Towards an integration of objectifying and (inter)subjective stances in relation to the body in psychotherapy

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Some of his other writing is available at www.soth.co.uk. The website also has information about training and teaching events, including some seminars designed to follow on from this paper, making the ideas applicable across the various therapeutic approaches.

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Abstract

In Soth (2006) I had begun to trace some of my own development as a therapist through the shadow aspects and pitfalls of traditional Body Psychotherapy towards an integration of holistic-embodied and relational-intersubjective perspectives, illustrating this with examples from work with a client I called Max. In this second paper I propose that the crucial concepts arising from this integration, relevant to all modalities of psychotherapy, are re-enactment and an extended notion of parallel process. Paradoxically, the re-enactment of the client's original wounds, as experienced in the 'here and now' between client and therapist, constitutes both the worst and best that therapy has to offer. Through understanding the therapist's conflict in the countertransference as part of a complex relational body/mind system of parallel processes, containment of the re-enactment and spontaneous transformation may become more likely. This requires that the therapist can 'enter' the re-enactment experience as it manifests across the full body/mind spectrum. In summary I call this an integral-paradoxical approach to the 'fractal self' in relationship.

Keywords: embodiment, objectification, re-enactment, 'fractal self', paradox, integral

Introduction: Learning from the failure of the embodiment project

Whatever our therapeutic approach, sooner or later there will be a client who traps us in our most cherished assumptions about therapy. As described in Soth (2006) 'Max' was such a client for me. All my assumptions, my whole mind-set, based on an idealisation of the body and traditional Body Psychotherapy, acquired a profoundly counter-therapeutic function in relation to him, exacerbated by the fact that consciously he shared these assumptions.

I now am grateful to him and the process with him for helping me de-construct this limiting mind-set which I was hiding behind as my therapeutic identity. But at the time, I had severe difficulties with finding myself de-constructed. Then, I did not have the conceptual tools and was in no way prepared for the processes by which the client's unconscious constructs the therapist as an object; let alone could I conceive of the possibility that the ensuing de-construction of the therapist might be a therapeutically useful and necessary process. It may not have been the end of the world, but it was the end of my precious personal-therapeutic one. It took me a while to learn from this shock – with hindsight now it seems very straightforward and obvious.

The therapist as enemy of the client's ego (and self-care system)

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. Based on an idealising fantasy of the body as the uncorrupted 'core', along the lines of: 'the

body never lies', I saw my task as siding with the body against the restrictive ego (which at the time I saw naivély as equivalent with the disembodied mind) and to thus liberate the client from their life-denying inhibitions and repressions. In simple terms: I was constructing myself as an enemy of the client's ego, not just with Max, but with all my clients.

In the apparent pursuit of embodiment, catharsis and aliveness, I was taking a fixed, habitual position in which, although being acutely attuned to Max, I was also being relationally oblivious in many respects. I was pro-actively manoeuvring myself into a position in which I was participating in a re-enactment of the client's internal body/mind split *between the two of us*. Far from helping to heal the body/mind split, which was the avowed intention, this was undoubtedly exacerbating it.

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, let alone begin to work with it.

Max would often comment on his numbness. Typically (and not 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?

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

One simple way of thinking 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, a large part of Max's body/mind was in a bio-psychological energetic state where he might just as well have been in the same room with his father: his body was furtive, alert, anxious. Judging by his spontaneous experience he was in an emergency situation, expecting attack.

However, 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 whose message was: "I am unhappy with you and your body as it is". 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 him, that he needed to change and be different, and especially have a different body. Unconsciously, and on a non-verbal and pre-verbal level, therapy for Max had always been constructed as a repetition of his father. And unconsciously, from the beginning, I had fallen into this dynamic and, under the guise of my best therapeutic intentions, pro-actively acted into it. Therapy for Max, therefore, became both an internal and external re-enactment of the father.

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 being given the opportunity to experience a flavour of his childhood reality.

Re-enactment

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 the extent and pervasiveness of projective identification. It took many years to understand the processes of transference and countertransference in body/mind terms and integrate this understanding with established Body Psychotherapy principles and techniques. The sustained attempt to do justice to the body/mind complexity of re-enactment later developed into the more comprehensive map of 'the five parallel relationships' (Soth 2005).

A description of this map goes beyond the topic of this paper. 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.

