

How the wound enters the consulting room ...

by Michael Soth

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This article charts the influence of the 'medical model' in the field of counselling and psychotherapy, from its origins in the late 19th century to now - the first years of the 21st century. Having initially been taken for granted by Freud as a fundamental paradigm for the work of psychoanalysis at the conception of our profession, over the 100 years since then the 'medical model' has been criticised and questioned from many therapeutic perspectives and for many reasons: is the 'medical model' valid for psychotherapy; if so, how and to what extent? Or - as some people claim - is it fundamentally inimical to it, incompatible with the therapeutic process and its principles? What role do we need to accord it within the psychotherapeutic frame?

The article starts from the premise that the 'medical model' implies a dualistic split between practitioner and patient which ring-fences the 'wound' in the patient. That split has been critiqued and comprehensively de-constructed by a series of insights into how the patient's wound refuses to be segregated and does indeed 'enter': the consulting room, the therapist and even the supervisor. Whilst therapy cannot be subsumed under the 'medical model', neither can it fully be excluded from the therapeutic endeavour, as I spell out in some other writings. Here, though, I focus on its limitations as an exclusive or dominant framework and mindset for therapists.

The clash between 'medical' and 'psychological' relating

The title of our BACP conference in October 2006 boldly stated what some perceive as an emerging consensus: "it's the relationship that matters." That being accepted, we are confronted - as Ernesto Spinelli elaborated - with the question of what do we really mean by 'relating'. How do we define 'relating'? What therapeutic activities does 'relating' include, and which ones doesn't it? Is it in and of itself good and therapeutic, or does it have complications, complexities, shadow sides? It seems clear that 'relating' is one of the crucial features which distinguishes us from what in the NHS is still considered the 'treatment of choice': CBT. However, relational ideas are becoming not just accepted, but fashionable, and they are already being applied to CBT. As counsellors we may understand that making CBT treatment relational is a bit like fitting a round peg into a square hole, but the move to prop up the weaknesses of the paradigm underlying CBT - by grafting on interpersonal, body-oriented and mindfulness techniques - is well under way. Without understanding the fundamental paradigm clashes and inherent contradictions between the 'medical model' and relational work, such attempts will have to remain superficial. But there is a danger that the meaning of the term 'relational' will be watered down to just another soundbite, and it is in our interest to clarify how the relationship is and always has been the essence of our work as counsellors and therapists.

So what are the implications of the statement that "it's the relationship that matters" ?

I think if we look at ourselves honestly, we'd have to admit that - in the late 20th century - counselling as a whole is pervaded by a fairly fundamental confusion as to what our professional relating actually involves.

Most person-centred counsellors tend to equate 'relating' with a warm, empathic, essentially loving presence, providing the kind of human interaction which actively fosters contact and growth. It is the client's lacking this kind of presence and contact, now or in their past, which is understood to be underlying and fuelling their problem, and which the counsellor therefore seeks to provide¹.

Psychodynamic practitioners, on the other hand, are all too aware of the dangers of collusion which inhere in such a one-sided definition and would guard against inviting the kind of relating which to the client may be indistinguishable from an offer of friendship. Because of those and many other reasons we set up professional boundaries and frameworks including standards and ethical accountability - all of which makes it perfectly clear to outsiders that the counselling relationship is *not* equivalent with friendship and that we can responsibly operate within the inequalities of an essentially asymmetric professional relationship.

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But does that professionalism necessarily have to resemble a doctor? Does it require us then² to maintain a benign but essentially neutral, clinical and authoritative quasi-medical stance, from which we bring to bear our knowledge and expertise? Most clients would assume that this expertise is what they are paying us for, and many would actually feel disturbed and threatened by some of our notions of *mutual* relating as essential to the work.

Without expanding further on the details and permutations of the underlying confusion and ambivalence, we could say that most counsellors tend to steer a wavering and oscillating course between the Scylla of 'cold', clinical objectification and the Charybdis of 'warm', friendly collusion. Most will - in a semi-conscious compromise - do sufficient justice to both polarities in their journey with the client, to satisfy the competing claims of what - I believe - are, at root, two valid ingredients in our professional relating: therapy as treatment versus therapy as relationship.

