

# The 'Relating Cure' – a 21st century body/mind approach to the psychology of psychosomatic symptoms and physical illness

by Michael Soth

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*Counsellors in general practice are working in the body/mind war zone, says Michael Soth. In response to some questions by the editor of the Journal, Penny Gray, he offers some thoughts on how to negotiate the territory in a way that facilitates integration for both practitioners and patients.*

## 1. When is it appropriate to say that physical symptoms may have psychological and emotional roots?

We could ask the question the other way around: how is it possible that we have come to treat the physical-biological and the emotional-psychological as separate?

This separation is profound, and fundamentally structured into our health system. As a culture, we obviously think of the body and mind/*psyche* as separate - on a philosophical, meta-psychological and theoretical level. But why?

We think of them as separate because we experience them as separate: our thinking reflects our immediate, given, experiential reality, and that reality - which most of us are immersed in it like fish in the sea - is conditioned by a body/mind split, as many writers have suggested. Ken Wilber calls it, more precisely, 'the European Split'. It's a condition of dissociation between mind and body and of an underlying conflict between them, structured into our pre-reflexive experience. It's a condition which is reflected in Cartesian philosophy and perpetuated by it. But although we are landed with it - in Heidegger's phrase: "find ourselves thrown into it" - it is not justifiable to universalise this predicament into the human condition *per se*. It is a condition which has evolved, it is socio-culturally constructed and it is still evolving. From within the body/mind split, it feels and seems static (like a deadlock of equal, but opposing forces), but from beyond it we recognise that even then *it is still a process*, and we can work with it on that basis.

The 'European Split', which still dominates most medical orthodoxy, has now been comprehensively challenged and de-constructed by modern neuroscientists like Damasio (1994).

Allan Schore, the neuropsychologist, has stated that to him the distinction between psychological and somatic does not even make sense any more (1994).

For our purposes in counselling we can certainly say that this distinction tends to be more misleading than helpful. That does not necessarily mean that we throw the carefully and steadily developed paradigms and techniques of our profession out with the bathwater. But we do need to recognise that the field of counselling and psychotherapy inherits Freud's 19th century *zeitgeist* and is therefore built on assumptions which are severely limiting it. This is especially true in terms of the relationship between mind and body and the relationship between patient and therapist/doctor. These 19th century assumptions are still rife and dominant, and they still make it extremely difficult for us to simply answer your question regarding the link between the physical and emotional-psychological aspects of symptoms. There are two levels to a possible answer: the first one is scientifically more acceptable and in line with common sense - it is based on the psychological reactions associated with physical pain and symptoms; the second one is more far-reaching and counter-cultural and addresses the psychological roots ('causes') of symptoms, what we might call the 'meaning' of illness.

1. The psychological associations of physical pain and symptoms are commonplace and simple: when we are in pain or our health is threatened, we have feelings about it; when we suffer physically, we regress emotionally. We have all kinds of emotional responses to the physical symptom, as we struggle with and against it. That means, even if a symptom does not start out as psychosomatic, it soon becomes so: we have psychological reactions to somatic problems. By the time the patient walks

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through the door of the consulting room, these two aspects are thoroughly amalgamated, and we can guarantee that we do have some sort of a psycho-somatic complaint in front of us.

How easy it is to take health for granted, and how easily one little symptom in one little part of the body can make our life misery! How does our *psyche* deal with the fragility that becomes apparent in illness? And how do we cope with the attendant helplessness?

When we enquire into these questions from a psychological perspective, we can deepen our relationship to the symptom beyond the common sense. We can then notice how *our consciousness changes* in illness. As a simple example: when we are ill, it's not uncommon to want an omnipotent mummy to kiss it better. We long for a 'transformative object' (Christopher Bollas: "The Shadow of the Object") who can - apparently magically - take away the pain or at least facilitate our struggle. Our coping with illness relies on the extent to which our early experience was suffused with the presence or characterised by the lack of such a 'transformative object'. But that's just the first - generally valid - manifestation of it. If we investigate further into the regressive effects of illness, we discover more precisely how our unconscious cannot help but personify the symptom and relate to it as if it were a person, typically one of our habitually unconscious 'internal objects'.

This recognition constitutes an important avenue into the exploration of symptoms.

2. The notion that there is 'meaning' in illness is a problematic one and has been used to cover a multitude of sins. It has been one of the achievements of the Enlightenment to demythologise illness, which was previously conceived of as God's punishment for sins. Scientific medicine understands illness as biological, therefore without emotional, relational, psychological meaning, but also without the burden of guilt which adds insult to injury. But over the last century there has been a stream of independent recognitions that - for all the blessings of enlightened medical science - our dualistic conception of the body/mind creates more problems than it solves. Body/mind dualism underlies the bulk of the iatrogenic effects for which medicine is increasingly criticised. For all the advantages of a purely biological-scientific approach, we can't get away from a nagging intuition that there may indeed be psychological meaning in illness.

However, that intuition re-introduces the notion of subjective agency and the idea that we are at least co-responsible for our symptom and our illness. In recent years this idea has become quite fashionable, as presented, for example, by Louise Hay (1984).

Her message may be approximated like this: "You create your own reality and therefore also your illness. Therefore you also have the power to uncreate it. You can choose to get rid of your symptom and decide to create health."

While some people swear by this kind of philosophy and have been helped by it, in the inner world of many clients it has often fuelled and exacerbated a kind of self-persecution, every inch as virulent as religious guilt. For many people these New Age ideas, when sown into the fertile ground of a solipsistic and latent narcissism, acquire a reactionary and dangerous function. Theories concerning the meaning of illness can thus become psychologically unhealthy, or exacerbate pathology, precisely because the underlying body/mind split fuels irrationality and 'magical thinking'.

And that is why many people, including medical practitioners, shy away from such ideas. They are quite rightly suspicious of un-scientific theories rooted in subjectivity and psychology, especially when these intrude on their area of competence. But that, in turn, fuels further the divide between a scientific, but reductionistic approach to *soma* and an un-scientific, but subjectively needed approach to *psyche*.

