The Relational Turn

By Michael Soth and Nancy Eichhorn

Do we have a shared understanding of what we mean by 'relational'?

The term 'relational' has recently achieved buzz word status. Therapists are quick to quip they are 'relational' because they see themselves as relating well to their clients and because they consider that the 'quality of relationship' with their client/patient is crucial to the work. Books are written, conferences are held, workshops are offered based upon the increasingly wide-spread conviction that healing takes place in the relationship – 'it's the relationship that matters'. And it is indeed a precious achievement that the profession is now placing such significance on the relationship, rather than primarily on the supposedly 'correct' therapeutic theory or technique, whatever it may be. But unfortunately the apparent consensus across the profession around the centrality of the relationship in therapy is only skin-deep; the closer we look, the more apparent it becomes that being relational means profoundly different things to therapists from different approaches.
Each therapeutic approach tends to assume that relationality is to be understood through its own framework, neglecting the important recognition that different approaches understand therapeutic relating in diverse, and often profoundly contradictory, ways. Relationality, therefore, is too easily appropriated by the paradigms and preconceptions of each partial approach, without the field having plumbed the depths of the fertile and precious conflicts, contradictions and paradigm clashes between the approaches
Sure, there are some agreed-upon active ingredients, considered conducive to quality of relationship and to a robust working alliance, such as Rogers' core conditions (empathy, unconditional regard and congruence), psychoanalytic neutrality, secure attachment, embodied or right-brain-to-right-brain attunement, reciprocity or mutual recognition, but "what do we mean by relating? How do we define relating? What therapeutic activities does relating include, and which ones doesn't it?" (Soth, 2006).

Relational Body Psychotherapy Panel at the 13th International EABP Congress for Body Psychotherapy (Sep. 2012)

These questions and more will be approached during the Relational Body Psychotherapy panel at the 13th International EABP Congress for Body Psychotherapy in the United Kingdom this fall. The panel members – through the background of their own training, therapy and further development – represent an integrative mix of paradigms and approaches which they will bring to the exploration. Shoshi Asheri, Asaf Rolef Ben-Shahar, Roz Carroll, Nick Totton, and Michael Soth bring together an integrative wealth of personal and professional experience, around a shared core of somatic psychology and Body Psychotherapy, having partaken in Chiron Holistic Psychotherapy, various schools of body psychotherapy, psychoanalysis, and other humanistic and energetic forms of therapies as they evolved in the United Kingdom. Their panel interaction is designed to clarify the significance of relational ways of working within Body Psychotherapy and will touch on topics that may deserve deeper, more intimate inquiry. One of these topics has been called 'the relational turn' by Michael Soth and, based upon a recent interview with him, forms the central point of this article.

Different kinds and modalities of therapeutic relatedness

That there are different kinds of relating, different kinds of therapeutic relatedness is an idea which has been established in the US by Martha Stark ("Modes of Therapeutic Action"), and in the UK by Petruska Clarkson ("The Therapeutic Relationship"). Validating different and diverse kinds of relating (or modalities of the therapeutic relationship) is a significant step beyond the traditional dogmatisms of the therapeutic field, where certain therapeutic stances embedded in the different traditions used to be taken for granted. That they are *all* valid at certain times with certain clients establishes an integrative foundation which allows us to think beyond 'which approach is right (across the board)?' and become interested in the particular relatedness between client and therapist right now, as part of a dynamic, shifting process. Clarkson initially identified and distinguished five modalities: working alliance, authentic, reparative, transference–countertransference, transpersonal (but these have been added to by various suggestions by others). But the ideas of relationality which have developed since these initial integrative steps were taken in the early 1990's point to another possible paradigm shift beyond an integrative embrace of the different modalities.

A Student's Take on an In-depth Conversation

For me as a student entering this field with a passion for knowing, a zest to understand what was and what potentialities exist, I want leaders who are willing to broach the forefront of our developing approach with new insights based on both scientific research (statistical helps) and personal experience. I want possibilities and exploration, I want to reach out and experience, and from my sense of being allow Existence to guide my work. My views may sound simplistic and perhaps even naïve. And yet, interviewing Michael Soth, an Oxford-based integral-relational Body Psychotherapist and a member of the EABP panel on Relational Body Psychotherapy, I heard a deeper level of knowing combined with a keen sense of what may be - the questions he posed motivated me to ponder, moved me energetically to experience his what-if's and see how they applied to my own clinical practice, as well as to all relationships in my life today. I felt a shift, a sense of 'pleasure' as Al Pesso would say, when the right words matched the bodily sensations and a release occurred (personal communication, January 2012).

How helpful is neuroscience to Body Psychotherapy?

