Towards an understanding of the psychodynamic processes of the body

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ABSTRACT Counselling clients frequently mention bodily symptoms, yet, within the therapy world, the body largely remains off-limits. This, in some part, is undoubtedly due to the prevailing issues around the touch taboo. However, the symptoms emanating from the body may well have profound psychodynamic meaning. This paper sets out to describe a psychodynamic perspective for how these symptoms may arise. Notions such as libido and preverbal theories, along with primal defence mechanisms, are used to show how the body becomes involved in unconscious processes. A case study is presented as illustrative of some of the psychodynamic concepts that may be implicated. It is argued that bodywork may help in providing a preverbal supportive environment from which a therapeutic alliance may develop, thus allowing for a verbalization of unconscious conflict.

KEYWORDS Preverbal, libido, somatic, bodywork, defences

INTRODUCTION

> The ego is first and foremost a bodily ego.
>
> (Sigmund Freud 1923: 364)

Observations made in my practice as a registered osteopath lead me to believe that the aches and pains presenting to me frequently have no obvious physical or pathological cause. Indeed, to refer to these

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pains in such a disembodied way highlights the manner in which pain is perceived within our society. The notion is that pain must have a physical meaning since it is physical in nature; thus a search is made for an exogenous cause for this pain which is somehow outside of the person. Often it becomes a holy grail, an endless search; an external cause must be found so that an extrinsic cure may be taken. Many different physical therapies and practitioners may be used and consulted. In fact, almost anything is done other than an effort being made to understand any intrinsic meaning of the pain.

Such pain is ubiquitous in health care settings within Western society, the medical term given to this condition being somatization (Ford 1986; Coen and Sarno 1989; Lipowski 1988; Craig and Boardman 1990; Barsky 1992; Shaw 1994a). In this paper I hope to show how some of the theories of psychodynamics help to explain how psychological conflict can erupt in the soma. Various concepts will be employed, including how the unconscious expresses itself within the body. Our past experiences, I believe, have a bearing on how we react in the present, and the idea of preverbal communication and its relation to libido theory will be discussed.

The essence of this work is that bodily pain may have a psychosocial aetiology. This pain can be acknowledged initially at a very basic and supportive level by manual therapy, and then the psychosocial reasons may be aired, and thus a deeper understanding reached of why the pain is present. This may result in a resolution of symptoms combined with an understanding of the link between mind and body. Therefore, I suggest that some insight into the cause of the symptom could be achieved as opposed to palliative symptomatic relief.

CONCEPTUAL FRAMEWORK

> Every increase of muscular tonus and rigidification is an indication that a vegetative excitation, anxiety or sexual sensation has been blocked and bound.
>
> (Wilhelm Reich 1945: 340)

The unconscious

The concept of the unconscious is central to the understanding of psychodynamic body processes. There are areas of mind of which we are consciously unaware and these unconscious entities may include mem-

ories of past traumas. The theory here is that the body, the soma, represents these unconscious conflicts, 'the body being the language of the unconscious' (Randell 1992b). This opens up a whole area for potential understanding of the psychosoma, as the 'psyche grows out of the soma almost from birth' (McDougall 1974). Since we use our bodies to communicate, we can communicate unconscious desires and feelings through our bodies. It also lays the body open to become a reservoir of unconscious conflict, of dashed desires and repressed anger, of undischarged emotion locked in a body desperately trying to cope with external pressures and internal conflict.

The unconscious is also the seat of instinctual behaviour. This provides us with a constant source of conflict, as our unconscious wishes or instincts can be overridden by conscious thought. Freud described the mind in terms of the id, the ego and superego (Freud 1923). From a somatic perspective, a simplified but useful way of understanding these concepts is that the id represents the bodily instinctual needs which are largely unconscious; and the superego is a controlling moralizing influence on the ego, a conscience which is derived from socialization. All three are linked and affect each other. It is a useful model for my purposes since, by working with the body, the id can directly be influenced. This could then affect the ego and superego. It is thus possible to bring unconscious id impulses to the preconscious and conscious mind by bodywork and thereby allow the ego to recognize these feelings. This ties in neatly with Freud's oft-quoted phrase 'Where id was there shall ego be' (Jacobs 1988: 8). The unconscious becoming conscious seems to be the aim of traditional psychoanalysis so, wittingly or unwittingly, therapists who work on the soma achieve this result.

