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Extending Understanding of 'Care' as an embodied phenomenon: Alexander Teacher Perspectives on Restoring Carers to Themselves

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Abstract:
Data from an international survey of teachers of the Alexander Technique – an embodied form of self-care – illustrate their perspectives on how AT supports caring by combatting carer self-loss. Understanding of care as an embodied phenomenon is furthered by describing (i) specific embodied habits that seem highly pertinent to care of self and others, and (ii) how they might be (re)-acquired in learning AT. In offering both practical and philosophical ways in which AT differs from alternatives, the article invites fresh thinking about theory and practice in supporting care, and argues that AT research in the context of caring is warranted.

Key words/short phrases:

embodiment; Alexander technique; self-loss; self-care

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Introduction

Internationally, public reliance on care has been underlined by the COVID-19 pandemic, with shortcomings in existing provision laid bare. Under these 'pressure cooker' conditions, the responsibilities for care placed on those at home have further increased (Fine and Tronto, 2020: 95). This article employs practitioner perspectives to illuminate how embodied self-care via the Alexander Technique (AT) can support the wellbeing and resilience of informal carers (hereafter 'carers') through reconnecting them with their bodies and restoring aspects of selfhood eroded by caring.

The AT is an 'educational self-development self-management method with therapeutic benefits', supporting active participation in one's own health (Woods, Glover & Woodman, 2020: 190). Though robust clinical studies indicate that the AT can improve physical and psychological functioning in ways that are relevant to caring, such as musculoskeletal pain and disability and self-efficacy (e.g. Little et al, 2008; MacPherson et al, 2015; Stallibrass et al, 2002; Woodman et al, 2018), few studies deal specifically with the caring role. To address this gap, an international survey captured AT teachers' experience of teaching carers and of applying the AT in their own caring roles. Findings are presented under three themes: re-connecting with the body, re-discovering the self and relating to the other.

The idea that the AT has potential to impact favourably on caring is both novel and intriguing. It is novel in that, pre-pandemic, the relevance of the AT to care was not widely considered. Indeed, the reasons why carers were having AT lessons with our survey respondents typically had nothing to do with caring. Any teacher-reported benefits for caring were therefore indirect and, presumably, unanticipated by their carer students. This is intriguing.

In considering the puzzle of why the AT might support caring, 'care' is seen as a universal, embodied phenomenon: knowledge held in the body as habits that can be developed or lost (Hamington, 2004). As academics with first-hand experience of the AT and of caring, our discussion also draws on direct, embodied experience. We propose that a major strength of the AT is that it works in both tacit and explicit ways to reinvigorate selfhood and to renew, or develop, valuable embodied resources for the care of self and others.

The article extends understanding of embodied care through (i) presenting expert practitioner perspectives on how embodiment is relevant to care of the self and others; and (ii) discussing two specific embodied habits of care and the means by which such habits may be acquired, or restored. Further, in highlighting fundamental ways in which AT differs philosophically from other carer interventions, it opens up avenues for fresh thinking about theory and practice in supporting care, thus responding to calls to think in 'daring new ways' about care (Fine and Tronto, 2020:307). In offering a means whereby aspects of embodied care can be translated into practice, tested and evaluated, the AT has a significant contribution to make in developing the theory and practice of embodied care, and warrants inclusion in future research and practice initiatives.

Care as an embodied phenomenon

'Care' here is understood as an embodied, phenomenon. Care is *felt*, or experienced, and conveyed more by touch, tone of voice, or facial expression than by words or actions. Care involves those myriad acts that sustain us throughout life and that almost everyone is required to carry out at some stage in their lives. Care is often repetitive but 'full of the unpredictable, the spontaneous, and the intensely personal', a process within which small acts can carry 'powerful significance' and give 'dignity and meaning' to the lives of carer and recipient (Bunting, 2020: 7). Our data concern 'informal' care, or the daily unpaid work involved in supporting the wellbeing of another human being, whether sick, disabled, frail or otherwise dependent. This form of care, though fundamental to all human prosperity, is largely invisible to the societies it underpins.

Hamington, drawing on Merleau-Ponty's notions of 'the body's role in creating, maintaining and expressing knowledge through habits' (Hamington, 2004: 41), outlines three interwoven aspects of embodied care: caring knowledge, caring habits and caring imagination. First, beyond what is known intellectually, 'caring knowledge' encompasses what is known to the body. If someone knows how to reassure and soothe through touch, facial expression and tone of voice, it is because they have experienced being soothed in these ways. If they flinch at another's pain, it is because they too have experienced pain. Much of what is known of others is 'rooted in our bodies' and therefore not readily available to our consciousness (Hamington, 2004: 5). For Hamington, though shaped by environment and culture, the capacity to care is inherent in the human body. Like other forms of knowledge, 'caring knowledge can be developed and attended to, or it can be neglected and lost' (Hamington, 2004:4).

