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Talking through your Wrists: Using Nonverbal Cues to Assess Mind-Body Congruence in a Chiropractic Care Setting

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Abstract

Based on observation of 30 client visits in a complementary care office, this article describes an innovative way of “talking to the body” to achieve greater health. Ethnomethodological analysis reveals how participants interactively make sense of a treatment modality known as Neuro Emotional Technique. As the same time, this exploration considers how the assumptions of a traditional Chinese medicine model and a contemporary nonverbal model apply to the interactions. Although the medical model and communication model originated more than 3,500 years and 6,000 miles apart, their central tenets are remarkably similar and reflect many of the assumptions displayed by actual participants. From each perspective, nonverbal communication is regarded as a useful way to bridge the gap between mind and body and to reveal emotional issues unrealized by the mind.

Keywords: Communication; Nonverbal; Complementary and alternative medicine; Chinese medicine; Ethnomethodology; Mind-body link; Meridians; Qi

Introduction

“The other doctors call me the Voodoo Princess,” said the smiling woman extending her hand to me. I smiled guiltily in return. Could she tell I was a bit apprehensive about venturing into the realm of alternative medical care?

Although I had completed research studies in half a dozen more conventional medical settings, this one created a unique type of anxiety. I was a little afraid of what might await me in this setting. Would there be out-of-body experiences, strange incense, mystical occurrences? Rationally I thought not, but still there lurked the suspicion that this experience might exceed the boundaries of what I considered familiar and comfortable.

At least the doctor seemed normal, standing before me, smiling, frankly admitting that her work was “voodoo” to some people’s way of thinking. The setting helped me relax as well. The office was sunny and homelike, opening onto a front porch furnished with wooden rocking chairs.

I had come to Dr. Clark, a chiropractor and homeopathic care provider, seeking insight about communication between clients and complementary care providers. She had agreed to let me observe her interactions with clients over several months’ time, provided the clients didn’t mind being included in the study. My literature-based knowledge of complementary care had led me to expect there would be a great deal of open talk about diverse issues in clients’ lives. I was soon to learn that not all complementary care settings or providers adhere to the more-talk-is-better ideal. Instead, I was introduced to a means of “talking through the body” rather than using words.

One of my goals in conducting this study was to shed more light on complementary care—an arena of health care that remains a mystery to many despite its growing popularity. This article provides a behind-the-scenes look at one complementary care setting based on data collected while observing 30 client visits with Dr. Clark. The focus is on communication, particularly the way Dr. Clark and her clients use nonverbal communication to identify emotional hotspots and to encourage the flow of healthy energy throughout the body. To do this, they employ a method called Neuro Emotional Technique (NET)

designed in the late 1980s by Scott Walker, a chiropractor in California [1]. Although NET is a fairly contemporary innovation, it has roots in ancient Chinese ideas about vital life energy, meridians, and the mind-body connection.

Another goal was to encourage an interdisciplinary approach to health communication. This study examines health care interactions from three perspectives: (1) a medical model, based on assumptions about the nature of health and illness, (2) a communication perspective, based on assumptions about the nature of human awareness and self-expression, and (3) the perspective of participants themselves. The goal is to see if the assumptions of the medical and nonverbal models are consistent with each other and with the expectations communicated by participants in an actual medical setting.

Literature Review

Whereas conventional medicine has focused mostly on biomedical components of health, many complementary therapies consider physical condition, emotions, energy levels, spirituality, and other factors. The emphasis on intangible phenomena can seem as unfamiliar as voodoo to Westerners raised to revere science and technology. As a chiropractor and complementary care provider, Dr. Clark is part of a long-standing tradition that has been alternately respected and denounced as quackery.

Although therapies such as chiropractic, homeopathy, and acupuncture were regarded with widespread suspicion in many Western cultures throughout the twentieth century, their popularity is on the rise. Since 2002, the proportion of adults in the United States

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who has used complementary or alternative therapies has risen from 36 percent to 42 percent or higher [2,3].

Public sentiment is not entirely favorable, however. In a 1999 editorial in *Time* magazine, Leon Jaroff denounced complementary care as nothing but irrational mysticism. Public criticism has been more measured in the years since [4]. But physician Paul A. Offit, author of *Do You Believe in Magic?*, offered a similar sentiment in a CNN article in 2013, in which he wrote: "Current gaps in medical knowledge aren't going to be filled by energy fields, acupuncture meridians, or the notion that all things natural must be good for you" ([5], paragraph 19). Offit isn't entirely dismissive of complementary methods, but he is among those who openly encourage skepticism about their usefulness.

The current study is not designed to address the efficacy of complementary treatment methods. Instead, it acknowledges, first, that we live in an information environment that involves conflicting messages about such methods, and further, that within that environment, it falls to us to negotiate the meaning of ambiguous information about them. As you will see, some of the patients described in this study were regular patrons of NET. Others were introduced to it without prior exposure, during what they expected to be fairly routine chiropractic sessions. It is informative to see how Dr. Clark presents the option and how the participants interactively negotiate what to make of the experience as it unfolds.

