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Body Awareness - A Vital Aspect in Mentalization.

Experiences from Concurrent and Reciprocal Therapies

ABSTRACT

Background: A psychomotor physiotherapist and a clinical psychologist had collaborated on patients consistently for several years, when their individual therapeutic approach had turned out to be insufficient. **Aim**: The aim of this study was to investigate the therapists' understanding of their patients and the therapeutic processes they had been involved in, and to develop concepts in order to understand the concurrent therapeutic processes.

Design and method: This qualitative study is based on a grounded theory approach. The two strategically chosen therapists participated in "mini focus-group" interviews, in data transcription and in the analyzing process.

Findings: Three empirical categories emerged from the therapists' experiences. The core category "Body awareness: a vital aspect in mentalization" was comprised of two main categories, "The over-stretched children in the grown-up patients", and "The traumatized children in the grown-up patients."

Conclusion: Reduced body awareness seemed to correspond with lacking or fragmented memories of their own life history. Body awareness was a vital aspect in the therapeutic processes. Future challenges seemed to become manageable for the patients once they had realized that the resources for coping with these demands were available within themselves.

Key words: Dynamic psychoanalytical psychotherapy, Norwegian psychomotor physiotherapy, body awareness, dissociation, mentalization.

INTRODUCTION

In this qualitative study we wanted to elucidate the clinical experiences acquired through collaboration between a specialist in Norwegian psychomotor physiotherapy (NPMP) and a specialist in clinical psychology and dynamic psychotherapy. The therapists had been referring patients to each other when their individual therapeutic approaches had turned out to be insufficient, just for an additional assessment, or for reciprocal and concurrent treatment processes.

In Norway, clinical psychologists and psychiatrists have been collaborating with NPMP physiotherapists on the treatment of patients with somatoform disorders, musculoskeletal disorders, anxiety, depression and other subjective health complaints ever since the collaboration between the physiotherapist Aadel Bülow-Hansen and the psychiatrist Trygve Braatøy in the period between 1946 and 1954 (Bunkan, 2010). Braatøy was concerned with how physical and emotional stress affected the body, and wanted Bülow-Hansen to use her knowledge to reduce the patients' bodily resistance, and thus, giving access to emotions in psychoanalytic therapy (Bunkan, 2010). Bülow Hansen developed a form of massage "that could be used in a complementary way with a psychoanalytically oriented psychotherapy" (Heller, 2007:11), also described as "a neuromuscular massage technique successful in softening muscular armouring and releasing emotional tension" (Schaibel, 2009, p. 37). Bülow Hansen found that a local examination was not enough, and that the whole body had to be examined and given treatment. She integrated knowledge about body, emotions and the patient's social situation in her

treatment, and saw the body as an interconnected whole where one part could have an impact on the functioning of another (Bunkan, 2010). Heller (2007: 12) describes how Bülow-Hansen and Braatøy's patients became more aware of their emotions and their breathing, how they felt a loosening of their muscular tension, and how the combination of physiotherapy and psychotherapy gave the patients an experience of being able to contain their emotions and be more creative in psychotherapy.

Theoretical and clinical framework

In NPMP the body is understood as an integrated psychological–physiological phenomenon, as the center for experiences, where bodily and emotional reactions are fundamental both to the examination and the treatment (Bunkan, 2010; Thornquist and Bunkan, 1995, Ekerholt and Bergland, 2008; 2006; 2004). The aim of the examination is to identify the patient's level of distress, enabling the therapists to adjust the therapy. "A full NPMP will focus on relaxation related to passive respiration, on flexibility, the sense of the body, and these approaches might put the patient in closer contact with his or her emotions" (Bunkan, 2010; Thornquist, 2010; Ekerholt and Bergland, 2008; 2006; 2004). Methods used are massage, exercises and movements. Massage includes manual grips, passive bending and stretching, while exercises and movements are both passive and active (Thornquist, 2010). The therapy will always focus on body stability, body control and body awareness, and in cases of severe distress the relaxation aspect is toned down. In those cases, the therapist will mainly emphasize exercises which are intended to center the joints in the trunk and in the lower part of the body (Bunkan, 2010).