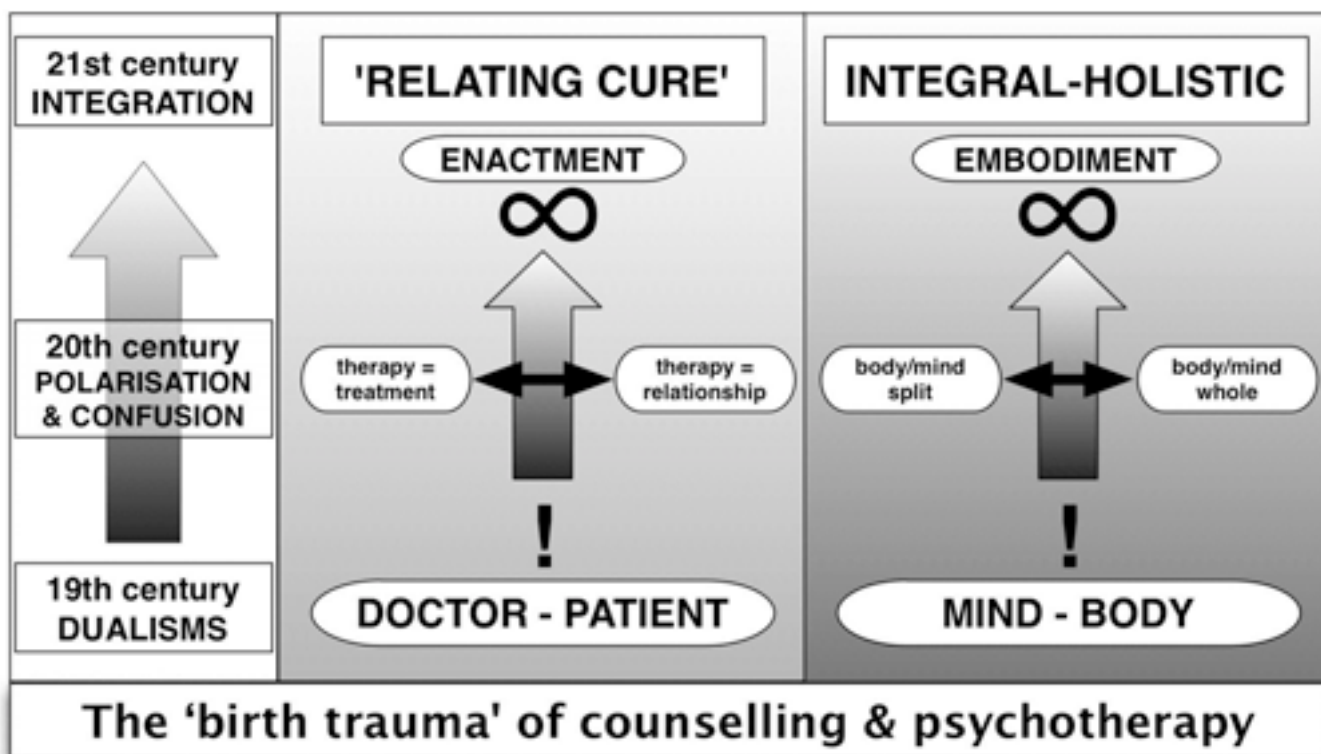
If both are indeed valid, we must not over-simplify what we mean by 'relating'. This is a theme that obviously has special relevance for those working within the NHS or other medical contexts, and I presented a workshop at the Faculty of Healthcare conference last May "Embracing the paradigm clash between the 'medical model' and counselling". The title of the workshop conveys what to me is a crucial idea: there *is* a clash, an apparently irreconcilable conflict, but that conflict can be embraced. We can arrive at a position where both 'therapy as treatment' and 'therapy as relationship' are considered valid, necessary forms

of relating, albeit profoundly antagonistic and intensely contradictory modes.

In this third position, as will become clearer as we proceed, we do not fudge the conflicting polarities, neither do we just oscillate from one to the other - we accept and engage the conflict fully, but hold the tension between the polarities as a *paradox that is essential to the work*. By the counsellor inhabiting that paradoxical position, the contradiction between 'therapy as treatment' and 'therapy as relationship' can actually help to shape and deepen our work.

Inhabiting the paradox goes beyond just recognising the tension and unresolved ambivalence between these two modes of relating and merely acknowledging it. There is a split between the two which has been with us since Freud and is - in my opinion - one of the most un-integrated issues in therapy today.

In my lecture at our conference "No 'Relating Cure' without embodiment", I suggested that this is one of the two dualistic splits - both originating from within the *zeitgeist* of the late 19th century - which continue to limit our theory and practice. One is the dualism underlying our conception of the relationship between 'doctor' and 'patient' and the other is the dualism between mind and body. In my view, these two dualisms presided as godparents over the birth of our profession (as well as that of our sister disciplines neuroscience and genetics) and over the last 100 years have persistently confused and restricted our work. That's what I call the 'birth trauma of counselling and psychotherapy'.



That birth trauma of our profession has been addressed and grappled with by a variety of approaches and practitioners, in a variety of ways which we can learn from. For ways of approaching and transcending the body-mind dualism we can draw on Body Psychotherapy as well as modern neuroscience. For dealing with the doctor-patient dualism we can, for example, look to the humanistic critique of the 'medical model' as well as modern psychoanalysis, especially the relational and intersubjectivity branches.

This is the theme that I want focus on here, by presenting a simple – simplistic – outline for how, over the last century - the doctor-patient dualism can be seen to be breaking down by paying attention to how the wound enters the consulting room.