Data Collection

As stated, I collected data for this study during naturalistic observation of 30 client visits with Dr. Clark (not her real name). Dr. Clark is a European-American woman in her mid 30s. At the time of this study, she had been a chiropractor for about 10 years and an NET practitioner for about 7 years. Her office was located on a pleasant street lined by small businesses and historic homes. The majority of her clients (approximately 75%) were women between 30 and 50 years of age. Over three months' time, I observed 27 female and 3 male clients, which constituted a typical patient load for her. The clients' ages ranged from 3 days old to about 65 years old. In all, I observed 4 children and babies and 26 adults. Only clients who visited Dr. Clark during my observation period were included in this study.

Before the study, I met with Dr. Clark and her receptionist to discuss the protocol for securing informed consent. I asked Dr. Clark to use her judgment to select which clients might be comfortable being observed and to ask them if they would like to be included in the study. She typically introduced the study in this way: "I have a communication professor in the office today who is studying how doctors and patients communicate. Do you mind if she sits in during your visit?" Verbal consent of this type was deemed to be less obtrusive than written consent and allowed me to avoid having any record of clients' names. Clients were informed that they were not obliged to participate and could request that I leave the room at any time. (Fearing that the clients would hesitate to do this, I asked Dr. Clark to signal me if she sensed that any client was uncomfortable in my presence). Clients were assured of anonymity. A handout explaining the study and providing information on how to contact me (the researcher) was made available. The university institutional review board approved this protocol prior to the study.

While I was conducting observations, Dr. Clark asked every client except one to participate. (She felt that client would not be comfortable being part of the study.) Every client she asked agreed immediately to be observed. Dr. Clark assured me that the clients did not seem

uncomfortable in my presence, and she never signaled me to leave the room.

During observations I tried to minimize my influence on the participants by sitting quietly to one side in the treatment room. I carried a pen and spiral notebook, which I used to record as much verbatim dialogue, nonverbal cues, and contextual cues as possible.

Methodology

I approached the field study without a preconceived hypothesis, simply an interest in how the participants would negotiate the terms of complementary care. As the study progressed, I began to draw upon tenets of ethnomethodology to reveal how the participants subtly managed the encounters. In a setting replete with talk about meridians, magnets, and mind-body congruence, it was interesting to observe how the participants made sense of what they were doing.

Ethnomethodology, conceived by Harold Garfinkel, is oriented to how people make sense of occurrences in their lives and how they cultivate a sense of orderliness in their social interactions [6]. One means of maintaining a sense of orderliness involves the use of "frames" [7]. Frames distinguish where a communication episode begins and ends and what type of episode it is (e.g., a promise, a prank, a storytelling, or so on). Most people know what occurs within the frame of a medical visit. Although there are few explicit laws governing what one should say or do as a participant in such an encounter, people are aware that they should behave in an orderly and relatively predictable manner or risk being typified as rude, crazy, or stupid. The risk of being viewed negatively may be particularly threatening considering the high value of seeking expert help for personal health issues. In episodes in which people are not sure what to expect or do, their efforts to make sense of the situation are likely to be more effortful and evident than usual. As the ensuing analysis illustrates, this was often the case in Dr. Clark's office.

Another premise of ethnomethodology is that sense making is not a solitary endeavor. People work together to display their understandings and expectations, negotiate how social interactions will occur, and collaboratively interpret the world around them [6]. Without this collaborative effort, there would be little chance of achieving a shared sense of order and rationality. To negotiate meaning in this way, social actors must make their understandings known (as in "I see what you're up to! You're joking around with me."), and they may campaign for particular interpretations or actions ("Okay, let's get serious now. We're wasting time.") Comments such as these display how a participant regards and wishes to manage a situation. Of course, such maneuvers do not stand alone. Another participant may bid for a different interpretation or agenda ("This is no joke," or "Relax, we have plenty of time!"). In this study, I identify statements such as these that display the participants' interpretations and preferences to each other. (Ethnomethodology does not propose to reveal social actors' inner thoughts. The focus is on people's preferences and interpretations as they are displayed to others.)

I was interested in how Dr. Clark and her clients used verbal and nonverbal cues to collaboratively manage and make sense of their interactions. Dr. Clark helped acquaint her clients with unfamiliar routines by telling them (in varying degrees) about the Chinese medical model on which NET is based. As such, this model became an apparatus for making sense of the situations. The participants did not mention nonverbal communication theory (nor would I expect them to). However, I was also interested in how well such a perspective would

apply as a means of making sense of the situations I observed. The result is an integrated three-part analysis that examines the assumptions and preferences of: (1) the NET medical model, (2) a nonverbal communication perspective, and (3) the people I observed.

Results

This section begins by describing the NET model and a nonverbal communication model. The aim is not to test either model in an empirical way or to assert that any one model is more accurate or true than another. Rather, the goal is to see how applicable the models are as explanatory frameworks for the episodes I observed in Dr. Clark's office.

Neuro Emotional Technique

Although Dr. Clark does not use needles, NET is based largely on the principles of acupuncture, a practice begun in China during the Xia dynasty (2140-1711 BC) [8]. Acupuncture is based on the belief that all life is sustained by energy. The life-giving energy that flows through the body is called Qi or chi. From ancient times, traditional Chinese have believed the body is healthiest when Qi is strong and well balanced [9,10].

