two or three days. He also says that he now wakes up in the morning and notices how tense his muscles have been while sleeping, and how weary his body feels.

The patient tells the physiotherapist that he has been an active sportsman. A few days ago he had played a little football. After about three minutes, his pulse was racing. "I don't understand what it is that has happened to me, I'm used to being in good shape". The physiotherapist believes that the sudden increase in heart rate can happen because of his rigid thorax. This rigidity may hamper satisfactory ventilation, a condition that offers his breathing function great resistance. This condition seems to be most obvious when he is cold. The patient asks once more why he is in such poor shape. The physiotherapist tells the patient that he puts in too much effort. "You're working with your handbrake on".

The expression "working with the handbrake on" appropriately illustrates one way of understanding muscle tension. Increased muscle tension hampers natural movement in any joint, including the chest, stomach and throat, meaning one has to apply much more force, "give more gas" to create movement. But, despite all the effort, the body won't "roll along" naturally. We run out of breath, we need more air; like the car running out of petrol. Being overworked like this will in time create a wear and tear on the body. Even while sleeping the body's "handbrake" may be on. If this be the case, the person will wake up in the morning with a tiredness in the body as if he or she has been doing hard labour during the night. Muscle tension, or our metaphor the handbrake, is indeed hard work; work often being performed without the person's conscious awareness of doing so.

The physiotherapist tells me that the handbrake-metaphor gives people an immediate feeling of the waste of it all; the brakes are worn out, the engine is worn out and still demanding ever more effort. This is a mechanical way of thinking, but lets us grasp the simple fact that, regardless of the cause, this is how our mechanism functions. Not only does tension cause pain, it is also interferes with the ability to move freely and easily.

Pt: patient. PT: physiotherapist.

Pt: When breathing trouble starts, I become restless. I'm annoyed at having this kind of problem, it shouldn't be like this.

PT: How are these problems now compared to before starting with NPMP?

Pt: Possibly worse now.

PT: What about the legs?

Pt: They feel better, but my knees hurt after training. I can feel dizzy after treatment. I'm not very active at the moment so I'm gaining weight. That makes me feel uncomfortable, and I've started holding my stomach in.

PT: Your musculature is in a process of change. Try to be content with less training now until you are able to move in a more relaxed way. Movement is good for you, so walk, go swimming, but avoid intense training.

Pt: I'm not so wild now.

This preliminary conversation lasts about 15 minutes. I sense a pleasant atmosphere, a good dialogue between the physiotherapist and the patient. What do I see and hear to give me this feeling? The patient is allowed to speak and the physiotherapist listens with great state of presence without interrupting him. The patient seems to appreciate being both seen and listened to. The patient and the physiotherapist appear to be on each other's wavelength, they are about the same age and the same sex. To me, this is a good encounter between two people in different roles.

The physiotherapist is of the opinion that the fact that he and the patient are of the same age, is one factor that might contribute to this pleasant atmosphere. It enables the physiotherapist to kind of feel the patient's body as if it were his own; the physiotherapist can sense his tension and thereby in away comprehend the patient's ill-feeling.

The patient had many "aha-experiences" and was given several "eye-openers" during the examination; he felt that he probably could benefit from NPMP. This kind of treatment made sense to him. He discovered that what happened during sessions was of great importance. He became tired, he was moved. At first, he would only focus on his knee. Subsequently he realized that the job they were doing concerned his whole body. He was permitted to talk about his knee, he was given time, and after a while he started talking about other things.

The physiotherapist tells me afterwards that the patient had been referred to him because of knee pain. It is quite unusual that patients with this kind of problem are referred to NPMP. After the first examination the patient started talking about his breathing problems. These had commenced quite soon after splitting up with his girlfriend, a topic he spoke about openly. The patient had a feeling that there could be some kind of connection between this and his breathing complaints.

Since the patient seemed to respond well to treatment, the physiotherapist meant that he could begin working directly on loosening up the patient's respiration. The patient easily released his tensions, he was spontaneous in both comments and breathing response, but he also experienced an increase in his breathing problems. The patient was not "on guard" as we say, meaning his respiration and his musculature responded freely to the applied treatment. The physiotherapist reflected on the following: should he have worked more on the patient's legs before he to such an extent challenged his respiration pattern? But at the same time the patient was very much in contact with the process going on in his body, he was so alive. Because of this the physiotherapist saw no reason to readjust the treatment this far.

About Training

NPMP may certainly represent a new and unfamiliar way of thinking to patients who are used to high tempo exercise requiring raw power, to those who function within in a fixed pattern of movements. The physiotherapist must always individualize his or her approach. In every way the physiotherapist must aspire to make the treatment *suitably unusual*, as described by Tom Andersen.

We frequently see that those who already do a lot of exercising will often increase their amount of training when their bodies have "gone astray", so to speak. They believe that *doing more* of what they already do is their key to recovery whether they have problems with their breathing, have a tired back or their hip is painful. "I just need to exercise harder, then the problems will go away" they say, and in some instances that certainly might happen . . . However, in states of increased tension, we often see that when they continue moving in the same tense pattern, and even accentuate the intensity of moving, then problems will increase instead of being relieved. One has to do something new, something *suitably different*, something that deviates from the habitual movement patterns that have become so troublesome. Can a tense person be swift and strong? Yes, he probably can, but on the other hand, since we know that tension hampers movements, extensive training will certainly give poorer results than expected. Tension limits the outcome of training; tense muscles' functioning can never be optimal regarding strength and endurance. By moving the way nature originally intended us to, muscular function and joint weight will be distributed perfectly throughout our body.

Treatment in Upright Position

The patient is standing on the floor. The physiotherapist is working on the tension in the buttocks and around the knee caps of both legs and comments on the patient's muscles that they are tense and that the knee caps don't seem to move freely.

The physiotherapist gives instructions, and the patient explores the exercises both in standing position and sitting against the table. The patient concentrates when doing these movements. The physiotherapist rests his hands on the patient, and gently guides the patient's movements; the muscles involved in these movements are unaccustomed to this kind of work. The physiotherapist alternates between guiding these movements and massaging and stroking the muscles that need relaxing. As the patient is seated against the table, the therapist massages the thigh muscles and comments on the left thigh being stiffer than the right one.

> Try to sit squarely on your buttocks and keep your feet on the floor. Let the knees glide apart and jiggle them – jiggle them in a rocking motion. The intention of this exercise is to invite you to experience a sense of relaxation around the hips. Sitting like this one may explore what is happening in the hip- and pelvis-region.

The intention of this exercise is to influence a relaxation-response around the hips; this will allow the breathing to flow deeper down to the stomach region and open up to freer circulation through the pelvis and down to the legs. Does this exercise affect my breathing function? Does it affect the temperature of my legs? Is there any movement in my lumbar region or in my stomach?

To be able to answer these questions one needs to be in possession of a conscious awareness of one's body, of its subtle movements and function. Feeling tired after running or after having done traditional back-, stomach-, and thigh exercises is easy. However, simply allowing oneself to be influenced by small, slight movements or accepting a feeling of relaxation through 'jiggling' movements can be more of a challenge. It may be difficult, but this is crucial body knowledge, acknowledging the well-known statement: less is more. This is about listening to your body, and doing what it tells you. Nobody else but you can feel your pain, your weariness, your limits.

The patient gets up on his feet and the physiotherapist looks out for any change. The buttocks' tension is still present and the physiotherapist thinks this may have something to do with the calf muscles being too short and tight. The patient is then shown a simple exercise for stretching these muscles. He places his forefeet on a phone-catalogue and, with knees straight, he pushes his heels towards the floor. Any thick book or a high door sill can function quite adequately as "training-apparatus"! The calf muscles will be stretched, sending a stretch-impulse to the rest of the body. This, in turn, may induce a breathing response. The patient is encouraged to do this as a home exercise.

Home Exercises

Home exercises are usually an important element in NPMP. To begin with, the patient gets only one or two exercises to practice on between each session. After a while, the patient might come to enjoy doing them. When tension is released one may be able to consciously experience one's own reactions and sensations. These exercises, or movements, are meant to be adaptable to situations in every-day life. As a result of doing and becoming acquainted with them, specific exercises may be spontaneously applied whenever feeling oneself tightening up again. To some extent this enables the individual to deal with own health problems. One is allowed to assume responsibility for one's own life, enabling him or her to take action when breathing problems start or when the legs start shaking. It may then be possible for patients with tension in the jaw area to break the tension pattern simply by jiggling the jaw and moving the tongue around. A deep breath often follows, and this may set off an impulse that activates a relaxation-response. The constant tension in the muscles of the jaw is released for a while. One might say that one of the principles in NPMP may be expressed in the following three stages: move, stretch and let go.

Treatment in a Sitting Position

The patient is asked to sit on a stool and gently rock his legs, apart and together.

Pt: A 28 year old body like mine shouldn't be like this. I spend so much time on the couch relaxing, and still…
PT: Like you said yourself, you're not rested after having slept. You're probably working in high gear all the time, spending a lot of energy.
Pt: Rocking the legs gives me a pleasant feeling, it's relaxing.

The patient sits on a stool while the physiotherapist massages the muscles of the buttocks and assists the patient in rocking his legs. The physiotherapist then asks him to lean forward; to let his head drop first, and then to let his back follow. The patient keeps hold of his head; if he lets go, as instructed, then this generates back pain. The physiotherapist tells him that he probably unconsciously holds his head to avoid pain. They then work together, and the patient tries to let his head drop without pushing back the lumbar region. He tries to let his neck and upper body relax and drop forwards, at the same time making allowance for his breathing. The physiotherapist sees that the back yields because the patient releases his stomach tension. The physiotherapist checks once again the muscles of the buttocks. He repeatedly goes back, looking for changes, thus finding out whether or not he may continue working on the same muscle groups.

Treatment in a Prone Position

The patient lies down on his stomach on the treatment table. The physiotherapist rocks his legs a little, pushes the buttocks down with a flat hand on the seat and a flat hand that follows the movements of the torso. This hand on the torso moves around a little.

PT: How does what I'm doing now feel to you?
Pt: It's a bit of a change for me having to describe how everything feels, I'm quite unaccustomed to it, and I find it tricky.
PT: What do you think about me asking you these questions?
Pt: It feels a bit odd. We boys aren't used to that. But I see the connection and understand why you ask. It's about that "being good to yourself" thing. The patient laughs.

It may be prove difficult to arouse one's own fine, subtle movements and it certainly may complicate the matter having to pay attention to one's own response whilst being moved and massaged by the therapist. And even more unfamiliar and difficult having to find the words to describe how one feels. The patient uses the word change. This is what the therapist and the patient work on together. When we work in this way, we often find that change takes place at different levels. Readjustment of the body can change the way one speaks, what one talks about and how it is expressed. This patient says that he is unaccustomed to it, "it feels a bit odd"; this is describing precisely what readjustment in fact feels like. The more tied up we are, meaning in our muscles, our breathing, and our movements, the more awkward or uncomfortable this new body state might make us feel.

PT: I can see that the tension in your back's muscles has changed.
Pt: It was really cool, the first time, when you told me they were some of the most powerful back muscles you had ever seen.
PT: And now we are letting them go . . .

The patient becomes talkative. He addresses me; he invites me, the observer, into the conversation. I answer his questions about where I'm from. As we talk, the physiotherapist presently stops working with his hands and steps aside. The patient stops talking once I'd finished answering. Through this action the physiotherapist lets me understand that he doesn't want the patient to be sidetracked. He removes his hands and

steps aside, and I think it is this gesture that makes the patient refrain from talking to me any further. The physiotherapist continues stroking the patient's back calmly, working on the shoulder blades in order to give the patient an impulse to open up his breathing. Psychomotor physiotherapy requires concentration. Closed rooms without music, telephones or distractions are necessary.

Treatment Sitting on the Table and in a Supine Position

The patient sits on the table, legs as straight as possible. Now he follows the physiotherapist's instruction to let his head drop forwards, then let his upper body follow and at the same time keep his knees extended – in this bent forward position, the musculature of the whole back side of his body is stretched.

The patient then rolls down till he ends up lying on his back. The physiotherapist bends the patient's legs toward his stomach and pushes the small of his back firmly down on the table. Presently the patient yawns deeply. The patient remembers that he used to feel discomfort across his throat when he was on his back like this. It feels better now.

The small of the back rests on the table, with a folded towel underneath to create a greater area of support; this is of great importance, and will be explained in the following. When standing upright the foot soles represent the area of support, as does the seat when sitting, and when lying on the back support is given by the torso, back and seat, arms and legs. One might say that the opposite of a good area of support is like "sitting or lying on needle points", meaning touching the surface only at some points. This reduced area of support may impair our ability to fully succumb to the pull of gravity, and make it difficult to optimally relax our muscles and to breathe freely.

The physiotherapist massages the calf muscles.

Pt: It doesn't hurt that much now. My calf muscles are completely overdimensioned, probably because of all the different sports I've been doing over the years: gymnastics, football, tennis and handball.

Now the patient is instructed in a new exercise. He is asked to contract his thigh musculature; by doing so the knee cap is drawn upwards, in the direction of his hip. He is to pay attention to what happens when he does this.

> Gently rock the straight leg and let your fingers feel where your knee cap is situated. By constricting the thigh muscles, the knee is stretched and the knee cap is pulled upwardly. Can you feel the difference between holding and letting go? Does the leg twist inwardly? Do the buttocks clench? Are the toes pulled up? In this way, one may become aware of small but significant nuances. Working only on the thigh musculature requires little effort.

This exercise may be useful, especially to those who feel their legs are weak and jittery, or to those who suffer knee pain. The exercise can be done in numerous positions but the easiest one is in a supported position, for instance sitting on the floor with one leg bent and one straight.

The physiotherapist now takes hold of one of the patient's legs, bending his leg at the hip and the knee. The patient tries to remain passive; passive meaning passing the leg's full weight on to the physiotherapist.

Pt: I can feel myself letting go, I remember how I did this the first time.

The patient demonstrates this.
The physiotherapist repeats the exercise with the other leg.

PT: It looks like you're letting the leg go more now.
Pt: I can feel it myself. The legs are like jelly.
PT: Are you lying comfortably now?
Pt: I'm comfortable. My throat feels a bit tight.
PT: Then you can roll over on to one side.

The patient moves over to his side, pulls his legs up to, assuming what resembles the foetal position and rocks himself slightly.

Pt: No, it was better on my back.
PT: Okay, roll back again.

Dynamics of NPMP

The dynamics of NPMP imply that the patient consistently shifts positions; he or she stands upright, sits on a stool, sits against the table, sits on the table, lies on his stomach and lies on his back. The physiotherapist shifts from one group of muscles to another but often returns to the previous group before going to the next. One shifts between active and passive movements. One shifts between watching, feeling, sensing the patient while the patient concentrates on how he is affected, and the patient watching and feeling the therapist's movements. One shifts between silence and natural conversation.

How these alternations occur varies from session to session, from patient to patient and of course from physiotherapist to physiotherapist. The time factor is an important element in the dynamics of NPMP. The patient may do a movement at different rates – one movement may be done quickly, another one slowly. The number of repetitions varies also; once, several times. Should the physiotherapist massage now or wait, say something now or wait; there is a constant reflection going on about what is to be the next step?

NPMP is Not a Standardized Method

NPMP requires that the therapy applied is continuously readjusted, always paying heed to whatever reactions arise. This is not a standardized method, and there is no single way of doing a session. The patient's breathing and response/reactions to what has been said and done is what lays the premise for the next step. Many are the approaches that may influence change.

A precondition for the dialogue is that the patients are encouraged to pay attention to what is happening to/inside their bodies and are able to put their new awareness and reflections in words. These elements may turn out to be of great significance to the progress of therapy; they will also serve as guidelines that influence how the physiotherapist chooses to continue. Consequently the patients may experience that their own feelings are important, what they say is important, being of significance both to themselves and to their surroundings. In other words they learn to rely on themselves and their own feelings. This illustrates the dynamics and sense of mutuality between patient and therapist, and how this influences the quality of their "team-work". The patients are encouraged to speak up when something is too uncomfortable, painful or unusual. This is about learning to set one's own limits, and, not least important, learning to express these limits to others. Many patients relate that this is invaluable knowledge for them, and that learning this often leads to a positive change in their every-day life.

Resting

Fifty minutes of the one-hour session have now passed. The physiotherapist covers the patient with a blanket, the lights are dimmed and the physiotherapist and I leave the room. The patient rests for about five minutes and we re-enter the room.

Ending the session

Pt gives himself a good stretch.

Pt: That was a good rest.
PT: What does your breathing feel like?
Pt: It feels like something going on inside my stomach. I could never have managed to lie like this in the beginning.

Pt easily rolls up to be seated on the table.

Pt: Now I notice how I hold my breath in many situations.
PT: That's good. We all hold our breath when situations in life are threatening. When you notice this, it enables you to remember to let go when you are "out of danger". Perhaps this is something you can make use of in other situations.

The session is coming to an end, and the patient gets up on his feet. The physiotherapist says it looks like he's standing easier, more relaxed, and by checking the knee-caps he comments that they at present can be moved more freely than before. The patient stretches his calf-muscles and the physiotherapist accentuates the importance of doing this home exercise regularly.

The patient gets dressed. They make a new appointment in two weeks.

Closing words

The patient was referred to NPMP because of knee pain. During the session, other complaints were mentioned: uncomfortable increase in heart rate, breathing problems, weariness even after a good night's sleep. In addition to this, he has mentioned discomfort directly related to the treatment. Regarding this patient, the muscle tension was not restricted only to the painful area of the knee; the entire body's balance was upset. Another principle in NPMP is about understanding the body's total interaction between its details and the body as a whole; including every single component and every dimension existing *inside* the body, as well as the body's existence in the world.

A central concept in psychomotor physiotherapy is about how pain and muscle tension impairs and restricts respiration, and how this increases the state of tension in whole groups of muscles while others are left under-stimulated. Movement range is restricted as is one's ability to

move freely. This will influence, as well as be influenced by, our general state of health, in all dimensions, emotionally and physically.

NPMP treatment offers no easy solution to any problem. Readjusting the body is a demanding and challenging process. None the less, many are those who find this therapy exciting and rewarding, their movement repertoire being widened, their senses reopened, and they are given help to seek other ways of being present and alive in the world. If movement, respiration and words are stuck or "frozen", pain and other ailments will often break out as a consequence of this state. A patient once said: "It feels like I have set off on an expedition in my own body".

During treatment, body memories might be aroused. The patient experiences something now that is in connection with things from the past. The patient concentrates on the quality of various movements, and how they feel *now* compared to earlier. He makes room for memories, emotions and *new* images. The body's memories of pain and experiences as a consequence of bodily change, may turn out to be important tothe therapy's process and progress. The patient is allowed to be more acquainted with his own body and his body's reactions by reflections and conversation together with the physiotherapist. Memories and pain can often be connected to certain parts of the body and may resurface when we work on these areas.

Our task as professionals is to find out what has become frozen or stuck, and then seek its location. We try to induce a change in close cooperation with the patient. We cannot merely remove discomfort, nor may we take control of the patient, and definitely not put all the responsibility on the patient himself. We work together towards a readjustment, a change in the body. And as the body changes, so will the person, as a natural and unyielding consequence.

Berit Ianssen

Body Dialogue

I started writing this story about Eva shortly after our first encounter. Her doctor had referred her to me for psychomotor physiotherapy and she did not need to wait long for her first appointment at my clinic. She herself made the first call, it was her idea because she had heard about this kind of therapy through friends and was interested. I was on the lookout for someone that I could write about for this book, I was totally open about who it should be and what it should be about. Although I had never met Eva previously, there were several elements about her symptoms that stood out, but neither her story nor her symptoms were overwhelming. She suffered no muscular pains, only gastric catarrh, so this was unusual and interesting. After our first meeting I had the feeling that we would accomplish something together, and this made me highly motivated in my decision to write about Eva for this book.

I never asked her to take down personal notes about her own process during therapy, although I certainly wished I had, but I was scared that this might spoil her process, and that she would experience some kind of achievement pressure, so this kept me from asking. Fortunately she actually did keep a diary; she told me this about midway. Sometime later, before the summer holidays, I presented to her the idea of this book, and asked her if she would consider contributing to it with some of her own material from her diary. Some months later she brought me an excerpt from her diary, and this has been incorporated into the text as “Pt diary”. Later we met to adjust and clarify what we had written together. Exerpts from this post-therapy conversation is presented in itallic throughout the chapter.

When two people meet, conversations arise. What happens between two people is sometimes difficult to put into words. Every meeting is bodies in dialogue. When two human beings meet, like we met in this story, there arises a wealth of signs and symbols in our interaction. This interaction between two human beings, between two bodies, may be too complicated for words. The following account tries to grasp what happened; it is about my thoughts and reflections according to what I saw, heard and felt; Eva passes on her own experiences.

First Session – January

Eva is married to Hans, they have adolescent children and she works at a school. She has been referred to psychomotor physiotherapy by her doctor because of stress-induced stomach ailments. She did however have some problems with her neck and shoulders at the time that her children were small. After being at home for several years whilst her children were growing, Eva resumed her work at school. This is when her gastric-catarrh problems started. These ailments have come and gone during the past ten years, always being at their worst during holidays. They peaked last spring, and she was hospitalized. A stomach ulcer was suspected and this was proven correct when doctors discovered a small ulcer in the upper part of her stomach. The region around her diaphragm seems to be the seat of pain, and she suffers hyperacidity. She never feels tired, not until she is absolutely exhausted. She wishes to learn how to stop before it gets that far.

Her Story about Her Body's Function and Ailments

Her feet are often cold, and they sweat a lot. Her legs are restless; she has to move them all the time. Menstruation, digestion and bladder all function regularly, and are seemingly not influenced by stress. She has never had any kind of back-ache. Her armpits are often sweaty, mostly morn-

ing till midday, and this remains unchanged whether she is stressed or not. Lately she has complained of a slight feeling of constriction of her chest. Many years ago she suffered some head-ache, but not during the last ten years. She sleeps well, and is perfectly okay with her family. They give her energy.

What I See, and My Reflections After Our First Meeting

I notice that Eva moves easily on entering my room and she makes herself comfortable on the stool while we talk at the beginning of the session. She had steady eye-contact, open, and she explains herself clearly. In short, she seems perfectly comfortable. She undresses, and I look at how she stands upright. Her weight is evenly distributed through the body's mid-lines. I bend down and test the mobility of her knee-caps. The left one moves freely, the right knee-cap is a little stuck. I ask her to tighten and loosen her knee-caps (by use of the quadriceps muscles), and she does so without any difficulty. I also see that her breathing is even and abdominal. This quite simple assessment tells me some things about Eva's body-function, and that her body appears to provide a good basis for the onset of psychomotor physiotherapy.

Still seated on the stool I let her drop forwards, first her head, then her chest with the rest of her back following on. Her neck lets go nicely and easily, as does her upper thorax. Ideally in this position there should be an even curve from the neck and the whole way down to the lumbar spine. In Eva's back I note a little sway in the area of her lower thorax, precisely behind where her catarrh is situated. Her lumbar spine is almost straight, indicating some stiffness here. Now Eva lies down on the treatment table in prone position. I cover her legs with a blanket so that she will keep warm, and not feel so naked. To me she seems to rest comfortably in this position. For a while I simply stand by her side, gently stroking her back and the upper part of her buttocks. This is to give me a feeling of her, to get her "in my hands" so to speak, and equally impor-

tant: let her be acquainted with my hands. In this simple way, we get to know one another. This is an important moment in our first meeting; my hands and her skin meet for the first time. I'm not looking for anything in particular, neither for tense nor flaccid musculature. The only thing I do is stroke her back with my open hands, calmly and in even rhythm, in sensitive dialogue with her skin, muscles, movements and breathing. She and I endeavor to get in a suitable dialogue for both of us – we must find our mutual rhythm.

Now I start examining the muscles that cover her thorax and go upwards towards her shoulder girdle. The muscles across her lower thorax are a little firm but apart from this they are nice and soft. I try to lift her shoulder blade, freeing it a little from her thorax. Ideally this can be done with ease but Eva's scapula feels like it's sucked on to her thorax. I ask her to roll up so as to be seated with her legs resting on the table. This gives us a little pause, I go and fetch a couple of towels. I make two rolls out of them, one for support under her lumbar spine, and one for her neck.

Eva is allowed to settle a little, and check out how she feels after I have worked on her back. We don't say much; we are both encompassed by our meeting, our first body dialogue. She rolls down on to the table into the supine position, and towel-rolls are placed under her neck and lumbar spine letting her rest comfortably. First of all I examine by palpation, her calf-muscles and her quadriceps. They seem strong, resilient, and smooth. I move her legs and ask her not to participate, just let me move them passively. She offers a little resistance; she does not pass on to me her legs' full weight. This is perfectly normal, being the first examination. However I do make a note of it since there are scarce findings so far. I place myself on a stool at the head of the table to make an assessment of her head, neck and face.

In the course of this preliminary assessment I closely observe her breathing motion and rhythm. I watch her breath and listen to its sounds. My hands feel this when I place an open hand on her back, her chest or her buttocks. I'm hardly aware of it, I just feel and observe with my hands

without linking my thoughts to the observations, this being as a result of many years of experience in doing just this. Everything I see, hear and feel during a session is my guideline, and through this I am guided on how to proceed. I need to be alert and at the same time relaxed in this kind of dialogue. This is how change is allowed to happen.

I'm at her head, she is on her back with a sheet covering her to just above her chest. If or when a patient becomes relaxed in the course of a session they may become cold, and this will automatically increase the body's muscular tension. I sense that Eva might still be a bit cold, so I tuck her in a woolen blanket. Lights are dimmed so her eyes may rest. I rest her head in one of my hands, with my other hand I examine her neck- and throat-muscles. They are soft, smooth and resilient. I proceed to the muscles in her face, those responsible for her facial expression, and I ask her to jiggle her jaw whilst I stroke her gently across her forehead. Everything until now has felt perfectly fine. All along, my gaze rests on her belly and her chest. It is important not to be obtrusive; she must not get the feeling of being stared at. That's why it's perfect sitting her at her head, this gives me a full, but discrete view of her breathing while she is lying there in this relaxed position. I closely study her breathing movements. Ideally, respiration should start in the abdominal area, moving in a slow, even rhythm, then spreading upwards, filling the chest more or less according to whether a person yawns, stretches him- or herself or reacts to some unpleasant incitement. Eva's breathing stays in her abdomen, it does not go beyond the area of her catarrh pain.

Today's assessment is over. Eva seems to be comfortable lying there, so I give her some minutes more while I give her a short summary of what I have observed and felt with my hands. She gets up on to the floor, gets dressed, we make a new appointment in one week and she leaves the room. I tell her to try to make specific notes of how she feels straight after the session, during the course of the rest of the day, and in the following couple of days. Our first meeting took 60 minutes.

Summary

Eva moves with ease, has firm eye-contact and explains herself clearly. Her complaints are: pain in the area of her diaphragm and a tight, constricted feeling in her chest. She is a little reluctant about being moved passively. Her breathing motion stops at the level of her diaphragm, and her shoulder blades are tensed tightly against her rib cage. Her lower back is a little stiff, and the muscles across the area of her lower thorax are tense. This area corresponds to where she experiences pain from her catarrh. Her sweating (feet and armpits) indicates some kind of imbalance in her autonomic nervous system. Other than this there are few findings, and she seems healthy in muscles and movements. In my opinion NPMP should suit her perfectly.

Excerpt from her diary, the week following our first meeting:

> Pt diary:
> I immediately gained confidence in Berit. Her treatment was pleasant. I felt quite ready to accept what she offered me, and it was okay to be partly passive. My body felt comfortable and relaxed, and this feeling lasted several days. I felt nice and drowsy, slow in a way.

PT: What was it that made you feel so comfortable that first time we met? Did it have anything to with my hands, or was it the slow pace?

Pt: Most of all it was about you, the way you met me, your voice, the way you lay your hands on me, all of this suited me very well. I immediately liked being in the same room as you. I felt very relaxed.

Second Session

Eva had enjoyed quite a pleasant feeling in her body the first couple of hours following our first session. Even the following days she had felt “nice and drowsy”. This is normally a good sign, this means she responds

to the therapy, and it gives her a feeling of well-being. It's just as if her body is telling her that this is the right path to follow. In this second session I worked on her on the treatment table, and I went through her whole body. I observed that her breath filled even more of her abdomen, and this time she let me move her passively without giving me resistance, or helping out. In short she managed to allow me to "do the work". She had a nice rest at the end of the session.

Resting at the end of a session is something we let the patients do as long as they have not had any specific reactions. I dim the lights, make sure they are lying comfortably and keeping warm. I leave them alone for some minutes, assuring them that they may do what they feel like, turn around, move themselves, or just lie perfectly still. Little by little the patients often sink into a deeper and even more relaxed state, and when I enter the room once more, they start stretching, and many begin to yawn. This allows them to let what we have done during the session to sink in to their bodies.

> Pt diary:
> I looked forward to the second session. It certainly felt quite similar to the first one. Afterwards I felt completely drained. It's nice to be able to go home and relax all on my own. I had trouble drawing air afterwards. It was as if my breathing needed to find a new rhythm, a new path so to speak. It was frightening; I thought this must be what asthma-exacerbation feels like.

PT: You tell me you felt drained after the last session – does this mean tired, empty or kind of "set free"?

Pt: It was more like a kind of discharge. My body had lowered its state of tension, and I felt totally out of energy. I had no wish whatsoever to fill in anything new. It was kind of a pleasant sort of emptiness. I felt open, cleansed in a way. I enjoyed this feeling.

Third Session

Her shoulders had become stiff after the last session. Ten to fifteen minutes after she had left the room she had experienced a very unpleasant feeling in her chest. She was unable to breathe properly; it was as if her breath was stuck in her chest, then this feeling had passed, leaving her calm and comfortable and she had felt relaxed the rest of the time. However she feels that her body does not properly obey her like it did before. It's as if it doesn't have the energy to do what she wants it to do.

