

Robert Shaw

towards integrating the body into psychotherapy

Integrating the body into psychotherapy poses a problem from a Western cultural perspective; the dualism of mind and body is an entrenched position. This article emphasises how this dichotomy is unrealistic, that the mind and body are one, therefore what happens within the body is also important for psychotherapy

The body occupies a peculiar space within psychotherapy. There is an assumption that intra-psychic phenomena must be aired by verbalisation, whilst those feelings associated with the body tend to be ignored. Undoubtedly this echoes the cultural mind-body dualism of the Western world; psychotherapists must deal with the mind, whereas perceived physical problems must be handled by body specialists, be they medical doctors or manual therapists. In contrast, I believe that the rich source of material which emanates from the body requires serious attention from a psychotherapeutic perspective. I hope in this article to demonstrate the importance of the somatic component within psychotherapy. In order to achieve this I will use the concept of preverbal communication with its potential links with somatisation, and explore the benefits of providing physical preverbal support by the use of manual therapy. A synthesis of these ideas is important in assisting the preverbal to become verbal, thereby enabling an integration of the body into psychotherapy.

touch in therapy

Psychotherapy faces a practical problem of how to approach the body. The most obvious way to tackle the body is by touch, which leads into the very murky waters of the touch taboo.

Traditional psychoanalytic therapy decried any form of touching (Kertay and Reviere, 1993). The whole area of touch in therapy has since become fraught and, as a consequence, a real ambivalence has developed towards touching clients.

Accounts of abuse in therapy obviously contribute to this bodily confusion (Masson, 1988; Jehu, 1994; De Lozier, 1994) and a strong argument is put forward for the absence of touch within therapy (Alyn, 1988). It is almost as if any form of touch or embrace will inevitably lead on to sexual contact between therapist and client. This sends out a message of danger to therapists and understandably, leaves them feeling uncertain in the area of physical contact. However, touch is a vital part of human communication so, by ignoring this aspect, it may be that psychotherapy is ignoring a part of human experience which is of critical importance. There are therapists who advocate the use of touch (Wilson, 1982; Kupfermann and Smaldino, 1987; Woodmansey, 1988) by the touching of hands or placing a hand on a shoulder. This sort of touch, though,

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seems almost miserly, and such contact belies the need for holding and really feeling. Touch, it has been argued, is potentially very useful as a part of psychodynamic psychotherapy (Goodman and Teicher, 1988) where it can be seen as developmentally important, enabling a movement towards the verbalisation of feelings. It is at the early developmental stages that touch makes such an impact. At these early stages of life, we need to communicate our needs, and in order to do this we use our bodies. The body thus becomes heavily invested in the process of communication.

preverbal communication

Before we learn to verbalise our mode of communication is via our bodies. We first learn to communicate through movement, cries, screams and touching. The whole body becomes important in relating our emotions to the outside world. In this preverbal stage of life we are dominated by our bodies' needs which are conveyed by libidinal yearnings. In this context, libido refers to the pleasurable sensations associated with all bodily functions, not simply to ones sexual in origin, but including functions such as seeing, thinking, micturating, defecating; in short, all major bodily functions are heavily invested with libidinal desires (Frankl, 1990). Preverbal communication, therefore, represents the most fundamental level at which we appreciate ourselves and our environment. The new-born child swarming with libidinous impulses, instincts to be obeyed, immediately communicates these to the outside world. This is done not merely by sound, but by the contraction of muscles. If needs are not fulfilled, the area associated with those needs may become tight in a struggle to have that need met. An example of this is the young child's needs to be fed which, obviously, are very strong. Any disruption here may lead to muscle tightening around the lips, jaw, neck and shoulders. As a concomitant to the squeezing of skeletal muscle, internal smooth muscle may also react to the child's strivings for food. Thus the whole of the intestinal tract from mouth to anus becomes involved. It may be that the whole gastrointestinal tract becomes a site of anxiety which may, in later life, lead onto eating disorders, irritable bowel syndrome or low back pain (McDougall, 1974; 1989). However, slowly but surely, socialisation takes over and verbalisation becomes the main method of communication. Basic bodily instincts are curbed; these may result in a concomitant control of feelings. Preverbal language must thus be repressed, defences learnt, built and maintained. In adult life these old preverbal pathways are still present. However, these are now subtly changed in that no obvious signs appear, but the squeezing of muscle, the contracture of sphincters, may result in the scream of unconscious conflict as it erupts in the soma as pain. Many other somatic problems could therefore be related to this stage of life, including asthma, ulcerative colitis, psoriasis and musculo-skeletal pain (McDougall, 1989; Frankl, 1994). Fischbein (1988) suggests that somatic irruptions represent a repetition of crucial preverbal events, and Rolf and Muller-Braunschweig (1988) link preverbal experience to psychosomatic disturbance. This early stage of development and the way the body reacts would, therefore, seem an important area of psychotherapy to consider. Thus, by concentrating on the verbalisation of feelings, not only do psychotherapists put an intellectual demand on their clients, they may also be trying to ask for the preverbal to be translated into the verbal, potentially a very difficult task.