Qi is regulated by meridians, which serve as channels or rivers that direct energy throughout the body. Traditional thought recognizes 12 meridians, each corresponding loosely to a bodily organ such as the heart, liver, and kidneys. Vickers and Zollman explain: "Qi energy must flow in the correct strength and quality through each of these meridians and organs for health to be maintained" ([9], paragraph 2). Stimulating meridians (through gentle touch, deep massage, lasers, acupuncture needles, or other methods) is believed to influence energy flow.

Meridians are also considered to be the seats of particular emotions. For example, anger is associated with the liver, sorrow with the lungs, fear with the kidneys, and so on [11]. The implication is that—if meridians regulate energy flow throughout the body and also serve as the seats of emotion—overwhelming or enduring emotions may interfere with Qi. In other words, emotions may manifest themselves in physical ways, distressing bodily organs and disrupting Qi.

NET is designed to identify emotional hotspots that may be draining or diverting the body's energy and then free that energy to resume a healthy, balanced flow. During an NET session, the caregiver applies gentle downward pressure to the wrist of a client's outstretched arm while saying a series of words, phrases, or questions. The client should be able to maintain a steady position, except when an emotionally charged issue is mentioned, in which case his or her arm will drop noticeably. The premise is that statements a person considers untrue or emotionally loaded will cause the person to experience a momentary decline in physical strength. The process—known as muscle testing—is similar to a polygraph test in the sense that incongruent or emotionally loaded issues may cause detectable physiological arousal [12]. One of the first studies on the arm-extension muscle test used with NET suggested measurable differences. As participants in the study spoke true sentences, they were able to withstand 17.2% more downward force on their wrists and were able to maintain the out-stretched arm position for 58.9% longer than when they spoke untrue statements [13]. However, a more recent overview of the literature suggests that scientists have not been able to demonstrate that muscle testing consistently reveals hidden emotions [14]. Evidence about the effectiveness of NET is also mixed, although some data suggest that the technique can be effective in reducing anxiety [15,16] and chronic pain [17].

During an NET session Dr. Clark might say, "I'm okay feeling healthy." If this statement is not congruent with what she calls the client's "emotional reality," his or her arm should momentarily drop several inches. The movement is not intentional, and it need not be based on rational thought. Dr. Clark is quick to point out that emotional reality is not always rational. For example, she says, "If, as a child, you learned that life is painful, as an adult you might find a way to make it so. It doesn't mean you want to." An issue can be irrational but have emotional (thus physical) implications. For that reason, NET is said to allow communication with the body rather than the mind.

One tenet of NET is that people may be unaware of emotions they have manifested in physical ways. Dr. Clark did not usually ask clients to comment verbally on the process until she had identified a point of origin for a particular emotion. Even then, she requested only a very brief description of the issue. For example, she might say, "Your body is telling me you originally experienced this type of sadness at age 10. Can you briefly tell me what was going on then?"

Even once an emotional issue is identified, the client is not encouraged to "talk it out." To the contrary, Dr. Clark says, the goal is to let go of the emotions through energy work involving the appropriate meridians. This energy work involves the use of gentle touch and rhythmic breathing. As Dr. Clark explains it: "It's okay to feel emotions. But they should flow through you, not take up residence." She describes energy work as a way to "clean house" by releasing pent-up emotions.

Dr. Clark sometimes uses magnets to draw energy and blood flow to certain areas. She may also round out energy work with a homeopathic remedy such as a squirt of water containing small traces of a natural element associated with the meridian in question.

In summary, NET is based on the belief that health relies on a strong and well-balanced Qi, which can be disrupted by emotional issues that are harbored in various regions of the body. Health can be encouraged through the use of focused touch, rhythmic breathing, and homeopathic remedies. NET prescribes a means of identifying and dissipating emotional roadblocks based on the following assumptions: (1) A person may unintentionally convey emotions through body language, (2) Emotions displayed nonverbally may not be rational or even within a person's awareness, and (3) Nonverbal communication such as touch can be cathartic even in the absence of verbal communication. In other words, talking about an issue may be less important than physically expressing it and "letting it go."

Each of these assumptions is relevant to the study of both health and communication. The following review of nonverbal communication presents an interesting basis for comparison.

Nonverbal communication

Theorists have approached nonverbal communication from a number of angles. In this study, I apply a perspective summarized by Peter Andersen, who defined nonverbal communication as "analogic, nonlinguistic, and typically governed by the right brain hemisphere" ([18], p. 3, italics in original). In other words, nonverbal cues are naturally linked to what they represent (analogic), making them more universal and easily understood than linguistic symbols such as words, which typically have little innate similarity to what they represent and which vary from language to language. From this perspective, not all silent cues are nonverbal. Gestures that convey specific words such as "okay" or "touchdown" are linguistic rather than nonverbal because

they are language- and word-based. Consequently, their meaning varies across cultures.

The final portion of Andersen's definition maintains that nonverbal cues are processed in a part of the brain (the right hemisphere) that is relatively holistic and non-analytic. The effect is that nonverbal cues tend to be conveyed with less conscious thought and less precision than verbal cues. As a means of shorthand, I refer to this perspective as the "nonlinguistic perspective of nonverbal communication." A number of assumptions are embedded in this perspective. I focus here on three assumptions relevant to the current study—that nonverbal communication is (1) spontaneous, (2) biologically based, and (3) well suited to convey emotions.

