

The Body in Counselling

Introduction

It is unfortunate that discussions regarding the role of the body in counselling so often revolve around technique and the issue of touch. As described in Bernd Eiden's article 'The History of Body Psychotherapy - An Overview' in this issue of the magazine, the body-oriented tradition has moved on a long way from the 70's emphasis on discharge and catharsis and has more to offer than a set of techniques. It shares with the psychodynamic perspective a focus on the relationship dynamic in terms of transference and countertransference. It shares with the Gestalt approach an emphasis on phenomenology, immediacy and the 'here & now'. It shares with the person-centred and humanistic traditions more generally an appreciation of human potential, including congruence, transparency and authenticity. As most psychotherapy, it has an ambivalent stance towards the 'medical model' which it can neither exclude nor subscribe to.

How we conceive of the relationship between body and mind is fundamental for our work, and has implications - whatever our approach and perspective as counsellors - for the three main areas of our work: a) our technique b) our theory and meta-psychology, and c) our underlying conception of the therapeutic relationship including what constitutes a 'therapeutic position'.

I don't want to focus on these abstract questions directly, but explore them in terms of clinical relevance: how are counsellors confronted with the body in everyday practice? How does the body make its presence felt in the session even when it is not explicitly addressed by the counsellor?

Somatic symptoms - the body as messenger or dumping ground?

The most immediate and obvious way the body enters the consulting room is through physical symptoms, either chronic or reported as occurring between or in sessions. These symptoms may be reported incidentally (as nothing to do with counselling) or as implicitly or explicitly connected with counselling (e.g. "I had the most terrible headache *after last session*"). If the client is bringing such symptoms into the session - rather than taking them to a doctor - the client's body does become the counsellor's concern. The client implicitly acknowledges their deep intuition that there may be meaning in the physical pain.

This raises the thorny subject of the psychosomatic connection. We can easily agree that any physical pain, especially if it's intense and/or chronic, will acquire emotional significance. As we all know from our own experience: we have feelings *in response* to pain; we want to be taken care of, we regress; or we feel irritated and angry, etc.

The more complicated link between psyche and soma is the notion that physical pain *expresses* feelings, or - put more strongly - that sometimes we have physical pain *instead* of feelings. Without this important notion it's difficult to see how we can do justice to the intricacy of the psyche in its subtle effects on body and mind. However, it is also an idea which can and is being abused in a multitude of ways as it lends itself to persecution of the client by a variety of approaches.

It can, for example, take the form of: "you are responsible for your illness", "your cancer is an expression of your repressed anger and resignation", or "your heart attack means that you have lived without love for so long that now your heart has to attack you in order to draw your attention to it."

Even psychodynamic theory is not immune against being used in this fashion: somatisation (converting a psychological process into a physical one) is considered a form of 'acting out'; it can constitute an active avoidance of symbolisation. In some ways, it's the client's last line of defence: if the counsellor considers translation of the unconscious into cognition as a necessary gateway to therapeutic change, then this is a great form of resistance: it stumps the practitioner who has restricted their area of engagement with the client to verbal and mental interaction. It is tempting to react against being stumped like that by interpreting somatisation as avoidance which - true though it may be - adds insult to injury.

These are examples of the general danger that any suggestion of illness having a psychological meaning can confirm the patient's internal persecutory dynamic (where they are probably feeling guilty for their illness and attacked by themselves already). Because of these dangers, many clients and practitioners tend to dismiss such a psychosomatic perspective out of hand, claiming that as it cannot be proven, it has no place in counselling. This is no solution, either: the problem is that most persecutory accusations probably have a kernel of truth at least some of the time.

Deeper and non-defensive exploration often reveals that on a primitive level the psyche at least seems to operate *as if* there was such a psychosomatic connection. In our culture the body *does* lend itself - both literally and symbolically - as a preferred dumping ground for conflicts which we can't and don't want to face. In analytic terms: the client relates to the illness as an internal object. Once we accept that, it becomes increasingly apparent how the illness gets mixed up, associated and conflated with those characteristic internal relationships which shape the person's inner world. This recognition opens out the significance of *any* physical symptom for the counselling process.