There are, of course, many scientists and psychologists doing wonderful work to bridge this divide, but in the client's and the counsellor's reality, when they meet in the consulting room in the context of a GP referral, that divide can appear as intransigent, dominant and relevant as ever. Is the client going to follow a purely pharmaceutical approach? Or are they going to dabble with the Pandora's box of their 'inner world'? And if they do, what good can possibly come out of that? And even if it does, will it fix the symptom?

In the face of these questions, the counsellor's rootedness and faith in a holistic and relational psychological perspective is only too easily lost. On what basis are counsellors going to stand up for the reality of *psyche* in illness, considering their lack of status in the medical hierarchy?

Unless counsellors have one foot firmly planted beyond the culturally dominant dualisms, they wisely restrain themselves to one half of the psycho-somatic divide, and hope that any shifts on the emotional level will in time filter through to the somatic of their own accord. And often, that does happen and is, indeed, good-enough.

There is, then, no generally valid answer to your question, as everything depends on the relationship between counsellor and client. It depends on the depth of the client's split and the intensity of their pain (as well as their beliefs and capacity for a commitment to the process), and the

capacity of the counsellor to meet and contain that pain (as well as the degree of risk the counsellor is willing to take). That, in turn, depends on the personal-professional support we can give counsellors, theoretically and practically, and their own commitment to continuing professional development.

To start with, counsellors in GP practices need recognition that they are working in the body/mind war zone which is also a territory of paradigm clashes. They are doing a very difficult job at the psychological frontline of the health system (which is not always beneficial to the counsellor's own health, we might add). And - within the limitations of the psycho-somatic divide - they are usually doing a pretty good and undervalued job, as well as giving badly needed emotional support which GPs do not have the time to provide to that extent. So even without challenging the dualism at the root of that divide, counselling does fulfil an important function. However, to make a serious impact on the many psychosomatic challenges we are facing, that dualism needs to be recognised and tackled. Even though interest in the body/mind is increasing, a vast potential remains untapped. Holism is becoming fashionable, but usually in the context of a complementary practitioner advising and functioning within the framework of a holistic theory, but otherwise relating and 'treating' the patient every bit like a medical expert. Whilst these therapies may be helpful and precious (and I am a patient in quite a few of them myself), they do not necessarily facilitate the client's awareness of their emotional process, nor help them explore the psychological subjective meaning of illness, let alone open out the possibility of symptom as symbol.

Building on the 80-year old tradition of Body Psychotherapy, which is one of the very few *psychological* approaches that have addressed the body-mind split, holistic concepts and methods are now beginning to be developed which *can* bridge the psycho-somatic divide and work with body and *psyche* and mind in a way which does not segregate them or absolutise any one of them. More importantly, there are now integrative ways of working which attend to the underlying wholeness of the person in a way which works *with the relationships between physical, emotional and mental aspects*. In the course of such an exploration, the client can discover layers of meaning in illness which cannot be proven, but which fundamentally transform not only their illness and their relationship to it, but other aspects of the client's life as well. With hindsight, it can then appear as if these changes in the client were called forth *through the illness*, if - and only if - its possible inherent meaning could be attended to. The client will then say quite unequivocally that their illness has or had a meaning for them.

So, in summary, when is it appropriate to say that physical symptoms may have psychological and emotional roots?

The cheeky answer is: when the client's unconscious thinks so (i.e. almost invariably). The safe and defensible answer is: whenever the client's symptom is sufficiently severe or chronic to have activated an emotional reaction pattern (e.g. a habitual stress or trauma response) which now exacerbates the symptom and interferes psychologically with treatment and healing. The radical and counter-cultural answer is: always (at least as a counsellor or psychotherapist, sensitised to the neglected and hidden power of the psyche, I always want to stay alert to the possibility and engaged in what can always become an ever-deepening exploration).

## **2. You talk about a paradigm clash between counselling and the medical model. Please can you say more about this?**

In my opinion this is one of the most confusing, confused and un-integrated areas of counselling and psychotherapy as we know it. The overall ambivalent position which we find ourselves in vis-à-vis the 'medical model' goes back all the way to the conception of our field in modern form through Freud.

Years ago, Emmy van Deurzen-Smith suggested that counselling is providing those emotional functions in society which were traditionally taken care of through the intuitive art of mothering, and that counsellors are now called to do the same thing in a scientifically accountable and validated way. This is a compelling argument, and I have no doubt that counselling and psychotherapy *do* acquire that social function.

But I argued at the time (Soth 1997) that whilst it may be true that we are seen as 'the mothers' *by the public*, this may be not be a definition of our profession which it is wise to identify with *for ourselves*. For a start, as feminism has helped us recognise over the last few decades, mothers attract both impossible idealisation and irrational hate and contempt.

Critics of counselling, as for example psychiatrist Raj Persaud, have exploited this collective projection of 'Mother' onto counsellors by characterising the stereotypical counsellor as ineffectual and woolly-minded, blindly lost in a world of undifferentiated, merged feeling.

"There is no coherent theory, and no evidence that it works." "Full-time counsellors will say they do it because they are interested in people - certainly one rarely feels that they are engaged in a demanding intellectual pursuit." (Persaud 1997)

Identifying with this stereotypical counsellor-mother - as opposed to the superior doctor-father-psychiatrist - does not really help us in the long run, not as a profession in the public eye, and not in the consulting room with our clients. It just gets us trapped in the mother transference, both with the individual client, and with the public in general. And the part of van Deurzen-Smith's thesis that I argued against most strongly is that - based on being identified as the feeling-dominated, woolly-minded mothers - the onus is on us to validate our work scientifically by the parameters and standards of the superior fatherly 'medical model'.

Within the field of counselling and psychotherapy all kinds of attitudes to the 'medical model' co-exist side by side, usually with the left hand not knowing what the right hand is doing.

Some therapists see their practice firmly within the scientific paradigm, construct their therapeutic position as indistinguishable from a medical expert, and denounce everything else as unprofessional. Some therapists vociferously maintain that *any* 'medical model' attitude on the part of the practitioner is fundamentally inimical to the therapeutic process and will abort the authentic meeting which they see as the core of the therapeutic encounter. The psychodynamic tradition typically hovers in between those extremes, sometimes embracing the ambiguity, sometimes unconsciously acting it out.

