

It is a very remarkable thing that the Ucs. [unconscious] of one human being can react upon that of another, without passing through the Cs [conscious].
Freud, 1915:194

Introduction

The surprise in Freud's statement is an expression of the *zeitgeist* of his time: his conception of the relationship both between body and mind as well as between patient and doctor was steeped in 19th century Cartesian, positivistic paradigms. Since the 1930's Reich has helped us deconstruct the mind-over-body bias in ways which are being confirmed by modern neuroscience (Damasio 1994, Schore 1994, 2003). And since the 'countertransference revolution' of the 1950 (Samuels 1993: Chapter 2), modern psychoanalysis has come to appreciate the patient's and therapist's inner worlds as enmeshed and interwoven to a degree which radically deconstructs traditional assumptions regarding the therapist's role and function (Mitchell 2002, Samuels 1993). A further recent development is the notion of 'parallel process' (Hawkins & Shohet 2000, Searles 1999): not only can one person's unconscious communicate itself to the other person in the room, but the relationship dynamic between client and therapist can unconsciously be re-enacted in another relationship, i.e. between therapist and supervisor.

The body psychotherapy tradition has a refined body/mind understanding of transference (Reich 1972; Leites 1976; Mindell 1982; Conger 1994; Johnson 1994; Totton 2003). Modern psychoanalysis (including relational, intersubjective, object relations and self psychology approaches) has a refined relational understanding of countertransference (Heiman 1950; Langs 1981; Greenberg and Mitchell 1983; Mitchell and Aron 1999). These traditions have grown out of classical psychoanalysis, and a (re-)integration of their theoretical frameworks may generate an holistic phenomenology of relationship (Boadella 1987, Fairbairn 1958, Lowen 1958, Schwartz-Salant 1998, Winnicott 1971) see Fig. 1.

I will attempt to bring the two traditions together, without minimising their contradictions or reducing one to the other, by formulating both transference and countertransference, internal and external relationships in body/mind terms as parallel process. I will propose several fairly large-scale extensions to the established notion of 'parallel process', with relational dynamics being embodied and reflected on different levels intra-psychically and enacted interpersonally. This model allows us to consider 'embodied countertransference' as a cornerstone of an holistic, integral (Wilber 2000), relational framework which sees the therapeutic relationship as an intersubjective, culturally contextualised system of complex parallel body/mind processes. To make this abstract framework applicable and practical, I will focus on the therapist's stream-of-consciousness in relation to that system. As within any system, spontaneous processes of self-organisation (Maturana & Varela 1980) are always already occurring: we can attend to the body/mind phenomenology of the integrations and dis-integrations, the transformations and repetitive patterns of the system itself and the two people within it who are both wounded and whole.

How to apprehend, understand and facilitate these systemic processes is, of course, therapy's essential conundrum. How can I do this when as the therapist I am part of these processes, including my unconscious, my subjectivity, my countertransference? How can I facilitate a system when I am part of the system?

Clinical example

I will use one clinical example throughout the chapter, as reported by his therapist.

