What therapeutic hope for a subjective mind in an objectified body?

A presentation given at the UKCP conference 'About A Body – working with the embodied mind in psychotherapy' on September 10th 2004 in Cambridge, UK by Michael Soth.

Michael Soth is an Integrative Body Psychotherapist, trainer and supervisor, living in Oxford, UK. He is Training Director at the Chiron Centre for Body Psychotherapy in London and over the last 20 years has been teaching on a variety of counselling and psychotherapy training courses.
Michael practises Integrative Body Psychotherapy, bringing together a variety of analytic and humanistic approaches. Other areas of work include organisational consultancy, group facilitation, conflict resolution, work with men as well as a project applying Body Psychotherapy to illness, chronic symptoms and psychosomatic disease. Some of his writing and published articles are available at www.soth.co.uk. The website also has information about training and teaching events scheduled for the coming year, including two one-day seminars designed to follow on from this presentation and applying the ideas to our practice.

The title of this presentation could equally well be:

What hope for intersubjectivity between two subjects in objectified bodies? or:

What therapeutic hope for *psyche* in an objectified body?

A) Introduction: modern psychotherapy as an ambivalent response to the 'disembodied mind'

We would not be organising a conference subtitled 'working with the embodied mind', unless we all shared an implicit recognition of the 'disembodied mind'. All psychotherapy, whatever the specific approach, is involved with and affected by the blessings, the contortions, the vicissitudes of the 'disembodied mind'.

1) Freud and disembodiment (dismissing the body versus listening to the body)

As Suzi Orbach reminded us yesterday, the origin of modern psychotherapy as we know it is inextricably bound up with the recognition of disembodiment. Hysteria directly de-constructs the prevailing paradigm of mind over matter: the bodies of Freud's hysterical patients were doing their own thing, irrespective of and against voluntary control. It did not take a Freud to recognise that there was something wrong there somewhere. No, the revolutionary thing Freud did was to take hysteria seriously. Freud bothered to listen to the distress and the body. He held out for the possibility of meaning in hysteria.

It turns out that Freud's reaction was a pretty worldchanging event, after a couple of millennia of patriarchy. You remember that feminist comment on Christmas: the birth of a man who thinks he is god is not such a rare event. Well, in my experience a woman being in pain and a man NOT dismissing her as hysterical *is* a vary rare event, indeed. I'm not sure why men so readily call women 'hysterical', it's like a congenital reflex, there must be a gene for it, or maybe Jaak Panksepp can tell us about some brain circuit reserved for the male population.

Freud did not do that. He took the hysterical disembodiment seriously as a meaningful communication. Instead of saying: "let's get these bodies to do what their owner's minds want them to do", he said: "maybe these bodies are saying something intelligible, maybe these bodies are right in some way."

As Freud often remarked, extreme cases can show us more clearly the dynamics of what we call 'normality'. The hysterical symptoms of Freud's patients show us *in extremis* the 'disembodied mind' – the ordinary unhappy dis-integrated relationship between body and mind in all of us and in the culture at large. So with embodiment and the brain-mind-body relationship becoming relevant topics within the psychotherapeutic field, the central question is:

2) How *does* disembodiment transform into "the psyche indwelling in the soma"?

It seems clear to me that if the mind is disembodied, eventually both mind and body suffer. *Both* lose some of their potential, and start to function well below capacity. Yesterday all kinds of examples were mentioned which illustrate the pain of disembodiment, of not having a sense of the body, of an internal war against the body. The client who comes to the session, cutting herself, being trapped in that war, how can she arrive at some sense of – in Winnicott's phrase – the "psyche indwelling in the soma", the – as Suzi Orbach called it -body/mind state of 'yum'?

What can happen in the consulting room, between client and therapist, that has a lasting transformative effect on habitual, engrained, repetitive patterns of distress, which in my view are nearly always concomitant to some sort of pattern of disembodiment ?

3) Extending the limits of what we can bear

One significant factor, as mentioned yesterday, is how much distress the therapist can actually bear to be with. And yesterday the recognition was implicit that our theories and approaches - as helpful and valid as they are - also have a protective function. A large chunk of our psychotherapeutic theory and practice is the ‘disembodied mind’ in action right there under our noses (or 'behind' our noses), protecting us from what we can’t bear. The disembodied mind reveals *and* occludes. Obviously, this limits the transformative capacity of the therapeutic space we offer. Sometimes no force on the planet can extend the limits of what I can bear. Sometimes there seems to be some leeway.
So what can I say here today that might extend the limits of what we can bear ?
Let me try to de-construct some of the protective mechanisms of my tradition by responding to Suzi Orbach’s challenge.

B) Two ways of using the body:

1) The challenge to Body Psychotherapy's habitual position: the body as an objectifying, gratifying short-cut to protect the therapist

The challenge to my tradition of Body Psychotherapy is that we idealise the body, and that we short-circuit the depth of the pain by providing gratifying and soothing interventions. That is, in my view, an entirely valid and correct challenge. The interventions of the Body Psychotherapy tradition (including body awareness and bodywork techniques) *can* and *have been* used to ‘make better’, to sidestep the depth of the pain, and to minimise, counteract and circumvent the heat of the transference. I have used them like that.
A lot of the talk I had prepared before I came yesterday was precisely about owning that idealisation, and owning its shortcomings, its failures and its damaging effects. If as Body Psychotherapists we can allow the deconstruction of our habitual position and our attachment to it, we might yet salvage something precious.

2) The body as one avenue, one of the royal roads, into the depths of psyche, into the traumatic depths of disembodiment, into subjective and intersubjective depth and into spontaneous transformation

There is a way in which the spontaneity of the body – both the client’s and the therapist’s - *can* become one avenue, one of the royal roads, into the depths of psyche, into the traumatic depths of disembodiment and into subjective and intersubjective depth.
Let’s see whether I can get us from A to B within the allotted time ...

C) Objectification of the body

1) Case illustration - introduction

Following Freud's idea about extreme cases revealing the dynamics of 'normality', if we want to contemplate how to go about re-including the body in psychotherapy, we might want to think of people who are extremely disembodied.
Years ago, when I first started, I once worked with a client, let’s call him Max, who knew he hated his body. He hated his appearance: he thought he looked thin and weedy. His grandfather had coped with being an immigrant by becoming a boxer, and had taught his son accordingly. My client grew up with the constant certainty of his father’s and grandfather’s contempt for him. He was not the same kind of man as they, and they were the only kind of men he knew. When he came to see me years later, in his mid-30’s, he was habituated to living with that contempt and self-hatred as a constant companion. By that time he had been through quite a therapeutic journey already.
He had spent his 20’s in a fairly isolated state, without a social life, working long hours in front of a computer. This helped him forget his body and ensured a social status that would protect him from the powerlessness and uncertainty which his father’s family had suffered from.