Second, Hamington defines ‘caring habits’ as ‘the practices of embodied beings that contribute to the growth and wellbeing of self and others’ (Hamington, 2004: 4). An expression of an individual’s caring knowledge, such habits are ‘physical practices of knowledge held in the body’. These include basic habits of perception and attention, and more complex social habits of care. Third, in Hamington’s framework, care involves the interweaving of these embodied practices with imaginative processes. These include empathy and the ability to consider one’s own subject position in caring, thus aiding an individual to avoid exerting undue power over the cared for, or losing themselves in caring for them.

In Merleau-Ponty’s corporeal epistemology, ‘heeding embodied knowledge is a choice. If we choose to attend to our bodies, we can “reconnect” with the world’ (Hamington, 2004: 48). However, technological advances now make it clear that, far from being ‘all in the head’, sustained or traumatic stress can interfere with what scientists call ‘interoception’, the individual’s ‘awareness of subtle, sensory body-based feelings’ (van der Kolk, 2014: 95). Psychological research indicates that the ‘unexpected career’ of caring can lead to a cascade of stressors (Pearlin and Skaff, 1996: 242) and ‘engulfment’ in the caring role can contribute to a ‘loss of self’, associated with depressive symptoms and reduced self-esteem and mastery (Skaff and Pearlin, 1992). It seems plausible that carer stress might lead to a reduction in corporeal awareness and hence hamper the ability to ‘heed embodied knowledge’.

Van der Kolk (2014) draws on wide-ranging research and decades of experience working with people with post-traumatic stress symptoms using both mainstream and alternative, embodied interventions. Compromised interoception can have significant consequences, including reducing an individual’s capacity to recognise and act on danger signals from the body, attunement with others, problems with attention and loss of agency. Further, compromised interoception tends to deaden positive sensations and experiences and lessen the individual’s capacity to feel fully alive (van der Kolk, 2014: 92). If caring is understood as embodied, it can be inferred that interoception compromised by stress will have adverse consequences for an individual’s wellbeing and capacity for care, both of themselves and of others. Neuroscience may thus offer a clue as to why embodied practices like the AT may support effective caring.

The Alexander Technique and embodied care

Like all bodily experience, how the AT is learnt and applied is not easy to put into words, [though see Woods et al (2020) for an extended illustration]. Significant in terms of selfhood, rather than a treatment given by others for a specific condition, as a method of self-care, the AT offers *agency* in how the student applies it in daily life. In the UK, some teaching takes place in organisations such as music academies, drama schools and community groups, but most teachers work in private practice, often in the teacher's own home.

The person as a whole is the point of departure in AT lessons. Habits in the way people sit, stand and move, as well as how they respond to internal stimuli (eg troubling thoughts or bodily sensations) or external ones, such as people and circumstances, can become relatively fixed over time. Because they are largely unconscious, these habits tend to reduce choice in how the person moves, thinks and reacts. The AT teacher uses their senses, particularly a specialist form of touch (Jones and Glover, 2014), to learn about a student's patterns of muscular tension, way of breathing, moving, standing, etc, which convey information about their unique habits.

AT teachers use their hands and spoken prompts to calm and to guide students towards more accurate interoception: a sense of the boundaries of the body, location of the joints and patterns of holding in the muscles. Students are made aware of habits of tensing in response to stimuli, and learn not to react instantly but instead to consciously apply thinking that countermands these habitual tendencies. The AT student also develops greater awareness of their surroundings, position and movement of their body in space, and where they are directing their attention, with practice becoming more able to stay present and control what they attend to. They are reminded that they can exercise choice over whether or not to react, and creativity in *how* they react, which leads to greater freedom of movement and thought, and a greater sense of ease and control. As they learn to apply the technique more independently and in more varied circumstances, the student gains confidence in their ability to cope (Woods et al, 2020).

Research in two main areas supports the authors' direct experience that the AT has potential in enabling carer wellbeing. First, large-scale clinical studie supported by a wide range of smaller-scale published research, demonstrate that AT lessons can offer long-term reductions in (i) persistent musculoskeletal pain and disability (Little et al, 2008; MacPherson et al, 2015); (ii) disability associated with Parkinson's (Stallibrass et al, 2002); and (iii) improvements in carer relevant psychological factors, such as self-efficacy, coping and perceived stress (Stallibrass et al, 2002; Woodman et al 2018; Kinsey et al 2021). Such improvements can help combat common problems in caring, including 'the logistical

requirements of daily life' among older or disabled carers (walking, bending, lifting, impaired faculties, etc) that can further deplete coping resources (Pearlin and Skaff, 1996: 242). Woods et al (2020) offer an introduction to the AT, including an overview of published evidence of its benefits. In the same issue, Cacciatore et al (2020) provide scientific insights into how the changes to neuromuscular mechanisms brought about by the AT may help explain its wide-ranging health benefits.