It is by the judicious use of bodywork that these preverbal messages may first be recognised and only then may it be possible for the cognitive process of verbalisation to occur.

Wilhelm Reich (1983; 1990) was the first therapist to recognise areas of rigidity and armouring in his patients and devised a system to treat them by vegetotherapy, working directly onto his patients' bodies with massage techniques. The theory was that, by acknowledging the existence of these areas of intrapsychic defence, the unconscious conflict would become conscious. It was one of Reich's achievements to bring the body centre-stage when regarding unconscious processes. However, as Frankl (1994) points out from his own practice, vegetotherapy alone cannot dissolve unconscious conflict; repressed psychic processes still require confrontation by means of some form of depth psychotherapy. An incorporation of some form of body work with psychotherapy would, therefore, seem appropriate in order to work with such phenomena.

The initial stages of bodywork may make it possible to allow for the preverbal to become verbal. The support provided by bodywork acknowledges the patient's physical as well as cognitive experience. The body becomes "a means of expression and communication between patient and therapist" (Edmond, 1982). At the preverbal level, touch can be profound, introducing a sense of separation from the outside and recognition of the reality of the body (de Loisy, 1989) and thereby challenging the feelings that reside within the soma. Our sense of self is developed in this early preverbal time. We gain information about the environment and interact with it by all our bodily senses and by physically moving our bodies through our surroundings (Kepner, 1993); thus muscular activity has profound links to our preverbal past. Also of importance to the developing sense of self is the belief that the infant, far from observing the world in an uninterested way, is now considered to "have a very active subjective life" (Stern, 1985, p. 44) which helps the infant eventually to form a sense of identity and separateness. The body provides a boundary with which to do this, and affect the "primary innate biological motivating mechanism" (Kaufmann, 1993, p. 16).

Affect could be considered as the primary form of preverbal communication and acts as a driving force for instinctual behaviour working at the level of physiological function, an essentially body-orientated method of communication.

Any disruption of our environment at this early time may therefore have profound influences on how we feel about our bodies and perceive our sense of self.

manual therapy

Areas of preverbal activity are, I believe, a common occurrence and a form of somatic defence. This may provide a link with the concept of somatisation which is a common presenting complaint in primary care settings in Western culture (Ford, 1986; Fisch, 1987; Coen and Sarno, 1989; Lipowski, 1988; Barsky, 1992; Craig et al., 1993). Indeed, it is one of the enduring myths of the medical model that physical pain must have a demonstrable physical or pathological basis, otherwise the pain is perceived as being purely psychogenic or discounted as all in the mind (Evans, 1993). Although to be fair, contemporary health psychology researchers do accept that almost all pain involves both physiological and psychological factors, however, in practice health care workers still cling to the notion that mind and