2) Negative objectification: the body as an ignored and exploited slave

a) Ignore it and use the body as long as it is working

During this pre-therapy period of his life he illustrates an attitude towards his body which we recognise as fairly common in our culture: the body as an ignored and exploited slave. This is what I would call 'negative objectification':
This quote from Ken Wilber puts it neatly: "I beat it or praise it, I feed it and clean and nurse it when necessary. I urge it on without consulting it and hold it back against its will. When my body-horse is well-behaved I generally ignore it, but when it gets unruly - which is all too often - I pull out the whip to beat it back into reasonable submission."
In other words: ignore it and use it as long as it is working, fix it and get it to perform when it's faulty. When normal disembodiment breaks down, we run to some helping professional, who is obliged to provide the illusion that we are in control of it all.

b) 10 minutes – 23:50 hours

With another client, whose main concern in therapy *is* about his body performing, we have developed what we call the 10-23:50 principle. He had spent an enormous amount of money and energy in the gym and various therapies, including sex therapy, on behaviourmodificating, educating, training and forcing his body into shape, in order to guarantee its sudden springing to life when needed.
He now realises that having ignored his body and been oblivious of it all day, it is not only the explicitly sexual 10 minutes of his day which are the problem, it is also his relationship to his body the other 23 hours and 50 minutes of the day.

The objectification of the body is not very visible as long as the body can be ignored, but it does become apparent when the body gets unruly. It then gets treated like a machine that needs fixing, so we can go back to using the body the way we are used to.

c) When denial and ignoring of the body break down, fix it and get it to perform

My client's body finally did become unruly: he developed colitis and started seeing complementary practitioners. They told him his lifestyle was damaging and that he should take care of his body. That is not easy for a person who is consumed with self-hatred for his body.
My client being a thorough and conscientious person, he started taking care of his body in the only way he knew, quite brutally. Having always hated the look of his nose, Max re-appeared after one summer break, with a new, improved nose, thanks to cosmetic surgery.
This is an illustration of the degree of delusion that is possible in the 'disembodied mind' – he thought he was taking care, whereas all I could see was an enactment of his hatred for himself and his body.
No longer allowed to ignore his body altogether, he was confronted again with the underlying self-hatred – it was staring him in the face. His looks now became terribly important, especially his physical appearance. He did not go as far as joining a boxing club, but he did make it to the gym. Without improving his physique, he was convinced that his chances of attracting a relationship were non-existent. In fact, he became a regular gym addict. So even when he was tired after a long days work and resented it, he had to go because otherwise - as he called it - "the rot would set in".

The whole thing was, of course, completely irrational because what the world had always seen from the outside was a good-looking attractive man. Now he started taking his cue from Hollywood celebrities and became obsessed about his fitness, his health and his diet. He went to massage regularly. He showed all the outward behaviour of someone who takes care of his body, long before magazines like 'Men's Health' spread the message.
During this period of his life he illustrates an increasingly wide-spread attitude towards his body, modelled by global fashion icons all over the media – an attitude which we might call 'positive objectification':

3) Positive objectification: the body as post-modern fashion accessory

The body is fast becoming a post-modern fashion accessory, treated like a car as a substitute for self, an advertisement for self. Maybe with the advances of cosmetic surgery we will at some point all be able to download the perfect designer body off the internet, but that attitude – shaping and training the body to fit our chosen image of it - only brings home the full extent to which we *use* the body, rather than identify with it.

I am obviously not at all criticising the many wonderful holistic and complementary therapies we have available these days – I myself do Tai Chi, have massage, go to osteopaths, homeopaths and acupuncturists. All of these are helpful and precious practices. But from a psychotherapeutic perspective there is more at stake than turning a neglectful, demanding, exploitative relationship to the body into a caring, careening, positive one. Both negative, exploitative objectification of the body and benign, caring, helpful, therapeutic objectification of the body is objectification.

4) Objectification is the more obvious, visible 'far end' of underlying experience of disembodiment

I can only use my body with that degree of arbitrary nonchalance, if I am no longer connected or identified with it at all, if it is indeed an 'it' which 'I' drag with me through life as an appendage underneath my neck, if I am habitually disembodied.

Both kinds of objectification, negative *and* positive, are the 'far end', the - both collectively and individually - easily visible manifestation of the extent to which our culture suffers from an underlying pervasive disembodiment ("which is a peculiar lesion in the modern and post-modern consciousness" Ken Wilber). As was mentioned in various ways yesterday, by Jaak Panksepp and others, after a few hundred years of Cartesian duality, enlightenment, positivistic reductionist materialism, we have ended up thinking disembodiment is the human condition.

D) Disembodiment

1) Disembodiment: we have lost any sense of identification with the body

As a result, we have lost every sense of identification with our body, to the point that when Body Psychotherapy elder Stanley Keleman re-discovers it, it sounds like a revelation:

"You are your energy. Your body is your energy. ... The unfolding of your biological process is you ... as body. Your body is an energetic process, going by your name. It delights me to say that I am my body. It gives me identity with my aliveness, without any need to split myself, body and mind. I see all my process - thinking, feeling, acting, imaging - as part of my biological reality, rooted in the universe."

Max *never* experienced anything like this. That kind of statement was inconceivable to him. Most of his life Max could not actually *feel* his body, let alone derive an identity from it. He, his identity, his subjectivity, (if it was anywhere) was – without a doubt on his part – located in his mind, his principles, his alert and acute mental and cognitive consciousness. His body was an 'it' which he was responsible for, but a hated, disturbing, troublesome 'it' which 'he' was identified against and struggled against. That was a never-ending battle.

He spontaneously experienced his body as an 'it' – disembodiment was a given, an experience which he found himself thrown into. And through being trapped in his father's hatred of it, which he experienced as self-hatred, he was also internally perpetuating the objectification. This internal relationship between 'his identity' in his mind and his body we might call his self-objectification.

These are the two facets of the quintessential 'objectified body' I refer to in the title of my talk – it's both a spontaneous experience which we are landed with, and it's an internal, ongoing process – the mind-body relationship is also an object relation (father-son). He was caught in a constant internal re-enactment which he could not help but act out externally, in his life and in therapy. His unconscious construction of therapy and me as his therapist always already contained these two poles and the dynamic between them, long before I had even entered the room.

Our culture is pervaded by an underlying stance which treats the body as an object rather than a subject. The objectification of the body is rampant in the culture, in our clients and in the field of counselling and psychotherapy.

2) The way psychotherapy tries to re-include the body mirrors the way clients bring their body

Clients understandably want to function and perform, and they want any dysfunctions fixed, they want us to make them better - that's usually what they think they are paying us for. That's true generally, and it also applies to the body.
In response to this demand, the way we are inclined to use the body inevitably mirrors to some extent the way in which clients bring their bodies to psychotherapy:

a) either not at all, or ...
b) as something they want to conquer – the body as an avenue for a simplistic, physical and un-psychological 'cure' ('making better', fixing), or ...
c) as something they are at the mercy of – the body as the most engrained locus of the uncontrollable, unreachable, unchangeable symptom.

You see, like our clients, if psychotherapy bothers about the body at all, it tends to fall foul of the 10: 23:50 principle: we tend to pay attention to the body only when it becomes symptomatic, when it protests. In our conferences we then focus on the clinical use or the clinical extremes of the body, i.e. either body techniques (often reduced to: whether to touch or not) or body symptoms (addictions, eating disorders, self-harm, trauma, sex).
We get caught in talking about how we can *use* the body, for example, to more effectively treat otherwise recalcitrant conditions like trauma, eating disorders, addictions and strong resistance. There is temptation to make the body a treatment option for certain special conditions, a specialism to be grafted onto standard psychotherapeutic practice.
The way we try to re-include the body is not entirely free from the objectifying tendencies in the culture. But as long as we are caught in such an objectifying stance *against* the body, we cannot possibly appreciate the potential for spontaneous, autonomous subjectivity emerging *through* the body.