Second, emerging evidence indicates the potential of AT specifically within the context of caring (Woods et al, 2022; Woods 2021). In the USA, the non-profit Poise Project's trial of AT (www.thepoiseproject.org) as a support for carers of people with dementia and Parkinson's shows promise (Gross et al, 2019). Hanefeld et al (2021) illustrate how AT can assist the wellbeing of women during neonatal care. Although types of care differ in these studies, AT was found to support common aspects: reduced effort in moving the care-recipient, or assisting them to move; less tiredness; greater optimism; responding less habitually to the care-recipient; and a generally calmer and less reactive approach.

Research methods

This study took a mixed methods approach in exploring open and closed questions via a survey.

The survey

An anonymous on-line written survey was devised for certified teachers of the AT to investigate their experiences of caring and of teaching the AT to family carers. Closed items were included to collect basic frequency data, along with open-ended items.

Following a pilot, an invitation to participate and a link to the survey were distributed via email, initially to all members of the Society of Teachers of the Alexander Technique (STAT) in the UK, and subsequently to members of international affiliates. Participation in the survey was entirely optional and experience of caring was not essential. The study was granted ethical approval by (name removed).

Online survey data were collected using JISC Online Surveys software over several weeks in autumn 2020. Although data were collected during the COVID-19 pandemic, respondents were reporting pre-pandemic experiences.

[See appendix A for the definition of 'family carer' and questions used in the survey.]

Qualitative analysis

In making sense of responses to open-ended items, content analysis offered a well-structured and empirically grounded approach. Largely descriptive codes were generated initially; these gave a sense of the prevalence of topics and ideas in the data. These were discussed among the authors to ensure adequate precision, and a summary text prepared providing an overview of the content. The authors all have experience of AT and of caring, and thus are members of the social group surveyed: two authors teach the AT and have cared for parents with dementia, and one is an expert in dementia and student of the AT. We took care to consider whether our interpretations would have the usual social meaning for the group (Olsen, 2012: 64) and stayed as grounded in the data as possible, using actual words, phrases and quotations from respondents to illustrate ideas throughout the summary text.

With repeated re-readings, discussion and re-drafting of the data summary, the three main themes reported below emerged. There was considerable consistency in the data and the main interpretative challenge lay in presenting the themes and discussion for readers without direct experience of AT.

Findings

Respondents and their work with carers: overview

Responses were received from 84 AT teachers working in the UK, Germany, Canada, South Africa, Austria, Spain, the Netherlands and Switzerland. About half of respondents had experience of working with family carers, in most cases teaching one-to-one in private practice to address a specific health problem. A few respondents referred to working with groups of paid or unpaid carers in institutional settings, or with an individual together with their care partner.

Respondent experience was most commonly with carers of people with conditions often associated with older adults; half had experience of teaching carers of people with dementia. Respondents had also taught parents of disabled children and carers of adults with a diverse range of conditions or problems (eg Parkinson's, cancer, COPD, stroke, autism, and cerebral palsy). About two thirds of respondents also had direct experience of caring for

family members themselves. Respondents' words are included in italics in the remainder of the article.

Respondents understood the centrality of the caring role for many, recognising its '*impact on their lives and their whole wellbeing"*. They acknowledged the tumultuous change that becoming a carer can bring about:

> '… *hopes and dreams had been scuppered, and many of them had had to put aside their own needs and wishes in favour of looking after their loved one in ways they never envisaged'*.

Teachers recognised the toll that long term caring can take, one observing that carers of people with dementia arriving for lessons can:

> '… *present in a very depressed state. Like they are faint versions of themselves. They are very fragile. There is underlying anger. The dementia feels, they say, like it has seeped into them. They feel old. They feel confused themselves. Stunned is often how they arrive*'.

In terms of the teaching approach used with carers, AT teacher training involves learning how to adapt lessons in an evolving and intuitive way to suit the student at that particular moment, whether tired, in pain, calm or upbeat. Though respondents mentioned specific ways they supported highly stressed or exhausted carer students (eg lessons that make few demands, paying special attention to breathing, ensuring the carer-student feels '*comfortable and that they are in a safe space*'), respondents' general approach was broadly similar to working with any population. As one teacher explained, all individuals who come for AT lessons have their own '*resistance, defences, and manifestations of exhaustion and worry',* with carers no exception.

Reported benefits for carers

Perhaps unsurprisingly, AT teachers, both with and without direct experience of working with carers, were unequivocal in their belief in the potential of AT lessons to support carer wellbeing and resilience, with 100% agreeing that lessons would be beneficial and help carers to '*know their limits'* and '*avoid burnout'*. Those teachers with personal experience of caring referred to how AT had helped them as a parent, or when looking after another family member.