I have written elsewhere that whilst psychological therapy cannot fully subscribe to the 'medical model' without losing its essence, neither can we avoid or exclude it without restricting the therapeutic space. Ultimately, this is one of the inherently paradoxical aspects of our profession. In order to make that paradox work in a way which facilitates the client's process, we need to embrace our inescapable conflictedness as practitioners between these mutually exclusive allegiances.

What is the relevance of the paradigm clash on the level of everyday practice? In simple terms: practitioners of the different helping and medical professions get into polarised positions and misunderstand each other. They use different languages, they understand and interpret apparently common jargon terms differently, they focus on different aspects of the patient's reality, they use different faculties in their work, they pursue different goals and priorities.

One fairly neat dividing line to polarise around is in terms of objective, exterior, observational descriptions and subjective, interior, relational descriptions. Each practitioner can be talking about clearly relevant 'clinical data', but within such a polarisation the 'twain shall never meet'. This can be deeply painful, frustrating and undermining of both practitioner's feeling and motivation at work.

Every counsellor working in a GP practice I have ever talked to has been able to effortlessly illustrate that general point with examples from their own experience. In many practices a productive co-existence of medical and counselling practitioners side by side seems to work fairly well.

But do doctors really understand what counsellors get up to with the patients they refer? Cynics suggest that GPs accept the presence of counsellors in their practice not because they appreciate and support that other paradigm, but because counsellors take the heart-sink patients off their hands in a cost-effective way. The upshot for counsellors is: you cannot take it for granted that your work is understood even by a sympathetic GP. On the whole, I think for counsellors to explicitly understand and embrace the inherent paradigm clash, and to face it realistically, is more affirming and supportive of their work within medical practice than coming up against it again and again as if against an invisible brick wall. Explicit awareness of the paradigm clash does not necessarily make for an easier life, but then that is usually not why counsellors got into the work in the first place.<sup>1</sup>

But I want to make it clear that - although I think it is important to recognise the paradigm clash as pervasive and ubiquitous - for myself I do not make an ideology out of it. Having clarified it, we can then also recognise the many ways in which it is being addressed and worked with: there is, for example, in the pioneering work of Michael Balint a well-established tradition of bridging the medical and psychological domains in the UK which many GPs will have come across or at least heard about. And General Practice keeps the medical practitioner involved with the messy frontline in a way which demands pragmatism and realism - over time GPs develop perceptive insight into the psychological dynamics of their patients, even if there is no explicit space or structure for applying these perceptions.

In simple terms, there *is* a paradigm clash, but as a therapist I do not have to subscribe to it or feel trapped by it. As psychological practitioners we do not have to *act into* the split just because we recognise its existence. We do not have to *believe in it*, nor do we have to exacerbate and perpetuate it - we can *work with it*, and treat it as we do any emotional split which has defensive and protective functions.

But we also need to be realistic about the capabilities of our own profession. As yet, we are not qualified to reach beyond the emotional domain, even if we can see the limitations imposed on us by our one-sided, un-integrated position within the paradigm clash.

Counselling in its current form (including theory, technique and meta-psychology) cannot have more

than a haphazard effect on physical symptoms. It just does not have the conceptual and practical tools to do that. If we want to do justice to our intuitions of a more holistic, integrative perspective, we need to work on ourselves and our own practice, to expand it in such a way that it a) can address the body and the mind and the relationship between them, and that it b) can embrace the full range of therapeutic positions between authentic meeting and professional 'quasi-medical expert and the tensions between them.

### **3. The concept of 'wholeness' seems to underlie your approach. Why is it so important to healing?**

It is a concept, but for some of us it is much more than that, too. You may remember that interview with Jung when he was asked: "do you believe in God?" and he answered: "I do not believe - I know!" The same might be said for 'wholeness' (which - to Jung's mind - is probably not that far away from God, anyway). The idea of 'wholeness' is irrelevant unless we can experience it, unless we can feel something like it in our bones, pulsating through our flesh, running through our mind, containing our *psyche*, informing our relationships. But it's an important idea because Western civilisation has all but forgotten about it and is busy proving it never existed and never will. However, we can't help longing for it. We can't eradicate the idea, the fantasy, the notion of it, nor the impulse to seek it. People often say, 'wholeness' is just an idea - it's not 'real'. Just because we can't point at it with a finger or break it with a hammer, does not mean it does not exist. Mathematics is full of ideas which nobody has ever set eyes on or filled their stomach with, but nevertheless it is granted with the capacity to provide a powerful 'theory of everything'. Like all ideas, 'wholeness' can be misunderstood and misused. With that proviso, what could be its place and use in counselling? It could fruitfully be argued that irrespective of the presenting problem and the client's stated reason for coming to therapy, what they are really seeking is their lost and/or as yet un-realised 'wholeness', or at least small bites of the cherry.

This way of constructing the counsellor's task usefully generates enormous dilemmas for ourselves: we put ourselves into a position where we champion some potential in the client which they do not even know they have. Without knowing it, they are drawn to counselling as a relational space which holds out the promise of complementing and balancing their habitual one-sidedness and limited identity, potentially ushering into an unsuspected sense of wholeness. But that automatically also threatens their existing identity, and the counsellor is faced with the impossible question of whose side to take: the side of potential wholeness or the side of the existing

identity (which in many ways is doing its damndest to avert and abort any coherent manifestation of wholeness)?

Jung, who is one of the psychotherapists who have chewed this through most thoroughly, believed that 'wholeness' pulls us toward it like an instinct, that we are driven teleologically. But, as any goal or 'absolute', 'wholeness' lends itself to endless idealisation, disappointment and misunderstanding and thus covers a multitude of sins. Therefore, Jung was at pains to distinguish the drive towards wholeness from the obsession with perfection.

One of the manifestations and intimations of potential wholeness which chronically and most painfully eludes us in our culture is 'body/mind integration' - the experience of the body/mind as whole, but differentiated. Without that experience, it is next to impossible to have faith in the self-organising forces at the root of both health and illness.