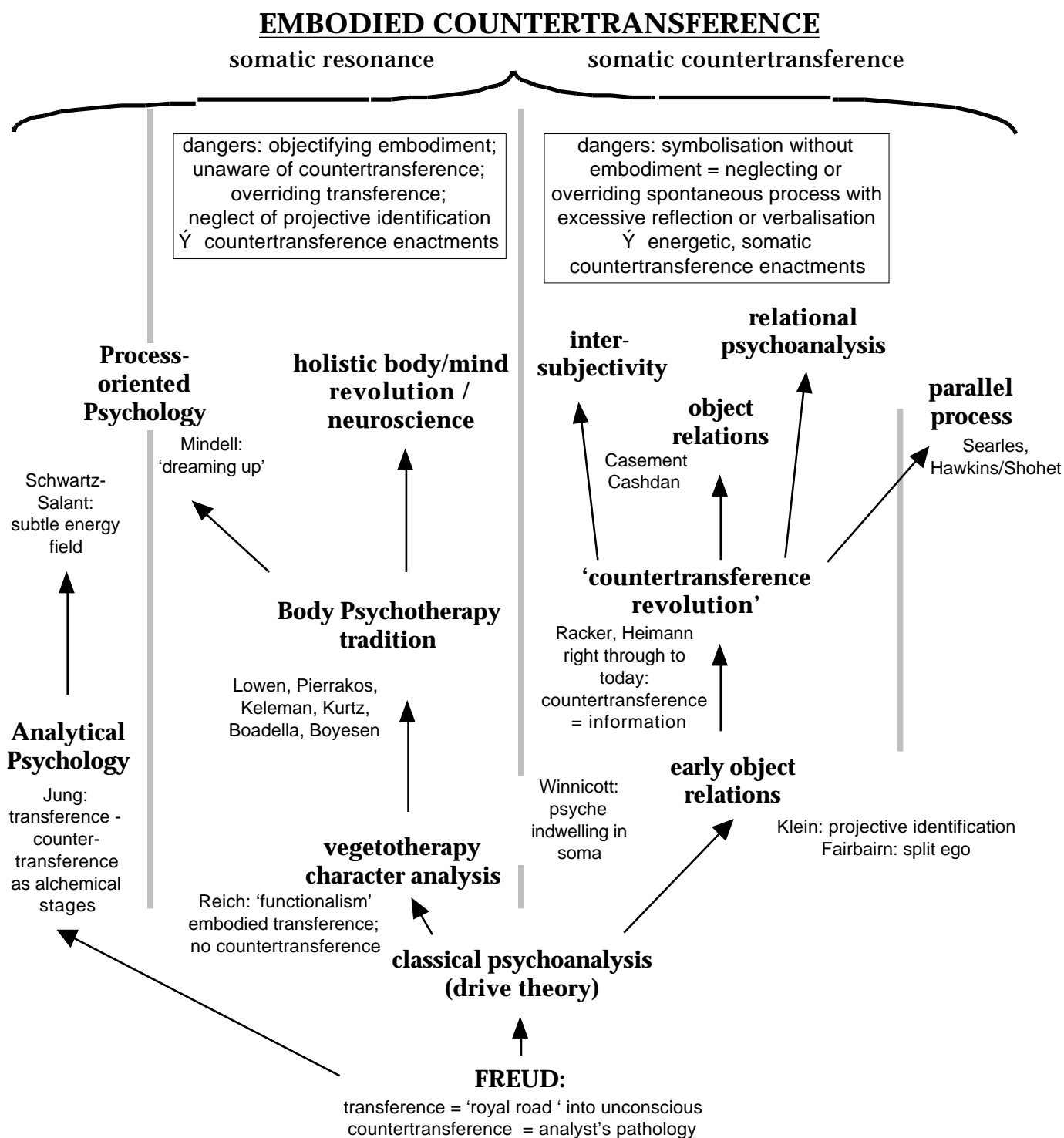
For several weeks, M. has been bringing issues around his job. Having talked about another incident at work, I saw M. feeling upset and felt moved. When I empathically mirrored his feeling state, he deflected by adding more detail about the story. We then got into discussing his role in the project, and he was able to consider the pros and cons of various courses of action. Throughout this, it was clear to both of us that his feelings are nothing to do with an actual lack of capability. We then establish that his sense of competence wanes at particular moments with his manager. But in exploring this, we reluctantly come to the same conclusion: his feelings cannot be explained within the parameters of the current situation. There's nothing about his manager's behaviour which would justify his reaction. However, as soon as I ask him about his feelings in relation to the manager, his eyes begin to dart about and he looks agitated and uncomfortable. He then says he is not thinking very clearly, but obviously feels under pressure to do so. He cannot explain his reaction to his manager, and feels ashamed about not answering my explorative questions succinctly. At one point M. looks tearful, and again I reflect this verbally. He says he is not aware of feeling tearful. I feel momentarily lost and unsure how to respond to his evasiveness.