Though it is important to be clear that it is AT teachers, rather than carer-students themselves, who were surveyed, the changes observed by respondents are entirely consistent with everyday teacher experience and the AT research cited above. First, typical *physical* changes mentioned included reduction in musculoskeletal pain, along with greater confidence among carers about managing persistent pain more effectively. Teachers noticed a reduction in patterns of physical rigidity or '*holding'* and a greater ease of movement generally, potentially resulting in *'less injuries*' and '*greater physical comfort'* over the longer term for carers subject to heavy physical demands. Respondents remarked on the energy and motivation that this reduction in muscular effort can bring about, perceiving students to be '*revitalised*' and more ready to '*return to the fray'*. Carers, like other AT students, '*stand truer'*, with a more upright bearing after their lessons.

Changes of a more psychological nature mentioned included being more '*calm',* '*self-confident'*, having' *improved mood'*, being '*more resilient and less anxious*', '*recovering their sense of humour'* and '*holding their responsibility more lightly'*. Various respondents referred to the fact that AT lessons provide valuable practical tools for self-care in the face of adversity, providing what one respondent described as '*improved management of stress and the ability to keep going*.'

AT and caring: key themes

Theme 1: Re-connecting to the body

One teacher described the process of calming and improving the interoception of carers as follows: '*Each lesson feels like easing the pieces of them back together as gently as possible*'. Teachers described carers in this more embodied state as physically 'l*ess held',* and exhibiting *'less shock/freeze in the body from unexpected emergencies'* and having choice in managing their '*reactions towards the person they are taking care* of''. Further, teachers observed the conscious thought processes they were teaching carers (to counteract their habitual physical reactions in daily life) as a way of building *resilience* in their carer students: '*As a teacher, I am looking to get them back on to solid ground, so they can survive their difficult home territory a bit longer'.*

As well as improving awareness of harmful habits and building resilience, the teachers surveyed referred to positive experiences and feelings that they believed more embodied carers appreciated. Being more *'present'* and aware of their surroundings was one source of

pleasure. The quieting, non-demanding touch of an AT teacher was described as '*a special treat'*, and important for bringing about a state of *'peace'* and '*ease*' for highly stressed carers. Teachers also referred to feelings like relief and achievement. One teacher stated that: '*Many carers have told me that it is a relief to have someone caring for them for a change and that this can make a tremendous difference*'. Another made reference to the '*huge sense of achievement*' felt by carers in attending lessons and '*actually doing something for themselves'*.

At the very least, AT lessons were seen to offer carers a physical and psychological break from their situation: a '*welcome distraction*' an '*escape from the talk of illness'*, or in the more extreme cases, *'time away from the awfulness of it all*'. Lessons were a chance to forget their '*worries and concerns for a while and come back to the present moment*', to be '*absolved from the carer role for the duration of the lesson',* to '*have some time when they don't have to be responsible for the patient*'. However, the data make clear that, from the perspective of these teachers, their lessons offered more for carers than the benefits of 'me time'.

Theme 2: Re-discovering the self

References to carers' sense of self were very prevalent in the data, with various aspects mentioned. First, AT teachers wrote about carers recovering a general awareness of the self. They referred to helping carers '*find themselves in the situation'*; '*prompting them to think about themselves'* and helping them notice '*where attention is, i.e., <u>not</u> on themselves'*. Respondents mentioned the way that '*the AT enhances your ability to stay aware of yourself while being with another'* and helps carers to '*be aware of their own needs and how to meet them in the situation'*. One teacher wrote of '*soothing them [carers] into acceptance of themselves as desperate, as overdoing it, accepting what is, in order to open up to a slightly bigger picture of themselves*'.

Respondents viewed a significant aspect of growing self-awareness for some carers as acquiring, or re-acquiring, the '*ability to value oneself*'. The fact that *'the carer could make choices'*, allowed a greater distance, or degree of detachment, from their role. This bolstered sense of self, and clarity around their role, was described as the AT teacher helping the carer '*rediscover themselves'*, to stop '*being a slave to their situation'*, to see themselves as '*more than a drudge*'. One teacher noted that with this growing awareness, both carer '*self-criticism and judgement of others changed beyond belief.'*

Second, teachers believed AT lessons helped carers understand the need to prioritise self-care in order to care effectively for another person. One referred to her own caring experience and the need to '*give myself the time, patience and resources to cope'*. Some teachers made the importance of self-care an explicit focus of their lessons. One reported giving '*emphasis on taking care of the carer, and the importance of time and skills for self-care*'. In learning self-care strategies and tools, respondents believed that carers appreciated '*doing something positive*', '*learning something constructive'*, '*having a positive thing to take away and think about'* to help them manage their day-to-day lives better. Having access to coping tools was believed to give '*greater choice in how they did their work',* so that they did not have to *'be trapped in only one approach'*, and '*a sense of empowerment that they can manage*'.