This dynamic is obviously more explicit when the client brings symptoms into the session and expects counselling to have an effect on them. Many counsellors are inclined to reject this, and point the client towards their GP. This ethically entirely responsible strategy, however, omits to differentiate the physical and psychological aspects of illness and fails to ask which is likely to be addressed where. Whether the client volunteers a link to counselling or not, the psychological aspects of the illness may carry an importance in relation to the counsellor which can easily go uncontained, even when the client reports how a symptom is perfectly well taken care of by medical treatment.

A client with chronic and severe hyper-acidity of his stomach, which did not seem to respond to any of the common treatments, had finally been diagnosed with an ulcer. This had long been expected, but in order to assess the possibilities of further treatment, the doctors needed to first establish what was causing the ulcer, and specifically whether cancer was involved or not. Although there was increasing danger of rupture, the client kept putting off the necessary gastroscopy. This involves a long tube being inserted through the client's mouth and throat in order to examine the stomach from the inside. The doctors became increasingly impatient with him, but did not know that he had been a victim of sexual abuse. He had been forced into oral sex and was physically experiencing the abuser as still inside him, destroying his boundaries quite literally from the inside. This seemed both symbolically and emotionally true, as well as tangibly translated on a physical level. Unbeknownst to the medical team, the proposed operation was re-enacting the abuse in the cruelest possible way. Having fought against the effects of the abuse on him through years of counselling, he could not bear to face that some of the effects "are still in my body". It was not until he began to embrace the emotional significance of his illness, through being able to experience some of the unbearable sensations locked into his throat and chest, that he could bring himself to consent to the gastroscopy, which did turn out to be very important for his chances of recovery.

There isn't the space here to pursue this further, other than to make clear that this is a minefield, but one we can't afford to avoid entirely. In terms of the body as messenger or dumping ground - usually it's not one or the other, but both, and it depends to some extent on the counsellor's response which of the two aspects gets neglected.

Intellectualising and deflecting - the body as container and conveyor of the 'repressed' and the 'shadow'

In exclusively verbal work, mainly oriented towards mental functioning, the body easily becomes the vehicle for everything that is unresolved and uncontained. There are clients who have had to develop the capacity to let emotionally significant interpretations glance off them to such an extent that the counsellor begins to experience futility.

An intellectually sophisticated, emotionally compliant counselling trainee approached a counsellor in order to fulfil his training requirement that he undergo his own counselling. Having been fairly anxious and hesitant in the first session, the counsellor's experience of him switched in what followed. Once accepted and 'taken on board', he increasingly became domineering, holding forth on the topic of the latest training session. This was an entirely habitual mode, as by profession he was an academic lecturer. His counsellor began to dread the sessions. Coming more from a 'feeling' orientation, she began to reflect to him what little feeling she could detect in him, but began to raise the stakes on these interventions to the point of disclosing her irritation with him.

As her supervisor I understood that her irritation represented the surface of deeper feelings of humiliation which connected her client to her own father. In order to break through his 'resistance', she was inclined to supplement her 'feeling' interventions by getting him to focus on his awareness of his body, in order to "get him out of his head". Fortunately we managed to contain in supervision the process of projective identification, by which she 'carried' his denied feelings of humiliation on his behalf (as well as her own). This enabled her to indeed use body awareness as a technique, but without exacerbating the polarisation which was occurring. Through bringing his awareness to his body while in lecturing mode, over a number of sessions he accessed both his "sense of masculinity" and eventually also the deep insecurity which he was constantly in the habit of trying to compensate for.

In this way everything the counsellor might have wanted to interpret in terms of his denied emotional reality was eventually 'discovered' by the client himself through attending to 'first-hand' somatic experience. Being verbally interpreted, however 'true' and accurate in content, represented a form of relating which resembled too closely his own defensive style. He couldn't help but interpret interpretation as being lectured to - a repetition of his relationship with his father which he - quite wisely - resisted.