Libido

Libido is another fundamental notion when applying psychodynamic concepts to the body. Freud defined libido as 'a quantitatively variable force which could serve as a measure of processes and transformations occurring in a field of sexual excitation' (1905: 138).

It is unfortunate that libido has come to mean a mainly genital feeling. The concept is far broader, encompassing how we feel about ourselves and our perceived world. Genital activity is just one, albeit important, area of the body which has become libidinized. Other areas include the lips and mouth, the functions of the musculature, sensation of the skin, urethral and anal functions, looking, listening,

touching, tasting and even thinking – in short, all major bodily functions are heavily invested with libidinal desires (Frankl 1990). Mother nature has shown her sagacity in supplying these basic functions with libido, for it makes these activities pleasurable. We need to defecate, micturate, see and feel, as well as be sexually active in order to live. These basic functions, these vegetative instinctual drives are the essentials of life.

The body implicitly provides pleasure by way of libidinal discharge; our superego may wish to deny pleasure and, by action of the ego, repress libidinal desires. This denial of pleasure is a learned behaviour, as our superego derives from external experiences. These may be picked up from parental upbringing and later societal indoctrination: we may learn that pleasure is bad. As our bodies are a prime source of pleasure, we may learn to despise our bodies. What better punishment for this source of pleasure than to create pain within it, to create pain in the soma, to somatize. Thus profound psychological processes are at work to create pain of psychosomatic origin.

At a deep psychological level the ego and libido can be considered to be intimately connected, as the needs of the ego are fuelled by libidinal desires stemming mainly from the soma. As Frankl (1990: 25) puts it, 'the libido is directed inwards towards the self, and outwards towards mother, father, siblings, authority figures, community and society.' The way in which such transformations happen and affect our feeling of self is important in character formation (Frankl 1990). It was at this level that Reich extended Freud's theory of libido to the realm of the body armour. Reich (1942, 1945) observed in his patients areas of rigidification within the soma; he termed this 'body armour' and suggested a mechanism for this process in that the 'ego assumes a definite form in the conflict between instinct (essentially libidinal need) and fear of punishment' (1945: 338). He suggested that the ego becomes rigid.

Rigidified areas within the soma therefore represent unconscious conflict. These areas of armouring can also be considered as an adaptive response to past or present events. This concept of creating pain in the soma has been recognized by other cultures. Ancient Buddhism believed the process of exchanging psychic pain was an adaptive achievement, since there was a treatment for physical pain (Goldberg and Bridges 1988). I suspect such treatment involved some form of manual therapy akin to latter day osteopathy. Shamanism has also recognized the mind's ability to create pain in the soma (Achterberg 1985), as has Chinese medicine (Ots 1990).

The armouring reduces the capacity of the body to feel pleasure by blocking out libidinous urges. Areas of the body become numb by encapsulating the libidinal feeling into a site of muscular tension. Such areas of unyielding muscular tonus symbolize denied preconscious and unconscious feelings. It requires energy, physical and psychic, to maintain such tightness; in a sense these areas can be regarded as psychic defence mechanisms aimed at preventing the conflict becoming conscious. These zones of defence contain a high concentration of repressed libido (Randell 1989). However, there are times when the conflict breaches such defences as the squeezing of muscle can no longer hold back the unconscious urge. At such times these muscles send messages of pain to the conscious sensorium, which is unable to ignore the screaming of the unconscious.

Thus, armouring reduces the capacity to achieve libidinal pleasure by decreasing the body's ability to feel, and that character armour 'fulfils its function by absorbing and consuming vegetative energy' (Reich 1945: 339).