E) *Using* the body: the body as object rather than subject

As long as I am *using* the body in an objectifying fashion, I am not identifying with it, thus perpetuating disembodiment.-We cannot talk about how to 'use' the body in psychotherapy without some recognition of the 'use', mis-use and ab-use of the body under 'normal' circumstances.
We cannot expect more than superficial alleviation of symptoms if we focus all our efforts on the 10 minutes rather than the remaining 23:50 hours.
We cannot hope to work *with* the body unless we have an understanding how much we are always already caught in a culturally constructed stance of working *against* the body.
We cannot fully address the pain and problems manifesting in the body without addressing the problems inherent in our dualistic conception of the body/mind relationship.

1) Overview: Two ways of (re-)including the body in psychotherapy

I hope to show today that there are two ways of using and (re)-including the body in psychotherapy. Both are helpful and necessary. They have much in common and are complementary, but in some respects they are also antagonistic and opposed as they imply radically different aims, theories, potential results, and demands on the therapist.
In simple terms: I can take a third-person perspective and relate to the client's body in an objectifying way. Or, I can take a first and second-person perspective, and relate to the client's and my own body intersubjectively, even when we are disembodied or trapped in self-objectification.
As I will clarify later, in my view all therapy, and all therapists, are caught between a) allowing and 'entering' the inevitable repetition of the wound in the here and now of the therapeutic relationship and b) responding to the wound, the far end of which is a reparative 'making it better'. If the therapist can bear and hold that tension, and *be* in it, spontaneous transformation of the wound can occur. The two ways of (re)-including the body in psychotherapy match those two polarities. I will propose that we need *both* and to develop the capacity to work with the tension between the two.
So here is a condensed sneak preview of what I am working myself towards, and I hope it will get clearer as we go along.

Relating from a third-person (monological-objectifying) stance	Relating from a first and second-person (dialogical-hermeneutic) stance
· making embodiment happen	· relating to the body as an avenue into the already existing disembodiment, in client and therapist and the therapeutic relationship
· taking a quasi-medical therapeutic position, in order to *reverse* the client's disembodiment and *counteract* the body's exclusion	· the body as an avenue into 'what is'
· deliberately affect change (change through 'translation' and 'contradiction')	· rather than taking a position which tries to change the habitual patterns, conflicts and dissociations (which we find ourselves in) from the *outside*, I am surrendering to relating from *within* them
· symptom-reduction	· reflect on any objectifying therapeutic impulses I might have as possible re-enactments
· if I want to meet the client where they are, I need to collude with the client's self-objectification and their expectation for me to take a 'medical model' third-person stance	· consciously entering the same experience which the first approach tries to change (and therefore treats from a third person perspective), but entering it as a dialogical, relational dynamic
· treating the body as the 'it' which the client experiences it as, anyhow	· holding out for the possibility of spontaneous transformation (rather than deliberate, strategic change)
· it is the logical opposite to overly rational, mentalist approaches, but it is using the dualistic paradigm even as it is contradicting it	· hold the tension between embodiment and disembodiment, spontaneity and enactment, subjectivity and continuing objectification
·	· resting in conflict and paradox as necessary ingredients in the therapeutic position

a) Relating from a third-person (monological-objectifying) stance (doctor)

One way is working from a third-person, monological perspective. It is, therefore, operating from within the objectification implicit in the existing dualistic body/mind paradigm to make embodiment happen. It is about taking a quasi-medical therapeutic position, in order to reverse the client's disembodiment and counteract the body's exclusion. In this way of using the body, I bring my knowledge, authority and expertise to bear in order to deliberately affect change (change through translation and contradiction). I am aware that the client suffers their individual version of the culturally-constructed supremacy of the mind over the body, and that where it hurts they are helplessly trapped in it. Everything they do with their mind, every strategy they use, just makes things worse. So quite naturally, if I love and care, I have an impulse to ease their pain – so the first way is mainly about symptom-reduction.

In any case, if I want to meet the client where they are, I need to collude with the client's self-objectification and their expectation for me to take a medical model third-person stance. This way of using the body therapeutically is, therefore, treating the body as the 'it' which the client experiences it as, anyhow. It is the logical opposite to overly rational, mentalist approaches, but it is – in terms of its implicit relational stance - using the dualistic paradigm even as it is contradicting it.

b) Relating from a first and second-person (dialogical-hermeneutic) stance (relational)

The other way of including the body is less well-developed, but just as necessary. It is about relating from a first and second-person perspective, i.e. what hermeneutics calls a dialogical stance. Paradoxically, from within this stance we relate to the body *as an avenue into the existing disembodiment*, in client and therapist and the therapeutic relationship.

Rather than taking a position which tries to change the habitual patterns, conflicts and dissociations we find ourselves in *from the outside*, I am surrendering to relating from within them. It is about consciously entering the same experience which the first approach tries to change (and therefore treats from a third person perspective), but entering it as a dialogical, relational dynamic. By entering I do not imply any activity other than being aware of the relational body/mind reality we find ourselves 'thrown into'.

In this stance, as I will try to illustrate later, I reflect on any objectifying therapeutic impulses I might have as possible re-enactments because I am holding out for the possibility of spontaneous transformation (rather than deliberate, strategic change). I do not entirely refrain from such impulses as a policy, but I try to hold the tension between embodiment and disembodiment, spontaneity and enactment, subjectivity and continuing objectification. This way of attending to the client's and my own body, therefore, is all about resting in conflict and paradox as necessary ingredients in the therapeutic position.
The value of this way of including the body arises from the recognition that by being active all the time in making change happen, an exclusively objectifying quasi-medical stance interferes with an important principle – it interferes with allowing myself to be constructed as an object by the client's unconscious. Here I am interested in entering the relational experience of that construction whilst letting it be, attending to its manifestation across the whole spectrum of body/mind processes, again in client, therapist and the therapeutic relationship. In other words: it involves bringing the therapist's full and spontaneous body/mind reality into the consideration of the countertransference.

This second way of including the body is a necessary ingredient for developing an holistic phenomenology of relationship, and for making sure psychotherapy keeps doing justice to its core values: subjectivity and intersubjectivity.

The first way is a necessary, but in itself limited plain reversal of disembodiment and the existing power dynamic of mind over body. As history teaches us, the error - and the hubris - of too many revolutions is to stop short at such a plain reversal of the power dynamic.
Whereas the first way of using the body is necessary for counteracting and counterbalancing disembodiment and the still dominant 19th century body/mind paradigm, the second is necessary for actually de-constructing and transcending that paradigm.