body are discrete entities (Sarafino, 1994). Thus, for people in pain without the label of a definitive pathology, a problem arises as to the cause of the symptom. I would suggest that this pain is real and, at a deeply profound level, full of psychological meaning. However, such people are often labelled as somatisers. Pain of this type may, therefore, be a metaphor for psychological distress. As such, the body becomes inscribed with psychological meaning. Within my own practice as osteopath and counsellor, areas of muscular rigidity are ubiquitous (Shaw, 1994). They could be described as repressed infantile traumatised libidinal desires which remain locked into our adult bodies. As such, they need to be respected and treated with care. In effect, osteopathic treatment which involves deep soft tissue massage, rhythmic articulation and manipulation of joints is akin to Reichian vegetotherapy. The whole osteopathic treatment regime is, from a psychotherapeutic perspective, strong stuff. Typically, osteopathic patients are asked to undress and lie on a treatment table, thereby allowing processes of regression to take place. The treatment itself involves holding the body physically, in a supportive manner reminiscent of early childhood, when preverbal communication was of paramount importance. The osteopath, now seen as a parental transference object, soothes away the pain by the expert and gentle application of treatment which, by the rhythmic methods involved, could induce a mild hypnotic state (Yeates, 1988; Randell, 1989). Thus intrapsychic defences are literally held; the initial stages of this preverbal hypnotic induction are highly supportive and offer a form of primary care rare in our society; that is, holding someone's body, feeling their unconscious and therapeutically taking away unpleasant sensations. However, at this stage of the treatment session, a powerful preverbal shock is inflicted on the patient by means of a rapid manipulation, or mobilisation of joints (usually spinal). This frequently results in an outburst of screaming, swearing, crying or manic fits of laughter. It is as if the unconscious conflict has suddenly been released and an act of preverbal recognition has occurred.

Although this often results in a decrease in symptoms, a sort of minor catharsis, the underlying psychic process which produced the symptom remains unaddressed. Thus manual therapy, which includes not only osteopathy but also chiropractic and physiotherapy, can often produce dramatic symptom relief but this is more likely to be palliative than curative. Indeed, from my own observations as both practising osteopath and teacher of osteopathy, the relapse rate of symptoms is high within osteopathic practice. Therefore, a powerful symptom-alleviating therapy it may be, but curative and insightful it is not.

The lack of insight is, perhaps, not so surprising if we consider that people in bodily pain in our culture will seek out a physical manual therapy rather than a therapy of the mind. I am suggesting that mind and body are indivisible. Thus, just as it would be useful for manual therapists to have some psychological insight, mind therapists could also acknowledge the somatic processes which occur in their clients. In fact, Reich advocated that all psychotherapy practitioners should undergo training in physiology and anatomy (Prochaska and Norcross, 1994).

I have observed in my own practice that there comes a point in the manual therapeutic relationship when the patient may wish to talk. The preverbal sensations become conscious and verbalisation of feelings may be possible. It is here that a truly integrative approach may be beneficial, since the conflict may become conscious. Not everyone will wish for this, and it may take many treatment sessions on the soma before the patient feels able to confide and wish for a deepening of the therapeutic relationship. Whilst this process occurs, the therapist becomes a "friend of the body" (Randell, 1992), continually supplying

good sensations of a reliable nature. Gradually the patient is reintroduced to good feelings, to their libido. The body, once seen as a reservoir of pain and misery, can be viewed as pleasure-giving, thereby giving the patient access to good self-feeling.

Thus osteopathic vegetotherapy can reintroduce the patient to her denied unconscious libido. Once the patient has learnt to expect these reliable good feelings, then she may be able to talk. This stage is crucial since, without the groundwork provided by vegetotherapy, "the full impact of their libidinal despair" (Randell, 1992) would be too much to bear. The reasoning here is that the pain within the soma was created as a way of not feeling. The body, seen as a bad object from introjecting the "bad breast" (Klein, 1988) also becomes the bad self, thus "the self becomes a depriving object that has to be attacked" (Frankl, 1990). Providing the soma with pleasant reliable sensations re-educates the person that the body is an innate source of pleasure, and therefore does not need to be attacked. The mind no longer has to divorce itself from its body. The body no longer has to hurt, and mind and body are allowed to be integrated. Thus preverbal behaviour can be interpreted via supportive bodywork which implicitly works with the unconscious, and then, in the hands of a therapist with some psychological insight, the preverbal pleas may reach consciousness and so the unconscious may be aired and worked through. True autonomy is achieved by patients as they gain insight into the reason for their pain.