Andersen's definition of nonverbal communication assumes that nonverbal cues are spontaneous and mindless in that they do not require conscious thought [18]. Anyone who has tried to stop blushing, hold back tears, or stifle a laugh is aware that nonverbal communication is often involuntary. Of course, people may intentionally present nonlinguistic cues, as in smiling when they feel sad, but evidence suggests they will not be successful controlling all of their nonverbal displays [19]. People tend to leak cues to their internal states even when they would rather not.

A second assumption holds that nonverbal communication is rooted in biology. Around the world, nonverbal displays of enjoyment, anger, fear, sadness, disgust, and surprise are relatively similar [20]. This suggests that humans are predisposed to display certain nonverbal cues regardless of the cultures or languages most familiar to them. In other words, nonverbal cues may have universal meaning not found in verbal language.

Third, the nonlinguistic perspective is grounded in the assumption that nonverbal communication is especially well suited to convey emotions. The right brain hemisphere governs emotions and the communication of emotions (especially through nonverbal channels), whereas the left hemisphere governs cognition and symbolic communication [21]. This suggests that people are capable of feeling—and communicating their feelings—without cognitive effort. For example, you may feel disgusted by a sight or smell (and show your disgust) even before you think about the cause of it. This occurs partly because feelings and nonverbal communication originate in the same area of the brain, and partly because emotional reactions are often more rapid and spontaneous than cognitive reactions. For these reasons, nonverbal displays may be particularly well suited to convey emotions, even emotions of which we are not aware or do not rationally endorse.

In summary, unlike verbal language, which relies mostly on conscious thought and cultural appropriateness, nonverbal cues seem to be more spontaneous and may reflect emotions that are not part of conscious thought. This nonlinguistic perspective of nonverbal communication supports the following assumptions: (1) People often display nonverbal cues spontaneously, without conscious thought, (2) Nonverbal cues are based in large part on biological programming, and (3) Emotions are likely to be conveyed through nonverbal channels. Following is an analysis of how this perspective compares to the assumptions of NET.

Theoretical comparison

The medical and nonverbal communication models presented here originated more than 3,000 years apart—one in the Eastern world and one in the Western. One model is designed to identify the basis of health and healing, the other to express the nature of human expression and

social interaction. Yet there is a remarkable degree of overlap between them. Similarities and differences are described here.

Both models maintain that nonverbal communication is well suited to convey emotions. Furthermore, they assume that nonverbal cues may be displayed without conscious thought, providing a means of conveying feelings that might be rejected or ignored by the conscious mind, thus excluded from verbal language choices. This is interesting from a communication perspective because nonverbal displays are typically regarded as more genuine and trustworthy than words [22]. For similar reasons, NET practitioners look to nonverbal displays for cues about emotional issues people are either avoiding or have blocked from conscious consideration.

Perhaps the most important link between the two perspectives is the shared belief that there is an organic basis for nonverbal communication that transcends language and culture. NET practitioners presume that the body manifests pent-up emotions in the form of physical weakness and that energy flow can be restored using focused touch, breathing, and gentle remedies rather than words. Theorists within the nonlinguistic perspective consider that nonverbal communication is based primarily on biological programming, not only on cognitive choice or cultural appropriateness. In this way, nonverbal cues may ease a dilemma faced by practitioners who accept a mind-body link but are stumped when people do not know which thoughts and moods are influencing their health. NET assumes that nonverbal cues provide that information.

The models differ in that, unlike nonverbal communication theory, NET is directly addressed to issues of health and energy. NET asserts that energy imbalances will be conveyed through specific nonverbal cues (momentary muscle weakness) and that health can be restored by nonverbal means (touching and breathing). Nonverbal communication theory does not make these types of claims. Although Andersen's model proposes a strong biological imperative for nonverbal communication, it allows that nonverbal communication is influenced to some degree by culture and personality, and the model makes no explicit claims about the relationship between health and self-expression [18].

On the whole, the overlap between NET and nonverbal communication is remarkable, supporting the viability of integrated theories of health and communication. Although the two models were developed within different worldviews, they embody many similar assumptions and preferences. How will these assumptions and preferences play out in the real-world theater of social interaction? In applying these frameworks to folk methods of sense-making in Dr. Clark's office, I considered whether the participants displayed belief that: (1) nonverbal cues can convey legitimate meanings not known to the mind, (2) nonverbal communication reveals information about the body as an organic entity, (3) nonverbal cues accurately reveal information about emotions, and (4) emotions can be released using cathartic touch and breathing. The first three assumptions are common to both NET and the nonverbal model described. The fourth assumption is unique to NET.

Folk methods of sense-making

While observing client visits over several months, I was able to identify some of the techniques participants frequently used to negotiate meaning. Space constraints (and my desire to provide a deep rather than superficial analysis) require that I narrow the focus to two episodes. I chose the first episode because it is typical of many that I observed. The participants' efforts to negotiate meaning were visible but not disruptive or problematic. I chose the second episode for the opposite reason. It provided a rare look at what happened when the doctor's sense-making

effort was challenged by a client. In both cases, my analysis revolves around the folk methods participants used to negotiate the encounters and how the assumptions the participants displayed compare to the medical and nonverbal models already described.