Over the last 15 years, neuroscience has confirmed what many body psychotherapists have intuited all along. Even Reich got a posthumous leg up as current research finally validates what he knew and others in the field know today – what he called 'functionalism' is today's systems view of holism by another name. Reich pioneered a holistic view of the bodymind as a mutually interwoven whole system – rather than a top-down mind-over-body dualistic view as implicit in 19th century neuroscience and early psychoanalysis. Neuroscience now compares the brain to an 'orchestra without a conductor'; this resonates deeply with decades of humanistic and body-oriented intuitions which encourage surrender to the wisdom of the bodymind and its self-regulating and self-organizing capacities. Many body psychotherapists are riding this wave of credibility and recognition. However, many people, myself included until I spoke with Michael, may not fully recognize the double-edged implications for our practice when we try to draw conclusions for our subjective and intersubjective discipline of therapy from another field such as neuroscience which relies upon and is pervaded by objectifying assumptions. Buoyed by the support and credibility which neuroscience is lending to 80 years of holistic intuitions, we may be importing objectifying attitudes, assumptions and even instructions for practice which undermine and sabotage the intersubjective relational foundations of our work, unless we do so

consciously, with an appreciation of the inherent paradigm clash between subjectifying and objectifying modes of relating.
I have heard statements to the effect that neuroscience now ‘proves’ that interpretations don’t work, or that confronting a traumatized client is inevitably damaging rather than empathic or reparative, and that as neuroscience has proved that broken attachment is the root of all later difficulties so parents and therapists 'must be' attuned. According to Michael, these are simplistic conclusions extrapolated from partial half-truths, and they have limiting and restrictive, and sometimes damaging, effects on therapists who try to adhere to them, as well as on their practice. And while it may be true that broken attachments (insecure and disorganized) do have an impact, practitioners cannot just turn scientific findings into formal instructions for therapy without over-simplifying reductively the relational complexity at the heart of the therapeutic encounter (e.g. a plethora of workshops are now offered on attachment-based psychotherapy). Using supposedly objective findings to create a training curriculum for therapists creates an objectifying paradigm that is liable to cut across the essence and basis of our work which is ultimately rooted in the therapist's subjective stance, sense of self, and embodied stream-of-consciousness.

Traditional Body Psychotherapy - reversing or transcending body-mind dualism?

The name ‘Body Psychotherapy’ was coined in the early 1990s with the word 'body' in the label reflecting, according to Soth, the prevalent idealization of the body inherent in the theory and practice of the post- and neo-Reichian community of practitioners at that time. Soth remembers and reflects, "We quite accurately diagnosed the body-mind split at the root of all psychological problems and were passionately attempting to overcome mind-over-body dualism, which we recognized as dominant in the culture as well as in the field of psychotherapy. We declared with Perls that "all reasons are lies", and "lose your head and come to your senses". These are all valid, precious and true, but at the time we thought we had already arrived at a final destination. However, we did not understand that you cannot overcome any sort of dualism simply by reversing it or turning it around. The fallacy of mind-over-body cannot be transcended by the reverse fallacy of body-over-mind. We oversimplified the problem of the body-mind split by equating the head with the ego and with suppression; we saw inhibition as caused and maintained only by the mind, specifically by the disembodied, dissociated, patriarchal mind. We equated the body with the life force, with the unconscious, the 'noble savage' to be liberated through primal catharsis.

Objectification – how do we 'treat' the objectified body?

Objectification is one of the main symptoms of disembodiment. The more an individual or a culture is disconnected from the direct experience of their living body, their moment-to-moment sensations, the more they tend to treat their body as a 'thing', as an appendage below the head. This stance of objectification then becomes visible and symptomatic in and via the body. Take for example body image. Michael suggests that we can recognize two forms of objectification: there is the negative objectification of the body as a slave (to the mental identity), and the positive stance of the body as a narcissistic fashion object (to mirror the attempted perfection of the self-image). Under the banner of the valid postulation that ultimately the body can be experienced as much more than that objectified shadow of what it could be – i.e. the recognition that the sense of self is rooted in the body, and that the body is an essential ingredient in subjectivity - led many body psychotherapists to pursue therapeutic strategies which unwittingly exacerbated the existing objectification of the body through techniques, exercises and interventions intended and believed to enhance embodiment.

The therapist's stance: doctor, teacher, body expert?

“There’s this sense floating around in the space of the relationship that the therapist is being paid to be some sort of body expert or body magician,” Soth says. “It’s tangible in how the therapist positions him/herself as the one who apparently knows better, and - based upon that superior knowledge and understanding - makes interventions geared to change the client's current state of disembodiment, somewhat like a doctor administering a treatment. Operating as the body expert is a bit like being a doctor who says, ‘Sure it’s bitter medicine, but it’s good for you” while the therapist says, ‘Here, you’re angry, bash this pillow, it’s good for you.’ Subliminally the client perceives and experiences the therapist's implicit stance as authoritative doctor, and reacts to it through their own established relational pattern, so the hidden and disavowed ‘medical model’ paradigm operating in the background of the therapeutic relationship is *also* tangible in how the client relates back to the therapist (but then it is often understood and interpreted as the client's 'stuff').”