The main focus in the psychoanalytical two-person relational and structural system is the psychological development of a human being, focusing on the analysis of childhood experiences and the interaction with key caregivers. During therapeutic processes, new relational experiences are created, as a basis for recognizing, understanding and changing old patterns (Michell and Lewis, 1999; Aron and Harris, 2005). This is consistent with the neuro-psychoanalyst's focus on childhood association with close caregivers, brain development, and the human ability to regulate stress (Shore, 2002). "Under stress, individuals with poor attachment histories will experience not discrete and differentiated affects, but diffuse, undifferentiated, chaotic states accompanied by overwhelming somatic and visceral sensations which lead to a restricted ability to reflect upon their emotional states i.e. poor capacity for mentalization" (Shore, 2002: 62).

The concept of mentalization is an innovative form of psychodynamic psychotherapy, designed for individuals who have failed to develop the ability to mentalize within the context of a secure attachment during childhood. The therapy focuses on the patients' "current mental state linked to her subjectively felt realities, with the aim of building representations of internal states" (Fonagy and Bateman, 2006: 415). Situations in which the patient talks about mental states that he or she cannot link to subjectively felt realities should be avoided, i.e. conscious or near-conscious content should be preferred to the unconscious meaning, which is often the main focus in psychodynamic techniques. Mohaupt, Holgersen, Binder, and Nielsen (2006) show that there seems to be a substantial overlap between the concept "affect consciousness" and the concept "mentalization ability." Both conceptualize the ability to perceive, reflect upon, and adequately express affect. They also increase the ability to distinguish clearly between one's own mental state and that of others (Shore, 2002:19). Affect consciousness is vital in the contact with and understanding of feelings (Monsen and Monsen, 2000), and the ability to differentiate the body's

sensory signals is central to the process of exploring the experiences and emotions attached to these sensations (Fonagy, Gergely and Jurist, 2007).

As far as we know, there are very few previous studies which have discussed the collaboration between a psychologist and a NPMP physiotherapist seen from the therapists' point of view, apart from some interviews with the late Bülow-Hansen (Bunkan, Radøy and Thornquist, 1982; Husum, 1991). The aim of this study was to investigate the therapists' understanding of their patients and the therapeutic processes they had been involved in, and to develop concepts in order to understand the concurrent therapeutic processes.

Material and Methods

This is a qualitative study based on interviews with two strategically selected therapists, both of whom had had about 30 years of clinical experience. The physiotherapist has a municipal contract and a private practice; the psychologist has a contract with a public health organization as well as a private practice. Both work in a medium sized municipality in Norway. The interviews were built on a patient base of about twenty patients.

A 'mini-focus' group (Kitzinger, 1995) was established, consisting of the two therapists and the moderator (first author). The participants reflected upon and discussed their experiences during the meetings, seven times over a period of six months, in total 30 hours. The initial questions were open: "Could you describe the reasons for referring patients to each other?" "How would you describe your experiences of this collaboration?" The moderator could easily ask follow-up questions based on her own experience in the field. Data collection was ended when the material

reached "saturation point" (Strauss and Corbin, 1996), i.e. the moderator began to recognize statements, stories, and elements of the topics that had been discussed earlier.

The interviews were audiotaped and transcribed. The informants took part in transcribing, analyzing, and interpreting the material. When using the grounded theory approach, the researcher does not begin a project with a preconceived theory in mind, but rather begins with an area of study and allows the theory to emerge from the data (Strauss and Corbin, 1996). The analysis began with a line-by-line analysis of the transcribed material, i.e. each interview, which was broken down into discrete parts, closely examined and compared for similarities and differences in order to find themes, ideas, and the meaning contained therein, so-called "Open Coding." Each interview was coded and re-arranged so that important elements in the original text were collated according to different areas of the therapists' experiences. During a further step in the coding process, Axial Coding, data were put together in new ways, linking data around two main axes, showing important characteristic features of patients. Further analysis revealed that the two phenomena "Body awareness" and "Mentalization ability" were highly inter-related and very important aspects both in the assessment and treatment of the two groups of patients. These phenomena were chosen as the core category in the material, describing the link between the patients' lived experiences, the therapists' assessments and the therapeutic approaches. Strauss and Corbin, (1996) state that the core category should relate to the other categories logically, being analytically useful, and explaining the variation and main points in the data.

Quotations are presented in italics, and marked with (P) for psychologist and with (PT) for the physiotherapist.