Psychodynamic defence mechanisms

These mechanisms are primal features; we learn and acquire them in early infancy when our body is our main means of communication. From a body-centred perspective they are important because they represent the effects of infantile libido. That is, in the preverbal stage of life, which is also pre-oedipal and pre-ego, we are dominated by our bodies' needs which are governed by libidinal yearnings.

Repression and splitting

Repression refers to the process whereby emotions and feelings are bound up in the unconscious in an attempt to prevent them becoming conscious. These emotions tend to be of a traumatic nature. Such traumata often happen during infancy and live on into adult life where they may be expressed as physical pain (McDougall 1989; Frankl 1990) or abuse of offspring (Miller 1987a, 1987b). This repression interferes with the child's and then adult's 'ability to feel, to be aware of and to remember' (Miller 1991: 2) so that, literally, the torments of childhood are banished from consciousness. The early stage at which repression happens was noted by Melanie Klein (1957) who suggested that repression as a defence was linked to the

phase in early infancy when demarcation between the unconscious and conscious arises. At this stage the ego is weak and therefore in a vulnerable position. Trauma will, therefore, overwhelm the ego unless it is repressed; thus Winnicott (1966) suggested 'psychosomatic disorder relates to weak ego'. Here the phenomenon of splitting allows for distance to be put between the weakened ego and the unpleasant feeling or trauma. Splitting, therefore, underlies the process of repression by allowing contradictory feelings to be held in check, the unpleasant feeling being submerged in the unconscious.

However, what is repressed usually finds a way of being expressed, even if it is in the way certain defences are employed to keep the repressed feelings at bay (Jacobs 1988); for example, denial could be an aspect of repression, a kind of defence against a defence.

Returning to the somatic component, repression could emerge as a symptom within the body. As Joyce McDougall (1989: 54) puts it, the symptoms 'act as punishment for libidinal wishes'. As adults a potential mechanism for somatic pain is the repression of libidinal desires, which originate as infantile traumata long-buried in the unconscious world. McDougall goes on to suggest that diseases such as ulcerative colitis, which involves forceful ejection of bowel contents, and bronchial asthma, where the sufferer fears to let go of their breath, are linked to repressed feelings. On a psychic level these feelings represent a fear which remains repressed to the point of causing disease. The repressed libido, unable to discharge normally, reacts by attacking the body.

This could be viewed as a form of splitting, since, by separating the mind from the body there is no need to sort out feelings from the mind, as a cure is sought for the physical symptoms for the body. This enhances repression by preventing any link being made between bodily pain and psychological traumata. It is, therefore, important for the person in pain to maintain a dualism for fear of recognizing consciously the true nature of the symptom, or, as Winnicott (1966) suggests, 'the real illness being the personality split which is organized out of ego weakness and maintained as a defence against the threat of annihilation at the moment of integration'.

Introjection and projection

Introjection is linked with libido. We introject nourishment not only in the form of food, but also as feelings. This has a profound effect

on our psyche. Again, this is an important process in early infancy and is, in a sense, one of our first impressions of the world. Introjection can be a defence when its effect is to impede growth and maturity (Jacobs 1988). We learn about pleasure and punishment by introjection. We take in the outside world and by doing so start to gain an impression of our own identity. The infantile object which provides much nourishment is the breast. If the breast is giving and the process pleasurable, then a positive self-image begins (Frankl 1990). If, on the other hand, the breast is unyielding, cold and lacking in libido, the process of introjection becomes associated with aggressive behaviour towards the breast. The increase in muscular tonus is reflected throughout the body, as the whole soma becomes sensitized to having to fight for its food. In effect, the bad external object has become introjected.

At a deeper level, Frankl (1990) describes projection as involving the ability to identify oneself with one's product; this is termed 'self-affirmative projection'. If this does not occur, identification is denied and thus is referred to as 'splitting projection'. Again, libido is involved but, unlike introjection which uses oral libido, projection is associated more with anal function. This area has its own taboos with feelings of guilt and filth. Yet instinctively we have to defecate and, like it or not, it is invested heavily in pleasurable sensations. Here again a defence occurs in that a whole host of somatic complaints can be conjured up to deny pleasurable access to anal libidinal feelings; such conditions could include constipation, irritable bowel syndrome and low back pain.