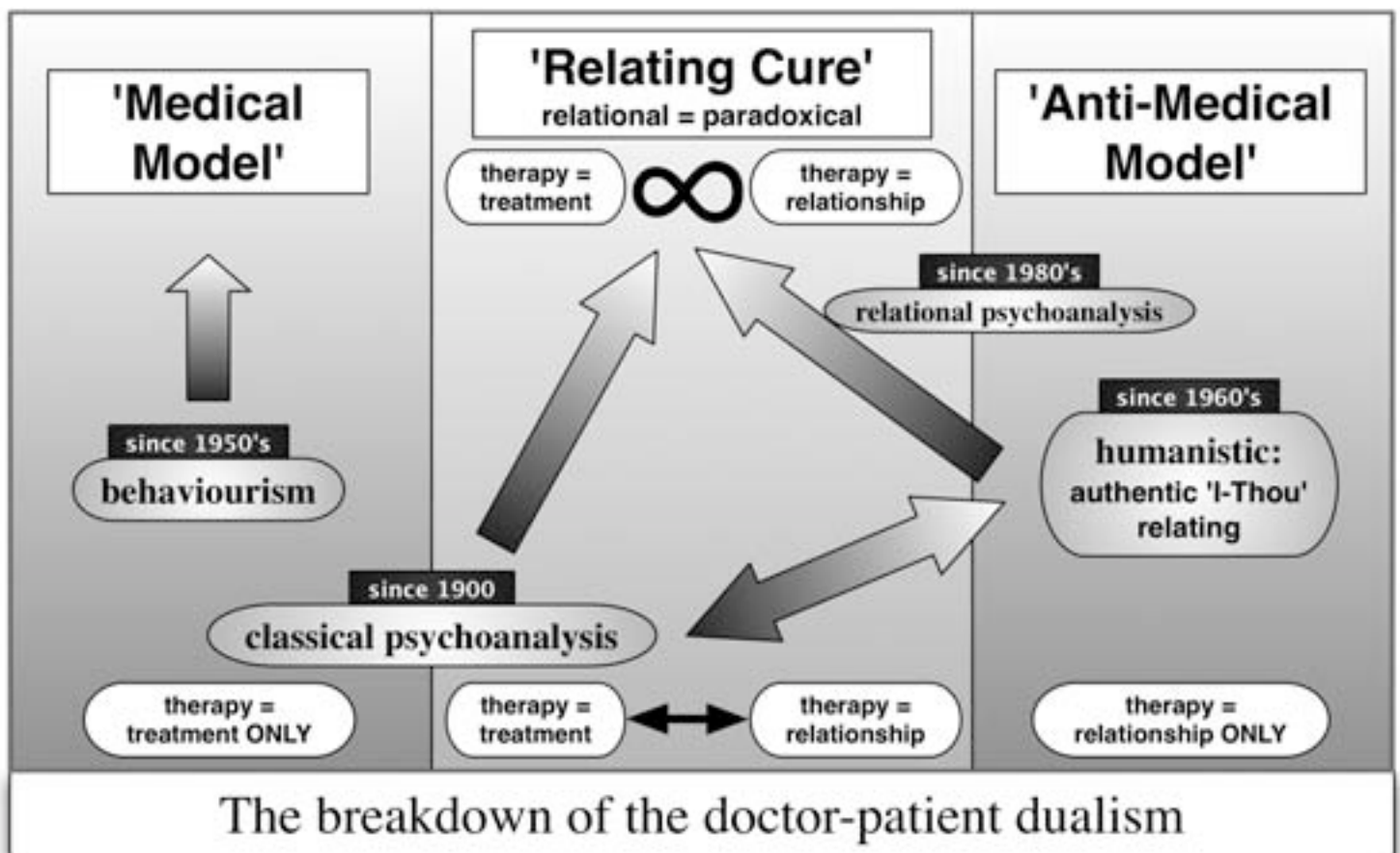
The breakdown of the doctor-patient dualism

The overall movement in transcending a dualism one is initially caught in, leads from taking it for granted, to recognising and naming it, to protesting against it, often by swinging into the other extreme, until some dialogue evolves which validates both polarities, leading eventually to the willingness to embrace the reality of conflict as creative and eventually to the capacity to hold the tension between the polarities in a paradoxical embrace.

It is then that we inhabit a position where what was originally perceived as mutually exclusive antagonistic opposites is now *also* recognised as mutually constitutive: there *is* a battle between the polarities, but they *also* create one another and depend on each other.

In terms of the particular dualism I am focussing on – 'therapy as treatment' versus 'therapy as relationship' – we can recognise that initially psychoanalysis was embedded in the 'medical model' as it was taking the 'therapy as treatment' polarity for granted.

But psychoanalytic work could never sit comfortably within the paradigm underlying the 'medical model', with countercultural influences challenging and questioning the dominance of that paradigm from the very beginning and all along. But fundamentally it is, of course, the work itself which undermines the clear, dualistic division between doctor and patient: the engagement with the patient's inner world inevitably activates the therapist's own unconscious, as Jung recognised early on, and loosens the therapist's holding onto, and hiding behind, a fixed therapeutic position (*whatever* theory that position may be based upon).



The swing from the 'medical' to the 'anti-medical model'

During the mid-20th century, the multiple challenges to the 'medical model' eventually led to the humanistic revolution and the profoundly necessary swing into the other extreme: a position I call the 'anti-medical model'.

On a philosophical level this now fully established polarity between the 'medical model' and the 'anti-medical model' arouses fierce debate and heated polarisation, and has been doing so for the last decades.

There is no space here to elaborate on the meta-psychological discussion from a perspective which actually embraces both polarities, but we can prepare such a potential integration by focussing on one particular aspect of the issue: in an earlier article ("Body Psychotherapy Today", *Therapy Today*, November 2005, Vol 16 No 9) I suggested that the history of our profession could be written in terms of our relationship to the client's 'wound'³, and how that wound enters the consulting room.