### **4. You talk about three 'cultural blocks' to our regaining wholeness. Please can you say more about these and how they can be transcended?**

That distinction you mention was just an arbitrary list for heuristic purposes. I am sure I could find more than three cultural blocks to wholeness! But in terms of working with illness, for the purposes of a presentation to counsellors working in the health system, I identified three dominant issues which we are confronted with every day in working with patients. And with regard to each of them, the field of counselling is nourished by some implicitly counter-cultural notions which feed into our work and give us - so to speak - a leg to stand on.

I called these three cultural restrictions:

- a) pain-phobia = objectification = "fixing" = addiction to avoidance of pain
- b) mind over body
- c) literalising 'flatland'

I will briefly address each one in turn:

#### **a) Pain-phobia**

Our culture is obsessed with medically and self-administered pain-relief. The slightest discomfort provokes a sledgehammer reaction towards anaesthetising, numbing, de-sensitisation. This pain-phobia is also imported into the public preconception of counselling and psychotherapy which are assumed to have the same function and outcome, i.e. to *remove* emotional and mental pain. However, the counter-cultural intuition running throughout our field and implicit in most therapeutic theories and techniques is that pain and suffering are also necessary transformative elements in development / individuation. As

counsellors we are, therefore, always caught between trying to soothe unbearable pain and entering transformative pain, but even that attempt at a balanced position is already far outside the cultural consensus.

### **b) Mind over body**

Our culture takes for granted that meaning resides in 'mind over body': the mind observes, interprets, manages and controls the body. The concomitant assumption is that if there is any problem, then the solution is in the mind, through rationality, consciousness, will or understanding.

These Cartesian assumptions are also structured into counselling and psychotherapy (manifest as a bias towards insight, symbolisation, verbalisation, reflection, mental understanding), with the consequence that 21st century psychology is still operating with 19th century concepts.

On an everyday level, this 'mind over body' paradigm manifests very simply and is visible in our clients as an attitude of either ...

- 'negative' objectification: where the body is ignored and treated like an exploited slave, or ...
- 'positive' objectification = where the body is treated as a postmodern fashion accessory, i.e. as a substitute or advertisement of self.

For a more detailed exploration of these issues, please see my presentation to the 2004 UKCP conference: "What therapeutic hope for a subjective mind in an objectified body?", published by UKCP (see Soth 2006).

Modern neuroscience and complexity theory have boosted the counter-cultural intuitions regarding the body / mind which have always existed within complementary therapies as well as at the fringes of psychotherapy (e.g. Body Psychotherapy). They question the traditional conception of the body / mind as a hierarchical, top-down arrangement, with the 'brain-as-central-computer' controlling the organism. Instead, they see body and mind as related via mutually interlinked, reciprocal feedback loops, organised into a complex system, with consciousness and subjectivity existing *on all levels across the body/mind spectrum* (ranging from biochemical, neurological and muscular to emotional, imaginal and mental levels).

This perspective of the 'fractal self', as I call it in shorthand, takes us into a holistic and holographic universe where outer and inner relationship parallel each other: past and present external relationships are reflected in the dynamic processes occurring in and throughout the body / mind matrix, on the various levels and between the various levels. <sup>2</sup>

What's relevant here is that the physical or psychosomatic symptom...

- ... alerts us to the prior habitual dis-integration of our body-emotion-mind system (Wilhelm Reich's notion of 'character') *before* the symptom appears
  - ... bridges the mind and the body, the subjective and objective, the psychological and the biological and alerts us to and draws us into potential wholeness
  - ... can therefore be a gateway into transforming the dysfunctional relationships within our fragmented and conflicted body / mind system
- This is the cultural block which counselling itself is most limited by, and therefore needs to attend to most urgently.

### **c) Literalising 'flatland'**

Our culture is dominated by a reductionist materialism which engenders an obliviousness to what Hillman has called "the poetic basis of mind", i.e. the imagination. This manifests in a tendency to concretise and literalise our perception of reality, reducing the mysteries of the human soul to an epiphenomenon of brain chemistry. In what Wilber has called "flatland", where evolutionary theories imagine human depth, interiority and creativity as "frisky dirt", there is no such thing as an unconscious and no room for emotional, relational, psychological meaning, certainly not in illness. It is this culturally dominant disconnection from symbolic reality and the incapacity to apprehend the symptom as symbol, which provoked Jung to say: "the ancient gods have become diseases."

Again, much of our profession is already thoroughly informed by counter-cultural intuitions in this respect, which is partly why counselling is both so titillating and fascinating to sensationalist media, and so dismissed, misunderstood and ridiculed. As counsellors we know about the therapeutic potential of human attention which opens out access to subjective and interior reality. Beyond that, we discover layers of experience that take us into the depths of an inner world which turns out to be just as 'real' and influential as concrete, rational reality is to the rest of the culture. The intuition of the symbolic processes at work in the unconscious is one of the main tools of our field, and there is no hope of approaching meaning in illness without it.

## **5. Why do you describe counselling as 'the relating cure'?**

If Freud was alive today, I believe he would be into *relational* psychoanalysis and psychotherapy. To him, in terms of the *zeitgeist* of his time, talking was equivalent with relating, and so psychoanalysis got nicknamed the 'talking cure'. But as has been suggested before (Totton "Water in the Glass"), Freud was grappling towards ideas which he

would have needed the language of information and systems theory to adequately express, so we have to make some allowance for a possible gap between *what* he is saying, *how* he is saying it and *what* he is referring to.

On the question what Freud really meant to say, Freud's followers themselves are, of course, deeply divided: a polarisation continues to exist between drive theory and object relations (as elucidated two decades ago by Mitchell and Greenberg in "Object Relations in Psychoanalytic Theory").

This polarisation is often presented as two mutually exclusive traditions of psychoanalysis, but I think there is more mileage in seeing that polarity itself (between drive and contact, between biological instinct and social attachment) as essential to our practice. At the risk of oversimplifying, the two terms 'cure' and 'relating' could be seen as representing these polarities within Freud himself, within the tradition of psychoanalysis and in all of us.