Ethical conditions

The study was approved by the Data Inspectorate, and it was not considered necessary to apply to the Regional Ethical Committee, as it was research on the two therapists' experiences from their clinical practice. No patients were directly involved in the project or directly mentioned in the material.

RESULTS

Our analysis revealed an overarching theme, the core category "Body awareness – a vital aspect in mentalizion" appearing in the two main subcategories "The overstretched children in the grown-up patients" and "The traumatized children in the grown-up patients". This core category was identified as central in the data, revealing that the patients' lacking or fragmented body awareness was closely associated with their reduced or fragmented memory of their own life history, and a reduced ability to mentalize their own experiences. The therapists describe their therapeutic approaches, which are based on empathy, seeking to integrate bodily sensations and emotions, through the patients' increased consciousness of their own bodily reaction. Important therapeutic changes occur when patients are able to keep their attention on their own bodily sensations and become aware of how their bodily and emotional reactions interact with each other. These processes make them increasingly able to verbalize and mentalize their lived experiences.

Body awareness: a vital aspect in mentalization.

If the psychologist (P) found that the patient's symptoms of anxiety, depression or post-traumatic stress disorder were combined with significantly reduced psychological and emotional

consciousness, she wanted the physiotherapist (PT) to undertake a NPMP examination, to obtain a more extensive assessment of the patient's problems.

> *"When they have little memory of their life history and little ability to articulate what they are struggling with, when they are in pain and have bodily reactions which I as a psychologist do not understand, I need to find out how their bodies are affected. Do they have any body awareness at all?"* (P).

The psychologist stated that the NPMP assessment could thus expand her understanding of the patients' problems:

> *" If a patient comes with symptoms of anxiety and the NPMP assessment reveals excessive tension in the body and the lack of an ability to describe or feel their body, I will then have a different and broader perception of their problems"*(P).

If the patients who were referred for NPMP suffering from musculoskeletal disorders, breathing problems, headaches or other stress-related conditions revealed significantly reduced body awareness and /or excessive autonomic reactions or dissociation, or the patients would speak about serious mental problems, the physiotherapist said she would ask the patient to apply for an additional psychological assessment. In those cases, it frequently turned out that the patients had experienced previous severe negative and/or traumatic relational experiences which seemed to have been "forgotten," or which could hardly be verbalized.

> *"Extreme findings of any kind, too slack or too tight, – or very strong autonomic reactions, i.e. numbness, trembling or nausea during the body examination, - these*

findings can reveal a high degree of mental distress. Pain is not always what principally bothers these patients" (PT).

The therapists stated that they used body awareness and bodily experiences as vital elements in the therapeutic process. They suggested that this could be a way of establishing an initial ability to verbalize bodily sensations, starting an emotional and cognitive integration process, thereby leading to a growing ability to mentalize.

"If the patient's emotional awareness is low, the body is very tense and they are unable to express their feelings in words, they are left to experience through the body in order to gain access to emotions and feelings. Working with different aspects of body awareness is the somatic counterpoint to what I'll call "to work in the inner, emotional room.. You have to be able to stay in this "inner room" if you are to be able to reflect upon your own thoughts, be aware of what you need, what you want and what you are feeling. Without this contact, it's impossible to establish emotional borders and to learn to be aware of these borders and how to use them in different ways" (P).

According to the therapists, the therapeutic processes could differ and the time frame for treatment processes varied, depending on the patients' problems. In general, patients with traumatic experiences usually needed lengthy treatment processes, NPMP of one to two years, whereas psychotherapy could even last up to six years.

"Building relationships is something that takes a long, long time; these patients have never been able to rely on others – they need many, many confirmations to ensure that their experiences are valid. Relationships and predictability will constantly be the main focus" (P).

The therapists described how they have had regular meetings in which they discussed ongoing therapeutic processes. The patients were well informed of their meetings, and this knowledge seemed to improve the therapeutic work.

> *"There are many levels in a person, intellectually, emotionally and physically. We have to find out which level is most easily accessible, and which level needs consolidation and support .Thus we three participate in the same process, we have a common goal, and the patients will usually notice and greatly appreciate our mutual understanding"* (P/PT).

