Body, Movement and Dance in Psychotherapy,
March 2006; 1(1): 43–56

Routledge
Taylor & Francis Group

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

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Abstract
This is an article based on a presentation given at the United Kingdom Council of Psychotherapy (UKCP) conference 2004. Our modern attempt to re-include the body in psychotherapy brings with it the inevitable danger that we import the culturally dominant objectifying construction of the body into a field which may represent one of the last bastions of subjectivity, authenticity, and intimacy in an increasingly virtual world. The paper addresses the question how embodied subjectivity can be found within a relational matrix pervaded by disembodiment and self-objectification.

The ubiquitous objectification of the body in our culture and in the field of psychotherapy is illustrated in the paper. It is described as a manifestation of an underlying experience of dis-embodiment. Two ways of re-including the body in psychotherapy are then distinguished: one based on a ''third-person'' ''medical model'' stance and the other on a ''first-and-second-person'' ''intersubjective-relational'' model. By formulating these two contradictory *and* complementary ways of using the body in terms of the therapist's implicit relational stance, attention is drawn to what is considered an underlying paradox inherent in *all* types of psychotherapy. I am hoping that practitioners from across the approaches will be able to recognize and relate to both sides of the dilemma, and through this to both ways of re-including the body in psychotherapy.

As the medical model stance was the prevalent default position of what we may therefore call *traditional* body psychotherapy, and the relational one has become available only in the last decade, a case illustration is used to trace some of my own development as a therapist through the shadow aspects and pitfalls of an exclusive reliance on the first towards an integration of the two and to an appreciation of their necessarily conflicted co-existence in the paradoxical core of the therapeutic position.

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ISSN 1743-2979 print/ISSN 1743-2987 online/06/010043–14 © 2006 Taylor & Francis
DOI: 10.1080/17432970500418385

Keywords: *Body psychotherapy, embodiment, objectification*

Introduction

Modern psychotherapy as an ambivalent response to the ''disembodied mind''

UKCP would not have organized a conference in 2004 subtitled ''working with the embodied mind,'' unless as psychotherapists 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. While having developed special expertise in working with the body over the last 7 decades, and claiming to champion the body, traditional body psychotherapy has also subscribed to and exacerbated the culturally prevalent objectification of the body. In this paper, I am attempting to work through some of the shadow aspects of the body psychotherapy tradition. It then becomes possible, I believe, for body psychotherapy to make its own unique and precious contribution towards the development of a twenty-first century relational psychotherapy which does (re-)include the body.

My work with ''Max''

Following Freud's idea about extreme cases revealing the dynamics of ''normality,'' in contemplating how to re-include the body in psychotherapy, we might want to think of people who are extremely disembodied. Years ago, when I first started out as a psychotherapist, I worked with a client, let's call him Max, who *knew* he hated his body. He hated his appearance: he thought he looked too 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-30s, 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 20s in a fairly isolated state, without a social life, working long hours in administration. This helped him to forget his body and ensured a social status that would protect him from the powerlessness and uncertainty from which his father's family had suffered.

Objectification of the body

Negative objectification: The body as an ignored and exploited slave

During this pre-therapy period of his life, Max illustrates an attitude towards his body which is 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'' (Wilber, 1979, p. 106).

The ''10 minutes to 23:50 hours'' principle

With another client, whose main concern *is* about his body performing, mainly sexually, we have developed what we call the 10 minutes to 23:50 hours principle. He had spent an enormous amount of money and energy in the gym and various therapies educating and forcing his body into shape to guarantee its sudden springing to life when needed during sex. But having ignored his body and been oblivious of it all day, is it only the explicitly sexual 10 minutes of his day which are the problem, or is it not also his relationship to his body during the remaining 23 hours and 50 minutes of the day?

The implicit objectification of the body may remain invisible to its ''owner'' as long as the body can be ignored, but it does become apparent when the body gets ''unruly.'' When ''normal'' disembodiment breaks down, the common reaction is to go to the doctor, or other quasi-medical expert, who is obliged to provide the illusion that *somebody* is in control of it all. The doctor gets paid to fix the engine, ideally in a scientifically validated fashion, so the patient can go back to using the body in the normal way they are accustomed to.

In summary: ignore it and use it as long as it is working, fix it and get it to perform when it's faulty.

Max'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 contempt for his body. No longer allowed to ignore his body altogether, he was confronted again with the underlying hatred; it was staring him in the face. 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 a self-mutilating enactment of his hatred for himself and his body. Max's care was quite brutal.