We work through her whole body once more. I notice that she is in the process of change. I feel it in her muscles. They certainly did feel fine in the beginning, but now they seem full, and even more soft and resilient. She easily lets me move her leg, it seems like she has found out that letting go is okay for her and I am allowed to take over the full weight of her leg. Her respiratory movement is also undergoing change; it's flowing more freely, even if it still hasn't fully reached her chest. None of this is very obvious, but they are small changes that I take in. She is not very talkative this time; to the contrary she is in fact quiet and introvert. She seems to be in deep concentration, this makes me choose to be quiet too because I feel that words would disturb her now. Should this silence turn out to be a pattern for sessions to come, then I will at some time have to consider "breaking in", but for the time being, it's quite okay like this, and seemingly necessary for her. I expect that words will come naturally when they are ready to be spoken.

PT: How did you experience the quietness in the room?

Pt: There and then it felt like the most natural thing in the world. I was in no need for speaking. I recall appreciating this feeling of peace. The peace and quiet made me feel relaxed, and I could fully concentrate on what was going on in my body. Normally I use the spoken language extensively. Speaking so little during that session felt somewhat strange – but it was definitely nice this way.

Being the therapist, mine is the responsibility when it comes to creating

the room's atmosphere. I believe that stillness is essential to allow one to sink deep into oneself. To feel and experience what is going on inside one's own body is a prerequisite for discovering and creating change. Gradually the spoken word will come naturally.

> Pt diary:
> This week I feel that my body doesn't obey me. I have difficulty in coordinating my arms and my legs. When I wish to lift my arm, it doesn't seem to follow the order; I even trip over my own feet. And I have had an outbreak of acne!

PT: Acne, is this a frequent problem of yours?
Pt: Yes, periodically. But this time they were excessive.
PT: This means that the changes you have experienced have given you a hormonal reaction.

Fourth Session

After the last session she has slept a great deal. She has been tired and drowsy. However, when in daily activity she functions quite okay. Her limbs have been feeling so heavy, and she has made herself less busy than she normally is during the day. After having been in any kind of activity she tires in a pleasant sort of way. She no longer has that tight, constricted feeling inside her chest.

Today she mostly lay prone on the table while I worked on her back and diligently on her shoulder blades, for the purpose of relaxing their position towards her rib cage. I also worked on the muscles in the area of her lumbar spine with the intention of relaxing this part so as to give room for a deep basal breath. Afterwards she sat up, legs resting on the table. One at a time, and effortlessly, she let her arms move forwards, allowing her shoulder blades to glide freely along her rib cage. Her breathing motion is in steady progress.

Pt diary:
My walking is slower. I don't seem to be able to increase my pace, even if I want to. It feels like my body doesn't obey my head. I'm getting annoyed at not being able to walk faster. I almost feel stuck in my chair when I want to get up. My body is full of tension, I feel like I'm constantly premenstrual.

PT: Can you tell me a little more about this? What kind of tension, uneasy, creative?
Pt: Definitely not the creative sort. More the uneasy type. My body was restless; I did so feel the urge to be in balance. The way I felt is very accurately put by comparing it to being premenstrual.

Fifth Session

After the preceding session she had not felt as tired as before. Now she feels more like usual, and stable. All the same, there is definitely something going on in her body, something making her feel premenstrual, even if she feels pretty much in balance emotionally. She dreams more, and in the morning she is more tired. She feels a little dizzy when getting out of bed.

Today her calf-muscles are more tender and ticklish. She practices kicking her leg out straight, both in supine position, and seated on the table with legs out in front of her. I do some work on her hip-flexors, the ones situated profoundly in the region of her lower abdomen. They are pretty tight and tense, and these may resist basal, low-abdominal breathing. The medial area of her thighs is also more tender than before, especially the region down towards the inside of her knee joint. During today's session her stomach rumbles.

This time we have mostly worked on her hips and legs. They are more tense than usual, signalling to me that something is happening, something is changing her body's way of functioning. Her legs have

work to do, in quite a different manner from what they are used to. For a period of time this might prove a little uncomfortable for Eva. Perhaps this fact accounts for her dizziness, her legs don't carry her the way she is used to.

When she has gotten off the table and resumed a standing position after treatment and rest, I notice her waistline drawing in. She pulls her belt in tighter than usual because she likes this feeling of tightness around her waist. I continuously assess every change that happens. Do I sense any resistance to change on her part, or is it all a part of the ongoing process? Does drawing in her waist line mean that she holds her breath, or is it because her legs and hips are taking more of her body's weight, and therefore rendering the muscles of her abdomen short for a while? In short: is she putting her brakes on, or is all of this a part of change happening in her body? Most often a situation like this will contain both of these elements. I do something that induces change in her body and, she portions this out for herself so that the change that happens suits her. Not too quickly, not too slowly.

> Pt diary:
> I notice that my speaking has got slurred in a way. I feel that my tongue and my lips don't obey me. I also feel lethargic, everything, even my thinking capacity is slow. The treatment sessions still leave me drained, and I can sleep for hours on end when get home.

Every time I read these few lines, it makes me wonder: What is the act of thinking? What is the spoken language? During these five first sessions we have worked quietly, my tools have been massage and movements. Her tongue and lips won't obey her. Won't obey whom and what? Are her tongue and lips actually unable to word her thoughts, meaning not being able to physically express the words needed for any specific situation? She also experiences her thoughts as sluggish. What connection is there between mind and body? How may mind be separated from body? Is this possible? Is it so that when change happens in the body, the mind and also the spoken language change correspondingly?

Sixth Session – February

Eva felt fine after our previous session. Her body feels more nimble, and her upper body is more relaxed. However, her arms and legs are still badly coordinated and she feels clumsy and often trips or stumbles. Now she is actually able to recognize her own emotions. She immediately knows how she feels and is therefore more capable of making decisions in her everyday life, be they large or small. Coordination problems also affect her speech. Even her articulation feels clumsy, but this improves little by little. Her mouth feels different now, and she speaks her mind more spontaneously, what she says has become more direct and clear.

Today we start by letting her stand with knees slightly bent, and head, upper body and arms bent forwards, hanging down. She lets herself drop nicely forwards into this position. She is quite relaxed but there is a minor tension in her neck. With Eva lying prone on the table, I start where I left off the previous session, working on her left shoulder blade, with the intention of relaxing the muscular tension between the shoulder blade and her rib cage. I still feel that they are hanging on to each other. She rolls over on to her back, and we work extensively on the area around her knees. I knead and massage the muscles; she works on her knee extension, alternately left and right side. We also work on her calf muscles, alternating between my massage and her pushing her knee into extension. I see clearly that her foundation – hip-region and legs – are stable and functioning well. In the next session we will concentrate on her arms.

> Pt diary:
> I'm scared of driving because my reactions are too slow; my ability to react appropriately seems to be impaired. There have been a few close calls recently. I lack initiative, and in the house and at work I do no more than absolutely necessary. This seems to be okay with Hans. He does whatever needs to be done, and is very interested what is happening to me.

Seventh Session

It's been a good week, and Eva has felt light-hearted. She has experienced such a strong feeling of happiness in her heart. Her chest does still not contain her breathing, but it's definitely on its way. My plan from last time was to work on her arms this time. This plan was not followed. It didn't seem right.

> Pt diary:
> I feel very self-centered. It is so exciting witnessing what's happening to me, physically and emotionally. I need to be by myself a lot now, but not for thinking, or solving problems. I need to "meditate". I don't feel so involved with people and activities around me. I'm even quite indifferent to my parents, my husband, and my children.
>
> Eighth and ninth week – Winter holidays:
> It been good for me not to be in treatment and under her influence the last two weeks. But now I look forward to our next session. I feel that some things are about to fall into place.

Eighth Session – March

No particular reaction after our last session. She felt a little heavy and a lack of energy to day. We worked through her whole body, without emphasizing any special part.

> Pt diary:
> I feel anti-social and spiritual. I experience inner peace, and I write and draw a lot. During the last weeks my tummy has become larger, and my breathing has moved down. It feels so good. It feels like my breath has discovered new inner spaces in my body. Drawing and painting is easier for me now, my expression is more direct, and my line is more sensitive and sincere. I'm not afraid of expressing my-

self, I've regained my self-confidence, and currently my products are better than before. I have a quite distinct feeling that drawing is important to me.

Ninth Session

Eva had slept for three hours after our last session. She woke up feeling so fresh. The muscles around her knees feel a little tender. Her abdomen has become larger, and her trousers tight. She pays attention to her tiredness, and is not as dependent as before on having to know what the time is. She is lying in prone position on the table, and she tells me that she laughs more, not because there is more to laugh at, simply because she feels laughter bubbling inside of her. When the abdomen changes its shape like this, then I know that her breathing pattern has changed. Where and how we breathe shapes our bellies, this specific change is of fundamental importance, and hasn't been controlled by either one of us. Many of you will ask what's so great about her belly becoming larger? Most people like them to be nice and flat. To this I can only say that her abdomen is now behaving perfectly naturally. Our bellies should be soft and ever-changing according to the changes in our lives. I ask you, the reader: Imagine being a uterus, intestines or a bladder, and all the tissues around you are still, and static. You would certainly feel better if everything around you moved in a soft and sensitive rhythm, like seaweed swaying in the ocean. In our inner organs there is continuous activity, never-ending movement. They certainly function better when their environments also move.

PT: Eva, how did you react when you became aware of the fact that your breath went all the way down to your lower abdomen?

Pt: It felt like I had opened up new airways, new passages – it felt like my breath reached places that until now had been closed. When these closed places opened up and let my breath in, so to speak, I became aware of a new kind of sensation in this area.

Pt diary:
All this time I have a strong feeling of confidence and assurance towards Berit. I am deeply grateful for what she has brought forth in me. During the previous session I remember experiencing an emotion I have felt only some few times as an adult – it felt like she was a kind of redeemer, though not in the religious sense of the word. I had the same feeling towards the midwife who delivered my first baby, and towards the painter who taught me the art of drawing and painting. One day I experienced this fantastic feeling right in the middle of a class. It came suddenly, this feeling of steadiness in standing and feeling so secure. It was a strong awareness of being present in my own body.

Tenth Session

Today I inquire about the pains related to Eva's gastric catarrh. I wonder if they have changed character at all? Yes, she answers, in fact these pains are completely gone. She is also aware of the fact that she is not as stressed as before, and colleagues remark that she no longer rushes down the corridors between classes. At times she is more tired than before, in various periods during the day. She misses the feeling of abundant energy. She actually feels a little lazy. I tell her that change is demanding; besides I think that what's new to her is that she now is aware of being tired, contrary to earlier when she simply persevered, ignoring the signals of tiredness. I tell her that since she comes for sessions as often as once a week she probably is especially observant of what's going on inside her.

Another change worth mentioning is her increased ability to make decisions, decisions on small everyday matters, or more important ones at school. It comes easier to her whether she should say yes or no, and is more certain about what is right for her. What has happened to make decision-making so much easier? Does her body speak more loudly and clearly? Does this loudness drown the voice of the normally so loud-spo-

ken common sense? Perhaps at present these two voices are more in balance.

We work gently through her body, she is still a little stiff across the chest, her breast muscles slightly over-tense. However, she is soft around the area of her diaphragm and her upper abdomen. I continue thinking out loud on what we talked about in the beginning of today's session. When she started this series of treatments her muscles did not hurt, there were no aches and pains, only this gastric-catarrh business. So how do we explain all that has happened to her during these few months? She feels like being in flow. Her breathing flows nicely into her chest, and also down into her abdomen, also the lower parts. It changes its route, adapts itself in accordance to my stimuli. She rests nicely at the end of the session.

Pt diary:
The last couple of weeks it's been easier for me to make decisions. I seem to know, without delay, what's for the best. Besides, I have left much of the control and responsibility to Hans – things I don't have time or energy to do myself.

Thirteenth week:
I feel calmer, more relaxed, and more secure in social settings. I am more present in the "here and now". When it came to packing for the Easter holidays: this went ever so peacefully. It was easy for me to leave be whatever I didn't manage to do. Can't be everywhere, I told myself. I was perfectly relaxed in the car even as a passenger. Normally, in this role, I am much more stressed, that's why I like to drive myself. I have also noticed being more connected, and more concentrated on reading. I have been able to sit in the living-room with lots of people around and about, and let myself get absorbed in my book.

Eleventh Session

Eva had felt pretty tired after the previous session; not anywhere in particular, just all over. After this she had felt in perfect shape. Energy is on its way. She feels strong, stronger than before, it's like a source of power coming from within; her own power. She feels calm, relaxed, and in balance in body and soul. This feeling is often experienced by people who are aware of positive changes in their bodies. They become strong and relaxed at the same time.

Today Eva starts by sitting on a stool. She is sitting perfectly comfortably, and I let her drop forwards while seated. I make note of the same stiff, straight section from her lower thoracic vertebrae down to her sacrum but her tummy is nice and soft. Sometimes back stiffness may be caused by high tension in the abdominal muscles. This is certainly not the case here. Eva has never suffered any kind of back-ache, so we just leave this stiffness be, for the time being. All the same, I do massage the muscles in this area; they are tense, and hurt when massaged. I assume they have been a part of the state of tension her diaphragm and her chest have been in. As she lies in a supine position I massage the muscles of her right calf and we alternate between my massage and Eva actively kicking out her leg. As her leg slides down onto the table, she lets her knee drop sideways so her leg is outwardly rotated on its way down. While working on this, we talk about Easter, the weather, and about what books we are reading. She is reading about female archetypes, I'm reading about women in China. In the end I work on her facial muscles, alternating between my massage, and her pushing her jaw forth, and gaping. She rests nicely on her back. Afterwards her calf-muscles are smooth and even.

In the previous session I asked her if she would like to start coming for sessions once a fortnight instead of once a week. Today she says it was lovely to have two weeks between this and last session. She was spared the tiredness she always experienced after a session but at the same time she was a little apprehensive, afraid she might relapse into the state she had been in. As a therapist, one might also be worried that this might hap-

pen. However, being in treatment is very demanding – constantly being brought out of balance, and having to find a new way of getting back in. Checking out if the change has been established is certainly important, both to the patient and the therapist. We wish for change to continue even when therapy is less frequent because this is also a way of learning that change takes time. We agree on going over to sessions every second week, and I tell her that I think this will be just fine; if not, then we can easily go back to weekly treatments.

> Pt diary:
> I feel that all that is new in my body has found its place, and I waver between wanting to stop and wanting to continue. I'm calm, in harmony with myself and my surroundings. Lately I have felt my emotions, unfiltered, and this is a good thing, but at the same time painful. I'm surprised that this therapy has awakened so many positive and pleasant feelings. I had thought there would be more of the hurting ones.

Twelfth Session – April

Once again Eva felt perfectly fine after our previous session. She is doing well and doesn't get as tired as she used to after therapy. Since we last met I have attended a course in psychomotor physiotherapy, and today I feel very much inspired and intent on working specifically on certain places. I spend quite some time massaging the tender areas around her lower thorax and her shoulder blades. I am quite persistent, my firm grips hurt. In the beginning she pulls herself out of my grip but after a while she reacts by sighing, moaning and moving herself. I work on her in different positions: at first sitting on the edge of the table, then standing with bent knees, upper body hanging forwards. Her movements are good, and her muscles in back and front are quite relaxed. The rest of the session we worked on the table from prone and supine positions.

When the session has come to an end, I ask her if she had experienced anything different this time. Yes, she has thought of me as being more technical, contrary to previous sessions where she has been allowed to be more participating. My own reflections on this session was that I have been more precise and more demanding. I wonder how she will react this time; will she feel more anger, or more sadness? After her rest she tells me that she didn't go into as deep a state of relaxation as she had done earlier. When she gets off the table and on to the floor her legs feel nice and easy. She happens to mention that she feels much more rooted to the floor when reading out loud in class or singing in the choir, and she has had much more breath. Her voice no longer tires by reading or singing.

What happened during this session? Who follows whom? I probably was rather eager and persistent. Maybe I am a little out of balance because I'm very much concentrated on my own agenda – my own professional updating. Perhaps this makes me lose track of our, her and my, mutual rhythm.

> Pt diary:
> I feel that some kind of balance has been disturbed. Right now I feel precisely the same way I felt after the first sessions – premenstrual, uneasy, acne etc.
>
> Seventeenth week:
> I'm not sure continuing this therapy was the right thing to do. I remember Berit mentioning that many went on too long. What did she mean? Is all that has been built up during the winter broken down? I'm not sure what to think, but right now I do not know if it is wise to continue.

Thirteenth Session

Eva feels that it all got muddled up the last time. Everything that had been going so well has just become a mess. She feels that she has been pushed out of balance once more. It annoys her; she trips and stumbles more, she has become more restless, and has lost her inner peace. This uneasiness reminds her of the symptoms from the very start, and she is definitely not motivated for reviving this phase. At the time it was okay, but now she wonders if we are on the wrong track. I ask her if she is emotionally unbalanced. She answers no, but admits to easily losing her temper when she trips over something. I said something about why the previous session turned out this way. I explained to her how inspired I had been after attending the course, and how I considered her to be adequately stable, so as to able to tolerate new impulses. Stable enough to travel on.

Today's agenda is about checking out what has happened to the area of treatment from the previous session, and then to work more generally through her body like we had done before, hoping to be able to restore her balance. The muscles I had worked on specifically the last time feel fine. However, she is more in control of her breathing; her respiration does not shift spontaneously in response to my in stimuli. She tells me that she has had some diarrhea, and has felt nauseous the last couple of weeks. There's a lot of it about, thinking she might have caught something contagious, but on the other hand it has lasted too long to be something of that kind. She sweats more than usual, but at present this is a little better. I inquire more about this condition of hers. She says that when she goes to bed at night she feels chilly. Although she normally sleeps with windows open, now she keeps them shut. Some mornings she wakes up drenched in sweat, it's probably 10-15 years since the last time that happened. Now she's back to feeling overpowered by tiredness. She goes to sleep for an hour after school, at around one o'clock, and she sleeps like a log at night and she doesn't dream much. I inquire about her drawing. She tells me that she does draw a lot because it's easy to resort to drawing when she is like this. Her artistic expression is eas-

ily accessible, spontaneous and she sees that her drawings have become better, less cliché, more of her own personal expression.

That same evening I need to sit down and reflect on what's happening. My patent is experiencing considerable reactions in her autonomic nervous system; reactions like sweat, chill, nausea and diarrhea. This may signify some subconscious resistance to the change she is undergoing, on the other hand it might be necessary for her to go through with this. She was more in control of her breathing today; meaning we might be on the wrong track. However she sleeps a great deal, the quality of her sleep seems to be good, her artistic expression is more open and the muscles I had worked on last time had not resumed their state of tension. Based on these facts, I reason that we are still on the right track.

I became aware of the that I was faintly dreaded meeting Eva for our next session. I wondered why. What happens as a result of therapy is certainly my responsibility though I do not always know precisely why I do this much of this and that. By doing too little, progress will not happen; too much, then reactions might be too harsh; balancing between "too little" and "too much" lies in the art of this profession. It is demanding, and I am responsible.

> Pt diary:
> I regret the decision to continue. The nice and confident feeling I had a few weeks back is completely gone. I also sense that Berit is unsure of how she should proceed.
>
> Nineteenth week:
> I still feel this uneasiness inside. I am so indecisive. Now I suffer deep anxiety about losing Hans. I feel jealous.

Fourteenth Session

The first couple of days after our previous session Eva felt better, but then things got messed up once more. She doesn't trip or stumble as

much now, but her articulation has worsened. She has difficulty in finding words, has to concentrate more when talking, and this again makes her less spontaneous. As before, she sweats a lot in the morning, and she eats her food hastily. She tells me that she has hardly any energy, and her arms feel so heavy that Hans had said half-joking, that either I had to give her an energy-boost treatment, or they would have to get themselves a housemaid. I inquire about her emotional state, and her answer is that she hopes she will manage her job until the summer holidays.

However, from the autumn semester she has made up her mind to consider reduced time. Previously this has never been a subject for discussion. She dislikes feeling so lazy. Last weekend she and her husband had visited some old friends. They had talked about how seldom they had been angry or annoyed the last few years. They did not think it had to do with bottling up their feelings, they felt the reason was simply that they had lost some kind of spark, and they had lost their commitment.

We do a little work in the standing position first and I notice some stiffness across her chest. I know she has been like this earlier, but I haven't seen it as clearly as I do just now. She lies down on the table in prone position whilst I work on her back for a long while. Calmly and easily, long slow strokes from buttocks and up to her neck, from side to side, involving the whole of her back, along and across. Her breathing flows throughout her back, and I let her rest for a short while in the middle of the session. She takes pleasure in feeling she has such a "large" back, so much room for air.

Pt diary:
I'm in touch with emotions I recognize from when I was 20. I feel fat, and I want to go on a diet. I'm jealous, and I'm afraid of speaking in public. I feel I've been really set back, or have these feelings always been there, only subconsciously?

Fifteenth Session

Since our last session Eva has felt fine. Her energy level is increasing, but she still feels like she is balancing on thin ice, so this is our topic for today, out of pure necessity for the both of us. The whole situation needs clarifying.

I explain to her how I have experienced this series of treatments so far. I talk about how she made progress, slowly but surely, and then how the situation changed following the session where I had been more persistent. I explain to her my feeling that she is more reserved and doubtful about her ongoing process. Eva says that this is exactly how she feels now. She tells me that she doesn't quite know where I'm taking her, and she doesn't know if she wants to come along. Furthermore she has heard horror-stories about patients who have had this kind of therapy becoming; how some have become seriously ill and never have recovered. We have a serious talk about this matter and I tell her that I think we've come far enough. She has undergone a bodily change, she is more in balance, and the pain from her stomach-catarrh has completely gone. At present I envision working on securing this balanced state, making things fall into place after the recent distress she had experienced, and then finishing off when we meet one final time after the summer holidays. That will let her go through summer without any influence on my part. This clarifying talk took us about 20 minutes. We completed the session by working throughout her body and she had a good rest at the end.

The Three Following Sessions Until the Summer Holidays

Eva had one episode during this period of time when she suddenly got back her old catarrh-pains, but much more intense than before. She just let them be, and believed that they would pass in due course. Her experience after having been in psychomotor physiotherapy was that pain could come and go. This proved to be correct once more.

I worked quite a bit on this area that had hurt so much – at the top of her tummy, directly beneath the rib cage. The muscles in this area were pretty "thick", meaning dense and tense. Being massaged in this area, gave her a good feeling because afterwards she felt free, and happy to be rid of something as painful as this. Her state of sweating remained unchanged, it came over her at the same time in the morning every single day.

We make a brief summary the last session before the holidays. Among other things she tells me that because I have constantly been asking for her bodily experiences and changes, she has become more aware of what is going on inside her. I wonder if I have inquired too little about how she has experienced all that has happened to her. She says that my questions influence what she tells me. There are some emotional topics and reactions that have not been mentioned, but she has not had the need to tell me about these things.

Pt diary:
Lately Berit's treatment has been comfortable and relaxing. Again I am sincerely grateful for what she has done for me, and for helping me out once more. I get a lovely, warm feeling when she works on my face.

Twenty-fourth week:
I am more present in everything I do now,. I don't really care what I do, it's how I do it that counts. It's important to me that what I do gives me a good experience. I enjoy doing things I thought nothing of earlier. It's okay to stop now. I've regained my peace, I am able to go on in my life without Berit.

Thirty-third week:
I've enjoyed being on my own, not constantly being under the influence of psychomotor physiotherapy. Things have calmed down. Strong emotions bring on pain in my diaphragm. However the pain

is different, sorer in a way, compared to that constant lump I had before. A lump I mostly kept at bay, and occasionally let loose, depending on the circumstances.

I haven't yet retrieved that feeling of peace and calm I experienced at one point during the series of treatments. Perhaps this isn't necessary? Not until quite recently did my tongue rest back in place. Now my articulation is as clear and distinct as ever.

Nineteenth and Final Session

We've had a two and a half month's break due to Summer holidays. We have agreed to meet once more just to check out if it's okay to stop now, or see if there has been any kind of set-back. Eva has had a nice Summer and feels that her body is in a constant process of change. I note that she is in balance and that her breath flows freely, in chest and belly. She is still a little stiff across her lower back but if, in time, this stiffness gives way, she might feel a little vulnerable as her lumbar spine "investigates" its newly won freedom. We agree on stopping for now but she must feel free to get in touch with me any time should she need my help some time later.

The First Winter Afterwards

During autumn and winter, Eva attended one of mine movement groups, in a gym in our home town. She had one back-ache episode, from which she recovered quite swiftly. She also got the flu, which she hadn't had for a great number of years. She enjoyed participating in the group. She was definitely in balance. We met again in January when we had this talk that you have been allowed to listen in to. I will finish off this chapter by letting her summarize the change she has been through:

PT: Could you say more about how this change in your breathing pattern and the pain release from your gastric catarrh was for you?

Pt: Normally I would stop unpleasant or offensive impressions or stress from getting past the area of my upper abdomen. Letting my breath pass through this area and also go deeper down meant allowing myself to feel the pain. Until now I have only periodically let my breath drop down into this region. I could do it when it suited me, when I had time after a busy period. When my breath moved downwards, pain and nausea followed, and this was frightening. Now I no longer have a choice. My breathing passes through the place where I until now had stopped it, and it does so quite automatically. In this way I experience what happens to me there and then. Earlier I could keep it away from conscious experience. One consequence of this being that I immediately know it if I'm eating something that is not good for me.

Epilogue

A year and a half after we ended our treatment series, Eva has read through what you have just been reading. She thinks it over, and reflects on how it has been for her since then, and how her condition is now:

PT: How about your gastric-catarrh pains?

Pt: The following year after our final session the stomach pains were off and on. They never lasted long, though. A pain trigger could be e.g. irregular meals, or eating food with too much fat or other types of non-tolerance food. This kind of pain was more direct, more intense than my usual catarrh-pains. It was like a punch, not the usual aching and tormenting kind of pain. Earlier I was able to stop the pain at the top of my stomach, control it, not let it down. In a way I stored it away, thinking I could "meet" it later, when I had the time and energy for it.

In the beginning of our NPMP sessions psychomotor physiotherapy I lost this control, and the pain reached the bottom of my stomach. This made it easier for me to find out what the pains were related to/where they came from, and I got a clearer understanding of the relationship between behavior, emotions and pain. This had until now been quite vague, probably because I always stored the pain away.
My body is more flexible, my back is "softer". I do things differently now, choose other positions, I need to be more attentive to my body's signals because I notice that I strain my back differently now. I am more in harmony with myself, I make choices easier, and I recover quicker after having been tired. In short, I am in good shape and my self-confidence has grown in step with my gradually improving health.

Ingeborg Hanssen

Lost for Words – Lost Expression

I am a psychomotor physiotherapist, and I work in an adult psychiatric policlinic. A few months ago a psychologist asked me to examine a patient of his. This patient had been seeing him once a week during the last month, so far without any results. The patient is a 45 year old woman; her doctor says she is invalided by her anxiety. Quite recently, this woman had mentioned to her psychologist her feeling of body tension and aching muscles. I give her an appointment, knowing nothing of her story.

At our first meeting I note that her handshake is light, and there is scarce eye-contact between us. She sits on the edge of the seat of the chair, her legs are crossed. I ask her if it's okay if we talk a little before we do the examination her. It would give me a head start in trying to get things sorted out If she could express her anxiety in words, and tell me what this anxiety feels like in her body. She does not communicate easily, and answers my questions very briefly. She seems to make great effort in expressing her answers, drawing her breath deeply before pressing out the words. She is still sitting hunched up and cross-legged. Her back is rounded, her front shortened and tense. Her shoulders are drawn upwards, her jaws move scarcely, and in her face there is only slight mimic. It seems to me that even the act of speaking is done with great effort.

We are through the preliminary conversation, and I am able to get some things sorted out, seeing more clearly the order in which things have happened. Three years ago she experiences uneasiness, anxiety, for the first time. It was just as if it came out of the blue and was extremely frightening. This anxiety has stuck with her ever since.

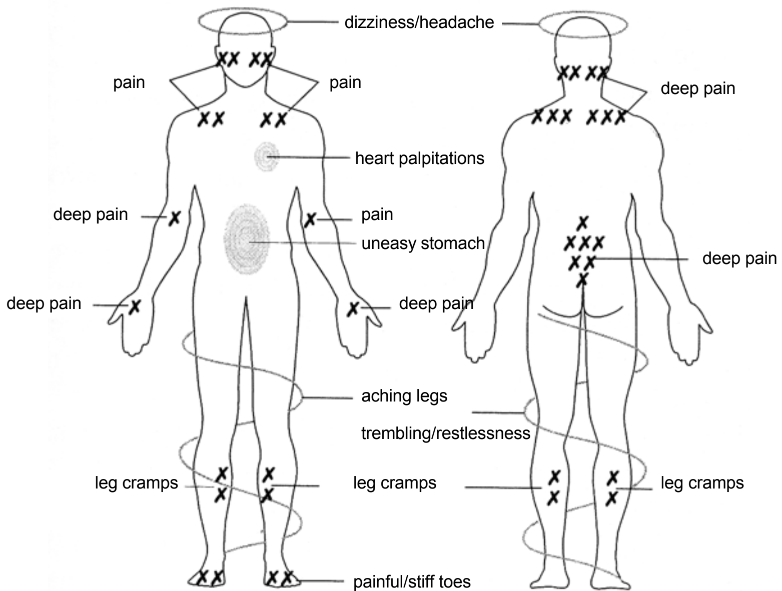
During the last year, fear and uneasiness have prevailed, resulting in 100% sick leave for six months. She is afraid of going out on her own; even quite easy house-keeping is a big challenge to her and she often needs to lie down for a rest. Her symptoms show up as: trembling at first, then next a sensation of uneasiness comes over her, before agitation and restlessness take over and her heart starts pounding heavily. However, the worst has yet to come: airways tighten making it difficult to draw air. These episodes completely wear her out, and afterwards she is bed-ridden for a long time. Regaining daily activities demands great effort on her part. For about a year her body has become increasingly painful, and at the present the aching across her back is constant, she has specific painful points all over her body, her legs ache and she suffers frequent cramping of her calf-muscles.