Starting from our origins in Freud's – albeit ambivalent – obeisance to the 'medical model', we can trace the steps by which the profession increasingly recognises how the lived actuality of the wound, the here & now flesh-and-blood experience of the wounding process cannot and does not remain outside the consulting room⁴.

The dualism breaks down, the wound refuses to stay confined to the patient's life and the patient's mind, and enters - not only the client's reality of therapy, but also the therapist's and the therapeutic relationship as a whole. I believe it is this recognition which is at the heart of our assertion that – as in the title of our conference – "it is the relationship that matters."

So here I present my whistle-stop tour of how the wound enters the room and de-constructs an exclusive 'medical model' perspective in six and a half easy steps:

The client's wound comes into the room and enters the ...

1	... client's 'here & now' experience as non-verbal process
2	... client's <i>perception</i> of the therapist (= transference)
3	... client's <i>experience</i> of the therapist (= embodied transference)
4	... therapist's awareness (= countertransference)
5	... therapist's experience (= embodied countertransference)
6	... supervisor's experience (= 'parallel process')

The wound comes into the room (1)

... and enters the client's 'here & now' experience as non-verbal process

As modern neuroscience is elucidating⁵, the client's intense experience of painful patterns *outside the room* and *at other times* is gauged by the therapist on the basis of subtle perceptions of the client's nonverbal signals *in the 'here and now' of the consulting room*. These perceptions get automatically and usually correctly extrapolated to the otherwise unknown rest of the client's experience. The therapist's empathy with the client's experience depends on this implicit extrapolation which happens subliminally in the therapist's mind. In this way *all* therapists depend on the wound coming into the room and being communicated subliminally, non-verbally. This is true even for therapists whose model does not include these processes, i.e. the way even a cognitive-behavioural therapist perceives and engages with the client's 'negative schema' and 'faulty thinking' is through unconsciously monitoring the non-verbal signals *originating from the schema* as and whilst it is being talked about, addressed or worked with.

This is true not only in regard to the therapist's perceptions and empathy, but equally valid in terms of the timing, emphasis and delivery of the therapist's interventions. No therapist can function without continuous subliminal perception of the client's feeling state, and specifically the coming and going of the client's pain: how the wound gets activated and moves – however unconsciously – into the foreground of the therapeutic space, or how it recedes or is denied, constitutes the basic compass for the therapist's attunement and intuition – those myriad of nonverbal cues which we approximate and subsume under the label 'intuition'.

The wound is always already in the room and even the most unrelational practitioner depends – not in their theory and strategy, not in their explicit thinking – but implicitly in their perception and diagnosis, in the timing, pacing and modulation of their therapeutic responses on nonverbal cues which originate in the here & now aspects of the wound.

The wound comes into the room (2)

... and enters the patient's 'here & now' perception of the therapist (= 'transference')

That the symptomatology of the wound enters the consulting room was recognised by Freud from the beginning, and was the basis for his initial focus on catharsis. Perceiving and understanding the unconscious connections in symptoms and dreams, as well as eliciting an abreaction of the traumatic roots of the wound was all perfectly feasible from

within a standard doctor position, admittedly focussed now on psychology rather than the body, but following conventional medical procedure nonetheless. One of Freud's moments of genius arrived, however, when he recognised that the patient was not willingly cooperating with the treatment, but mis-perceived the doctor's intentions and interventions *through* the patterns, idealisations and denials surrounding their wound. At first, Freud thought about these mis-perceptions and projections, the 'transference neurosis', as resistance to the treatment. But in a bold move, he recognised that – rather than an avoidance of the wound and an obstacle to the presumed ideal of helpful 'medical' relationship – the client's transference mis-perceptions originated *from* the wound and therefore constituted the 'royal road' *into* the wound. This recognition has been the foundation of psychodynamic thinking and a pillar of analytic work ever since.

In everyday practice the manifestations of transference are most simply noticeable through the contrast between the 'verbal' and 'non-verbal' working alliance⁶. To the observant practitioner, there are frequent signs that the patient's willingness to engage with the counsellor is incessantly and unwittingly undermined by denials, distractions, avoidances and other reactions which sabotage the counsellor's helpful intent and sidestep their facilitative perceptions and interventions.

I realise, of course, that the concept of transference is not undisputed, and that it lends itself – like any other concept, maybe even more so – to being used defensively. As by definition it is largely unconscious, any objection by the client to the practitioner's interpretation of it can be seen as resistance and therefore used as further confirmation – a potentially water-tight tautological system in which the analyst always knows better and is always right. But even within approaches based on the centrality of the transference to the therapeutic relationship, there is wide divergence as to the degree and extent of its pervasiveness and certainly as to how to work with it. Different approaches imply different intensities and degrees of surrender to the transference experience on the part of the therapist.

In reaction against its defensive uses and the hierarchical, authoritarian implications it came packaged with, 'transference' as a theoretical concept was initially rejected by humanistic approaches, many of which, however, have been re-integrating it into their framework over the last 20 years in varying degrees. Having formulated congruent and authentic 'I-Thou' relating as a valid and essential ingredient in therapy, humanistic practitioners have recognised that their own ideas and concepts can *also* be used defensively, and that *no* therapeutic model or tool in and of itself is immune against becoming counter-therapeutic or

inauthentic. Whether or not the client actually receives and responds to the counsellor's offerings of authentic relating, or continues to mis-perceive the counsellor through the idealisations and negative projections inherent in their woundedness, becomes a question which counsellors of all orientations can attend to. Transference versus authenticity then becomes a phenomenological investigation of the specific contact here & now between client and counsellor, rather than an ideological issue.

