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SCIENTIFIC CONTRIBUTION

To be held and to hold one's own: narratives of embodied transformation in the treatment of long lasting musculoskeletal problems

Randi Sviland · Kari Martinsen · Målfrid Råheim

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Abstract This study elaborates on narrative resources emerging in the treatment of longlasting musculoskeletal and psychosomatic disorders in Norwegian psychomotor physiotherapy (NPMP). Patients' experiences produced in focus group interviews were analyzed from a narrative perspective, combining common themes across groups with in depth analysis of selected particular stories. NPMP theory expanded by Løgstrup's and Ricoeur's philosophy, and Mattingly's and Frank's narrative approach provided the theoretical perspective. Patients had discovered meaning imbued in muscular tension. Control shifted from inhibiting discipline and cognitive strategies, towards more contingence with gravity and sensation, and increased freedom to be what and who they were. Trust, time, open speech, and being respectfully listened to were described as therapeutic pre-conditions. The body was experienced as the source of their voice as their own. As tension patterns transformed, novel experience in sensation appeared to feed narrative imagination, reshaping past plots, embodied identity and future prospects. NPMP was disclosed as a treatment integrating detection, battle and repair as narrative subplots, but the core narrative was the journey of transformation. Novel embodied narrative resources nourished the quest for a life and identity in tune with the body as one's own.

R. Sviland (✉) · M. Råheim
Department of Global Public Health and Primary Care, University of Bergen, Bergen, Norway
e-mail: randi.sviland@igs.uib.no

K. Martinsen
Harstad University College and Haraldsplass Deaconess University College, Bergen, Norway

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Introduction

Long lasting musculoskeletal conditions cause much suffering, challenge healthcare, involve substantial social benefit expenses (Lærum et al. 2013), and are often associated with depression and anxiety (Bair et al. 2008; Breitve et al. 2008). A physiotherapy approach, Norwegian psychomotor physiotherapy (NPMP[1]) was developed in a borderland that intertwines the psychological and the somatic. It grew out of the collaboration between psychiatrist Trygve Braatøy[2] and physiotherapist Ädel

[1] NPMP is a post graduate specialization taught at the University College of Oslo, and as a clinical master at University of Tromsø. Some courses have are run in other Scandinavian countries. Patients are referred to NPMP by their medical doctor. It is one of the physiotherapy methods practiced within the National Health Service and covered by national insurance with its own financial rate.

[2] Braatøy (1904–1952), Norwegian psychiatrist, was one of the first psychoanalytically trained doctors in Norway. In his attempt to bridge the diverging opposites between experimental medicine and psychology, he searched for what they had in common, which could transcend the divide between body and mind. Central to the theory of NPMP is that muscular functions of posture are molded by social and cultural norms and, express a person's attitude to his emotions. In nervous minds muscular conflicts between posture and spontaneous movements may thus express that a person is in conflict with himself, the attitude may arrest the motions of emotions and inhibit the person from being aware of how strongly impressions have affected him/her. If muscular conflicts are dissolved, emotions and memories may emerge. Braatøy was also known for introducing a client centered approach to the medical practice in Norway.

Bülow-Hansen[3] in the 1940–1950s (Ianssen 2012). This individual physiotherapy treatment approach is used for patients suffering from longlasting musculoskeletal and tension ailments,[4] often entwined with emotional burdens and the stress and strain of life. Massage and exercises are used to readjust tension of muscular, postural and respiratory patterns, closely guided by the patients' physical and emotional response. Long-lasting muscular tension is often imbued with past and current life experiences, which the therapeutic attitude must accommodate for (Bunkan and Thornquist 1991; Ianssen 2012). NPMP challenges an instrumental approach of repairing the broken bodies (Steinsvik 2008) by understanding the body as the centre of experience and field of expression (Thornquist 2006). Previous research of patients' experiences with NPMP indicate that this treatment may promote perception and reflection on one self and being more in touch with one's own body (Ekerholt and Bergland 2004, 2006, 2008; Dragesund and Råheim 2008; Øien et al. 2007, 2009). Braatøy and Bülow-Hansen understood the patients' symptoms in relation to past and present life experience (Braatøy 1947/1979; Bunkan et al. 1982; Bunkan and Thornquist 1991) at a time when a narrative approach to research was not yet explicated. Except for three recent studies (Øien et al. 2007; Øien 2013; Sviland et al. 2012) narrative research in NPMP is scarce. Time is central in a narrative perspective. Patients who come to NPMP have usually suffered from ailments for a long time (Breitve et al. 2008), and therapy takes time, usually years. We wished to investigate patients' experiences with this physiotherapy approach, including exploration of the dimension of time. Our interest was to explore how patients make meaning of their experiences with NPMP, and to interpret core meanings according to relevant theoretical perspectives. For this investigation we invited patients who attended NPMP to discuss their experiences in focus groups.

First we describe the conceptual framework of the study and, how this is integrated with other theoretical and philosophical perspectives relevant to NPMP. Subsequently the method of focus group interviews, the construction and analysis of the material are described. Analysis had a double focus. Findings are therefore presented in two layers. First, common narrative themes are presented, which emerged from across group analysis. Secondly, there is a particular story presented, exemplary of each common theme. This story is analysed individually. Analysis of individual stories portrays how these common themes unfolded in a particular persons experience with NPMP.

Theory: A narrative perspective

During NPMP, which is hands-on physiotherapy, episodes emerge in the interaction in which expressive movements, emotions, reflections and recounted stories may take place. Sometimes such emergent narratives are important moments of change (Øien et al. 2010; Sviland et al. 2012). Narrative meaning may emerge in the interaction between patient and therapist as enacted clinical plots (Mattingly 1998, 2000, 2010), but also as verbal reflections. When exploring NPMP from a narrative angle, we draw on the enacted perspective of Mattingly[5] and the recounted perspective of Frank.[6] Both, from separate angles, have elaborated on how narrative genres act within health care and give voice to those who struggle, but are not easily heard (Mattingly 1998, 2000, 2010; Frank 1994, 1995, 2012). Mattingly argues for a narrative phenomenology for analysis of the small dramas of ordinary life of particular events and persons (2010). She contributes with an enacted

[3] Aadel Bülow-Hansen (1906–2001), Norwegian physiotherapist, discovered how muscular tension was associated with respiratory inhibition. Together with Braatøy she explored the connection between respiratory inhibition and emotional regulation and social adaptation. With her practical skills and in depth knowledge of anatomy and the moving body as a comprehensive unit, she developed NPMP as a method, which she then taught her colleagues, who subsequently developed a system of education and training. In the passage from clinical practice, where it originated, to becoming a clinical master program, claims as to documentation and theory have increased. It is likely that practice has changed somewhat over time, but no studies have documented this.

[4] A wide variety of conditions and illnesses may be referred to NPMP, such as: long lasting low back pain and shoulder/neck pain, asthma, headaches, migraine, fatigue, fibromyalgia, anxiety, depression, anorexia, post-traumatic stress syndromes, Multiple Sclerosis, hemiplegia, or complications after surgery or accidents i.e. whip lash injuries. Many patients will have complex conditions involving several diagnoses at the same time. They are often referred after many attempts with general physiotherapy, chiropractor treatment, acupuncture, or various alternative treatments. Some have been to or, are attending psychotherapy simultaneously. When applicable, NPMP therapists and psychotherapists collaborate. NPMP is directed more towards how a person reacts and adjusts as a whole, rather than the diagnosis.

