



Sensomotorische Körpertherapie
nach Dr. Pohl®

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The application of Body Therapy in cases of Hypogastric and Pelvic Malfunction

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Theoretical basis

I am neither a gynaecologist nor a urologist, but a psychotherapist. What I would like to portray today, however, is a theory and the resulting therapy which encompass aspects of several of the normally distinct fields of conventional medicine. This concept will presumably be as alien to you now as it was to me at the beginning; it is a different perspective of the human being. In short, I would like to demonstrate today that, in the case of diverse pelvic and hypogastric complaints, the problem lies in the malfunction of this part of the body itself - to be precise, the motional impairment. One experiences pain, tension and other unpleasant physical sensations at those points where muscles are no longer able to move, due to their being held, albeit unconsciously, in a state of permanent contraction. These contractions function parallel to certain patterns in the central nervous system (CNS) and can result in unpleasant psychic sensations, for instance, when they are concentrated at the front of the lower abdomen. This is most effectively treated by loosening the muscles in question and helping them to move again in the natural way, thus allowing the CNS to assimilate the relevant new patterns, eventually

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banishing the discomfort. Later, I will explain exactly how this can be achieved, with reference to a concrete example.

First of all, however, I would like to explain the theoretical foundations. As enlightened, up-to-date individuals, we all believe that hypogastric and pelvic complaints result from psychosomatic processes. Moreover, we generally subscribe to the belief in a one-sided causal model: it is assumed that mental problems and anxieties, or more deeply repressed emotional impulses, are directly responsible for physical malfunction, or that these ailments serve to give expression to the fundamental psychic problem. In terms of effective therapy, this supposition suggests that one need only influence the emotional reflexes of the afflicted for the good (or eliminate them altogether) and the physical reaction will disappear of its own accord.

In my work as psychologist and psychoanalyst, I was, for a long time, convinced by this theory. I can, however, no longer advocate this standpoint. Today, I am of the opinion that the following psychosomatic model, put forward by Moshé Feldenkrais, not only corresponds to the reality, but is also more practical for therapy. Every state in which a human being finds himself during his life comprises the following four dimensions: feeling, thought, perception and movement. These dimensions are four distinct aspects of the same thing - similar to the observation of the various sides of a die: the one aspect does not give rise to the other; they are rather consistent parts of a whole.

One such state, that of depression, makes itself apparent in all four dimensions: feeling, thought, perception and movement are all depressive. You are all familiar with the reduced freedom of movement and general "slowing down" of both the mimic and the motoricity of patients suffering from depression. The same phenomenon applies to the states, or better described, the processes, of both "fear" and "joy". In each case, all four levels of our being are affected. In the comparison of fear and joy, not only are one's feeling and thinking

significantly different, but also perception and movement. Generally speaking, we are prone to relax our musculature when experiencing positive feelings, while tensing up and holding that muscular tension when experiencing negative feelings, particularly when we are not in the process of expressing any reaction or emotion physically. The physical phenomena are, therefore, neither the result of, symptom, nor somatisation of the psychic condition, but rather themselves constituent elements of the complete state, without which it would not exist.

The workings of our muscles and nerves are connected to our feeling and thinking in two ways, as are our perception and movement: if a stimulus from the outside world, or a conception from our being itself, is classified as threatening, our muscular system, reacting to impulses from the CNS and the efferent nerves, tenses up. This state of contraction, firstly, influences the breathing (and thereby numerous chemical processes in the body) and, secondly, is transmitted via the afferent nerves to the brain in the form of mental feelings, in other words, a frame of mind. This concurs with the theory put forward by the neurologist Antonio Damasio, that the brain "scans" the body. Everything that it registers is then experienced in the form of feelings or "mood". It follows, that without motoricity and physical feeling, which are indeed spatially in the entire CNS closely linked, there can be no emotional stirring. Since mental feelings are physical processes, we can even determine and indicate where in the body we perceive them. For example, if you close your eyes and imagine a situation which, for you, triggers feelings of fear (for instance, on the motorway, a car races towards you head-on) and then try to feel inside your body and sense exactly **where** you feel the fear, most of you will probably be aware of a spot on the front-side of the torso. Fear and anxiety are perceived in the chest, the abdomen and the neck; this applies also to depression. Anger, on the other hand, leads us to activate the extensor muscles - predominantly the rear side of the body. No one experiences anxiety in their back, their elbow or their big toe.

Similarly, undesirable physical habits (job-induced bad posture, for example) can

have an adverse effect on the mental well-being, as well as resulting in pain. One consistently required to lean forward, for instance, would stand an increased chance of becoming depressive, not to mention the resulting abdominal and pelvic complaints. This consequence of posture on the emotional condition has been clinically proved (Döring-Seipel 1996)

In terms of therapy, the indivisibility of body and soul implies that we can work on just one of the four aspects (feeling, thought, perception or movement) and achieve a change in the state of health as a whole. Traditionally, we are accustomed to striving for an improvement in the elements of feeling and thought, thus inducing the regeneration of the physical processes quite automatically. It is, however, possible to influence the psychosomatic from the physical side; motoric and sensory elements are brought into order, thus altering feeling and thinking.