The wound comes into the room (3)

... and enters the client's 'here & now' experience of the therapist (= 'embodied transference')

From within a dualistic conception of the patient's body/mind, both the symptoms of the wound as well as its transference implications were traditionally understood as processes in the mind, as mental representations. It was the achievement of Wilhelm Reich, one of Freud's students and colleagues, to recognise and formulate both the patient's wound *and* the transference as bodymind processes. The far-reaching implications of Reich's theories have not yet been absorbed by the field of counselling and therapy, but they did inspire and originate the tradition of Body Psychotherapy (which later had a major influence on the humanistic movement).

Suffice to say in this context that Reich developed a holistic theory of the wound, integrating biology and psychology. 70 years before neuroscience began to confirm some of these ideas, he described how emotional and psychological trauma affects *all* levels and systems of the bodymind's functioning, from basic physiology and anatomy through vegetative and autonomic nervous system reactions to the voluntary and involuntary muscles and breathing, including the expression and inhibition of emotion as well as memories, images, perceptions and thoughts. In simple terms: the wound affects and pervades the whole complex system of body-emotion-fantasies-mind – the *whole* person. This challenges the dualistic notion that if there is a subjective mental experience of pain, the problem must originate and be treated in the mind; that psychological suffering is restricted to the mind and can be cured by insight or the correction of 'faulty thinking'.

What matters for the purposes of our theme here, is that the only reason and the only way a past wound can re-appear and be re-experienced in the client's current life (as well as manifest in the here & now interaction between client and therapist), is because it has been internalised and stored. Reich showed that the bulk of this was not a mental process, but relied on 'body memory': our accumulated life experience, our whole life history – including our unresolved traumas and wounds – is frozen into our organismic system across all

bodymind levels as a habitual pattern he called 'character armour'⁷. When a wound is frozen in time and structured into the bodymind, what this means in simple terms is that on some level of somatic reality the trauma is constantly experienced as if it were still happening NOW. In some tangible, felt sense, there is never any respite from the trauma, and no chance to relax or recover from it, because it's never over. It's still going on because it never stopped.

That also means, it does not just stop by virtue of the client entering a consulting room. We therefore need to extend this recognition also to the client's experience of therapy, and can say that the wound gets experientially constellated in the therapeutic relationship. This, of course, profoundly affects the non-verbal alliance I referred to earlier: in simple terms, the safer the client feels with the counsellor, the more likely it is that the client can afford to feel the previously unacknowledged or repressed reality of the wound. It is one of the paradoxes of the therapeutic endeavour that precisely *because* the relationship is experienced as safe, that the deeper levels of the wound and with it the transference can emerge. The safer the therapeutic space, the more likely that the pain will – finally – surface. But the more the pain of the wound *does* surface and colour the client's bodymind experience in and of therapy, the more the client tends to experience the therapeutic space *through* the wound. For those of us sensitive to the multitude of spontaneous processes on a somatic level, it becomes visible and tangible that the client's body begins to react as if it were trapped in the wounding relationship NOW. The client then experiences therapist and therapeutic space not only *through* their wound, but as *wounding*. Implied in this formulation is the notion that we can distinguish two aspects of the 'embodied transference':

3a) the wound enters the client's construction of the therapeutic space; we might call this the 'transference to therapy' (in general), a habitual pattern irrespective of the particular counsellor, well in place before the counsellor has even entered the room.

3b) the wound enters the client's experience of the specific counsellor; this is the 'transference to the particular therapist', and there are major disputes regarding the question how blind and automatic this transference is, or to what extent the counsellor's subjective reality contributes to it and co-creates it.

The wound comes into the room (4)

... and enters the therapist's 'here & now' awareness (= 'countertransference')

Inasmuch as Freud recognised the transference of past experience into the present as a feature of the human mind, this inevitably applied to both patient *and* analyst. But in line with the taken-for-

granted requirement of the doctor's neutrality, objectivity and rationality, countertransference was assumed to be an *obstacle* to the analyst's capacity to conduct proper medical treatment. The assumption that the analyst could and should be 'completely analysed' to the point where no further irrational manifestations of their own wound could cloud their professional judgement was only deconstructed - after Freud's death - in the 1950's. Through Melanie Klein's investigation of early development and the more 'primitive' reaches of the human mind, the ground was prepared for noticing how the sensations and feelings of the wound do not stay confined to the patient. The more we recognise experiences of merging and fusion between infant and mother, and how these experiences get structured into our bodymind and carried forward throughout life, the less we can hold onto a clear, dualistic distinction in any human relationship, including the one between patient and doctor. The discovery of 'mirror neurons' and their functioning⁸ has lent profound neuroscientific support to what self-reflective therapists have been noticing for decades: the sensitive attunement to an other opens our subjectivity to theirs in such a way that our 'minds' intermingle. This intermingling starts with an unavoidable and essential basic ingredient of our therapeutic stance, i.e. empathy. It is our empathy which opens the door, but through that door can enter what psychoanalysis calls 'projective identification' and Process-oriented Psychology⁹ calls 'dreaming-up': we can experience aspects of the client's experience¹⁰ because - in simple terms - their sensations, feelings, images and thoughts can appear in the therapist's stream-of-consciousness, to the point that the therapist may take them to be 'their own'. In the countertransference the client's and the counsellor's experience may become indistinguishable, and the counsellor may end up identifying with what has been projected. When we take on board this essentially 'identity-undermining' process, we are entitled to feel confused and threatened, and many practitioners go through a professional crisis when they begin to attend to and work with the extent to which projective identification pervades the therapeutic relationship. However, we soon recognise that this threat to our identity is also a blessing: it is through this channel that we 'under-stand' an other more fully, and specifically those aspects of their reality which are kept unconscious as they hold too painful or unbearable a charge. That is why they get projected, and why such projective mechanisms can be considered as extending the realm of our empathic reach.

