ABOUT RELATIONAL BODY PSYCHOTHERAPY

EDITED BY COURTENAY YOUNG

BODY PSYCHOTHERAPY PUBLICATIONS

The Relational Turn

Michael Soth & Nancy Eichhorn[3]

Do we have a shared understanding of what we mean by 'relational'? The term 'relational' has recently achieved buzz-word status. Therapists are quick to quip they are 'relational' because they see themselves as relating well to their clients and because they consider that the 'quality of relationship' with their client/patient is crucial to the work.

Books are written, conferences are held, workshops are offered based upon the increasingly wide-spread conviction that psychotherapeutic healing takes place in, and as a result of, the therapeutic relationship – "It's the relationship that matters". And it is indeed a precious achievement that the profession is now placing such significance on the relationship, rather than primarily on the supposedly 'correct' therapeutic theory or technique, whatever that may be. But unfortunately, the apparent consensus across the profession around the centrality of the relationship in therapy is only skin-deep; the closer we look, the more apparent it becomes that being relational means profoundly different things to therapists from different approaches.

Each therapeutic approach tends to assume that relationality is to be understood through its own framework, neglecting the important recognition that different psychotherapy approaches understand therapeutic relating in diverse, and often profoundly contradictory, ways. Relationality, therefore, is too easily appropriated by the paradigms and preconceptions of each partial approach, without the field having plumbed the depths of all the different

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Sure, there are some vaguely agreed-upon active ingredients in therapy, considered conducive to quality of relationship and to a robust working alliance, such as Rogers' core conditions, (empathy, unconditional regard, and congruence), psychoanalytic neutrality, secure attachment, embodied or right-brain-to-right-brain attunement, reciprocity or mutual recognition, but *"What do we mean by relating? How do we define relating? What therapeutic activities does relating include, and which ones doesn't it?"* (Soth, 2006).

Different Kinds and Modalities of Therapeutic Relatedness

That there are different kinds of relating, different kinds of therapeutic relatedness, is an idea that has been established in the US by Martha Stark (*Modes of Therapeutic Action*) and in the UK by Petruska Clarkson (*The Therapeutic Relationship*). Validating different and diverse kinds of relating (or modalities of the therapeutic relationship) is a significant step beyond the traditional dogmatisms of the therapeutic field, where certain therapeutic stances, embedded in the different traditions, used to be taken for granted. That they are *all* valid at certain times with certain clients establishes an integrative foundation which allows us to think beyond 'which approach is right' (across the board) and become interested in the particular relatedness between client and therapist right now, as part of a dynamic, shifting process.

Clarkson initially identified and distinguished five modalities of relating: working alliance, authentic, reparative, transference–countertransference, and transpersonal (but these have since been added to by various suggestions from others, including Soth himself). However, the ideas of relationality, which have developed since these initial integrative steps were taken in the early 1990's, point to another possible paradigm shift beyond an integrative embrace of the different modalities.

A Student's Take on an In-depth Conversation

Nancy Eichhorn: *For me, as a student entering this field with a passion for knowing, a zest to understand what was and what potentialities exist, I want leaders who are willing to broach the forefront of our developing approach with new insights based on both scientific research (statistical helps) and personal experience. I want possibilities and exploration. I want to reach*

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ignores the presence and relevance of our own subjectivity in the therapeutic process, and thus objectifies both the client and the therapist, ultimately with damaging, counter-therapeutic results.

I have heard statements to the effect that neuroscience now "proves" that interpretations don't work, or that "confronting a traumatized client is inevitably damaging, rather than empathic or reparative", and that "as neuroscience has proved that broken attachment is the root of all later difficulties, so parents and therapists 'must be more attuned'."