Resistance and displacement

Resistance occurs when there is an inability to verbalize feelings; the defence is put up to prevent conscious access to these feelings. One way of helping to look at resistance is to look to the body which may be expressing these feelings. Strong psychic forces are required to keep the unconscious urges from discharging; body armour may help prevent such discharge (Reich 1945). Again, a link with primal libidinal forces can be made. The urge to discharge is a pleasurable one, yet must remain in abeyance due to resistance, the result of which is a form of self-punishment, in a sense a fear of letting go. This fear could well be linked to childhood traumata (Miller 1987a, 1987b) where children unable to escape are repeatedly abused, and so consign their feelings to the deepest recesses of their unconscious.

These feelings may appear within the soma as pain. The inability to identify or express feelings allied to a difficulty in distinguishing between feelings and the bodily sensations of emotional arousal has been identified by medicine; the name give to this is alexithymia (from the Greek 'absence of words for emotions'). It has been suggested that the study of alexithymia could help in the understanding of psychosomatic medicine (Taylor *et al.* 1991). I think this concept represents resistance in that the feelings cannot be expressed verbally, but rather are locked unconsciously into the soma as pain. Access to these feelings is, therefore, resisted as they are too psychologically painful to confront consciously. The paper by Taylor *et al.* (1991) observes that psychosomatic patients find it difficult to express their emotions. This could be a comparison with osteopathic patients who have deep-seated resistances and cannot consciously verbalize their feelings, but rather create pain in their soma. The undischarged urge may lead to displacement (Fenichel 1990), in the form of anger which is acted out, not against the object of anger which, if parental in origin, is taboo in our society (Miller 1991), but against someone else or the self. If the latter occurs a somatic pain could ensue. Over the years such conflict may progress through many layers of displacement, so that a presenting problem would be viewed as a culmination of events rather than a one-step process.

Interestingly, both resistance and displacement play an important role in dreams. 'Dreams are constructed like a neurotic symptom; they are compromises between the demands of a repressed impulse and the resistance of a censoring force in the ego' (Frankl 1990: 20). Symptoms and dreams could be seen as deriving from the same source; they are products of resistance and displacement and may, therefore, be open to interpretation.

Preverbal communication

This is our very first mode of communication; before speech we used our bodies. We spoke through our movements, cries, screams and touch. This method of communication lives on in adult life, body language being one form, but in our muscular armour, our patterns of rigidity, it lurks, masquerading as pain at times. This most basic level of communication is vital when considering the psychodynamics of the body. It is communication at an unconscious level. It is where intrapsychic defences can be felt, with no need to verbalize.

Preverbal communication represents the most fundamental level at which we appreciate our environment. The new-born child swarming with libidinous impulses, instincts to be obeyed, immediately communicates these to the outside world. Here lies one of our culture's paradoxes. As the child screams, instincts yelling from every pore, the parents, socialized and con-ditioned against acting on instinct, look on almost as impotent bystanders. The child, although communicating, cannot make itself understood. Man born with instincts is denuded of them by the rigours of socialization. Instincts must, therefore, be curbed, for this is the trade-off to living in a 'civilized society'. Control of instinct leads to a concomitant control of feelings: preverbal language must be repressed, defences learnt, built and maintained. The unconscious still makes itself heard as an adult, it still makes use of the primal routes of pre-verbal language. However, these are now subtly changed in that no obvious signs appear, but the squeezing of muscle, the contracture of sphincters, the scream of unconscious conflict erupt in the soma as tightness, to such a degree that muscles become rigid, so laden with libido that they are painful to the lightest touch. These are regions of preverbal defence, of high anxiety, and may represent a point of contact for understanding somatic psychodynamic processes. Within my practice as both osteopath and psychodynamic counsellor such areas of somatic rigidity are ubiquitous.