The therapists assumed that the concurrent and reciprocal therapies turned out to be successful in helping the patients to obtain reduced bodily and mental problems, thereby increasing the patients well-being, and they said:

> *In general, headache, muscle tension and breathing problems disappear or decrease, while excessive autonomic reactions and panic attacks become less frequent. The patients learn to reflect upon and reconstruct their life histories, and they most often manage to reorganize their lives through cognitive restructuring, increased body awareness and emotional tolerance"* (P/PT).

The overstretched children in the grown-up patients

The therapist supposed that the patients belonging to this category were persons who had had exhausting demands made on them, either self-generated or from others, along with a decreased ability to put limits on their usual activities. They were:

> *"Persons, who have had lots of negative relational experiences when they were children, and had learned to master situations that were really too difficult for children. They apparently did this very well, but the costs had been huge, they had stretched the elastic*

band too far. Generally, they suffered from massive anxiety and this anxiety finally made them totally exhausted or 'over-stretched'" (P).

Their coping strategies were described as established in early life, continuing as habitual patterns of suppressing emotions and feelings, combined with the anxiety which follows the childish feeling of helplessness. This can be exemplified as*:*

"This mental distress has a somatic counterpart; you cannot relax physically when you are psychologically taut. They are afraid to loosen up their defense, and cannot put limits on themselves and on others. The main issue in therapy will be, "Am I allowed to say no?"(P).

The characteristic bodily symptoms of "the overstretched" patients were described as pain and stiffness, restricted and controlled breathing, while their body awareness was fairly adequate. These patients usually showed some ability to relax and they had no problems in remembering their life history. Those two last aspects were the main differences between the two groups of patients, as shown in the following quotation:

"If the body awareness is adequate, and they reveal an ability to relax, I don't see much limitation on the scope for therapy; these patients do really benefit from the relaxing elements in NPMP" (PT).

The overstretched ones achieved increased ability to relax and to recognize bodily signals through the NPMP, while psychotherapy focused on how to sort out their negative and insecure attachment styles. According to the therapists the concurrent therapies helped these patients to find new ways of reacting in demanding situations, thus learning to protect themselves from the

demands which were still put on them, by themselves and by others, and to be able to put limits to their activities.

> *"The over-stretched ones are still children inside; they need to learn that they are grown-up persons now. When they realize that "this is not dangerous any more", they are ready to let go the old feeling of anxiety" (P).*

The traumatized children in the grown-up patients

For the "traumatized children", emotional and mental distress seemed to be the main problems. The therapists usually found that psychotherapy most often was first priority when these patients applied for therapy.

> *"They did survive, but they are still terrified, traumatized children. History haunts them; they have no peace. They are so anxious, have so little contact with their bodies and emotions, which are perceived as dangerous and unsafe. They are those who have the greatest need for NPMP, but it's a dilemma that what is most needed, bodily and emotionally, is not tolerated"* (P).

The physiotherapist stated that the NPMP assessment could reveal severe bodily findings, confirming the patient's need for psychotherapy.

> *"I have learned what so-called "contradictory findings" could mean; when seemingly well-functioning persons cannot stand being touched, they cannot tolerate lying on their backs, they dissociate mentally, or they can't feel their bodies. In those cases I need a further assessment of the patients, done by the psychologist. Most often psychotherapy is first priority here"(PT).*

For most of these patients, the common coping strategies for enduring mental distress had been to dissociate mentally or to shift away from bodily sensations and experiences, mainly focusing on intellectual and cognitive activity, as shown in the following quotation:

> *"These patients have diverged widely from their emotions as well as from their bodies, they usually talk and talk. Some of them dissociate when they have to concentrate on feeling their own body or talk about their life history. They are trying to get out of emotional problems by logical exercises through a paradoxically circular cognitive process" (P).*

Bodily reactions were associated with discomfort and lack of control, and to increase their body awareness could be scary. In those cases, the therapists could use the parallel treatments as an important therapeutic tool; NPMP was adjusted very sensitively according to the patient's reactions, and the reactions experienced with the physiotherapist could be sorted out by the psychologist. This process could often serve as a gateway to further emotional exploration.

> *"They can only take small doses of concentration about bodily sensations without dissociating, they need to protect themselves, they are afraid of losing control" (PT).*
> *"They are terrified of feeling anything. Whenever there is a new bodily sensation, they are afraid. Then I would say, "Of course you are afraid, but it is not dangerous, you are relaxing now, then the fear will also be released. Your body carries it all, along with the fear of saying something. Therapy means painful experiences before you can feel that things are improving. Most of those who are so scared, regain control when they have processed this mentally*" (P).