We all work within the tension between the instinctual and the rational, the social and the 'natural', the body and the mind, the relational and the objectifying stance, to name just a few. And in our practice we do justice to these tensions in varying degrees and with varying degrees of explicit awareness or theoretical reflection. Some of these tensions we may be doing justice to *in spite* of ourselves and our theoretical orientation. So the gap between what we do and what we say we do exists not just within Freud, but obviously in each one of us.

It may be true to say that we can recognise a tension in Freud between his 'medical model' aspirations, his hydraulic metaphors and mechanical theorising on the one hand, and on the other his delicate and incisive recognition of the ground of subjectivity and intersubjectivity in the unconscious. In that sense, Freud can be read and applied quite readily both in an objectifying, biological and reductionist perspective (i.e. = cure), and - equally valid - in a relational, psychological and even hermeneutic fashion (i.e. = relating) (Ricoeur).

But rather than demanding that Freud be consistently one or the other and resolve the tension for us, we can use his version of these polarities to shed light on our own conflicts, not because these conflicts are professional shortcomings in terms of theoretical clarity, but because they are necessarily inherent within the therapeutic position. Whoever said that there was supposed to be a simple, linear, logical theory and procedure to our work?

All of the above tensions can be experienced and conceptualised as irreconcilable opposites (ontologically given, i.e. the human condition), or they can be apprehended and lived as creative sources of developmental process. One of Freud's achievements is the recognition and formulation of

the depth and intensity of 'splitness' which human beings can be subject to. Responding to this 'splitness', to this 'divided self' in another person, and being committed to the pain inherent in it, is a profoundly challenging endeavour, fraught with contradictions. As I have tried to express elsewhere ("Psychotherapy: paradoxes, pitfalls & potential", *Self & Society*, 30(6), Feb/Mar 2003, p.34 - 44), I see the therapeutic position as necessarily conflicted, and the term 'relating cure' neatly puts us between the hammer and the anvil of the profession's essential paradox.

## **6. But there are difficulties with this concept, aren't there?**

Well, as I said, there *is* a paradoxical tension between 'relating' and 'cure' - counselling and psychotherapy live and breathe and exist in that tension. The difficulty with that concept is not in the concept, it is *with us* because we do not like living the tension of the paradox. The field of counselling and psychotherapy is rife with all kinds of manoeuvres to minimise or override or short-circuit that tension.

How can you be - at the same time - an empathically attuned fellow-human, identifying with the client's woundedness and relating to it, AND at the same time appear as a quasi-medical expert, hopefully as uncontaminated by the client's pain as possible and obliged to eradicate that same woundedness?

The client's idea of cure hinges on denial, and relating depends on the therapist *not* succumbing to the denial, so it seems it's either 'cure' *or* 'relating'. It's a tall order doing justice to both sides of that conflict. But it is a conflict which the counsellor is required to enter and bear and survive, *if* a 'relating cure' is to occur.

In short: the difficulties with the concept quite nicely reveal the inherent difficulties of the counsellor's job, which in turn reflect the patient's difficulties in life, internally and externally. I do not want to enlarge on this here, but I see the counsellor's conflict as necessary mainly because the patient - in their inner world - usually suffers an equivalent of that conflict in an unconscious and implicit way. The conflict is structured into the client's body/mind existence as various degrees of psychic and often primal, and therefore invariably avoided, pain. When we can rest in the paradox of the 'relating cure', 'relating' and 'cure' are BOTH utterly and irreconcilably opposed AND perfectly reconcilable relationally.

Another way of formulating the difficulty inherent in the idea of a 'relating cure', more immediately relevant to counselling in primary care, is through the patient's expectations of the counsellor as a 'doctor for the feelings'. Having been referred by the doctor, patients see the counsellor as an extension of the doctor, operating by the same

treatment principles and in possession of the same power over life and death on an emotional level as a 'god-in-white-coat' is presumed to be on a physical level.

This pushes the counsellor into a corner in which they feel appropriately helpless and inadequate. In psychodynamic terms, we might try to understand this as an instance of projective identification: the patient's unconscious is letting the counsellor know that an early experience of helplessness is constellated and that somewhere the patient feels at the counsellor's (and the symptom's!) mercy. This infantile reality is significantly at odds with the patient's explicit communication which can be frustrated, angry and demanding. The patient's demand for a medical-style 'cure' both reveals and occludes its own source: the demand both expresses and denies the reaching for a 'transformative object' (which - by definition - *can* cure through relating). What is simultaneously being conveyed on a primitive level is both the longing for that 'transformative object' to appear and the disappointment that it doesn't. Moreover, the angry demand is based on an underlying resignation that it ever can and will be forthcoming. This understanding links the counsellor's apparently irreconcilable conflict in the face of the patient's impossible demands for cure back to its roots in infantile relatedness. That does not make the patient less angry or frustrated, but it can give our therapeutic presence more depth and compassion in response.

## **7. Why might a 'relating cure' be expected to work with physical and psychosomatic symptoms?**

Modern neuroscience has established a link between emotion and anatomy: emotionally-attuned relating in the infant-mother dyad affects and conditions the development of the baby's brain. That means psychology and biology are now mutually interlinked - at least it's now recognised as a two-way street.

One of my pet hates is the unscientific way in which scientists have traditionally tended to reduce the *mutual* influence between psychology and biology to a one-way street. They notice a statistically significant link between a physical fact on the one hand (e.g. eating chocolate or the quantity of serotonin), and what they consider a psychological variable on the other (e.g. depression or aggression), and in a professional sleight-of-hand which ignores the achievements of a couple of millennia of scientific logic, short-circuit to the assumption that one caused the other: obviously biology must have 'caused' psychology - full-blown reductionist materialism without even announcing itself as such. The conclusion then is just as self-evident: alter the biology through administering significant doses of expensive

chemicals, and - whoopee! - you've altered the patient's psychological state.

Any 11-year-old can tell you that if you have two statistically linked variables A and B, that there is more than one logical possibility regarding their connection: it may be that A caused B, but logically it is just as possible that B caused A, or both are caused by an unknown third C. Not so when it comes to the biochemical 'causes' of psychology. Every day, in every newspaper I happen to investigate, I find at least one occurrence of this 'professional foul' presented as scientific breakthrough and trashed out to millions through the media.