[5] Anthropologist Cheryl Mattingly Professor, Department of Anthropology, University of Southern California, USA and Aarhus Institute of Advanced Studies, Aarhus University, Denmark. Based on ethnographic studies she has written about how clients, families and clinicians work together in rehabilitation processes. She has also studied how narratives help clinical reasoning and therapists endeavor to tailor treatment for the individual clients' particular needs.

[6] Sociologist Arthur Frank is Professor Emeritus of Sociology at the University of Calgary, Faculty of Art, Department of Sociology. His research is related to narrative inquiry and narrative practice of illness experience. It also encompasses health care and bioethics, sociology of the body and sociological theory. He was awarded the Writers' Award from the National Coalition for Cancer Survivorship (Washington, D.C.) in 1996 for his book *At the will of the body*, based on his personal experience of surviving a heart attack and cancer. *The Wounded Storyteller: Body, Illness and Ethics*, which has inspired our article, is widely known within medical sociology and humanities in medicine.

angle to narratives. We asked patients attending NPMP to recount particular events and meanings from the therapy process. Since the present study investigate recounted rather than the emerging of such enacted clinical plots, we needed to complement Mattingly's narrative perspective and, therefore turned to Frank. Frank's research of recounted illness stories has particular focus on body problems. Since their research is not in the field of NPMP, we also complement their perspectives of narrative genres with theory and philosophy, which we have found relevant to the field of NPMP (Sviland et al. 2007, 2009, 2010, 2012). We also suggest to expand on the theoretical perspective of NPMP by outlining aspects of Ricoeur's narrative philosophy[7] (1991, 1992) and Løgstrup's phenomenology,[8] exploring sensation, fictional space and narrative resources (1976, 1978, 1983a, 1984).

Core narratives described by Mattingly and Frank

Based on the idea of the body as a machine, narratives of medicine can be illustrated as detective, battle or repair stories. In stories like detecting the virus, fighting the battle against cancer or repairing the broken bones, members of the medical staff are the main characters. Culturally shaped core narratives reflect the paradigms of a society. Mattingly see them as canonized medical genres, and Frank calls them restitution narratives. They authorize action frameworks for how things should unfold in treatment. What should be attended to, count as evidence and constitute facts, and what is concealed. Narrative resources may shape the rhythms of activity and the experiences and expectations of participants and, even refuse some realities (Mattingly 2010).

According to this narrative perspective, healing depends on the capacity of the narrative resources available to the person. Narratives express meaning and shape meaning making and how human identity develops in narrative causality, entwining the individual and the cultural. Particular stories express individual lives with core narratives entwined within them. This raises the questions: How potent are the culturally shaped core narrative genres of medicine as trajectories for patients' struggles and suffering? And, to what degree are they appropriate trajectories for patients with musculoskeletal tension and ailments in their struggle to get a grip on their lives? Do they provide the necessary narrative resources?

The concrete physical interaction between patients and physiotherapists in NPMP juxtaposes Mattingly's practical action focus on emerging stories. However, the research material of this study is developed from patients' recounted meaning making of such treatment experiences, where experiences and events have been structured and told in a group context. These stories about healing processes related to the particular therapeutic approach of NPMP do not exactly compare with Mattingly's fieldwork or Frank's illness stories.[9] We therefore draw on both perspectives when analyzing our material. Frank proposes three core narratives: the Restitution, the Chaos and the Quest (1995, 2012). They do not match precisely the narrative genres developed by Mattingly, but their angles seem to supplement each other. Frank's Restitution narrative displays illness as a transitory phenomenon and the cure is the triumph of medicine. This corresponds with three medically canonized genres of detection, battle and repair described by Mattingly (2010). The core narrative of Chaos described by Frank (1995) is not identified by Mattingly. It denies any possibility of restitution. It is like a hole or that which is *lacking*; it is beyond speech and cannot be told except in retrospect. Mattingly's (2010) genre of "healing as transformative journey" displays people changing over time, where ill persons give voice and perspectives to their own enacted stories. She (2010: footnote 16, Chap. 12) comments on how this compares with Frank's Quest narrative, where they both use the journey as metaphor. When investigating what kind of narrative genres unfold and what they hold within the field of NPMP, these core narratives provide analytic perspectives to this article (Table 1).

Stories of illness and healing from an embodied perspective

Frank (1995) pinpoints four body problems in illness, which are potentially fruitful to pursue, when exploring NPMP experiences: control, other-relatedness, body-

[7] Paul Ricoeur (1913–2005) is most famous for combining phenomenology with hermeneutic interpretation. He draws on several fields of research such as literature, history and linguistics, but also in-depth knowledge on and analysis of Freud's work. Drawing on this he develops a narrative theory of identity.

[8] Knud E. Løgstrup (1905–1981) is Denmark's most famous philosopher next to Kierkegaard. He belongs to the Danish philosophy of life following Gruntvig. His philosophy encompasses extensive discussions with philosophers such Husserl and Heidegger. He also discusses with and opposes Kierkegaard and structuralist Hjelmslev. Løgstrup's phenomenology is first and foremost inspired by Hans Lipps (a student of Husserl and Bergson), whose lectures he attended in Göttingen. Løgstrup is most famous for *The Ethical Demand* published in 1956. It is claimed to present an alternative understanding of interpersonal life upholding interdependent basic trust. Løgstrup's phenomenology of sensation is developed later but is implicit in his thinking already in 1956. Løgstrup is much referred to within health care research in Scandinavia. Some of his work is available in English translation in: Løgstrup (1997) *The Ethical Demand,* Notre Dame, Indiana University of Notre Dame Press, Løgstrup (1995) *Metaphysics,* Milwaukee: Marquette University Press.

[9] In *The paradox of hope,* Mattingly investigates how children suffering from fatal disease or sever handicaps, and their families struggling to cope. In *The wounded storyteller* Frank's stories are related to people suffering with chronic disease or terminal conditions of various sorts.

Table 1 The correspondence between Mattingly's and Frank's core narratives

Described by Frank	Described by Mattingly
Restitution narratives	3 genres: detective, battle and repair stories
Chaos narratives	
The quest narratives	Healing as transformative journey

relatedness and desire. We do not follow the typology Frank develops from this. It is more concurrent with the purpose of our study, to discuss these four aspects of body problems with theoretical elements developed from a previous study of NPMP through the angle of Løgstrup and Ricoeur (Sviland et al. 2012). We relate control, other-relatedness, body-relatedness and desire to muscular functions, sensation, time and narrative identity. Thereby we see embodied life and narration entwined in the concept of identity, as analytic perspective in the present focus group study. We will first outline central philosophical aspects from Ricoeur and Løgstrup, before integrating these with the body problems described by Frank.

Life and stories are interwoven, and narrative fiction is "an irreducible dimension of the understanding of the self" (Ricoeur 1991: 435). Ricoeur helps us integrate interpretation and narration in NPMP, which involves mediation between man and the world, man and man, and man and himself. In other words reference, communication and self-understanding, and vivid metaphors will play a part in interpretation processes, also in NPMP (Ricoeur 1991; Rendtorff 2000; Kristensson and Kemp 1992).

A person's life experiences, structured in a unified story, are closely linked with his or her identity. Entangled in stories we learn to narrate our own story, and "we do not cease to re-interpret the narrative identity that constitutes us in the light of stories handed down to us by our culture" (Ricoeur 1991: 437). Thus, a concert of voices and intrigues offers various roles to experiment with, when we with imaginative variation search for self-understanding. The narrative self is taught by culture and develops in the tension between sedimentation and innovation. Narrative models provided by tradition are continuously under pressure by the innovation of new particular stories, and identity concurrently evolves in the dynamic between the overlapping poles of sedimentation and innovation. *What I am* expresses "the set of lasting dispositions by which a person is recognized" (Ricoeur 1992: 121), like characteristic features and acquired habits, which remain the same despite time, what he calls sameness. Selfhood, on the other hand, represents permanence in time connected to *who I am*. This self-constancy occurs over time, as in the *process of developing* habits or being a trustworthy person who keeps one's word, expressed in action and narration. Ricoeur (2004) later illuminates an aspect of memory where repetition acts as a memory in action of something that no longer exists.