The third recurring idea in relation to selfhood was that the carer's prioritising of attention to the self was beneficial for carer and recipient alike. Teachers wrote about the need to '*care for yourself while staying open to the needs of others'* and the emphasis in their teaching '*on the message that … self-care is an investment in themselves and the person they care for*'. The benefits cited were not merely about the carer remaining physically strong enough to continue in their role, but also about the relationship between the parties: *'they [carers] take care of themselves first, and are happier and more loving as a result*'. One concrete example comes from an AT teacher who worked with a couple: '*she learned not to respond immediately, so could look after herself. She said herself, and her husband commented, that she smiled more'.* Carers being in touch with their own feelings and needs seemed to enable both the carer and cared for to experience and enjoy the relational aspects of caring more fully.

Theme 3: Relating to others

The interpersonal dynamics in the carer-recipient relationship are fundamental to the lived experience of care for both parties. Respondents were convinced that AT lessons helped this dynamic in various ways, with one stating: '*All the carers I've worked with have expressed a change in relationship with the other person*'.

One way that AT lessons were believed to benefit both care partners was via the quality of physical contact. Teachers reported teaching carers to '*move them [*care recipient*] more gently and experiment with their care* approach' and '*to use one's body well in lifting (...) how to lift with their whole* being'. Not only was this '*more comfortable'* for the carer and '*safer for their back*', but this less effortful support was perceived to be experienced by the recipient as being done more gladly and in a more caring way. One terminally-ill partner described the

difference as being '*handled with feeling, as a human, not like a sack of flour'*. This illustrates how greater awareness among carers of how they use their bodies and their hands during physical contact provides a powerful means of improving the experience of being cared for.

Second, respondents saw AT lessons as helping the carer handle the demands of 'l*iving with a 'helpless' or 'demanding' person – it can be difficult not to exhaust yourself and step over your own limits'.* Some AT teachers wrote about teaching carers boundaries to help them maintain some emotional distance, and to signal their own need for autonomy to the cared for:

> '*I always teach them boundaries and how to stand their ground, which helps tremendously'*.
>
> *For the man with the disabled child, learning boundaries changed the child's behaviour to being much less invasive of the dad, and I think it helped reduce the violence he experienced from his son (…) With other parents with disabled children, the issue of invasiveness always comes up, along with repetitive annoying habits. To have a better sense of one's own self really helps cope with this sort of thing.*

Respondents referred to how their own caring relationships, or those of students, had changed as they became better able to manage their reactions to challenging behaviour. The following quotation illustrates how this enabled one AT teacher to better support her daughter with mental illness:

> *I had to learn a sense of when to say something and when just to give love and total acceptance. I learnt to take her anger without being bothered by it, as I knew I was the only person she felt safe to fling it at.*

Understanding that ***not*** preventing reactions to negative emotion can ultimately lead to frustration and exerting undue power, one teacher expressed the view that AT lessons can '*ensure that the carer was seeing the person as a person and treating them with the respect they deserve.*' Another wrote of '*matching*' the behaviour of someone with dementia, of learning to experience it '*new each time (…) rather than being frustrated or distressed that they aren't as they were, or can't be, reasoned with'.* Others referred to AT lessons developing the '*patience'* and *'tolerance'* needed for caring.

Finally, respondents referred to increased self-confidence and sense of purpose among their carer students after AT lessons, enabling them to '*see the bigger picture*' and '*not feel*

helpless'. This more self-assured frame of mind was seen to have implications for interactions with people other than the cared for, and for the carer's ability to access support or make important decisions. Being 'm*uch calmer and clearer around their caring work and their situation'* was enabling them to *'deal in a more effective way - by not getting overwhelmed - with the various agencies'*. This in turn could help carer-students '*get help, advice, search for additional care or residential care, as may be required',* by communicating their needs more assertively and effectively with medical and social services or other family members.

Discussion

The above analysis offers new, expert practitioner perspectives on embodied care, and observations of physical and psychological carer-relevant changes that are consistent with research cited earlier. Rather than *outcomes* of AT lessons for carers, in this discussion, we first focus on the under-explored question of the *process* by which these outcomes may come about: *how* embodied knowledge is conveyed during lessons. Because it was circulated among STAT qualified teachers, survey responses assume AT knowledge and experience. Our discussion is informed (i) theoretically by embodied care concepts from Hamington (2004) and Kontos (2005); and (ii) concretely by our experience of caring, and of AT teaching and teacher training. It offers, for a lay audience, an understanding of how AT lessons might, often as an unintended consequence, strengthen important habits of care, and outlines significant ways in which the AT differs philosophically from common approaches to care.