Object relations

Up until now the concepts used have derived mainly from the early Freudian drive theories. However, the object relations school of psychoanalysis provides important insights into the early psychological developmental stages of life. This is an important consideration when dealing with a therapy which incorporates bodywork, as preverbal material is likely to be induced. Also, since object relations are early intrapsychic structures mediated partly by preverbal contact with the world, it is possible that elements of these structures will be present within a body contact therapy. Holding and supporting is an essential aspect of Winnicott's 'good-enough mothering' (Davis and Wallbridge 1981), and is certainly an aspect of bodywork where the patient, over a period of time, can come to rely on and expect to receive supportive preverbal contact where the therapist becomes a 'friend of the body' (Randell 1992a).

In such a setting a close and intimate relationship is liable to occur between the patient and therapist. It is likely that the patient in a regressed state may be able to access preverbal material, which may, not surprisingly, be difficult to verbalize. However, concepts from object relations, like Kohut's self-object (Johnson 1987), may help to explain some of the behaviour by patients observed in these situations. An example would be how, over time, the body therapist may become a self-object for the patient, i.e., the patient has difficulty in differentiating the body therapist as separate (Shmukler 1991). In such instances, patients often express the wish to fall asleep or stay on the treatment table all day. When viewed from an object-relations perspective, phenomena such as these may give insight into the level of regression and the developmental stage of the therapist–patient relationship.

Transference and countertransference

These important aspects of psychodynamic theory have a bearing on any relationship, and require addressing in the context of bodywork. Transference, as Freud (1962: 83) suggested, is 'the true vehicle of therapeutic influence; and the less its presence is suspected, the more powerfully it operates'.

There has been much debate about the issue of countertransference and touch, centring around whether touch is a need of the client or therapist (Alyn 1988; Kepner 1993; Kertay and Reviere 1993). Some therapists positively advocate the use of touch, seeing it as a developmentally needed part of the therapeutic process (Johnson 1987; Goodman and Teichner 1988; Kepner 1993), or as a means of acknowledging somatic processes within therapy (Schwartz-Salant and Stein 1986; Clarkson 1989). However, the form of contact which I advocate and suggest is that of holding and really feeling preverbal elements of somatic discomfort (Shaw 1994a, 1996) by means of deep soft-tissue massage techniques. Such contact is unequivocally supportive and provides a level of tactile contact rare in our society, that is, feeling someone else's intrapsychic defences as they present within the soma. There can be little doubt that this process enhances the transference relationship, as there is an implicit induction of regression. The patient in osteopathic settings is frequently asked to undress to their underwear and lie on a treatment table. In such a vulnerable position, the practitioner takes on the parental figure in the patient's mind. Since the treatment involves

the application of manual skills and literally holding, images of early childhood experience are likely to arise. This adds to a deepening regression and underlines any transference already present.

The traditional psychoanalytic perspective around such intimate body contact would raise many issues around the needs of the therapist and the part played by sexual arousal in the countertransference. However, from the perspective of approaching the body as a body therapist, the issues of arousal and sexual feelings are lessened by the therapist's being orientated and thoroughly versed in the art of bodywork. The type of contact involved is unequivocally supportive and not sexual in nature. It is important to acknowledge the different level of touch involved here in order to be clear on what sort of countertransference is likely to occur. In such situations patients often project archaic needs as preverbal material is likely to be evoked; these needs may be picked up in the countertransference as feelings of despair or intense loneliness. Frequently, the concomitant palpable texture of the muscles is tight and rigid, almost craving to be held and supported.

In such cases, the projections from the patient may be used in combination with an acknowledgement of the fact that the therapist can physically feel the tightness within the soma, and this can help move the patient towards verbalizing the preverbal material.

CASE STUDY AND COMMENTARY

At this point I would like to describe a brief case study. The purpose of this is to show how some of the concepts so far discussed apply to a real case. This is presented for illustrative reasons as it was a very short-term piece of work. I hope that it will indicate some of the psychodynamic processes present within the soma.