His looks and physical appearance became terribly important to him. 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 day's 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 Max started taking his cue from Hollywood celebrities and became obsessed with 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. During this period of his life he illustrates an increasingly widespread attitude towards his body, modelled by global fashion icons all over the media, an attitude which we might call "positive objectification."

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 chosen to fit our image of it. We think we can do to it anything we like; we use it to approximate our ideal image of the body rather than identify with the one we already are.

From a psychotherapeutic perspective, there is more at stake than turning a neglectful and exploitative relationship to the body into a caring and positive one. Both negative, exploitative objectification of the body and benign, helpful, therapeutic objectification of the body is objectification.

I can only manipulate 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. I can only abuse and exploit the body in such objectifying fashion, if I am already habitually disembodied, if my spontaneous, given, first-hand experience is that I am not *in* it, let alone that I *am* it. Both kinds of objectification, negative and positive, are collectively and individually easily visible manifestations of the extent to which our culture suffers from an underlying pervasive disembodiment.

Disembodiment

We have lost any sense of identification with the body

After a few hundred years of Cartesian duality, enlightenment, and positivistic reductionist materialism, we have ended up thinking disembodiment is the human condition. Our culture has lost every sense of identification with the body to the point that when body psychotherapist 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 (Keleman, 1975, p. 24).

Max never experienced anything like this. That kind of statement was inconceivable to him. For most of his life, Max could not actually feel his body let alone derive an identity from it. He, his identity, his subjectivity was 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," a fact of existence, 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 hated body guaranteed his continuing self-objectification.

These are the two facets of the quintessential objectified body I refer to in the title of my paper: objectification is both a spontaneous subjective experience which we are landed with (a background body–mind state), and it is an internal, ongoing process (the mind–body relationship is a continuously repeated object relation). His father's relationship to him was paralleled by the relationship between his mind and his body. It was structured into an incessant conflict between his habitual mental state and his spontaneous body–mind processes. He was caught in a constant internal re-enactment which he could not help but act out externally, in his life and in his therapy. His unconscious construction of therapy and me as his therapist always already contained these two conflicted poles and the dynamic between them.

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

The objectification of the body is rampant in the culture, in our clients and in the field of counselling and psychotherapy. Clients understandably *want* us to make them better. That is usually what they think they are paying us for. They want to function and perform, and they want any dysfunctions fixed. However, from within a state of ongoing self-objectification, clients often cannot help but construct therapy as "more of the same." To the extent that they expect therapy to be helpful in terms they can understand, they anticipate it to be a more effective version of negative or positive objectification. In response to this demand, the way psychotherapists are inclined to use the body inevitably mirrors to some extent the mindset in which clients bring their bodies to psychotherapy in the first place: (a) not at all (ignore the body and use it as long as it's working); (b) as something they want to conquer, the body as an avenue for a simplistic, physical, and un-psychological cure (making better, fixing, i.e., as the rescuer); (c) as something they are at the mercy of, the body as the most engrained locus of the uncontrollable, unreachable, unchangeable symptom (i.e., as the victim).

Like our clients, if psychotherapy bothers about the body at all, it tends to fall foul of the 10 minutes to 23:50 hours principle: psychotherapy as we know it tends to pay attention to the body only when it becomes symptomatic. In our conferences we then focus on the clinical use or the clinical extremes of the body: either body techniques (i.e., often reduced to whether to touch or not) or body symptoms (addictions, eating disorders, self-harm, trauma, sexual impotence). Similarly, if we pay attention to the therapist's body at all, it is when it protests in extremis: the fashionable notion of somatic countertransference is understood to refer to disturbing physical symptoms which erupt as painful peaks out of the otherwise ignored and irrelevant

plain of the body, as if the body was not an ever-relevant aspect of the countertransference also during the remaining 23:50 hours.

In this frame of mind, 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 a temptation to make the body a treatment option for certain special conditions, a specialism to be grafted onto standard psychotherapeutic practice. Generally speaking, the way psychotherapists try to re-include the body is not entirely free from the disembodied and objectifying tendencies in the culture. 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. 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 fully address the pain and problems manifesting in the body without addressing the problems inherent in our dualistic conception of the body–mind relationship.

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

This paper is based on the belief that the return of the neglected, dissociated, and repressed body can inform and transform counselling and psychotherapy as we know it today. If our discipline is to move into the twenty-first century, it is essential that we learn to attend to the therapeutic relationship as a body–mind dynamic. In the attempt to re-include the body, we can draw on the tradition of body psychotherapy, but not without addressing some of the shadow aspects of that tradition first. Body psychotherapy has important concepts and tools to offer to the rest of the field; without these it will be hard to apply the precious insights of modern neuroscience to our practice.