And psychological practitioners themselves, including counsellors, often swallow this kind of thing wholesale. It regularly annoys me, and I have not even started yet on multi-causality, synergism or non-linear causality in complex systems. Well, to the extent that modern neuroscience has any clout in psychology, this kind of thing should really not be allowed any more: we now know that intimate relating (or equally its absence) should carry a health warning - it can seriously affect your physiology and brain chemistry.

This is, of course, the old nature - nurture debate, but the crucial thing is that the boundaries of what was once considered 'plain nature' (i.e. genetically determined, 'given' biological reality) are being pushed back. There is less and less 'plain nature', less and less biology uncontaminated by psychological and social context. This goes well beyond neuroscience: there are serious studies which suggest that gene activation and gene expression can be initiated and influenced by your state of mind. That means, whether your body/mind activates and accesses certain genetic potentials, may depend on your emotional development and your consciousness (which, of course, in turn depends on your anatomy and physiology).

This may give us the idea that in the complex system which is the human body/mind biological and psychological processes are interlinked in mutually reciprocal, endlessly interdependent feedback loops. That does not solve the nature - nurture debate, but it fundamentally changes the previously one-sided terms of engagement and discussion<sup>3</sup>.

So, generally speaking, we are now scientifically entitled to at least not dismiss out of hand the possibility that therapeutic relating may affect physical and psychosomatic symptoms. But that - unfortunately - opens out another minefield. If therapy can have physical effects, should we not be required to give an account of our practice in these terms? If our practice can affect the body, are we then not straying onto forbidden territory which is considered the province of science - can I satisfy the regimes and ethical requirements of such activity? I am sorry to say that in normal everyday

practice I fall miserably short of this. Much as I would like to, I am utterly incapable of giving causal explanations for these phenomena, covering physiology, brain chemistry, endocrinal pathways, neuropeptide distribution, autonomic nervous system activation and how they each influence and are in turn each influenced by the client's feelings and their unconscious, ideally including transference reactions. I would dearly like to be able, at least, to explain the functioning of the immune system, sensitive as it is to both emotional and physiological processes and mediating between them, and therefore a prime candidate for investigating the connection between psychology and illness. The discipline of psychoneuro-immunology is forging ahead in precisely that abundantly rich vein of investigation. But personally, apart from reading Candace Pert's "Molecules of Emotion" (1997), I have to admit that not one of my clients has so far benefited from such understanding.

I take heart from the fact that no other discipline, especially when applied to human suffering and wellbeing, can boast any more accomplishment. Economics, sociology, ecology, meteorology, genetics, even medical science all operate without understanding the complexity of the systems they investigate and interfere with, and the most experienced and wise protagonists of each discipline frankly admit this. In a participative universe, intervening in any complex system is more like white-water rafting than paddling from point A on one side of the pond to point B on the other. Scientific oversimplification of non-linearity into a close approximation of straight lines has had many benefits, but it has also engendered a kind of arrogance and over-blown faith in gross human models which do not work at all well in times of turbulence - that recognition was one of the origins of chaos theory.

Regarding the two-way street between emotional relating and the body in therapeutic practice, I humbly suggest that this applies to all human contact, and especially to its absence. I therefore think it's unlikely that the government will prohibit all further relating until we have a suitable scientific theory describing comprehensively the holistically interlinked nature of relating and the body and its dangers and vicissitudes.

In practice, I have no omniscient model to describe the connection between feelings and body, nor between meaning and illness, nor can I omnipotently predict the precise effect of my interventions, on my client's body, feelings or mind.

In spite of this, I can assure you that none of my clients, after a certain amount of time, has got the slightest doubt that their therapy affects their body and their symptoms, not always in a pleasant or comfortable way, I hasten to add.

And they do come to expect quite naturally and legitimately, as a result of previous experiences where their body has reacted quite profoundly to a session, more of the same. I consider this a healthy expectation, and usually this kind of faith in the process and surrender to it as a body / mind dynamic quite effortlessly supersedes the client's demands for a specific 'cure'. But the client can indeed emerge feeling 'cured', sometimes in spite of the fact that some of their symptom persists. The more I can suffer the paradoxes of my omnipotence as a therapist, in both its legitimate and absurd manifestations, the more the client may find their - potentially deeply satisfying - power to be with their own fragility and mortality. By the end, they hopefully are 'cured' from any deep-seated, defensive and omnipotent notion of 'cure' - which can then drop away as irrelevant.

I have taken pains to deconstruct the idea of 'cure' and to try to reveal the paradox at the heart of it. As I said above, we cannot fully subscribe to it, nor can we afford to dismiss or exclude it.

The more we transcend the underlying medieval dualism between body and mind, reflected as a dualism between psychology and biology, the less this question of how one affects the other continues to get in the way.

## **8. Might you go further to say why traditional 'cures' can sometimes be counter-productive in the context of chronic illness?**

If illness has, or at least acquires, emotional-psychological meaning, then symptom-reduction and symptom-removal can - in simple terms - be categorised into two kinds of 'cure': as doing justice to the inherent meaning on the one hand, or as overriding that meaning on the other hand.

That latter possibility is obviously the one we need to be concerned about. There is a sheer endless list of examples, where the symptom can actually be seen not as a manifestation of the illness itself, but as a by-product of the body's self-healing process *in response to the illness*. Suppress the symptom, and you interfere with the healing process. As a simple example, fever can be seen like that, but my guess is it applies to most manifestations of pain. By killing the messenger, pain killers - apart from constituting a major hidden addiction in the culture - help us override the problem, thus ensuring that it grows bigger and more virulent. Homeopathy criticises allopathy with a similar argument: by overriding the symptom and self-healing processes, it contends, the pathology is driven deeper, and becomes more hidden, less accessible and more dangerous. Such symptom-removal based on suppression is therefore bound to create more virulent symptoms later, and should not deserve the name 'cure' within any more long-term holistic perspective.