Scenario 1: I can't turn my head.

A woman in her early 30s arrived for her second visit with Dr. Clark. She mentioned that she had recently had a baby, but that her primary concern was a stiff neck. The client was barely able to move her head from side to side. After massaging the woman's neck and back, Dr. Clark suggested they try "muscle testing" (NET). The client had never taken part in NET before. (DR denotes doctor speaking, CL denotes client speaking.)

(1) DR: Let's try some muscle testing. It's about congruency. Hold out your arm like this.

(2) (Client extends arm)

(3) DR: I'm just going to apply very light pressure like this. When your brain and your body

(4) are congruent, you'll stay strong. I'll show you. Repeat after me: "I'm female."

(5) CL: I'm female.

(6) (Client's arm stays strong)

(7) DR: kay, now say, "I'm male."

(8) CL: I'm male.

(9) (Client's arm drops several inches.)

(10) CL: Wow! That's weird (both laugh).

(11) DR: Say: "I'm okay being pain free."

(12) CL: I'm okay being pain free.

(13) (Client's arm drops several inches. Client raises her eyebrows in surprise.)

The doctor quickly calls out a list of emotions. The client's arm stays firm until the doctor mentions anger, at which point the client's arm drops.

(14) DR: It doesn't have to be logical, but why would you be angry about being pain-free?

(15) I'll tell you the number one answer if you can't think of one.

(16) CL: Okay. Tell me. I'm lost.

(17) DR: Because if I'm pain free I'd have to do even more.

(18) CL: es!

(19) DR: ou've got a new baby and you're swamped.

(20) CL: Yes!

(21) DR: (testing with arm again) Original anger about being pain free—birth, 1 to 5

(22) years, 5 to 10 years, 10 to 15 years-

(23) (Client's arm drops)

(24) DR: 10, 11, 12, 13-

(25) (Client's arm drops)

(26) DR: What was going on about age 13?

(27) CL: (looking astonished) Oh gosh! I was a runaway.

(28) DR: Okay. Here. There are meridian access points, almost like little electrical currents

(29) going through you that go to different body parts. The liver is the meridian for

(30) anger. Place one hand here over your liver and the other hand on your forehead.

(31) Breathe in and out.

As the client does this Dr. Clark taps on her spine in areas believed to channel energy to the liver. Then Dr. Clark pushes on the client's outstretched arm while touching various meridians.

(32) DR: I still get anger on that liver meridian. Where's that coming from? You,

(33) family-

(34) (Client's arm drops)

(35) DR: Family now, family of origin-

(36) (Client's arm drops)

(37) DR: Mom, dad

(38) (Client's arm drops)

(39) DR: Without giving me too many personal details, what would you be mad

(40) at your dad about?

(41) CL: Mad at him for leaving my mom.

(42) DR: (pushing on wrist) Mad at him for leaving your mom.

(43) (Client's arm stays strong)

(44) DR: ad at him for leaving you.

(45) (Client's arm drops)

(46) CL: (smiles and nods slowly) Yeah. But I'm putting all that behind me. I'm going on

(47) with my life.

(48) DR: (pushing on wrist) I'm okay seeing what's behind me.

(49) (Client's arm drops)

(50) CL: There's too much back there.

(51) DR: (smiles sympathetically) So you won't ever look back. Just look straight ahead. Of

(52) course you COULD get a crick in your neck so you can NEVER look back .(smiles)

(53) CL: It's kind of funny that you're doing all this right now. This is the stuff I'm trying to

(54) deal with.

(55) DR: (smiles) Well, you came here for a reason, didn't ya?

From the beginning, the participants in this scenario displayed a preference (and willingness) to frame the "muscle testing" episode as a

legitimate means of health care. Dr. Clark's reference to NET as "muscle testing" rather than "NET" (line 1) suggested that she was attempting to frame the encounter as not-so-different than the chiropractic care the woman specifically sought, and by that point had already received. Presumably, people are more receptive to procedures that are familiar to them. Additionally, Dr. Clark's early female/male demonstration (lines 4-9) was ostensibly meant to show the client that the wrist method works. The client displayed a willingness to engage in the process by extending her arm and repeating statements as she was requested to do. Her reaction when her arm dropped several inches ("Wow! That's weird," line 10) suggested she was surprised (but not unpleasantly so) by the female/male demonstration. Although the client called her arm's reaction "weird," the "Wow!" suggested she acknowledged the event as a legitimate occurrence.

Throughout the encounter, Dr. Clark displayed a number of assumptions grounded in the NET model. She referred to a mind-body link when she said the client's arm would be strong as long as her brain and body were congruent (lines 1-4). Even more striking was her closing suggestion that the client's stiff neck was a physical embodiment of her mental determination "not to look back" (lines 51-52).