Explicit and tacit learning

There are references in the data to explicit teaching of content (about anatomy, breathing, boundaries, etc). Passing on information through words and images, in combination with embodied experience, is a significant element in AT teaching and training: as a system of self-care, the student needs ideas to experiment with and apply consciously in daily life, in order to develop proficiency and autonomy. Hamington's understanding of care as habits held in the body and passed on unconsciously to another allows for another way, not captured in the data, of acquiring relevant knowledge through AT lessons. As he asserts, the ability to sense the needs of others and respond accordingly is 'not magic' but involves habits that can be acquired through modelling and conscious effort (Hamington, 2004: 49). It

is our contention that, although respondents may not have been wholly conscious of this, AT teachers were *modelling i*mportant habits of care.

For Hamington, habits of care that our bodies know are not instinctive but learned, and include 'arms that know how to comfort, hands that know how to share joy' (Hamington, 2004: 57). He illustrates this process with the subtle interaction between his body and his daughter's as he teaches her to ride a bike: 'Our conscious attention is on the task at hand – learning to ride a bike – so that the subtext of the dance between my body and my daughter's goes largely unnoticed'. With a reassuring voice and a hand on her back, and soothing her when she falls, Hamington's 'daughter is explicitly learning how to ride a bike but implicitly learning how to care' (Hamington, 2004: 59). In communicating care, Hamington argues, he is also modelling the habits of care in ways that his daughter's body captures, thus contributing to her own embodied resources for caring for others.

Training to teach AT involves a minimum of three years' intensive work. Knowledge is acquired experientially largely via one-to-one hands-on and verbal guidance from experienced teachers in a way that bears a striking resemblance to the modelling process described by Hamington. Through physical contact with senior teachers, the trainee is explicitly learning about AT processes and teaching procedures, while implicitly learning highly specialised embodied habits of care from the senior teachers' model. Two such habits are echoed throughout the data: 'sympathetic perception' and 'foregrounding the self'. Both concern aspects of perception, and both are fundamental to AT training and to care.

Habit 1: Sympathetic perception

Applying Merleau Ponty's phenomenology to care, Hamington argues that the unconscious affective knowledge of others garnered through non-verbal means far exceeds what is available to consciousness. It is this 'corporeal knowledge' that 'creates the potential of sympathetic perception that makes care possible' (Hamington, 2004: 54). One specialist habit of perception acquired via AT teacher training concerns this sympathetic perception of others through a highly specialised form of receptive, non-demanding touch (Jones and Glover, 2014). This contact allows for the exchange of immensely subtle, fleeting bodily responses that defy verbal description, as one AT student put it: '*If it had involved a lot of talking, I don't think it would have been as good a way of communicating*' (Armitage, 2009: 71).

When the AT teacher supports or guides someone with their hands, to enable the teacher to experience the other person fully, they must retain a sense of connection of their upper limbs

with the back, and their attitude must be one of openness and non-judgement. Rather than manipulate a limb, or use force to help someone out of a chair, the AT teacher must sense through touch if there is tension in the student's body impeding movement and when there is a state of readiness. The desired action should be completed jointly, when the AT teacher senses that the other person's body allows it. Rather like couples moving round a crowded dancefloor, when the pair are attuned and sufficiently skilled, this communication takes place at an unconscious level, without effort.

The possibility of heightened sympathetic perception has profound implications for caring. First, the form of open, non-demanding physical contact being modelled provides an additional avenue for communicating care: where words will not be perceived, or comprehended, or are inadequate or unnecessary, it conveys the sense that the care recipient is cared about as well as cared for. It is unlikely that the mere application of a lifting technique by his wife made the terminally-ill husband referred to above feel more like '*a human, not like a sack of flour'*. Experience suggests that she had acquired, or rediscovered, what supporting another human in a fully embodied way feels like via the AT teacher's modelling of this in guiding the woman's own movement.

Second, heightened sympathetic perception is relevant to a sometimes-overlooked aspect of care: it is in its embodied aspects that the *joys* of care reside. The open, non-demanding contact being modelled offers a means of connecting deeply that can make care routines more enjoyable for both parties. This is reflected in phrases about carers '*holding their responsibility more lightly',* '*smiling more'*, '*being more loving'* and '*recovering their sense of humour'*. The feelings of calm, enjoyment and relief that this contact can impart is captured powerfully in the testimony of carers following a group AT session (Woods et al. 2022).

Third, besides the explicit teaching of ideas to apply consciously to give greater choice of care approach referred to in the data, heightened sympathetic perception acquired by carers through modelling could also stimulate carer experimentation. Writing about caring for her mother, who had dementia, an AT teacher writes:

> Helping my mum with her personal care had to be just that - *helping* her - a genuine negotiation of the task at hand. If ever this implicit understanding was broken and my mum discerned too much will, there would be resistance (Woods, 2021: 22).