She tried a series of physiotherapy three months ago, with heat packs and massage but afterwards she was dizzy and felt quite sick to her stomach. Moreover, the symptoms of uneasiness and tightness of breath gradually increased. After a period of vomiting after each session she decided to cease this therapy. I asked her if she had told the physiotherapist about how she had reacted to the treatment. She answered no, because to her, not tolerating the neck massage meant there was something wrong with her, not with the treatment.

Sometime later, her doctor decided to refer her to our psychiatric policlinic. In the meantime, while waiting for this appointment, she took medicine that helped her calm down when the attacks were too severe. She told me that being referred to us was her doctor's idea; he felt that this approach might help her. His opinion was that the symptoms of trembling and muscle pain probably originated out of psychological factors. I ask for her opinion on this point. She doesn't know what to think about it. There is a short moment when none of us speak. Suddenly she draws her breath, holds it, and then utters with great effort that she has read about something called fibromyalgia, and she recognizes her own symptoms in the description of this disease.

Later on, during the same session, I give her a drawing of the human

body, showing both back and front, and I let her mark off her own painful areas:



She gazes at the drawing, without saying one word. I tell her a little bit about Norwegian Psychomotor Physiotherapy and briefly what the treatment is about. I offer her an examination in a few days time, or, if she likes, we may start at once. She wants to begin straight away, and tells me that she wants me to examine her back. She takes off her pullover and her trousers, and I commence by assessing her in an upright position.

In this position her body's line of gravity is drawn backwards. To be able to keep her balance she has to clamp her toes to the ground and keep knees slightly bent. Her back is rounded, her shoulders are sloping forwards and chest and belly seem crushed together in the front. Her elbows are slightly bent, her head pulled forward. Her legs soon start shaking and so I let her be seated on a wooden stool. She maintains the

same posture when seated, with her rounded back. Only a small part of her seat touches the stool's surface. Her abdomen is actively tightened and pulled in. I wish to check how mobile her hip joints are by gently rocking her legs, but the attempt is futile, I can see and feel that the movements are stuck. Her head is increasingly arched forwards. In this way she tells me, without words, that she is uncomfortably seated on the hard surface of the stool. I presently ask her to pull her chin inwards, and let the upper part of her body drop towards her knees. She doesn't get far, both head and trunk being restricted by highly tensed muscles along her spinal column. On rolling up to an upright position she becomes dizzy, even if this is done with great caution.

I ask her to be seated on the treatment table with her knees kept straight, this however is not possible because of shortened musculature on the back of her thighs and calves. I make a note that there is no change in her breathing pattern, no matter if she is standing up or sitting down. I can barely observe any breathing at all, only some discrete movement in the upper part of her chest. I also note the way she tightens her jaw.

The prone position gives her trouble with her neck. By way of pillows and towels I try to give her back and neck support. However she is still uncomfortable lying on her stomach. Her throat tightens, and I immediately let her sit up. Back on the floor, we do some simple exercises together. These exercises give her the experience of standing upright but all the same sensing the pull of gravity. She actually feels the weight of her own body. She walks a little, to and fro, carefully shaking herself and loosening up. I ask her how she is feeling. "Fine" she answers, but her breathing pattern remains unchanged and her jaw is still clenched. I offer her a glass of water. She turns down the offer.

During this first part of the examination she is quiet, giving only short answers to my questions. When speaking, her voice is dry and strained. The session is over, and we make a new appointment in one week. I inform her about how we are going to proceed, I will go on with the examination, and we will do more of the exercises we started on today.

Reflections

After Our First Meeting

This woman's body is highly tensed, and her ability to move and breathe freely is impaired. She has a rigid way of moving, she tires easily and controls her breathing.

About Restricted Breathing

I observe her posture, and while reflecting on her rounded stature I note that her chest and stomach have little or no way of expanding during inspiration. Her breathing inside this rigid chest is greatly restricted. There is little room for diaphragmatic motion, thus her diaphragm's function of freely contracting downwards and relaxing upwards is impaired. The act of inspiration and expiration needs space. This observation leads to an understanding of her feeling of discomfort and explains why she is so easily exhausted. As a consequence she gets worried and anxious, fearing there might be something seriously wrong with her.

About Pain and Tender Points

This woman hurts a lot, and marked off numerous tender points on the body chart. On examining her I made a note of her elevated shoulders, her rounded back, and hips that she would not "let" me move. She holds her front by way of tensing/shortening her chest- and stomach-muscles. If this habit of muscle tension is sustained, then in time, the muscles will tense and shorten exceedingly, resulting in even more disturbed muscular function and impaired circulation. Muscles with impaired blood flow weaken; they hurt when touched, and lose their function of freely lengthening and shortening at need. This constant tension strains and irritates the tendons. This is frequently experienced as tender points in the area of bony protuberances, and deep, aching muscular pain.

About Lacking Full Body-Stretch

She is unable to fully stretch her legs when walking, due to the muscle-

shortening on the backside of her thighs and calves. There is no propulsion in her gait's toe-off phase, no muscular effort pushing her forwards. With knees bent, she is unable to utilize her muscles' full capacity, meaning some muscles are inactive whilst other groups of muscles are overworked. This leads to a muscular imbalance, muscles on one side of the joint being too short; on the other side they are over-stretched. In time the consequence may be excessive joint strain.

She is unable to fully stretch her upper-body, her stomach and diaphragm being under constant tension. This results in a posture where her head is drawn forward, her neck is sharply arched, and as a consequence of this position, she tenses her jaw and the muscular floor of her mouth. Ideally speaking, the head should balance freely on the top, without excessive muscle-work. This patient's head is positioned forwards, compensating for her off-balance body. Now I do understand why it was so uncomfortable for her to lie in prone position.

About Her Silence

The unfavorable neck/head position creates a constant pull at her jaw and in the floor of her mouth. This is where the tongue is anchored and I wonder if the tension in this area is that what makes the act of speaking strenuous. There are two points I must consider here: Firstly the tongue might not be free to move as easily as desired and secondly for the voice to make sound there must be space to enable air to flow past the vocal chords. Her breathing is restricted, meaning there is scarce movement when breathing. These factors together might contribute to the fact that she is a woman of few words. When speaking she seems to make a great effort of it, resembling a take-off, then on exhalation she presses the words out. It would be easier for her if she could speak while simply letting her breath go.

How We Are to Proceed

She needs help to move more efficiently; meaning learning to let her arms and legs move more freely, and eventually be able to achieve a full,

optimal body stretch. This will give her back her free and full length. Some muscles need strengthening and they need softening, in other words they need to regain their elasticity. This will enable her to resume a flexible posture and give her a flexible balance. She needs to learn to trust her own body, to trust its ability to keep her upright. If not, then progress will be hard to achieve. I still do not know her well enough to be certain as to what extent she will be able to do this body-work. How much, and how often?

Theraphy in Progress

Second session

She tells me how tired she had been after the first session and about how her thighs stiffened. “It’s strange” she said, “It didn’t seem like we did anything at all.” Her feeling of uneasiness and fatigue is unchanged. We commence the session as we did last week: in the upright standing position. We test various hip movements, just gently rocking. Subsequently we practice knee- and hip-bending, and she is instructed to try to release the tension in her buttocks. She now sits on a stool, and we continue doing movements involving the hips; every exercise is to be performed slowly. I am also seated, faced towards her, demonstrating the exercises. Then we try doing the “upper body drop”, letting the chin drop first, then head following along with the chest, and so on until the upper body stoops (still seated), attempting to succumb to the pull of gravity and her body’s own weight. Short summary so far: There is no movement whatsoever in this woman’s hips, abdomen and back.

We proceed. Now she is seated on the treatment table, back upright, legs straight. This position gives access to her calf- and thigh muscles. The muscles are tender, thin, stringy and tense, especially on the left side. Still sitting on the table, now with knees bent and leaning slightly backwards, with her arms supporting her, I let her practice extending her knee, and flexing her ankle by contracting and stretching thigh and

calf muscles. She works on contracting the large thigh muscle in front, thus getting in touch with her quadriceps muscle; in the meantime I stimulate the muscle by stroking it lightly and gently.

She watches closely with a strained smile, and admits to having stiff legs. I confirm her feelings by telling her that I can see and feel the same as she, and comment that this must be very uncomfortable for her. I wonder if she suffers from leg-cramps, and she tells me that she wakes up almost every night with cramps, mostly in the left leg. She also has restless legs, experiences a kind of tingling sensation when going to sleep.

I now let her do a gentle rocking motion with her hips, afterwards she may pull her knee towards her stomach, and let the leg gently drop back into a relaxed position. She is still sitting on the treatment table. She gets down on to the floor after approximately ten minutes and she is asked to walk around a little, shake her legs and then be seated on the edge of the table. She now practices standing up and sitting down, without using her shoulders. After three repetitions her legs are trembling.

While doing this exercise I ask her to pay attention to what is happening in her diaphragm and her stomach when she clenches her jaw, and to compare what these places feel like when her jaw is relaxed. I suddenly remember how Aadel Bülow-Hansen used to demonstrate on her own body. She liked to exemplify her points to the patients. She would, e.g. let them feel the tension in her stomach and then compare this to the feeling in their own stomach. If my patient could experience only this one thing, it would be great! I observe a slight relaxation of her jaw, lasting merely a second or two, and notice some scarce movement in her stomach. She nods, tries once more, and smiles faintly. “Hmm what a strange feeling” she says.

I ask her to walk a little around the room, and we end the session by doing just a few exercises in the upright position. These simple exercises give her a feeling of being in control of her leg muscles, and she is also in contact with the surfaces of her feet. I give her a new appointment in one week.

Reflections on Session Number Two

So far, my patient is shut off, tense and immobile, and I find it hard to get hold of any of her thoughts or feelings. During the sessions she has spoken about pain, restlessness and fatigue, but never mentioned what all of this really feels like to her. Her movements are stuck and she is unable to move her hips without using her trunk as well. She elevates her shoulders when rising from a seated position. When she practices using her legs only, as in the squat exercise, they quite soon start to tremble. Her legs do not have the necessary strength and she is not in such a condition so as to be able to take on the challenge it would be to strengthen them. It is extremely unpleasant for her not to be able to breathe freely, and her frequent heart-pounding frightens her. Her body's ability to move, and life in general is limited.

Considering her state, I conclude that she will hardly tolerate any profound, or radical treatment. At the same time I perceive that she needs help to move out of a life-situation where everything has come to a stand-still. I think the best treatment for her would be to give her a few easy-going exercises; the primary aim being for her to experience the actual motion, meaning just getting the feeling of moving. Eventually she may be given exercises that challenge her balance, that make her more aware of her surface contact. These exercises may be done in upright and seated positions. I realize that I have to proceed cautiously, encompassing slow progress. I must be attentive to her reactions and always take into consideration her demeanor that day.

Some Days Before Session Number Three

Shortly before our third session the psychologist, whom she always sees between our sessions, asks me this unexpected question: ”What have you done to her?” There had been quite a sudden change in their sessions. She talks more, even tells him about present-life hardships, and speaks about how she feels. I have no answer to this. I wonder if some significant change really did happen during our last session. Maybe something actually did start moving after all? I am excited about meeting her again.

Third Session

The patient comes to her appointment. She tells me that her legs, thighs and calves, stiffened after our previous session. She had fallen asleep that same afternoon, and slept deeply. Now her shoulders ache constantly, and she can hardly do any house-work. Her stomach is uneasy, and she has diarrhea.

Much to my surprise I note that some of her tension has loosened, her chest seems more relaxed, as does her stomach, and her shoulders have dropped a little. We start doing the now so familiar exercises. While doing so, and without me asking any questions, she tells me that she has become aware of her shoulders. She tells me about the following episode from home:

> She is about to climb the stairs, and when she is half-way up she notices that she is climbing with her shoulders elevated. She stops, turns around, and goes back down again. She starts over, this time with relaxed shoulders and jaw slightly open. And then she shows me how she has been practicing getting up from a chair without using her shoulders. She tells me all of this with a cheerful smile on her face. I give her full support on this new discovery of hers. We both laugh.

We proceed, and practice more on hip- and knee-bending and also on the rocking of hips from the seated position. Her right hip is looser and moves more freely now. She is more conscious of her legs, and is able to move them without clenching her jaw or using her shoulders. We do exercises involving the arches of her feet, and we do careful arm-swing. She is definitely more concentrated and alert when doing these exercises than she was earlier. And her legs don't start shaking so easily. After half an hour she has a hectic blush, and that is a sign for me to end the session at this point.

Reflections on the Third Session

During this session there is a definite change. Something has happened to her, and I get the notion that this blocked manner of hers is on the move. She has new pains, her digestion is disturbed, but even so I consider this to be something favourable. She is on the move, she is responding to what we have been practicing.

I reckon there are many people who would shake their heads at this kind of reasoning, and question the fact that she is getting worse when she should be getting better.

My answer to this is the following: Her shoulders have become painful due to the fact that the muscles in this area are now working around a new mechanical axis. Her chest has dropped a little, her shoulders follow naturally. Consequently the muscles behave differently, some are more stretched, others are more relaxed; in short they are activated from new positions, with a new length. This may result in disturbed and irritated muscular points of attachment. This is what is happening to my patient and pain is aggravated. The feeling of uneasiness in her can be explaines likewise. Her chest drops a little, thereby allowing her diaphragm to move more freely. Increased movement of her diaphragm gives her intestines "a little shove". More often than not, this mechanical influence may result in passing unstable digestion while adjusting to the new conditions.

I have countless reflections after this third session. My reasoning is as follows: Her chest has become more flexible, more functional, and this allows her breathing to become freer and more effective. This will ease the strain of talking and I wonder if this may have had a positive effect on the quality of communication with her psychologist. Or is it because she has discovered a new way of moving, her new body-experiences influencing her way of thinking? This again might give her access to her own feelings, making it easier for her to speak of these naturally to others.

She now knows who I am, and what our sessions are about; this lets her feel more secure in these situations. Perhaps this why she now is slowly opening up to, not only herself but also to others?

Fourth and Fifth Sessions

Her shoulders are getting worse, so bad that her doctor has to put her on anti-inflammatory medication. She wonders how on earth her shoulders can become so painful without me having treated them at all. I explain to her, demonstrating on my own body, how the shoulder muscles adjust their way of action according to the chest's position. I show her this in front of a mirror. I demonstrate the rounded back, letting her see how both my chest and my stomach get limited moving space, with increased tension both places. Then I alter my position, I let go of the tension in my stomach, and demonstrate how this leads to a more "open" chest from where my shoulders are able to move more freely. She tries this for herself, and while nodding slowly admits to experiencing additional and new movements in her upper-body…

She tells me about an episode the other day. She was to reverse her car, and when turning around to look behind her, she undoubtedly felt that this movement was freer than ever before.

During the following sessions we practice exercises where we wish to achieve full extension of legs, as well as stabilizing them. We mostly practice in the standing position, sitting on a stool and sitting on the table. I also massage her legs, pulling softly on her muscles. Her calf-muscles are still tender, but the pain is no longer intolerable. She does not resist my massage by tightening up, she simply says "ouch", and stretches the painful muscle group. Her hips move ever more freely, her right side still being the more mobile of the two.

Reflections on the Fourth and Fifth Sessions

The patient seems to be both skeptical and interested. I do understand her being in doubt, because after 5 sessions, her shoulders are in fact more painful than ever before. At this point I am aware of the need to be utterly specific; my explanations need to make sense to her. I am certain of the fact that her shoulder pain is a passing ailment due to the process her body is going through. However I do notice that she is not just skepti-

cal, she is interested as well. She asks questions, she gives me feedback on how her body has reacted after each session, and this awareness of how her body moves is so new to her. However it is easy to understand that she is in sincere despair about her shoulders.

I am so excited about what is happening. The woman's tense movement pattern is undergoing a change; she is aware of this, and she is able to express her feelings in words. In other words: There is slight progress in a tense body, and these tiny steps of progress are necessary to promote the process of change and restructuring.

Sixth Session

She still comes for weekly sessions. Her stomach is more at ease; her shoulders are almost pain-free. She goes for walks, short ones she tells me. During her last walk her legs got shaky towards the end, and when she got home she had a new seizure of heavy heartbeat and laboured breathing. She had to resort to medication to be able to get some sleep. This happened two days ago. She is still exhausted after this episode, and she says her body feels heavy.

I can understand that these have been tough days for her, they have been like a relapse; reappearance of her old anxiety and uneasiness, and again needing medicine to bring her through. At this point it is important that she retains her confidence in me, and does not lose her grip on what she is about to accomplish. She is on the move, and she is wavering because her new body experiences may yet seem somewhat uncomfortable.

During this 6th session we do only familiar exercises. I closely observe her reactions. Her legs are noticeably more powerful, and she is able to do more repetitions than before without the usual trembling. However it is clear that her jaw has tightened, and she is quieter. It seems that some of her taciturn way of being has returned.

Following this session, her psychologist and I have a meeting. The psychologist informs me about their previous session. They had entered sensitive topics that brought her in touch with memories from the tough

time when she broke out of her marriage. The psychologist is of the opinion that it still is hard for her to speak of these things, she prefers to forget memories that hurt.

Seventh Session

During this session she is more talkative. She describes how she is more conscious of how she actively tightens her jaw, and how she notices that her legs increase their tension quite simultaneously with the increase in jaw tension. She has been more restless, and leg cramps are frequent, especially after having had an angry outburst at home. I ask her then if it is normal for her to display and express anger. She answers: "No, that's the strange thing about this, I am normally never angry at anyone, ever. Folks at home were astounded, wondering what on earth is going on". Later on they had been able to laugh at the matter, and this enabled them to speak about things they never have talked about before. This had seemed to "ease the pressure", just a little bit.

I let her practice kicking, and then shaking her legs. I observe that she is livelier, her breathing is freer, and she reacts spontaneously and naturally to my massage and muscle-stretching, instead of tightening up like she did before. At the end of the session she feels tired. I told her to be prepared for the need of rest today, and I ask her to remember to jiggle her jaw and her fingers. I suggest that her legs might need extra stretching after her walks.

Eighth Session

She arrives on time for our 8th session, looking more free and easy, more relaxed. She told me she had had a good afternoon nap after the previous session and she seemed very satisfied.

We commence, doing exercises first in the standing position, as always, and then sitting. Everything seems easier today. I comment on this and she tells me that she feels lighter, that in some way weight has dropped off her shoulders. She sleeps better, enjoys her walks, she feels calmer than before, and not as restless as she has been. It's been a long

time since she has felt this good. Her jaw muscles are a little sore, she has been yawning such a lot and her stomach is a bit upset.

To begin with, we go through the usual exercises. Having done these, I ask her to lie down on the table, in prone position. Today it is okay for her to lie in this position. I place a small pillow under her stomach, and I can work on her without creating any discomfort in her throat or her stomach. I carefully massage and stretch the muscles of her lower back, continuing to the long back muscles on each side of her spine, and finally reaching across the back side of her shoulder girdle. I make a note of her not tightening up against this massage; she rests calmly on the table. She lets out a sigh, and says she can hardly remember how painful her back was before. Now it feels quite okay.

I end the session by instructing her to do exercises in a standing position, exercises that increase her stability, and that help her to experience standing securely on her own two feet. She recognizes these exercises, we have done them many times before, and she does them nicely. When she leaves, she is feeling in good shape.

Reflections after Eighth Sessions

Her legs are stronger. When she breathes, her chest and her lower abdomen move a little more than before. She has started yawning, and this is a good sign, meaning her breathing and her muscles are more in balance. She is able to lie on her front without any discomfort. The constant tension that probably was the cause of her pain and exhaustion had loosened. She sleeps better and has regained the important balance between tension and relaxation. In the whole she has become stronger, and tolerates more strain in her life. Her complaints are no longer as easily triggered as they were before.

As I write, we have reached the 15th session. She still is in touch with both her psychologist and me. She is not rid of her anxiety, but it is tolerable she tells me. She has been able to speak about events from her childhood and about her relationship with her parents. She married

young, and her married life was not so good. She broke out of her marriage after her children had left home. She started a new life for herself, a new job, everything was safe and her life came to rest, so to speak.

Out of this new life situation arose an anxiety and a bodily uneasiness, completely paralyzing her ability to lead a normal life. This uneasy feeling still is a part of her, but now she understands why, therefore it doesn't frighten her any more.

At this point it seems appropriate to quote from a book written by Gudrun Øvreberg and Tom Andersen, *Aadel Bülow-Hansens fysioterapi*:

> By letting go, one both lets something out and lets something in. When exposed to pain and anxiety, one should stretch oneself out of their hold, rather than clinging to them and cowering in their shelter (Andersen and Øvreberg, 1996).

For this woman, life became more livable once her body became more mobile, her breathing more flexible, and her legs got strong enough to support her. The regaining of all of these qualities, the expansion of her repertoire regarding breathing and motion, enables this woman to gain new experiences. These new experiences will give rise to new thoughts, self-knowledge and insight. To her, this means no longer being afraid of her own feelings. She comprehends their origin, and understands now how much they have been hurting her. She is a little stronger, she moves more freely, she has opened up to her own breath, her neck and jaws are looser. She has come alive.

Afterthoughts

I never stop wondering about how moving, breathing and feeling are so closely linked together. I would like to recount a small episode I witnessed the other day, on my way home from work:

The last couple of days it had been snowing heavily; wonderful, dry fresh

snow. In a park nearby I saw a bunch of kids, playing around in this beautiful element of winter. Their faces were open and sparkling, their laughter loud and resounding. I watched their every movement, running, tumbling in the fresh snow, falling over, getting up again, relentlessly chasing their mates. Just standing there watching these children's play, brought memories back from my own childhood; not a worry in the world. I came to think of all our outdoor-playing during the winter, definitely cold, but with the best footwear in the world: knitted woolen socks made into outdoor "slippers". With these on my feet I simply became the fastest, and the most light-footed of them all. At least, that's what I felt like. We climbed uphill and raced downhill, by sledge or kick-sledge. I never forget how we screamed and yelled, racing downhill in a train of kick-sledges, five of them locked together. We tossed and tumbled in the snow. Our stomachs tingled, and our bodies felt so wonderfully alive. We lay on our backs, making "angels in the snow", we gazed up at the stars and watched the Northern lights flickering across the sky. We stomped around in the fields where the freshly fallen snow lay untouched, each of us making our own little den.

Suddenly a snowball from the park hit me, and woke me up from my day-dreaming; I laughed, and tension dropped from the children's faces. Walking on home, my physiotherapist mind was reeling, now in a more professional manner: This playing in early childhood was all that we needed to ensure us our natural development. Our arms and legs were constantly in action, demanding ever more mobility and strength. Playing also meant competing, bawling, laughing, even crying, all the movements and expressed emotions gave room for easy breathing. Our fantasy and our own personal and bodily development was elicited by all the hurly burly, the activity, our physical contact, our testing of each other strength.

My thoughts drift on, returning to the point where I left work for the day, leaving behind all the people with their aches and pains and other ailments. So where has it gone, our playfulness; our inner child? Has it disappeared, been replaced by grown-up life where all our doings are

scheduled? How is it possible that lives can become so disabled by pain and anxiety? How come the process isn't stopped before it gets so far? I believe that there must be some signals from the body that are being neglected. Taking care of, or taking heed of one's feelings, being aware of one's own movements when moving becomes restrained, this seems to be of low priority. Do people not notice that the brakes are on before they are close to a break-down, the symptoms being so numerous and so severe that daily functioning becomes seriously impaired?

This chain of thoughts leads me to where we all start, floating in our Mother's womb, being lulled by her movements, feeling her heart-beat. We are born into this world, we can breathe and we can move. Our emotional, intellectual and motor development is utterly dependant on those who are close to us. We learn by way of our senses, through our mouth, by touching, we see and we hear. Later on the child is more determined in its actions, it turns its head towards the sound to see where it came from, and the hands reach out to grasp things. Subsequently the movements involve more and more of the body, the child turns around, rolls over, then eventually gets up on all four and starts crawling. During what we call a child's motor development, it practices an ever increasing variety of movements. Babbling turns into words. In this primary stage, in order to develop, we need our senses, we need closeness, and we need the possibility to move. The curiosity and joy in exploring our newly-won skills make us continue, repeating what we already master, and at the same time continue our search for new challenges. I do wonder, do we not need these conditions throughout our entire life? Learning, practicing, exploring, searching for new challenges. I remember many encounters with residents of nursing-homes, all the sick and lonely. To these people there seems to be no point in moving, lacking closeness and stimulation. Moving no longer gives them any pleasure. The spark of life, their vitality is ebbing away. Some of this I see in the dejected patient, and the one suffering from chronic pain. They may be younger, but the same pattern arises, restricted breathing and impaired movements.

When functions of both breathing and moving are impaired, we discover that not only does this put a strain on our joints and muscles, it also lessens our ability to feel joy and makes us lack the curiosity that made life so exciting when we were young.

At this moment an image described by Gudrun Øvreberg comes to me quite clearly. She used to compare movements to the keys of a piano:

> Restricted movements are like a repeated note, or a simple scale. The whole variety of moving, with all its nuances, is like playing *numerous* scales in a variety of tones, music in major and minor. This gives us our full repertoire from which we may choose to play – or simply to move.

Ingar Kvebæk

Lonesome Sorrow

”I’m dyslexic. When I write, my right arm and shoulder cramp awfully”.

This is how the treatment session started, an encounter with a boy who gripped me right from the very beginning. There was something about him, something that made me wonder: Has anybody really understood this lad?

Our session started off quite unlike how I normally initiate a psychomotor treatment-session. I skipped the usual assessment, the way we learnt at school. I had this urge inside me to remain more “passive” than usual, and simply let this boy take the initiative to what we should do. After our first encounter, I was totally committed. Following each of the first five sessions I wrote down what happened in great detail. This was important so as to be able to understand what happened between us, understand how the two of us worked together as a team and to explain why I thought the quality of this team-work was quite essential to the outcome of our sessions.

I also thought about the school deputy who had referred him to me in the first place. Through this action she displayed an awareness of this boy’s problems. She seemed to find some connection between his muscle-aches and -pains and his dyslexia. In due course we learnt that his body-pains and tension was a result of, not only his dyslexia, but also other painful incidents in his life, incidents he has kept to himself and never spoken about to anyone.

Perhaps this may come as a surprise to the reader, but the treatment actually proved beneficial also in regard to his dyslexia. Dyslexia, mean-

ing impaired ability to learn to read and write, is not a constant condition. When we start treating and relaxing his tense muscles, his reading and writing improves, and he hurts less.

Our Five Encounters

First Meeting

Today there's a 14 year old schoolboy coming to see me. The school deputy got in touch with me because this boy had been complaining of neck- and shoulder-pain. She suspects that the pains have something to do with his dyslexia. One of my colleagues tells me that the boy's father died in a car accident four years ago.

When he comes to my clinic he is mistaken about where to go, and he walks straight into my office instead of going to the waiting room. He is dressed in a huge, heavy, black leather jacket and he is wearing a pair of large, black cowboy boots. He is tall, thin and he has an extremely long fringe. His neck is bent forward, making eye contact difficult. I like him. I ask him to go sit and wait in the waiting room. A little while later I call him in. He has hung up his jacket and taken off his boots. We say hello, we shake hands and as he tosses his head, we make eye-contact. He moves around in the room and eventually finds a place to sit down. He takes a seat on the edge of the treatment table. I place myself on a stool some yards away from him. He says:

> I'm dyslexic. When I write, my right arm and shoulder cramp awfully, sometimes in my head too, especially in English class (1st foreign language). Until fourth grade I couldn't even write my own name. In some subjects I'm allowed to have the tests done orally. Then I often get top grades. In written tests I get the lowest grades. When we have English I get cramps, just thinking about it makes me sweat all over. I do better in German (2nd foreign language). I think maybe that's because we started later, and by that time I was better at reading and writing. It didn't all fall to pieces, like it did in English. I'm used to

working hard, I'm an active person. The strange thing is, when I'm active I don't hurt.

The boy looks down while he speaks, almost hiding behind his long fringe. After a while he looks up, and looks at me, and wonders when I'm going to examine him. I tell him quite briefly about what I am going to do. He undresses, and tells me that he has previously been to a physiotherapist, but that he only worked on his neck. "I didn't get any better". I ask him to stand on the floor.

(PT: Physiotherapist, Pt: Patient)

Standing

PT: Your right foot is placed a little behind your left foot. Can you put them straight?

Pt: But that makes me lopsided!

PT: Yeah, that's right, but as you can see, now they are standing perfectly equal.

Pt: Hm…., that's queer.

PT: Do you notice your right knee is a little bent?

Pt: No, I always stand this way.

I grasp his knee-cap and try to move it. It's absolutely stuck. His thigh and calf muscles are extremely tight and tense. Gently I push his knee backwards, so as to gain full extension, but it offers great resistance.

Pt: That pulls on my calf-muscles.

PT: Do you notice that when you stand like this your pelvis and your back are a little twisted?

Pt: No, I always stand like that.

Reflections

This first part of the examination was different from how we normally examine in psychomotor physiotherapy. Normally I would lead the session, but this time it was he who took the initiative. Why did this happen?

I have already mentioned that I spontaneously liked him. I sympathized with him and I soon got the notion that I shouldn't be too leading, too dominant when doing the initial assessment. He took the initiative about what to do and when to do it, and I allowed him to speak his mind, without any interruptions.

So far, I have found out that his legs are extremely tense. He is off balance, that is, he spends a great deal of energy and muscle power, just keeping himself upright. He himself is not aware of this, but when I point this out to him he does get a slight feeling of this tension, and he certainly did feel lop-sided when standing with his legs straight. His awareness, and his ability to express what he experiences spontaneously without thinking too much, is good. Now I'm curious about whether or not the muscular tensions change in character when he sits or lies down.