M. is familiar with the idea that current feelings have antecedents in the life story. He volunteers a story about bringing home his exam results to his Dad, and how he feared his father's frustrated, intimidating reaction. This sounds like a valid and very relevant association, but throughout this I continue to feel uncertain myself. I remind myself to focus - as I was taught to do in such moments - on the essentials: what is the client feeling?

I remember my fleeting sense of his tears - it's now disappeared, but I am convinced it's the key thing. So I ask him: "what are you feeling now?" He suddenly lashes out and accuses me: "why do you always ask me about my feelings? I don't know what the hell I am feeling, and I don't think it's helping me you going on about them." I felt helpless and confused, so I am bringing it to supervision.

This vignette is not untypical in terms of what therapists might report after a session. It contains perceptions, thoughts, feelings, fantasies, about self and other - body/mind fragments of the therapist's stream-of-consciousness which are remembered after the session, especially for their emotional charge and significance.

Fig. 1: 'embodied countertransference' as a concept arising out of re-integrating the traditions of Body Psychotherapy and psychoanalysis



Transference as parallel process

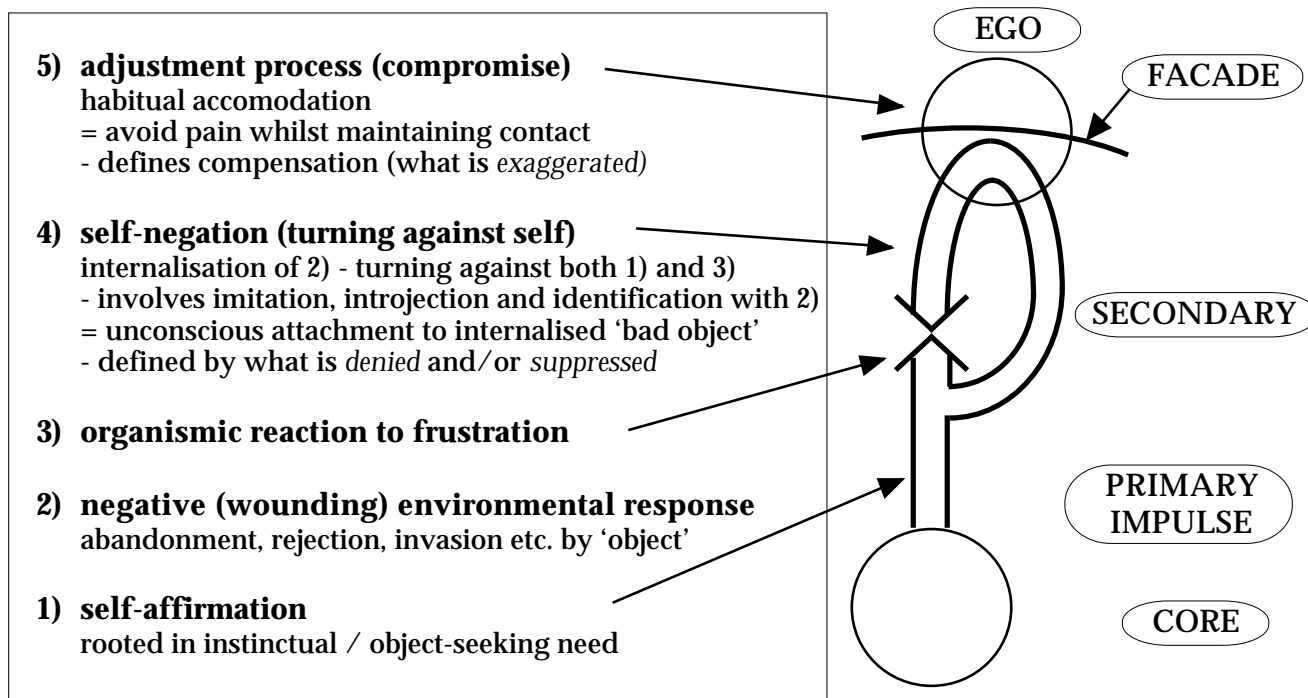
Body psychotherapy and modern analysis share an understanding of the origins of transference (Soth 1999, 2003, Jacobs 1986, Masterson 1985): the originally wounding relationship gets internalised - as a script, a working model, a character structure, internal object relations.