Apparently we are justified in trusting the interconnectedness between humans, and with this the accuracy of empathic processes, a whole lot more than our 19th century conception of ontologically separate individuals would suggest.

On this - in many ways counter-cultural - point both psychoanalytic and humanistic philosophies agree, although they use very different language to describe the experience.

If we can use the term 'countertransference' in the widest sense as encompassing the therapist's whole internal process, then - in a move similar to Freud's re-visioning of the transference - we can say that the wound enters the therapist's experience and that the 'countertransference' therefore contains information about the client's inner world. Thus the countertransference is reframed from an obstacle to the therapeutic process (i.e. from a pathological interference with the therapist's 'medical' neutrality) into one more 'royal road' into it.

What has been called the 'countertransference revolution'¹¹ started off with seminal papers by Heimann and Racker in the 1950's, and developed from there into modern object relations and relational psychoanalysis. In these traditions the 'communicative' and 'intersubjective' aspects of countertransference are now a well-established principle in the work.

Traditionally attention to the therapist's internal process was focussed on mental processes and reflections, giving countertransference a too mental bias. This had somewhat been challenged by the idea of 'somatic countertransference', but it is not until recently (late 1990's) that a more comprehensively holistic and relational formulation of countertransference has become possible¹². The overlaps and differences between the notions of congruence and countertransference were the subject of debate in this magazine [the then BAC magazine *Counselling*] some years ago. As I have proposed previously, an integration of these two concepts becomes possible through grounding both in phenomenological attention to the therapist's internal moment-to-moment process, as soon as we get beyond conceiving that process through the lens of body-mind dualism.

The wound comes into the room (5)

... and enters the therapist's 'here & now' bodymind experience¹³ = 'embodied countertransference' = enactment / re-enactment

It is one thing to notice that the wound occasionally enters the client's perception of the counsellor, or that aspects of it 'jump' at times into the counsellor's experience and appear in the countertransference. When using roleplay in experiential training, with practitioners from a wide variety of orientations, I have never had any difficulty establishing a shared perception that between client and counsellor processes do occur which the terms transference and countertransference point to. I recognise that these terms carry historical baggage, and that many people react against them, for many valid reasons.

What matters at the end of the day is that we recognise these processes, work with them and can jointly reflect on them. Terminology is one issue, but what really splits the field is the question how frequent or pervasive these processes are and therefore what significance to attribute to them. This is where close attention to the therapist's bodymind process in all its intricate detail in the here & now of the therapeutic interaction becomes paramount, as the only way we can experientially address these questions without getting lost in therapeutic ideologies and theorising.

The more we embrace a two-person psychology (rather than an exclusively objectifying one-person perspective), the more we recognise that the dynamics of the therapeutic relationship are co-created, and not simply transferred and projected by the client onto the supposedly 'blank screen' of the counsellor.

We can understand the notion of the 'blank screen' as a historical remnant of the 'medical model', designed to protectively shore up the analyst's separateness, precisely because it was under threat from the intensity of transference forces which inevitably draw the practitioner into the experience of non-separateness from the wound, the client's and their own. It is not possible to empathically attend to the wound of another without both identifying with their experience and simultaneously being receptive to projective identifications: the wound of the other would tend to touch and re-stimulate ours in any case, but the more we recognise the pervasiveness and prevalence of ubiquitous projective identification processes, the more this takes us into another dimension. The client's and the counsellor's wound will inevitably entwine and intermingle, making new demands on us to embrace the 'wounded healer'. A clinically useful summary, also relevant for supervision, can be stated as the principle that – sooner or later - the client's conflict becomes the therapist's conflict.

Rather than the counsellor passively 'receiving' the transference, a modern relational perspective sees both client and counsellor contributing to impasses and deadlocks which they are both stuck in. In some profound way, the process *needs* the counsellor to participate in the wound *and* the wounding. Inevitably, the client is full of ambivalence in relation to their wound, whether to deny it or surrender to it, whether to embrace it or continue to fight against it, and the counsellor *needs* to be drawn into these conflicts. The therapist's participation – often unwittingly so – in the repetition of the wounding can be captured in the term 'enactment', or – because it repeats a painful pattern, often established in early development – 're-enactment'. This is a notion I have been developing as central to my work since the mid-1990's¹⁴, attempting to bring a bodymind understanding to how enactments occur

spontaneously not only as inevitable, but as *necessary* aspects of the relationship between client and therapist. This is typically the point where a relational perspective takes us beyond what even the most sympathetic supporter of counselling is prepared to put up with: how can a re-enactment of the client's wounds *in* and *through* the therapy and the therapist be anything but counter-therapeutic?