At this point the counsellor did not consider it wise to confront the full extent of the transference by interpretation. This could, of course, also be construed as her circumventing the transference. I think about this mainly as a question of timing. It was not until much later that the counsellor felt able to confront the client with the extent to which the whole counselling process represented to him his father's shaping of his identity. Then it seemed possible for the client to make use of this insight rather than to just take it on board superficially, but defend against it all the more emotionally.

Body memory - the body as storehouse of the frozen past

For decades the body-oriented tradition has been working with the notion that memory is not at all an exclusively cerebral process. Although well-recognised clinically by practitioners working in this tradition, the depth and significance of this is not sufficiently appreciated in the rest of the field. Where does a repressed memory get stored ?

Reich's explanation, as extended by Gerda Boyesen and others, implies that it is not constantly available, but that its accessibility is a function of the emotional and energetic 'tides' occurring in the body/mind system. Emotionally significant interactions become internalised in a variety of ways, and Reich proposed that relational positions within the early environment become frozen in the body as 'character structure' (see Stephen Johnson).

He conceptualised the physical aspects of character mainly as muscular tension, an armouring of the voluntary muscle systems, including the breathing. But he was well aware that more primitive neurological levels were involved and affected, right down into the vegetative nervous system. While we are nowhere near formulating a comprehensive 'emotional anatomy' which includes tissues, metabolic, endocrinal, lymphatic and biochemical processes (e.g. neuro-transmitters), we understand enough to say that these are all part of the process of remembering. Memory involves the body/mind as an intricate whole, and not just the brain.

Non-verbal maternal holding - the body as arena of pre-verbal fusion

Early suggestions by Winnicott that interpretation is not the only 'therapeutic thing' which analysts provide have been substantiated more recently by writers such as Daniel Stern. The therapeutic presence, the therapist's 'being' rather than 'thinking', 'doing' or 'speaking', the 'ambience' (including the client's experience of the consulting room) are by now well-recognised elements.

But most significant is the therapist's relational capacity for both intimacy and detachment. Initially the therapist may offer a balanced readiness both to identify with the client as well as to be separate and differentiated. However, when the therapist is experienced as available to being used as an object by the client's psyche, the process will push the therapist way beyond this readiness into extremes: there may be icy denial of connection (to the point of the therapist feeling annihilated) on the one hand or desperate demand for fusion (again, to the point of the therapist feeling annihilated) on the other.

The therapist's availability, their 'non-resistance' to being used as an object, and how the therapist survives this threat to their identity posed by the relationship process, is not mainly communicated in words. It is subtly negotiated on a level of pre-verbal fusion. What we might call the 'energetic', non-verbal interaction between client and therapist is as eloquent as the verbal. It is a level of communication which the therapist's conscious intention has little influence on, and which strategy and technique can only detract from rather than add anything to.

Just as an understanding of the rich, sophisticated and mutual interaction between mother and infant has expanded our developmental theory, the equivalent recognition of pre-verbal communication in the therapeutic relationship is bound to transform our notions of the therapeutic process. To be clear: some therapists consider the main function of therapy as analogous to the mirroring in the early stages of mother-infant fusion. I am not at all suggesting such an exclusively reparative model. But by being tuned-in energetically and vegetatively, i.e. occasionally allowing movement into more merged, pre-verbal states (internally or sometimes with the client), the counsellor communicates an availability for fusion, in order to not exclude such more primitive modes of relating from the relationship by default. I am not saying that such presence on the part of the counsellor is in itself therapeutic, but that it is a pre-condition for the process addressing that level of body/mind functioning at all.

What does this mean practically ? In some ways it's easier to say what it doesn't mean: some counsellors constantly maintain a focus on the content of verbal interaction; their awareness centres on their own and the client's thinking and on relatively differentiated feelings, i.e. on the separateness of the two egos in the room. We could call this 'habitual countertransference': the counsellor's reaction against the client as a maternal object means they resist that energetically fused state as the backdrop of the interaction. Any intervention can then become a vehicle of distance regulation based on the counsellor's fear of fusion.

