USING MIME AND REENACTMENT TO SUPERVISE BODY-ORIENTATED THERAPY

by
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What's wrong with traditional Supervision?

The traditional procedure for supervising psychotherapy involves the presenting therapist giving a verbal summary of the patient's situation, including the presenting problem, the patient's manner of relating to others, and details of the therapist-patient interacting. I remember, during my psychiatric training, how I brought for supervision detailed notes regarding my patients' problems and what happened during our sessions. Nevertheless I would now raise questions, even at this late date, regarding the real usefulness of these supervisory sessions.

When I later progressed from doing individual and group therapy to practising family therapy, I became still more conscious of the limitations of normal supervision procedures during which the therapist mainly "talks about" his session with the patient. It became clear at a very early point that the richness and specificity of a family's interaction could hardly be transmitted by verbal recounting. This brought me to make tape recordings of the therapy sessions and select out for the supervision the most salient sections, the recordings reproducing people's tone of voice, emotional emphasis, rapidity of response, change of voice intensity, interruptions and so on. This was an advance over purely verbal descriptions, but I was well aware of how it still lacked all the visual elements: facial expressions, posture, gestures, and all the nonverbal expressions that link family members as well as the therapist with the family. When a therapist sees a video film of his work with a family, he is usually shocked to recognize the many subtle gestures and communications that he totally passed over during the therapy session. At that time during my training, video had not yet been developed, the one-way screen, which is now used in most family therapy training programs, was also not yet available to my supervisory sessions.

The Job of Communicating Non-Verbal Events

The need to portray more of the therapy session than simple words can say became still more evident when I began to work with body-oriented techniques.

How can I tell my supervisor with mere words my way to stand close and give the patient full eye contact, my tendency to slightly mirror spontaneous movements and even voice tone, my rhythm in responding during a role-playing period, my way of lifting the client's arm so as to facilitate breath movements, and so on? What words might I have used?

"The patient had a tense, anxious look on his face".
"The patient's breathing had a peculiar pattern because his shoulders were hunched and back was rounded".
"The patient's eyes rolled in a certain way whenever he talked of his mother and how she spanked him".

These verbal descriptions of nonverbal behaviour raise more questions than they answer: What kind of anxious look on the face? What kind of peculiar breathing pattern? What kind of flight by the eyes? And so on. What did I actually see? And how could I repeat it in words? Even more to the point: how could I say with words only my way to give receptive holding during the discharge of vulnerable feelings or to give catalytic body contact during the discharge of rage and anger?

The problem is actually more grave than indicated by these limitations of trying to portray the therapeutic interaction. Up to this point we have emphasized the barrier of representing what is already going on during the therapy session. But the supervision meeting is also meant to helpfully modify the therapist's way of intervening. But how much real modification can actually take place if therapist and supervisor merely talk about the desirable changes rather than actually show them in action? Imagine the supervisor saying, "Can you use more tenderness with your eyes?", or "You might respond with greater spontaneity when the patient makes direct demands". What do these indications actually mean? Perhaps the supervisor will renounce giving suggestions that regard ways of intervening and will restrict his work toward understanding what is happening. But can the appropriate words be found, even for understanding, when the reference involves the nonverbal gestures of therapist and patient?

In summary, the verbal description of nonverbal expression by the patient and of nonverbal interaction between therapist and patient is totally inadequate to accomplish the supervision task. Therapist and supervisor must share other modalities of communication, that is, nonverbal modalities, in order to attain the several aims of the supervisory session:

1. Portrayal of what happens in body-oriented psychotherapy.
2. Reflection upon this material.
3. Transformation of the therapist's specific interventions and of his general manner when he is with the patient.

To use video recordings of therapy sessions is one evident way to accomplish at least the first aim, that is, to transmit the nonverbal aspects of the session, this being achieved through the video image and sound. However, I have noticed that supervision around the video tends to remain too often strictly verbal. Thus, a special effort is still needed to jump from the discursive modality of verbal discussion to the non-discursive modality of **showing through direct body action** what you mean to communicate.

"Don't say it, do it!"

Given these obstacles which limit the effectiveness of "talking-about-it" supervision for body-oriented psychotherapy (and Gestalt, Encounter, Rebirthing and other humanistic psychology methods as well), what might we do? My proposal is that we use mime and reenactment methods during supervision. The supervisor suggests, "Show it rather than talk about it". The therapist creates a make-believe therapy session, and then mimes and reenacts what happens from the moment the client enters the therapy room. "Mime" means to perform the actions without words. "Reenact" means to perform the actions with the words that were used. The presenting therapist passes from one to the other according to which feels more comfortable. The supervisor might also say, "Can you also show me what your client is doing?" This is the Gestalt/Psychodrama instruction, "Play the Other". The outcome is to create a baseline of "raw material" that is an event and not a description.

The subsequent steps of the supervisory session can involve discussion and additional reenactments. The point is that discussion which is based on, "What have we seen and heard when the therapist recreated the therapy session?", will be very different (and more fruitful, we believe) than a discussion based on, "What did we hear the therapist say **about** the therapy session?" (1)

One objection is that the therapist will deform the therapeutic session that he presents. Our point of view, however, is that the body language of mime and reenactment inevitably reveal more than the presenter is aware of. Therefore, the therapist can always learn more about himself from others' feedback. In addition, the deformations, like Freudian slips, reveal further aspects of the therapist's character, and thus introduce new material for understanding the therapist as a person. Finally, as members of a supervision group gain confidence in one another and acquire practice of the reenactment method over a series of supervisory sessions, there will be a gradual growth over time toward true-to-life portrayal.

How Would Other Do the Same Thing?

One additional feature of "supervision through reenactment" that I find especially useful: After the initial presentation and

discussion, **I will ask other members of the supervisory group to REPLAY the same session,** that is, to take the same client-therapist problem and demonstrate alternative ways for the therapist to act. The client role may be taken by the original therapist or by another member of the group. After three or four group members have replayed the therapist's part, we have a basis for very rich discussion.

Each member's presentation is appreciated for its positive features. The emphasis upon appreciation is important, the purpose is to help therapists think and act creatively with trust in themselves. In addition, when criticisms are made, the emphasis is put upon the suggestion behind the criticism. Finally, a multiplicity of presentations helps communicate the deep truth that there is no "best way" of therapy, but that each way (including each therapeutic intervention) has advantages and disadvantages. Thus the variety of therapeutic approaches revealed as different members confront, in their own way, the same therapeutic problem, shows in concrete terms that the therapist always has a number of options to choose from. In addition, this last procedure also increases the opportunity for active learning (learning-by-doing) by the whole group.

Conclusion

Body-oriented therapy has brought the entire field of psychotherapy to a new stage of development, with new problems to confront and new methods needed to solve them. The overall point of this article is to appreciate this pioneer adventure and to encourage creative thinking among all those entering this unmapped forest.

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(1) In a longer article, "Experiential Vs. Theoretical Knowledge", (to be published), I develop more fully the theme that experiential knowledge (as portrayed by mime and reenactment) is totally different from theoretical knowledge (as transmitted by verbal description). These two very different types of knowledge use different modalities for transmission and require different criteria for validation.

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