Now let's use this principle not just in relation to the body, but extend it to the whole body/mind where it gets infinitely more complicated. The established psychoanalytic notion of somatisation implies that a physical symptom can have a psychologically defensive function, i.e. avoidance of a particular feeling<sup>4</sup>. So the question then is: what does removal of the symptom imply? Does the feeling get felt and appreciated?

There is a whole complicated minefield here regarding the biochemical management of psychological pain and the question of who it is that cannot bear it. This applies, for example, to the drugs given to children diagnosed with attention deficit disorder. We are breeding a whole generation whose aliveness gets labelled as restless, and whose pain and protest apparently disappears from view, only to re-appear in 20 years' time in the most destructive fashion.

In 'flatland', the children's diagnosed restlessness can be treated as without meaning, although it clearly 'means' a lot, to the point where it needs to be eradicated. Don't get me wrong: I *do* have sympathy for parents who are finding their child impossible to deal with. But I shudder to think what unconscious messages are being internalised by the kids, under the guise of there being apparently no psychological or relational message at all.

Anybody who has any sympathy at all, needs to attend to, and help those affected – parents and children – attend to, the symbolic realities which are being massacred in 'flatland'.

There is a simple way of expressing this: a part of the client's soul *lives in the illness* – on an unconscious level the client is identified *with* the symptom, just as much as they are consciously identified *against* it. This is rarely understood. The psychological meaning and the emotional 'lessons' of illness cannot possibly reveal themselves as long as we are exclusively engaged in a fight *against* the illness. Fighting the symptom can – at times – be a functional and therapeutic response (and it is therefore included in the eight stances in relation to the symptom – see below), but as a habitual, automatic and sustained reaction it is inimical to symbolic processing and psychological understanding.

Russell Lockhart in his book "Words as Eggs" gives a beautiful illustration – it's not quite a case of 'operation successful – patient dead', but of 'symptom successfully removed – patient's *soul* dead'.

## **9. I was fascinated to hear about your eight ways of relating to the symptom. Please can you say a little about each of these?**

As long as the culture is pervaded by the 'European Split' and its aberrations and rationalisations, we cannot expect our health system to be anything but suffused by theoretical, philosophical, interdisciplinary and institutionalised splits. Unless I can live – and by my own presence model, demonstrate and communicate – the possible integration of these splits, I am not in a position to complain or condemn. As I have indicated, I believe that there are concepts and techniques emerging in the field of counselling and psychotherapy which allow some degree of integration in our practice, especially between body and mind, biology and psychology, as well as between relational and medical models of therapeutic relating.

From a more embracing integrative perspective, the fragmentation of the field with its schisms, dogmatism and tribal parochialisms appears as a rich plurality, reflecting the competing realities in the client's inner world. The different therapeutic modalities which exist within the field can be seen as doing justice to different aspects of the proverbial elephant. Each therapeutic approach is sensitive to different aspects of the human *psyche* in all its richness and contradictoriness. Each approach tends to exemplify and emphasise different forms of relating, interpersonally and intra-psychically by addressing particular splits in the patient and the pain inherent in them, even whilst being oblivious to others.

The question is: how do we bring the diversity of the disintegrated field to bear on the client's own fragmented wholeness? How can a disintegrated field facilitate an integrative process?

I think only by owning and surrendering to our own woundedness, both personally and professionally, and by gathering the fragments of our own partiality.

So I proceeded by assuming that everybody is right in some essential, albeit partial way, and catalogued the different relational stances which I saw clients taking in relation to their symptom and which I saw therapists offering to their clients as well as to the symptom. If *relationship* is the essential core of our profession, then such a categorisation based on relational positions might make more sense than a differentiation based on theory or technique.

In order for it to remain accessible, I narrowed the list down to eight stances, and called them:

1. denying,
2. fighting / contradicting,
3. listening,
4. understanding,
5. following / amplifying,
6. containing spontaneous conflict,
7. belonging,
8. dialoguing.

To go into each of them, would require a longish article in its own right. Let me just say that I assume that *each* kind of relationship can be helpful, functional and transformative or defensive, dysfunctional and counter-therapeutic, depending on timing, context and the client's habitual patterns.

If there is 'meaning' in illness, the symptom as multi-dimensional symbol deserves an appreciation of *all* the relational possibilities. We cannot assume that the psychological significance of a symptom has been grasped fully unless *all* have been explored.

Generally speaking, I placed the different relational stances along a spectrum from total denial of the symptom to increasing acceptance of relationship to the symptom. Once I accept – whether I like it or not – that I *am* inevitably relating in some sort of way to the symptom, we can distinguish different degrees and depths of engagement in that relationship. Although a rough idea of progressive deepening across the spectrum is implied (with deeper ones not fully available until earlier ones are integrated), this is not at all a linear or strictly sequential hierarchy.

The main aim of this integrative spectrum of relational stances is not academic or theoretical accuracy, but usefulness for training purposes. Whilst the existence of these - often contradictory - relationships to the symptom can be quite easily recognised, in order for the counsellor to feel able to work with them, explore them and do justice to them (in the client *and* in the therapeutic relationship), familiarity with a range of therapeutic modalities, approaches and techniques is required.

Theoretically we can associate different kinds of relationship to the symptom with different therapeutic models and practices. But there are many reasons why the correspondence between relational stances and therapeutic models is not at all straightforward, and that's why in training I keep the focus on the counsellor's relational stance rather than these misleading correspondencies. We are so used to polarising and taking refuge in our respective approaches, that we lose sight of the parallel process I mentioned earlier: the main source of the counsellor's conflict is the client's conflict and pain, *whatever* the counsellor's approach.

This becomes relevant especially when we work across the body/mind or the psycho-somatic divide.

To feel confident about meeting the symptom in an appropriate fashion, the counsellor ideally needs:

- ... to be able to access and perceive the 'European Split' within themselves, the client and their established way of working
- ... to have all modes of relationship and all therapeutic models available
- ... to not be dogmatic or biased about *any* of them, but reflect on the actual relational effect the different modes are having on the therapeutic relationship

To my mind these would be the main aims of counsellors' further development, especially for counsellors in primary care.