We possess our body and our experiences. This means, according to Ricoeur (1992), that the earthbound body is the invariant source of narratives and identity. The imaginative variations around the body as one's own are variations on the self and its' selfhood. The corporeal selfhood inhabits the world, as the world is corporeally inhabited. Thus the earthbound embodied self is the existential mediation between the self and the world and, our corporeal anchoring in the world. Ricoeur does not further expound the existential significance he attributes to the Earth, but he takes this as a foundational stance for his narrative perspective on identity. This stance is not dissimilar to Løgstrup's perspectives, where the existential dimension of coming to one's self is understood as finding one's bearing in body and language, in a life which is interwoven with the world in sensation (Løgstrup 1987/1993). In NPMP the muscular aspect of finding one's bearing involves the dynamic regulation between posture and motion, in relation to gravity, emotional regulation and sociocultural adaptation (Braatøy 1948/1952; Sviland et al. 2007). Here, Løgstrup offers a possible bridge between concrete muscular functions and existential meaning making. From this angle, we wish to expand the narrative perspective of this article with a phenomenological and existential approach on sensation.

Løgstrup (1983a, 1984) criticized modernity for understanding human life in isolation. At the same time he opposed to seeing everything as culturally dependent. As already underscored, Løgstrup insists that human life is interwoven with the world in metabolism, respiration and sensation. We are without distance in sensation, tuned and moved by impressions, towards expressing these tuned impressions. It is an effort to prevent expressing impressions. With his phenomenology Løgstrup elaborates on what is different in phenomena that appear to be the same. Several unifying opposites (Løgstrup 1983b) come forth. These are phenomena that are different, yet interdependent. They keep each other in cheque, and give life to life. Awareness is illuminated through this dynamic thinking. There is a certain degree of awareness in ubiquitous presence, awareness in sensation, through which we have access to the world. Impressions in sensation needs clarification, and aided by language some distance is created to what we are moved by in sensation. Sensation stretches into the open fictional space where awareness may reach the level of understanding. At this distance we are able to grasp and reflect upon impressions in sensation. There is a continuous dynamic shift between awareness in sensation and awareness in understanding mediated by clarification (1976, 1978, 1984). Løgstrup was more concerned with life as interwoven with the world in sensation and

understanding than with body awareness as such. In NPMP body awareness is central, and here the dynamic between sensation and understanding illuminates how we may have knowledge through body experience on a preverbal level. The fictional space is open for multiple angles and voices, fantasy and creativity and, bridges the tension between the culturally dependent narrative resources and the sounding board of sensation. Memory provides awareness of distance in time, but retention is awareness in sensation of resonance ebbing away with time, Løgstrup claims (1978). Løgstrup (1956/2000, 1968/1994, 1978) has described phenomena like trust, vulnerability, hope, guilt, shame, compassion, mercy and open speech as sovereign life utterances. They are not qualities of the individuals, but unfold in the interdependent space between people. Acting behind our backs they make life easier. Supported by them we spontaneously become ourselves. However, human life can get trapped in self-orbiting cognitive emotions, circling around our own reactions in compulsive introvert thinking (Løgstrup 1968/1994: 102).

Now, returning to how we integrate NPMP theory and philosophical perspectives into the body problems described by Frank's (1995): control, other-relatedness, body-relatedness and desire. Rather than seeing them in continuums between polarities as he does, we emphasize the dynamic interdependence, in line with Løgstrup's unifying opposites (1983b). We follow Frank's notion of control in the polarities of contingence and predictability, but accentuate the role of muscular regulation of control in dynamic tension between posture and motion, attitude and emotion and norms and spontaneity. This muscular dynamic weaves into the regulation of awareness in sensation, and is thus related to predictability and contingency in relation to natural forces like gravity, as well as emotional regulation and sociocultural adaptation (Sviland et al. 2007, 2009). Other-relatedness will be explored in relation to having a sense of boundaries in tension between the untouchable zone and openness (Løgstrup 1983b). We see body- relatedness in relation to embodied awareness in sensation (Løgstrup 1983a, 1984), in the tension between the body as one's own (Ricoeur 1992) and the body as a thing, at a distance to and separated from the self (Øien et al. 2007; Steinsvik 2008). As suggested by Frank a body may lack or produce desire. However, equally important is the capacity to sense and act in attunement with desires, and to engage in life (Sviland et al. 2009).

How do time and memory affect these body problems of action? Løgstrup's distinction between memory and retention of resonance, and Ricoeur's memory in action may contribute to a deeper narrative understanding of what Braatøy called muscular deadlock. Muscular deadlock means that muscular tension arrests the motion of impressions and suppresses the memory of what once happened (Braatøy 1948/1952).

This study explores how patients' particular stories about going to NPMP tap into core narratives and some basic/ontological phenomena, and how experience from NPMP may weave into the plots of these patients' stories and identity. We are searching insight into narrative threads evoked by NPMP and woven into the web of life stories in these patients struggle to heal.

Method and methodology of focus group interviews

Focus groups are considered suitable for investigating common experiences and attitudes in a setting where several people interact, and the researcher decides the thematic focus of the discussion (Malterud 2012; Krueger and Casey 2000; Morgan 1997). Research material is developed from the combination of group interaction and thematic focus of research (Halkier 2010). It has lately been used to develop research material about patients' experiences of health care and physiotherapy (Dragesund and Råheim 2008; Larun and Malterud 2011; Steihaug et al. 2002; Sudman 2009).

The goals of the project must guide how to use focus groups (Malterud 2012). Experience from NPMP may be sensitive and thus be better suited for individual interviews, one might argue. Kitzinger (2006) however argues that groups may not always be inhibiting and inappropriate when researching sensitive themes. On the contrary, group dynamic may potentially facilitate openness and mutual support. This is supported by Madriz (2003), whose experience suggests that focus groups may empower people and enable them to speak and accentuate empathy.

We do not explore the private and intimate life stories, but rather how the therapy was experienced by patients; what narrative resources may have emerged, and how patients weave their treatment experience into their life story and narrative identity. When searching for what is at stake for patients in the process of NPMP, we saw focus groups as a context which could provide space for discussion among fellows, a stage for their agency, where shared experience could provide an evocative context for some themes to be revealed in their various shades. The agency, which focus groups tend to evoke, was anticipated as potentially stimulating to discussions with this purpose.

Recruiting participants to the focus groups

Patients receiving NPMP individually were invited to participate in focus group interviews to share their experiences. Seven experienced NPMP-therapists asked patients that they thought might be interested in participating. Three focus groups were held, two groups of six and one of five, i.e. seventeen participants, three men and fourteen women. Mean age was fifty-four, ranging from twenty-six to sixty-

nine. Ailments varied largely: burn-out, numbness, dizziness, post-traumatic stress disorder, muscular tension, breathing problems, depression, anxiety, general pain, chronic pain in shoulders, neck, back, arms or legs. Some problems were related to work or accidents. One possibly had a rheumatic disease, another struggled after cerebral stroke and cardiac insufficiency.