According to Soth, these are simplistic conclusions extrapolated from partial half-truths, and they have limiting and restrictive, and sometimes damaging effects on therapists who try to adhere to them, as well as on their practice. And, while there is no doubt that broken attachments (insecure and disorganized) are a key factor in human pain and distress, practitioners cannot just turn scientific findings and diagnostic typologies into formal instructions for therapy without over-simplifying reductively the relational complexity at the heart of the therapeutic encounter (viz: the plethora of workshops which are now offered on attachment-based psychotherapy). Using supposedly objective findings to create a training curriculum for therapists creates an objectifying paradigm that is liable to cut across the essence and basis of our work, which is ultimately rooted in the therapist's subjective stance, sense of self, and embodied stream-of-consciousness.

Traditional Body Psychotherapy – Reversing or Transcending Body-Mind Dualism?

The name 'Body Psychotherapy' was coined in the early 1990s with the word 'body' in the label reflecting, according to Soth, the prevalent idealization of the body inherent in the theory and practice of the post and neo-Reichian community of practitioners at that time. Soth remembers and reflects, "*We quite accurately diagnosed the body-mind split at the root of all psychological problems and were passionately attempting to overcome mind-over-body dualism, which we recognized as dominant in the culture, as well as in the field of psychotherapy. We declared, with Perls, that 'all reasons are lies', and 'lose your head and come to your senses'. These maxims are all valid, precious, and true to some extent, but, at the time, we did not see their partiality – we thought we had already arrived at some final destination.*"

"*However, we did not understand that you cannot overcome any sort*

of dualism by simply reversing it or just turning it around. The fallacy of mind-over-body cannot be transcended by the reverse fallacy of body-over-mind. We oversimplified the problem of the body-mind split by equating the head with the ego and with suppression; we saw inhibition as caused and maintained only by the mind, specifically by the disembodied, dissociated, patriarchal mind. We equated the body with the life force, with the unconscious: the 'noble savage' to be liberated through primal catharsis. All of these assumptions are not so much untrue as partial – they are helpful and valid in some situations some of the time and up to a point – but no more than that."

Objectification – How Do We 'Treat' the Objectified Body?

Objectification is one of the main symptoms of disembodiment. The more an individual is disconnected from the direct experience of their living body—their moment-to-moment sensations—the more they tend to treat their body as a 'thing', as an appendage below the head. This stance of objectification then becomes visible and symptomatic in and via the body. Take for example the topic of 'body image'. Soth suggests that we can recognize two forms of objectification – the negative objectification of the body as a slave (to the mental identity), and the positive stance of the body as a narcissistic fashion object (to mirror the attempted perfection of the self-image).

Under the banner of the valid postulation that ultimately the body can be experienced as much more than that objectified shadow of what it could be (i.e. the recognition that the sense of self is rooted in the body, and that the body is an essential ingredient in subjectivity), led many Body Psychotherapists to pursue therapeutic strategies designed to 'treat' the body, to overcome disembodiment and 'make embodiment happen'. These kinds of one-sided agendas and strategies can unwittingly exacerbate the existing objectification of the body, through a variety of techniques, exercises and interventions intended and believed to enhance embodiment.

The Therapist's Stance: Doctor, Teacher, Body-Expert?

"There's this sense floating around in the space of the relationship that the therapist is being paid to be some sort of body expert or body magician," Soth says. *"It's tangible in how the therapist positions him/herself as the one who apparently knows better, and based upon that superior knowledge*

and understanding, makes interventions geared to change the client's current state of disembodiment, somewhat like a doctor administering a treatment."

"Operating as the body expert is a bit like being a doctor who says, 'Sure it's bitter medicine, but it's good for you', while the therapist says, 'Here, you're angry, bash this pillow, it's good for you.' Subliminally the client perceives and experiences the therapist's implicit stance as 'authoritative doctor', and reacts to it through their own established relational pattern, so the hidden and disavowed 'medical model' paradigm, operating in the background of the therapeutic relationship, is also tangible in how the client relates back to the therapist (but then it is often understood and interpreted as the client's 'stuff')."