Sitting

When he is seated on a stool, he straightens out. This may indicate that there is muscular imbalance in his legs and pelvis, which again may affect the muscular balance in his pelvis and back. His right shoulder is elevated. He resists my attempt to rock his legs and he notices that he does so. I ask him to drop his head, but he immediately jerks it back. He says there was such a strain on his neck muscles. I ask him to let himself drop forwards, more gently this time. Now there is an even, smooth curve all the way down his back, and an even stretch. There is still some resistance somewhere, he is still holding himself back. I check his stomach, it's tight, and this may explain why he doesn't sink deeper down. He doesn't let his arms drop whilst hanging forward in this way, they are being held in position by some big muscles that cover a large area of his back.

Lying Down

When lying on his front in the prone position on the table, he tightens his buttocks, and his legs are rotated outwardly. His right shoulder blade is drawn inwards, and his arm is held close to his body. The muscles around his lower back are tight. He controls his breathing, and

the breathing pattern is not influenced by the change of position. His breathing is neither deep nor free and his chest is stiff. He does not allow me to push or loosen his shoulder blades; the muscles between his shoulder blades, his shoulders and neck are active and prevent this motion. He lies down on his back in the supine position and I observe that the whole pattern of tension remains unchanged.

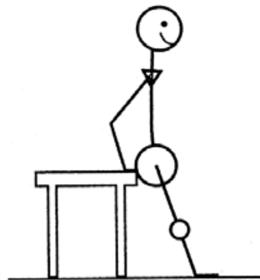
I do not allow him to linger in these positions; they are obviously uncomfortable to him. I observed that he went into an "on guard" position by tensing his muscles and controlling his breathing. This is a way of protecting oneself. Especially the controlled breathing makes me aware of the fact that there might be emotional problems. By controlling our breath and tensing our muscles, we are able to control our emotions. He gets up, and I ask him how this was for him.

Pt: Yeah, it was okay to have my whole body examined.

PT: From what I have seen and felt, I am going to concentrate on your legs in the beginning. In a way, your legs are your body's foundation wall. To put it to you figuratively speaking: Your foundation is slanting, the doors are squeaking, and there is not much air going up the chimney.

Pt: Ha ha, yes, I know what you mean.

I show him an exercise:



Tightening and loosening the knee-cap, by use of the quadriceps muscles.

It's easier for him to do the exercise in this position, because here the muscles that do the knee-extension are in a slacker state, and they don't have to do postural work. His left leg still works better than his right. However, gradually he tests the same exercise without support, and after a while actually manages to achieve full extension in his right knee. This is certainly quite encouraging.

Reflections

After this session, I was aware of the fact that I needed to pay close attention to what was happening here. Is NPMP the right kind of treatment for this patient, or not? He was definitely "on guard", especially in the supine position. There was certainly a muscular imbalance in his legs, and they were constricted in a flexed pattern. However, I decided that I should attempt and try to relax the muscular tension in his legs, so as to give him a chance of achieving a full and free extension. When the knees are extended, this will often be accompanied by an impulse that loosens breath-control. This straightening, or extending of the legs leads to a profound stretching in the upper body. If he is able to do this, and at the same time let go of his breath-control, he might then experience, and be acquainted with his body, in a way totally new to him. I omitted enquiring in detail about his case history because I believe this kind of focus would have got in the way. We got on well together and I wished to keep it at that.

Second Meeting

PT: How did you do after having been here the last time?

Pt: My legs felt lighter, free and easy in a way, but shortly afterwards I was back where I started. I've tried standing the way you showed me, but it just makes me feel all lopsided. I've also tried to do that knee-cap exercise, but I don't think I've done it right.

He undresses, and I immediately note that he stands precisely like he did one week ago. I ask him to lean against the table, like he did the last

time, and do the same exercise. It is still easy for him with his left leg; he is, in other words, in perfect contact with his left side "knee-extensors". When he tries to do the same exercise with his right knee he activates a whole number of muscles, in addition to the actual muscles in question. He activates his toes, his knee-flexors, the muscles of his buttocks, and the adductor muscles responsible for pulling his legs together, as well as his abdominal- and back muscles. In other words: he makes a great deal of effort doing something that ought to be easy. There is no "pure" contraction of the muscle in question. I massage his thigh muscles, and round the area of his knee cap. The muscles are in high tension, and hurt when touched. He reacts to the pain by twisting his foot away. He tries to tighten, and then release his knee-cap, first on his left, no problem, then on his right. He switches between left and right, trying to get the knack of it on both sides. Eventually he seems to get more in contact with his right leg, but the relaxation-part is still difficult. He does manage it, but with effort, the muscles tremble as he does so. He says: "This is kind of weird, but I feel like I'm in control of that muscle. I've never felt anything like this before. Now it feels like pins and needles." I explain to him a little about how our muscles function. It surprised him to learn that one may control muscle action in this way, "I thought it was all done automatically". After some thought he tells me:

> My thigh always starts hurting when I run, and when we have Gym at school. I never understood why. The same thing happens to my arm and neck when we play volleyball, or basketball. Sometimes I stiffen, and can hardly move my neck afterwards. So you mean this is because my muscles are so tense?

When he has fully grasped the idea of this exercise, I ask him to stand freely on the floor, without support. Now he is to bend and then stretch his knee. Once again, it's easy on his left but to do the same movement in his right knee he needs to compensate by increasing his pelvic angle, and at the same time by moving his pelvis backwards. "When I stretch my

right knee it feels very tight behind the knee, and in my calf-muscles". I ask him to lie down on his back on the treatment table, and I massage these muscles, wishing to loosen them up a bit. I massage, and alternately ask him to push his heel down, in a longitudinal direction. Pushing the heel in this manner, away from oneself, so to speak, is meant to fire a reflex contraction of the muscles on the front of his thigh (the quadriceps muscle). However this did not happen, the muscles on the back (Hamstrings) being too tense and short to allow this natural reflex to take place. While working on these muscles I notice how his leg becomes more relaxed. I also see that he lets go, just a little, of his "breath-control". He still keeps his right arm and shoulder a little bent, and held close to his body. He rests in a fetal position. "I felt pretty tired, lying here. It hurt when you touched me, but now it feels okay".

Once more he gets off the table and up on the floor. No support, he has straightened his right knee a little, he carries his weight more evenly and he notices this himself. Before leaving, he wonders about what will happen if the tense muscles start relaxing.

Pt: I suppose they will tighten up again, because of my dyslexia?

PT: I'm not so sure about that. I don't believe that your dyslexia is the one and only reason for why your muscles are tense and tight. For some reason or other, I believe that in the course of many years, this is how your body has responded. Having dyslexia just makes the matter worse. Therefore I don't believe that you will automatically tighten up again.

We make a new appointment. He prefers a change of day, so that he won't always be absent from school at the same time, from the same subjects.

Reflections

It's clear to me that he is now prepared to involve himself in this kind of treatment. He had tried out some of the things we did the first time, and

he notices that it is difficult for him. He has registered a feeling of stiffness in his body. During the treatment session, associations are evoked in him, e.g. he recalls how his body reacts during gym. All of sudden, things he has been pondering about make sense to him. And last but not least, he shows signs of having a potential for change. When he lay on his back, he was not persistently on guard. His legs relaxed a little, he loosened his breath control, even if just a little. However, I must take care not to relax his arms too much, they were definitely on guard. At the end of the session his way of standing has improved, he is more in balance. This is certainly change!

Third Meeting

Pt: It's been an awful week. I hurt a lot when I write. One night I woke up completely stiff, and my head was twisted towards the right. I got out of bed, and just walked around the room. Eventually I was able to relax and regained my neck's motion.

PT: This certainly might have something to do with what we've been doing here. When the tension level in muscles changes, the outcome may be different from what you might have anticipated. It's great that you tell me what you have experienced, what you think and how you feel after each session. This helps me to understand that it's not only writing that increases your muscles tension-level.

We commence by starting where we left off at the second meeting. He is in his usual standing position, without support, and we have leg-work to do. This time it goes much better. Compared to how he did it last time, he compensates by contracting other muscles to a much lesser degree. By this I mean he does not put as much effort in doing a simple movement as he did one week ago. Now we work on what we call weight transfer; that is swaying to and fro, letting his pelvis move forwards and backwards, legs straight and relaxed. This is fine for him, as long as he doesn't have to make too big a movement, but increasing the range of movement causes him to tense his pelvis and legs. He alternately bends

and stretches his legs at the knees lightly; just tiny movements, making as little effort as possible. I emphasize this to let him experience the easiness of it all. I wish for him to experience what it feels like to stand with knees extended, straight and at the same time relaxed, how it feels to be in balance, a steady stance, without having to contract and tighten his muscles. This time, when he lies down on his stomach, he does not contract his buttocks; his legs assume a relaxed, inwardly rotated position. He lets me move them passively.

I massage the muscles around his lumbar spine and the lower part of his chest, and slowly, slowly he lets go, and his breathing becomes freer and deeper, moving down in a basal direction. From this I may conclude that something is changing, and that this change represents a move in the right direction. The tension in his muscles, first of all regarding his legs, is slowly being relaxed, and this leads to liberation of what until now has been a restricted breathing pattern. The muscles are still clearly tensed around his shoulder girdle. This tension is so pronounced, his "on guard" state, that I choose to leave this be for the time being. He gets up, on to the floor, does a little "leg-work", before he once again gets on the table, this time in supine position. Now he definitely lets go of his legs, and lets me move them passively in all directions. I pull his pelvis in a downward motion, towards his heels, thus straightening a little bit out the sway in his lumbar spine. His breath responds and I concentrate on massaging his legs. Alternately I let him push his heel away from him, wishing to set off this reflex contraction in front, so as to gain full knee extension. His right leg does still not respond to this impulse, he bends his knee when the heel is pushed downwards. I notice a little loosening in his right shoulder, I move it a little and he immediately tightens it up once more. I let it be.

He rests in this supine position, and I leave the room. A little while later, when I re-enter the room, he has turned over on his side. "I'm so tired" he says. We make a new appointment, and I tell him that the deputy head wants a meeting with me.

Reflections

After the second treatment he got a reaction. He's felt worse the whole week, and woke up one night completely stiff in his shoulder and neck. Bodily change did happen, and I wonder if it was too much for him to cope with. Did this change make him tighten himself up again, and if so, why? So far, all we have done is leg-work, and his body has reacted by giving him a stiff and increasingly painful neck!

I reflect on the following after session no. 3: He relaxed his legs, and they stayed relaxed, even after I had massaged them while he was lying on the table; and most important, he did not actively/reflexively restrict his breathing as a result of this. So my opinion is that we may continue.

It is clear that when change takes place in this youngster's body, being in such a high state of tension and imbalance, it must come to show in some way or another; perhaps as some kind of reactions, be they muscular, emotional and/or autonomic. In his case, it was his neck which suffered the reaction. The fact that he experienced increased tension during the night as well is interesting, so maybe this will let him understand that his tension is not purely because of his writing problem. His muscular reaction at night-time may be understood as follows: He has released some muscular tension and this allows his body to be even more relaxed during sleep. This results in his body's reflex impulse to "restructure" its muscular state, the act of which may be preliminary, treatment being in an early stage. While sleeping, his neck-muscles possibly react instinctively by increasing their tension so as to counteract this impulse of change. However, he certainly did achieve full knee-extension in both knees, and he was more relaxed on the table than he was the first time. I need to constantly relate to his breathing and to how he instinctively protects himself, by way of the "on-guard" principle. This tells me not to rush progress. The consequence of my not being attentive to these factors may be increasing muscular protection on his part. A too sudden liberation of his, until now restricted breathing pattern, may lead to unpleasant bodily reactions.

Meeting With the Deputy Head

The deputy head got in touch with me. We met for an hour in my office. The outlines of our meeting can be listed in the following points:

- He has an uncouth behavior, and may act aggressively towards the teacher in classes where he has problems.
- He will not accept any kind of help as long as fellow pupils are in the room.
- Paediatric Welfare Services (PPD) calls his dyslexia, atypical.
- He and his family were followed up closely when his father died.

Reflections After Meeting the Deputy Head

I felt that the deputy head and I had a different point of view regarding the reason why he suffers pain and stiffness in his neck and arm. Her opinion was that his musculoskeletal problems were a direct consequence of his dyslexia, and that my treatment's aim was simply to remove his pain, and only this.

To the Deputy Head the following statement is true:

DYSLEXIA → MUSCULAR PAIN

He has difficulty in writing; he has to put great effort into this, and as a consequence his muscles hurt. She put forth a static problem, with a linear solution. My part in this was to be the one to remove the symptoms created by his dyslexia. All the same, I had a notion that this condition of his dealt with more than simply being a dyslexia problem. Of course, it goes without saying that having a reading/writing problem is a heavy burden. This may manifest itself in a pattern of muscular tension that will affect the whole body, not only his "writing arm". My notion that his problems have to do with more than his dyslexia is based on my findings from the initial assessment, and this feeling is strengthened by the PPD

calling his dyslexia “atypical”. I believe that if his tension pattern and bodily imbalance changes, this will have an influence on his reading- and writing-skills. I certainly do not mean that we only see:

MUSCULAR PAIN → DYSLEXIA

Rather we have the following situation:

MUSCULAR PAIN <-> DYSLEXIA

Fourth Meeting

I tell him that I have been in a meeting with the deputy head.

Pt: Yeah, I know. This week has been a little better, but I do feel kind of tensing up. I try to adjust my way of standing, but it feels all funny.

This time it seems easier for him to assume a good standing position. I do not register any excessive tension neither in his legs nor in his pelvis. All the same, he is still slow when performing different exercises (cf earlier accounts), especially exercises involving his right leg. As before, I alternate between massage, stretching and creating body-awareness from various starting-positions, such as sitting on a stool, standing, or sitting on the edge of the table, with his legs hanging down. When he lies down on his stomach, he certainly releases tension in his legs and his shoulder blades, just like the last time. However, he still keeps hold of his arms and shoulders. I massage his lower back, the lower part of his thorax, and give a gentle downward shove of his pelvis. His breathing moves deeper down. “Phew…..that felt really great”. He noticed this opening up to his own breath and almost simultaneously he relaxes his arms. This makes me wonder for a moment if I should continue working on his arms, but then I decided not to, simply because I wish for him just to lie there and feel what it is like to have relaxed arms.

Pt: My arms feel so heavy, and I feel so tired.

The next step was to check whether or not he had put his legs "on guard", that is if there would be any increase in his legs' tension. He rolls over on to his back. I test if he lets me passively move his legs, he does, but he is not able to fully extend his right knee when he pushes his heel down and away. There is a strong pull on the back of his knee-joint. The muscles of his calf, the back and inside of his thigh are tight and short. He has been standing with his right knee bent for such a long time, so naturally it will take time relaxing and lengthening these muscles. While I continue working on his leg I notice that his arm and shoulder stay relaxed, and I see that his breathing is abdominal, basal. In this supine position he is resting nicely. This tells me that he does not have to tense up to protect himself now; both legs and breathing are unaffected. I left him on his own to rest for a little while. By the time I returned to the room he had drawn up his right leg and turned it slightly inwards and his right arm was more tense than before his rest. His head was turned to the right but he himself had not noticed this change, and was a little surprised when I pointed this out to him. He told me that his shoulder felt stiff.

PT: During this session you were considerably more relaxed than you have been until now. But your tension increased during your little rest. Perhaps we loosened you up a little too much. This must be taken into consideration the next time we meet.

Reflections

What made him tighten up during his rest? Had he been loosened up too much? How might I have avoided this reaction of his? I had been hesitant about working more on his arm when I noticed that it had relaxed slightly. I decided to leave him be in peace, restful and relaxed, not taking any chances of him tightening up as a result of being worked on too much. This was not necessarily the correct thing to do, or not to do. Perhaps we could have established more contact and awareness of his right arm by stimulating extension of the elbow, his arm being in such a relaxed condition. Maybe I should have told him to move and stretch

his arm if he felt it stiffening. Perhaps he should have rested in a more convenient, "safe" position. Then he might not have had to go increasingly on his guard like he did this time.

Fifth Meeting

I call him in from the waiting room, walking behind him as we move towards my therapy room. His hands are in his pockets, he is stooped, and when he walks, he doesn't move his body much. Approaching the therapy room, I yawn, and he comments on this:

Pt: Seems to be not only me who is tired… I was really exhausted after our last session.

PT: I wouldn't say I'm tired. Before I went out to call you in I had a little spare time. I stretched out. I was rather tired after my last patient; in this case stretching is a good thing to do. Then you came, and I yawned; this yawning was a result of me stretching out just a short while ago. It's like this: stretching sets off yawning, and yawning stimulates even more stretching. Envision a cat, see how it yawns and stretches itself. But of course we can suppress a yawn, but then we have to "pull ourselves together" and we do this by increasing our muscle tension.

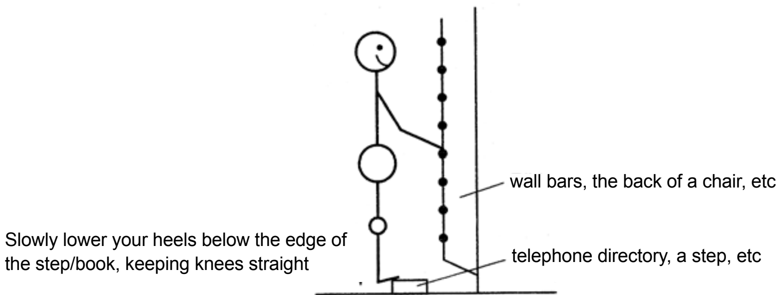
PT: Gosh, this means I can yawn during lessons at school, and when the teacher tells me to go to bed earlier, I can tell him that you have encouraged me to yawn freely, whenever I need to. Ha ha.

Pt: Yeah, you do just that.

PT: Anyway, when I write, my arm does feel a little more relaxed, but it hurts more, and now it feels stupid standing like I did before. Actually everything feels daft, the old way and the new way! I've always got tired from standing, that's why I always look for something to lean on or sit on.

Pt: There you are then, that's exactly the reason why we have to do so much work on your legs. They don't keep you up.

Now, in the upright standing position he seems to be more in balance than before. His right knee is still a little bent and I note that he puts less effort in doing the “flex and extend” exercise. This means that he no longer activates a whole number of muscles when extending his knee. He simply uses his quadriceps muscles but he feels the stretch in the back-side of his knee joint. His left knee functions perfectly. I show him a new exercise, “the telephone directory exercise”:



He must do a bit of work himself, like stretching his calf- and Hamstring-muscles. They are so short and tense, they need stretching out, and it will not be sufficient only to do this during our sessions. I now ask him to sit down on the treatment table and let his legs swing freely. His legs certainly don’t “dangle”, and I can feel a tense thigh muscle, quite close to his right hip. I let him feel this for himself, and compare this to what he feels in the same place on his left side. He felt that this muscle was much more relaxed, and this came as a surprise to him. I ask him to elevate and then drop his thigh, focusing on the “drop”, but this did not lead to any significant tension release.

PT: This is how I feel when writing, my leg kind of stiffens. I once broke my ankle. Do you think that is the reason why the muscles are so tight?

Pt: I do not believe this serves as the whole explanation, but it might probably have had an influence on the matter.

PT: I have broken almost all bones in my body! I broke my right leg twice, my ankle once and my lower leg once. I have broken my forearm and two ribs on the left hand side. I've always been restless and clumsy. Once I broke my thumb during a fight. During one period of time I was incredibly aggressive, but now I've learnt how to control it.

Ph: Earlier you wondered if your broken ankle was responsible for your tense muscles. Of course this is possible, but there are other explanations to this muscle problem of yours. You see, one way of controlling our anger is to tighten our muscles, pull ourselves together, clench our jaw. So, when you tell me that you've learnt to control your anger, you may have done so by constricting your muscles. (He pays great attention to what I am saying, but he makes no comment on this. He continues talking about his fractures.)

PT: I think my bones were pretty brittle at the time. During fourth and fifth grade I ate very little. Eating made me sick. In fact I think I was a little anorexic. During sixth grade I was absent altogether for almost 6 months.

Ph: Why was this?

PT: I suffered from nausea, and had a lot of headache. Probably there was something psychological/emotional in this. I shut myself away after my Father was killed in a car accident. (He tells me about the accident). For quite some time after the accident I sat in my room watching videos. I became aggressive, mere trifles could make me fly into a temper. Once I almost strangled a boy in my class, but a teacher came; otherwise I would never have let go. Nobody understood what was happening. My Mum was too busy taking care of herself. I almost became part of the furniture in the doctor's office. There was always something wrong with me, but for all the check-ups, the doctor never found out anything.

PT: Didn't anybody ever mention getting help from Child Welfare Services?

Pt: No. My teacher was decent. In fact she was too decent and understanding and I began to take advantage of this. Gradually I realized

that I had come to a dead end, I no longer showed any feelings. Things went better when I started in secondary school, new social settings, the pupils were older. The pupils in primary were so incredibly childish. I do have a best friend. He is older than me.

Pt: Well, I think that the story you just now have told me is of great importance when it comes to trying to understand why your body is behaving the way it does. And it seems like you yourself have understood a little bit of the connections between your story and your ailments. Everything you have told me now, your fractures, your nausea, all the visits at the doctor's office, the tragic story about your father's accident, all of this put together makes sense when we try to understand why your body has reacted in this way.

Reflections

At the beginning of our sessions I started off by working on what was obvious to me. I endeavoured not to be too provocative, because I noticed that he automatically protected his tensions when I tried to loosen them up. Gradually, his body's pattern of tension changed, and he told me this story during our fifth session. It came quite naturally; it came when the story was ready to be told.

During our sessions he was allowed to be completely honest. I did not know him, nor was I acquainted with his story. Here he could be completely at ease, he could just be himself, quite contrary to how he behaved at school. There he had created himself an image, an image he had to live up to. I never criticized his behavior, this probably made him more at ease, and he gave an opening for other qualities to appear. This discovery let him see himself in a new light, rendered possible because he was given the time needed, and I believed in him. This relationship has been important to him, giving him an opening so as to be able to bring forth memories in his stiffened body. He has tensed up to suppress pain and memories. This attitude of his: "I'll get through this, Mum was too busy taking care of herself to notice me" has gradually become burdensome. He told me that he felt quite optimistic about this kind of therapy.

Therapy in Progress

I wish to give an account of the most pronounced bodily changes, the ones he himself experienced, and those which I observed as we proceeded.

First of all, it was noticeable was that he hurt less when being touched. He became increasingly aware of when and where he increased the tension in his muscles. At the arrival of the summer holidays, we had been through 12 sessions. During the last couple of sessions he experienced substantial loosening up, his respiration responded freely and adequately, his abdominal muscle tension dropped to a normal level and he felt tired in a pleasant sort of way. During the summer holidays he had had one severe attack of asthma. He told me that this had also happened to him during a period of time after his father's accident, but rarely ever since. Asthma attacks may be triggered by anxiety.

We resumed therapy after the holidays, and he had certainly not relapsed into his old pattern of tension. In the course of the autumn semester the most interesting change was his improvement in reading and writing. He told me that his writing had become neater, and that other people actually were able to understand what he had written. He had read out loud in an English class, for the first time ever. It went great! When he started reading he had noticed a lump in his stomach, and that his right arm grew increasingly tense, but both these feelings passed swiftly. He was asked by the school to take part in lessons involving younger pupils in social subjects. Other changes worth mentioning were his improved balance, "I don't fall as often as I did earlier", "I am in much better shape"," I have more energy", " I haven't gone into any fit of rage this autumn".

When the therapy had come to an end, I got in touch with the deputy head. I wished to inquire if they had noticed any changes in the boy during this period She referred me to the Norwegian teacher, she knew him the best. This teacher told me the following:

> He has always been an engaged pupil. However, for a period of time he resisted learning. I think this was due to his physical problems. All

of this changed after he started going to psychomotor physiotherapy. Even his writing improved. He has always had high expectancy of himself, now it seems he has become more self-confident. I must say, I have noticed something else, and that is that he seems happier, his attitude is more positive. To put it simply, he seems more in harmony with himself. He has always been very tired in class, often lying across his desk, sometimes even falling asleep. Then he started stretching himself, and yawned a lot. It was just like a revival.

Six Months Later

He got in touch with me six months after we had ended our series of treatments. He told me that his neck and right shoulder occasionally would tighten up, but more often than not he could manage to undo this all by himself.

I examined him and concluded that he was more or less in the same condition as when I saw him last. What was most interesting was the fact that his legs were in balance. It was mainly the muscles round his right shoulder blade that were in high tension, so for treatment that day I could concentrate on this area. I recalled something he once told me: "Inside of me there are many petty-kings, especially one strong one in my right arm". He commented on this quite spontaneously: "Now I am the King. The petty king in my right arm is rebellious at times, but now I am able to resist his attack!"

We agreed on continuing therapy for a little while more, to give the last of his tensions a chance to let go. What happened now was that his tensions loosened nicely after each treatment, but during the time between our sessions he resumed his original tension pattern. We have to conclude with the fact that he must accept and live with this kind of tension. Of course his dyslexia is to blame for the excess tension in his "writing muscles". To put it simply: having dyslexia makes writing hard, annoying, unpleasant, and demanding, all of this leading to increased muscular tension. However, this might still not be telling the whole story?

After one of our session, he came to mention that he disliked being on the phone. The worst part was answering the telephone. When in these situations, he had noticed how he tightened his right shoulder. Lately this had been especially noticeable when he was making a date on the phone with a girl he fancied. Another occasion when he noticed this tightening up was after having received a message on the phone about a friend of his who had been severely injured in a car accident. When he told me this, I recalled him telling me about how he received the news of his Father's death. He was only a youngster, and he got this message on the phone, from someone he didn't know. Nobody was at home, except his very religious Grandmother. Her only comment was: "This must be God's intention".

I tell him that connecting this event to his shoulder and neck problems is perfectly adequate. When we are in difficulty we pull ourselves together. And what do we need to do to be able to do this? Pulling oneself together is not merely a figure of speech, not just something going on in our brain, or in our soul. It's quite specifically present in your body, muscles tighten and the breathing is controlled.

This point is easy to understand if we imagine a child falling and bruising its knee. The child will clench its jaws, holds its breath and tighten its muscles, especially around the hurting area. This helps for a while, but then we see how the tears come when Mum or Dad or some close grown-up arrives. The child lets go of its tension, and opens up to its feelings. Perhaps this was what happened when the young boy received a message too strong to bear, too hard to perceive; and he was all on his own. So he pulled himself together, braced himself, became hard on the outside so as not to feel the hurting inside. He received the message of his father's death through his right side, he tightened up, and this allowed him to "forget" the insufferable fact that he would never see his father again. For quite some time after this there was no one to talk to, there was no one there who could help him let go. "Mum was too busy taking care of herself . . . I shut myself up in my room and watched movies".

Like I said earlier in this chapter, we see that memories may be re-

vived once muscular tension relaxes. Well, if this is so, then we might also presume that memories can fade or disappear altogether when movements are lost?

To begin with I said that I thought the boy had been misunderstood by the grown-ups close to him. I considered three different points:

- I did not believe that his dyslexia was the only cause of his physical ailments.
- I did not believe that his reading and writing problems were constant; I certainly did not believe that he had to live with these problems forever.
- I did not believe that he was an unpleasant and aggressive boy. I saw this as his way of surviving.

There are always more ways than one of living our lives. This therapy helped him discover new opportunities for himself.

Eli Rongved

Interplay

In the following I will give an account of an “unsuccessful” treatment session. The session was concluded without coming to a conclusion and I, the therapist, was a participant, at the same time confused and in periods almost feeling paralyzed. From the first time we met, I was totally engaged in this patient. I took detailed notes after each session, and I thought a lot about her.

It seems easier to get the whole picture in retrospect. By reflection and afterthought one is able to understand more of what happened at the time. Sometimes one is not capable of seeing the situation clearly when standing right in the middle of it all. In retrospect one may also gain new insight, provided one is able to recreate the situation in one’s mind. For the title of this chapter I have used a musical metaphor. Making psychomotor physiotherapy work depends on a mutual commitment between the patient and the physiotherapist. Interplay is not unlike the mechanisms that are needed for a chamber orchestra to make music. Dissimulation from any of those involved is purely destructive, listening and true participation is necessary shall progress be accomplished.

It was important for me to discuss this session with the co-authors of this book. The questions they asked helped me to recollect specific details from the session. Consequently I was able to fit things together in a way that would have been difficult had I been sitting writing on my own.

Gry is the name of the patient referred to me for treatment. Because of these talks within the group, the whole treatment process

has enlightened both Gry's and my own story, and enables me to reflect more clearly than I did when I started writing.

I was deeply engaged in the treatment process the whole time Gry came to see me, and at the end I was unable to find any way of understanding why it should end in this manner. However, in the light of the new reflections resulting from my discussions within the book-group, a new hypothesis appeared and I would like to share these thoughts with our readers.

Almost three years have passed since Gry and I set off on our process using psychomotor physiotherapy, and a year and a half has passed since it came to an end. I give her a call to find out how she is doing. She does not seem surprised at my calling her, nor does she inquire my reason for doing so. She tells me that she is awaiting hospitalization in Nordland Psychiatric Hospital, after a consultation with a psychiatrist at a local psychiatric policlinic. I get the impression that she is looking forward to this, and is expectant of good results. Gry tells me that she has stayed at a health resort for some time, and felt okay during her stay. Now she is on antidepressants, and is still on sick leave. She has registered for a data course, and finds this enjoyable but she is in bad physical shape, and is not capable of doing much for the time being. Then she says:

> The psychomotor therapy was good for me, it helped me become more aware of my own reactions, my way of being, so to speak. But my ailments, they are the same as before.

At present she is undergoing treatment from a local physiotherapist. The physio treats her current problem, whatever it may be at the time, so the treatment varies from session to session. Gry is quite content with the treatment since this physiotherapist perceives the principles from psychomotor physiotherapy. Gry is depressed, but neither will nor can settle with the fact that she never will recover from this condition.

There are several reasons for me wishing to write about the process with Gry. One reason is my desire to understand more of her story,

another reason is my need to put my own puzzlement into words, and look closely at what choices I made in my state of uncertainty.

The Danish Philosopher Søren Kierkegaard states the following: "Life can only be understood backwards; but it must be lived forwards". This saying goes for me now.