Performing the focus group interviews

First author acted as moderator, and last author as co-moderator. Each group was interviewed once, lasting for 2 h. Interview questions related to the participants' situation before they started NPMP, the first encounter and particular experiences during NPMP, and future prospects. They shared their experiences willingly, listened attentively to each other, gave supportive nods and comments, and answered follow-up questions asked by the moderator, and sometimes also by the co-moderator. The patients were encouraged to comment and ask each other questions, which they did. Mainly, however, they were telling their own story as a response to our questions. One person's story seemed to give cues to other participants to catch on to, a trajectory to return to their own story. Ricoeur (1984) refers to discourse when somebody is telling something to somebody about something in a given context. This research material emerged from people who had experienced NPMP, and who recounted this to other people with experience from the same treatment approach, and to two researchers with particular interest in NPMP. They were informed that the moderator was an experienced NPMP therapist, and that the co-moderator had personal experience with this treatment. The interviews were held in the evening, at the moderator's private clinic downtown. A colourful table was set up, with refreshments, in a spacious therapy room.

Constructing and analysing the material

The last author wrote field notes after each group discussion, and the first author transcribed the interviews verbatim. During the group interview and, in the discussion between the moderators immediately afterwards, common preliminary themes came to the surface within each group. Also the field notes and the transcription process supported this. While reading and rereading the whole material, these themes also emerged across groups. To better grasp how the informants made meaning of their NPMP experience, in a more coherent way, we felt that we needed to follow the storyline of each informant. For this purpose, the group material was deconstructed, and seventeen particular stories were reconstructed. This implied some narrative smoothening where comments and discussions within the discourse were integrated in the individual stories. Central themes were identified in each story during repeated reading, before searching for themes across the stories and groups. This analysis across the groups unfolded four common core themes. Hence, the analysis shifted between exploring individual stories, and common narrative themes. During analysis the emerging themes resonated with theoretical perspectives, which helped further identification and, gave them more comprehensive meaning. The whole transcript was reinvestigated to ensure that they really were core themes in all groups. For each core theme, one story was analyzed individually, and illustrated in this particular context. These four stories were picked to illustrate the width and variety among the informants' stories and, because they were particularly informative to the narrative themes common across group discussions.

Narrative themes

Common core narrative themes in the groups as a whole tied the individual stories together. The core themes are: Time and trust, embodied identity, speaking out, and the paradox of control. The four selected stories are chosen as the most powerful illustration of each of the core themes.

Time and trust: to be "the main character"

Time and trust were at the heart of the matter in all three groups. Fast recovery had failed and time had often caused stress in previous treatment experience. Always being in a hurry was associated with stress, disease and even accidents. They explained that they experienced time differently in NPMP, the feeling that there was time was essential. They learnt to allow time to breath and sense the moving body. One hour each session in NPMP was highly appreciated. To be told that treatment could take years had been relieving to many, but discouraging to some. Changing old patterns was difficult. It takes time, they said, to change what the body remembers. Also, after profound changes had taken place, to manage without support was experienced to take time.

It was underscored that trust implied feeling safe. This involved being understood, believed, respected as a whole person and cared for as who you were. To be listened to, on one's own terms and to have one's own focus and experience as the point of departure was emphasised.

Mona:	Mmm, Yes …. I said something about feeling safe
Co-moderator:	Yes, feeling safe, I thought that was kind of interesting.…

Kurt: Yes, feeling safe, this is about always knowing that when I come for treatment we concentrate on what has happened between the treatments. In that way I know that the treatment I get is based on my current situation, there and then, not where I was a month ago. The therapist always allowed the session to be my time and not the time of a pre-planned treatment

Amy: Mmm, mmm…They see you in a different way perhaps

Kurt: Yes, yes, yes …

Some underscored that learning how symptoms connected with life experience gave coherence and a sense of safety. Trust may be all-important if opening up is difficult. Talking about dramatic life experiences may aid getting a grip on oneself. Some felt trust immediately and confided about work, private life and illness experiences, others needed years before talking about conflicts and wounds. One described how the non-verbal, bodily teamwork between her and the therapist felt as a safe and meaningful way to explore her pain. Combined with being listened to, this gave her a breakthrough in the healing process. The participants trusted the therapist would be there for them as long as it was needed, although one felt she might have needed more time than she got.

Trust is a sovereign life utterance, a basic condition without which life becomes difficult (Løgstrup 1968/1994). This foundational meaning of trust was clearly stated: *"You can't have therapy without trust*." Trust and time were entwined in the participants' stories. Rita's story is about how much time she had required to restore trust, and the importance of being given the time it takes.

Rita's story: From chaos and turmoil to tranquillity and hopes for the future

Twenty six-year old Rita had attended NPMP for 5 years. She started by explaining that participation in a group interview would have been impossible until recently. "Half a year ago I would not have been able to formulate an understanding of myself. Words have just popped up the last couple of months," she explained. She expressed that she previously had no reflective grasp on her life. "I just walked in circles around myself and, didn't understand what was happening."

Her history has strong connotations to the Chaos story, which cannot be told in present time, only in retrospect (Frank 1995). Frank claims that a clear genesis keeps the body out of chaos. Rita seemed to lack genesis, coherence and recognition of how one thing may have led to another. She had struggled with asthma and allergies, which in retrospect she believed were symptoms manifesting her anxiety. Massive insecurity led to self-injuring behavior. She had been in and out of psychiatric wards. Psychotherapy "didn't work for me," she said. The situation she depicted showed little sense of narrative order. Typical of this non-plot, she had been unable to see how life could get better.

From her first encounter with NPMP she remembered sitting on the floor in a corner, in a fog of anxiety. This was new and very scary. Rita allowed no hand-touch for half a year, and refused to sit on a chair for a year. "I sat by the wall. It had to be hard behind my back; it had to be hard beneath me, because that felt safest." Contingent with chaotic anxiety rigid strategy appeared to create some predictability. In turbulent chaos, physical hardness may have helped Rita feel more interwoven with the physical world in sensation (Løgstrup 1984), providing some safety and a sense of anchorage.

The therapist allowed Rita the control necessary for her to feel safe. Rita expressed gratitude for the time she was granted: "It took time to move forward from prior abrasions." With a similar metaphor Frank explains that chaos stories are told on the edge of a wound and the edges of language. Rita was used to betrayal and it took time to trust her therapist "as somebody I could relate to, at least." When trust has been violated repeatedly it is difficult to relate to others (Løgstrup 1968/1994; Løgstrup 1956/2000). Rita had to learn what normally is taken for granted. The severity of this problem is evident in her persevering resistance to be touched, the inability to sit on a chair face to face with the therapist and, the time she needed to trust her. She explained that trusting her medical practitioner, who had recommended NPMP, made her endure the anxiety it provoked, even though the night before was always ruined, and she could never study the day she had treatment.

Lack of desire is associated with incapacity to receive comfort (Frank 1995). Illustrating this, Rita had declined her therapist when offering a rug on the floor she sat on. When asked if it was cold, Rita answered "YES, but I don't care." Her desire for change, however, drove her to go to this therapy that frightened her so much. She also strongly desired to accomplish her studies.

There was a subtle balance between Rita's acute need to be in control and to move forward at her own pace. "It has to go at such a slow pace because I have to feel safe," she said. The therapist tuned in with her, but if it had been all up to Rita, she would have gotten nowhere. She lacked initiative and had difficulty making choices. She explained: "I used to just shut up if I was unable to make a choice," demonstrating how the chaotic body has no voice (Frank 1995). "I have to be pushed," Rita insisted. Gradually, it had become easier for her to say that she was unable to decide, or: "No, I don't want to!" or "Stop it!" The therapist made Rita move forward, but not too fast or before she felt safe.