Johnson (1994) provides an integrative account of the internalisation process through the 'steps of character formation' (see Fig. 2). Once internalised, the wound gets projected, repeated and replicated in all relationships, including the therapeutic relationship: it gets re-externalised in the transference.

There is, therefore, a parallel between the originally wounding relationship, the internalised relationship and the transference relationship (which, therefore, can be said to constitute three parallel relationships). The transference dynamic then gets carried by the therapist into supervision where it is re-enacted in turn, generating what we traditionally know as 'parallel process'. To formulate an *embodied* account of transference, we need to extend these three parallel processes into five, by differentiating the internalisation process in body/mind terms.

Fig. 2: **STEPS IN THE FORMATION OF CHARACTER**

based on Johnson (1994) "Character Styles" and Reich (1972) "Character Analysis"



What is implied in Johnson's model and what we find phenomenologically is:

- both poles of the wounding relationship internalised as spontaneous process: traces of the child *and* the parent can be found embodied as a relationship between different parts of the client's spontaneous (characterologically 'given') reality.
- the client's ego countering and resisting the re-experience of the wound - here the wounding relationship gets paralleled as an opposition between 'ego' and spontaneous processes.
- a split ego (Johnson 1994, Fairbairn 1974, Gomez 1997) with conflicted and opposing parts which reflect in their relationship to each other the originally wounding relationship.

The originally wounding relationship is internalised as a body/mind matrix of three parallel relationships: between different parts of the ego; between the ego and spontaneous forces, and between physically anchored spontaneous forces in different parts of the body/mind. In short: a conflicted ego in conflict with a spontaneous conflict.

To illustrate: *As soon as the therapist focuses on the currently painful relationship with the manager, the client's ego has a negative reaction against the immediately constellated feelings of fear. Having barely noticed his anxiety, one part of the client's ego takes a judgmental and shaming attitude, indistinguishable from the originally wounding father (ego=father, body=child). However, this is not the only way in which the originally wounding relationship can be paralleled as a relationship between spontaneous and reflective forces in the client's body/mind: it is also true to say that another part of the client's ego is as intimidated by the uncontrollable spontaneous forces as he was by his father (ego= child, body= father). It is this part of the ego which apologises for not being able to explain himself.*