First we need to learn from the failures and fallacies of body psychotherapy. There are many, partly justified, prejudices against it, and many misconceptions about it. Inevitably, in championing the body, body psychotherapy has attracted to itself the cultural ambivalence about the body. Surrounded by fears and fantasies, idealization and contempt, exciting and frustrating, libidinal and anti-libidinal objects, the actual body (and the actual theory and practice of body psychotherapy) can remain elusive and unknown.

This paper is based on the notion that there are two ways of using and (re)-including the body in psychotherapy. They correspond to the two sides of an essential paradox which, I claim, is inherent in all psychotherapy and therefore recognizable by practitioners across the approaches. In simple terms: I can take a ''third-person perspective'' and relate to the client and his already objectified body in an objectifying way. A third-person perspective tries to treat the patient as a case, an 'it', objectively, scientifically. It perceives and diagnoses the patient's pathology, applies a theoretical framework regarding the aetiology, dynamics, and structure of that pathology, and on that basis prescribes and administers a treatment plan. As this is what patients typically expect from a doctor, we may for simplicity's sake call this the medical model.

Otherwise, I can take a "first-and-second-person" perspective, and relate to the client's and my own body intersubjectively, *whatever* state that body is in (i.e. even when we are both disembodied or trapped in self-objectification). A first-and-second-person perspective recognizes the presence of another subject, another I, whom in essence I cannot possibly meet or dialogue with as long as I take an exclusively objectifying attitude. We might call this the "intersubjective-relational" model.

There is a polarization within the field of psychotherapy around this issue. One of the problems of this formulation is that we are not actually dealing with one polarization only, but a series of associated, and easily confused, polarizations which may overlap, but do not actually coincide. The objectifying stance, for example, is more readily associated with drive theory and therefore is suited to disclosing the self-regulating dynamics of the individual in isolation (e.g., the biologically-rooted instinctual nature of human motivation). The relational stance, on the other hand, tends to disclose the interdependent nature of object-seeking needs arising in human attachment and contact, and is more readily associated with an object relations view. Neither perspective needs to be thought of as more real or valid; each is sensitized to different aspects of human reality and therefore more suited to allowing us insight into them. However, although they are easily associated, drive theory and medical model are not identical. Nor does the fact that a therapist adheres to object relations theory necessarily exclude all medical model attitudes from their actual presence and practice. This illustrates that we are, in fact, dealing with different polarizations along different dimensions of the therapeutic space. With this caution in mind, we can say that each stance also tends to engender particular therapeutic dangers. If the medical model can get lost in the dualism, non-mutuality, and the power-over dynamic inherent in the objectifying doctor, the relational model taken to the extreme presents an equivalent danger of the therapist degenerating into a collusive friend.

As exclusive and habitual positions, either stance can clearly be detrimental to the therapeutic process. It is when we recognize the contradiction between them as necessarily inherent in the endeavour of therapy that these stances disclose an underlying essential paradox which, in my view, all therapeutic activity is subject to. I see all therapy as caught between (a) allowing and "entering" the inevitable repetition of the wound in the here and now of the therapeutic relationship, a re-enactment of the wound in and through the therapy, and (b) responding to the wound by counteracting it, relieving, soothing, modulating it, the far end of which is a reparative "making it better."

If the therapist can bear and hold that tension, and be in it and both act and relate from within it (i.e., engage from both sides of that tension), spontaneous transformation of the wound can occur. The two ways of (re)-including the body in psychotherapy correspond to those two polarities: I can use the body to try and contradict the wound, or I can attend to the body as an inescapable dynamic feature in the re-enactment of the wound.

I propose that we need *both* and, more importantly, need to develop the capacity to work with the tension *between the two*.

The first way of using the body is the historically established one and was the only mode available to what can be called traditional body psychotherapy. The other has become available to us only recently, to the extent that the traditional shadow aspects have been recognized and worked through. Both uses of the body obviously require a holistic understanding and therefore have much in common. Both are necessary and complementary, but, inasmuch as they correspond to the two sides of the underlying paradox, they are also antagonistic and opposed as they imply radically different therapeutic stances and meta-psychologies affecting, in turn, therapeutic aims, theories, techniques, and potential results, as well as requirements of the therapist.

In order to present these two ways of including the body in psychotherapy more comprehensively later, I want to share with you first some of my journey from an exclusive reliance on the first to an appreciation of their necessarily conflicted co-existence in the paradoxical core of the therapeutic position.