Ben

Ben is 45 years old and unemployed. He lives with his wife Margaret and two teenage children. Ben's mother, with whom he had a close and affectionate relationship, died when he was 18 years old.

I saw Ben when I worked on a counselling placement in an NHS mental health unit; his method of referral was interesting in that he had a long history of back pain, which osteopathy is famed for treating. He was, though, referred to me solely for counselling to help with his feelings of depression, even though I made it clear at

his case discussion that I thought a combination of manual therapy and counselling could have been of help. In a sense this highlights the problem of integrating physical symptoms and emotional distress within a medical setting. Even though I am trained in a manual therapy I was perceived as only being able to offer one 'service' at a time, in this case counselling.

As it transpired Ben's back problem had been so severe that it was now impossible for him to do the manual work he had done in the past. When I saw him he complained of several somatic complaints in addition to low back pain; these were constant headaches and neck pain.

As I was present in the unit for only a short time, I saw him just three times. The first session was spent talking about his feelings regarding his depression. This seemed to stem from his being unemployed, difficulty in relating to his son and daughter, an inability to express affection, especially towards his wife, and general lack of being able to enjoy anything.

At the second session, I treated Ben osteopathically. The muscles of his back, legs and neck were all very tight and rigidity of spinal joints was well marked. I manually massaged these areas in a gentle and supportive manner combined with gentle rhythmic stretch to some of the spinal joints. During and after the treatment, Ben talked about how he felt there was little affection in his life, and how he wanted physical contact with Margaret.

At the final session he reported having had the best night's sleep for nine years; he had felt his tension decrease and had started listening to classical music. I performed a similar treatment to the previous one, after which he reported feeling no pain, and his headache had disappeared.

A few weeks after leaving the unit, I was told by one of the members of staff that Ben had continued to improve and that his wife had said of him 'I don't know what's got into you'.

Commentary on Ben's case

I built up a good rapport with Ben which I feel was enhanced by the bodywork component. As mentioned earlier, transference processes are working at a profound level with this form of body contact. I treated Ben osteopathically at the beginning of the second and third sessions; he undressed and lay on a treatment table, allowing me to treat him. I felt that this provoked a deepening of Ben's trust

in me, and a therapeutic alliance was established quickly because the process of undressing and being handled had elicited elements of regression. This may have been enhanced by Ben's viewing of me as a self-object, and by the level of regression evoked connecting with early developmental transference processes such as merger and twinship (Johnson 1987), this being demonstrated by his reluctance to leave once the session had ended. The emotion primarily present with his mother's death was of anger at being left, which he found difficult to verbalize. However, while I was working on his body there appeared to be other feelings Ben was projecting on to me, namely loneliness and despair. I suspected these may have been behind his anger, the concomitant physical feeling in his body seeming congruent with feelings of abandonment. This also suggested to me that there may have been early material around.

The notion of needing touch also related to his current home situation with all his family in that he occupied a position isolated not only from his wife but from his son and daughter. The fact that he was also unemployed doubtless underlined this isolated position and feelings of abandonment, which probably added to his depression.

The countertransference issues in this work were not around what I felt in my own body, but rather the acknowledgement of some of the projections of which I became aware while working on Ben's body. Although he presented with current life problems, I suspected the sort of abandonment issues which arose related to an earlier developmental phase and, unfortunately, there was insufficient time in which to explore those issues.

Empathically it is possible to acknowledge the patient's feelings in this type of work as the therapist can feel the discomfort within the body. This frees the patient from the sometimes frustrating task of having to find words for their emotions. I took over a supportive parental role and by means of preverbal bodywork provided his body with pleasant feelings. This gave him a sense of the affection he craved from his wife, and the kind of unconditional support he had received from his affectionate mother. He realized very quickly that his body could be a source of pleasure, and not a seat of pain. While working on his body I was surprised at how well his muscles responded to massage. In essence, the focus of this piece of short-term work was contact at a primal preverbal level, that is, providing support via bodywork as well as by counselling. It was as if his soma