Rita told us she trained relaxation in NPMP, but little about how. Perhaps this reflects the state of chaos she had been in. The turning point in her story was the day she discovered tranquility. She had come in quite aggressive and wanted to run out again. While talking she had become able to settle down on a chair. Finally, she lay on the plinth. After some massage the therapist gave her 10 min to herself, as usual. Nothing important had been done or said. The feeling of tranquility was totally unanticipated, she said. For so long she had been training relaxation, and suddenly "it" was there. Just when she realized how good it felt, she was knocked out, sleeping like a log for 1 h.

Rita suffered from sleep deprivation. Rest, she explained, had meant being motionless, with turmoil inside. She was restless every waking hour, always spending energy, rarely regenerating any, and unable to imagine how to change. From the day tranquility was revealed to her, she trusted that this sensation could be revived, and used the coming nights. "I know it is there. I just have to find it," she had reassured herself. She developed routines which could bring the sensation back. Life became less gloomy. She could function with 4 h sleep since she could rest calmly the remaining night. With tranquility future prospects changed, "the future is not so dark," she said. "I got a new vision of how it could become, compared to what I had." This way out of turmoil made her prospects less hopeless. Learning about tranquility in theory had little impact on Rita. It wasn't until she had awareness in sensation (Løgstrup 1984) that tranquility became real for her. When this sensation stretched into her fictional space (Løgstrup 1978), a new narrative resource became available.

Rita's life had changed dramatically since she was in and out of the psychiatric wards. Treatment had been very demanding but equally rewarding. Without the struggles she would not have reached the boon. Transformation of attitude is typical of the Quest narrative where physical, emotional and social suffering eventually leads to a boon, which is usually about valuable insights, and change may involve a new self and new ways of thinking (Frank 1995). With prospects of a brighter future Rita was on the way to get a better life with herself, "hoping for a Rita that would be easier to live with."

In medical terms, Rita might be described as incompliant, a difficult patient. The story she shared in the group, however, depicted struggle and despair. To think of this in terms of a Chaos Narrative upholds the futile incapacity she had been in. Her recounted story also demonstrates how narrative episodes can emerge in a treatment situation (Mattingly 2000). For Rita this had the narrative power to shift the plot line in her story, counteracting chaos and initiating a quest for new possibilities. For this to happen, trust appeared as essential. Løgstrup pinpoints that trust is not a quality of a person, but rather a phenomenon foundational to life, acting behind our backs and in the space between us (Løgstrup 1968/1994). It took more than 4 years for Rita and the physiotherapist to create a space in which trust was allowed to support her so that she could let go, and allow the physical sensation of tranquility. She described this as something that came to her. Following Løgstrup, we are interwoven in the world in sensation, but this may be ligatured. Thinking with Løgstrup, Rita's story suggests that when trust was given space, relaxation allowed Rita to experience being interwoven in the world, in awareness in sensation. This is very different from her previous attempt to control panic and chaos by sitting on the hard floor up against the hard wall. Rita was able to allow this to stretch into her fictional space. With imagination she found ways to revive and to feel the resonance. The experience weaved into her story. Ricoeur underscores that earthbound anchorage is fundamental to identity (1992). This may indicate that the physical sensation of tranquility, with the weight of her body resting on the ground, could have given such anchorage for Rita's identity. It was the turning point where the teller's voice emerged, the beginning of a self-story where somebody is experiencing and discovering something. Rita's treatment story was not at the end. After 5 years she now felt excited, curious and ready for new experience.

Embodied narrative identity: finding one's own voice

Rudolf:	Feeling the sole of your feet and that you step on the ground is of major importance because they are connected to the whole of the body, which rests on them
Beth:	You are better grounded
Rudolf:	Yes, it influences so many things
Moderator:	So, when your contact with the soles of the feet and the ground is better, then what?
Rudolf:	We are talking about finding your own voice. To have good contact with my own body helps me, and the foot sole is essential, to get better contact with my own voice. What do I want now? What are my wishes? I simply know more about who I am

Generally, the group participants shared that they had discovered that body and emotions are inseparable and, that illness is situated in a context. One explained how relieved she was to feel body and mind connected, and that she had learnt to understand herself through her body. Instead of controlling her surroundings from "the head" she was present in situations by entering and sensing her body. To put her foot down and say "NO" had become a concrete possible muscular action. They seemed to find their own

voice by listening to their body. A key question was: "Who can tell us who we are if not the body?"

Transformation of narrative identity is possible through the variation of stories around the invariant corporal anchoring in the world (Ricoeur 1992). NPMP is a treatment of corporeal conditions with transformation of patterns of movement, posture and respiration. The body as one's own may be invariant as earthbound anchorage in life. How each individual body solves this will, however, vary and, may change, thus generating variation of stories that influence identity.

Joanna's story: Who am I? A seed is taking root and sprouting strength

Fifty seven-year-old Joanna described immense neck and back pain and, visual disturbances following a whiplash injury after a fall 5 years prior. After 2 years she had been unable to walk without crutches, living a very limited life. Walking made her worse. Joanna struggled to explain all the therapies she had been to, showing some chaos. The first encounter with NPMP was a turning point, although it was just an introduction. While waiting 2 years for individual NPMP, traditional physiotherapy combined with attending a group for NPMP exercises helped her get back on her feet. At the time of the interview she had attended individual NPMP for one and a half years.

Joanna had felt very insecure about pain. "Is it real, or not? How can we know that the pain is true? Do I exaggerate or not?" Because her uncertainty had been taken seriously at the first encounter Joanna had felt seen, understood and believed. Joanna had felt the connection between body, thoughts and events before and after the accident, and how "the body remembers". It was reassuring that somebody from the health service acknowledged this. For Joanna trust was all-important, and trust had come spontaneously in relation to her NPMP therapist.

Pain had changed Joanna's balance and posture; shoulders and chest pulled back, buttocks tucked in, and the back had been firmly straightened up. As NPMP helped her chest to get back into place and breathing became easier, exhaustion had overwhelmed her. She explained how amazingly tired she was from holding herself upright. Tension easily returned, so she kept reminding herself to let go, sink down and breathe. The massive tension and fatigue in her chest had gradually improved as well as her posture. At the time of the interview she felt less exhausted, but she still had to practice.

Joanna had become aware that her contact with her legs was poor. In NPMP she was asked: "How do you feel the ground? Where are your feet?" Joanna usually felt the floor, but little weight or contact in her feet. Perpetual focus taught Joanna to sense weight descending through her body. She explained how her legs felt heavy as lead at the end of the sessions. To go out, into the world, with this clear sensation was delightful. "I trample down the road with HEAVY FEET," she laughed. This feeling helped her in uncomfortable situations when she could think, "Ok, when you just get contact, Joanna, it will be all right." Joanna's therapy experience was of concrete use in her daily struggles. Her life had been difficult. "I have been very cognitively oriented," she said. She had experienced much confusion, which she now related to lack of contact or sense of her body. By feeling the weight of her legs, awareness of her feet and how they touched the ground, Joanna had discovered a new kind of balance by sensing the centre of gravity within herself. Joanna explicitly associated the reshaping of posture with a shift towards less cognitive and more embodied control and, more contingence with gravity. The body which had been a painful and troublesome "thing" became the source of her identity. Her body had found new physical possibilities of anchoring in the world.

She made it clear that these experiences were essential to the whole feeling of who she was. "Who am I? Who is Joanna? This is to do with my legs," she insisted. Joanna's descriptions of her tense posture suggested that her fictional space had been provided with little supporting sensation. Lack of contact may have been compensated for with cognition, but was associated with confusion, and muscular tension and inconspicuous sensation, rendered her in, what Løgstrup (1968/1994) calls, self-orbiting cognitive emotions. As tension subsided, movement of breath, contingency with gravity and awareness in sensation emerged; pivotal to change, but trust was paramount for this to happen.