How It All Started

It was winter-time when Gry first came to see me. She was 42 years old at the time and worked full-time as a teacher. She had three children, two of them grown-up, and a nine-year-old. She had been referred to me by her doctor, who pleaded that I might take her in straight away. He called me and said the following: "This case is so complex and at the same time so diffuse. So I think the best treatment for her now must be psychomotor physiotherapy". This was my only information about Gry.

Gry described her symptoms in a serious and subdued manner. She told me that to top it all, not only had she suffered physical complaints during the past three years, but six months ago she had her first anxiety attack. Since then the attacks often came when she was in stressing situations. She was always tired, often completely exhausted. She had become clumsy, and her right arm and leg would not obey her. Her headache made her dizzy and she always felt tense regardless of what kind of situation she was in. It seemed impossible for her to relax. She had been through a jaw-operation, two or three years ago, allegedly because of some problem with the meniscus in her right jaw-joint. After the operation she had to wear braces for some time. She easily and frequently caught a cold, and was always freezing. Her neck was painful, aches and pains wandered throughout her entire body. All of these problems came utterly out of the blue; she could hardly recognize her own self. I examined her, and sent the following note to her GP:

> The assessment shows me an overworked person in high tension; she demonstrates an ability to relax, and seems susceptible to change.

> The primary findings are related to neck/jaws/face, however secondary reactions are extensive. We will begin as soon as possible. Due to the findings from her neck, which I understand being a segmental dysfunction[1], I wish that this, in time, can be assessed by a Manual Therapist. The patient is highly motivated.

In my survey form I have written the following:

> She is better at sitting than standing. In standing, she doesn't seem to connect with her legs, her right leg in particular is highly tensed. When she sits she does pull herself together, but in spite of this, she manages to consciously loosen up her breath, and this enables her to sit more freely. It's striking, though, how her body constantly adjusts to her head's position; regardless of the consequences, her body seems always to pursue her stiff neck.

To me, these observations indicate that the findings in her neck are the primary cause of her ailments. In retrospect I wonder, should I not have been more concerned about her legs? In a way I was "dazzled" by her body's ability to adapt itself to different circumstances, like sitting, or lying down. I have made a note of how the muscles in her right side in general are in higher tension than her left, moving her right side is painful, and she is in a way more detached from this side of her body; that is, she feels in a sense that it doesn't obey her, it feels weak, and the muscles respond poorly to the command of isolated contraction. I also register the correlation between Gry's experienced sensations and my observations and palpation.

Two weeks later Gry comes for a new session. She tells me she felt completely drained after the examination and that her neck hurts all the more. I try out different ways of approaching Gry. She begins by trying to put her weight on alternately her left and then her right foot. This treatment is about trusting each side, but specifically her right side. I ask

1 Segmental dysfunction: Impaired intersegmental mobility

her to check out how much weight she may put on her right foot, and then how freely she may move this leg. She experiments, both standing and sitting. When standing she holds her breath and her right foot feels very weak.

Now she sits down, and tries out different ways of moving her hips. On doing this, her breathing eases itself downwards towards her belly, and the tight muscular corset around her lower back and stomach releases its grip. She lies down on the table, on her front (prone), and I go on working on her till her breathing flows freely way down to her lower back. Immediately there is a spontaneous reaction, her chest tightens, she gets short of breath, and this is pursued by a feeling of anxiety. She gets up, trying to get rid of her feeling of powerlessness and anxiety by kicking, moving her arms and hands, and voluntarily influencing her breathing pattern. This does help; she calms down, and lies down once more, this time on her back (supine).

Her legs are cold, they are tense, and they are tender to touch. I massage her legs gently. Just as I feel that they are starting to loosen up, and she regains the ability to move them spontaneously, she gets dizzy and her neck starts hurting. Once again she gets up, and sits on the table, legs hanging down. She moves her legs, catches her breath, and the dizziness subsides. She lies down for a rest, but gets up shortly after, ice-cold. She is actually quite excited after this session. It seems to her that we are on the right track.

How Did It Go?

Gry comes to me for psychomotor physiotherapy every second week. She is reticent, does not say much about herself, only when answering my questions. I calmly await her reactions, her response. Am I to hesitant, too careful? Should I challenge her more, ask questions even more directly than I have done until now? Would it have helped if I had been more challenging, forcing her to reflect more directly on what may be

the root of her problems? I give this a lot of thought as the sessions pass, one after the other resulting in little or no improvement. She is hesitant, holding something back, her weight is on her heels, her back is actively erect, and her neck is tense. She radiates a kind of strength, but at the same time so full of tension that she is on the verge of snapping.

She keeps her gaze on something far ahead; she never lowers this gaze, nor does she let her head drop, when she is tired, she simply lets her eye lids close down, then she blinks rapidly, several times. This habit of hers makes me wonder if she is exhausting her visual "channel", and I continue trying to give impulses that challenge her kinaesthesia. I "ask" her body.

As weeks pass by, she eventually tells me that she finds driving here and back too strenuous. She comes a long way for her sessions, 70 kilometers each way. She also reveals having some difficulty at work, partly because of problems among her colleagues. This is a recurrent subject from now on.

Four months have passed since we started and she realizes that she stands steadier on her feet and her legs feel softer. However she still experiences, as often as ever, that she has seizures of weakness throughout the whole of the right side of her body, especially the arm and leg. In addition she frequently "falls out" and experiences spells of dizziness. I have a colleague, Jostein, who is a manual therapist and I ask him to take a look at her. His examination of Gry gave the following conclusion: "Reduced function in the upper cervical segment, also between C4, C5 and C6". He believed that specific manipulation of these segments might help her. They had altogether six treatments, during this period we took a pause. Her headache got better.

We made an appointment immediately succeeding her final treatment with Jostein. That last time he manipulated the segment C4. Gry has recently been suffering from facial pain. When we meet again, her body is wonderfully in balance. Her back is nice and soft and flexible, even when seated on a stool. She is gradually discovering the movements of her pelvis, and she lets her breath follow every movement. The muscles

across her lumbar spine are tender to touch. When in supine position her pelvis eases itself gently downwards, her lumbar spine rests against the table's surface. I feel so great; this is really what I've been waiting for. Her breath flows freely throughout her thorax; all that exists in the moment is peace and tranquility.

I ask her to lift her head, and after a split second her throat muscles tighten, her lower lip starts trembling and she bursts into tears. She is shivering, and she notices the return of the pressure on her chest. I tuck her in a blanket, and after a while I leave her on her own. She prefers it this way.

When I get back in the room again, Gry has fallen asleep. I have to waken her up, and fortunately there is time to let her become properly awake before she has to set off on the long journey home. Her comment on this episode is that her reaction didn't surprise her at all, and assures me that it was not unpleasant. Then no more talk about that.

I feel a little apprehensive about our next session. I wonder if this reaction of hers will be a road to travel on, or will it make her even more hesitant of letting go; will it make her "keep back" so as to restore her feeling of control? Should I have secured her from releasing her control instead of interpreting those fine signals, her breathing, her movements, the softness of her body as her own wish to *get on with her life*, so to speak.

Gry came, and she told me that she had felt uneasy and restless after our last session, but also extremely relieved. There is no increased tension in her neck muscles, and she feels her body more distinctly. Her right side, the more tense side of the two, gives her a twisted feeling, at present she feels extremely lopsided.

In this session we focus on stabilizing exercises. She practices on being able to adopt different positions, without holding her breath or tightening up; in standing, in sitting, when shifting from one position to another, she is to be in perfect balance. I am much more careful this time, having no wish to trigger off a reaction like the one she experienced the last time we met. I want her to have the feeling of self-mastery; mastery of her own body, of her own reactions. On looking back

and reflecting on this, I'm sure this was the right thing to do. Maybe it was simply my intuition telling me that I would not be capable of getting her any further, therefore I anchored her here, a few steps down on the ladder of improvement.

Presently Gry tells me, quite spontaneously: "There have been many hardships, things I have never got any help for. Therefore my pain threshold is extremely high, and I tolerate far too much." I wait for her to say more, to put more substance to what she had just told me, but she stops here. Why do I not ask her directly? What is it that makes me stand at such a respectful distance from her? Normally I am not so reluctant to go head to head with my patients.

Our treatment sessions continue throughout spring and summer, but there seems to be little or no progression. She still feels clumsy, her right side doesn't seem to obey her. There is apparent weakness in her right side, and she lacks contact. Seizures, making her "fall out", come and go, as does her headache.

Her summer is pleasant, and she feels quite well. However, towards the end of the holidays, school-start coming up, she gets worse. She has taken it easy all summer with little stress, and she is curious about why her condition worsens once we resume our sessions. Her physical condition is poor, her legs feel so tired. Her chest has clearly stiffened, face is tense, and her sinuses are clogged. Presently I observe that she doesn't roll on her right foot, it simply slaps to the ground, and she is more than ever lacking contact with her right leg. She now quite often experiences the feeling of her right leg giving way, and when trying to walk a straight line, she is automatically being pulled towards the right. All of my semi-conscious thoughts arise at the same time: is this actually a neurological case? Have I been so busy looking for all the details that I have missed the whole picture? I call her doctor and Gry is referred to a neurologist.

I am at a loss, more than ever. Is she suffering from some neurological disease and is this kind of treatment good for her? What about the great distance she has to drive, just to get to these sessions? Does that only accentuate the problems? What about her serious conflict with the

rector at the school she is working at? What about the manipulation of her cervical segments and my recommendation of this kind of therapy?

My thoughts toss and tumble, as do my feelings about the ongoing treatment. I'm afraid I no longer execute specific PMPT, I'm fumbling. I openly admit this to Gry. She responds by telling me that she needs someone to talk to, someone other than her doctor. "I'm so unacquainted with speaking about myself; I never did like to. Now I need to, but I can't find the words…. It's a tough job thinking when you have no words to think with" Later that same autumn she attends her work part-time. She borrows the video *The Body – Friend or Foe?* (Fadnes and Leira, 1994) and she writes me a letter after having seen it saying: "The content of this film shows my life in a nutshell".

In November she is examined by a neurologist who refers her to a MRI-examination (nuclear magnetic resonance imaging) in Tromsø. One month later she receives a letter from the neurologist: "The MRI-pictures show several cerebral infarctions probably resulting from tiny blood-clots". The neurologist prescribes Albyl E, and puts her up for a new MRI some later date. I make a telephone call to the neurologist. She has little more to add to the information already given, and informs me that Gry may be pressured a bit, if the diagnose is correct. But they have in fact considered the diagnosis multiple sclerosis (MS) as being a possibility. I am now greatly in doubt whether we should continue or not. Gry claims that coming for these treatments does her good, but that the driving is tough, maybe too tough.

To summarise we have not achieved much after all this time, and I feel a complete failure as a therapist. I've lost control of the whole picture, I have forgotten what goals we had from the start, and I am scared of doing something that might worsen her condition. If she in fact does suffer from MS, then she must not exhaust herself. If she has had a "mini-stroke" resulting from a transcient ischemic attack, then she may be pressureded a little . . . There is altogether too much uncertainty.

Gry and I have a talk about this. She really wishes to address her problems, and finally feels ready for psychotherapy but she won't go

just anywhere. Modum Bad, an internationally recognized center for residential psychotherapy, education and research, is her place of choice. So we finally make a decision: Our treatment sessions have come to an end. She makes an appointment with her doctor, wishing to discuss further progress in her process. To be let off the exhausting driving is a relief to her, but she admits that she will miss our sessions.

Afterthoughts

I'm left behind with numerous questions, and a clear impression of what was missing at the time. I lacked the necessary closeness to my client, and this closeness made me lose the overall view of Gry's situation. The treatment became "short-sighted", and too preoccupied with details. The whole treatment session was too much under the influence of my fear that something should turn out to be seriously wrong with her, something undiscovered, and that I should misinterpret her symptoms as symptoms coming from a psychosomatic disorder rather than neurologic. In a way this kind of paralyzed me. I was not capable of asking the right questions, nor am I satisfied with the way I lead our conversations. Perhaps her diffuse answers to my questions made me overcautious. There was too much speculation, to little certainty. Goals became unclear, the treatment unspecific, I lost sight of what aims I originally had . Throughout the whole session with Gry, I really did miss someone with whom I could cooperate, with whom I could confer.

Let me begin at the beginning. Gry was referred to me by a doctor from a neighbouring municipality. He called me, and asked me the following: "I have a patient here whose condition is diffuse and complex. When I have this kind of patient, I immediately think about you and psychomotor physiotherapy. Could you see to this patient straight away?"

I took her in, even though I have a long waiting list. The first time we met, Gry told me: "I went to see her doctor primarily to have someone to talk to but he didn't believe that the talking would be sufficient to help me, he preferred to have me try this instead".

During the talks about Gry within the book-group, this point proved crucial for our further discussions, based on three points of utmost importance; three points that make it clear that something was wrong right from the very beginning:

- She wants somebody to talk to, e.g. a psychologist.
- Her doctor does not acknowledge this wish of hers, nor does he take it seriously. He demonstrates this lack of confidence in her by advising her to engage in something quite different from what she had suggested.
- Sitting here, in front of me, she is in a way here on her doctor's command, not by her own choice. She is clearly not very motivated for this.

In the light of this reflection I do now see it all quite clearly. There and then I had no thoughts about that what seems so clear at present.

Let's take a look at my role right from the very start:

> I had a telephone call from a doctor who over the last five years had referred quite a number of patients to me. These referrals had been quite appropriate; meaning psychomotor physiotherapy certainly was good for these patients. This was a doctor with whom I wished to continue our, until now, close cooperation. At that time I did not reflect on my own definition of a close cooperation, which in reality meant nothing but the fact that he referred patients to me. I would send him a written assessment, go on with the treatment, and then send him a final report when the treatment session had come to an end. That was all. He never took any initiative to follow up the patients during the session, or to get in touch with me in any way. But at the same time, my patients were always quickly given appointments if there was any need for a doctor-visit, he was nice to talk to on the phone, and I knew that he spoke favourably about psychomotor physiotherapy whenever he had the chance.

So, when this doctor calls me, and asks me to call Gry in straight away, I transpose his request so as to feel it is coming from my own "inner voice", so to speak, without doing an analysis of *who is it wanting what*?

Now I'm tempted to toy a little with the idea of what would have happened had I been more conscious of the question Who wants what, and had I dwelt a little upon what an order actually means. If I had listened more attentively to what the patient actually said, and not let her voice be drowned by my own loud inner voice, which in this case in reality was the doctor's "order", then maybe things would have turned out differently.

This is just one case, but I am convinced that this phenomenon is not unusual. Patients normally speak quite clearly about their ailments and what they think might be the underlying cause. They formulate their hypothesis and they often place an order, meaning they have an idea of what might help them, but we don't listen carefully enough. Like I have said before, the patient's voice is drowned by the loudness of our own inner voice.

From my point of view, my challenge for future treatments is to take the patient seriously, take her at her word, even more so than I have done until now. This means that we must never trick ourselves into believing that we know more about what our patients are feeling than the patients themselves. We simply must believe them.

Our interplay, my way of handling and treating Gry was influenced by not only one, but several "inner voices" on my part. The problem at the time was that I didn't see or hear them clearly enough to be able to define them. Not until I had my talks with my co authors was I able to see these elements more clearly.

What I ultimately realized was the following: Gry's way of holding her head high was striking, and I made note of this right from the very start. In retrospect, together with my coauthors, I was able to recognize that this habit of hers reminded me strongly of someone very close to me. This person had always signaled some kind of sovereignty and at the same time having a reserved manner, with a special way of tossing her head. To

me, this movement expressed: ”And what exactly do you think you can do for me?” I’m sure this accentuated my pending attitude towards her, my hesitance, my lack of self-confidence, not being able to trust my own assessment of her condition. Her body-expression was deeply rooted in my subconscious mind, fundamentally doubting my competence.

The choir I had been listening to was a mixture of voices coming from the neurologist, who was not quite sure of what diagnose to give her, whose uncertainty became my uncertainty; and the manual therapist who told me that he was sure that her problems originated from dysfunction in some small joints in her cervical spinal column.

This made me see it all from his point of view, and I let his voice sound in my ears.

So, what becomes of one’s own voice in the muddle up of the other voices? Is it at all possible, or even desirable, not to be influenced by other professionals, to let one’s own tone sound loud and clear, without letting the other voices in the choir mix in and put, in a manner of speaking, more colour to the music? Does interdisciplinary work complicate matters? May it lead us astray and make us lose track of both the road and the goal? When it comes to guiding someone through problems with their body’s demeanor, we must never allow ourselves to exclude the patient’s voice from the choir, from the interplay.

Gry’s own voice was too feeble to be heard amongst the choir of voices from the professionals and from my own memories. In spite of the fact that she actually very clearly expressed her wish, I let my expert-role dominate our relationship, even if from the outside, I seemed quite the opposite.

Mobilizing somebody’s potential for self-development, be it the therapist’s, the patient’s or both, is only possible by way of a living dialogue, a *conversation*, where both voices are of equal dominance. At present I reflect upon how the whole treatment session might have turned out differently had Gry’s voice been allowed to blend with ours. I believe that Gry and I experienced the same thing. I can easily imagine how she had the whole “expert choir” singing inside her, drowning her own voice to the extent that she herself could no longer hear it.

Psychomotor physiotherapy's chief goal is *helping the patient to learn self-help*. To get there, the therapist must be capable of assisting the patient in discovering his or her own tools. We believe that the tools for self-cure exist inside each and every person, ready to be put to use. The first steps on the road is discovering, and then starting to listen to, *one's own voice*; and it must be distinguishable from all the other voices. Learning to know one's own voice and to rely on it is prerequisite for any kind of interaction, or interplay, as I like to call it. Gry puts it in her own words: "It's so hard to think when one is unable to speak".

Postscript

I get a strange feeling as I read this chapter about Gry in retrospect. Four years have gone since we ended our treatment session, and I realize that I, the therapist, have changed. I have changed to the extent that I believe I would have done things differently had she sought my help today. I definitely believe I would have been not as much an expert as a conversation partner, bearing in mind the importance of the mutual and fruitful dialogue. I have written earlier in this chapter, that "I let my "expert-role" dominate our relationship, even if I, from the outside, seemed quite the opposite". This "being careful", perhaps one might even say "passive", became part of this expert-role. The patient was not given any substance to work on, and was thus deprived of the possibility of accomplishing progress.

In the last chapter of this book we use the expression: *being together in the dialogue*, meaning that conversation between two people is taking place, and both voices are valued equally, both may speak from their own perspective; two equal participants. When a relationship and the dialogue are in balance, then this is when both participants experience true development.

To me it is now quite obvious that through the work on this book I was given new insight; this insight has definitely influenced my practice, and it has led to a significant change in my therapeutic work.

Gudrun Øvreberg

Mai's Story

A NPMP Perspective on Tension

In 1993, at the time Mai came to me for individual therapy I started writing down this story. I wished to illustrate how Mai was so overwhelmed by tension that it took control of her whole life. She feels as if she has been under enormous emotional and social strain all her life. In the beginning Mai told me about her life up until this very day:

> I am 39 years old. My partner is some years younger than me. We argue a lot and he is short-tempered. I greatly disapprove of how his language affects our three year old child. We can never discuss anything calmly, I must always take care not to let him hear me cry.
>
> I also have a 13 year old daughter from a former marriage which I broke up because he abused me. Perhaps my yearning for closeness made me rush into a new relationship.
>
> Thinking back on my own childhood, if I *did* have one, I can only remember continuous anxiety, fear, and insecurity. Mum was an alcoholic and I was an only child. I never knew where she was or in what condition I might find her. Quite often, when she was at home and drunk, she would lock herself up in her bedroom. She would shout out that she was going to cut herself up, commit suicide, etc. I used to sit outside her locked door, scared to death, shouting at her, begging her to come out.

I do recall how the never-ending anxiety went straight to my stomach; I always had this pain in my stomach. For many years they took me to the doctor because of all my aches and pains, that's why I thought I was seriously ill. Nobody ever asked me if there was anything I was afraid of, and I can still recognize how fear goes to my stomach, giving me diarrhea, uneasiness, pain and nausea.

Dad was a shift-worker. Although he never managed to help my Mum get herself sorted out, he was very kind to me. We were on good terms and he supported me and backed me up. We had hobbies and leisure activities in common, things we could do outside our home.

For some time I stayed with my grandparents. They lived quite far away from home and I was happy to be there, but I was constantly worried about my mum, about what she might do to herself when I wasn't there to take care of her. It's really true, I still feel so strongly this concern for my Mum. I never allowed myself to be a one hundred per cent child, if I may put it that way. I never dared tell my grandparents because I didn't want them to worry, I didn't want to hurt them by telling them the truth. After all, they were my mum's parents, weren't they? I felt sad and lonely, not being able to share my thoughts and feelings with anyone. I thought nobody else in the world had problems like mine. Looking back, I do wonder what reason my parents gave my grandparents for asking if I could stay there for a while.

Later in life I received 50% disability benefit because of my musculoskeletal disorders. My employer treated me very well but the actual work was sedentary, albeit hectic. The work was often monotonous, although of late it has become more varied.

At present I live in my own house and I'm in control of my economic situation. Earlier I kept fit and exercised a lot. My dad supported me in this. I loved it and in fact I actually won some regional competitions. I enjoy being active, and strangely enough I do feel strong, I must be strong, because my whole family depends on

me, and needs my support. This burden is sometimes just too heavy. For example: my dad comes to visit me once or twice every day. Mum lives close by. She leads her own peculiar life, but I still look after her. She doesn't hurt me like she used to. Things aren't easy, Mum and Dad got divorced ages ago, but they are near me, always.

What Do I See?

Mai and I get on well together. Every time we meet, we talk for as long as she wishes. Mai mostly talks about her aches and pains, and asks me a lot of questions. She wants to know why her body hurts like this, "My pains must show, somehow or other". Mai expresses herself clearly and concisely. Gradually she opens up to her inner thoughts as well.

Mai is plump, of average height with shoulder length hair that hangs loosely, partly covering her face. She has this worried look in her face, her expression also seems reserved. She has a keen eye, observant, thoughtful. Her face can suddenly brighten but occasionally she sheds tears. Quite straightforwardly Mai tells me that her life is extremely difficult just now, and she is on the verge of giving up.

Her movements are okay, but there are signs of uneasiness in them. Taking off her sweater is obviously painful for her, and she needs to support herself when taking off her trousers. She never sits for long in one position. Her sitting position is crouched; she crosses her legs and her arms. When I have seen her on the street she walks in a normal pace, slanting forwards. She is always dressed in sporty clothes, like a sweat-suit, or in dungaree, and wears a wind-proof jacket. She does not wear make-up and appears informal. She is always punctual, and she says she looks forward to coming to the sessions.

May Suffers Aches and Pains

Mai tells me that her physical problems started in her early twenties, before the birth of her first child. From then on things only get worse, even if she has some short periods when her symptoms are slighter.

This is what she tells me:

Last Autumn something extremely frightening happened to me. It was as if I was completely off balance. The first time, it came over me quite suddenly. I was scared to death. I was dizzy, I felt sick. This was why I contacted my doctor. He examined me, he referred me to further examinations, but nobody could find anything wrong with me. So I asked my doctor to be referred to you, to psychomotor physiotherapy. I had heard so much about you and your kind of treatment, and I wished to give this a try. I've been to a great number of physical therapy treatments; it hasn't helped me much though.

I hurt all over, more or less, and I can't breathe properly. I feel this terrible tension across my chest; it's worst during the night. You have no idea how often I have been out wandering at night-time, both due to not getting enough air, and because I feel so restless and uneasy. I shiver inside. I often walk close by the hospital because then I know that if I do collapse, help will be right round the corner. I only occasionally have a head-ache. What is worse is the pain in my neck, pain that moves down into my arm, especially my left one. It feels like it's withered. My shoulder-joints are painful when I move them. In bed I can hardly lie on my left side because my back, hip and my leg hurt more on this side. I sleep restlessly and wake up absolutely exhausted. The lump in my throat makes me choke and I frequently have trouble swallowing, especially if the pieces of food are large. My mouth is often dry.

My face, and mostly my left side, feels kind of stiff. My nose is often stuffy even though I don't have a cold. I hark and I cough because I always feel that I need to clear my throat. It feels tight. My arms and legs feel swollen and stiff. I alternate between diarrhea and constipation, though mostly constipation. Sometimes my bladder leaks a little. My tummy ache has been my companion all of my life. Right now I feel that the pains get worse for no apparent reason. I'm so afraid of illness and it's hard to believe that I am not seriously

ill since I am in so much pain. However they have examined me, again and again, all over, and they can't seem to find anything wrong with me. They have discovered a few polyps; maybe this could be something serious? They are to be removed. (They were removed autumn 1993). When I have these shivering spells, I freeze inside, and break into a cold sweat. Afterwards I'm hot as an oven, I almost choke from overheating. I get this inner vibration when I try to relax, or when I am about to fall asleep.

Now I feel that everything is stuck inside me. I walk and walk, but inside me I feel there's absolute chaos, almost like panic in periods. That is why I asked my doctor to write to you and ask for priority so that I shouldn't have to wait so long. (The doctor sent me a handwritten note, describing this patient's desperation). My doctor is very kind. He lets me come for a talk when things are bad.

Response Pattern Is Born

Life shapes Mai, and all the rest of us, right from life's very beginning. It's perfectly normal for children to respond to insecurity by getting a tummy-ache. Most parents have experienced this with their own children time and time again. When we are in our teen ages, we recall what we call the feeling of butterflies in our stomach. Even as adults we remember our exam nerves and constantly having to run to the toilet. Our body reacts when we are nervous about something, or we are afraid or we feel insecure. Imagine being in an alarming situation for a period of time, maybe for years on end. If this be the case then our organism will maintain a state of emergency preparedness. If this emergency state is never allowed to be deactivated, then a person will be kept in a constant state of high tension. The intensity of it all will vary, depending on what kind of situation the person is in. When a person's average state of tension is generally elevated, physical reactions may be triggered off by a mere trifle. A response pattern is born and this creates a hyper-reactive state in the organism, meaning: always prepared for something bad to

happen. In this respect we may say that the organism remembers. What originally set off a reaction may no longer be a topic, and the person's conscious memories of the actual incident may be erased. However, the body certainly remembers, and will react as if what happened then (even if many years back) is still happening. Slowly but surely, this response pattern becomes a habit, a habit that is accentuated with every strain that happens later in life. This pattern ties up and shapes the person, emotionally and physically. It influences the person's breathing pattern, movement pattern and posture. This response pattern comes to show in the person's expression, behaviour and mood.

Tension affects our body's functioning. The quality and intensity of the additional strain or stress determines how, and to what extent the body is affected; the pattern expands in correspondence to what challenges life offers us.

Stomachache Shapes Our Posture

We automatically demonstrate our stomach-pain and -discomfort by clutching our stomach and crouching. In time, this will come to show in a posture where the pelvis is drawn backwards and the tummy is pulled in. This position will prevent our breathing from moving down into the lower area of the abdomen. Our line of gravity is displaced backwards, and our balance must adjust itself accordingly. We lack full hip- and knee-extension; our lumbar sway is moved further up influencing the body right up to the very top. This is how Mai stood, and of course she tired quickly, standing like this. As for her sitting, one might say she sat without sitting *down*. When she lay down to rest, she did not lie *down*, meaning she was unable to give in to the pull of gravity; consequently her breath was unable to find its way down to basal areas. Lying down did not indeed give her the rest she so badly needed. She held her arms tightly, and she actively, (but not consciously) tensed her pectoral muscles. Her breathing was superficial and was spread unevenly throughout her chest.

No matter what kind of position she was in, she held herself upright, and was of course constantly tired. Little by little she learnt to relax her arms and her pectoral muscles. However, having been in this high state of tension for such a number of years, muscle tissue had shortened and made restrictions on her arm movements, thereby also preventing her from breathing freely. She maintained her crouched position and in bed she adapted a kind of fetal position. She always lay on her right side. Most people with this kind of excessive tension pattern will prefer to lie on their right side because the unpleasant feeling of their heart-pounding is more pronounced when they lie on their left.

Years Pass . . . and Time Is Not Always a Healer

Any particular situation at all may trigger off a cascade of body reactions. Tightening a group of muscles is a defense reaction meant to offer protection. In time this will create other complaints that will trigger off new defense mechanisms, and so the story goes on. Layers of non-expedient solutions are established in the body. This is how life influences our movement pattern. Traces of life are left in our body experience and in our habits, and they influence our further development. Life experience can never be separated from the body's experience. Most of what happens in life is forgotten, meaning absent from our conscious mind. However the body's reactions to these forgotten memories may still be present and influential, making us move, act and react in accordance with our body's learned responses.

The Patient's Story and her Insight

As Mai experiences and learns how closely her symptoms are connected to each other, memories arise. Mai reflects and recollects her story. As tension is released she gains insight and forgotten memories are revived. *When snow melts, what lies underneath the snow is disclosed.*

Patients are used to talking about their illnesses, injuries, operations, examinations, what medicine they take, etc. To a psychomotor physiotherapist, a case history like this is incomplete. We must encourage the patients to tell their *own* story, including their ordinary complaints, what they worry about, if they are under any kind of strain or stress and so on, in present and as far back as to their childhood. Only then might we be able to summarize and acquire a clearer understanding of how this state of imbalance came to be. Together we discover how logically the whole picture may be assembled; how life's strain and stress and the nature and consequence of the patient's symptoms are so closely connected to each other. Once the patient is able to fully understand this context then his or her attitude towards the symptoms will often change. The patient becomes a participant in his or her own process, our collaboration becomes more fruitful, and as a consequence of this the drama of their symptoms may defuse. We do know that injuries, operations, even examinations are strong emotional and physical experiences. How the patient actually experienced these incidents is important information.

Mai was communicative by nature, and had a doctor who related to her as a human being, and not just a patient; she was well prepared and ready for psychomotor physiotherapy. Mai's doctor who had detailed knowledge about this kind of physiotherapy.

