Psychotherapist embodiment

The therapy world has for too long sidelined the importance of the body, says therapist and former osteopath **Robert Shaw**. If we can learn to understand more about the significance of our own physical reactions in the consulting room, then we may be able to use them as therapeutic tools

THISarticle is only of any interest if you have a body. Once you have checked that out I hope you will read on. The purpose of writing this article is to encourage practitioners to think much more seriously about the types of bodily feelings they experience whilst working as counsellors or psychotherapists.

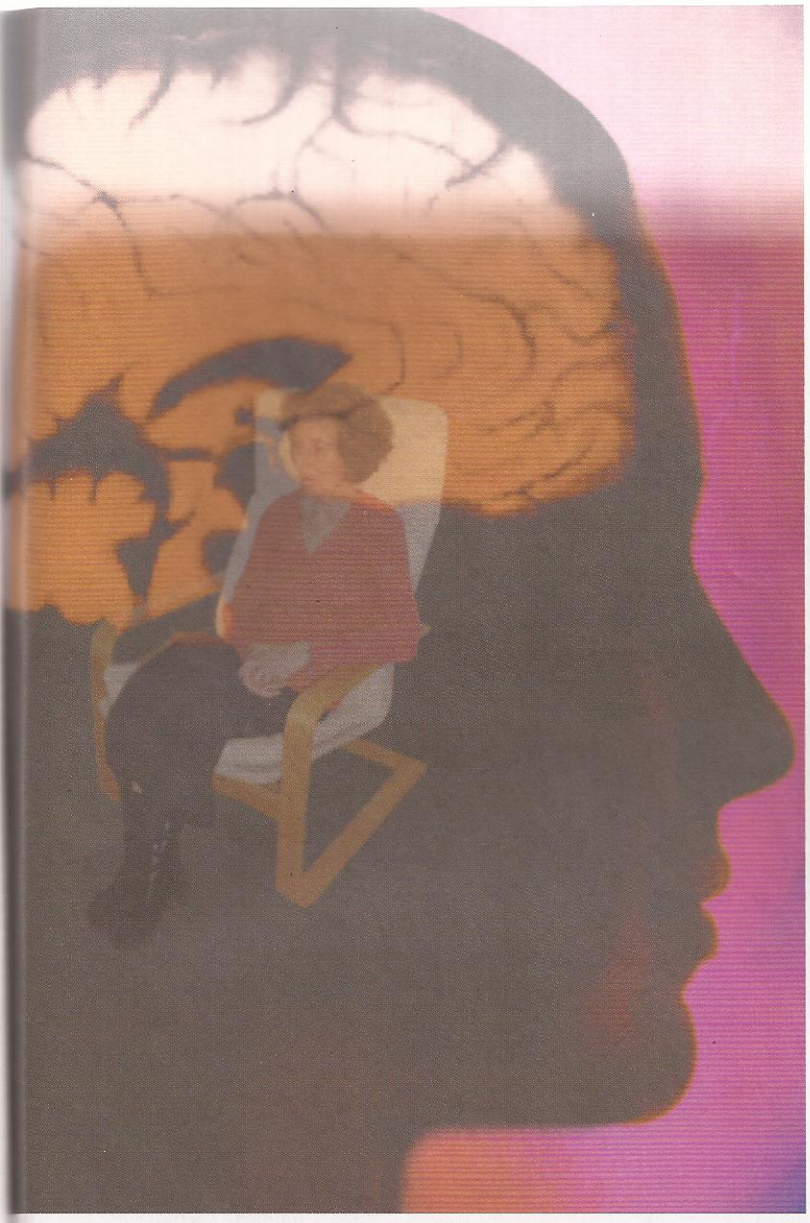
But first a bit of background, because after all who am I, what am I, and what have I to offer this particular debate? I currently work as a psychotherapist, but am also a registered osteopath. I started my practice career as an osteopath and, during this time, I became interested in the stories that were being told to me, and I realised that I needed some training if I was to respond in any meaningful way to what I was being told by my patients. I therefore undertook a diploma course in counselling followed by training in psychotherapy. It was during this time that I became aware of the contentious nature of the body in therapy which, at the time, was rather confusing for me, as I was well versed in a body-orientated discipline.