Relating from a third-person (monological-objectifying) stance	**Relating from a first and second-person (dialogical-hermeneutic) stance**
is necessary for counteracting and counterbalancing disembodiment and the still dominant 19th century body/mind paradigm	actually de-constructing and transcending that paradigm
is a necessary, but in itself limited plain reversal of disembodiment and the existing power dynamic of mind over body	developing an holistic phenomenology of relationship
	doing justice to subjectivity and intersubjectivity

Let me repeat that I am not trying to establish one as right and the other as wrong, or that I am implying some kind of superiority or inferiority. *Both* are essential and necessary because they each meet and reflect two aspects and potentialities in each and every client. They also reflect a tension between to modes of relating which each and every client has to themselves.
I am therefore primarily interested in the tension between the two. There is relational information in how I experience that tension in the countertransference with each particular client. The tension between these two modes of relating has been with us since Freud and is – in my opinion – one of the most un-integrated issues in psychotherapy, and therapists identify with one or the other in a rather absolute fashion. Some therapists staunchly and exclusively identify with the 'medical model'; others as fiercely attack it, denying it any validity within 'true' therapy. Most therapists – as Freud himself – oscillate uncomfortably between the two polarities, switching between them in response to transferential pressures. It is important to locate the origin of our countertransferential conflict between these two stances in the client's inner world.
As we will see in more detail later: the client also is conflicted between these two modes of relating to themselves, and specifically their body as the root of their spontaneous experience of themselves. Clients are caught in internal relationships which treat their emerging 'self' as an 'it' or an 'I'. Their relationship to their body is usually the most visible manifestation of this tension or conflict..

F) The diagnosis of dis-embodiment

1) My past idealisation of embodiment (why embodiment and the wisdom of the body)

If you'd asked me 20 years ago to talk at a conference on the embodied mind, it would have been easy: I would have said that the 'disembodied mind' is the root of all evil and embodiment is the solution. I thought I had cracked the code, and I was on a mission.
At that time, I only knew about the first way of using the body, and my whole therapeutic style, thinking, theory, meta-psychology was immersed in an idealisation of the body and embodiment. That was the time when a friend of mine wrote a book on 'How to feel reborn', and I knew what he was talking about - I had been there. We had breathed together, gone through the heaven and hell of regression and catharsis, and we had felt a wondrous sense of aliveness better than anything we had hoped for. If we, and everybody else, could feel like that all the time, there would be no need for war and oppression and addiction and unhappiness. All it apparently needed was surrendering to the body, the feelings and the breath, and everything else would sort itself out.
I saw myself as an expert on embodiment, a body magician, whose task it was to make people return to their birthright: a blissful existence in their true home, their physical, sexual, animal being. Reich said that there was a pure, good, loving core which we could get back to, and I was dedicated to this - what postmodernists these days like to call - retro-romantic fantasy. Catharsis, feeling our feelings, was the key to health and happiness.

2) 'Character armour' as the frozen traumatic developmental history (short)

Whatever our therapeutic approach, sooner or later there will be a client who traps us in our most cherished assumptions about therapy. Max was such a client for me.
My client being an intelligent, well-educated, politically-aware, intellectual man, he had over the years tried to make sense of his condition. By the time he came to me, he had a clear analysis and self-diagnosis of his own numbness, the denial of his feelings and his disembodiment. Through doing co-counselling, he had arrived at a perspective similar to my Reichian one.
In fact, that was one of the main reasons he sought me out. You know that co-counselling is a mutual form of self-help therapy, where client and counsellor swap roles. He was so good at it as a counsellor that he became a teacher of co-counselling. I should have listened up when he said the only problem was that he was a very bad as a client. He was so good at avoiding and anticipating the counsellor's manoeuvres, that nobody could get through to him and his feelings. Coming to see me, was a fairly explicitly an attempt to bring bigger guns onto the battlefield – you can see the set-up, and the perpetuation of his self-hatred.
So we shared a lot of assumptions, Max and I, and in my infinite naiveté at the time I assumed that would make the work easier. For those of you not familiar with traditional Body Psychotherapy, let me summarise my key theoretical assumptions at the time.
To keep within my time I have shortened this section. I can just refer you to Stephen Johnson's summary of his life's work of integrating Reichian character structures with the developmental theories of ego-psychology, self-psychology and objects relations in his book "Character Styles" and to Jack Rosenberg's book "Body, Self and Soul". They sum up the essentials of my perspective at the time. In a nutshell, both my client and I assumed that his disembodiment was the result of early trauma that had been frozen into his body/mind as character armour. We assumed that his hatred of himself and his body was an internalised version of his father's contempt for him. We assumed that behind his mask were buried intense feelings and aliveness which he was denying and avoiding. We assumed that by accessing and expressing those feelings, he would return to healthy, alive functioning.
Most approaches have their own language for describing the double-edged nature of defences: protective, and self-sabotaging. The Jungian analyst Donald Kalsched, in his book "The Inner World of Trauma", for example, has described the 'self-care system' which traumatised people develop, a defensive-protective mechanism which provides some kind of safety, but at the expense of aliveness. Kalsched describes how the 'self-care system' is intent on defeating the therapist and the therapeutic process (putting me in mind, also, of an early statement by Wilhelm Reich: "all patients are hostile to therapy & therapist").

If it is clear that it takes severe, systematic trauma to shock somebody out of their body for good, into habitual disembodiment, what constitutes trauma is more relative and debatable. In a culture where only what can be seen and measured is real, only extreme, violent, visibly brutal trauma is noticed – this was the only form of trauma Max could understand and conceive of. He could not allow himself sufficiently any imagining of infantile, emotional reality to appreciate the kind of psychological trauma which attachment theory shows us at the root of developmental damage.

Summary 'Character armour'
It takes trauma to create disembodiment.
It takes terror and self-hatred to maintain disembodiment.
Temporary disembodiment becomes a chronic, habitual structure through the process of character formation by which the client …
- dis-identifies from their physical, spontaneous processes, …
- identifies with their reflective, cognitive capacity to withhold and suppress these processes and …
- ends up with an ongoing internal process of self-objectification (in simple terms: the body as 'it' rather than 'I').
Three forms of disembodiment (which I will not discuss in detail):
· repression, the main issue in Freud's Victorian times
· dissociation, as the result of severe trauma
· lack of integration, the modern disturbances of the self (narcissism, borderline, etc)

G) The project of embodiment

Apart from this little difference, we agreed on the hypothesis of early trauma and the project of uncovering it. I completely agreed with his self-diagnosis. And I completely agreed with his proposed solution. If we have diagnosed the problem as disembodiment, than the solution must be the opposite: embodiment.

1) The two main manoeuvres of traditional Body Psychotherapy:

There are two main ways in which the body can be used in therapy to counteract the client's disembodiment, contradict the client's disembodied patterns and undercut the client's defences and resistance:

the hard, masculine way: crack and break through the armour

- to provoke catharsis at a primal level by breaking through resistance ('armour')

the soft, mothering way: melt the armour

- to undercut the pseudo-autonomy of the social facade by nurturing the pre-verbal self

2) My attack on disembodiment

Armed with my idealistic notions, these two main manoeuvres and the whole toolbox of active interventions (Gestalt, biodynamic, bioenergetic, breathing) at my disposal I went to work. Considering his explicit demand for and willing cooperation in the attack on his armour, it was not that difficult to occasionally break through his resistance, to make him feel feelings, to force cracks in his armour, to touch his longing. These breakthroughs did provide him with glimpses of a different, more alive universe, a different sense of being. They *were* precious experiences. But I only understood later that because they arose in the context of a re-traumatising re-enactment, which we were both oblivious of, they could never be fully integrated.
The only other result of these breakthroughs - apart from these glimpses which seemed to confirm the validity of our project - was that it was getting more and more difficult to produce them. With every breakthrough he learnt more about the cracks and weak spots in his armour and became more adept at anticipating further breaches. My client's self-care system used every successful embodiment breakthrough to more comprehensively prevent the next one. His self-care system was learning fast, and I was fast running out of tricks.