Developing a greater sense, through modelling, of how their desire for speed, or trying too hard, might be contributing to resistance by the cared for, could prompt carers to pause and identify a mutually acceptable way forward.

A fourth implication of this heightened awareness referred to by respondents concerns questions of power. In the above quotation, the mother's resistance is illustrative of the body's own 'intentionality and agency' separate from cognition (Kontos, 2005: 558). Touch provided a means of communicating this to the daughter, who acknowledged and responded by ceasing to exert her own will. In this example, AT touch might be understood as a channel for the reciprocal expression and acknowledgement of what Kontos (2005) has called 'embodied personhood'. This more negotiated, mutual, approach offers a potential means of reducing conflict and battles of will in the caring relationship of the kind that may lead to frustration and undue exertion of control. The data include a number of references to ways that their AT lessons were altering carers' perceptions of the cared for along these lines: '*ensuring that the carer was seeing the person as a person and treat(ing) them with the respect they deserve'*; exercising greater '*patience*' and '*tolerance*'; and how '*judgement of others changed beyond recognition*'. These phrases hint at the emergence of a more person-centred and empathetic approach.

The fact that this sympathetic perception also gave rise to reduced *'self-criticism'*, is indicative of a changing attitude to the self as noted in other AT research (eg Hanefeld et al, 2021; Jones and Glover, 2014). This kinder, more empathetic, attitude towards the self is also highly significant for care.

Habit 2: Foregrounding the self

A second specialist perceptual habit the trainee AT teacher acquires is that of resisting the body's 'spectacular ability to place itself in the background' in activity (Hamington, 2004: 50). This tendency to exclude the self from awareness at the moment of perception can lead to engulfment in the cared for and the self-loss cited in caring research. The body *does* have the potential to be aware of itself as it allows us to experience the world, but normally this potential is not utilised. The AT teacher, however, is required to develop awareness, and ultimately mastery, of their own habitual bodily responses while in contact with another person: to see themselves as both subject and object of perception.

The data make clear that respondents understood the significance of carers being enabled by their AT lessons to attend to the self while attending to the cared for. Teachers refer to

explicit teaching, such as '*prompting carers to think about themselves*', urging them to '*take self-care seriously'*, and '*teaching boundaries*'. We would argue that significant tacit learning is also taking place, the AT teachers modelling their capacity to attend to themselves while in contact with their carer pupils during lessons. This is supported by data from a professional caregiver in a care home setting. Though not taught this explicitly, this caregiver had developed her ability to see herself as both subject and object of care, which helped her manage her relationship with a particularly aggressive resident. To avoid getting '*stressed out'*, she says:

> 'I stop and think, "Right, I can help this person". So I calm right down and it's a lot better for me and a lot better for her' (Woods, 2021: 17).

Even where care for another is a priority, there is scope for a 'healthy sense of ego and balance' (Hamington, 2004: 68). As in the kind of boundary-testing described in the data, there is choice as to whether to comply with the instincts of the body: the imagination allows for the consideration of different scenarios in decision-making. Through modelling the ability to retain balance between self-awareness and awareness of the other, it is our understanding that the AT teachers were stimulating the self-reflexive imaginative leap required to allow the carer permission to exercise choice and to care for themselves. Ultimately, the greater sense of agency and self-assurance inherent in this balanced approach lies at the heart of the observation cited above, that AT lessons might enable carers to handle challenging interactions and make difficult decisions if required.

A fresh perspective on caring?

Though detailed discussion of carer interventions lies outside the scope of this paper, brief comparison with the AT is instructive. Meta-analysis of carer intervention studies notes problems of generalisability beyond Europe and North America, given the impact of cultural factors on carers' lives (Kishita et al, 2018). The geographical spread of respondents in this survey mean similar limitations apply to the AT. The fact that the kind of tacit, embodied knowledge discussed above requires actual physical contact further limits accessibility. That said, combining hands-on AT work with group and on-line teaching to improve availability has become increasingly commonplace since the Covid-19 pandemic. As the data illustrate, the AT involves learning to think in new ways and being more mindful. Supplementing hands-on AT work with successful online mindfulness or CBT interventions for carers might be a way of increasing affordability and accessibility (Kishita et al, 2018): generally those who attend AT lessons are self-selected in terms of ability to pay and openness to non-mainstream approaches to health.

Aspects of the macro and micro-environments and individual factors combine in complex ways to make every set of carer needs and experiences unique. The effectiveness of any intervention will be constrained by political decisions that shape care policy and practice at all levels in any given society (Fine and Tronto, 2020). What distinguishes the AT in the context of care is that it represents a challenge to the standard paradigm in ways that have implications for developing theory and practice. Western conceptions of selfhood are profoundly cognitive, affording the body 'only instrumental status' (Kontos, 2005:558). In contrast, mind and body are indivisible aspects of the self in the AT, and the AT's underlying assumptions differ from common carer interventions in important respects.