Dr. Clark suggested that emotions displayed nonverbally need not be logical ("It doesn't have to be logical," line 14), and she implied that the client should not talk at length about the emotional issues she identified. For example, although Dr. Clark asked an open-ended question ("... why would you be angry...?" line 14), she immediately offered to provide the answer herself ("I'll tell you the number one answer if you can't think of one," line 15). Soon after, when the client divulged she was a runaway at age 13, Dr. Clark preceded immediately to nonverbal energy work and meridian scanning (lines 28-31). Likewise, when Dr. Clark asked why the client would be mad at her dad, she prefaced the question with, "Without giving me too many personal details" (line 39). These moves imply that Dr. Clark preferred not to engage in much talk about the issues, preferring to use silent energy work instead. These preferences are in keeping with the assumptions of NET.

The client treated the issues revealed by her physical responses as legitimate. For instance, she did not object when Dr. Clark asked, "Why would you be angry about being pain-free?" (line 14). In different circumstances, we might expect someone to say, "I am okay being pain-free!" – that being an ostensibly more logical and rational position to take. And, although the client pronounced herself "lost" as to how to explain this suggestion (line 16), she twice reacted with an enthusiastic "Yes!" (lines 18 and 20) when Dr. Clark suggested that she was angry because being pain-free meant having to do more work. The client also treated Dr. Clark's question about her experiences at age 13 as being a surprising but legitimate discovery ("Gosh! I was a runaway," line 27). Perhaps most strikingly, the client accepted her own nonverbal reaction as being more valid than her verbal assessment when the two were contradictory. Although the client professed herself "Mad at him for leaving my mom" (line 41), her arm stayed firm when Dr. Clark repeated this statement. However, the client confirmed her nonverbal response to a different suggestion ("Mad at him for leaving me [client]," line 44) with a "Yeah" (line 46). Although the client did not respond directly when Dr. Clark suggested she had developed a stiff neck to avoid looking backward, the client did say, "This is the stuff I'm trying to deal with" (lines 53-54), suggesting again that the issues raised were legitimate.

Neither Dr. Clark nor the client explicitly commented on the therapeutic value of touch, which is one assumption of NET. Their willingness to engage in "muscle testing" – which includes touching the

wrists and meridians point – implies that they were receptive to the idea. It is easy to imagine a more conventional medical setting in which these procedures would not be treated as valid treatment. However, Dr. Clark did not explain the benefits of touch to the client. Neither did the client explicitly display that the process had made her feel better or improved the crick in her neck. Thus, the participants' belief in the healing power of touch was implied but not clearly demonstrated in this episode.

All in all, the participants' overt efforts to make sense of this NET session were in line with the assumptions of NET and Andersen's conception of nonverbal communication [18]. Throughout the encounter, the participants displayed an acceptance of nonverbal communication as more revealing and honest than verbal communication. Even the client seemed to trust her nonverbal responses more than her verbal assessments. The participants also seemed to accept the notion that nonverbal cues reveal information about the mind and body, even when that information is not part of conscious thought. Although the client said she was trying to put certain issues behind her, her body was seen to reveal that those issues were still present.

Appropriately enough, the episode ended with a statement that framed the encounter as being reasonable and goal-oriented. When the client remarked, "It's kind of funny that you're doing all this right now" (line 53), Dr. Clark's assessment, "Well, you came here for a reason, didn't ya?" (line 55) portrayed the encounter as having a reason and a goal in line (at least at some level) with the client's wishes for it.

Scenario two: "No, that's not it."

A petite woman in her mid 40s arrived to visit Dr. Clark. She was an established client who suffered from chronic pain in her arms and legs. Dr. Clark asked her "What's up?" and the woman responded, "Well, several things. I know it's pain and I know it's emotional." Although the client smiled as if to offset the dramatic nature of this declaration, Dr. Clark responded with a serious expression and reached for the client's arm. They immediately began an NET session, having apparently done so many times before. Before long, the subject of money arose.

- (1) DR: Money
- (2) (Client's arm drops)
- (3) DR: Actual money-
- (4) (Client's arm drops)
- (5) DR: Job, finances, career.
- (6) (Client's arm remains strong)
- (7) DR: So we're talking about actual money here. Fear-
- (8) (Client's arm drops)
- (9) DR: Yours-
- (10) (Client's arm drops)
- (11) DR: (to client) Fear?
- (12) CL: Yeah. But I don't know what. I don't want to have to worry about money.
- (13) DR: Maybe irritation about having to worry about it.

The doctor has the woman breathe deeply with one hand on her forehead and on her right side.

- (14) CL: I think you've actually helped me a lot. I mean, this is a good one [referring

(15) to current relationship]. But I mean it had been 7 years. Do you think that cleared

(16) me a little bit?

(17) DR: I don't know. See how it feels for the next week or so. (motions to therapy table)

(18) Climb aboard.

Dr. Clark performs a chiropractic adjustment on the woman, and then they resume NET.

(19) DR: Money, love, you, family-

(20) (Client's arm drops)

(21) DR: Family of origin-

(22) (Client's arm drops)

(23) DR: Family now, friends. Okay, family of origin.

(24) (Client's arm drops)

(25) Sibling 1, 2, 3, 4-

(26) (Client's arm drops)

(27) (to client) How is sibling four?

(28) CL: Fine.

(29) DR: Are you mad at him?

(30) CL: No. Not at all.