In order to try to marry together my professional roles as psychotherapist and osteopath, I embarked on a research journey which, via a PhD, has resulted in a book, *The embodied psychotherapist* (Shaw, 2003)[1]. In all, some 90 therapists from the UK and mainland Europe took part in this study, representing all the major schools of therapy, although the dominant school was humanistic. The central finding from my research is that we as therapists really must take our bodily sensations much more seriously and try to understand these phenomena, since I believe they provide vital clues to our therapeutic work. In my opinion the therapy world has for too long ignored the body or sidelined its importance. My contention is that our physical reactions are an essential component of therapy. These physical reactions, or embodied phenomena, are, I believe, a fundamental part of any therapeutic process. If we can understand the significance of these somatic sensations then it may be possible to use them as therapeutic tools.

Embodiment

The idea that therapy is an embodied experience is not new. Indeed there is a growing acceptance of the importance of this concept. There are several authors now addressing the crucial concept of the body and embodiment in relation to therapy (Boadella, 1997; Sampson, 1998; Staunton, 2002; Totton, 2003)[2,3,4,5]

My ideas on embodiment are very much influenced by the phenomenological movement, of which Merleau-Ponty was a significant instigator. He encourages a realisation of the importance of studying embodiment,: 'It is through my body that I understand other people' (Merleau-Ponty: 1962; 186)[6]. The way that we interact with the world is through our bodies. Our understanding of our world is through our bodies. We can do nothing other than perceive our environment through our bodies. It must be that in the therapeutic encounter we do the same, and my assertion is that this is an inherently embodied relationship. What I feel in my body must say something about how I perceive this relationship, not necessarily what the client perceives. Thus we can see then that embodiment is very much about the subjective aspects of our being. Indeed, if we didn't have a body we quite simply couldn't enjoy a subjective life or, put another way, 'subjectivity is truly embodied' (Depraz, 2001; 172)[7]. This leads me to the notion of intersubjectivity: when two bodies meet then there is the opportunity for two subjective experiences to meet as well. As you will by now be aware, I am keen to emphasise the role that embodiment plays in this interaction. As a therapist I think it is a fair assumption to acknowledge that what we work with much of the time is subjectivity, either the client's experience or our own. From the therapist's perspective this is a form of resonating with the client, or as I term it, 'body empathy'. What is clear, though, is that some bodily experiences are occurring, and I strongly contend this has something to do with the



therapeutic encounter and, therefore, the intersubjective space between therapist and client. All this may sound rather abstract, but it is important to mark out some frame of reference with which to understand some of the varied phenomena that therapists talked about during my research.

Narrative

Before I present some examples of how therapists experience their bodies during therapy, I would like to introduce some of the ideas of the narrative movement. In a sense this is very straightforward as all 'narrative' means is telling a story. The radical aspect of this is to view therapy as a story-telling process. If we do this then we run the risk of having to leave our jargon or discourse outside the therapy room, as this approach fundamentally challenges the notion of therapist as expert. In this approach we acknowledge that the client has a story to tell and the way it is told is crucial. But therapy also becomes part of the story, thus a co-constructed narrative evolves between therapist and client. As we must also remember, we bring our own story to the therapy. This process, I argue, is an embodied one, and the feelings we experience at the somatic level are important in helping to build the co-created therapeutic narrative.

This is by necessity, a thumbnail sketch of a growing and increasingly influential movement within the therapy world (I hesitate to suggest reading chapter 4 of my book Shaw, 2003 for an overview, but also please look at McLeod, 1997; Speedy, 2000 and Bruner, 2002)[1,8,9,10]. It cannot be emphasised strongly enough that the narrative movement represents a very strong critique of therapy and I am a supporter of this movement towards a more egalitarian version of therapy.