For other patients, the stabilizing elements in NPMP could modify their emotional reactions when with the psychologist. In those cases, a feeling of physical stability and strength could change the patient's experience of distress and anxiety.

> *"Working with stabilization and body awareness can create a sense of a physical as well as a mental foundation through the feeling of bodily anchoring"* (PT).

The therapists emphasized the importance of realizing that for some patients parallel treatments could be too demanding.

> *"It can be overwhelming for some patients when the therapists want to collaborate. They cannot rely on more than one person at a time. It is asking far too much of them that they should have confidence in two therapists. In those cases, we don't start any collaboration or we'll stop the collaboration immediately" (P/PT).*

The therapist supposed that the combination of therapies increased the patients' sense of connection between bodily sensations and emotions, and an increased experience of embodied emotions seemed to have emerged. It also seemed as if the therapists' collaboration was especially important when working with the traumatized patients.

> *"When their panic relating to bodily sensations decreases, new areas open up for them. All previous conscious activity has been in their minds – now they begin to 'move from the head into the body', establishing a connection with emotions which are situated in the body. Realizing that body and feelings are inter-related can reduce the chaos in their minds. If you introduce these therapeutic elements by very small steps, the patient can*

tolerate and benefit from them, establishing a vital emotional reconstruction.The main issue in therapy will be:"Who am I?" (P).

DISCUSSION

The main focus in this study was to investigate the therapists' understanding of their patients as well as the therapeutic processes they had been involved in. The referrals seemed to have reflected a medical view that maintained a distinction between somatic and psychological disorders, and suggested that these disorders would need either bodily or mental therapeutic approaches. The experiences presented in the result section, show the importance of the combination of NPMP and psychotherapy through concurrent and reciprocal therapeutic approaches. The interpretation of the results will be presented as three empirical categories: "Bodily sensations as an important aspects of being able to say "No", "The process of integrating bodily sensations and emotions", and "Creating an extended therapeutic room."

Bodily sensations as an important aspect of being able to say "No".

The therapists had experienced that the "over-stretched children" had coped with tasks that had exceeded their capacity, combined with early negative relationship experiences. Their patients seem to have learned always to fulfil the demands of others, and had never been able to refuse and say "No". As grown-up persons they were unable to put limits on themselves and on others, which might lead to constant increased emotional and bodily arousal, such as increased muscular tension, bodily stiffness and restricted breathing movements.

According to Mohaupt, Holgerson, Binder and Nielsen (2006) habitual bodily patterns such as those described here can easily turn into psychosomatic diseases, musculoskeletal disorder or chronic pain. The therapists found that these stressful patterns of self-regulation were developed "as negative relational experiences in the childhood", often connected to insecure attachment patterns (Mohaupt, Holgerson, Binder and Nielsen, 2006). Landale (2009) suggests that those who suffer from somatic, painful disorders have often had to learn to control impulses and ignore their feelings long before they were developmentally ready to do so, and thus have learned to undermine the natural balance between the stress and relaxation responses, which in turn will decrease the ability to be aware of their own limits. Chronic pain can be incomprehensible for the person affected, making it impossible to perform simple, everyday tasks (Dragesund and Råheim, 2008), at the same time as painful experiences include a shift in consciousness to an explicit awareness of the body, drawing attention to the body through discomfort, disability and anxiety (Rudebeck, 2001). However, the therapists found that the "overstretched patients" could remember their life history, they had a certain ability to verbalize their experiences and their body awareness was fairly adequate. The physiotherapist could use the relaxing elements in NPMP, thus proving relaxation through an increased parasympathetic activity (Rothschild, 2003). The concurrent therapeutic processes had great focus on bodily sensations, using them as a tool for conscious mentalization of relational experiences. Gyllensten, Skär, Miller and Gard (2010:18) state that "to be within the body gives awareness of tension signals and allows a reduction of tension before pain develops." The patients' headache, muscle tension and breathing problems improved, which in turn might mean an increased feeling of coping.

The process of integrating bodily sensations and emotions.