> 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. And the therapist's presence, their way of being and their therapeutic responses and activity are inexorably drawn into this relational universe in way which reaches beyond the therapist's professional identity into their own subjectivity and wounds. Because to a large extent this entanglement repeats 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 as a body/mind process unless I had been trained to attend to the body and its energetic state, in constant, minute detail. But whilst I stumbled into it through following the body into the depth of the body/mind split and disembodiment, the notion of 're-enactment' is relevant to all psychotherapy. So here is the second version:

> The central significance of re-enactment for all psychotherapy: it is impossible for a therapist to follow a strategy of overcoming or changing a dysfunctional pattern without enacting in the transference the person in relation to whom that 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', both 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. The therapist, through their attunement and empathy, is inevitably drawn into conflicting responses and therapeutic impulses which constitute an 'acting-into' the client's relational universe.

Re-enactment must obviously appear as irrelevant to therapists who subscribe to an exclusively objectifying 'medical model' stance. I would maintain that it occurs, anyway, but 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.

The paradox at the heart of the therapeutic position

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. The countertransference revolution and the shift towards relational perspectives in psychoanalysis has helped us appreciate the existence and significance of re-enactment. The tradition of Body Psychotherapy can provide a profound holistic phenomenology of re-enactment across all the levels of the body/mind in both client and therapist. In that sense I absolutely concede that I am not inventing a new 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. There are

many ways to deny it, or gloss over it or dress it up (e.g. as the client's resistance, or insufficiencies in the therapist's approach or style). As I have described for myself, it is perfectly possible for a therapist to be so invested in their own particular therapeutic identity that they would not want to notice the ever-present pervasive dynamic of re-enactment right under their nose. But as the relational perspective is gathering momentum across the various approaches, re-enactment is going to become an increasingly central concept in psychotherapy.

In the same way in which previously transference and later countertransference have been reframed from obstacles to the therapeutic endeavour into avenues leading us into the heart of therapeutic transformation, we can also reframe re-enactment. The more we accept re-enactment not only as a 'necessary evil' in the therapeutic relationship, but as the paradoxical core of the therapeutic position, the more we recognise that this position is built upon an inherent conflict: whatever the particular model and approach, the therapist feels necessarily torn between using their skills to help and alleviate symptoms and proactively change and improve the client's wound on the one hand, and allowing on the other hand the inevitable repetition of the wound within the therapeutic space. Inasmuch as we are recognising and holding out for the possibility of profound spontaneous transformation, the nature of the beast requires us to go through the eye of the needle of re-enactment.

It is our incapacity to grasp and stay rooted in this paradox as a *necessary*

feature inherent in the therapeutic position that fuels much of the polarisation between therapeutic approaches and schools in terms of theories and techniques.

I suggested in Soth (2006) that in framing the underlying polarities of the paradox, we are actually dealing with several overlapping polarisations which can easily get confused. As an approximation, I called the two poles of the underlying tension the ‘medical model’ versus the 'intersubjective-relational' model.

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. Therapists tend to identify with one or the other polarity in a rather absolute fashion. Some therapists see their practice firmly within the scientific paradigm and construct their therapeutic position as indistinguishable from a medical expert, and denounce everything else as unprofessional.
Some therapists vociferously maintain that any ‘medical model’ attitude on the part of the practitioner is fundamentally inimical to the therapeutic process as it will abort the authentic meeting which they see as the core of the therapeutic encounter.
Most therapists, as Freud himself did, oscillate uncomfortably between the two polarities, often switching between them in response to transferential pressures. But in order to access the relational information inherent in the therapist’s conflict, it is important to link our countertransferential conflict between these

two stances to dynamics in the client's inner world. The recognition of the parallels between a) internal object relations, b) spontaneous and reflective body/mind processes and c) the therapist's conflict within the therapeutic position opens out a holistic and intersubjective world of parallel processes. I will come back to this.

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

The challenge to my tradition of Body Psychotherapy has been that we idealise the body, and that we tend to short-circuit the depth of pain by providing either directive and invasive or gratifying and soothing interventions. That is, in my view, an entirely valid and correct challenge. The techniques of the Body Psychotherapy tradition (including body awareness, touch and bodywork) can and have been used to 'make better', to evacuate, discharge and sidestep the depth of the pain, and to minimise, counteract and circumvent the heat of the transference. *I* have used them like that. Working with the body then becomes a denial and an avoidance of the necessarily inherent re-enactments, and therefore tends to exacerbate the therapist's unwitting participation in them.
A substantial part of this paper is precisely about owning that idealisation, owning its shortcomings, its failures and its damaging effects. However, we do not want to throw the baby out with the bathwater. If as Body Psychotherapists we can allow the deconstruction of our habitual position and our attachment to it, we might yet salvage something precious that should not be dismissed

altogether.