What Are My Findings After the Clinical Examination?

When I palpated Mai's musculature, I found that it was compact, and both subcutaneous tissue and muscle felt hard. There was increased tension and pain anywhere I touched her. Her joints were hyper mobile. When I moved her limbs passively, joint motion wasn't restricted by the joint itself, but by short and tense musculature. This combination of short, tense muscles and "spacious" joints seems to account for pain in surrounding tissues. Hyper mobility is congenital.

Muscular tension in arms, legs, back, pelvis, chest, jaws, face, scalp and neck caused Mai's stiffness. She constantly held her breath, and

because of this tension was generated in her stomach, chest, throat and larynx. Tension in front influenced tension in her back. All of these findings allowed me to fully acknowledge the reality of all of her aches and pains. As I worked throughout her body, palpating, sensing, Mai noticed the stiffness and the tenderness underneath my fingers. Being able to observe this for herself, her symptoms became less mysterious, more understandable and less scary. Mai's tummy bulged, something we see quite often in patients in this kind of condition. When she stood, she tensed her buttocks, a little less so when sitting or lying down. We may now reason by logic how tension affects function, circulation and tissue in this area. The diaphragm is not given enough space to move in the way it is intended to. The diaphragm's piston-like action, moving downwards under contraction and letting go upwards under relaxation is necessary for our inner organs as well as our circulation to function optimally.

Tense hip flexors together with highly tensed adductors make conditions cramped in the groin area, impairing circulation to and from the legs. This explains why our feet may become swollen when we sit for an extended period of time such as in long haul flights. In addition to this, the quadriceps' tension influences the knee-caps' gliding function, and may in time lead to degeneration of the joint between the femur and the knee-cap. Pain and stiffness lowers a person's level of activity, and this is of course unfortunate.

Literally speaking, Mai truly *gave her all* in order to make it through. This kind of *pulling oneself together* attitude is definitely a muscular action as well as an emotional one. This means for example physically clinging on to the ground with one's toes and knees, clenching jaws and holding one's breath.

When Mai lifted her arm, she activated her pectorals, when she moved her jaw she tensed her neck muscles, when she straightened her elbow she elevated her shoulder. In short, she activated a whole number of muscles unnecessary for the action intended. In fact, they were not only unnecessary; they actually *interfered* with the intended movement

instead of assisting it. Mai was unable to move her body parts freely and separately. When a person is in an elevated state of tension like Mai's was, then breath is continuously repressed and functions as a "central lock", figuratively speaking. Working on a hard floor, high working tempo, and overweight are all conditions that put an additional strain on an already worn out and over-tense body. This had been Mai's situation for many years.

During pregnancy, women in this state of tension often develop pelvic girdle pain, due to pelvic distortion. The situation of being loose-jointed and having short and tense muscles seems to aggravate this condition, especially if the tension level is different in the right side compared to the left. The way I see it, this kind of consistent tension, especially in combination with joint hyper mobility, will often cause symptoms in the joints. These complaints cannot be discovered by x-rays.

What is, and what is *not* usually examined?

Reflections

When it comes to musculoskeletal problems, physiotherapists and doctors are mostly interested in examining arms, legs and backs. They seldom reflect on the role of the stomach, chest, throat and face. However, according to our experience in these matters, this is where the primary "brakes" are put on. Tension is so often emotionally conditioned; this is the subject matter that I have reflected upon so far. The muscular state in one's back, arms and legs adjusts itself according to the breathing motion, and breathing responds to emotional strain. Of course, tension may arise anywhere and for any reason, but nothing like emotional stress affects our breathing so extensively. This explains why the patient's breathing pattern is such an important issue. We observe breathing in regard to frequency, depth, variation, and we look for what areas are filled with air and what areas are not, variation. We listen closely. Does the patient sigh? How do the actions of breathing and talking relate to

each other? Does massage influence the breathing pattern or what about movements or changing position? How does the breathing respond to a relaxed state and so on? Speaking is breathing. Words are brought forth by our breath, be it a whisper, a growl, a hum or a song. Or words can be held back by tensing the tongue, the jaws and by restricting breathing. We do say things like: "Keep your mouth shut, hold your tongue, shut up, etc…".

Today's public health service is mostly interested in breathing capacity relating to our physical condition, our fitness. Reflecting on the fact that our physical condition is very much dependent on being able to breathe in a flexible chest is quite uncommon. *Lungs do not work by their own action.* The lungs' function is totally dependent on the chest's ability to expand. This explains why this kind of assessment of breathing function is so important.

Mai had never had anyone to whom she could express her meanings and feelings. Tears had been held back, waiting to be shed until she was on her own. When in need of a conversation partner she had only had herself to talk to. When we talk to ourselves our thoughts often go round in circles, bearing no fruits of reflection. It is in the dynamics of the interchange between *inner* and *outer* conversation that we learn to grow as human beings.

Muscles Movements Are All Over the Place

A tense muscle is a shortened muscle and short muscles evidently shorten or narrow whatever they are attached to, be it the stomach, the chest, the throat, the larynx, the floor of the mouth or the tongue. The patient might describe the symptoms in the following way, feels tight, feels constricted, feels like a belt around my chest, a lump in my throat, can't get enough air and so forth. Professionals often regard these as vague symptoms. Knowledge about how to assess these complaints seems to be insufficient but should be considered equally important as other medical examinations.

This group of patients have been through countless examinations, often with negative results: “There is nothing wrong with you…”. This of course makes the patients quite bewildered: “Nothing wrong? But why is it then that I hurt so much?” The professionals involved ought to inquire if there are other ways of examining these patients; examinations that actually might give some answers.

Mai recognizes that unpleasant feeling of not being believed in because there were no specific medical findings. “Maybe I don’t feel what I think I feel? Maybe I don’t explain my symptoms well enough? Maybe I have to get even worse for them to take me seriously?” Mai was constantly going through some kind of medical examination; her heart, lungs, stomach, knees, shoulders etc. “How come all my pain doesn’t show up anywhere?” Being touched means being taken seriously. By omitting assessment of muscles’ quality and function, movement and breath, one lessens the chance of fully understanding the patient.

In public health-service, it is desirous to base clinical examinations on objective criteria, and I am certainly not opposed to this. However objectivity is not always as objective as one likes to believe. Comparable examinations and assessments may be carried out and evaluated differently, and diagnoses are made based on evaluation of multiple results. In this sense then, the conclusion, or diagnose, will vary depending on who is making it, what back-ground and experience he or she has, and so on.

Long-term functional impairment, like we see here in Mai’s case, may over the years lead to joint changes of degenerative nature. It will often come as a great relief to patients in Mai’s category if this condition is diagnosed, seemingly giving them their long sought for explanation, and not least an acknowledgement of their state. However, in the long run, leaning on a diagnosis may deprive the patient of own insight, own efforts and potential for change.

When a person in a state of high tension falls, or crashes with something etc, the outcome is often more serious than for a person of average tension. *A stiff branch snaps easier than a subtle one.* The result of

high state body tension is a body lacking in compliance and flexibility. However, in most bodies we find both rigidity and subtleness, and it is at the transition between the two that we are most vulnerable.

We function at our best when we are *naturally* subtle and our movements are free and easy.

Time Aspect Once More

Time squeeze and this desire for a "quick-fix" leads to short-term thinking and often creates a distance between the patient and the helper. In the spur of the moment, the symptoms become more important than the symptoms' *possessor*. This *possessor*, meaning the patient, needs time to able to tell his or her story. This is not because the patient consciously holds back information, but because it takes time to develop the kind of insight I previously have spoken about. Insight is necessary to be able to associate and attach symptoms to one's life history. It takes time to grasp the meaning of it all – one needs time for necessary contemplation, and it takes time to be able to put all of this into words. It also takes time to get familiar with this kind of conversation. The patient must be helped to trust his or her own observations, and that new insight in itself is valid information.

One important element in psychomotor physiotherapy is offering the patient the time needed for conversation and for the process of change. In the sports-world it is self-evident that it takes time to become well-trained, and many years to reach the peak of sportsmanship. Our patients are expected to change their whole way of moving, practice getting out of the grip of illness or of life's stressors, in no time at all. It goes without saying that physiological laws apply to them as they apply to sportsmen. The expectancy of hasty recovery for this group of patients is totally illogical. It may even undermine the patient's chance of gaining own insight, and spoil effort and motivation.

Time aspect is most interesting when studying children's motor development. When children play they repeat over and over again new

movements, new sounds and new words to establish their newly won skills.

Time and *repetitions* are key words in therapy.

Mai and Psychomotor Physiotherapy

Mai had thirty treatments from May 1993 to June 1994. Slowly but surely her muscles relaxed, and she diligently followed the instructions and advice given. She experienced a number of reactions, pleasant as well as unpleasant ones. In the beginning her body reacted by giving her diarrhea, her muscles and joints stiffened, and her whole body became tender to touch. She definitely felt that she was undergoing some profound change. Her nose opened up, and her breathing no longer felt constantly constricted. During this period she got more headaches, and after the fifth treatment she experienced inner trembling and uneasiness. All the same she actually did sleep better. Her body felt lighter and warmer as the trembling gradually subsided. But, even when this trembling occasionally came over her later, she no longer panicked; she knew how to bring it down.

Mai's body became less painful; in short she experienced a greater variety in her body function, it seemed to gradually come out of this chronic state of tension. She felt re-vitalized and managed to cope with everyday chores. It became clear to her that she herself had to draw her own limits, meaning she had to make it very clear to the people around her what she did and did not want from them.

Mai managed to organize a family gathering, much to the family's astonishment, as well as her own. Afterwards she suffered a harsh reaction: pounding heart, the well-known breathing problems, chill and diarrhea, and she stiffened and hurt all over. We had a long talk afterwards, and Mai did then understand the connection between her symptoms and the stress caused by this gathering. Her doctor was once again there for her, and he examined her heart to reassure her that

there was nothing wrong. This set her mind at rest, she could relax and her symptoms subsided. This turned out to be an important experience for Mai; through this she gained increased knowledge about her body and its reactions.

In the course of this series of treatments, we had one "round the table-conversation". Those present were Mai, her doctor, a psychiatrist (Professor Tom Andersen, one of the coauthors of this book) and myself. This was an intense experience for Mai. "I had never thought that I would be so moved, it did me such a lot of good. Afterwards I was so relieved, even if the whole meeting rummaged in my mind for a long while. It was nice to be allowed to cry there".

Mai was certainly allowed to cry, in the course of that meeting as well as during our sessions. She couldn't cry at home, but gradually she understood that her partner's rage actually covered up the fact that he was afraid. At that time he did not want to be involved in any kind of therapy, but one year later he agreed to participate.

May caught a cold the following week; this is quite normal after having been in a stressful situation. She was constantly tired, also a perfectly normal reaction as one's long-lasting tensions finally begin to lose their grip.

During this period Mai's and her partner's relationship was troubled. Mai had begun to mark her opinions clearly, and she wished to be put on sick-leave. Slowly but surely she grew stronger. She understood now how everything in her life was in some way connected, and she accepted this fact. Mai's reactions involved her muscles, her autonomic nervous system and her emotions, simply because this was her normal way of reacting.

By June we agreed that the therapy should soon come to an end. Minor symptoms came and went, and this is how it would be in the future.

The point is: she understands her own context, and is able to help herself when necessary. Her process does not come to an end even if the individual treatments stop. She has been guided on to another track in life, and that helps her discover her own solutions in everyday life. This

is not about being sick or even about recovering; this is about change, about getting out of sickly and unpleasant processes in life.

Mai's process Continues in a Movement Group

Ever since she was a child, Mai had always enjoyed being physically active. Inside her she had positive experiences regarding movement, mastering, social gatherings and abreacting. So Mai enjoyed her home-work, the movements/exercises let her become acquainted with herself in a new way. She learnt that her body is a whole, she learnt about movements and balance. She practiced earnestly in connecting with her own subtle movements, being careful not to put more effort into the movement than necessary. She paid attention to her breath, making sure she didn't hold it when doing the exercises. She learnt that relaxed movements are more enduring than strained ones, and that the way she moves affects her way of living.

I was prepared to let her attend my movement group when she was ready, meaning emotionally ready as well as physically. I had to be sure that she could both take instruction and be able to set her own limits as to how much or how little she felt was right for her to do. This movement group is called: *Exercise and Relaxation.* Each session lasts one hour, and we meet once a week, 12 times per semester. This is a private enterprise so the participants pay the cost themselves. The participants are former patients of mine as well as others who simply wish to take care of their own health. In June Mai and I agreed that she should start in September 1994, and attend the autumn semester. Mai started in November. She told me she had had a relapse and had been very depressed, and that a strong feeling of insecurity had taken hold of her, this was why she had delayed the starting date.

Once she gets started, she enjoys herself and seems to settle in nicely. "I like getting comfortably-tired". The exercises are easy for her. She smiles to herself as she moves to the music, enjoying the rhythms.

Mai takes no notice of the others, but we two make eye-contact now and then. Mai finds her own place close to the wall and the door; she has one person in front of her, and one behind her. She opens the door when she needs more air, and slips out when she needs to drink water. It's quite clear to me that she is having a good time.

Mai continued through the spring semester. She met for the first session in January and quite spontaneously told everybody that she had looked forward to joining us again, that she coped well with everyday life, and that she really felt fine. Some friends of hers attended this and other similar groups, and so she had somebody to share her experiences with, somebody who knew what she was talking about. Gradually Mai discovered that other people in fact had problems similar to hers, people who also needed to work intentionally with themselves.

Progress develops naturally from here on. Mai admits to having become bolder in many situations, she finds herself more daring in general. Earlier everything hurt, and all this pain frightened her, making her avoid any potentially "dangerous" situation. She is definitely on her way out of this imprisonment.

Closing Words

This story about Mai has been told to demonstrate how complex life may be, and to illustrate how everything fits together: our life experiences, our development, our muscular state, our way of moving, how we communicate, and how we express ourselves. Norwegian psychomotor physiotherapy attempts to promote change, so that life may take a new turn, away from the original symptom-generating road. For this kind of change to happen, the patient's own effort is required; by way of movement and by getting acquainted with one's own response-pattern. A time may come when the whole process comes to a halt. Perhaps one just needs more time, perhaps one may be in need of counseling, perhaps one's life situation must change to be able to continue, perhaps we need to make a pause from therapy.

Time has come for ending therapy when the patient and physiotherapist together acknowledge the patient's ability to continue on his/her process on their own. Mai suffered a childhood of insecurity and naturally she needed somebody in the health service to relate closely to, someone she could trust, when her life came up against a brick wall. However, one must take care not to make the patient ever-dependant on therapy or on the therapist.

Mai Does Not Let Go of the Group – I'm Happy to Say

In October 1995, Mai came back to the group. Her arms had started hurting again and she had been on sick-leave since the beginning of September.

She moves swiftly and easily, is in good shape, but her arms are troublesome. She tells me that she has been to a counseling group at the adult psychiatric clinic in April. Her doctor had referred her to this group at her own request, and she found this very rewarding. Later she attended a self help group which she very much appreciated.

I tell Mai that I am writing about her and I ask her if she would like to read the paper and tell me what she thinks. She is grateful and excited, reads it through and writes down her thoughts and reflections.

My co-authors were given permission by Mai herself to read what she had written. Professor Tom Andersen suggested that she should come and speak to all of us. I invite Mai to our next meeting and she gladly accepts the invitation. Tom writes about this meeting in the next chapter.

Mai continued attending my group through spring 1996. She got better in every way. In the beginning of the autumn semester, Mai showed up. She had lost 9 kg. She was so alive in all her movements as well as in her expression. Proudly she showed us a photo of her and her partner. "He's not so bad after all" she told us. "Actually he is really a good boy. We are fine now. We are able t otalk to each other."

It takes as long as it takes.

Tom Andersen

Meeting Mai, January 1996

It is autumn 1995, and Gudrun Øvreberg has told Mai that she is writing a story about her. Gudrun asks Mai if she would like to read the story, and Mai would certainly like to. After having read it through, Mai wrote down her own comments. She gave us, the co-authors of this book, permission to read her paper. This is a small excerpt of what May wrote:

> For so many years I had been scared and lonely and all this pain had made me anxious, I felt as if there was no joy left in my life. I could not understand where all the pain came from, nor could the doctors. Nothing felt right, and my thoughts went around in circles. Every thinkable disease came into my mind, like bone cancer, other kinds of cancer, brain tumors etc. In the end I had lost control of my reasoning. Every single physical sensation made me so afraid.
>
> But now I understand more of what is going on in my body, including my emotions. This new knowledge about what to do when symptoms arise in my body is so wonderful. I feel so happy when something opens up inside me, and the pain disappears. Absolutely everything in my life has changed. Among other things I can mention being able to speak my mind more clearly and I can make demands on others whereas earlier I only made demands on myself.
>
> However, I still have work to do regarding professionals in the public health service. I want to make them understand the proper order

of my symptoms: it starts in my stomach and then pain spreads throughout my body, and finally it all bursts out in anxiety. They still believe that it is the anxiety that leads to pain, and not the opposite, as is the case. But most important of all: I have finally understood it myself.

These notes made us curious about how she had experienced this collaboration with Gudrun, so therefore we invited her to come and talk to us. Six of us came together in Harstad at the end of January 1996 to continue our work on this book, and there Mai joined us.

Mai, Gudrun and Tom spoke together first, the other four of us were listeners. Then as Mai, Gudrun and Tom took over the listening role, the others spoke together about what they had picked up from the conversation between the three. Afterwards we all spoke freely, whoever wanted to (Andersen, 1995 b).

In the following we will use these abbreviations: G=Gudrun, M=Mai, T= Tom, A=Alette, I=Ingar.

First of all Gudrun was asked to share her reflections with us. She said that in the course of the sessions with Mai, she had become acquainted with her movements and her reactions.

G: I often wondered if the sessions were friendly enough, or if her feelings had been offended in any way. Had I been sufficiently open, so as to let her speak her mind freely? Was I too pushy, or was I too reserved? Did I miss anything?

When the therapy was coming to an end, in June 1994 I had suggested that she should join one of my movement groups, but she didn't show up, and naturally I wondered why. But eventually she did turn up, as late as November.

In Spring 1995 she had sought help from an adult psychiatric polyclinic. This made me wonder if there had been something I had missed out on. Then I reasoned that perhaps everything just takes its time, and that things happen in due course, when the right time has

come. In Mai's case this meant that she needed time to be prepared for this psychiatric polyclinic; just like she needed time to be ready to attend the group.

M: (Mai is crying, and she is asked to comment on what Gudrun had just said.) When I listen to Gudrun just now my heart is pounding, and I also feel so sad. It was really hard to stop coming to her, and I have missed it ever since. My common sense told me that this kind of treatment must come to an end at some time or other. There are so many people on the waiting list and they must also be given the same chance I got. We had spoken about finishing for quite some time, and therefore I ought to have been prepared, but I really hadn't been able to take it in. You see, I had finally found somebody I could talk to, we spoke about things I never had spoken about to anyone, and suddenly it was all over. This business of me going to the polyclinic had nothing to do with you missing out on anything, Gudrun, it had quite simply to do with my need to talk. You see, there was so much more to talk about, more than we could do here at your clinic, and my hesitance towards attending your movement group was just because I needed time to get used to the fact that I was not going to have you to myself. I do enjoy myself there, but I must admit that I am very concentrated on everything you say and do. You see, during all this time together with you I grew very fond of you. That's just how it came to be.

T: When we read what Gudrun has written about you, we understand that you were very satisfied with the treatment she gave you?

M: Yes I was. I especially wish to emphasize the fact that she took me in so quickly – that she gave me priority over the waiting-list that I had been on for a while. At the time I thought I was suffering from all kinds of diseases, and I could hardly walk. I kept losing my balance and in one period I even became temporarily deaf. The doctor told me I had a virus in my ear which affected my balance mechanism and this frightened me more and more. I started thinking: maybe this virus will spread to my brain, and then what…? I was scared to

death, and completely worn out and then Gudrun called me in. After having examined my whole body, she said that it was easy to understand that I was in so much pain. This immediately filled me with such enormous relief. I myself was not aware of the fact that my muscles were so tense, but Gudrun had felt the tensions with her hands, and then I felt them also.

It was so wonderful to be allowed to ask about everything that worried me, e.g. the trembling at night-time, and the heart-pounding. She explained this to me, and reassured me that none of these symptoms were serious. During the first session, I managed to draw air, I could breathe! This was such a relief. You have no idea how absolutely exhausted I was at the time I met Gudrun.

T: To me it sounds like you were really feeling discouraged.

M: Yes, absolutely.

T: Were you so worn out that you were on the verge of giving up? (She nods, and for a long time her gaze is lowered. A long-lasting silence follows, and we are all immersed in our own thoughts about what we are witnessing.)
Was it so bad for you that you had difficulty in envisioning a future for yourself? (She nods once more, and cries silently – for a long time.)

We are all deeply touched and moved by what is happening in the room. And we try to imagine what it must have been like, to be in so much pain, to be so afraid, and to be so alone. The thought that May could have been departed now, shakes us all up but at the same time we are filled with great joy because she actually is here with us, and because of what she and Gudrun have accomplished together.

T: What do you make of this, Gudrun?

G: I am so impressed by the way Mai took care of, and utilized her potential. Nor must we forget the doctor who wrote me this cry for help. I remember vividly his hand-written letter to me, displaying

such genuine involvement in Mai and her case. I cooperate very well with this doctor. Every time something happens in therapy, e.g. the patient has some kind of reaction and I need him to make an assessment afterwards, he does so without delay. In turn when he says something is urgent, then of course I respond likewise.

It is a fact that it is extremely important to find the right moment for bringing therapy to an end. I constantly reflect on when the time is right, when the patient no longer needs me to lean on. Patients must be given the chance to get on in life without the therapist. For many of them it has proved helpful continuing in a movement group. Here they leave the patient role behind, and are normal human beings who enjoy and benefit from this kind of movement training. Most patients do wish to continue individual therapy; this is why I need to prepare them for some time for the termination of therapy. Together we must find out when they are ready.

Regarding the movement group, I must admit I did wonder why Mai did not show up. I considered giving her a call, but then I thought: "No, she must decide for herself".

T: What are your thoughts when you hear about the sadness Mai experienced when the therapy had come to an end?

G: Well, sorrow is an activity, a process. This was something that she worked on. It had been worse had she given up, and just wanted to come back to me. Of course, sorrow hurts, but when one works on it, like Mai did, then that means getting on with life. No, I really do believe it was time for the treatment to come to an end. And Mai managed fine without me, didn't she?

T: (Addressing Gudrun) How does it feel when Mai talks about how important you have been to her?

G: Of course it is nice to hear this. It is certainly encourages me to continue working the way I do, but crediting the reason for success either to Mai or to myself would be a big mistake. We did this together. Of course each of us contributed, but the results we got would never have been achieved had we not walked the line together. We

took one step at a time. Had Mai not been so open-hearted and communicative, then she would never have got this far, and in the midst of all the physiotherapy was our conversations. There was a natural progress the whole way and besides, I too have learnt so much. My experience with Mai has been valuable, and has influenced my practice. (Gudrun turns to face Mai): Was there ever anything you said that I did not catch?

M: Not to my memory.

G: But were you given enough time?

M: Yes, certainly.

T: (Addressing Mai): Do you recall any incident in particular?

M: Once I suffered severe heart palpitations, and I told Gudrun about it. She asked me if I wanted to stop coming to her but I answered "No, let's continue". When Gudrun told me that it wasn't harmful then I totally trusted her. I occasionally had this heart-beat at home, but instead of being afraid, I simply thought about Gudrun, I heard her words and her voice, and this calmed me down. This feeling of safety, was so outstanding; I felt it right from the very start. I don't quite know how to find the right word, but . . . yes, safety seems to be the word closest to my feelings. Her assessment of my body told her what was wrong with me, and this certainly agreed with me.

I especially remember one session, I was standing there, and she asked me to let go of the tension in my buttocks .We worked on this for some time, but nothing happened. Then suddenly one day I could do it; the buttocks' tension subsided and my bottom felt like it sagged down into place. So there I was, in a totally new position compared to just a moment ago, and compared to the way I stood earlier. It was such an incredible feeling! Afterwards I was tired and my body felt so nice and comfortable.

T: What have your children said about all this?

M: I haven't told them all that much. They had enough to think about, without having to be preoccupied with my problems as well. However, my oldest daughter did read my comments on Gudrun's

paper, and it made her very thoughtful. My husband has surely noticed that I have become short-tempered. I speak my mind clearly, and saying stop is easier for me now. My father, who used to visit me at all hours, now takes care to come when it suits *me*. He is a kind man, but he doesn't always take into consideration if his plans suit others. It almost wore me out, but, like I said, now he maintains a more reserved attitude and that's good – for all of us.

T: And what about your mother, has she noticed any change?

M: She has neither mentioned nor indicated anything of the kind. However, it's possible she has noticed that I am angrier and more determined, and I'm sure she must have become aware of the fact that I no longer take painkillers or tranquilizers. She must have noticed that I tell her off more.

T: Do think she might have reflected on wanting to have been to you what Gudrun has been?

M: Yes, that might be so.

Now the others, who had been sitting quietly listening, spoke about what they had been thinking while listening to the three of us. Alette said that she had especially given heed to the word sorrow, and found out that she wished to speak more of sorrow to her own patients in the future.

I: I think maybe we all experience some kind of sadness when a therapy session comes to an end, I know I do anyway. I grow fond of my patients, but this is something we don't talk about. What could be the best way to talk about how to end therapy? Perhaps we might simply say: "To me it looks as if you come a long way since we started, and maybe time has come for the therapy to come to an end. What do you think?" Anyhow, it is an important subject.

Ingeborg said that she had been very moved, especially when Mai had talked about how important the first meeting with Gudrun had been. Berit had reflected on the close collaboration between the two. Eli was not here with us. What would her reflections have been?

A: (Addressing Mai): When you met Gudrun, did you expect her to relieve you from your pains, or were you prepared to have to do your share of work?

M: When I started, I just thought that I was willing to try anything, but when I lay there on the table, I realized I was the one who had to let go, Gudrun couldn't do it for me. When I finally managed to, this understanding was confirmed: *I* had to let go.

T: If someone had requested you to explain what this psychomotor physiotherapy is about, what would your answer have been?

M: You get to know your own body, you breathe, and you get enough air.

In the end we ask Mai how it feels to have become a co-author of this book.

M: It feels pretty nice. After all, I do understand quite a lot now, don't I?

Gudrun Øvreberg

Norwegian Psychomotor Physiotherapy for Children

Children's aches and pains, tension-based stiffness and impaired functioning are underestimated conditions. Normally we simply dismiss their complaints and tell them that it will pass in due course, or this one: "You will grow out of it". They may also be told this: "You are so young; you can't have these musculoskeletal problems already?" This is an assertion that lacks evidence in real life. Tension as a possible explanation is seldom a topic, not only because tension is an underrated condition, and also because the public health service do not know how to assess this.

Unfortunately, it is a fact that tension-related ailments are increasing health problems among children and teenagers. There are countless reasons for this to be so, the following account tells two stories, just two out of many. I have chosen these two because they are very different, and they illustrate many important points. They give us insight, and we learn something about how we as physiotherapists may work when children become patients.

Who Refers the Children for Treatment and Why

Over the years I have developed a close cooperation with some of my home-town's general practitioners, as well as a pediatrician and a

pediatric physiotherapist. Together we have uncovered an increasing number of tension-related ailments in children. Most of the referrals for Norwegian psychomotor physiotherapy are made by their family doctor. The children's symptoms may be headaches, back-/shoulder-/neck-ache, hyperventilation, dyspnoea with heavy sighing, tummy ache, a syndrome containing hacking, hawking and sore throat, asthma combined with a stiff chest, diffuse joint pain, secondary ailments following injuries, or movement disorders where emotional factors are suspected. The GP often refers children to the pediatrician who makes further assessments. Having to go through thorough body examinations is often a very unnerving experience for the child. Should the doctor have the slightest hunch that the child's problems has something to do with its state of tension, then this should also be included in his assessment, by way of examination, case history and conversation.

I have taught the pediatrician how we assess this kind of problem by using some simple psychomotor examination techniques. He has had to practice and has learnt by experience. Practicing is crucial. Everyone needs to practice to be able to rely on one's findings. The pediatrician has learnt to question the children and their parents about conditions relating to muscular tension Because of this, his referrals have become more appropriate, and in turn, he understands my feedback. This close cooperation between us seems to generate a feeling of a trust between everyone involved.

The pediatric physiotherapist refers children for NPMP when suspecting that tension is preventing normal motor development. The referral may be about one single assessment, or for treatment.

The school physiotherapist also makes referrals, through cooperation with the school doctor or the child's GP. The school's health visitor is often the one who highlights children's problems quickly.

Children Are "Undisguised"

Children respond to life *today,* and relate directly to their context, quite

different from how we experience the adult patient. They have not yet learnt to disguise their being, their existence. Parents, guardians or others in the children's social circle are allowed to observe them in their natural context. Being physically close to a child opens up to a silent awareness of how the child is doing. However, the grown-ups themselves are not always conscious about this.

When the parent or guardian accompanies the child to the doctor, this gives the doctor information about the child's background. This information will be included in his total assessment, relating to the child's state of health and treatment potential.

Illness – Tension – a Circle of Pain

To be able to achieve an opinion of the logical development of the child's tension pattern, it is necessary to obtain information about previous or present illnesses, injuries and other stress factors in the child's life. In most cases a patient's condition is more easily understood in children than in adults, simply because it all happens in a shorter span of time, and, like I have mentioned earlier, a child's symptoms are more "undisguised" and therefore easier to interpret.

One needs to have an emotional relationship to a child to be able to understand the child's different ways of communicating by other means than words. This is how the people closest to the child may perceive and understand the child's communication through the language of movements, through its breathing by crying, laughing, screaming, or even through the absence of expression.