As parents we are constantly maintaining some part of our awareness as reserved for the infant, and specifically the rhythms and 'energetic tides' in the infant's body. A similar awareness can constitute the backdrop of the therapeutic presence. In terms of outward behaviour, this may manifest in such simple ways as drawing attention to the client's feeling before they are aware of it themselves.

Somatic countertransference - the counsellor's body as antennae and barometer

While an holistic conception of the connection between the client's body and mind is increasingly established, to think of the counsellor's 'being-in-representation' in terms of an intricate psychological body-emotion-mind system is still quite rare. Outside the body-oriented tradition, Schwartz-Salant has written about "gathering information somatically", "seeing through the body" and "psychic and somatic empathy" and proposed the notion of a subtle energy field as the locus of unconscious communication between patient and analyst.

Within the body-oriented tradition an implicit understanding has accumulated over the decades. As far as I'm aware, however, an holistic account of the counsellor's body/mind process has not yet been formulated in a clinically applicable form.

A counsellor was finding himself oscillating between drowsiness and an intensely physical restlessness - he reported it was all he could do to keep himself from constantly fidgeting in the session: something "made his skin crawl". This was in a long-term therapeutic relationship where the client's identification with his mother's messages of him as a burden and a nuisance were beginning to be addressed. The counsellor began to link the restlessness also to the father's departure after conception, his attempted return after birth and his final leaving when the client was three months old. The restlessness was mirrored in milder form in me as the supervisor when I found myself impatient with the counsellor's seemingly uninterrupted monotonous way of talking. The counsellor confirmed that this was indeed a parallel process, as he was finding it difficult to get a word in edgeways with the client, although the client was apparently talking very slowly, almost "torturously slow". It was clear to us in supervision that we were engaged with early infantile states and interactions, split off into neglected bodily sensations. The particular style of talking seemed to carry the mother's rejection of the infant, leading to a sense of trappedness in the recipient, of being pinned into skin-crawling restlessness. A few weeks after this had been worked on in supervision, the noticeable shift in the relationship between client and counsellor which occurred was that for the first time despair was openly and directly expressed and talked about. The counsellor experienced this as a positive shift although the states of restlessness did not diminish until much later in the process.

This is a good example of how the term 'somatic countertransference' is generally used, typically referring to interactions which we think of as involving primitive processes of projective identification. The danger with this specific and rather restricted use of the term is that we can easily forget that any countertransference experience is bound to also have a somatic aspect. It depends more on the selective perception of the counsellor's own internal process than on their actual experience whether they will report that somatic aspect.

In this sense the term 'somatic countertransference' owes more to psychotherapy's traditional focus on the therapist's thinking (as opposed to feeling and sensation) than to clinical accuracy and coherence. In other words: the term is still more a symptom of the return of the counsellor's own repressed body than an expression of its integration. From an holistic perspective, 'somatic countertransference' is like saying 'a swimming fish'.

But having said that, the term can retain some clinical usefulness if we're clear that the main feature is not the somatic nature of the experience, but the degree to which the body can be experienced as alien. This alienness is a function of the client's body/mind split, i.e. their internal sense of dissociation, which indeed can communicate itself to the counsellor through projective identification. The intensity of the counsellor's somatic experience is then a measure of the client's dissociation from it.

Working through regression - the body as carrier of deep and primitive affect

Western culture with its over-emphasis on individual independence rests on a deep terror in all of us of an experience of *interdependence* which includes the intimacy of the mother-infant bond. One of the perennial questions in counselling is how do we relate to and conceive of the client's ego, especially those defensive aspects which pursue independence and are compelled to control. The paradox, of course, is that the ego's need for control is largely out of control, i.e. automatic and compulsive.