3) Idealisation is not enough – the disembodied client does not readily embrace the body

That was a shocking awakening to me. Even when clients say they want their body back after having repressed, excluded and abused it for years, and I offer it back to them on a plate, they do not exactly embrace it with open arms: they resist, they struggle, they deny, they reject me, they escape, they leave! There I am, full of good intentions and out of the goodness of my heart trying to lead them back into the pleasures of embodied, grounded, alive, passionate existence, and they throw it back in my face - how terribly unfair.

4) Letting go into the body, the first thing we encounter in clients is not embodiment, but disembodiment = the objectified body

Of course, the body does have its wisdom. I had experienced that for myself. There are large kernels of experiential truth in my erstwhile idealisation of the body and Body Psychotherapy. There *are* possibilities there of depth, transformation, which many people in our culture have no idea about because they are chronically defended and identified against their body.
But unfortunately, when we let go into the body, the first thing we encounter is not a noble savage, blissfully self-regulating. The first thing we are liable to meet is the objectified body, the body as 'it', already cleaved away from any sense of self, already excluded, disavowed, the body as carrier of the shadow. Within that objectification we find disembodiment; and within that disembodiment we find trauma.

It took me a while to realise that the more I champion - out of my own ideological investment – the client's body, the more I tend to 'become' their body and they retreat into their disembodied mind. The more I pursue embodiment, the more we act out the war between body and mind between us. The more I insist on their embodiment, the more I end up getting in the way of it. I conclude that to try to make embodiment happen, is not just counterproductive, it is impossible.
Max's self-care system was, therefore, entirely right in resisting because it correctly intuited that it was being attacked, and that if it gave in, Max's body would lead us right back into the depths of his early trauma. But that is precisely what the self-care system was designed to avoid.
So understandably the client is not that likely to just jump at the chance of having their excluded body given back to them.

H) Bracket: The disembodiment of psychotherapy itself

That goes for clients, and that also goes for the discipline of psychotherapy as a whole. If the pursuit of embodiment with a highly intelligent disembodied client - who uses the vast bulk of his mental capacity to keep it that way - is a fraught procedure, the same might be expected to be true for the discipline of psychotherapy. Let me take a brief detour to draw out this parallel a bit more.
Like many of our clients, psychotherapy itself has long suffered from disembodiment, ever since its birth really, about a hundred years ago. Having as a discipline traditionally *ex*cluded the body, psychotherapy does not lend itself easily to including the body and does not readily take it back on board.

1) The birth trauma of psychotherapy

Now we all know that much wiser heads have been broken on the philosophy of the body/mind conundrum - Schopenhauer has called it the 'world knot'. Ken Wilber, summarising the research and writing on the subject, says: "the influential philosophers addressing the mind-body problem are more convinced than ever of its unyielding nature. There is simply no agreed-upon solution to this world-knot." (Wilber, "Integral Psychology", p175)
So I will not get into these deep philosophical questions now, but neither can we entirely ignore the philosophical assumptions underlying our theory and practice. If we think of the late 19th century as the time of psychotherapy's birth, and consider the prevailing zeitgeist and paradigms of that era, we might say that 'objectification' and 'disembodiment' are part of its legacy which we are still struggling to resolve. The project of embodiment, therefore, leads us to the root of the conception and birth trauma of modern psychotherapy. That trauma informs the recurring difficulties of modern psychotherapy and keeps restricting its full potential.

So if we now try to re-include the body, we are going to get into trouble. As I will later try to show more practically, including the body in psychotherapeutic practice creates inevitable dilemmas for the therapist which lead into the roots of individual and collective pain. If we follow these dilemmas, there is a good chance that we end up de-constructing psychotherapy as we know it.

2) Following in the footsteps of neuroscience to de-construct the prevailing body/mind paradigm

That, of course, may not be the end of the world. We now know that our mentalist, dualistic, hierarchical, objectifying conception of the body/mind relationship does not work very well, and we might take our cue from courageous neuroscientists who are trailblazers in deconstructing that very same mind-over-body dualistic paradigm which is at the foundations of their discipline as much as ours. Some of modern neuroscience is managing to completely dismantle its central dogmas and pull the carpet from under its own feet, re-inventing itself in the process. Modern genetics is apparently going through a similar process. Maybe psychotherapy can manage to do the same ?

I) Learning from the failure of the embodiment project

1) The therapist as enemy of the client's ego / self-care system

Well, in my process with Max I had severe difficulties with finding myself de-constructed. I was reeling. It took me a while to learn from this shock – with hindsight now it seems very simple and obvious. Based on a simplistic description of the conflict between the client's body and the client's ego, I had sided with the body *against* the ego (if I may be allowed to use this multi-faceted notion for now without precisely defining it). Based on an idealising fantasy of the body as the uncorrupted core, along the lines of: 'the body never lies'; I had taken it upon myself to see my task as siding with the body against the restrictive ego (which at the time I saw naively as equivalent with the disembodied mind) and to thus liberate the client from the inhibitions of their disembodied mind. In simple terms: I was constructing myself as an enemy of the client's ego, not just with Max, but with all my clients.

There was not much wrong with my perception of the client's conflict. There *was* an habitual conflict there alright, between the client's spontaneous, organismic reality and their cognitive, reflective identity and self-image. But typically I was taking a one-sided, biased position.

As any couple therapist knows, you cannot contain a conflict if you habitually side with one party against the other. Taking sides like that does not facilitate the spontaneous re-organisation of the conflict, its transformation, it actually keeps it going. Based on my idealising fantasy of the body, I was taking a fixed, ideological position which actually exacerbated the split between body and mind. In the apparent pursuit of embodiment, catharsis and aliveness, I was being relationally oblivious: I was re-enacting the body/mind split.

Whilst I could begin to see this in the abstract, I was still miles away from actually surrendering to it relationally. It took me a long time to catch up with Max's experience of the transference-countertransference entanglement I was lost in.

Max would often comment on his numbness. Typically (and not entirely incorrectly) I would take that as a criticism of my apparent impotence and inability to break through his self-protective, defensive mechanisms. Not being able to bear my sense of failure, I would re-double my efforts to make him feel. But, of course, I could not afford to become too determined and insistent, let alone outright aggressive, lest I start resembling his intimidating father. That was anathema to me. If I understood that his father's brutality had shocked him into disembodiment in the first place, then therapy had to be the opposite, didn't it? What would be the point if therapy was more of the same?

2) The gap between the verbal and the non-verbal working alliance

One simple way of talking about this would be in terms of two levels of working alliance: apparently Max and I had a good working alliance most of the time, on a verbal level. But on the level of non-verbal communication (which after all is 93%), we hardly had any.

To all intents and purposes, in his sessions with me, Max's body/mind was in a bio-psychological energetic state where he might have just as well been in the same room with his father, anyway: his body was furtive, alert, anxious, expecting attack.

3) Therapy as re-enactment of Max's father (internal *and* external)

But I was so entranced by our shared pursuit of the holy grail of Max's embodiment, that the last thing I was going to notice was that – in the perception and experience of his non-verbal self - I was turning into the very father whom consciously I was obviously trying to help him recover from.
My interventions, my assumptions, my whole therapeutic stance in relation to him was a re-enactment of the father who was unhappy with him and his body as it was. Like his father, I was behaving in an attacking and contemptuous manner towards his current way of being. Everything about me was corroborating the assumption that there was something wrong with his body, that he needed to change and be different, and especially have a different body.