During NPMP Joanna had sensed something black and hard like ebony inside, a kind of seed. It was embarrassing and shouldn't be there. One day this black substance descended down her feet into the earth, and transformed into power. "Suddenly my strength became grounded, and activated", she said. This vivid metaphor helped Joanna recognize her strength. She had a mind for metaphors, and explained how they usually emerged first as concrete sensation within her body before they became abstract visual images. Describing them made them clearer. In conversation with her therapist the metaphors were contextualized and became meaningful to her. The seed had been very clear, but it was when she discovered how it was connected to her legs that it gave meaning to the deeply felt sensation of strength growing within her.

Joanna's revelation of supporting strength from the rooted ebony seed illustrates how clarification of sensation aided by language may stretch into the fictional space. Anchoring sensations emerged from changes in muscular patterns allowing contingence with gravity. With narrative

imagination this sensation fostered new understanding. This illustrates how sensation and understanding are inseparably linked, yet different, as pointed out by Løgstrup (1983a, 1984, 1987/1993). The power of a rooted seed may be a standard saying and, what Ricoeur might call a "dead metaphor" (Rendtorff 2000; Kristensson and Kemp 1992). For Joanna this metaphor is imbued with experience in sensation, making it vivid and potent. It may not be an innovation in commonsense language, yet it may be innovative in Joanna's particular language as expression of her particular experiences.

The new experience of power helped Joanna to stay upright in a very difficult situation. She shared with the interview group what happened 1 day when she met somebody who used to control and dominate her. With her strength grounded through her feet she had stood firm as a pole, with both sorrow and joy. "I was able to take care of myself," she explained. To her, being able to stand up for herself was a serious matter, and very gratifying. She had trusted her own judgments, and felt safe within, thinking "I know what is me, and I know what is you, and I know that this is not mine."

With the rooted seed and growing inner strength Joanna's experience of what she was had changed. This supported her actions and had an effect on the plot of her story. She did not allow the dominating person to dominate her any longer, she acted in a new way. Ricoeur (1992) has underscored that who we are (selfhood) needs support by what we are (sameness). With the changes in muscular patterns and sensation, Joanna's body appeared as more supportive of whom she was as an acting and narrating person. When boundaries are violated the dynamic relation between openness and respect for what is untouchable may be distraught (Løgstrup 1983b). When grounded in her body, Joanna appeared to be able to clarify her boundaries and to hold her own against invasion of her private zone, indicating that body-relatedness and other-relatedness interrelate. She did not lose herself in relation to other persons. On the contrary, contingency with gravity in interwoven sensation seemed to counterbalance her timid boundaries. Grounded in herself she appeared less vulnerable.

Improved body contact had made a significant difference. Joanna claimed she felt more in place, and better about herself. She enjoyed being stronger as a person, but she admitted that she still had a long way to go, since serious neck pain still worried her. Rather than trying to lift herself out of her body to avoid the pain, she now searched for a best possible life. "I play on the same team as my body. My body wants to be with me, and I want to be and abide by it," she said. Her illness story was not at an end, but despite pain, her body now generated more desire and strength to act in tune with herself. Future prospects were uncertain, but she expressed the journey to be meaningful to her.

If repairing Joanna's neck was the sole goal, NPMP treatment had failed. To think of Joanna's experience with NPMP in terms of a journey of transformation or a quest helps us recognize what she seems to have appreciated so much. Løgstrup lays out (1976, 1978) how sensation, clarification and understanding interrelate, which illuminates how Joanna's imagination helped clarification of embodied sensation, aided by words while sharing this with the physiotherapist. By meaningful interpretations created in this relationship, new understanding could grow. When Joanna linked this to who she was, Ricoeur's (1992) notion of identity helps us elaborate on this. Confronted with the dominating person from her past, her embodied sensation of anchorage supported her action, story and capacity to hold her own. Ricoeur would relate this to selfhood, one of the two poles of identity.

To speak out

To all participants but one, the therapeutic dialogue was considered essential. They expressed deep gratitude for being allowed to speak from their own point of departure and respectfully listened to.

Nora:	She didn't stop me, so that I could be listened to on my issues, sometimes it could last for 20–30 min. There was little time for the massage (laughing a little). But … now, after one and a half year I don't feel the need so much. Things are easier, there are less dark thoughts
Elisabeth:	I feel she (the NPMP therapist) responded to my body. I didn't have much contact with my body. When I spoke, she saw where I was, from seeing my body. She took the body as point of departure, so this was where we started
Amy:	And also when you talk… when I told about pain and dizziness, it was confirmed and explained, kind of normalized. Often, I had been told to clench my teeth and get on with life. I had become insecure about what I felt. Did I imagine it all? It was good not having to pretend that you are stronger than you actually are
Co-moderator:	And also that it is reasonable to react, if I understood what you meant?
Amy:	Mmmm, mmm, yes. It was normalized somehow, and accepted, mmm

Participants explained that the dialogue assisted reflections on how body and emotions connect. It helped clarify

experiences, and understand and explain how ailments had developed. One informant experienced the attitude of his therapist who seemed to think: "How can I speak with you in order to loosen up the tension in the neck?" Braatøy (1948/1952, 1947/1979) underscored how a therapist has to respectfully listen and follow the patient's individual language, but why is this so important? If speech is tuned expressions of impressions we are moved by, and if to speak out is spontaneous life utterance, as claimed by Løgstrup (1976, 1978/1994), to prevent tuned expression requires muscular counteraction of the motions of these impressions. Thus muscular conflicts may express inhibition of open speech, and consequently conceal experience, which may be important to understand one's self and the world (Sviland et al. 2010). If the patients' voices emerge from body and mind entwined, Mary's particular contribution may illuminate the intertwining of muscular tension and the sovereign life utterances of open speech and trust that appears to be central to the plot of her story.

Mary's story: To get an untold story off the chest

Mary, 57-year-old, had a long illness story with recurrent problems, and frequent physiotherapy for many different kinds of ailments, persistent pain in shoulders and arms combined with breathing difficulties in particular. Restitution failed after a shoulder operation, and her physiotherapist recommended NPMP. After half a year of persuasion she reluctantly surrendered. She was angry with the physiotherapist, thinking: "Why couldn't she just help me with the pain instead of going on about all these other things?" She went to her first appointment, introverted and with aching stomach. However, she had felt sufficiently safe with the NPMP therapist to sleep well the following night, and to go back for the next appointment.

At that time, 4 years ago, she had been on sick leave and was at a dead-end, struggling to get back to work, wishing for a new job. Life had changed profoundly with NPMP. Support from her therapist enabled her to retrain through further education and she began to work full time in a new profession. It started with a sense of coming down to earth as a kind of contact with the ground and with her breathing. Mary's shoulders and arms became better after the therapist had worked a lot with them. She had longed to do physical exercise, but the local studio had steps, which she was physically unable to climb. Somehow the simple exercises they worked with in NPMP relieved the tension in her chest and gave back her breath, and with this a sense of security and faith in herself. Mary started training and lost a lot of weight. Her dream had long been to cycle a cross-country mountain-race. She had always liked cycling, but could not imagine herself fulfilling this dream. Her capacity to follow her desire grew with training and the freedom to breath. It was the greatest happiness ever to master what had seemed impossible, and now Mary had done the race twice.