Even practitioners who do not know or use the notion, instinctively understand that re-enactment is the *opposite* of therapy: it is what the client is trying to *get away from* by coming to therapy. The practitioner, often unconsciously and automatically, resorts to a whole host of manoeuvres to avert what is correctly intuited as a dreaded sense of failure and loss of therapeutic position. So how can re-enactment possibly be a 'royal road' into the heart of therapy?

In my view, this is the central paradox of our profession: the re-enactment of the wound and its transformation are two sides of the same coin. It is in the pit of re-enactment that deep and lasting transformation occurs – spontaneously. In surrendering to the re-enactment (what I call 'entering' it), the therapist has a sense of losing their position, and the last vestiges of 'medical model' duality – of the therapist remaining outside the wound, supposedly operating *on* it - are temporarily deconstructed. In the language of complexity theory, at this 'chaotic' edge, far from equilibrium, a new configuration of the system can emerge¹⁵.

Both possibilities – the acceptance of established structures and their destruction through emergent processes, both stability *and* transformation – are important aspects of what makes therapy therapeutic. Stability requires reliability and constancy in our therapeutic position.

Transformation requires flexibility and surrender to the wound. Our therapeutic position is only as solid as our capacity to survive losing it.

The crucial question is, of course: how can we ensure that re-enactment of the wounding between client and counsellor becomes transformative and therapeutic, rather than one more damaging 'nail in the coffin'?

Here, in my view, an integral-holistic perspective becomes essential. The re-enactment challenges us to give up *our* rigid and fixed therapeutic position in the face of the client's trappedness in *their* fixed character position. 'Entering' the re-enactment can become safe and ethical only when we are grounded and rooted in an awareness of the enactment as a bodymind process.

Relational psychoanalysis and intersubjectivity recognise enactment as a central issue of any two-person psychology, but do not describe it or work with it in holistic bodymind terms. But in the same way Reich provided a holistic formulation of transference (which had previously been

considered as a mind process of fantasy and mental representation only), we can now attempt to formulate countertransference also in bodymind terms. In taking this step, we are transcending both of the inherited 19th century dualisms (the patient-doctor and body-mind split) and reaching for a therapeutic position which holds both polarities in a paradoxical embrace – I have called this an integral-relational perspective.

The wound gets carried beyond the room (6)

... and enters the supervisor's 'here & now' experience = parallel process

This integral-relational perspective is not altogether comfortable. It involves the therapist fully in a participative, holographic universe, where there is no Archimedean fix-point, no firm, stable and unchanging anchor or guideline that a counsellor can hold onto in the face of the wound. There is no aspect of the therapeutic position, no theory, philosophy or technique that can be guaranteed to remain uncontaminated by the wound. We can never be entirely sure whether what we intend as helpful and therapeutic, is actually a repetition of the wounding and counter-therapeutic. Quite contrary to 19th century assumptions which confine all of the wound neatly in the patient and maintain the illusion of a dualistic split between patient and doctor, the wound refuses to be segregated and contained and potentially pervades the field of the 'helping relationship'. We have travelled a long way beyond dualism, to the notion of the 'wounded healer' and beyond, to the recognition that *the wounding relationship gets replicated and repeated in all later relationships*, but especially those that set out to address the wound or offer the promise of healing. This replication of the relational dynamic from one system to the next has been recognised in our field and has been called 'parallel process'¹⁶. The wound, having entered the consulting room and suffused it in all aspects, does not even stay confined there, but can 'jump' from the therapy relationship into the supervisory relationship. The wound – if uncontained - does not know boundaries, but will get carried beyond the confines of any system that does not successfully address it¹⁷. Parallel process is like a row of dominoes, with uncontained pain leaking from one system into the next until it finds a home of acceptance and involvement – somewhere! That home, in my view, needs to be capable of embracing the re-enactment of the wound even whilst attempting to heal it¹⁸, and ideally it needs to do so in an integral (holistic-systemic bodymind) fashion.