4) Re-enactment

I later discovered that there were, of course, further complexities, i.e. that the re-enactment of the father-son relationship went both ways: it was also true that he was being his father and I was him. These recognitions are not news for practitioners in the analytic tradition, but in the field of Body Psychotherapy at that time we were just beginning to discover projective identification and parallel process. I will not have time today to present the more comprehensive map of what these days I call 'the five parallel relationships'. This map, which is now part of my teaching, developed over the years to do justice to the body/mind complexity of re-enactment.
Let me just summarise the crucial lesson I formulated for myself, out of the shreds of my de-constructed therapeutic position, which I found to be applicable and useful in all my relationships with clients, and in supervision. I offer you two versions: one formulated in the language of my own approach of Body Psychotherapy, and one in terms which can be adapted to any psychotherapeutic orientation.

a) Re-enactment in the language of Body Psychotherapy

It is impossible to pursue a 'therapeutic' agenda of breaking through the armour or undercutting the ego's resistance without enacting in the transference the person whom the armour/resistance first developed against.
Enacting means that – whether consciously or unconsciously (usually the latter) - the client experiences and perceives the therapist - in the transference – as the person who participated in the original trauma or wounding. Because it is a repetition of an early dynamic, I usually use the term 're-enactment'.
The more we attend to the client's whole body/mind in the here and how, including how the original trauma has become frozen as a particular body/mind structure, the more it becomes obvious that the wound is always already in the room, in the 'here and now', and it is always already in relation to the therapist.
I don't think it would have been possible for me to recognise the full extent, the pervasiveness and the central significance of re-enactment unless I had been trained to attend to the body and its energy, in constant, minute detail. But whilst I stumbled into it through following the body into the depth of the body/mind split and disembodiment, it is relevant to all psychotherapy. So here is the second version:

b) The central significance of re-enactment for all psychotherapy

It is impossible for a therapist to follow a strategy of overcoming/changing a dysfunctional pattern without enacting in the transference the person in relation to whom the pattern originated.
When we address and focus on any dysfunctional pattern, its relational origin/context is increasingly likely to come into the room and determine the client's perception and experience of the 'here and now' of therapy and therapist. Whatever traumatic memory is buried within a dysfunctional pattern, sooner or later it will enter the room as a spontaneous, non-verbal process and therapist and therapy will be perceived and experienced through it. Re-enactment must obviously appear as irrelevant to therapists who subscribe to an exclusively objectifying 'medical model' stance. It becomes significant as a transformative possibility only in forms of psychotherapy which put the therapeutic relationship into the centre of therapy, i.e. approaches which include the relational dimension and the transference/countertransference process.

Large chunks of what I am proposing are ‘old hat’ to modern psychoanalysis and may sound like I am re-inventing the wheel. But it seems to me that neither traditional Body Psychotherapy nor traditional psychoanalysis quite grasp the nettle of the body/mind totality of re-enactment which pervades both the client’s and the therapist’s body/mind process. In that sense I absolutely concede that I am not inventing a wheel, rather I am proposing that we take two already invented wheels and get on our bikes and ride them.
In my view, re-enactment happens, anyway, in all therapy and nobody can do anything about it. There is no way *out* of re-enactment, there is only a way *in*. Every attempt to minimise or counteract it, actually exacerbates it.

So what can we do with it, in the countertransference ? I think the limits of what we can bear can be extended by theoretically understanding the inevitability of re-enactment, and by us surrendering to it, what I called ‘entering’ it. Because paradoxically, spontaneous transformation occurs in the pit of it. As Gestalt says: change happens when we accept what is. When we do this, with an awareness of the whole spectrum of body/mind processes, what do we find?

5) Surrendering to re-enactment as a 'here and now' body/mind process

Internalised objects, as described by modern object relations, are not mental representations only, they are body/mind processes. More specifically, we could say that every internal object is anchored in particular sensations, particular tensions and mannerisms, particular parts of the body. Both poles of an internalised relationship are actually embodied on a somatic level in the relationship between parts of the body. Max’s internalised father was, for example, particularly anchored in his eyes, the frightened child anticipating attack lived on, for example, in his chest: the child’s whole bio-neuro-psychological state was accessible through the sensations in his chest. In his chest, the past was constantly present - as if the father’s attack was happening now.
Modern neuroscience tells us that the attachment relationship affects physiological and anatomical development. Emotional interpersonal processes become internalised and embodied as body/mind processes. The way the infant is held and related to becomes the way the person’s mind is capable of holding and relating to their feelings, which is reflected in the way the brain relates to body physiology, which is reflected in the way different sub-systems of the brain relate to each other (e.g. the cortex to the limbic system). The important thing is not only that there are different systems – that is a brilliant thing to have established – it is more important for psychotherapy how they relate to each other. My hunch is that the fragmentation of the body/mind is reflected in a fragmentation of the brain, that body and brain reflect each other mutually, reciprocally. We will never get at this by chasing after the parts without looking at the emotional dynamic of their relationship, the overall Gestalt of the complex system and its relational function. The same thing applies to working with the different modalities which Roz Carroll mentioned yesterday – sensing, emotion, feeling, imaging, thought, self-reflexive awareness. It is great to explicitly work with the whole spectrum and have different techniques for getting involved with all of them. But as important is the relationship between the modalities – that’s where we can become aware of the re-enactment. As long as I switch modalities in pick’n mix fashion, I can remain oblivious of the relational dynamic *between* them.

Some indications of body-emotion-mind parallel processes from a neuroscience perspective:
· the attachment relationship affects physiological and anatomical development
· emotional interpersonal processes become internalised and embodied as body/mind processes
· the way the infant is held and related to becomes the way the person’s mind is capable of holding and relating to their feelings
· which is reflected in the way the brain relates to body physiology
· which is reflected in the way different sub-systems of the brain relate to each other (e.g. the cortex to the limbic system)

This perspective takes us into a holographic universe of parallel processes where past and present external interpersonal relationship is reflected in the dynamic processes occurring in the body/mind matrix on the various levels and between the various levels. This is a two way process: internal and internalised relationships, whether on a biochemical or neurological or muscular or emotional level, get constellated and acted out interpersonally. In this way, uncontained internal conflict, if we think of it in its body/mind totality, gets relationally (re-)externalised to find containment in the other.