(31) DR: Angry with anything going on with him?

(32) CL: No. He's doing great. I love him very much.

(33) DR: Well, you can love someone and be angry with him.

(34) CL: Now sibling number one-

(35) DR: You have some issues with him-or her?

(36) CL: Yeah. In fact I think that's why I'm here (half-hearted laugh).

(37) DR: (laughs) Well, your body's not telling me that.

After a few more minutes probing for issues relevant to sibling four, Dr. Clark suggests more NET.

(38) DR: Now let's do it again. Maybe brother number one will come up. Ill, self-

(39) esteem-

(40) (Client's arm drops)

(41) CL: He's 53 and he has severe memory problems. I don't know if this [NET]

(42) could help. I don't know if he could relate. A lot of stress on me cause I'm

(43) dealing with a lot of the decision stuff.

(44) DR: Original time when you felt this. Conception, birth, birth to 5, 5 to 10-

(45) (Client's arm drops)

(46) DR: 5, 6, 7

(47) (Client's arm drops and Dr. Clark looks questioningly at the client)

(48) CL: [Sibling number one's name]. He was always getting in trouble. I was having

(49) to cover for him a lot.

(50) DR: (sounding excited) Now he shows up! I knew he was there somewhere. I was

(51) thinking, "This is not working today!"

(52) CL: At least I'm wise enough to get here and get some help for myself although

(53) I'm using my brother as an excuse (laughs).

Although the participants in this scenario displayed many of the assumptions inherent in NET and Andersen's nonverbal model [18], they negotiated several subtle challenges to it as well. For example, Dr. Clark seemed to double-check the client's responses in several places. The client's arm dropped in response to "actual money" (lines 3 and 4) but Dr. Clark tried several other suggestions ("job, finances, career," line 5) without result before acknowledging, "So we're talking about actual money here" (line 7). She performed the same double-check when the client's arm dropped in response to "family of origin" (line 21). Dr. Clark tried "Family now, friends" before conceding "Okay, family of origin" (line 23). These double-checks eventually reinforced the idea that the initial responses were valid. However, Dr. Clark did not perform these double-checks with every client, suggesting that she was less than confident with the initial results in this case.

The most direct challenge was aimed at the assumption that the body conveys legitimate emotions not known to the mind. When Dr. Clark identified "sibling four" as being an emotional topic, the client resisted this idea. She insisted he was "fine" (line 28), she was "not at all" mad at him (line 30), and he was "doing great. I love him very much" (line 32). The client's insistence that "sibling four" was not an emotional hotspot because she was not aware of any anger toward him is inconsistent with the assumption that the body harbors emotions outside the mind's awareness. While the client denied issues surrounding sibling four, Dr. Clark attempted to identify emotional issues the client had not considered ("Are you mad at him?" . . . "Angry with anything going on with him?" . . . "Well, you can love someone and be angry with him," lines 29, 31, & 33). Finally, Dr. Clark abandoned the topic of sibling four and conceded: "Now let's do it [muscle test] again. May be brother number one will come up" (line 38). Interestingly, Dr. Clark was unwilling to talk about this brother unless the client's body first showed a reaction to him. She apparently had greater confidence in nonverbal cues than verbal cues, even when the client verbally persisted that "sibling number one" was really the issue. The problematic nature of this challenge (from Dr. Clark's perspective) was confirmed when subsequent NET work revealed a physical response to "sibling number one." Dr. Clark said with apparent relief and excitement, "I knew he was there somewhere. I was thinking, 'This is not working today!'" (lines 50-51). Her comments confirm previous anxiety about the fallibility of the model (or perhaps the client's refusal to accept it as valid) and her current relief that the model was again working as usual.

Despite these challenges, the scenario included a number of assumptions consistent with the NET and nonverbal models described. When Dr. Clark identified age 7 as an important year (lines 46-47), the client described "having to cover" for her brother a lot that year, treating it as a relevant and legitimate emotional time. The client also

confirmed the assumption that touch and breathing can be cathartic in themselves when she said, "I think you've actually helped me a lot" (line 14) after the energy exercise. Finally, the client overtly considered NET as a way to help her brother (lines 41-43), and as a repeat NET client, she presumably felt it helped her as well.

Episodes that threaten embedded assumptions are sometimes particularly illuminating. As predicted within Garfinkel's conception of ethnomethodology, sense-making efforts become more pronounced when social actors find themselves in unexpected or perplexing circumstances [6]. In my observations, it was rare for a client to deny the validity of an issue identified through muscle testing. In the rare challenge just described, Dr. Clark might have accepted the client's alternative explanation more readily if she were less invested in the reliability of NET. As it was, Dr. Clark directly challenges (albeit with a smile) the client's verbal assertion that sibling one was "why I'm here" (line 36) by saying "Well, your body's not telling me that" (line 37). Only when the client's body responded in concert with her verbal assertions did both parties seem content that the technique was working again. In a sense, order—however briefly challenged—had been restored when assumptions again predicted occurrences.

Discussion

This study is unusual in that it addresses how participants negotiate the meaning of a procedure such as NET, which is not well known to most people. Although some researchers have attempted to measure the efficacy of NET, none to my knowledge have examined it within a communication framework. The insights provided here may be useful for theorists and practitioners interested in the way that people work together negotiate the terms of this and others treatments that fall outside the scope of conventional care.