Parents are often good at interpreting their child's wordless body communication, probably by use of some kind of natural, biological instinct. However, this skill seems to be not so readily applied on themselves. The fact that many adults ignore or underestimate perception of their own body communication is probably owing to today's way of living. Perhaps it comes from all the noise, our agitation, our hasty pace,

everything is up-tempo, thereby neglecting or even lacking the time needed for afterthought and reflection.

Information about the child's life as a whole shows us how tension develops in logical order, and it makes it easier to understand how increased tension may in time develop into symptoms. According to a survey of when and how illness occurs at different age levels, during childhood there is a highest occurrence rate of illness in the ear, nose, and throat area, as well as in more central airways. So, in other words, the breathing organs are physically strained; in addition to this we know that our breathing is the body function that responds most sensitively to our emotions. When all of this is put together we may understand why so many symptoms arise from precisely these areas. Frequent laryngitis or sore throats leads to tension in muscles connecting to the larynx and throat; a secondary consequence of this is tense neck muscles. Front and back constantly work in conjunction with each other and cooperate closely. Frequent earache, or otitis, leads to tension around the ears, along the occiput and in the jaws. If this is sustained tension, then one of the consequences may be frequent headaches.

A stuffy nose will make the child breathe through its mouth. This may in time irritate the throat, which in turn leads to a coughing problem, and this may, in turn, lead to tension in the throat and chest. This is of course concerning cases of prolonged illness.

In the past, in the olden days mostly, stories have been told about children's horrific experiences from their stay in hospitals, and encounters with ignorant and arrogant health staff. In modern time one is fortunately aware of what a strain it is on a child to be hospitalized, and in today's health service children are met and treated in a much more humane manner.

Children learn from, and are naturally influenced by, their close relations and will often learn from them how to deal with their own illness. As we know, adults deal with illness in a number of different ways, not all being beneficial.

Dental Braces

Childhood often means time for dental braces. Braces are uncomfortable, and don't look all that nice either. Although the quality of today's braces has improved considerably, this may still contribute to restricted movements in jaws and mouth. If the child is tense in this area from the beginning, then it might aggravate the situation further if braces are put on. After the teeth have been straightened, then it proves harder to be able to loosen the tense muscles and so it is a good idea to work on these tensions before having braces fitted.

The First Session

The parent or guardian always accompanies the child to the first NPMP session. Later on we do what feels right, in accordance with the child's age and condition. I always address the child, even when the parent is there. What does the child think about the problem? What does it know about how muscles function and about what movements are? I try to invite the child to reflect together with me, ask questions, and participate in a conversation based on their level of understanding. I show them what we are going to do; among other things I let them feel my muscles so they may feel the difference between relaxed and tensed muscles. Exactly how and what we do depends on the child's age and maturity, and what kind of situation it is in. I examine the child's flexibility, assessing various kinds of movements from different starting positions. I closely observe their breathing to see if it responds to the child's movements. I make note of if the child pulls itself away, or stretches out, how spontaneously it responds to something pleasant or to something uncomfortable or painful. This kind of observation is essential when it comes to palpating muscles. If pain is induced by palpation then it is important for the therapist to let go at once, giving an opening for the child's spontaneous pain response. In a spontaneous reaction like this, breathing is of central importance. A free and natural breath response induces a free

and natural reaction in the body. We might say that the breath is like a "liberator". The child is encouraged to move freely, express the painful feeling etc, all of this with the intention of bringing him or her *out* of their learned response pattern.

Treatment and Reactions

In therapy, this approach applies more active movements for children than for adults. The younger the child, the more playful the therapy, aiming to stimulate the child's natural way of moving; trying to help it move out of the *grip of tension* so to speak. We wish to encourage the child to explore its movements, experience what it feels like to "give in" to gravity or to let tself be moved passively, among other things. When it comes to treating children I go straight to the point, and work extensively on movements involving breath, jaws, tongue, eyes and forehead. Speaking from a psychomotor perspective these are the central areas of emotional tension. Adults often need more time before these areas of tension can be "challenged". However, with children, the massage takes shorter time, and is alternated with guided stretching movements. I often dwell on scalp- and face-massage and children frequently react spontaneously to this, by liking or disliking it, by sighing deeply or holding their breath. In this way, they show me without words if they are ready to let go, or not.

This is what Trygve Braatøy and Aadel Bülow-Hansen[1] experienced; tension in the eye/forehead region is often the last place to let go. Tension control in this area gives us an indication of possibly withheld emotions. This area is easily accessible in children, and in most cases treatment here proves effective.

Should the tension be more of a kind of a "deadlock" phenomenon, meaning resulting from earlier illness or injury and not strongly emotionally conditioned, then the child will soon squirm, twist and turn and finally end up in a beautiful stretch. Figuratively speaking, this

1 Psychiatrist and physiotherapist. The founders of Norwegian Psychomotor physiotherapy.

spontaneous moving and stretching is the opening valve where tension is let out, or where they let off steam. We all have this “valve” inside us, but in children it has not been shut off for so long, and is therefore more easily opened.

We often see this kind of reaction during the third or fourth session. If this be the case, then synchronously the symptoms will subside, and the process of change has started. Then it’s time to stop, we don’t make any new appointments, but agree that they will be in touch should there be a relapse. We must not keep the children in the patient role longer than absolutely necessary.

Should these yawn-stretch-squirm movements fail to happen or we notice that the child is holding back, then this is a sign telling us about insecurity or some kind of emotional brakes. If this is so, then I get in touch with the child’s doctor, and we discuss what should be the next move. I frequently speak to the child’s teacher as well as one or both parents; it is so important for everyone to be in on what’s happening. Let me illustrate this by referring to two case studies from my practice.

Child Number One

Child number one is eight years old. She had been struck down by sudden illness one year earlier and has since then been under medical treatment. Despite this, she is an exceptionally brave, cheerful and alert child. She has an implanted venous access portal in the pectoral area, and her parents had noticed that her body had gradually become stiffer. Her movements were slower, more careful, less spontaneous, and the child started complaining of pain in her calves, thighs, arms, back and chest. True enough, the child had been given medicine that had tissue-pain as a side-effect, but this should not have affected her movements to such a degree.

When I examined this child, I did so only by way of active movements since she resisted my touching her. Of course, when a child draws the

line like she did, then these limits are to be totally respected by the therapist. Together we did movements when sitting, standing, sitting and lying on the table, movements in every thinkable way. The parents were present during the whole session and the child discovered that doing these subtle, careful movements did not hurt. She became bolder, was no longer so wary of moving; actually she seemed perfectly comfortable, her breathing responded naturally. In a way she seemed to understand what was going on there and then. The child was given some of these simple, easy movements to do for homework.

A few days later I gave the mother a call to inquire if there had been any reactions, and if the she would like to come back next week. The child already moved with greater ease, and would certainly like to come back, the mother told me. The next session was almost like a revelation, and illustrated how quickly children may readjust a pattern of tension, if only they are carefully guided to experience mastery. The venous portal was practically forgotten and had been replaced by the revival of her old joy of moving.

Through gentle massage on her neck and in her face, yawning and stretching happened spontaneously. It was a marvelous scene; like watching a flower unfold towards the sun. She seemed a little amazed at how the movements insisted on coming alive, and delighted in stretching. The child did not need to come any more, her natural playfulness and well-being had returned.

This example illustrates how symptoms, like those belonging to this child, may be resolved when there are no profound emotional elements involved. This doesn't mean that one shouldn't be emotionally involved in one's tension, in one's life situation – that is of course perfectly normal, that is about being alive. However this child was not caught in her emotions and therefore she could relieve the tensions so easily. Had this not been taken care of in such an early stage then the pattern of tension could easily have developed into a more long-lasting condition. In time this might have produced more pronounced symptoms that so easily could have led to faulty interpretations about what was wrong with her. It is essential to understand the whole context.

Child Number Two

Child number two is a ten years old girl, and comes with her mother. This child was not a planned birth, and much younger than the other children in the family. Her parents are divorced. The child moves slowly, is expressionless, shows an impassive face, is vigilant, gives monosyllabic answers, is slightly overweight and clumsy. She has been referred to me by the school physiotherapist who has been in contact with the doctor. This child has frequent headaches, suffers spells of dizziness seemingly uninfluenced by any position whatsoever. She is stiff, and her neck, back, knees and calves hurt. She feels a kind of pressure across her chest, lump in her throat, harks often, and has frequent tummy ache. She doesn't like gym at school. This has been going on for a long time but apart from this she is, according to the mother, a normally active girl. Mother is somewhat aggressive early in the session, assuring me that she has no emotional problems. "I get so angry with the doctors who insinuate something of the kind".

The examination is very carefully carried out. I test the child's flexibility and her ability to let herself be moved passively, I observe the dynamics of her breathing, and palpate the tension in her musculature. During the whole assessment she watches me out of the corner of her eye. She stands, sits and lies down quite still, without any spontaneous movements. She breathes without any sigh, small shallow movements. Her chest is expanded and stiff. I have no chance of moving any part of her body passively, no matter in what position. Her standing position is with knees slightly bent, actively tightened buttocks, hips, shoulders etc. She hardly sits *down* when seated. When she lies on the table, in supine position, her back is strongly tensed. I find that the muscles with increased tension are mostly situated on her left side. Most of her flexors, her "yielding muscles", are in high tension and they hurt.

This tension pattern is clearly emotionally conditioned, being considered quite extensive bearing in mind the girl's age. This is presumably a so-called fibromyalgia-patient for the future. The pattern is identical, but not as established as the one we observe in adult patients.

Mother calmed down as the session proceeded. I emphasized the fact that responding to difficult situations by tensing our muscles is perfectly normal. This is our normal defense mechanism. I could not make the patient participate in the conversation, even though I addressed her through the whole session. The child always looked for help from her mother. I gave her a few simple exercises for homework flex ankles, extend knees, and jiggle jaws and tongue.

The child comes on her own to the next session. She loosens up a bit, but is constantly on guard. We begin by doing simple movements. Her legs start shaking and she gets tired. After the third session her headache is getting better. She complains of a sore throat every morning before school. Her movements are freer. The child smiles faintly.

Now is time to get in touch with her mother, I wish to hear her opinion on how things are going. Since she is close family, her attitude towards the continuation of therapy is important. On the phone she tells me that through the years there have been substantial problems at home. The child's alcoholic father and uncle had bullied her throughout her childhood and after her parent's divorce, her father has forced her to come and visit him. Her father's visiting right was an order of the court. He can talk anybody into anything, the mother told me. During these visits, her father frequently drags her along to his friends. She is afraid of these friends, and according to mother, is hysterically frightened of any situation in which alcohol is consumed. The mother appears almost paralyzed, seeming to have trouble in coping with her own emotions and incapable of protecting her daughter from her father.

Our third session was in June. The child was to spend one part of her summer holidays together with her brother, afterwards she had to be with her father. In agreement with the mother, I contacted the child's doctor to inquire if anything could be done to prevent this. Sadly there was no way of getting out of the arrangement.

The mother did not get in touch with me after the summer holidays so I made her a call in October. She told me that her daughter had come home after one week at her father's. The child had called her, crying on

the phone and pleaded with her to be allowed to come home. For the time being the child had no headache, so mother didn't think that her daughter needed any further treatment.

Before that telephone call I had no information of the child's story, but the assessment showed me that here we were dealing with a condition termed "extensive tension". The child's demeanour was shaped by these tensions, influenced by the burden of her emotional problems, and there was no one there to help her out. The child herself was of course not capable of coping with them. She could speak about her pain but never about her fear. She had always kept her thoughts, words and delusions to herself. There was no sigh of relief in this 10-year-old – she was "paralyzed with fear", and she held her breath to keep control. You can see it if you know what to look for.

Looking back, and reflecting on these two stories, we will find that most of us are somewhere between these two extremes. Norwegian psychomotor physiotherapy assesses and attempts to change dysfunctional tension patterns, whether the patient is a child or an adult. We often observe that emotionally conditioned tension is more pronounced in children than in adults; more obvious and more responsive – that is if their life situation makes allowance for change.

Tom Andersen

Participating Practice and About Being-In-The-World

Some Working Reflections

We have had a thorough discussion about what we ought to call this chapter, and we decided that in the subtitle, *reflections* should be a suitable word. This word allows us to think freely, but at the same time it commits us to keeping to the subject we are reflecting upon.

We have deliberately let this be the final chapter because we wanted to tell the real-life stories first of all. We wanted these stories to be the foundation upon which we could reflect. All our discussions over the years, from as far back as the mid 1980's, have influenced what is written in the following pages. For a number of years we met in Harstad[1] with a new agenda for every meeting. We studied videotapes from treatment sessions; we arranged joint sessions with patients and their family doctors. We also had countless three-point-conversations between each of the physiotherapists, a chosen patient of theirs and myself; just the three of us. These meetings allowed us to sum up our experiences and gave rise to new ideas.

Steinar Kvale's broad definition of the word *research* is as follows: "The methodological production of new, systematic knowledge" (Kvale, 1996, p. 60). Our methods are not sufficiently systematic to fit into this definition, but if we look to another definition of research, inspired

1 a town situated 350km south of Tom's home town Tromsø, northern Norway

by Donald Polkinghorne then perhaps we are not so far off after all: Research is a search for knowledge; this knowledge is communicated to a community, and the community will evaluate the new information" (Polkinghorne, 1983, pp 1–4). So, whatever is accepted as relevant knowledge will determine the approach and methods to be considered acceptable as research. This leads us to an important question: who has the right to claim the correct definition of *research*? There is no simple answer to this.

In the academic world, research means first of all building a theoretical framework before practical studies based on specific methods can be carried out. When all is done, reports are written, and the results will lead to discussions; discussions based on the theories one initially based the studies on. Two things seem to be clear here: results are influenced and restricted by the applied theory, and the final discourse will never go beyond this theoretical framework. It will merely succeed in exploring the theory in greater detail. In other words, the object of this kind of research is not to question the theory but how to explore the theory in question.

Theories are based on reason and logic, and by staying within the theoretical framework one is kept within reason and logic, and perhaps one even gets stuck here. We have taken the liberty of using a broader starting line for our way of thinking, meaning we take into consideration the fact that we the therapists are *touched* and *moved* in many of the therapist-patient situations we are in. Of course this does not mean that we renounce reason and logic and consider them insignificant. Hopefully we integrate both of these elements, but we like to place our reflections in a wider perspective. We believe that by totally integrating the concepts *objective*, *neutral* and *correct* then the human aspect of the researcher will disappear. We do not want this to happen to us. Our way of reflecting on our treatment processes makes us more vulnerable, but perhaps this allows us to be seen as the human beings we are. This is how we want it to be.

Four Different Kinds of Knowledge

Roughly speaking, our modern history begins in the sixteenth century, some say from the birth of René Descartes (1596). In this era we speak of two categories of knowledge, *rational* knowledge and *practical/technical* knowledge. Rational knowledge can be grasped by intellect, by reason. *Practical/technical* knowledge deals with how to master e.g. some kind of measuring equipment, or tools, or a machine, or knowing how to write or how to express oneself. In a manner of speaking, one might say it's about a containing a repertoire of speaking and doing, a kind of know-how.

In natural science one concentrates on these two categories of knowledge, each of these being individually acquired, meaning being connected to a specific person. When a scientist seeks either or both of these categories, he or she creates a distance to what is to be studied and become an observer.

In this chapter, as in all our clinical practice, we make use of the two categories mentioned above, but we include two additional categories of knowledge; speaking here of *relational* knowledge (Gergen, 1994, pp 32–63; Andersen 1995a; Andersen, 1995b; Shotter, 1993), and *body'*-knowledge (Andersen 1995a; Engelsrud, 1995; Johnson 1987). We have certainly benefited from all of these four different kinds of knowing/knowledge. To us knowing and knowledge is not a static condition, but a continuous, ongoing activity. We may describe the verb "to know" as in comprehending, grasping, understanding, or as in knowing how to do something, mastering, performing, acting, executing.

Relational knowledge is about knowing how to relate to others; like "stepping into someone else's shoes" or "tuning oneself in" on the other person; both of these expressions illustrate being given access to what a situation might mean to the other person. We also need to learn how *participate* in the other person's situation to make the scenario meaningful to those present, ourself included. *Body's* knowledge is more or less synonymous with the concept of *sensing*, that is sensing/feeling responses from one's own body; reactions telling us that "there

something here", without necessarily knowing exactly what at the time (Engelsrud, 1995). The scientist who works from the *relational-* and *body-*knowledge perspective is more of a participant than an observer. We, the authors of this book, have made a point of playing the part of both the observer and the participant, but of the two we are no doubt chiefly participants.

The content of this chapter is neither "correct" nor "accurate", our simple agenda is to communicate to the reader our understanding of *knowledge* based on these four different categories.

Ambitions are much higher in the traditions of natural science because they endeavour to explain *and* predict; their objective being the making of common rules and theories for explaining and predicting phenomena and situations. This enables them to transfer rational and technical knowledge from one situation to another similar situation, even if in another time or space. This may be done in the kind of realm that natural sciences concentrate their studies on, meaning the realm that can be seen, touched, and doesn't move. When something does not move, then it can be measured, and if it keeps still long enough, one may even be allowed to come back and measure it once more. This kind of measuring is not possible in the human realm, where feelings, movements and opinions exist. All of these elements are constantly shifting, in time and in context. More often than not, they have changed, or even disappeared by the time one finally arrives for re-measuring, and considering the fact that these qualities are difficult to see and/or touch, one might not even quite know how to. Nevertheless we all have our *opinions* about the human realm, it's impossible not to.

So, there we are then. This book offers no scientific explanations; we merely communicate to you what we ourselves think we have understood. The concepts of understanding and explanation have this in common: they are both based on descriptions, and the descriptions are based on what is seen and heard. Facing the human realm, we experience how it shifts every moment; and every single moment is so full that it is impossible to grasp every detail of what is going on. We have

to be selective about what to listen to and look for to stand a chance of experiencing the moment in question. To do this we make ourselves a kind of "picture-sound" of what is going on. Making a choice like this certainly means having to make a selection of what we want to focus on, and this means eliminating other aspects of the moment; and aspects that are neither seen nor heard never reach our conscious awareness.

We have to place the descriptions in a perspective for them to make sense to us or. Or we can put it another way: we need to give the descriptions a background so that we may distinguish the situation or context more clearly. A context may be understood in many different ways, depending on what the observer has seen and heard, and from which perspective the situation is observed.

Perspective, background, framework of reference, these are all different words, but they mean the same thing. This will be illustrated in the following story.

Father and daughter both witness the same situation: Mother is sitting quietly, staring into space. The daughter's perspective is the following: everything that happens when people are together has to do with what is happening between the people present at that specific moment. Her understanding of the situation is that mother feels *sad and lonely* because nobody is talking to her. Father's perspective is different. He believes that everything a person says and does relates to one's inner core. His background for understanding the situation has to do with his wife's nature, her always wanting to be at the centre of everybody's attention. So he is convinced that she *is in a bad mood* because nobody is talking to her. The daughter might ask: "How are you, mother?", while the husband might say: "Pull yourself together", or simply leave the room without a word.

Now how can two people interpret a situation so differently, as this story from everyday life shows us? How can it be that we are so influenced by our own perspectives? Ludwig Wittgenstein and his successor Georg Henrik von Wright state that that "we are bewitched by devices in our language" (Wittgenstein, 1953; von Wright, 1993). In fact, I think we may

draw this conclusion as far as to say: it is impossible not to be bewitched by our language; frankly speaking, this is what being a human being is about. Every time we talk to someone, or even to ourselves, our spoken words contain our perspectives that guide us to what we should look and listen for. Words are powerful and certainly far from innocent. Words exchanged in a conversation are closely connected to the language we hold inside us. This means that the language we speak in our *professional* conversation will influence the outcome of any situation we are involved in. We choose what kind of language we wish to speak, in other words by which language we wish to be bewitched.

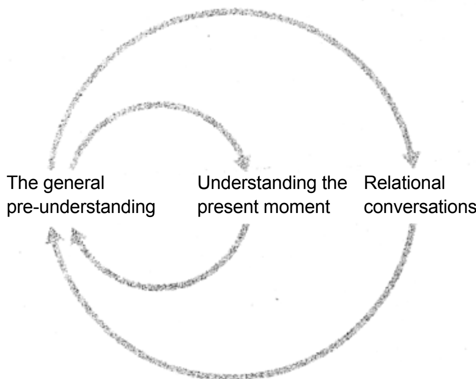
Martin Heidegger calls our perspectives, our ideas about what to listen to and look for, our *pre-understanding* (Wachthauser,1986). We assume that he means that we at all times bring with us some basic ideas of how we are to understand a specific situation. Hans Georg Gadamer says the same thing but with greater emphasis. He claims that we are inevitably prejudiced, that means we have presuppositions about how to understand or interpret a specific context or person, and our pre-understanding, or prejudice, is communicated by our language (Lindseth, 1988; Wachthauser, 1986).

Both in our practice and in this book we have intentionally chosen to speak and write in everyday language. In the treatment sessions we aim at communicating with the patient by speaking the patient's own, everyday language, and in this book we wish to communicate with the reader in what we believe is the reader's everyday language. We think it is for the best for the patients, the readers, as well as ourselves to let us all be bewitched by the same language. The everyday language, known to all of us, contains a whole specter of perspectives, and a whole diversity of seeing and hearing. The expert's language contains a limited range of perspectives. In this regard, the expert language is a limited language and in some way a poorer language, whilst the everyday language is complex, manifold and rich; quite a paradox really.

The Hermeneutic Circle

We will use a simple figure to illustrate the relationship between one specific situation, our pre-understanding, our presupposition and our spoken language. We understand a context in light of our presupposition. However, something totally new may enter into this specific moment, taking us back to our pre-understanding which, in turn, has to be extended to include this new experience.

This is the dynamics of pre-understanding: ever-changing and containing many nuances.



What Do We Believe We Have Understood?

We believe that the following understanding is essential:

- About the relationship between the person asking for help and the helper.
- About what creates change when change is desired?
- About what it is to be a human being?

We believe that we have understood more of what *not* to think or do. This may bring us at odds with more traditional ways of thinking or doing. To acquire a broader understanding, we have pondered over

all the experiences we have gathered together over the years. Some experiences are recurrent, and perhaps this makes our understanding more universal, meaning generally more accepted. However, sometimes what happens is quite exceptional, and then we can merely suggest a chance of this being some kind of general knowledge.

The *therapeutic relationship* and *change* are closely linked together. However, in the following paragraph, they will be discussed separately.

The Relationship – a Collaboration

It will be obvious to the reader that a close collaboration[2] between the patient and the physiotherapist, or simply the *being together* is essential. So we may ask what makes this relationship a success, and when is the outcome a failure? We are eager to investigate the role of the physiotherapist.

From the stories in this book it should be evident in which relationships the patient and physiotherapist collaborate well and in which relationship problems arise. Normally, to evaluate collaboration we consider it necessary to observe what happens over a longer span of time, but here we certainly witness a number of single moments of close collaboration. We have also introduced you to some quite special expressions, like: "They had the right chemistry". Sometimes everything works out smoothly, and it may be hard to put one's finger on what in fact is happening. The context of collaboration is ever-changing, and has to be worked on constantly. Now, a suitable question might be: When we witness a relationship consisting of what we think of as high-quality collaboration, what is actually happening here?

In Gudrun's chapter, Mai tells us something about this. First of all, after Mai had been referred to NPMP, she didn't have to wait long for an appointment. Then, after the first session, Gudrun had explained

2 Collaboration: ….. mutual engagement of participants in a coordinated effort to solve the problem together. (Dillenbourg et al ;1995)

to Mai that her suffering was perfectly understandable. Gudrun's acknowledgement of Mai's pains was such a relief to her. Mai had met someone who believed her, she was given an understandable explanation, and she had finally found a grown-up she could talk to.

Alette, who has written about a colleague at work, puts it this way:

> This preliminary conversation lasts about 15 minutes. I sense a pleasant atmosphere, a good dialogue between the physiotherapist and the patient. What do I see and hear to give me this feeling? The patient is allowed to speak and the physiotherapist listens with great state of presence without interrupting him. The patient seems to appreciate being both seen and listened to.

Ingeborg stands at her patient's side, in front of a mirror. The woman is in so much pain, her shoulders are aching, and she has no idea why they do so. Ingeborg says:

> I explain to her, demonstrating on my own body, how the shoulder muscles adjust their way of action according to the chest's position. I show her this in front of a mirror. I demonstrate the rounded back, letting her see how both my chest and my stomach get limited moving space, with increased tension both places. Then I alter my position, I let go of the tension in my stomach, and demonstrate how this leads to a more "open" chest from where my shoulders are able to move more freely. She tries this for herself, and while nodding slowly admits to experiencing additional and new movements in her upper-body.

In Eli's chapter we read about how the problems had been piling up, and how she went along, pondering and wavering, all on her own. The inner voices putting pressure on her and she, Eli, was bearing the whole responsibility – alone!

Berit tells us about the first session with Eva.

> For a while I simply stand by her side, gently stroking her back and the upper part of her buttocks. This is to give me a feeling of her, to get her "in my hands" so to speak, and equally important: let her be acquainted with my hands. In this simple way, we get to know one another. This is an important moment in our first meeting; my hands and her skin meet for the first time. I'm not looking for anything in particular, neither for tense nor flaccid musculature. The only thing I do is stroke her back with my open hands, calmly and in even rhythm, in sensitive dialogue with her skin, muscles, movements and breathing. She and I endeavour to achieve a suitable dialogue for both of us – we must find our mutual rhythm.

Eva writes in her diary that she immediately gained confidence in Berit. Later, Eva says: "This confidence had something to do with you; the way you met me, your voice, the way you touched me, everything suited me perfectly". Some time later Berit had attended a course, and this had inspired her to work more distinctly, more accurately. Influenced by this course, Berit massages some specific muscles deeply and thoroughly. At the end of the session, Berit asks Eva if she has noticed anything different this time, and Eve says that she felt Berit had been more technical. Reflecting on this, Berit inquires:

> What has happened during this session? Who follows whom? I probably was rather eager and persistent. Maybe I am a little out of balance because I'm very much concentrated on my own agenda – my own professional updating. Perhaps this makes me lose track of our, her and my, mutual rhythm." Shortly after this session, Eva writes in her diary: "I feel that some kind of balance has been disturbed. Right now I feel precisely the same way I felt after the first sessions". Some days later she writes the following: "I'm not sure continuing this therapy was the right thing to do".

However, Eva and Berit do resume contact, and therapy is continued.

Ingar gives us the following account of his first meeting with a schoolboy, a teenager:

> When he comes to my clinic he is mistaken about where to go, and he walks straight into my office instead of going to the waiting room. He is dressed in a huge, heavy, black leather jacket and he is wearing a pair of large, black cowboy boots. He is tall, thin and he has an extremely long fringe. His neck is bent forward, making eye contact difficult. I like him. I ask him to go sit and wait in the waiting room. A little while later I call him in. He has hung up his jacket and taken off his boots. We say "hello", we shake hands and as he tosses his head, we make eye-contact. He moves around in the room and eventually finds a place to sit down. He takes a seat on the edge of the treatment table. I place myself on a stool some yards away from him.

This account can only be given by someone who truly understands what is good for the other. This is exemplified by Ingar creating a suitable distance to the boy, a few yards away, taking care not be too close, nor too distant.

What is it that makes collaboration a success? It is essential that both parties are participants and that they partake together, *in accordance with their own* perspective. When two people are in a process, and this process is proceeding in the perspective of just the one of them, then difficulties arise. Like when Berit was full of new ideas and acted solely according to these. Or when Eli felt that everything was *her* responsibility, and naturally acted from her own perspective.

The patient can become a participant only if the patient and therapist begin together from the patient's own starting point. The therapist must be willing start here, and then gradually apply his or her experience, wisdom and perspective. It's "give-and-take" for both parties, and together they must seek the next step. The therapist must be willing

to enter into the perspective of the other, like when Ingeborg placed herself in front of the mirror, alongside the patient.

Of the two, it is the patient who knows what kind of step he or she is capable of taking, and when to take it. In some cases the patient may be able to put this knowledge in words, but this is *not* a matter of course; finding and expressing the right words is often extremely difficult. It is essential then that the therapist is acutely alert on what the person's body language expresses. Berit lets her hands be acquainted with Eva, searching for their mutual rhythm. Rhythm is about shifting between activity and rest, between talking to someone and talking to oneself, between grasping and letting go, etc. Finding this mutual rhythm is not easy. At times even finding one's own rhythm may prove difficult.

To put it simply we will point out two different kinds of "being-together". The one is characterized by the monologue, the other by the dialogue. Jaakko Seikkula, who has been inspired by the Russians Lev Vygotsky and Mikhail Bakhtin, has taken special interest in this (Seikkula, 1995). He says that being together in the *monologue* way, means that the conversation is predominantly influenced by one of the participants, taking place from one perspective only. Each question is asked from the leading part's perspective; the other person is only there to give answers. These are *closed* conversations. Given an answer, the dominant part asks a new question, like when the psychiatrist uses only his questionnaire to find the correct diagnosis.

Being together in the *dialogue* way, means that conversation is taking place from the perspective of both participants. Questions are asked by each of them, and they both answer. These conversations tend to create new questions, and they give an opening for new ideas and even new perspectives.

The Danish philosopher Knud E. Løgstrup speaks about the quality of *sensitivity* in a therapy-relationship (Løgstrup, 1956). When the patient expresses something, be it by stretching out, letting go of held breath, dropping a sigh, crying or laughing, then this person exposes him or herself. One cannot expose oneself towards nothing, so someone has

to be there at the receiving end. In a sense, the patient places a piece of his or her life in the hands of the physiotherapist. This may be a risky business, not knowing if the therapist will receive and/or accept that what is given. Accepting is acknowledging not only the expression but in fact the whole person. Should the opposite occur, and the therapist does not totally accept what is "given", then this may turn into a painful experience, and a doubt will arise about oneself and one's own human integrity. The therapist capable of being totally receiving and accepting, proves him- or herself open and available and tuned in to be touched by the patient's fear and insecurity.