was yearning for touch, his unconscious was preverbally craving for acceptance and reassurance. The massage gave him the reassurance that he did not have to hurt. At a primal level his defences were felt, were heard, and he was therefore able to communicate with a deep-felt need to be touched. As a consequence he was able to sleep. His body, having been turned on by an incessant stream of unconscious battering for years and years, had found a way of turning off, and what better way to do that than by one of our psychosomatic experiences par excellence – sleep (McDougall 1989). Ben was able to enjoy his body and thus enjoy his sleep. He also began to enjoy life; he returned to listening to music, taking in or introjecting good feelings, good libido. This was enhanced by the bodywork which allowed libido to flow to previously taboo-laden areas of his body; the defences of his musculoskeletal system, which had been tight and denying him access to pleasant sensations, were now free to accept, to feel and to enjoy.

Overall, his symptoms decreased dramatically and he developed a sense of well-being, which was acutely observed by his wife's comment 'I don't know what's got into you'. What had got into Ben was his own feeling of enjoyment and pleasure, which radiated from him and allowed him the freedom of letting his pain go and, by doing so, allowed him to enjoy life. The misery of his body had been left behind and replaced by the innate ability to feel good, pleasant, somatic libido.

Dramatic 'miracle-type' cures of this kind are, of course, not uncommon in any therapeutic situation. Indeed, if Kohut's model of real self, overlaid by false self and symptomatic self, is employed (Johnson 1987: 55), it is fairly clear that patients such as Ben presenting with a depressed symptomatic self, flip over into the false self after a brief time, with very little acknowledgement of the real self. It needs to be acknowledged that this case is not complete; there is no further information on his case other than a verbal report from a third party a few weeks after I left the unit. However, this case is presented as illustrative of some concepts within psychodynamic theory. It would also be easy to dismiss the type of reaction Ben had to physical treatment as a transference cure or as a placebo effect. This would, however, be missing an important phenomenological point, that is, his body armour did actually soften: muscle tone decreased as did his physical pain. Whether these two events are causally linked is another matter. The implications may be that

intrapsychic defences can be felt physically to lessen and relax. In the world of counselling such phenomena are frequent, but rarely felt in the soma of the client.

This case illustrates the value of good supportive preverbal contact, not only in enhancing the therapeutic rapport, but in feeling intrapsychic defences. At a very fundamental level it allows the body therapist to feel the unconscious, and as such these very intimate and personal links with the unconscious must be respected and treated with care. This case also demonstrates some of the psychodynamic processes present within the soma and that, by a recognition of these factors, a deepening of the therapeutic alliance may well develop. I would, though, be cautious in advocating the use of such bodywork for all counselling clients. Both therapist and client need to be comfortable, and the appropriateness of such contact requires much consideration; on medical grounds it could be detrimental to health. I would, rather, suggest that some of the processes I have mentioned may help to provide an explanation for how psychic pain becomes converted into somatic pain. If this is the case then the physical symptoms of counselling clients could be the result of intrapsychic phenomena. Therefore, bodywork could initially be helpful in providing a basis for the preverbal acceptance of somatic defences. It is, though, unlikely that somatic work alone will dissolve intrapsychic conflict (Frankl 1994). Some form of insightful talking therapy would also be necessary in order to achieve a full conscious acceptance of the cause of the somatic discomfort. I am, therefore, not providing a solution or panacea for all ills, merely suggesting that the bodies of our clients could be a source of rich material when engaged in the exploration of psychodynamic process.

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The use of experiential groups in the training of counsellors and psychotherapists

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ABSTRACT This paper examines the experience of consulting to experiential groups and endeavours to draw some conclusions about this significant element in training.

KEYWORDS Task, awareness, self-management, growth, society

In the course of twenty years' involvement with experiential training groups, first as a member then as a consultant and supervisor, I have become aware that colleagues undertaking the same work often have widely differing perceptions of their task. It seems important to try to clarify some of the issues and to open this area for discussion.

HISTORY OF GROUPS IN THE SERVICE OF TRAINING

Socrates advocated open-ended discussion in a group where members were free to explore concepts, build on each other's contributions

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