## **10. What does counselling – and in particular, your approach to counselling and psychotherapy – have to offer the clinician as healer ?**

Hopefully I have said *something* about this in the above. When we recognise how split and fragmented the field of health care is, between biological and psychological, between objective and subjective, between treatment and relationship, to name just a few of the endemic illnesses of the field, the *onus is on us as counsellors* to get beyond the splits. It's no good exhorting the other professions to become more inclusive of *our* paradigm. We need to start from our corner of the field, on our patch, doing justice to our principles of relating, of emotional intelligence, of subjectivity, but beginning to do justice to them in a more holistic fashion which bridges the splits. The other professions will then take notice, because fundamentally they will want what we then have. We already do have a good chunk of it - a chunk which their own paradigms and disciplines make it usually personally and professionally impossible for them to understand. But we need to expand our own work in a way which models a more comprehensive embrace of the physical and the mental, the biological and the psychological. As we are tackling fundamental splits embedded in the culture, including within ourselves, this places high demands and intense challenges on our own continuing professional development, and not every counsellor needs to or will want to pursue this. Illness is the painful route into this conflicted territory of the body/mind, so counsellors in primary care are the prime candidates for this development.

In bridging the biological and the psychological, we can take support from within science through the now fashionable discoveries of modern neuroscience. But we need to be careful not to get taken in by its exclusively objectifying stance, but remain true to our own homeground in subjective, emotional relating and its inherent subjective-objective ambiguity.

## The eight ways of relating to the symptom © Michael Soth

<i>Relationship to symptom:</i>		<i>Message to Symptom:</i>	<i>Symptom understood as:</i>
1	denying	"You don't exist !"	... overwhelming / traumatic
2	fighting / contradicting	"I want to get rid of you !"	... random / without meaning
3	listening	"I am willing to pay attention to you."	... needing attention / care /nurturing
4	understanding	"I want to understand <i>your</i> message to me."	... unconscious conflict / stress & anxiety / unlived aspect of self
5	following / amplifying	"Let me understand you on <i>your</i> terms."	... a held or repressed feeling / impulse
6	containing spontaneous conflict = identifying both with <i>and</i> against	"I surrender to you being me and to being in conflict with you."	... conflicted r'ship = internal(ised) object relation in context of client's habitual pattern
7	belonging (part of family system)	"I embrace you as part of my family."	... systemic identification / entanglement
8	dialoguing (ego-Self axis)	"I am committed to being married to you."	... edge-figure / shadow / unlived aspect of Self / archetypal force

### References:

- Bollas, C. (1987) *The Shadow of the Object - Psychoanalysis of the Unthought Known*: Free Association Books
- Damasio, A.R. (1994) *Descartes' Error*. New York: Putnam
- Greenberg, J. & Mitchell, S. (1983) *Object Relations in Psychoanalytic Theory*. Cambridge, Mass.: Harvard University Press.
- Hay, L. (1984) *Heal Your Body*. Hay House; 4 edition
- Lockhart, R.A. (1987) *Words As Eggs: Psyche in Language and Clinic*. Spring Publications
- Pert, C. (1997) *Molecules of Emotion*. London: Simon & Schuster
- Ricoeur, P. (1977) *Freud and Philosophy: Essay on Interpretation (Studies in National Policy)*
- Ridley, M. (2004) *Nature Via Nurture: Genes, Experience and What Makes Us Human*. HarperPerennial
- Schore, A. (1994) *Affect Regulation and the Origin of the Self*. Hillsdale NJ: Lawrence Erlbaum.
- Soth, M. (1997) "Collective Mothering and the Medical Model" - A response to Emmy van Deurzen-Smith's paper "The Future of Psychotherapy", *European Journal of Psychotherapy* 1997
- Soth, M. (2002) "What is 'working with the body' ? - A response to Maggie Turp's paper from a Body Psychotherapy perspective", *The European Journal of Psychotherapy, Counselling and Health*, Volume 5 (No2), p. 121-133
- Soth, M. (2003) "Psychotherapy: paradoxes, pitfalls & potential", *Self & Society*, 30(6), Feb/Mar 2003, p. 34 - 44
- Soth, M. (2004) "What therapeutic hope for a subjective mind in an objectified body? " - Presentation at UKCP Conference 'About A Body' Sept. 2004
- Soth, M. (2005) *Embodied Countertransference*. in: Totton, N. (2005) *New Dimensions in Body Psychotherapy*. Maidenhead: OUP
- Totton, N. (2003) *Body Psychotherapy: An Introduction*. Maidenhead: Open University Press.
- Wilber, K. (2000) *Integral Psychology*. Boston: Shambala

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- <sup>1</sup> If you do get into a polarisation with a 'medical model' representative, here is my recipe for handling the polarisation: do *not* fish for or expect yourself or your work to be accepted by 'Daddy'. Notice your felt identification with the patient and their often unheard emotional reality. *Trust* the other person's intention of care for the patient. Do not argue, listen! Try and get behind the words and inside the other practitioner's experience. If they express uncertainties or ambiguities (indicating psychological awareness), facilitate awareness of them. Help draw out awareness of the person's emotional intelligence, even if they do not think or talk in these terms. Every helping relationship is a *relationship*, and it emotionally affects *both* people. Support the other person in processing the effects of the relationship with the patient *on them*. In most organisations, the 'difficult' patient's inner world is manifested in the staff through 'parallel process': it is the patient's *inner conflict* which fuels and shapes arguments *about the patient*. There can be no resolution if the parallel process is not attended to by *somebody!*
- <sup>2</sup> For colleagues who are interested in pursuing these ideas in more detail, I suggest my chapter on 'Embodied Countertransference' in Nick Totton's 2005 book ("New Dimensions in Body Psychotherapy") which introduces the idea of parallel processes throughout the body/mind.
- <sup>3</sup> see "Nature *via* Nurture" by Matt Ridley
- <sup>4</sup> I happen to think that there are some serious problems about the way the idea of 'somatisation' is used, and the dualistic meta-psychology it is derived from, but that does not invalidate the phenomenon itself: physical symptoms *can* replace emotional ones