Claire

Claire is a 40-year old married woman with two teenage children. She has a psychiatric history of depression and panic attacks dating back four years. I saw her whilst on a counselling placement in an NHS mental health unit. She complained of a variety of somatic pains including low back pain, bilateral shoulder pain, neck pains and frequent headaches. All of these symptoms had been medically investigated and no definitive disease process had been discovered. She had been diagnosed as having tension and anxiety and was receiving 24-hour care within the unit. Her referral to me was via the consultant, primarily for bodywork as she was considered to be somatising.

As I was only at this unit for a short time, this was a brief piece of work over a period of four sessions. Claire initially struck me as introverted and depressed, and talked very little. Since she was very anxious, I decided to perform all examinations and treatment with Claire fully clothed. Treatment consisted of gentle soft tissue massage to the muscles of the head, neck and dorsal spine, with gentle articulation and massage of the shoulder joints. Claire mentioned to other members of the unit that she had enjoyed her first treatment because "someone else can feel the tension". At the second session she complained of a severe bitemporal headache, which was treated by gentle traction and massage to her neck. The headache disappeared. The following week Claire told me she had been sick three hours after the last treatment. She was depressed in this session and said she had a spinning, churning feeling in her head, ears and stomach. However, her other symptoms had decreased and she began to talk about her mother, who had died suddenly four years ago. Claire was very close to her mother, and she felt her family didn't understand this; as a consequence she felt very lonely and isolated. In our final session she felt less tension in her shoulders, neck and back.

I later learnt that Claire had thought the sessions with me had helped so much that one of the unit's occupational therapists was to start treating her with aromatherapy.

My approach with Claire was simply to provide basic preverbal support by using gentle massage techniques. From a physical viewpoint some interesting changes occurred. Overall, the tone of her musculature decreased and her symptoms changed on a weekly basis. After the second treatment she was sick, which followed work into her neck, and resulted in her headache disappearing. Although actually being sick is not a common occurrence, feelings of nausea are fairly frequent after working on this area. This area of the body, i.e. neck and jaw, are related very strongly to oral libido, and often become heavily armoured. Although it is impossible to say in this case to what in specific terms this armouring may be due, it is fairly clear that a release of her muscle tension, as evidenced by the improvement in her headache, brought about a fairly violent reaction. Working into these neck muscles may have induced a lessening of the armouring. In such a case, the cause for the armouring may have been recognised at a preverbal level and being sick may have been a reaction to this; in effect, a form of minor catharsis. It is interesting that it was at the session after this one that Claire actually began to verbalise some of her feelings. This was quite a change as, generally, she remained quiet and introverted throughout the majority of the sessions.

It seems as though the act of holding these tight areas of preverbal rigidity and supportively accepting them allowed for some sense of recognition of what they may have meant for her. This was summed up by Claire's own observation "someone else can feel the tension". The preverbal contact involved in such treatment implicitly acknowledges the existence of conflict or discomfort; this can be immensely reassuring to someone who is unable to verbalise their feelings. If it is the case that such phenomena are preverbal in origin, then perhaps it is then not surprising that they are difficult to verbalise, hence the significance of supportive bodywork. Also, in this case the fact that Claire found a way of having her preverbal pleas understood made it possible for this quiet, depressed and introverted woman to assertively verbalise a wish for this to continue. She was able to do this in such a manner that a member of the unit contracted to treat her regularly with aromatherapy, another form of supportive bodywork.

The implications of this type of approach are that there is not the need necessarily to verbalise feelings. This releases the client from an obligation to try and find the word or words which are often so difficult or elusive and lead to intense frustration. This form of working is obviously very helpful when people are considered to be somatising, as their preverbal language can be shared in that another person can feel their pain, without the need to verbalise. The "somatic symptoms are more common than emotional complaints as a way of presenting psychosocial distress" (Kirmayer, 1984) and a recent report by the Royal College of Physicians suggests that "up to 50 per cent of new medical hospital out-patients are suffering from psychological problems which may trigger physical symptoms" (Hunt, 1995). It seems that somatisation may have profound psychological meaning, and that one method of approaching people who are somatising is by an integrated use of bodywork and psychotherapy.

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