Just as psychoanalytic theory and technique can and has been used in an un-relational fashion, to provide a rigid, protective habitual position for the analyst, all other therapeutic models, including Body Psychotherapy, can be used in the same way. And if psychoanalysis can catch up with this dynamic, maybe Body Psychotherapy can do so, too.

I propose that 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, into subjective and intersubjective depth and into spontaneous transformation.

Two ways of re-including the body in psychotherapy

The two contradictory and complementary ways of re-including the body correspond to the two sides of the underlying polarities inherent in the therapeutic position and the paradoxical tension between them.

1. Relating from a 'third-person' objectifying (medical model) stance

One way of re-including the body is through working from a third-person, monological perspective. It is, therefore, operating from within the same objectifying paradigm implicit in the client's existing self-objectification (i.e. their dualistic body/mind relationship), but in order 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 what I call 'translation' and 'contradiction'). Here, I am aware that the client suffers their individual version of the culturally-constructed supremacy of the mind over the body. I recognise 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 this first way is mainly about symptom-reduction. In attachment language: it is about modulating and soothing the client's uncontained pain.

In any case, if I want to meet the client where they are, I need to collude with the client's self-objectification which is inevitably reflected in 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 and treats 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.

2. Relating from a 'first-and-second-person' (intersubjective-dialogical) stance

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 *dis*embodiment, 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 stance 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'. It does, however, require more than withdrawing into a passive, reflective, purely interpretive position.

In this stance I do not just act on any objectifying therapeutic impulses which inevitably arise as an extension of my empathy and the concomitant wish to ease the client's pain. But because I am holding out for the possibility of spontaneous transformation of the wound (rather than deliberate, strategic change through 'translation' and 'contradiction'), I refrain from easing, soothing and rescuing and reflect on these impulses as possibly objectifying re-enactments. 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 intersubjective-relational stance is a necessary counter-pole to the 'medical model' stance which, on its own, is incomplete and counter-therapeutic. Vast reaches of human experience and existential depth are by definition excluded from the grasp of an exclusively objectifying approach which turns the person into a 'case' - a mere instance of a more general category which can be defined and treated scientifically. Furthermore, by being active all the time in making change happen, such a quasi-medical objectifying stance interferes with an important relational principle: it interferes with allowing myself to be constructed as an object by the client's unconscious. Important areas of subjective reality can only be disclosed by following this principle, and they will not reveal themselves at all if I *only* take 'third person' position. If I want to allow space for the unconscious to construct me as an object, I need to enter 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 is where a body/mind perspective transcends the reflective-interpretive bias of traditional psychoanalysis.

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 two of its core values: subjectivity and intersubjectivity.

Integrating the two ways of re-including the body

The first stance is a necessary, but in itself limited 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 allowing de-construction and transformation of that paradigm. Let me repeat that I am not trying to establish one stance as right and the other as wrong, or that I am implying some kind of superiority or inferiority. The 'relational perspective' is better and superior only to the extent that it fully integrates and includes the ‘medical model perspective’ as one necessary stance on a paradoxical spectrum. The medical model perspective is psychologically counter-therapeutic only when it becomes an exclusive, one-sided, habitual position.

Both stances are essential and necessary in a psychotherapy which includes the body because they each meet and reflect two aspects and potentialities in each and every client. We can think of the client’s body/mind as caught, usually unconsciously, in internal relationships in which their emerging 'self' is treated as an 'it', rather than an 'I', in an ongoing, constantly repeating pattern. More specifically: the client’s ego also is conflicted between these two stances as opposing modes of relating which each client has to themselves. The ego’s

relationship to the body and its spontaneous experience is usually the most visible manifestation of this tension or conflict which parallels constantly shifting internal enactments of particular object relations. The therapist empathises with, gets drawn into and reflects the whole body/mind matrix of unreconciled and uncontained opposites in the client's experience.

I am therefore primarily interested in the phenomenological detail of the tension between the two stances, as that tension occurs in the here and now of the therapeutic relationship. There is relational information in how I experience that tension in the countertransference with each particular client.

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

From a relational perspective, one of the key issues defining the transformational capacity of the therapeutic space is the range and depth of human suffering and the extremes of pain and joy which the therapist can bear to feel, to engage with, to be drawn into. I think the limits of what we can bear as therapists can be extended by theoretically understanding the inevitability and necessity of re-enactment. But a lived understanding of how, paradoxically, profound spontaneous transformation occurs in the pit of re-enactment, can only arise by us surrendering to it, what I mean by ‘entering’ it. As Gestalt says: "change happens when we accept what is." And 'what is', I propose, always already contains the re-enactment of the wounding.