In the practice of this approach, the sought after improvements have proved to be significantly simpler and quicker to achieve, since perception and movement are more easily accessible than feeling and thought.

This is the foundation of my work today and my therapy has indeed become considerably more effective, as well as swifter in achieving the desired effects.

The physical processes involved in hypogastric and pelvic malfunction

In order to understand the physical side of the psychosomatic processes, one must first have a thorough grasp of the physics of this region of the body. Vague concepts, such as transformation, resomatisation, biphasic suppression and the like are not sufficient, since, from these, no reliable principles can be drawn. For this reason, I would, first of all, like to explain the physical processes involved in hypogastric and pelvic malfunction.

When under threat or under stress, in fact, in the case of all negative stimuli, the organism usually responds with a withdrawal reaction. If this occurs suddenly, it is

clearly recognisable as a startle reflex. The whole body draws itself together to the front, all flexor muscles contracting in the process. Feldenkrais described this action the "body's scheme for fear or of passive self-defence". Thomas Hanna named it the "Red light reflex" or the "Withdrawal reaction". This reflex is even evident in newborn babies when allowing them to fall. From the phylogenetic viewpoint, this is probably a primitive reaction to protect the inner organs, as can be observed by snails, when one touches the tentacles. In the case of human beings, the contraction applies principally to the following muscle groups: rectus abdominis, chest, intercostal, the diaphragm, throat and neck, the iliopsoas and the thigh adductors. This sudden drawing together of the muscles is steered unconsciously.

The negative stimuli capable of triggering this reaction include not only those designated as psychic, for instance the loss of a partner or chronic stress, but also those generally seen as physical, such as the cold or surgery, as well as those which threaten both the physical and emotional integrity, for example incest or sexual assault.

The contraction of the chest and abdominal muscles results, unavoidably, in impairment to the breathing; in this state, the lungs cannot extend down into the abdomen. If the rectus abdominis is too rigid, the diaphragm cannot extend downwards, preventing any movement of the pelvic floor and the passive movement of the inner organs. The entire abdomen stiffens up and the organs of the small pelvis are shifted out of position (Schmitt, 1969).

This impairment to the respiratory system has two possible consequences. Firstly, the volume of air inhaled is reduced, leading to a shortage of oxygen. The resulting lack of energy is often accompanied by feelings of depression. Secondly, the body overcompensates by breathing only into the top of the lungs, and too quickly. This can lead to hyperventilation and the associated vasomotoric problems: moist or shaky hands, dryness of the mouth, dizziness, shortness of breath, a racing pulse, the urge to pass water, etc. On the psychic side, one experiences feelings of fear

and nervousity.

All such processes, whether they lead to depression or to anxiety, occur against our own will, since they originate from relatively old, deeper reaches of the brain, to which our conscious control has no access. For this reason, one is also likely to experience feelings of faintness and helplessness. Emphatic movement in particular, but also habitual and reflex movement of the skeletal musculature does not arise from the neocortex, the source of arbitrary movement, but from deeper sections of the brain.

The repetition of such contractions leads to the gradual emergence of chronic tension of the front of the body, which manifests itself as a forward-leaning posture, prone to intensification in particular situations.

When the abdomen finds itself in this state, it is likely to respond with muscle cramps, as well as other muscular complaints, such as an irritable bladder, urine retention, abdominal cramps and restricted mobility. The inner organs are also likely to malfunction.

Humans with such a problem are often found to be suffering from a number of psychosomatic complaints, including feelings of oppression, stitch, chronic tiredness, gastritis and intestinal trouble. One is also likely to suffer from pain in the head, neck and upper back, since the head can, in this posture, no longer be supported by the spine. Instead, the muscles of the back and neck must be held permanently tense.

In some cases, this physical state can result in paradoxical respiration. When inhaling, the abdomen is pulled inwards, while the diaphragm is drawn upwards, which leads to painful cramps. Another scenario, not uncommon, is that the diaphragm suddenly becomes rigid whilst in the extreme inhalation position. The resulting painful, inflated abdomen contains none of the necessary oxygen.

The tensing of the front of the body is a prerequisite of hypogastric and pelvic malfunction. Depending on the form and the locality of the complaint, certain strains of the muscular network will be tenser than others. In the case of bladder irritation or pelvic floor myalgia, for instance, the tension is concentrated in the pelvic floor itself. The increased respiratory frequency in the case of an irritable bladder is, however, a symptom of anxiety of an advanced nature. In contrast, the muscular tension in the case of abdominal malfunction and urethral syndrome is centred around the rectus abdominis and obliqui abdominis. From the emotional side, depression and inhibition predominate. If the affliction is concentrated on one particular side of the abdomen, it is commonly the obliqui muscles (interni and externi), as well as the quadratus lumborum and the psoas which are affected. In this case, there is often no psychic contribution to be determined. Generally speaking, a permanent muscular contraction on one side only is of different origin; as a result of injury or job-related incorrect posture, the body has adopted a certain obliquity. One special case is demonstrated by those whose pain or paraesthesia are indirectly muscular, arising from the pressure of tense muscles lying against the nerves (for example, if the piriformis squashes the pudendus against the pelvic bone).