The diagnosis of dis-embodiment

My past idealization of embodiment (the wisdom of the body)

If you had 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 knew only about the first way of using the body, and my whole therapeutic style, thinking, theory, metapsychology was immersed in an idealization of the body and embodiment.

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. Wilhelm Reich (1983) said that there was a pure, good, loving core which we could get back to. Expression and catharsis were the key to health, happiness, and embodiment. As a therapist I thought I should and could make that embodiment happen.

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. Max, being an intelligent, well-educated, politically-aware, intellectual man, 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 his involvement with counselling, he had arrived at a perspective similar to my Reichian one.

Apparently, however, he was so good at understanding the counselling process that he could anticipate and avoid the counsellor's manoeuvres. He felt that nobody could get through to him and his feelings. Coming to see me was a fairly explicit attempt to bring bigger guns onto the battlefield. You can already 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. Some of the key theoretical assumptions at the time are summarized in the following section.

Basic assumptions of traditional body psychotherapy

As accessible introductions to traditional body psychotherapy are available, for example Totton (2003), I will refer only to a few strong influences. One such influence was Stephen Johnson's (1994) *Character styles*, integrating Reichian character structures with the developmental theories of ego-psychology, self-psychology, and object relations.

According to Johnson, whatever the child's age, developmental stage, and corresponding existential need or issue, developmental injury occurs and is internalized in the following sequence of interactions and experiences. The child's spontaneous expressions are met with a negative or ''not-good-enough'' response which initially generates an organismic, impulsive reaction. When this reaction also meets with a consistent and systematic failure by the caregiver to respond adequately, eventually the child, in a biopsychological gesture of turning-against-the-self, internalizes the negative environmental response. As this intensely conflicted state is not sustainable, a variety of superficial adjustment mechanisms are necessary which both repress the wound and present a compensating façade to the world.

The other book presenting a traditional way of integrating the body is *Body, Self and Soul—Sustaining Integration* (Rosenberg, 1985). These two books sum up the essentials of my perspective at the time. In a nutshell, both my client

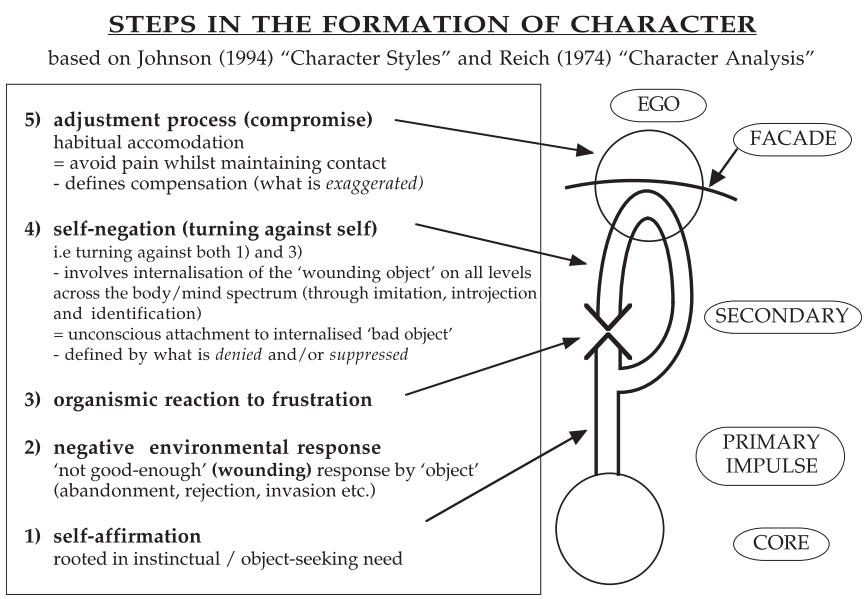

Figure 1. Steps in the formation of character.

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 internalized version of his father's contempt for him. We assumed that behind his mask were buried intense feelings and an aliveness which he was systematically denying and avoiding. We assumed that by accessing and expressing those feelings, he would return to healthy, alive functioning.

However, accessing those feelings required a circumvention of Max's defences which, according to his own reports, were rather effective and pervasive. Most therapeutic approaches have their own language for describing the double-edged nature of defences: they are simultaneously protective and self-sabotaging. The Jungian analyst Donald Kalsched, in his book *The inner world of trauma* (1996), for example, has described the ''self-care system'' which traumatized 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. This corresponds with an early statement by Wilhelm Reich: ''Every patient is deeply sceptical about the treatment. Each merely conceals it differently'' (Reich, 1983, p. 120).