In many clients (and counsellors) any threat to the 'independent' ego constellates immediately fear of regression. For most, this is equivalent to fear of the body - specifically the body's spontaneous processes. In most clients the ego may be quite amenable to taking on board new beliefs (including the therapist's 'helpful' ideas, whether spelled out or not), but usually it reveals its underlying fear and rigidity when confronted with explicit loss of control. Apart from relationships and dreams, the body is one of the main threats to the ego in terms of control. How we handle the ego as therapists is therefore inseparable in my mind from how we handle the body in regression.

To what extent regression in a general sense is 'malign' or 'benign', to what extent it is 'worked through', sublimated or further defended against within the therapeutic process, depends to a large extent on the therapist's attitude and response to specific regressive experiences. This is constellated every time when the client feels out of control, especially in relation to their body. Whether such experiences do at all occur, depends on the therapist's reaction to pre-verbal body states, and - by extension - on the therapist's attitude to the body and its spontaneous existence in general.

A quote from Reich's chapter on "Characteranalytic Technique" is as relevant now as it was then: "At issue was the concrete releasing of aggression and sexuality in the patient. At issue was the personal structure of the therapist who had to deal with and handle this aggression and sexuality. But we analysts were children of our times. We were dealing with subject matter which, though acknowledged in theory, we shied away from in practice. We did not want to experience it. ... The animal was and remained untouched."

The irony is that according to psychodynamic theory neurosis is all about conflicts around these 'uncivilised' impulses (for which Reich's "aggression and sexuality" is an oversimplifying shorthand), but then as now many psychodynamic practitioners are deeply afraid and suspicious of the actual experience of these impulses. Having said that, it also needs to be acknowledged that the Reichian tradition has fallen into the other extreme of idealising catharsis and disinhibition (building on Reich's preoccupation with 'release' as hinted at in the quote).

The dangers of body-oriented techniques

Like all other techniques, body-oriented interventions can be - and frequently are - used prematurely, inappropriately, defensively. There is a long tradition of practitioners using them to break resistances in the client, rather than working with the countertransference effect of the resistance on the therapist. The function of the resistance is often correctly perceived; in the most general terms as a defence against 'tender' feelings associated with vulnerability, need and longing or against the intensity of 'hard' feelings like anger, hostility and rage. And it is true that the body-oriented tradition offers powerful techniques to access these feelings in the 'here & now' of the therapeutic relationship where they can become a dynamic anchor of the client's sense of self.

However, having accurately identified both feelings and resistance in the client, too often practitioners are habitually drawn into taking sides in the client's internal 'war zone'. In the past, body therapists have tended to assume that expression of whatever is repressed is of itself therapeutic. 'Body-techniques' are then used exclusively to fight the resistance. By thus habitually taking the side of the client's 'feelings', the body therapist actively becomes an enemy of the client's ego and threatens the ego in the same way the ego already feels beleaguered by the 'unconscious'.

There isn't space here to illustrate this beyond the hints contained in the case examples, but in general we can say that it is impossible to pursue a 'therapeutic' agenda of breaking through or undercutting the ego's resistance without enacting in the transference the person whom the resistance first developed against.

When used *against* the client's ego and resistance, any technique is bound to become little more than an objectifying re-enactment of the client's pattern. This becomes most apparent when the 'technique' includes physical contact. The main dangers around touch are avoidance of hostility through collusive gratification and re-enactment of abuse through invasive techniques.

Such technique then confirms the prejudices of the traditional psychodynamic approach against any body-oriented perspective as too interventionist, directive, unbounded, uncontained, and oblivious of transference and countertransference. Whilst there are good reasons for the established rules of abstinence of the psychodynamic tradition, polarised discussion between the two approaches over the issue of technique can obscure recognition of our shared dilemma: the paradox that re-enactment of the client's early scenario in the therapeutic relationship is not just inevitable (in any approach), but that it is the very source of transformation, the force that propels us down the 'royal road' of the transference countertransference process. A too rigid insistence on correct procedure can abort the necessary vicissitudes which the relationship needs to be exposed to and survive - abstinence in itself does not guarantee safety, nor does it prevent re-enactment. The recognition of this paradox has mellowed my own parochial opinions within the therapeutic field immensely.