Psychotherapists' body narratives

One of the striking features of my research was that therapists had no difficulty at all in describing their physical reactions during the therapeutic encounter. I say 'striking' because very little is written on the subject. Some authors refer to embodied countertransference (Field, 1989; Samuels, 1985)[11,12], but what I uncovered during my research were commonplace and widespread bodily reactions, not occasional feelings as described under the term 'embodied countertransference'. When I began my investigations I ran some discussion groups with counsellors and psychotherapists to explore what, if any, physical reactions they experienced with clients (for a detailed description of the research methodology and data analysis see Shaw, 2000 and 2004)[13,14]. Some of the replies are as follows:

'With bulimic clients I'm hungry when they leave.'

'After seeing a chaotic client my notes were chaotic with inappropriate capital letters.'

These responses clearly point to the involvement of the therapist's body and this seems to be a reaction to phenomena exhibited in the client.

When I asked the question, 'Do you notice any physical pain?' I received, amongst others, the following reply:

'Particularly with some clients I am more strongly affected. I somatise myself. With an anorexic and bulimic client who talked of vomiting and diarrhoea, I felt I had a bug during the next client. I understood this as somatising from her. With a client in denial and cut off from feeling, I felt lots of anxiety in my body.'

It was clear to me that these physical phenomena, far from being isolated and infrequent events, appeared to be very common and part of day-to-day practice. I then embarked on a series of in-depth interviews with

psychotherapists to explore these phenomena in detail. What transpired was that there was an enormous range of reactions.

Summarised in the following list:

nausea/sweaty palms
gut reaction
pregnancy feelings
asthma
musculo-skeletal pain
body mirroring
internalisation
body reaction linked to abused clients
visual
revulsion and closing off
smell
cold and hot

I'll provide an example from this list from the 'musculo-skeletal pain' theme. (In fact many therapists reported feeling pain or physical discomfort whilst working.) It is important to remember that this pain is clearly located within the body of the therapist, not that of the client.

'I do experience things like getting pain across the back of my neck and across my shoulders, which usually again is to do with the client beginning to remember, or moving into something that's going to make them tense or scared. You're having to pull against it... '

I find it fascinating that, in effect, the therapist's somatic experience of physical pain becomes a part of the therapy. This is the point where such embodied responses can become part of a co-constructed narrative, although I do appreciate that this would require self-disclosure on the part of the therapist. Wouldn't it be interesting to see if our somatic experiences meant something to our clients? I think that we need to think about this issue very seriously and not merely regard it as some form of countertransference. Indeed, I am not at all convinced that notions of transference and counter-transference are helpful when it comes to understanding embodiment. I shall come back to this point at the end of this article.

In addition to physical reactions, there were many other ways in which therapists experienced their bodies. Often they would talk about their body as a 'barometer', as a means to gauge emotions within the therapy room. Many would view their body as a receiving device, which was sensitised to picking up cues from their clients. The 'body as receiver' seems to be a spontaneous passive phenomenon that therapists are tuned into by the nature of the work. In fact it became clear during our discussions that therapists use these cues a lot in their work and base many of their interpretations for the therapeutic relationship on this embodied information.

Other therapists, especially those who had been in practice for some time, tended to take their physical discomfort seriously and they would take up meditation or T'ai Chi or ensure they took time off to go on holiday. Many of these experienced therapists talked about there being a health risk to working as a therapist. They felt that if they didn't look after themselves physically they would become ill from their work; many of them referred to colleagues who had become very ill or stopped practising through ill health. Clearly this is an important issue for therapists to consider; as one therapist said:

'...that's a really costly way to make a living... to allow myself to be so impacted by somebody... to allow myself to know somebody to that degree and therefore, know myself to that degree, I mean there's wonderful rewards as well... but there's a real cost .'

At one stage in my research I did wonder whether working as a therapist should carry a health warning. But probably what is more important is that as therapists we become much more bodily aware. If it is the case, as my research suggests, that we react to the therapeutic relationship by experiencing physical symptoms, then we need to take care of our bodies. From a personal perspective I have been influenced by my research. I now limit the number of clients I see for psychotherapy whilst maintaining a balance of interests outside the therapy world.