If it is clear that it takes severe, systematic trauma to shock somebody out of their body into habitual disembodiment, what actually 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 post-hoc adult version was the only form of trauma Max could understand and conceive of. He could not allow himself sufficiently any imagining of his experience as a child (let alone his infantile emotional reality) to appreciate the kind of psychological trauma which attachment theory shows us at the root of developmental damage.

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 then the solution must be the opposite: embodiment.

The project of embodiment

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, provoke catharsis at a primal level by breaking through resistance (character armour)
- the soft, mothering way: melt the armour, undercut the pseudo-autonomy of the social façade by nurturing the pre-verbal self.

Body psychotherapy's 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 Max's explicit demand for, and apparently 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, and a different sense of being. They *were* precious experiences. But I only understood later that because they arose in the context of a re-traumatizing re-enactment which we were both oblivious of, they could never be fully integrated. In disappointing contrast to what I thought the textbooks said, these peak experiences, therefore, never led to sustained change or improvement. On the contrary, 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.

Idealization 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, and they reject.

Letting go into the body, the first thing we encounter in clients is not embodiment, but disembodiment and 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 idealization of the body and body psychotherapy. There are possibilities of depth, spontaneity, transformation, which many people in our culture have no idea about because they are chronically defended and identified against their body, distracting themselves from the underlying wounds through addictive, self-objectifying, and rationalized mechanisms which only serve to deepen the internal splits. In contrast to that reality, quite accurately and validly perceived by body psychotherapy, the body does indeed have an answer. But how to get into the body to find it? 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; within that disembodiment we find trauma.

It took me a while to translate my failure with Max into a general principle. At first I thought it was just me and my incompetence. I thought this debacle

was an anomaly in an otherwise perfectly valid therapeutic framework. But Max helped me recognize that the same dynamics occurred with other clients, only in more subtle ways.

My habitual position as a therapist

The problem was not with my perception of the client's conflict, but with the conclusions I drew from that perception and my therapeutic responses. My diagnosis was correct: Max *was* trapped in a habitual conflict, between his spontaneous, organismic reality and his cognitive, reflective, identity and self-image. But typically my responses to his habitual trappedness were coming from an equally trapped and habitual place within me: based on my idealizing fantasy of the body, I was constantly taking a one-sided, biased fixed position which actually exacerbated the split between body and mind. This fixed position was tantamount to an ideology for me, and I was blind to its effects.

It was only through Max being such an expert at avoiding embodiment that this began to dawn on me. I began to realize that the more I pursue embodiment and the more I take the side of the client's body *against* the client's mind, the more I tend to enact the client's internal dynamic between body and mind. I then 'become' their body and the client retreats into their disembodied mind. The more I champion (out of my own ideological investment) the client's body over and against their mind, the more the client and I end up acting out the war between body and mind *between* us. It became apparent that taking sides like that did not facilitate the spontaneous re-organization of the conflict into transformation; it actually kept it going.

In the apparent pursuit of embodiment, catharsis, and aliveness, I was being relationally oblivious: I was actually re-enacting the body–mind split between me and the client. I was forced to conclude that the more I insist on their embodiment, the more I end up getting in the way of it. To simply try to make embodiment happen is not just counterproductive – it is impossible. Max's self-care system was 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. These kinds of considerations eventually helped me understand that the client is not very likely to just jump at the chance of having their repressed and denied body given back to them.

Bracket: The disembodiment of psychotherapy itself

If that is true for clients, it may also be true 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 apply to the discipline of psychotherapy. Like many of our clients, psychotherapy itself has long suffered from disembodiment, ever since its birth really, about 100 years ago. Having, as a discipline, traditionally excluded the body, psychotherapy does

not lend itself easily to including the body, and does not readily take it back on board.

The birth trauma of psychotherapy

Now we all know that much wiser heads have been broken on the philosophy of the body–mind conundrum. Ken Wilber, summarizing the research and writing on the subject, said: ''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, 2000, p. 175).

If we think of the late nineteenth 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 psychotherapy's legacy, a 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 continues to restrict its full potential. So if we now try to re-include the body, we are going to get into trouble. As I will demonstrate more practically in a second paper to be published in a future issue, 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 deconstructing psychotherapy as we know it.

Deconstructing 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.

Acknowledgements

I want to thank my colleagues at Chiron who have struggled with me over the years and provided the support and context for me to formulate these ideas, and my wife, Morit Heitzler, without whose help and feedback this paper would not have come together.

Biographical note

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