When we can 'enter' the re-enactment, with an awareness of the whole spectrum of body/mind processes, what do we find? Where does that perspective take us?

To begin with, we immediately come up against the limitations of psychotherapy's inherited dualistic paradigm. An internalised object, as described by modern object relations, is not mainly or only a mental representation, it is a body/mind process (i.e. it's not a static object and it's not only in the mind). Its main manifestations is not mainly in the *content* of our thoughts and fantasies (whether conscious or unconscious), but, more importantly, it is structured into the *process of our thinking*, into our way of thinking. But not just our thinking: it is equally structured into the processes of sensing, feeling, perceiving, imagining, remembering, both in their psychological and their biological (physiological-neurological-anatomical) aspects.

On a physical level, more specifically, we could say that every internal object is anchored in particular sensations, particular tensions and mannerisms, particular parts of the body. Moreover, to take it beyond the idea of a singular internal object into an understanding of the 'relational unit' (which each object is constituted by, as, following Winnicott "there is no such thing as a baby"), 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 –

Max had no ‘felt sense’ of his eyes or the way he was looking. His awareness was dissociated from the experiencing of his eyes which functioned as a split-off object, the internalised father.

The frightened child anticipating attack, on the other hand, lived on 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. The relationship between the eyes and the chest, whenever he looked at himself in the mirror, encapsulated the whole re-enactment. This was the strongest, but by no means only manifestation of similar parallels throughout his body/mind system.

This is the extent to which patterns of emotional relating (and wounding) actually get embodied, not only in the brain, but throughout primary, immediate body/mind experience. Modern neuroscience confirms what Body Psychotherapy has taken for granted since the 1930’s: the attachment relationship affects physiological and anatomical development. The revolutionary recognition that ‘nurture’ gets internalised and embodied as what was previously conceived of as pure ‘nature’ lends scientific weight to the subjective and intersubjective endeavour of psychotherapy. Objective science is thus validating emotional reality and interpersonal relating. We are now capable of tracking the biochemical and neurological processes in micro detail, but the principle was implied in character structure theory all along: 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 recognition of the full spectrum of parallel relational processes across biological, emotional and mental levels still eludes even the most advanced neuroscience.

The 'fractal self': holistic and integral perspectives

It is, for example, in my opinion a brilliant and helpful insight to have established the existence of seven distinct emotional brain systems (Panksepp 2006), significantly expanding the information age metaphor of the brain as a computing and thinking machine. But the important point is not only that these functional systems, stretching across anatomical, physiological, neurological and psychological domains, exist. For psychotherapy it is more important 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, holographically, via parallel process. What gets mapped in the brain (and in memory) is not only content, but also process, relationship. We will never get at this by chasing after the parts without looking at the emotional dynamic of their inter-relationship, the overall Gestalt of the complex system and its relational functioning.

The same point could be made in relation to the different modalities of the Body

Psychotherapist (Carroll 2006): sensing, moving, emotion, feeling, imaging, thought, self-reflexive awareness. It is great to explicitly work with the whole spectrum of expressive and communicative 'channels' and to have different techniques for getting involved with all of them - that is one of the benefits of a holistic perspective. All of these modalities are avenues of experiencing and expressing self as process, for the client and for the system of the therapeutic relationship. It is important that therapists can expand their range of relating across the whole body/mind spectrum and all of these modalities. 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*. For me, this is the essential difference between - what I would call - a holistic-integrative framework and an integral-relational one, a qualitative quantum leap similar to the established difference between eclectic and integrative perspectives. On top of an holistic appreciation of the diversity and multiplicitiy of the many levels and dimensions of human existence, an integral perspective attends to the relationships between the parts, i.e. the meshworks and splits, the integrating and dis-integrating organising dynamics which weave the parts into a whole.

Paying attention to the parallel processes between psyche and soma, between psychology and biology, between brain and body, between memory and perception takes us into a holographic universe where past and present external relationship is reflected internally 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 processes are in turn reflected externally, and manifested interpersonally through enactment. Internal and internalised relationships, whether on a biochemical, neurological, muscular or emotional level, get constellated and acted out in external relationships (i.e. transference). 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. This integral view where parallel processes weave the tapestry both of our inner and outer worlds and knit them together in a complex mystery, is implied in, what I call the notion of the 'fractal self'.

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