The journey of transformation is a dramatic genre where the canonised medical genres are reduced to subplots (Mattingly 2010). Mary described a successful repair-story where pain and constricted breath was relieved. Despite this restitution, it is not so much the cure she pays tribute to, but the transformation of herself. Her story illustrates how vocational and personal changes are enactments of quest stories (Frank 1995). Mary's body had produced desire, but lacked capacity to follow and fulfill them. As long as tension constricted her breath her dream had been illusory. The capacity to do what she desired is closely linked to her physical capacity, but also to the sense of herself.

Mary explained that the sense of security she felt with her NPMP therapist affected everything. She became more secure about herself and her surroundings. She also started to understand past events differently. Early life experiences, which she had never talked about before, became clearer. What had happened grew strong, much stronger than before. Suddenly she knew she had to talk about it, after 2 years in NPMP. She couldn't see how, but she prepared her therapist that there was something she wanted to talk about, thus creating pressure to move forward on this. When the therapist grasped the opportunity of the moment Mary resisted. There wasn't enough time. However the therapist insisted that if Mary was able to start they could do it now. They had talked for quite a while. What they actually had talked about, however, was not shared in the focus group.

Just listening without judgment can be the greatest thing you can give somebody. Frank explains his longing for somebody to empathically audit his story "in order to make my suffering a relationship between us, instead of an iron cage around me" (Frank 1998: 198). Mary had kept her story within a rigid zone of untouchability (Løgstrup 1983b). Her history of muscular tension, her "iron cage", may be understood as her effort to keep strong impressions from being expressed. Devoid of the clarifying aid by language and sharing, the muscular action of holding back, in order not to tell her story, may have hampered her understanding of what had happened. With subsiding muscular tension, improved freedom of movement and breath, memories emerged with a growing need to get it off her chest. This illustrates how muscular tension may keep impressions at bay from awareness in understanding, and prevent the resonance of impressions from ebbing (Sviland et al. 2012). Tension had caused recurrent musculoskeletal pain, and what once happened had prevented her from following her desires and interfered with her future perspectives.

A sense of value and self-respect grew within Mary. She claimed this had helped her to talk about the difficult experiences. Telling had made her realize that what once

happened was not about her, which she had always thought. To understand and feel this was unbelievably good and made Mary trust herself. She could stand up for herself and do what she had wanted for so long.

Mary's story shows how dramatic experiences embedded in muscular tension may be. They may not only mask the importance of an episode, but also structure the causality of its intrinsic meaning. With higher degree of freedom of movement and respiration, tuned sensation is less inhibited from stretching into her fictional space. Telling the untold story appeared to be a turning point in her plot, and essential if tension in her arms and chest were not to reoccur.

Thinking with Løgstrup's notion of open speech as life utterance (Løgstrup 1968/1994) and Ricoeur's notion of memory in action, and combining this with Braatøy's concept of muscular deadlock, Mary's tension emerges as posture holding back repetitive motions of past impressions, preventing open speech. Reducing the postural function of arresting motions of past impressions, this inhibition will subside. Thus Mary was moved towards expressing herself. Løgstrup's clarifies the difference between remembering something with or without awareness of distance in time. For Mary, as muscular tension subsided resonance of the past kept increasing. By telling the story this resonance seemed to decrease. With awareness of distance in time she may have become able to see what had happened in a new light. It had happened to her, but not because of her. Her understanding of past experience, her identity and her story was thus recast; narrative causality changed. Future perspectives had also changed with a new job and regular physical activity. Telling stories may be a way to repair what has been wrecked, "redrawing maps and finding new destinations" (Frank 1995: 53). In Mary's story embodied changes were combined with telling the untold. This illustrates the interdependence between muscular tension and open speech, and why listening is so important.

The paradox of control

Amy: Yes, I felt that when I started to learn techniques to cope with these problems, it was very liberating because I felt I could start to take back the control over my body. It was so good to begin to feel that when I get into this [dizziness] I knew that if only I could calm down a little and put my feet firmly on the ground and do these breathing techniques, I would be able to get myself out of it, without falling to the ground. It was such a relief to feel that you could take back this control

Moderator: To take control… It is not about letting go of control? It is to take control?

Amy: Yes… I… yes, take control over the body. Eh, but you do let go in a way. Actually, it is a bit like…
It is these techniques, breathing and all that stuff…hmm…. But to let go… You asked about letting go, but that is a part of it. To take control is that you learn to let go perhaps…

Moderator: This is a kind of paradox, is it?

Amy: Yes it is. I heard that, when you said it

Moderator: To let go is to take control?

Nora: That was a good question

Amy: Yes it was. I felt that I…, but this is really the way it is

Nora: Yes

Moderator: Do you wish to expand on that?

Nora: Yes, what you asked, when she said "to take control". I thought it was very relevant. This question is very intriguing, because we have mentioned to shake loose, to release, to let go of control (laughs)

To move and to be moved are diverse aspects of human motion. This distinction is essential to NPMP in relation to how respiration, posture and movements are understood, and relevant to the intriguing paradox of control. Breathing is both automatic and voluntary muscular action, and muscular tension is considered potentially constrictive to this movement. Emancipation of respiration means to allow automatic breathing to move the body rather than to perform breathing movements actively. The pull of gravity will provide support to a well-balanced body and assist movements. Tension in less balanced bodies continuously counteracts the pull of gravity to prevent the body from falling, at the same time offering continual resistance to all movements, much like riding a bicycle with the brakes on. Human movements exist in dynamic interdependent interaction, where the prediction of active motion is carefully tuned in contingency with the properties of nature. Amy suggested, replying to moderators question that better control is related to letting go of control, but is somehow puzzled by this. John's story may contribute to more insight into this paradox.

John's story: From discipline to a sensing, moving and breathing body

John, 33 years old, had a history of high performance competitive sports. Pain had been seen as an excuse for laziness. At 17 his fingers were aching intensely. When medication for rheumatoid arthritis had no effect, John had

decided to ignore the pain and increase activity. Sports involved body exposure and John had shaped himself to the image of a top athletic body; straight back, belly inn, shoulder low. His coach focused on preventing postural deformities so John overcompensated to conceal this. He had learnt to live with muscle cramps, tension, pain and headaches. Regular sleep with pillows under his knees to prevent cramps, much liquid and carefully graded activity was necessary to uphold a high intensity job with little time off. Tension and pain had reached a climax two years ago. Bechterew's disease had been ruled out, and he was referred to NPMP 1 year ago.

There are no signs of chaos in John's story, only discipline. His body-relatedness features extreme cognitive control, in relation to moving, performing and controlling pain. None the less, at a certain point this kind of control collapsed. Similar to the other stories, coming to NPMP was a turning point, John said. He had been to doctors, acupuncturists, chiropractors, physiotherapists and a psychologist. The NPMP therapist immediately informed him that therapy would take time: "I will be there, with you, for years, until it works, if you want to." This was a major experience; somebody was prepared to invest in him. "Ok, I'll just sit here then," he had sighed with relief.

To John, conversation and trust was not important. He trusted people, and moved on if disappointed. If you don't expect anything you can't get disappointed, he explained. If therapy worked he would continue, if not he would quit. His muscles were tense, and "what I needed was to learn to feel myself," he announced. Perhaps John's clear boundaries demonstrated what Løgstrup (1956/2000, 1968/1994) underscores, trust is foundational and given with life, and distrust emerges from violation of trust. Equally foundational, however, are interdependence and vulnerability. His experience with so many therapists and no restitution, suggests that he was prepared for disappointments. His independent attitude may demonstrate an adaptation to the prevailing medical culture. Although trust was not an issue, he clearly appreciated the investment the therapist was prepared to make. As we shall see, in his story, the meaning of trust is more related to his own body, "to feel myself", than to other people.