The Wisdom of the Body – Easy to Experience, Hard to Pass On

Many therapists have embraced body practices such as listening, following (gestures and movements) impinging from within, stress positions, creative expression, etc., all based on the neglected wisdom of surrendering to the body. Embodied knowing emerges and becomes available through the experience of this surrender. All these practices are experiential avenues, as all Body Psychotherapists well know, into the wisdom of the body and the recognition that the body can be experienced as a source of subjectivity. Our tradition knows what it means to be 'embodied'. Our mentors have taught us how to experience this wisdom and we can now honour our own embodied sense of self. These experiences constitute an essential frame of reference, which, as body-oriented psychotherapists, we take for granted, but which is not generally understood by the rest of the culture, and therefore most of our clients. This frame of reference doesn't manifest spontaneously, and it does not manifest on the basis of mental or theoretical insight or belief – it does not come about just through reading a book, even if it is a book by Reich.

The ordinary client doesn't know how to feel into his/her body; they usually perceive it as an unruly, symptomatic servant, or as an enemy, or a threat, or as irrelevant. Most ordinary clients start from a place of being disembodied, dissociated, or repressed, or at least not-knowing. Bodily knowing and embodiment involve a profound learning (and un-learning) process: a healthy relationship needs to be established between the person and their body as the therapist and client explore what kind of relationship currently exists: *What is the dynamic of that relationship? Is it a one-way or a mutual relationship?*

What is the explicit, conscious version of that relationship, and what is the implicit, lived experience of that relationship?

And once acknowledged as a learning process, then we must ask, *"What relational position does the therapist take in this process? How do I, as a therapist, engage with the disembodiment that the client brings into the room? What is the process that helps the client move toward a more enlightened embodied state? What is the therapist's relational stance towards the client as he/she goes through that? And how does the client perceive and experience my stance? And how does their experience of my stance and of me relate to their characterological history?"*

Can We 'Educate' the Client into Embodiment?

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

"So, however appropriate an educational stance may be in many situations, none of this gets us around a fundamental relational conundrum that traditionally body-oriented and somatic practitioners have not paid much attention to. If I position myself as a 'body expert', my interventions might be translated (unconsciously by the client) as, 'Don't be like that with your body', 'Do as you're told', and, 'When you notice yourself repressing an

impulse, don't'. Doing therapy that way creates a relational atmosphere, a bit like a doctor's consulting room, with the therapist coming across like an expert or teacher: in short, one more authority who 'knows better' and who knows where the client 'should' end up (potentially exacerbating the authority and parental transferences which the client is projecting into the therapist, anyway). To integrate the work with the body relationally, whether or not the client experiences it as objectified or not, requires a different approach: perhaps even a new paradigm. Here we can take some inspiration (rather than direct instruction) from neuroscience's recent appreciation of how the infant's embodied sense of self develops originally, in an intersubjective dance with the mother," Soth says.

When an Objectifying Authority is not Good-Enough

Speaking from over 30 years of experience in this field, Soth offers his thoughts on relational Body Psychotherapy in general, as he personally transitioned through various stages of the Chiron Centre's evolution, including multiple name changes starting with Chiron Holistic Psychotherapy to Body Psychotherapy, to integrative, integrative-relational, and finally Integral-Relational Body Psychotherapy. These reflect the way his understanding of Body Psychotherapy has changed over the last 25 years, which can be summarised as two key differences, Soth says, one integrative, and the other relational.

In the past, he was invested in considering the special expertise of our Body Psychotherapy tradition as superior and opposed to other therapeutic paradigms, theories and approaches, especially the 'talking therapies' and the psychoanalytic tradition. Today, he recognises the partiality of our tradition, with its historically evolved strengths and weaknesses, and shadow aspects which tended to exclude and dismiss the wisdoms of other and contradictory approaches. Seeing the field of psychotherapy as a fragmented whole, with its inherited splits, divisions, and rivalries, he appreciates the diversity and richness and sees each tradition as contributing special and necessary gifts and sensibilities to particular aspects of the human *psyche*. He now takes a more integrative stance, within which there is a wider embrace of other therapeutic approaches, without privileging a particular tradition but bringing an embodied awareness to all of them. Thus there is now room for all knowledge, all theories, and all methodologies, within an underlying integral body-mind perspective.