Change

> I suggest to you, now that the word "idea", in its most elementary sense is synonymous with "difference"… We select a very limited number, which becomes information. In fact, what we mean by information – the elementary unit of information – is a *difference which makes a difference*, and it is able to make a difference because the neural pathways along which it travels and is continuously transformed, are themselves provided with energy. The pathways are ready to be triggered. We may even say that the question is already implicit in them (Bateson, 1972, p 453).

This is a famous quote by Bateson, and has proved invaluable to us. The most famous sentence here is a *difference which makes a difference*. The verb *makes* indicates that the difference made is made over time, and Bateson says that a difference made over time is a *change*.

I brought this view on *difference* and *change* with me when trying to understand central elements in Aadel Bülow Hansen's work at that time. (Andersen, 1978; Andersen, 1996). In following I will quote from a book we have written about Bülow-Hansens's work:

> In the course of the last 50 years, Bülow-Hansen has developed a physiotherapeutic approach which is about treating patients troubled with muscular tension; this often being part of a more extensive tension pattern. Right from the beginning she was concerned with the breathing function, and she regarded breathing and body-movements as inseparable components. The ongoing respiration cycle, inhaling-exhaling-inhaling.. and so on, continues without stop and is profoundly connected to corresponding movements throughout the body. To explain this we may say that we breathe in, and this inspiration spreads throughout the body, to the tips of our fingers as well as to our toes. For numerous reasons different muscles may become tense, thus preventing air from reaching these areas of increased tension and restricted motion. In many cases chest muscles are tight, thus restricting the intake of air, not just the air-flow. When a person holds back his or her expression or feelings, then this may result in restriction of *intake* of air. Emotions and words are expressed through our exhalation. Sometimes one may experience that in given circumstances one is unable to express oneself openly, neither verbally nor emotionally. One way of holding back expression is by restricting one's breathing (Andersen and Øvreberg, 1986).

Likewise one may limit exhalation by limiting the act of inhalation. Inhalation may be limited by tightening the body's flexor muscles; meaning flexors in throat, elbow, shoulders, hips, the body's front, knees etc. Increased tension in these muscles will impair the chest's flexibility, restricting the chest's movements. Speaking about flexors, one must not forget the facial mimic muscles and the muscles in conjunction with the jaws, the tongue and the front of the throat. Activation of any of these muscles by tensing or tightening them will also affect and restrict chest motion and flexibility.

Bülow-Hansen seemed to negotiate with the flexor muscles, e.g. the muscles on the back-side of the calf, by executing a special kind of

massage. This grip is pain-inducing, and is intended to stimulate the act of knee-extension. This will in turn stimulate inhalation. If the body is ready, then the following exhalation will result in reduced tension in the calf-muscles. When this tension is released then the muscles in the front may be capable of extending the knee even better. If this extension is held a short while then this will in turn stimulate a deeper inspiration, and one may understand how this "benign circle" can develop as opposed to the well-known "vicious circle". Stretching stimulates deeper inhalation, this will, in turn, induce a stretch-response which again stimulates inhalation and so it continues. This mutual influence continues until the chest is filled with air; to what extent the chest is filled depends on its flexibility. When air is let out by way of exhalation, then some of the body's tension is expected to be released. Bülow-Hansen's eyes pursue the patient's breathing motion as her hands work. If her hands induce too much pain, or she stretches a body part too energetically, the body will respond to this discomfort by restricting its breathing.

Her eyes give her incessant information about how to use her hands. At the smallest sign of her being too insistent, her hands will let go immediately. I learnt from her approach that the grip must be strong enough so as to induce some kind of breathing response. If it is too feeble then nothing will happen. Be it too powerful or held too long the patient will respond with a gasp, a sudden inhalation. However, the tension-releasing exhalation will not happen because the body will put up a defence against this discomfort by retaining air within the chest.

A variant of Bateson's *a difference which makes a difference* came out of this; we have three different kinds of *differences*, but only one of them makes a difference. The difference we speak about here is of the kind that is appropriately different. We have derived some main rules from this expression. In ordinary everyday language different may be rewritten and instead we use the word unusual. If a person is exposed to the usual, the normal, then no change will happen. If he or she meets something unusual, then this unusual might stimulate a response that makes a change. Be it too unusual, then the person will put up a

defence, and again we will experience that no change is made. This is why we, the so-called helpers must endeavour to promote that which is *sufficiently unusual*. In our conversation with the patient we must avoid topics that are *too unusual*; this includes the conversation's framework, its context and its form. Is the conversation *too* unusual? The patient gives the answer to this by responding with subtle or evident body reactions, and the alert therapist will notice all the signals, be they ever so small (Andersen and Øvreberg, 1986, p 13).

We may in fact find many examples in this book where we can read about the *sufficiently unusual*, but also about the too unusual:

In Alette's chapter, an account of a treatment session, the therapist asks how the patient is feeling during treatment. "It's unusual" he says. "We boys aren't used to it. But I see the connection and understand why you ask. It's about that being-good-to-yourself thing".

In Berit's chapter we read about what happens after she has attended a course in psychomotor physiotherapy. Berit is inspired by what she has learnt; to her, the course experience was *sufficiently unusual*. It created a change in her, and her next session with Eva is different because of this change. To Eva, this change is too unusual, and she considers withdrawing from further therapy.

Ingeborg notices in her first session that the woman is uncomfortable lying in the prone position. Her attempts to make her comfortable by supporting her with pillows and towel-rolls are in vain, so she lets her get up on to the floor instead, and invites the patient to feel her own weight and her feet's contact with the floor. The prone position was too unusual for her. Ingeborg encourages her to simply walk a little back and forth, and shake her legs lightly and easily. This was not much, but enough to give her body a new experience, and it made her curious. *Too little* and *too much* of the unusual kills curiosity.

At the end of the first session Ingar tells his young patient that he is going to concentrate on his legs in the beginning. "In a way, your legs are your body's wall of foundation. To put it to you figuratively speaking: your foundation is slanting, the doors are squeaking, and there is not

much air going up the chimney". The boy laughs and tells Ingar that he understands what he means.

When Eli looks back on her treatment sessions with Gry, she discovers that it was the doctor, and not Gry herself who wanted her to try NPMP. Gry wanted someone to talk to. This difference between Gry's wish and what she in fact got made things difficult. Physiotherapy deviated too much from her own wishes. This doctor and Eli had always until now been good associates, therefore she did not question his opinion.

To Mai, Gudrun turned out to be *sufficiently unusual*, in several ways; she was a listening adult, she was someone who could explain Mai what her aches and pains were about. Gudrun's voice made Mai feel safe; Mai hid Gudrun's voice inside her, so that she could fetch it out to help her to cope with difficult situations later in life. Mai mourned when the treatments with Gudrun came to an end, but she accepted it all the same. Gudrun says about children that they are more susceptible to change. It seems that their concepts of the *sufficiently unusual* are more spacious than they are for grown-ups.

So, to put it shortly: everything is about *this* present moment; in this moment we must seek the *sufficiently un-usual*. And the other person's response in *this* present moment is what tells us if we are on the right track or not, if what we have done has been too usual, too unusual, or simply sufficiently unusual.

The Human Be-Ing

In this chapter we may appear to be moving on thin ice. But we can't help doing so. We are going to play around with the truly major questions: What is life? What is a human being? What is existence?

These are ontological questions. Ontology is defined in several ways. As in the essence of things (Hornby, 1963) or a branch of metaphysics concerned with the nature and relations of being, or a particular theory about the nature of being or the kinds of existence (Webster,1989).

It may seem somewhat pretentious of us, this stepping into the

postmodern discussion. The philosophic discourse in the last half of the 20th century opposed esteemed values in the modern age. This will be commented on later. Our viewpoints represent a combination of what we ourselves have experienced, and the content of significant literature we have read. Since these viewpoints are far from complete, or final, they should be called preliminary, and function merely as an incentive for the readers to contemplate further by themselves.

The Usual

First of all we wish to say something about the pre-understanding of the human *be-ing* (being as in the nature of *to be*) that has been and still is predominant in Western culture (Greger, 1994; Shotter, 1993). Simply speaking one presumes that the human centre is situated within each individual. An inner core exists, and from within this core everything we say and do arises. It is assumed that the structure of this core is *either* biological *or* psychological.

To us, structure is a word that implies something stable over time, almost static. However, structures do change, but ever so slowly. We would like to discuss this idea of a structural *inner core.* But before we enter into this discussion, an appropriate question might be about where this idea comes from? There is no simple answer to this question because the idea originates from far back in time.

Georg Henrik von Wright and Åge Wifstad have been important sources of inspiration for the following reflections (von Wright, 1991; von Wright, 1993; Wifstad, 1997). The latter bases his study on the Germans Max Weber and Jürgen Habermas.

The middle ages, a period from the year 500 A.D. to 1500, was dominated by major authoritative doctrines. These were mostly put forward by the church and the sovereigns, and the individual was obedient to these doctrines. The Modern age, from approximately 1500A.D., some say from René Descartes, until the middle of the 20th century, there is major technical and economical development, and of great significance

is rational thinking, market economy and progress in general. Common sense, together with technology and science, are considered substantial elements out of which progress may develop. The developing society splits up into a number of individual services and systems: money and bank-service, legal and judicial systems, education systems, health service, social service, and so on. These systems represented *real life*; and eventually, along came the bureaucrats, and with them the so-called "expert-language" that displaced everyday language.

This modern period represents an uproar compared to what happened in the Middle Ages. The individual frees itself from subordination, and *freedom* becomes the most important word. The individual achieves more independence and is in control of its own life, no longer needing to depend on others. During this period the individual becomes responsible for own success and failure. Under these circumstances one may perfectly well understand how the theory about this *inner core* comes to be.

This *inner core*, situated inside the head, "conquers" the body in one sense, but expresses itself *through* the body in another sense. One may regard this core as a psychological structure containing different qualities and functions. If these qualities or functions are in conflict with each other, then we may believe that this conflict will cause an increased state of muscular tension. The spoken word may not be able to express this conflict, but body language always will.

This is what we wish to be subject for our discussion.

Some Other Ideas

In our work, we always base our observations on what we see, hear and feel. Our reflections are based on the other person's, as well as our own, *being-in-the-world* experiences, here and now. Now is what it's all about, now is always the starting point for the next step to be taken. This way of thinking feels right. It's important to note the word feel, this is about ethics; about developing a respectable relationship to the other person.

We do not base therapy on what we believe is the underlying cause.

Perhaps one's being-in-the-world now is the best place to start contemplating about the human be-ing? Many are those who have wondered about this being-in-the-world from one moment to the next (Bakhtin 1993; Heidegger, 1962; Merleau-Ponty, 1994; Thomassen, 1995; Wittgenstein, 1953). They suggest understanding a person from the perspective of how he or she is present *now*. Being present is an activity, and it is the activity itself that constitutes a person. Mikhail Bakhtin goes as far as to say that *being* exists only in the moment and a single moment happens only once: "*Being* as event, once occurrent" (Bakhtin, 1993, pp 12-13). So life may be considered a chain of events of *being-in-the-world*.

Movement and Balance

Among other things, *being-in-the-world* means being in bodily balance *now*; this again means there must be a perfect relationship between the flexor muscles for bending and the extensors for stretching. If one's way of *being-in-the-world* creates a painful or in other ways, uncomfortable body balance, then our task is to help the person find another way of balancing. If the other person does indeed discover an alternative body balance, then the problem is dissolved. Not solved, but dissolved. *Being-in-the-world* means being in steady movement towards ever-changing balance.

Movement and Expression

We consider expression to be a combination of words and body activity. Though words sometimes may be absent, body activity is always present. However words also contain a body component: the air that flows past the vocal chords and the oral and nasal cavities is produced by the body, and vocals, consonants and eventually words are formed by tongue, lips and palate.

Expressions Are Informative and Formative

Normally one considers expressions as being purely informative. When a person expresses something, then one informs others or oneself about something. However, we may also consider expressions as *formative*, meaning we are shaped to become who we are by expressing ourselves from moment to moment. (Andersen 1995a; Shotter 1993; Shotter, 1994). Expression is a human act; a human being is its own expression.

Words

Vygotsky says that when the small child learns its first words, then these are merely imitated sounds. (Vygotsky, 1988; Yaroshevsky, 1989). Through play, meaning playing with words *as well as* the body activity, the words become the child's personal belongings.

Wittgenstein says that we are in the language. Contrary to our usual way of thinking this means that we don't hold the words inside us, but *we* are *inside* the words, inside the language (Grayling, 1988). Jacques Derrida says that words relate to other words within the same language (Sampson, 1989). I.e. when we hear a word, the word is given its true sense by connecting it to other words belonging to our own language. This means that when we hear a spoken word, this word will remind us of something we have seen or heard earlier and this is how we let the word make sense to us.

Words and Voices

Words are brought forth and passed on by voices, of which we have two kinds: the outer voice and the inner voice (Bakhtin, 1993; Morson, 1986; Vygotsky, 1989). The outer voices can be heard by others, the inner voices can be heard only by the person him- or herself. The *inner* voices, of which we have many kinds, are in a sense the most important ones. They tell us how to understand what we are up against, and what to do

from one moment to the next. When we transmit our inner voice to our outer voice, responses or comments from others may be traced back to us and change our inner voices.

Bakhtin says that "We *are* the voices that inhabit us" (Morson, 1989, p. 8). These voices are normally our own, but sometimes a person may be inhabited by strange, inner voices, for example when in some kind of psychological crisis. Sometimes one of the many voices, the self-accusing or the hateful one, may totally dominate the person's inner conversation. Then the need comes up for discovering a different inner voice, one that may counterbalance the dominant one; as when counterbalancing the self-accusing voice with the commendatory, or the hateful voice with the forgiving (Penn, 1994).

Voices and the body

Nobody wishes to say everything to everyone everywhere. This means that our inner voices are often kept inside us, to the outer world silent. However, both the inner and the outer voices, are *always* accompanied by body activity, be they verbalized or not. One may therefore see the other person's inner voice even without hearing it. These body signs are what we call body language, a language some people seem to be eager to interpret. However, understanding body language the way we do, means we acknowledge the fact that these body signs belong to the person's inner voice, the voice the person wishes to keep to him- or herself. These moments leave no room for interpretation and more than anything they require sensitivity and courtesy.

Movements and Words

Maurice Merleau-Ponty and the American Charles Saunders Peirce believe that, previous to thought, the body is the first to perceive any situation (Engelsrud, 1995; Merleau-Ponty, 1994). The person will

then, by way of its inner and outer voices, seek through its repertoire of words to find those words that most accurately express what one has perceived bodily. Mark Johnson believes that the basic body experiences, movements upwards downwards, outwards and inwards etc. are where our metaphors come from; illustrated by the following examples: feeling down in the dumps, being in high spirits, feeling like an outsider, it's all ups and downs (Johnson, 1987).

Words and Movements and Emotions

We can put it another way. When words reach another person, and touch him or her, then some of the words will remind the person of something, and the person will be moved. The aroused emotions may be so strong that they can be seen or heard. The words, the movements and the emotions unite. Might we say that life is contained within the words and within the movements? Earlier we spoke about breathing and movements as one, perhaps we may upgrade this statement to express the following: *life is within our words, our movements and our breathing*. As words originate from our society, our tradition and culture, then we must bear in mind that these in fact influence every human being in every living moment.

Fewer Movements, Fewer Words, Fewer Emotions

Berit's patient Eva, said that when her breathing went deep down to her stomach, her emotions grew stronger. What was sad became sadder, the pain hurt more. In a way life became tougher, but at the same time richer.

Ingeborg's patient rediscovered her voice; when tension was released, the words came out and then her sad story surfaced.

Ingar's youngster encountered *his* sad incidence, his life's tragedy. We have puzzled a lot about this happening, and have made our own

version of his story: The boy was all alone when his father was in the hospital. He hoped that he would recover, but then he got the phone call telling him that his father was dead. We can imagine his inner voice crying out in pain: “NO!” We can see his hand clutching the telephone receiver; we can see how he holds his breath. By clutching long enough and hard enough, breathing is suppressed and pain will become less painful. But the cost of this appeared as the later onset of body pain and sleeplessness. When he and Ingar worked together, and his body’s tension was gradually released, then the story came back to him.

How is it that stories find their way back to their owners? We have experienced that they do so time and time again. Perhaps it can be explained in the following way: The story is united with the movements occurring at that exact time, at the time when one suffered some hardship in life. When movements are revived, then they bring with them the story they are united with. The story might lie within the muscular reaction to the dramatic event at that time, and reactions are movements. When a movement stiffens, or freezes, then the story “disappears”. The feelings of pain, fear or sadness that might have been a natural part of the reaction at the time will fade along with the “fading” of the movements, and thereby create a distance to these feelings.

We often say that this or that is suppressed. Wittgenstein gives us the following warning: do not put names or labels on that what we know nothing about. Claiming that something we know nothing about exists, is as bad as in fact claiming its non-existence. Let us use the word suppression as an example. Trygve Braatøy, who is mentioned in the foreword of this book, preferred to call the emotions *wedged-in,* or *stuck,* instead of calling them suppressed (Braatøy, 1947). We choose to say it like this: one’s *being-in-the-world* is at times of such a nature that words, ideas and experiences are lost. Perhaps the body’s movements play a more important part in remembering and forgetting than we normally consider them to.

Body and Experience

Gunn Engelsrud from Oslo, psychomotor physiotherapist, Dr.polit. and Professor of Health science, has devoted much of her professional life to reflecting on the relationship between body, emotions and thinking. In the following we refer to a special chapter called Body and experience in Engelsrud's book *Women in motion – between yearning and desire* (Engelsrud, 1990, pp 12–19).

Experience is a central concept in the philosophy of science. All the same, this concept is definitely a complex one, one of the most important questions being: how can we trust our own experiences, and how do we know if this knowledge is valid information (Levesque Lopman, 1988; von der Fehr, 1992; Whitford, 1992).

One way of expanding our area of focus could be by working on the concept of movement, and by way of movements bring forth several different levels of body experience.

Drude von der Fehr has conferred and worked on Peirce's experience–concept, to find information about women's own experiences (von der Fehr, 1992). Of immediate interest regarding Engelsruds project is that Peirce's experience does not primarily relate to cognitive or conceptual conditions. Peirce splits the concept of experience into three categories.

The first category is about the fact that experiences are experienced as feelings. This quality of experience is the major one; the one that may never be translated into any language or otherwise be articulated or verbalized. Von der Fehr says that experience –

> "... exists in the individual's conscious awareness of the exact moment, e.g. an impression of quality; a feeling is in other words a *qualitative* experience, and not something that we can translate into gestures or verbal language. This basic first category, is an understanding of experience that is about our existence, our *being-in-the-world* (von der Fehr, 1992, p. 49).

His way of saying this makes one reflect on the infant's development. Bonnie Bainbridge Cohen claims that the infant lives through the function of its endocrine system and organs; a kind of primary experience from its body (Cohen, 1993). This means that the infant's expression may shift from one second to the next, its mood is expressed directly to its surroundings. Anyone observing an infant will be fascinated by its ever-changing expression. This constant shift of expression indicates that the infant *must* express its body's information as a necessity. Ulla Britt Lilleås says that this communication potential, making allowances for information from the body, is slowly but surely "un-learnt" as one grows up (Lilleås, 1995).

Experience reveals itself in short glimpses, like passing pictures or a "surge" in the body. This should therefore be characterized as experience on a *primary level*. If these primary experiences are to influence the experienced subject, then they must be cultivated (Chopra, 1994; Yuasa, 1987). To become more experienced involvement and alertness is recquired. Even if the potential of becoming more *experienced* always exists within the body, the person must learn to dwell on and learn from this information. Deepak Chopra says :

> There is a very interesting mechanism … the mechanism has to do with sensations in the body. Your body experiences two kinds of sensation: one is a sensation of comfort, the other is a sensation of discomfort … it may be the *faintest* level of feeling – but it is there, in your body (Chopra, 1994, p.43).

Sensations of comfort and discomfort are emphasized by Chopra as important information.

For a child to be able to distinguish and differentiate comfort from discomfort, it is crucial that the *adult* acknowledges both of these body sensations.

Peirce's second experience-category deals with the reactions or resistance arising within our bodies when we meet the outside world.

According to Peirce this experience is not the kind that we can articulate in any kind of language (von der Fehr, 1992). It belongs to the child's own body's experience obtained as it moves around in the world. Here we have prelinguistic picture-screens showing *up/down, centre/periphery*, in *front/behind, over/under* etc; body experiences helping the child sort out the world by perception, and contributing to the shaping of the child's subjectivity. What kind of body experiences the child obtains when moving around in the world are ultimately influenced by what kind of feelings it is met with on its way: does it feel included or excluded, does it experience a feeling of fullness or emptiness (Johnson 1987; von der Fehr 1992). To this list of opposite sensations I would like to add: comfort/discomfort. The different body positions and the varirty of movements develop the child's perception and sense of direction, and this is the body's way of shaping the child's subjectivity (Bainbridge Cohen, 1993; Johnson, 1987; Shapiro 1985). These variants of movement start with the child's gradual movement in upward direction from the surface, in addition to how it experiences being handled and touched by others. It is of great importance that the adults are able to communicate with the child at a "movement-level". When a child learns to get up on its own two feet, the grown-ups are often nervous, afraid the child might fall. Often heard: "Watch out so you don't fall, be careful, don't go there" etc.

Daniel Stern is interested in the fact that adults are inclined to verbalize the child's experience; this verbalization can cause a breach in the rich non-verbal or pre-verbal world of experience the child only recently has discovered (Stern, 1992). The grown-up's language enters the arena and wreaks havoc in the child's newly-won discoveries. This interference of the child's movement-flow may actually put the child in an increased state of tension.

Only now, in Peirce's third experience category do we reach the cognitive stage (from cognescere: to be acquainted with; to know (Webster)), or what we may call experiences that are linguistic and can be articulated.

This trichotomy, dividing the concept of experience into three

categories, primary, secondary and tertiary is originally inspired by Peirce, but supplemented by body-experience theory and developmental theory.

The subject may interpret the body from to narrow a state of consciousness (von der Fehr, 1992), and will deem the body by use of unprocessed, conventional language. Scientists doing research in the field of psychosomatics and semiotics have emphasized the complexity of the functioning of the body's internal communication system.

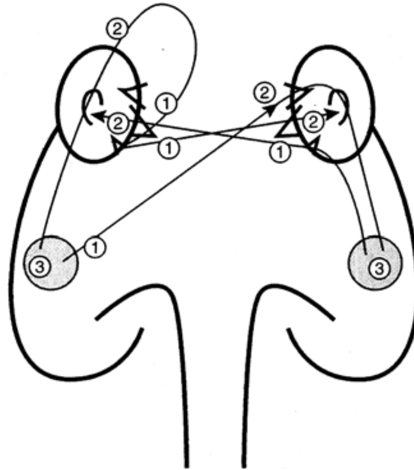
The body is irreducible in all its complexity. The intention of this project is among other things, to create the necessary space for us to understand that this complexity actually can be experienced (Engelsrud. 1990, pp 12–19).

Movement and Cognition

We believe that impression *generates* movement, while expression *is* movement. Moreover we have claimed that moving and breathing are two inseparable activities. The special thing about this is the fact that *expression* expresses something both outwards towards others and inwards towards oneself. In other words our expression becomes our own impression. Might it therefore be so that our most important conversation-partner ends up being oneself? Expressions appear in any situation, whether one understands what's happening or not. The person searches through his or her repertoire to find the right words, to find what *feels* like the right words. When a person expresses these words, they are heard not only by the others, but also by oneself. The words might remind the person of something he or she has seen or heard before, and accordingly the person may be *moved* by these words.

When you are moved, your balance gets slightly disturbed, and naturally you will wish to make a corresponding *counter-movement*, so as to find a new, or alternative balance. Just for the sake of repetition, one of the elements in this *counter-movement* is the search through your word-repertoire to enable you to make sense of the situation.

This illustration below represents what we think is essential about being human:



Expression, here we are talking about the spoken word, reaches one's own ears as well as the other person's. As mentioned above, expression, at the same time an impression, touches both the speaker and the listener. How much one is moved by this touch corresponds closely to how much the *impression* reminds one of something from earlier experience. To be able to understand what is going on, moving included, the person needs to search through his or her own words until sense is made.

In each and every moment, while this is going on, the person constitutes him- or herself; becoming whom he or she actually is. This doesn't mean that we are being constantly renewed; much of what we express may just be repetitions from earlier. But, in principle, change is possible in every single moment. When two people are together, expression from the one becomes an impression on the other; the other responds with an answer = expression and this again makes an

impression on the first one. The first person's expression leads to two new expressions, one from him- or herself, and one from the other.

We hope the following two examples will help make ourselves clear.

A woman once explained how "independence" had come to be a major word in her family. As she articulated this word, an expression full of sadness passed across her face. She was asked if the family expressed this word indirectly or openly; openly, she answered. The next question was if this word independence was meant internally about family matters, or if it was expressed as independence in general. When she answered that the word was aimed directly at the family members, she was requested to look *inside* the word independent. She said, laughing nervously, that she didn't like the word. The next question was what was it that gave her this feeling of dislike. She saw loneliness. Then she started to cry, and spoke for a long time about the hardships of growing up, how she had to manage on her own. As she spoke, her shoulders dropped a little and she gathered her hands in her lap. Gradually she confronted herself with this idea of always having to cope on her own, never seeking help from anyone. The more she spoke the more angry her voice grew, and in the end she straightened herself up and cast her arms up in the air.

Another woman, who distinctly emphasized that peace was an important word to her was asked if peace was a big word or a small word. A big word, she answered, and the next question was about what she would see or hear if she was to stroll right into this word. Without hesitation she answered that she walked into a meadow a summer afternoon, and she heard music. What kind of music? Mahler's second symphony. Which part? The final part, where the choir joins in. Are you alone, or together with someone? She was alone, and she started crying. A natural question following this answer was about who she wished had been there, what she had wanted them to do together, etc.

It is interesting to dwell on the fact that our *expression* is what we have

at our disposal, at all times. And as we discover alternative and new ways of expressing ourselves we will experience a new presence, and that just might make our lives easier to live.

A central element in our *muscular expression* is our ability to stretch and let go, to grip and let go, to hold and let go. If one can agree on the fact that our expressions are of utmost importance when it comes to living our lives, then one might then consider the professional helper's main contribution being about helping the patient expand his or her repertoire of expressions?

In this context, we must never forget or even underestimate the importance of playing or of the exercising of expressive arts.

Simultaneity

As we write this book the thought strikes us about how deeply rooted we are in the idea that *one thing follows the other.* It's hard to fully grasp the simultaneity of it all: We see and hear and put things in a perspective and formulate words and express and impress ourselves – everything at once, at the same time, *all the time.*

Some Significant Experiences

We must be careful not to *separate* physiotherapy from conversation. The physiotherapist works on the patient's body sometimes in silence, sometimes words are spoken. However we do think that if there is an extended period of time where conversation comes to be the main element during therapy, then one should certainly consider involving e.g. a psychotherapist.

We are concerned about the fact that one should maintain an attitude of utmost reservation when it comes to actively seeking the story behind the words or movements. Be there a story to be expressed, then the story will come when time is right, and the patient is ready. Moreover we are

generally concerned about this search for what lies behind anything at all. To us there is no behind. Our business is to fully concentrate on what is expressed. That is what we look for, listen to and feel. That is all. Everything else originates from this *now,* from one moment to the next. And we must take care not to engage in monologue conversations; we must include both the other person's and our own perspective.

A Summary at the Very End

Life comes to us by itself; life is a gift given to us, in each and every moment, sometimes it comes as a friend, sometimes as a foe.

Life touches us, life moves us. We wish to take part in the movements of life, and as we do so, our expressions come alive. Our expressions help us to understand. Our expressions let us become who we are.

The Authors

This group of authors originates from the professional environment around one of Norway's leading psychomotor physiotherapists, Gudrun Øvreberg. The four psychomotor physiotherapists have all been supervised by Øvreberg at her clinic in Harstad, Norway, where regular meetings with psychiatrist and professor Tom Andersen were included in the supervision. Tom Andersen sadly died in 2007. The other authors live in different parts of Norway, each one working with NPMP in clinical practice. Furthermore, some of them are involved with supervising students and arranging courses/seminars under the administration of the Norwegian Physiotherapist Association. In latter years the group has published two booklets: *A Collection of Gudrun Øvreberg's Written Material about NPMP (2002),* and *Aadel leads the Way* (2006). This material exists only in Norwegian. They have also produced two dvd's: *Gudrun Øvreberg – A Life in Movement. Documenting Norwegian Psychomotor Physiotherapy Practice* (2010), and *Tom Andersen – A Conversation, an Interview, a Lecture* (2011). Some of the film-material has recently been translated into English: *Gudrun Øvreberg – A glimpse into her practice and understanding* (2012).

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Tom Andersen gained his M.D. degree (1961), later he achieved the specialty in psychiatry and finally his Ph.D (1978) at the University of Oslo. From Oslo he moved up north to Tromsø. At the University of Tromsø he held the post Senior Lecturer and later became Professor in Social Psychiatry (1981). He has published numerous articles, and wrote the book *The reflecting team* (1991). The latter has been translated to nine different languages. The world-wide use of systemic family therapy and reflecting teams is linked to the groundbreaking work of Tom Andersen.

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Movements of Life **is about Norwegian psychomotor physiotherapy (NPMP), imparting with insight case stories from the authors' clinical practice.**

At the beginning we are invited into the tradition of this special branch of physiotherapy. Through the following six chapters we are given close accounts of six different case stories. The final chapter unites NPMP with theoretical and philosophical reflections.

This book aims to represent an extension of already existing knowledge and understanding in the field of body ailments and physiotherapy treatment approach.

The original Norwegian book was published in 1997. It has recently undergone a minor revision, before being translated into English.

Norwegian psychomotor physiotherapy is a university based, well-founded and documented postgraduate physiotherapy education in Norway. All professionals working in the field of physical therapy in mental health share the responsibility of international networking and exchanging knowledge and understanding. This is why the authors wish to impart their experiences from their special field with colleagues, patients and lay-men outside Scandinavia.