The therapists had experienced that the "traumatized children" had little memory of their life history, reduced body awareness, and little ability to articulate their problems. It seems as unresolved and unprocessed significant life events and relationships remained as constant mental and/or somatic pain, sapping the patients' feelings of mastery and coping. Prolonged stress, depression or trauma can affect the person's conscious experience of the body, emotions and thoughts. Trauma can take many forms and occur at any life stage, and must always be considered in the context of each person's individual perception, and traumatic experiences produce altered physiological or biochemical states in the person affected (Kirkengen, 2001: 337).

Kirkengen (2001:22) wonders whether "a person's medical history is adequately comprehensible without insight into the person's life history", stating that "hidden boundary violation seem to be a probable source of impaired self-esteem and well-being, not yet properly acknowledged by society and the health care professions." Her statements fit in with how the therapists describe the "terrified, traumatized children" in the grown-up persons. Their main symptom was a constant feeling of anxiety, and they were constantly seeking explanation and coping strategies to deal with their anxiety through "paradoxical cognitive processes", also called "intellectualization". The therapists describe them as "living their lives in their heads, - thinking and thinking, trying to solve emotional problems logically", and usually having great difficulties in getting in touch with emotional and bodily reactions.

Rudebeck (2001) shows that physical objectification takes place when the patient tries to come to grips with experiences that cause ailment or fear, and that the process of intellectualization is an expansion of the cognitive aspect of the totality of experience, decreasing the aspects of

perception and affect. The therapists describe this state as "being divergent from the emotions as well as from the bodies", struggling to resolve painful experiences cognitively and by means of reasoning. The material shows that the "traumatized ones" become highly anxious when body awareness was challenged, and they could respond with physical numbness, excessive vegetative reactions and/or mental dissociation. However, through a sensitive and step-by-step NPMP approach, the patients became aware of a variety of bodily sensations other than pain and physical stiffness, thus establishing a growing connection with bodily situated emotions (Damasio, 1999: 53-33).

The therapists' experiences describe how some of their patients dissociated when they had to concentrate on feeling their body or talk about their life history. Reports of research (van der Kolk, 1994; Ellert and Nijenhuis, 2001) state that persons who have experienced traumatic events or abuse may, later on, if these events were to be reactivated, be overwhelmed emotionally and bodily, even if their memory of their own life history is diminished or lacking. Shore (2002) states that persons who have been traumatized in early life will later have no explicit verbal memory of their traumas, but these experiences are stored as implicit memory, i.e. emotional memory to which they do not have conscious access. They will often react in the form of disconnected physiological responses, emotions or actions, as described by the physiotherapist as "contradictory findings", i.e. when patients cannot tolerate lying on their backs, they can't feel their bodies, or they show very strong autonomic reactions. These reactions could represent the mental dissociation's somatic counterpart, somatoform dissociative symptoms, i.e. incomprehensible pain and complaints, often called somatoform or conversion disorders. These symptoms should, therefore, be seen as an expression of the same serious problems, being signs

of early relational trauma in an emotionally neglectful and abusive social context (Ellert and Nijenhuis, 2001 p.19).

Nijenhuis (2000) states that both psychological and somatoform dissociation are mental phenomena, and that the term "somatoform dissociation" describes the existence of a disruption of the normal integrative mental functions which phenomenologically involve the body, while the psychological dissociative symptoms are those that phenomenologically involve psychological variables. "Thus "somatoform dissociation" denotes phenomena that are manifestations of a lack of integration of somatoform experiences, reactions and functions" (Nijenhuis, 2000:9). Statements like this support the therapists' experiences during the concurrent and reciprocal therapeutic processes. Their collaboration enabled their patients to reflect upon bodily as well as emotional reactions, and these reflections helped the patients to see how body and soul are inter-related.

Creating an extended therapeutic room.

The therapists were fully aware of that those patients who are in a state of constant hyper-arousal and are constantly expecting new dangerous situations to arise may find emotional as well as bodily confrontation re-traumatizing. They emphasized the importance of concurrent and reciprocal therapies as a better way of handling these therapeutic challenges. The feeling of safety is crucial if one is to change habitual patterns that have been protective mechanisms against painful memories (Hokland, 2006). Any experience of re-traumatization could easily create a secondary defensive armor from which it would be much harder to be released (Eiden, 2009). Shore (2002) states that patients who still suffer from earlier overwhelming experiences