J) Conclusion

1) The limits of an exclusively objectifying approach

Attachment theory shows us that some love comes through whatever activity two people are consistently engaged in: knitting sweaters together, playing boule, working in the garden or doing therapy. What, specifically, are we doing on top of that which we claim is helpful as therapeutic activity ?
And objectifying medical model type interactions, with or without the body, are necessary, helpful, essential to therapy. But they do tend to fall under the 10 – 23:50 principle. They are not all that a psychotherapy which includes the body can be, because no amount of symptom reduction – in and of itself - is ever going to generate a sense of self, or transform the underlying body/mind structure of disembodiment. No amount of objectifying therapy – however clever – is – in and of itself - going to engender a lasting and profound and spontaneous transformative experience of 'embodiment'. This statement depends, of course, on how we define the notion of 'embodiment'. I have seen it argued that Body Psychotherapy is making a big deal out of 'embodiment', that actually we are all embodied because we all have bodies. Therefore – the argument goes - psychotherapists of all schools cannot help but work and have always worked with their bodies. In my view, that is a gross misunderstanding of the notion of ‘embodiment’.

a) Definition of 'embodiment'

So let me define it: the way I understand and define embodiment is as a subjective experience, as a sense of being in my body, identifying with the 'lived body' moment-to-moment. There is a lot going on in the body, on all kinds of levels, every second, and it is one of the functions of consciousness to screen out the bulk of it. So 'embodiment' cannot mean that I am aware of everything that is going on, that is impossible. However, it does mean reflective awareness and spontaneous processes come together, pretty much like Winnicott’s phrase of "psyche indwelling in the soma". In simple terms it means sensing, feeling, imagining and thinking are working together as aspects of an organismic, embodied experience of self as process. The crucial aspect of embodiment, therefore, is not the body *per s*e, but the mutual, reciprocal, self-regulating and self-organising relationship of body and mind as antagonistic and complementary poles of experience: psyche and soma coming together, being experienced as intimately related, as the ground of subjectivity. In this definition, then, there is no 'embodiment' without subjectivity or intersubjectivity. Many of the most precious things we are intuitively after in psychotherapy elude an exclusively objectifying grasp. If we want to do justice to the client’s and our own whole body/mind, not as some harmonious transcendent fantasy, but as the ordinary, fluctuating body/mind reality, then love is not enough, technique is not enough, skill and competence are not enough. Nothing short of the therapist entering and being rooted in their own necessarily conflicted body/mind process, surrendering to the activation of their own wounds and the whole-hearted acceptance of their helplessness in the face of inevitable re-enactment will do.

2) Integrating the body both as objectified *and* as a source of subjectivity

By virtue of over-relying on verbal exchange, psychotherapy on the whole tends to find subjectivity in the mind, through the mind, and leaves the body to the (exclusive) objectifiers. The modern objectifiers appreciate the biological body in the context of the body/mind as a complex, mutual and reciprocally self-regulating and self-organising system, but they do not understand subjectivity, interiority. With psychological therapies under pressure from biochemistry and the medical model objectifiers, we cannot afford to leave the body to them, and retreat further into the realm of disembodied mental subjectivity.

Psychotherapy needs to do the same thing for the body/mind relationship (on its own terms, i.e. by doing justice also to interiority/ subjectivity), i.e. from a first and second person relational perspective, which neuroscience has done from a third person scientific-objective perspective.
In reaction *against* the cultural dominance of the 'medical model' and rampant objectification, various philosophical critiques have been formulated from humanistic, post-modern, hermeneutic perspectives which try to salvage remnants of subjectivity. Psychotherapy is, after all, one of the last bastions of intimacy and appreciation of 'interiority' which is why sensationalist media are so variously fascinated by it and hostile to it.
However, this reaction *against* 'medical model' objectification can get too polarised: the 'subjectifiers' amongst us –- whilst appreciating the inner world – tend to over-value the mind (i.e. thought, language and symbolisation), especially their own, as an agent of change.
However, unless we get at the verbal-nonverbal juncture, we are in danger of just re-labelling the same old psycho-biological states. The tradition of Body Psychotherapy, amongst others, has tried to address this danger, but – as I have tried to show in this presentation - has often been drawn into an enactment of the underlying objectification, rather than *relating to it*.
One of the controversial features of working on a non-verbal level (whether or not that includes the issue of touch which – as a preoccupation with technique - usually distracts from the deeper relational issues), is that it requires two people to be spontaneously engaged. In Alan Schore's formulation, psychotherapy depends on right brain to right brain interactions which are way beyond the therapist's conscious, let alone voluntary control.
If we do draw – interesting and valid - parallels between the early attachment relationship and the psychotherapeutic relationship, then we must not overlook the mutuality and spontaneity in the mother-infant dyad.

3) The therapist’s spontaneity

Working with the client's spontaneity from within a relational rather than exclusively objectifying stance is only possible by bringing the therapist’s own spontaneity, the therapist’s whole body/mind subjectivity into the room, what I would call an holistic account of countertransference. By attending to the threefold parallels between the client’s body/mind process, my own and that of the relationship between us, the body becomes one of the ‘royal roads’ into the complexity of the transference – countertransference process.
By not idealising the body as the solution, by not pursuing embodiment in an objectifying fashion, the body can become one avenue into the relational complexity of the client’s inner world and their corresponding experience of their body/mind relationship which includes both embodiment and disembodiment as paradoxical poles. Subjectivity emerges in that tension.
The same applies to the therapist’s internal process: the body can become an avenue into full awareness of countertransference which emerges in the tension between our reflective and our spontaneous processes both of which I need to identify with. What becomes available then is an awareness which recognises my own body/mind process – fluctuating as it does between embodiment and disembodiment - as an internal relationship which is a parallel process both to the external relationship and the client’s internal relationship.

If relationship is the central tool of psychotherapy, then we need an holistic body/mind phenomenology of relationship which does not succumb to or perpetuate body/mind dualism and the objectification of the body. That would imply also an holistic account of both transference and countertransference. The key to that, in my view, is an extended (holographic) notion of parallel process which embraces both interpersonal and intra-psychic (body/mind) relationship processes as mutually interweaving and influencing each other.

K) Appendix: Dis-integration & Integration:

1) Working with the whole spectrum of processes from unconscious to conscious, from spontaneous to reflective, from somatic to mental and psychological

If we want to work with the whole spectrum of body/mind processes (in both client and therapist), we might start with a simple list which might look like this: body - emotion - image - mind - intuition; (sensation, affect, image, left & right brain, cognition). I assume that the client's subjective sense of self is a stream which is fed by these tributaries. Even with that simple differentiation it becomes apparent that if the client's whole body/mind is the proverbial elephant, then the various therapeutic approaches represented in the audience/in the field each tend to favour certain parts of the elephant.
Of course, it is not as simple as that, but as a starting point we might say that, for example, the analysts and cognitive therapists in their very different ways favour the mind, the Jungians the realm of dream and image, the Body Psychotherapists sensation and emotion, and so on.

2) The field of psychotherapy mirrors the fragmentation of the client's body/mind

Each therapeutic approaches tends to favour and privilege certain processes over others, both in terms of their sensitivity to them and the importance they place on them as ingredients in therapy. I will be working on the assumption that nobody can be entirely wrong all the time. Each approach has areas of – sometimes obsessive - expertise and sensitivity and competence, and also shadow aspects of obliviousness.
Comparative outcome research into the effects of psychotherapy has consistently failed to show significant differences between approaches. The famous Dodo bird verdict ('All of them are winners and all of them must have prizes') states that all kinds of therapy work at times, and that differences in theory and technique are not the main indicators of differential in outcome.
To stay with the metaphor of the proverbial elephant, if each approach concentrates on its own partial truth, the Dodo bird verdict is not entirely surprising: after all, the trunk can not be said to be more truthfully the elephant than the ears or the legs.
So we can imagine a person having a significant life experience by challenging their repetitive, circular, blaming thinking and consequently formulating cognitive challenge to core schemata as a crucial ingredient in therapeutic change. And they would be right. They may become a cognitive-behavioural therapist and henceforth develop special sensitivity to the damaging, self-perpetuating effects of irrational thought. The question then is to what extent they remain or become sensitive to other - just as necessary - ingredients in transformational processes.
Or we can imagine another person finding their experience transformed by entering and following in active imagination a dream image which eventually helps them embrace and surrender to a part of themselves which they have always been at war with. It is understandable that this person might extrapolate attention to the spontaneous productions of the autonomous psyche as an essential ingredient in any therapeutic change. And they would be right. Again, the question is to what extent they remain or become sensitive to other - just as necessary - ingredients in transformational processes.
Or we can imagine a person whose experience of life transforms following a breakthrough and catharsis of primitive feeling, and how they might generalise this into a form of therapy deemed to be applicable to all psychological issues. And they would be right in assuming that without connection to deep, spontaneous feeling lasting transformative change is unlikely to occur.