John explained how he, through NPMP, developed muscular contact and relaxation as ways to meet his pain. Massage gave contact with areas of his body he had never felt before, and he had rebuilt his posture from the bottom up. This allowed energy to float freely all the way up and down, he said. What the therapist did, he used as tools for self-care. John acquired presence within his own body. He demonstrated this during the group interview by asking to change his chair. He explained how sensation made him aware of how the chair forced him into a painful posture, tension built up and respiration was inhibited. For John, what happened during the NPMP sessions was not the main treatment. He emphasised how life outside was the real treatment, where new revelations frequently showed him how he could change what otherwise might have led to headaches for days.

Initially John had been at a loss when encouraged to sense the ground. Having hardly touched the chair, he now discovered how all his weight could be fully supported while sitting, but also while standing and lying. John had been lifting himself up from a fixated pelvis with tension building up from rectal constriction, pulling up the tailbone, pushing his tense spine upwards, turning him into a tight knot. This sign of stress now prompted him to relax. He now knew that, when discomfort builds up breathing is inhibited. Sensing this had become a sign and a tool for changing what happened in the body. John was amazed to feel the concrete experience of his body as a space for himself. He no longer needed to think so much about this. It had become more subconscious, he said.

Sensation in a physiological meaning refers to the individual body. From a phenomenological angle Løgstrup (1983a, 1984) explains how we have access to the world in awareness in sensation, prior to reflection. In sensation John had discovered gravity and respiration as essential "tools" for his transformation. His body control had shifted towards more contingence with gravity and respiration, sensing himself in the environment. Following Løgstrup, John's body experience became more interwoven with the world in sensation. With Ricoeur, John's body as his own became anchored and earthbound. His story illustrates the paradox of control, to let go of control is to gain control.

John had lost 12 kilos since he started NPMP, without being on a diet. With postural change he let his belly out and regained sensation of hunger-fullness. He had lost this sensation during high school, due to extreme training combined with lovesickness. Great weight loss turned into consistent hunger and eating. He stopped training, but hid all the kilos he put on by pulling his stomach in. He ate according to the clock. The first time he felt hunger and fullness again, he had been amazed. "I didn't think about it. I was not conscious of it. It popped up… one day. I just suddenly felt hungry," he said. Gradually he had started to trust the sensation of hunger.

In NPMP, John was initially told to avoid physical training, and after 4 months he had been surprised to find that his fitness had improved. John had discovered that there are several ways of living as a body. As athlete the body had been a tool for achievement. "A poor posture and an untrained body are unnecessary, it is just to create a good posture and to train," he had thought. The catch of letting ideal images decide, however, is a body screaming with pain, he explained. He used to control his body by being very aware and directing the positions of all body

parts. Now he allowed body sensation to come to him in a more receptive way. It was less about performing and achieving, more about supporting life. His body had become a "tool" for living his life, rather than a reflection of the images imposed upon him. John compares this ideal with models walking on The Cat Walk. "Being a body is being oneself," John insisted. He will not accept criticism for being his body, the way he is. "People will have to take me, my body and me, or the body as it is."

According to Løgstrup, it is beyond human control that life is charged by tuned sensation. It may be energizing, but life may also be cruel and devastating. To become oneself, we are also always confronted with the existential necessity of finding our bearings in body and language (1987/1993, 1983a, 1984). John had made his body fit into ideal images. With disciplined control his fictional space seemed to have been his locus of control and, prediction was exercised through manipulation of the body as an object according to ideal images of the body in our culture. This strategy appears to have been challenged by lost love. Tuned in sensation by the loss, John's body was a space for suffering and at the same time an object for disciplined control and performance. This indicates a body charged with conflicting purposes. His rigid posture, shaped by competitive attitude and norms, may not have had capacity to support his spontaneous motions of emotions. The resulting muscular deadlock (Braatøy 1948/1952), numbing his sensation of emotions, desires and sorrows, may have reduced threats to his cognitive strategy of control.

With increasing contingency with gravity and respiration, a new kind of control emerged, offering support with less muscular effort and more relaxation. Shifting from manipulation of his body towards sensation, the body became space for life with desires and freedom, with a breathing sensing body to guide his life in a very concrete way. The relation between sensation and cognitive manipulation was reversed. As postural tension subsided, awareness in sensation, feeding awareness in understanding, assisted his transformation process. John's bearings changed from self-controlled performance to accepting his body as it is, allowing him to come to himself in sensation, bearings and understanding, the core of human existence (Løgstrup 1987/1993).

There is restitution in John's story, but not cure in a medical sense. Although much reduced, there was still pain. John was optimistic about the future, and he said he felt much better equipped for life. His NPMP experience has more connotations to a journey of transformation than medical genres like repair. John related changes to what his body was to him, the essence being more in touch with his body by allowing his body to be as it is. With a twitch of irony he said "I may consider changing personality if it is too imposing, but I will never let other people have any say about my body."

Methodological considerations

The method of recruiting participant to this study favours stories of success, a limitation which must be taken into account. The discourse within each focus group was not the main focus of the analysis, but an implicit part of it. Our research interest was related to common core themes and how individual patients weave experience into meaningful coherence. Although participants came to the groups with precontemplated stories, what they told, what was left out and the way they shared their stories was shaped by our questions and the dynamic within each focus group. Neither Ricoeur nor Løgstrup writes about clinical practices. Bearing this in mind, philosophy may offer possible ways of thinking, which can illuminate foundational phenomena in life, cardinal also to clinical practice, here physiotherapy. To think with philosophy in the field of NPMP implies thinking in analogies.

Final reflections

In this analysis, NPMP experiences appear with transformation as core issue, rather than cure or repair. Along with changing muscular patterns, meaning emerge from experience in sensations, actions, expressions and reflections, where past, present and possible future enter the stage of the therapeutic space. Acquiring a sense of mineness of the body comes forth as central in this transformation, which seems to involve the participants' sense of identity, as Ricoeur also points out. However, when John, for example, embraced the body as his own, this could be interpreted as if he was differentiating between his body and his personality. When Ricoeur (1992) describes two poles of identity as *sameness* and *selfhood*, he insists that identity is both related to permanence and transformation. The narrating and acting person refers to *selfhood*, and may correspond with what John refers to as personality. As Mary's story illustrated, with a growing freedom of breath a compelling need for her experiences to be told and attentively listened to, grew within her. Joanna demonstrated how embodied changes may support new types of actions. The vantage point of Ricoeur is that both *selfhood* and *sameness* are embodied, and it will not suffice to consider *sameness* as the body. What bodily experiences provides a sense of sameness, which can support selfhood, is perhaps more adequate to consider.

If chaos is dominating, as Rita's story suggested, time and trust can be kernel for change to occur. One story, however, resembled repair and cure. This participant claimed that her physiotherapist's capacity to nurture the hope that she had lost sight of was cardinal for this to come through. The possibility of repair should not be disregarded, but in this

study it emerged more frequently as subplots in the larger stories. Narrative genres like Journey of Transformation or Quest narratives can help traject processes over time, where ailments are not dissected from life itself.

We suggest that, the notion of narrative identity is concurrent with the comprehensive changes, which may take place during NPMP. However, the earthbound embodied dimensions need to be expanded by experiences from and in theory of NPMP, which has been the intention of this article. We believe additional investigations of patients' experiences in NPMP, can contribute to further development of the theoretical underpinning of NPMP and, provide valuable perspectives to the treatment of long-lasting muscular tension ailments.

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