The other key difference concerns the relational dimension of therapy. Soth arrived at a notion he calls, 'The Relational Turn' (formulated in the mid-1990s), based on the recognition of a conundrum that he now sees as necessarily inherent in the very idea of therapy: the inescapable paradox of enactment. The paradox, in Soth's words, is that transformative healing of the 'wound' via therapy is inseparable from the enactment of the wounding in and through therapy. This, he says, has far-reaching implications for every sort of therapeutic/clinical intervention, regardless of one's approach or methodological affiliation.

In the past, our relational stance was more fixed, based upon restrictive, implicit assumptions, not to say dogma, that attempted to legislate for supposedly 'correct' relational configurations, such as dialogic, humanistic equality that disavowed (as described above) the hidden 'medical model' or 'educational' elements of our practice. Our special focus on the body-mind came at the expense of relational awareness; in the pursuit of our embodiment agenda, we were relationally oblivious, so we did not follow through some of our theories into the experiential relational reality of therapy. From Soth's 'Relational Turn' perspective, the therapeutic relationship becomes much less etiologically and medically perceived and all the more complex and complicated. According to Soth, nothing we've been taught is untrue; it can all be included and valued. And, in fact, therapists will *have to* rely on every tool they have at their avail when confronted with these paradoxes.

Following Character Theory Through into the Therapeutic Relationship

The key to most schools of Body Psychotherapy is character formation, a model of developmental injury that leads to what Soth likes to call 'the wound' (of which there are of course many, on many interwoven levels, in terms of timing and in terms of the body-mind). Where some aspects of neuroscience simply see attachment and its disturbances (leading to a simple relational typology), Body Psychotherapy sees character structures and styles (leading to a complex body-mind, multi-dimensional typology, though traditionally not consequently followed through into the relational realm). The more we take the assumptions and implications of character formation seriously, and follow them through into the therapeutic relationship, the more we need to consider how the client experiences the therapy, and the therapist, *through* their character, *through* their wounding.

To What Extent Can the Client Experience Therapy From Outside Their Character?

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

The Essential Conundrum of Therapy

According to Soth, it is impossible to pursue a therapeutic agenda of breaking through the armour, or under-cutting the ego, or wrangling around the resistance, without the therapist being experienced by the client, in the transference, as enacting the very person against whom the armour, the resistance, the defence was first developed. In psychoanalytic terms, the therapist will inevitably be experienced as the 'bad object' (or as the 'wounding object'). The client's unconscious sees the bad object, enacted by the therapist, in the transference (and all the more so, if the therapist takes a fixed, one-sided relational position or ideologically-based attitude). What appears to be happening between the client and therapist, how each person experiences the embodied bad object, and how it enters the room, may have substantial impact on the relational interactions that follow.

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

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

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Editor's Note
There is another article by Michael Soth, later in this volume.

ABOUT RELATIONAL BODY PSYCHOTHERAPY

This volume contains a number of previously published articles all 'About Relational Body Psychotherapy'. This is a generic aspect of Body Psychotherapy focussing on the relationship between client & therapist and what is happening in each of their bodies, and how this affects the other.

After an introduction from the Editor, this volume contains substantive articles by: Nancy Eichhorn, Robert Hilton, Nick Totton & Allison Priestman, Michael Soth, Angela King, Julianne Appel-Opper and a themed series of 4 articles by Asaf Rolef Ben Shahar. There are then further articles on different aspects of Relational Body Psychotherapy from Julianne Appel-Opper, Angela King, and a case-history with a highly dissociative client by Asaf Rolef Ben Shahar & Kate Wood. The Nick Totton & Allison Priestman article is new (written especially for this volume), and the other articles have all been revised, edited and updated.

Courtenay Young – the Editor and Director of Body Psychotherapy Publications – is a Body Psychotherapist who has been working in different ways, with different client groups, and in many different settings for over 30 years. He currently lives and works near Edinburgh, Scotland.

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