First, a carer learning the AT is first and foremost a person. Their caring role may play little or no part in determining the content and process of their learning. The AT provides a means of supporting human beings, whoever they are, to make the most of their capacities in meeting whatever challenges they face. This recognition of personhood is fundamental where people's identities beyond being a carer are apt to be effaced by a role that places another's needs at its heart. The AT lesson gives the carer an opportunity to reconnect with themselves, enjoy the experience of being the person being cared for, and replenish their resources for care.

Second, in AT lessons the focus is firmly on learning, not instruction. The student may acquire anatomical knowledge, breathing, lifting and relaxation techniques, or other ideas to apply in daily life. However, there is no requirement to learn a body of knowledge. Much of the learning that takes place is unconscious and effortless. This is a significant benefit for carers struggling to find time for themselves, or where linguistic, educational, cognitive or other barriers may make formal learning less effective.

Third, implicit in many carer interventions is the idea of an individual deficiency or particular problem to be addressed, such as feeling anxious, or the lack of a specific skill, or knowledge. In contrast, the AT concerns universals, and teachers resist assumptions about specific problems and individual capacities: it is understood that most people coming for AT lessons have probably already learned how to move, to think, to feel and to look after themselves and others, but that these abilities can be compromised. The AT restores the ability to access knowledge held in the body in ways that often feel very familiar: moments of realisation that 'this is how life used to feel'. Alongside this largely unconscious restorative work, explicit teaching provides thinking tools that can help the student stay in touch with themselves over time.

Fourth, in building global effects like agency, control, choice and imagination, AT lessons do more than relax, ease pain, or provide information. They have the power to impact on all

aspects of lived experience of carer and cared for. Many of the effects most appreciated by AT students are of this global nature, and not readily captured in instruments designed to measure specific outcomes (although see Brough et al, 2021). A sense of humour, feeling fully alive, enjoying the people and places around us, the feeling that we have some choice and control in determining our own future. These are things that people may not even know they have lost, until they are restored to them.

Kontos argues powerfully for an embodied understanding of selfhood as a theoretical basis that can challenge the prevailing paradigm and bring about the 'transformational shift' (Kontos, 2005: 565) needed in dementia care. Our data and experience lead us to the conclusion that an embodied perspective adds depth in considering personhood in *any* caring partnership, from the perspective of either party, and in their interrelationship. It is only from an embodied standpoint that the unarticulated aspects of care, largely absent from the caring literature but central to the experience of care, can be made manifest.

The data and discussion presented illustrate how the AT provides a means whereby those involved in care can acquire, or re-acquire, embodied knowledge that is fundamental to care. In bringing these typically unacknowledged aspects of selfhood to conscious awareness, the AT has a further role to play in contributing to the development of research and theory in embodied care.

Conclusions

This exploratory study suggests that AT teachers have expertise that makes them valuable partners in exploring ways to support carer well-being and resilience. Participant observations are consistent with (i) research studies showing carer-relevant AT outcomes in terms of general physical and psychological functioning; and (ii) the idea that AT specifically helps restore embodied selfhood and resilience, thus counteracting carer self-loss and supporting care of self and others.

The concept of care as embodied habits that can be developed or lost offers a theoretical basis for understanding how AT teachers pass on specialist habits of care in both tacit and explicit ways. The data and analysis provide an illustration of specific embodied habits that would seem highly relevant to caring, and descriptions of both the practical and theoretical means by which they might be acquired, or re-acquired. Although data collected mainly refer to family care, these insights would seem relevant to other care settings.

The expert practitioner perspectives on the embodied habits of care presented challenge colleagues to think differently about what might constitute effective support for carer

wellbeing and resilience. We hope they will be persuaded to consider including AT in designing carer research and practice initiatives.

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Appendix: Survey

1. 'Family carer' definition:

'people who provide regular support for another person, who they may or may not live with, who has a long term health condition or support needs. Sometimes referred to as an informal caregiver, i.e. they are not paid or professional carers'.

2. Questions on AT and family care:

Do you have experience as an AT of working with family carers?

'Yes' respondents

- What conditions do/did the people they were caring for have?
- Please give us an idea of how many family carers you have worked with, an idea of the number of lessons you provided
- Did you adapt your approach in anyway because the person was a carer?
- Please expand on your answer in terms of changes made and/or reasons for making or not making changes

- What, if any, changes have you observed carers following your lessons (by this we mean changes in general not just those that might be related to caring)?
- Please tell us more about your experience(s) of working with the AT with family carers

'No' respondents

- Do you think that lessons in the AT are likely to be of value/ benefit to family carers?
- Please expand on your answer in terms of how you think the approach might help or your reasons for saying no

Questions for everyone

- Do you have any personal experience of caring (family/friends)?
- Please tell us a little about your experiences
- Any other comments?

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