It is not unknown that, in addition to that on the front side of the body, excess tension arises also on the rear side. This hollow back posture results in the tension of the entire musculature of the back, including the trapezii and the outer rotator muscles of the hips, as well as the quadriceps muscle at the front of the thigh. Thomas Hanna named this posture "Green light reflex" the "Action reaction". It is aggravated by situations in which one is challenged to prove oneself in terms of performance or standing one's ground. This sort of posture is associated, to a certain extent, with aggression, and is to be found principally amongst the male population. The leaning-forward posture is, in contrast, to be observed most commonly among women.

The patient himself is normally largely unaware of such damaging muscular tension. As a result of the restricted sensory and motoric facilities, we can only feel muscles which we are able to move and, likewise, only able to move those muscles which we

can feel. The consequence of such permanent muscular contraction was described by Hanna as "Sensory-motor amnesia". This implies that the brain "forgets" what the afflicted muscles feel like and how they are to be moved. In terms of the brain's vision of the body, the "map" is scattered with white patches, as if they were undiscovered.

One is not inclined to notice that there is a problem until pain or substantial muscular malfunction ensues. If this pain has exceeded a particular intensity, the patient is inclined to be aware of little else. The attendant depression is then either likely no longer to be registered, or considered, under the circumstances, to be a foregone conclusion. Patients undergoing therapy are likely, only after noticeable improvement of the physical condition, to notice in what a poor emotional state they must have been. A similar phenomenon is to be observed by those suffering from bladder irritation and urine retention; the associated feelings of fear are normally accepted, erroneously, to be simply the natural result of such symptoms.

In cases where depression or anxiety are considered by the patient to be the principal complaint - any pain or other ailments being seen, comparatively, as less intense - he is hardly likely to consult you in your urological or gynaecological practice, but rather seek out the aid of a psychiatrist or psychotherapist, whereby they are then classified as somatically depressive.

All the muscular conditions dealt with above can be detected with ease and without the aid of any medical apparatus; they are either visible or can be felt manually. Undesirable muscular tension manifests itself visibly as unnatural posture (fig. 1-3). Muscular tension is even more clearly visible when the patient moves, since the muscles in question do not participate in the movement in the way they should. For example, one can observe how the gait of those suffering from abdominal musculature tension is produced chiefly by the extremities, rather than by the body as a whole. In moving or manipulating the patient's body oneself, the tension is, of course, noticeable as resistance. On manual examination, the afflicted muscles

prove to be hard and inflexible. In chronic cases, myogelosi or "trigger points" are to be felt: punctual, tangible swellings on the muscle or in the connective tissue, painful to the touch and which maintain the contraction of the tissue.

The search for the over tense musculature - the source of discomfort - is rendered somewhat more difficult by the existence of "referred pain" (Travell and Simons, 1983, 1992). This pain is not felt at the root of the problem - the location of the tension - but at another point in the body. This phenomenon can, of course, lead to false diagnoses. For instance, the fact that pain from the quadratus lumborum in the back can radiate forwards into the abdomen has led to the misguided removal of many an innocent appendix. Of a similar nature is the radiation of the pain felt in the sacral region of the back, commonly experienced in cases of pelipathy syndrome and prostatodynia. While possibly deriving from the over tense musculature typical of a hollow back posture, the source is most often the iliopsoas muscles and is related to a forward-leaning, depressive posture. Referred pain is also responsible for chronic abdominal discomfort and dysmenorrhoea. The pain is perceived to be sitting deep in the abdomen, although the pain originates in the abdominal wall. Hormonal influences seem, in this case, only to play a role insofar as they either diminish pain surges or raise the likelihood of cramps, the latter exacerbating any existing tension. The removal of the tension results in the disappearance of the pain.

Body therapy in cases of hypogastric and pelvic malfunction

Since we know that muscular tension is the root cause of hypogastric and pelvic malfunction, it follows that any therapy must concentrate on the relaxation and remobilisation of the muscles (regular movement achieves the necessary alternation between tension and laxity). The subsequent mobilisation of the musculature in everyday life will ensure that pain, anxiety, depression and other adverse feelings and malfunction do not reoccur. That is, of course, somewhat easier said than done, since conscious tension can be arbitrarily relaxed only to a very limited degree. The command to "stand up straight", for example, certainly does not achieve the relaxation of intended tension at the front of the torso. The most likely result is the

incidental, over compensatory tension of the rear musculature. As soon as one stops consciously thinking about it, the old, forward-leaning posture returns. The conscious system is, when set against the unconscious, as good as powerless.

In spite of this, body therapy has developed techniques, with neurophysiologic detours, which bring about the enduring relaxation of the musculature. This treatment of, principally, the abdominal and chest muscles, the diaphragm, the neck and the adductors, allows the patient to erect himself automatically.

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