will not be cured by "talking cures;" they will need "communicating cures", based on the non-verbal right hemisphere of the brain, the locus of the bodily-based self and communicative skills. The material shows how the patients increased their body awareness and body stability through NPMP, gradually establishing experiences of anchoring and control, eventually increasing their ability to relax. The psychologist supported the increasing awareness of bodily sensations through consistent reflections on and confirmations of these experiences as important aspects in the process of becoming aware of emotions and feelings. Mazi (2001:211) states that "making sense of illness and injury, being encouraged to follow up on feelings as they arise and lead to further feelings, images, expressions and finally insight, is a process that can be supported, encouraged and facilitated by healthcare professionals ". Nijenhuis, van der Hart and Steele (2010) suggest that the treatment of trauma-related disorders should be phase-oriented, so a gradual and careful integration of the dissociative parts of the personality could emerge. The working alliance between the patient and the therapist is essential, and the therapists emphasize the importance of safe, long-term therapeutic relations with a gradual and predictable therapeutic approach. All the while they focused on getting the patients better acquainted with their own bodily reactions (Monsen and Monsen, 2000; Levy Berg, Sandahl and Bullington, 2010) and emotional awareness (Greenberg and Pascual-Leone, 2006:612). Their collaboration became a process by which they implicitly and explicitly interpreted actions and phenomena on the basis of internal mental states, aiming to improve the patients' affect regulation and interpersonal relationships (Fonagy, Gergely and Jurist, 2007; Fonagy and Bateman, 2006).

The therapists describe how they were deliberately honed in on the patients' "embodied emotional experiences", combining cognitive, emotional and bodily therapeutic approaches, and

how their patients should explore, reflect on and make sense of these experiences. The patient and the therapists had a common goal for the therapy, and allowed sufficient time for the therapies to develop. These elements seem to have increased the therapeutic outcome, helped to transform maladaptive states (Greenberg and Pascual-Leone, 2006:614), and prevented any possible therapeutic splitting. This process also fits with the salutogenic perspectives; in order to increase the sense of coherence, the patients have to be motivated to cope with and see the meaning of their own embodied reactions, thus being able to believe that the challenges they will meet henceforth are understood and that the resources for coping with these demands are available within themselves (Antonovsky, 1996:15).

Limitations

This study had limitations and strengths in establishing trustworthiness. Denzin and Lincoln (2011) discuss the criteria for trustworthiness for the terms of credibility, confirmability, and transferability. In this paper credibility refers to the fit between the experiences of the respondents and the researcher's presentation of them. A study is credible when it presents faithful descriptions and when colleagues or readers confronted with a similar experience can recognize it. In this paper credibility was enhanced by peer review carried out by four colleagues in addition to the authors. The authors returned systematically to the original text, which consisted of deep, rich and extensive transcribed material, to be sure that the findings were firmly grounded in the data and that quotations from the participants were used.

Transferability refers to the extent to which the findings can be applied to other contexts. The authors of this paper believe that the data presented have sets and descriptions rich enough to make judgments about the findings' transferability to different treatment settings or contexts.

However, the findings presented here represent the clinical experiences of the two therapists, and are not claimed to be relevant for most therapists in the field of NPMP and dynamic psychotherapy. We have described central aspects of the research as thoroughly as we could, and we hope the experiences may be of interest to other therapists and that the material will form a basis for further reflection and discussion.

The term confirmability deals with the researchers' ability to be neutral to data, which was the intention in this study. One could object to the participants' neutrality to data, as the two therapists in the material participated in transcribing and analyzing the data. This topic was extensively discussed, while we were constantly searching for different professional perspectives, all the time trying to step back from the text and to look at it objectively.

CONCLUSION

The experiences which emerged from the data show that the therapists had been collaborating on patients who were either overstretched and/or traumatized; it seems that they were all severely distressed as grown up persons because of negative or traumatic relational experiences in their childhood. The connection between body awareness and the ability to mentalize became obvious for the therapists, and body awareness turned out to be essential both in the assessment of the patients as well as in the reciprocal and concurrent therapeutic approaches. The material shows that the patients' state of health improved, and it seems that the therapists' focus on body awareness and mentalization had taught the patients to cope with it and motivated them to see the meaning of their own embodied reactions. This probably helped them to consider future

challenges as manageable and to believe that their resources for coping with these demands are available within themselves.

Declaration of Interest:

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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