The wisdom of the body – easy to experience, hard to pass on

Many therapists have embraced body practices such as listening, following (gestures and movements), impinging from within, stress positions, creative expression etc, all based on the neglected wisdom of surrendering to the body and the resulting embodied knowledge; these are all experiential avenues – as all body psychotherapists well know – into the wisdom of the body and the recognition that the body can be experienced as a source of subjectivity. Our tradition knows what it means to be embodied. We have been taught by our mentors how to experience this wisdom and honor our own embodied sense of self. These experiences constitute an essential frame of reference, which as body-oriented therapists we take for granted, but which is not generally understood by the rest of the culture, and therefore most of our clients. This frame of reference doesn’t manifest spontaneously. The ordinary client doesn’t know how to feel into his/her body; they usually perceive it as an unruly, symptomatic servant, or as an enemy or threat. Most ordinary clients start from a place of being disembodied, dissociated, or repressed, or at least not knowing. Bodily knowing and embodiment involve a profound learning (and un-learning) process. And once acknowledged as a learning process, then we must ask, “what position does the therapist take in this process? How do I, as a therapist, engage with the disembodiment that the client brings into the room? What is the process that helps the client move toward a more enlightened embodied state? What is the therapist’s relational stance towards the client as he/she goes through that? And how does the client perceive and experience my stance? And how does their experience of my stance and of me relate to their characterological history?”

Can we 'educate' the client into embodiment?

“Clients get attracted to body psychotherapy for their own reasons and through the lens of their own understanding or misunderstanding. They read about it and interpret the rationale of therapy, the notions of character armor, trauma and dissociation through their own life history and though the lens of their ego's partial and idiosyncratic perception of the world. One stance a therapist is likely to take is 'the teacher'; the explicit version of this is psycho-education, and we know from trauma work that this can have a calming, containing effect and be beneficial and necessary. But as an exclusive or dominant stance, a 'teacher' position is likely to have limiting consequences to psychological 'internal' and intersubjective work (which may *also* be necessary, or even more so). In that case, the therapist's 'teacher' position may become positively counter-therapeutic (just remembering many people's previous life story with teachers and authorities generally). So I can tell the client how important it is to notice how they are breathing and how

they have just stopped breathing. But as I do so, what kind of person am I being perceived as by the client, and especially by the client's unconscious (including their characterological disposition)?
So however appropriate an educational stance may be in many situations, none of this gets us around a fundamental relational conundrum which traditionally body-oriented and somatic practitioners have not paid much attention to. If I position myself as a 'body expert', my interventions might be translated (unconsciously by the client) as, 'Don't be like that with your body', 'Do as you're told,' and 'When you notice yourself repressing an impulse, don't.' Doing that creates a relational atmosphere like a doctor's consulting room, an expert or teacher – in short: one more authority who 'knows better' and who knows where the client 'should' end up.
To integrate the work with the body relationally, whether or not the client experiences it as objectified or not, requires a new approach. Perhaps even a new paradigm. Here we can take some inspiration (rather than direct instruction) from neuroscience's recent appreciation of how the infant's embodied sense of self develops originally – in an intersubjective dance with the mother," Soth says.

When an objectifying authority is not good-enough

Speaking from over 30 years of experience in this field, Soth offers his thoughts on relational body psychotherapy in general as he personally transitioned through various stages of Chiron's evolution, from Chiron Holistic Psychotherapy through multiple name changes including: holistic; body; integrative; integrative-relational; and finally Integral-Relational Body Psychotherapy. Based on these experiences, Soth arrived at a notion he calls the "Relational Turn" (formulated in the mid 1990s) based on a shift that seems to me potentially impacts every sort of therapeutic/clinical intervention regardless of one's methodological affiliation. From this perspective, the therapeutic relationship becomes much less etiologically perceived and all the more complicated. According to Soth, nothing we've been taught is untrue, it can all be included and valued. And in fact, therapists will *have to* rely on every tool they have at their avail working within this new paradigm. There are two key differences, Soth says to how he understood Body Psychotherapy 25 years ago: one integrative and the other relational. In the past our special expertise our attitude was partial to the Body Psychotherapy tradition which exclude other and contradictory approaches, while today we are able to take an integrative stance within which there is a wider embrace of other therapeutic approaches - there is room for all knowledge, all methodology, all ideology. In the past our relational stance was more fixed, based upon restrictive implicit assumptions, not to say dogma, that attempted to legislate for supposedly 'correct' relational configurations such as dialogic, humanistic equality which disavowed – as described above – hidden 'medical model' elements of our practice. Our special focus on the bodymind came at the expense of relational awareness – in the pursuit of our embodiment agenda, we were relationally oblivious; so we did not follow through some of our theories into the experiential relational reality of therapy.
Flying in the face of our own theories and assumptions about the bodymind, in the context of therapy we operated as if clients were always capable of some sort of mental dualism (dual awareness) by which the therapist and their emotional reality could be perceived from outside the client's characterological patterns; as if the client's brain were able to relive a traumatic experience whilst maintain a reflective, mindful presence vis-a-vis the therapist.

