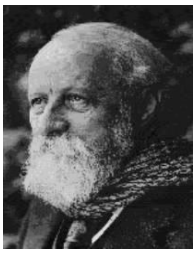
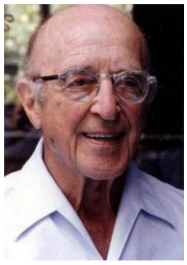
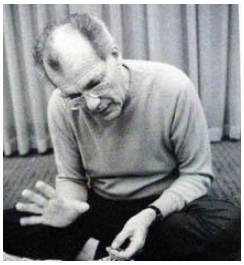
Client's Role: Cornerstones of Therapeutic Relationships



Buber: In the 1920s during the rise of psychotherapy as a profession, Martin Buber, world renowned anthropologist and philosopher, challenged the fledgling profession in three ways: A missguided emphasis on the past as creating the present; the objectification and labeling of the client's condition; and overlooking the relationship between the client and practitioner which he said is the main factor in all therapeutic work. I would add a fourth challenge: Only the client knows what is happening inside.



Rogers: In the 1950s psychologist Carl Rogers started a revolution in his profession by deciding that the true focus of therapy should be the client's experience rather than the practitioner's expertise or special technique. The client lives in that body and is an "expert" on her/his own experience. The practitioner's role then changes from expert fixer to accompanist who facilitates clients' exploration of their own therapeutic process.



Hanna: In the 1970s Thomas Hanna, philosopher, educator and later Feldenkrais protégé, argued for a "team" approach to body-centered therapies. It is a combination of the training expertise of the practitioner with the body-centered expertise of the client. He proposed that the client's first person experiences of his/her body is a key ingredient in the therapy process. That ingredient, he called somatic awareness, had been overlooked by almost all of the caregiving professions from medicine to psychology.

Gendlin: In the 1980s Eugene Gendlin, philosopher and protégé of Carl Rogers, published a series of books and articles based on a therapeutic approach he called Focusing. What he had discovered was that the practitioner could use certain verbal cues to guide the client into his/her bodily feeling state. The client could then explore that state which Gendlin called "felt sense," in a way that bypasses the preconditioned responses of the thinking mind. So the client could be supported to continually report what he/she is feeling and enter a therapeutic stage called a "felt shift." This felt shift produces changes in the client's body as well as mental and emotional state.

Shared Experience: In the 1990s new forms of therapeutic approaches started to develop independently of one another in which the emphasis of the therapeutic process is a state of present moment awareness in both the client and practitioner. No one yet has fully articulated this phase of therapy fully. This new layer of therapeutic approaches combines practitioner touch with

client sensory awareness. The client is feeling what is happening *now* in the body part the practitioner is working with. Both can feel and verbally articulate what is happening in that part of the body.

Each party is feeling into the same area, one from within and one from without. What seems to be take place is an active creation of a therapeutic *felt shift* that is experienced directly in both persons. Since the sensations of the shift only occur in the present moment there is a "bond of presence" that begins to form and then evolve during the therapy session. This bond of presence involves the active participation of both persons. It doesn't matter so much whether the mutual concentration is on a hypertonic muscle, some portion of the facia, a trigger point, a positional release placement, an acupuncture meridian, or a somato-emotional cyst.

Therapeutic Partnership: What seems to be taking place in all caregiving professions is more and more emphasis on the client's experiencing and the therapeutic relationship that grows out of mutual interaction between client and practitioner. In the past most caregiving professions have focused upon symptomatic relief. The outcome from this emphasis has been "fixing" or subdoing the symptoms. So the emphasis of most training has been developing expertise within the practitioner that can produce "results" in spite of the state of mind and emotions in the client. So drugs, "therapeutic interventions," protocols, monitors, diagnostic and life support machines, lab reports, diagnostic manuals, stimulating or de-stimulating devices… all have reduced the importance of the first person experiences of the body resident. Now we are coming back to a therapeutic partnership in which both persons blend their expertise within a sharing of presence. Perhaps this change of emphasis will produce a paradigm shift in the field of bodywork and other manual therapies.

Looking Deeper: Future articles in this series will explore: the role of the client in understanding the therapeutic relationship; misunderstandings of client practitioner communication that exist now; challenging assumptions of boundaries, ethics, scope of practice, transference that exist now; exploration of body-centered, client-centered therapies that exist now; educational development that includes college level classes in other caregiving approaches; existing paradoxes that exist about the client's role pointing towards a new paradigm in manual therapies; fixing vs mutual discovery and mutual expertise; what do clients think and feel while receiving; ways that we have shortened or reduced clients' involvement in their sessions.