References

- Clarkson, P. (1995) *The Therapeutic Relationship*. London: Whurr.
- Corrigall, J & Wilkinson, H. (2003) *Revolutionary Connections: Psychotherapy and Neuroscience*. Karnac Books
- Damasio, A.R. (1994) *Descartes' Error*. New York: Putnam
- Gallese, V. (2003) *The Roots of Empathy: The Shared Manifold Hypothesis and the Neural Basis of Intersubjectivity*. internet
- Gerhardt, S. (2004) *Why Love Matters: How Affection Shapes a Baby's Brain*. Brunner-Routledge
- Gomez, L. (1997) *Introduction to Object Relations*. London: Free Association
- Goodbread, J. (1997) *The Dreambody Toolkit*. Lao Tse Press
- Greenberg, J. & Mitchell, S. (1983) *Object Relations in Psychoanalytic Theory*. Cambridge, Mass.: Harvard University Press.
- Hawkins, P. and Shohet, R. (2000) *Supervision in the Helping Professions*. Maidenhead: Open University Press.
- Heiman, P. (1950) *On countertransference*, International Journal of Psychoanalysis, 31: 60-76.
- Jacobs M. (1986) *The Presenting Past*. Milton Keynes: Open University
- Johnson, S. (1994) *Character Styles*. New York: W.W. Norton.
- Masterson, J. (1985) *The Real Self: A Developmental, Self and Object Relations Approach*. New York: Brunner/Mazel
- Maturana, H. & Varela, F. (1980) *Autopoiesis and Cognition*. Dordrecht, Holland: D. Reidel
- Mindell A. (1982) *Dreambody: The Body's Role in Revealing the Self*. Arkana
- Mitchell, S. & Aron, L. (1999) *Relational Psychoanalysis: the emergence of a tradition*. Hillsdale NJ: Analytic Press.
- Reich, W. (1972 [1945]) *Character Analysis*. New York: Touchstone.
- Samuels, A. (1993) *The Political Psyche*. London: Routledge.
- Schore, A. (1994) *Affect Regulation and the Origin of the Self*. Hillsdale NJ: Lawrence Erlbaum.
- Searles, H.F. (1999) *Countertransference and Related Subjects: Selected Papers*. Guildford, CT: International Universities Press
- Soth, M. (1999) *Relating to and with the Objectified Body, Self & Society*, 27(1), p. 32 - 38
- Soth, M. (2000) *The integrated body/mind's view on 'Body/Mind Integration*, *AChP Newsletter* 2000
- Soth, M. (2003) *Psychotherapy: paradoxes, pitfalls & potential*, *Self & Society*, 30(6), Feb/Mar 2003, p. 34 - 44
- Soth, M. (2005a) *Counselling: the 'Relating Cure'*, *Healthcare Counselling & Psychotherapy Journal*, October 2005, Vol 5 No 4
- Soth, M. (2005b) *Embodied Countertransference*. in: Totton, N. (2005) *New Dimensions in Body Psychotherapy*. Maidenhead: OUP
- Soth, M. (2005c) *Body Psychotherapy today - an integral-relational approach*, *Therapy Today*, November 2005, Vol 16 No 9
- Soth, M. (2006) *What therapeutic hope for a subjective mind in an objectified body? - in: Corrigall, J., Payne, H., Wilkinson, H. (2006) About A Body*. London: Routledge
- Totton, N. (2003) *Body Psychotherapy: An Introduction*. Maidenhead: Open University Press.
- Wilber, K. (2000) *Integral Psychology*. Boston: Shambala
- Winnicott, D. (1971) *Playing and Reality*. New York: Basic Books

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- ¹ and our forefather Freud apparently agreed when he stated: "Essentially the cure is effected by love."
² as our forefather Freud *also* thought
³ I use the term 'wound' in its widest sense, as a non-partisan notion independent of particular therapeutic theories, to describe the client's 'problem', without implying any preferred model of how the wound comes about and what causes it; and of course 'the wound' is not singular, but a complex layering of wounds upon wounds, reaching through the developmental crises and transitions of the whole life story. Reich's theory of 'character formation' (with its implicit 'turning against the self') describes how at every developmental stage interpersonally wounding experiences become internalised as bodymind structure
⁴ The very idea that it might be possible to keep the wound 'outside', neatly segregated in the patient (i.e. the patient's pathological mind, diseased body and symptomatic life), with the therapist attempting to maintain a quasi-medical objective neutrality uncontaminated precisely by the patient's wound and pathology, is at the heart of the original 19th century doctor-patient dualism.
⁵ see Schore (1994): attunement = right-brain to right-brain communication; or Gerhardt (2004); or Corrigan & Wilkinson (2003)
⁶ this is an approximate and oversimplified distinction
⁷ see Reich (1972); or Totton (2003); Reich's work links with the idea of the 'organismic self' as used in the person-centred approach
⁸ see Rothschild (2005); or Gallese (2003)
⁹ see Goodbread (1997)
¹⁰ not in a 'pure' way, but filtered through the lens of our own subjectivity, but still astonishingly accurate
¹¹ see Samuels (1993)
¹² see Soth (2005b)
¹³ including the counsellor's ways of thinking & working, i.e. both the personal *and* professional aspects of the counsellor's presence
¹⁴ see Soth (2005b)
¹⁵ 'the system' implies in this context both the interpersonal system of the therapeutic relationship *and* the client's intra-psycho system (as parallel processes, see below)
¹⁶ see Hawkins / Shohet (2000); or Searles (1999)
¹⁷ The notion of 'parallel process', although usually only applied to the parallels between therapy and supervision, can be usefully extended, as I have suggested elsewhere (Soth 2005b). Parallel process can then be seen to be operating *throughout* the whole sequence of steps I have traced in this article, from the originally wounding relationship, to the client's bodymind internalisation of it, through its re-externalisation via transference and countertransference.

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- ¹⁸ By not having mentioned the therapist's wound so far, I do not mean to ignore it. The therapist's wound, of course, also enters the room (see Clarkson 1995) as ...
a) habitual countertransference (the therapist's construction of the therapeutic space and their role within it, irrespective of particular clients) and ...
b) the therapist's transference to a specific client and their particular story / wound
For me, the notion of the 'wounded healer' includes *both* the therapist's wounds and the therapist's susceptibility to the client's wounds (and the inextricable mixing of the two) as inevitable *and* necessary ingredients in the therapeutic process.