Each person has got hold of an entirely valid and real part of the elephant. But the existing fragmentation of the psychotherapeutic field would be impossible without each approach absolutising one aspect of themselves *and* the patients/clients they work with. This tends to be a habitual position for the practitioner who takes - for their own reasons - refuge in a particular one-sided 'solution'. We need to recognise that what manifests as a meta-psychological and theoretical conflict and difference also inheres in the psyche of the client. As a field, we parallel the splits and tensions in our clients' inner world. To the extent that we are focussing on and identifying with some aspects rather than others, we are unable to contain the tension itself.

3) Partial single-focus – the whole

If different approaches champion different parts, we would expect the outcome to be partial and haphazard, just as the Dodo bird verdict confirms. After all, focussing on each part does not do justice to the whole elephant, nor to the relationship between the parts.
But that does not mean – to my mind – that this state of affairs is the best we can hope for in psychotherapy. As mentioned before, a more comprehensive and integrative theory and practice is conceivable, once we have – as a field – gone through and survived a similar deconstruction of our 19th century heritage as neuroscience and genetics.
The integration of the - in many ways mutually exclusive - theories, practices and meta-psychologies of the psychotherapeutic field relies on the recognition that what each approach absolutises as the crucial factor in therapy is only a partial account of an entirely necessary, but not sufficient ingredient. In generalising a particular focus on a particular level of the client's body/mind, we sometimes find that we work with one level and the others come along effortlessly. A single focus *can* become an avenue into the transformation of the whole. But sometimes we bang your head against one level and the others do not come along at all. Sometimes a particular single focus *can* abort engagement with the whole. What makes a particular approach work with one client at one time, and becomes a countertherapeutic disaster at another, may be more to do with the *relationship* between the different parts in the client than the validity of our approach to a particular level. What I am working towards is the suggestion that ...
therapeutic transformation does not depend on working out one part/level, but it depends on *all of them* coming together and on the relationship between the parts/levels.
It is the whole body/mind matrix which shifts to generate a new sense of self.
It is the whole body/mind matrix which constitutes identification with a pattern or releases identification from a script.
The limitations of our notions of therapeutic change lie in the partial perception of the eye of the beholder. We might, therefore, hypothesise that the outcome of therapy would be affected significantly if the practitioner could do justice to the conflicting therapeutic perspectives, theories and stances as they are constellated by and reflect the respective tensions in the client's psyche and body/mind. In this perspective we are less compelled then to try to resolve the inherent contradictions between the theories, techniques and meta-psychologies of the different approaches. There *are* differences and paradigm clashes between the various branches of psychotherapy which may well be irreconcilable theoretically and philosophically. But in their functioning as – collectively and historically constructed - mirrors of conflicting aspects of the client's psyche, we can enter and productively work with the inherent dichotomies as necessary paradoxes inherent in the psychotherapeutic endeavour, if we can bear more than one 'truth'.
In this spirit we can usefully extend the initial simple differentiation of body/mind totality into body-emotion-image-mind-intuition, and make it more detailed and specific.
So what are the parts that make up the whole elephant? What are the body/mind processes which constitute both the structure and content of our awareness and understanding ? What categories can we phenomenologically distinguish when we attend to the full spectrum of body/mind processes in the client and in ourselves ?

- self-reflexive thought / meta-level
- mental: formal-operational thoughts (including voices, internal dialogue)
- mental: concrete-operational thoughts (language)
- images, fantasies, dreams
- complex feelings
- breath
- raw emotion
- spontaneous gestures / outer movements
- impulses (manifesting instincts/drives or object-seeking needs)
- inner movements, excitation, trembling etc.
- sensations, proprioceptions
- vitality affect / "felt sense"
- autonomous nervous system (sympathetic & parasympathetic) regulated processes
- energetic perception
- physiological processes* (the interlinked biochemical, neurological, physiological, vegetative & metabolic systems)

***** for a scientific exploration of the 'information molecules' throughout brain and body, linking neural & endocrine & immune systems, de-constructing not only the body-mind, but also the brain-body dichotomy, see Candace Pert "Molecules of Emotion")

For a more academic and scholarly treatment of this more differentiated list see Ken Wilber's writings.

Generally speaking, we can say that without any one of these ingredients /levels spontaneous transformation cannot happen. What we cannot afford to say is "this is the *one* ingredient which all depends on" without losing the inherent plurality and diversity, the relational complexity between the levels and therefore the potential wholeness of transformation. Having distinguished these various levels of body/mind experience, I will conclude by drawing attention to the issues addressed in this presentation, without having space to address the more clinical implications.

L) Notice that all of these different aspects, processes or levels of experience...

can work together (congruent, integrated),

against each other or ...

work in parallel, but dissociated.

We all have an immediate intuition about a person's spontaneously given body/mind matrix, i.e. how these different processes work in harmony or may be at odds with each other. This we might call the degree of body/mind integration or dis-integration. In practice, we can attend to that ever fluctuating degree of body/mind integration or dis-integration in ourselves and in the client in response to and as a function of relational processes, integrating a body/mind holistic perspective (as developed in 80 years of Body Psychotherapy tradition) with a relational perspective (as developed in the psychoanalytic tradition, i.e. relational psychoanalysis and intersubjectivity). Out of this we can develop a holistic phenomenology of the relationship, with re-enactment and parallel process as central notions (for experiential workshops on the practical application of this perspective, please check my website: www.soth.co.uk).

M) Notice that all of these different aspects or levels ..…

… can carry memory of past states, including past trauma
… are mapped onto the brain, holographically reflected in the brain (in a mutual, reciprocal rather than top-down brain/body relationship)
… can subjectively be experienced as *sources* of a sense of self i.e. subjectivity.
… can subjectively also be experienced as *enemies* of self, identity, subjectivity.
... apply to both the client's and the therapist's body/mind.

N) Notice that all of these different aspects or levels ..…

… can be approached in a first and second person stance or in a third person stance (they can be addressed as manifestations of subjectivity or as objectivity)
… can be approached by the therapist in an intersubjective fashion or in an objectifying fashion, dialogical or monological, depending on whether the therapist is connected to their own equivalent level of experience.
… can be worked with or without any reference to the client-therapist relationship in the room

For a discussion of these processes in terms of what Body Psychotherapy calls the 'body/mind split' and a re-working of that notion into the dialectic of spontaneous processes – reflective processes, see my "Re-defining the body/mind split" (www.soth.co.uk).

Over the last 10 years I have developed a range of teaching vehicles designed to help therapists attend to, access and work with the relational information inherent in the countertransferential conflict between objectifying and intersubjective impulses in the therapist. These are as yet unpublished, but I make them available in my CPD workshops for which you can find details at: www.soth.co.uk.

Michael Soth, October 2004