The tenets of ethnomethodology suggest that people are continually engaged in a collaborative process to make sense of the goings-on around them and that when situations are novel or unfamiliar, their sense-making efforts are often particularly effortful and apparent [6]. This seemed to be the case in my observations.

This article presents detailed analysis of two NET episodes with Dr. Clark. In these episodes, Dr. Clark facilitated sense-making by informing the clients about principles of NET derived from traditional Chinese medicine. Her descriptions of muscle testing, mind-body congruence, and meridians established their relevance to client's everyday health and provided a rational basis for performing NET. The clients displayed a willingness to follow instructions, even when the instructions must have seemed unusual, as in extending an arm or breathing rhythmically while touching a particular meridian point on the body. Most of the time, the clients affirmed the legitimacy of issues revealed by muscle testing, even when the issue was contradictory to the client's own verbal assertion. The "That's Not It" episode, in which the client did not unconditionally accept the issue raised by muscle testing, presented an interesting example of sense-making when expectations have been violated. In that episode, the participants eventually reached a satisfactory resolution of the situation to the obvious relief of the doctor.

As the expert, Dr. Clark was in a particularly influential position to suggest how NET should be performed and interpreted. From that angle, it is not surprising that the majority of communication behaviors in her office support the premises of NET—that people unintentionally convey emotions through body language, that emotions conveyed may not be rational or conscious, and that nonverbal displays can be therapeutic.

It is more surprising that the participants in this setting seemed to behave in line with the canons of nonverbal communication as defined by Andersen [18]. The applicability of the nonverbal model surely does not arise from the participants' familiarity with it. The more obvious explanation is that the nonverbal model applies to their understanding because it has a great deal in common with the presumptions of NET and the participants' own viewpoints. Burgoon and others have noted that people commonly trust nonverbal displays as being more spontaneous, genuine, and honest than verbal accounts, viewpoints consistent with the assumptions of Andersen's model [18].

At first glance it is not especially surprising that two models—one a medical model, one a communication—seem to accurately reflect the behavior of participants in a particular setting. However, it is easy to imagine models that would not co-exist so well. Mainstream medicine, for example, has not embraced the idea that health can be restored by touch and rhythmic breathing, or that caregivers can "talk to the body" by observing nonverbal responses to a series of words or phrases. Neither is psychotherapy—with its emphasis on talking problems out—consistent with the idea that health is best monitored and restored almost solely through nonverbal means.

Considering that Dr. Clark's methods are atypical of the way medical care is usually accomplished how that she is and her clients so readily make sense of their interactions? One explanation is that Dr. Clark's clients are particularly receptive to the tenets of NET or they would not visit a complementary care provider in the first place. This is undoubtedly true to some extent, but many of Dr. Clark's clients come to her for chiropractic care, initially unaware what NET is or that she provides it. Many clients (including the one in the "I Can't Move My Neck" episode) have never heard of NET before they visit Dr. Clark.

Another explanation is that the assumptions of NET and nonverbal communication are culturally familiar, even to participants who do not know the theories behind them. Although most Westerners are not familiar with terms such as Qi and meridians, Westerners do recognize a mind-body connection in their own ways. For example, athletes get "psyched up" for physical competition and people attribute success to the "having the right attitude" ([13], p. 1020). In a more figurative sense, individuals "die of shame" and experience "broken hearts" when they lose in love. Likewise, people often assume (rightly or wrongly) that they can tell if loved ones are lying by monitoring the way they behave. These folk beliefs mirror many of the assumptions of NET and nonverbal communication.

The study is limited in several respects. For one, it examines a relatively small, nonrandom collection of occurrences. Although detailed analysis requires this to be so, it does not enable us to generalize beyond the context described. In other words, we gain the benefits of an in-depth investigation, but in so doing forego the ability to broadly apply what we observe. Second, there is always a chance in observational studies that the researcher's presence has altered the flow of normal events. Although I am assured by Dr. Clark that the visits I observed were not unusual in any respect she could identify, the possibility is worth bearing in mind.

Despite these limitations, I believe the study offers some notable strengths and important implications. For one, it crosses theoretical boundaries. The usefulness of health communication research will be limited unless communication scholars consider how their ideas stack up to the assumptions of actual medical professionals and clients. It is useful to know whether communication models are in harmony or discord with what participants already believe to be true. Another

advantage is the study's use of naturally occurring episodes. By superimposing theoretical models on the sense-making efforts of folk participants, this study seeks to gauge the models' validity within the richness of life world contexts.

Further research may indicate if the experiences of Dr. Clark and her clients are common in other complementary care settings. At any rate, a closer look at the way medical professionals and clients negotiate meaning is worthwhile—both to understand the expectations of social actors and to compare scientists' sense-making models to each other. Especially in a medical age marked by rapidly changing methods, regulations, and vocabularies, it is encouraging to find areas of common understanding between medical professionals, clients, and communication scholars. When models that originated thousands of years and miles apart are shown to share the same basic assumptions, there is hope that scholars today can transcend the disciplinary boundaries between them with important results.

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