A key concept that emerged was of 'body empathy'. Many therapists felt strong reactions with clients where the work had been particularly intense. One therapist who experienced a particularly intense feeling of cold even though the ambient temperature was warm, termed this an 'existential cold', and drew upon the story of Dante's Inferno to help him explain his feelings. (In this story Virgil helps Dante through Hell, which can be seen as an allegory of the therapeutic journey where Virgil is the therapist and Dante the client, and the bottom most circle of hell is frozen.)

'Virgil actually goes with Dante through the depths of Hell and the frozen depths so he gets bloody cold with it.'

One of the ways this therapist makes sense of this phenomenon is to suggest that an empathic bond has been established:

'I was with someone, there was an empathic bond.'

This would suggest that a connection at a profound level had been made between the client and the therapist. Overall, 'body empathy' seems to be an active process, which is a form of heightened body awareness.

A word of warning – Reification

An issue that has caused me some concern is the use of professional discourse. Obviously as therapists we do need to be able to communicate with each other and jargon is useful shorthand. But it became clear to me that therapists have a habit of assuming that subjective phenomena are

somehow real things in themselves; we reify these phenomena.

A common example of this was the idea of client material:

'But I do pick up client material very quickly in my body.'

There is a clear implication here that something is transferred from the client to the therapist. This must be challenged. What we feel in our bodies is our experience. It may have something to say about the intersubjective nature of the therapeutic relationship, but this does need to be checked out with the client, otherwise we start to make interpretations based on our bodily sense, not on what may be happening for our client. This is why I find countertransference problematic. Therapists tend to use the experience of counter-transference (felt in their body) to make interpretations about another body, that of the client. I'll provide another example to illustrate my point. A therapist had been working (with a client) for about a year when she started to experience very uncomfortable stomach pain when her client started talking about a certain period in her life. I asked this therapist what meaning she attributed to this physical reaction, she replied:

'So what I was doing I think was picking up the unconscious body memory (of her client)*.'*

When I first heard this I found it to be a plausible explanation, but on further reflection I realised that this therapist was making a claim to feel someone else's body memory. This is remarkable, especially as this memory is also unconscious, and has emphasised to me that the use of language has its problems and that as therapists we do need to be careful about the claims we make. Clearly we can't claim to know what another person's unconscious body memory feels like, but we can gain more of an understanding of our own body processes.

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My argument is that we need to examine our bodily reactions to clients in a much more rigorous fashion. This also may have health benefits for practitioners.

It seems clear to me that our bodily reactions are a central part of the therapeutic encounter, and to this end should no longer be marginalised or regarded as some hazy form of countertransference. Indeed, I am advocating that the notion of countertransference hinders our understanding of embodiment.

We need to develop a new language that is more accessible. I would suggest concepts like 'body empathy' and 'body as receiver' are much better ways to encapsulate how embodied states become part of therapy. These terms are no more than metaphors for describing the complex relationship between two bodies in the

therapy room. It is time for us to realise that embodiment is an endemic part of therapy or, as one therapist said:

'I mean, I live in my body, I would have nowhere else to live if I didn't have a body, so yes I am embodied.'

As therapists we simply have nowhere else to be but in our bodies, and possess no other view of our work than that viewed through our bodies. We are embodied beings as well as embodied therapists.

Summary of implications for practice

- Embodied responses can be used within psychotherapy to enrich the co-constructed narrative between client and therapist.
- There are dangers inherent within current therapeutic jargon, which tends to describe subjective experience in concrete terms.
- In order to address the above points, we need rigorously to research embodied phenomena, and critique the language we adopt to describe them.

It is time to reclaim the body for the counselling and psychotherapy world, and a deeper understanding of the embodied nature of the therapeutic relationship is a good place to start ■

The Embodied Psychotherapist *by Robert Shaw is available from www.brunner-routledge.co.uk or call 01264 343071*

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