Re-enactment - the body as carrier of the unconscious relationship dynamic in the 'here & now'

To embrace the necessity of (re-)enacting as part of the process the very thing therapy is supposed to 'overcome' sounds manageable in the abstract, but is of course - over and over again - deeply painful for both client and therapist in the intricate emotional detail which is their particular relationship. The client needs us to lose whatever we identify as our 'therapeutic position' sufficiently so that we are available for re-enactment. Only in externalising and re-experiencing in the therapeutic relationship what was unbearable in the past and uncontainable by the client's ego in the present is the full extent of the client's pain sufficiently accessible to transform itself. I think it is true to say that body-oriented techniques have been used in the past to short-circuit this painful and unpredictable process, and escape from the apparently inescapable re-enactment. But once this is not just recognised, but worked through, awareness of the body can become as strong an anchor for the unconscious relationship dynamic as before it may have been used as an escape route. It can strengthen our awareness of the psyche and those unconscious processes which analysis has always considered the key to the therapeutic endeavour.

A weakness of traditional object relations theory is the assumption that the 'internal objects' and their relations are purely mental processes. From an holistic perspective we see the process of internalisation as occurring both on a mental and a physical level (or more precisely: as involving a multi-layered matrix of body and mind). Body memory involves introjecting the body language of the internalised object, which thus becomes an internal representation on a muscular level of gesture, posture and physical self-sense as well as an image, an inner voice and mental presence. One simple conclusion for the counsellor's perception of the client is therefore to try and trace every internal object also in its manifestation on the physical level.

A client has been working for weeks on a life-long issue of looking to men for guidance and support, but continuing to end up disappointed and dejected. Finally she bursts out in exasperation, throwing her hands up in the air: "I understand how I keep putting myself into a humiliated position and how I set up situations in which I do that, but I still continue to do it." Some of the exasperation is initially directed at the (male) counsellor - she is on the verge of a new relational possibility here (i.e. for once not to give the man's need for 'emotional protection' absolute priority), but by the end of her outburst it has already turned back against herself again. It's the client's body which communicates most clearly that the process is happening even while the client is naming it: whilst imploring the counsellor for 'stronger medicine', her body is taking a powerless and humiliated position in relation to the counsellor, right here and now. The client's ego appears focused on a desperate attempt to release herself from the pattern (with the counsellor's guidance), whilst her body - her shoulders, neck, eyes and voice - is 'in it'. If he attempts to help by providing guidance, he confirms her humiliated position. The counsellor's heart-felt sympathy in the face of the client's urgency misses the re-enactment whilst he is mainly focused on her verbal communication. As long as he tries to find an answer to her desperate plea, he unwittingly contributes to another twist of the screw. In supervision he remembers his fleeting perception of her hunched posture. This opened up for him productive imagining of how else he might have responded to the client's plea.

Conclusion

In my view, paying explicit attention to the body is not a technique or a shortcut past some sort of resistance. On the contrary: it is a way of paying attention to the full intensity of pain and conflict which is shaping our inner world. The body tangibly carries the emotional legacies of our early years and maintains a protective inertia over and against the client's deliberate and often compulsive efforts to deny their past.

Do we shrink away - like the client's ego - from physical symptoms like hyperventilation, cramps, panic attacks, muscle twitching, shaking, vibrating, and attempt to calm the client down and 'bring them round' ? Or - like traditional body therapy - do we side with the body in overwhelming an already beleaguered ego? Or do we stay with the conflict between the ego's need to control and the body's spontaneity (in relationship, in the 'here & now'), until spontaneous transformation occurs. This is my current oversimplified formulation of an integrative principle which includes the body. If anything, awareness of the client's conflict on a physical level confronts both the client's and the counsellor's ego with their limitations in the face of spontaneous processes (including the 'unconscious'). The ego's helplessness is a necessary gate to a more mutual and complementary relationship between body and mind.

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I use both the terms 'client' and 'patient' in different contexts to reflect their use by particular traditions. All client material is either adapted, amalgamated beyond recognition or explicit permission has been sought.

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