Following character theory through into the therapeutic relationship

The key to most schools of body psychotherapy is character formation, a model of developmental injury which leads to what Soth likes to call 'the wound' (of which there are of

course many, on many interwoven levels, in terms of timing and in terms of the bodymind); where neuroscience simply sees attachment and its disturbances (leading to a simple relational typology), Body Psychotherapy sees character structures and styles (leading to a complex bodymind, multi-dimensional typology, through traditionally not consequently followed through into the relational realm). The more we take the assumptions and implications of character formation seriously and do follow them through into the therapeutic relationship, the more we need to consider how the client experiences the therapy and the therapist *through* their character, *through* their wounding.

To what extent can the client experience therapy from outside their character?

The chronically frozen embodiment of the wounding within and throughout all levels of the bodymind also has implications for how clearly and realistically the client can see the therapist. Or, conversely, to what extent the therapist is going to be seen and experienced *through* the wounding experience. The more the wounding experience has become unconsciously embodied, the less reflective capacity we can take for granted, and the less the client will be able to recognize and reflect on the degree to which they transfer the wounding into therapy and onto the therapist. This constitutes a conundrum which so far has largely been ignored or not sufficiently recognized.

The Conundrum

According to Soth, ***it is impossible to pursue a therapeutic agenda of breaking through the armor, or under-cutting the ego, or wrangling around the resistance without the therapist being experienced by the client in the transference as enacting the very person against whom the armor, the resistance, the defense was first developed***. In psychoanalytic terms, the therapist will inevitably be experienced as the 'bad object'. The client's unconscious sees the bad object enacted by the therapist in the transference. What appears to be happening between the client and therapist, how each person experiences the embodied bad object, and how it enters the room may have substantial impact on the relational interactions that follow.

"Neuroscience often looks at the therapist from a reparative bias. It is already presumed that the therapist experiences him/herself as being reparative, and the bad object is excluded from the reparative construct. You cannot exclude the bad object without short-circuiting the fullness of spontaneous transformation we are envisaging as possible. The embodied experience of the bad object is not cognitive; it is not a mental image in the client's mind. Just as once said, 'the issue is in the tissue,' the bad object is in the tissue (as it is on each and every level of the 'turning against the self' which we recognize as essential to character formation).

"We can include the body in psychotherapy in a way that doesn't minimize the transference or side-steps the bad object. The wound always already includes the bad object. Deep therapy at the characterological level inevitably enacts the wound. Rather than presume that therapy only *heals* the wound, I now bring awareness to the enactment, invite that awareness to deepen across the bodymind and relational dimensions of the therapeutic relationship, and the more the enactment can be included in awareness, the more a spontaneous process of the wound healing itself becomes likely," Soth says.

For more information on Relational Body Psychotherapy and the 'Relational Turn' be sure to attend the panel on Relational Body Psychotherapy at the 13th International EABP Body Psychotherapy Congress.

About Michael Soth

Michael Soth is an Oxford-based integral-relational Body Psychotherapist, trainer and supervisor (UKCP), with more than 25 years' experience of practicing and teaching from an integrative perspective. Drawing on concepts, values and ways of working from an unusually wide range of psychotherapeutic approaches across both psychoanalytic and humanistic traditions, he is interested in the therapeutic relationship as a bodymind process between two people who are both wounded and whole. He has been pursuing the notion of enactment as central to therapy for the last 15 years or so.
He has written numerous articles and several book chapters and is a frequent presenter at conferences. You can find information about his work at www.soth.co.uk (extracts from his published writing as well as hand-outs, blogs and summaries of presentations), and his training work at www.counsellingpsychotherapycpd.co.uk (the website of INTEGRA CPD).

References

Soth, M. (2006). How the wound enters the consulting room and the relationship. *Therapy Today.net*.

Soth, M. (2008). From humanistic holism via the 'integrative project' towards integral relational body psychotherapy. In L. Hartley (Ed.), *Contemporary Body Psychotherapy—The Chiron Approach*. UK: Routledge.