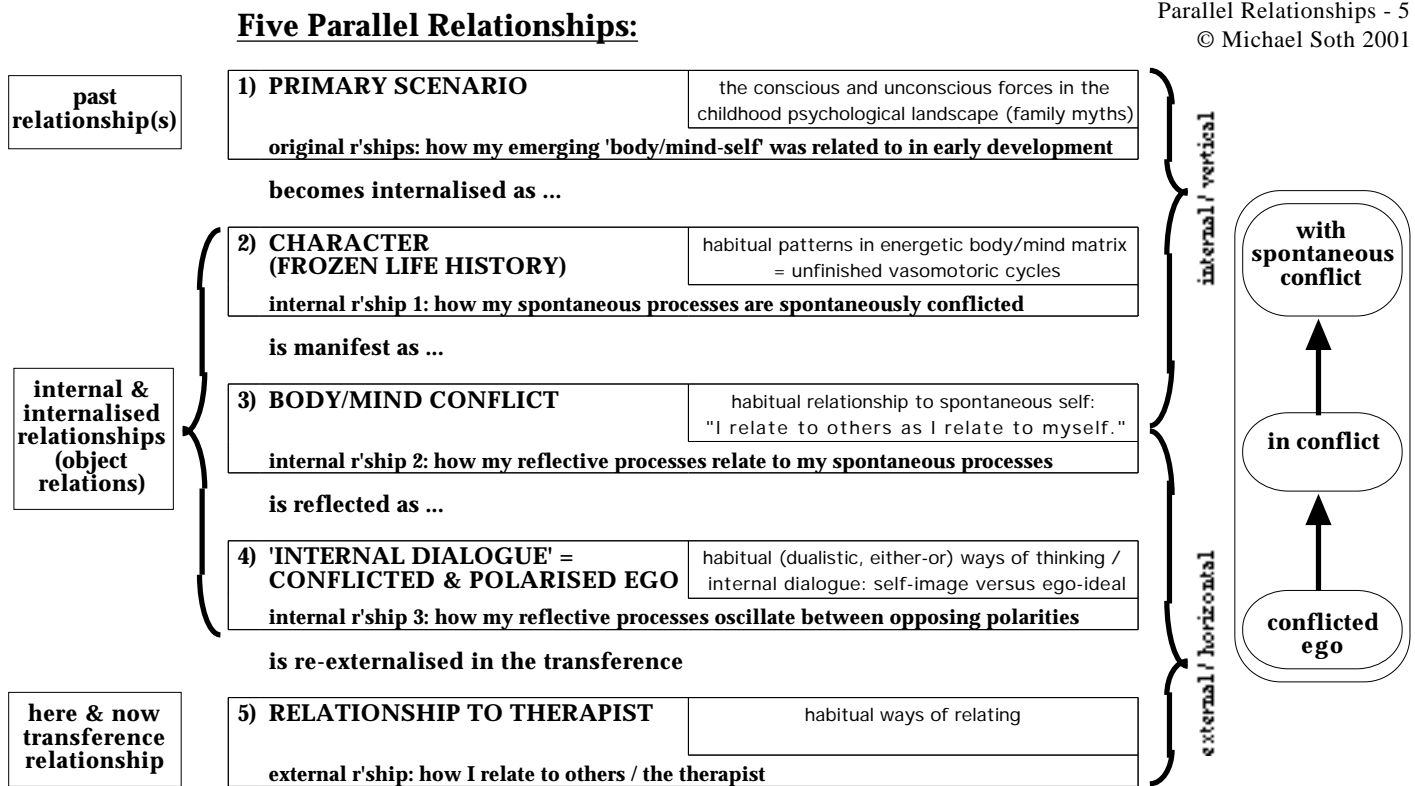
An aspect of internalisation which tends to get neglected in character structure theory (Reich 1972, Lowen 1958, Boadella 1987, Johnson 1994) is that *both* poles of the originally wounding relationship manifest in the client's spontaneous experience (e.g. both the wounded child and the internalised father). In characteristic holding patterns on a muscular level and throughout the rest of the body/mind spectrum, the client's body reflects - like two superimposed negatives - *both* the child's original and fixated experience *and* the wounding parent's body/mind, as perceived and internalised by the child. It is usually not difficult to find at least one physical anchor each for the various internalised objects.

In our example: *the client's chest carried predominantly the inflated, bullying father, and the stomach churned predominantly with the child's fear and shame, with the diaphragm constituting the battleground between the poles.*

By subdividing the internalised relationship into the conflicted ego in conflict with a spontaneous conflict, we thus arrive at a totality of five parallel relationships, manifest in the here and now between client and therapist (see Fig. 3). We can then include parallel process in its established sense, and consider the repetition of the client-therapist dynamic in the supervisory dyad the sixth parallel relationship. It is possible to take the original dynamic back into the dynamic between the parents, and further into the inner world of each of the parents, opening out into possible transgenerational parallels as explored in family constellations (Hellinger 1998, Schuetzenberger 1998).

Fig. 3: **THE CLIENT'S CHARACTER CONFLICT AS A RELATIONSHIP PATTERN**

Parallel Relationships - 5
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Allowing transference to construct the therapist as an object

It is in the nature of parallel process that every relational experience is over-determined: it resonates with multiple other relationships *from which* the dynamic has been internalised or *in which* the dynamic has been acted out, through 'osmosis', projection or projective identification (Bion 1962). Parallel process in the extended definition proposed here matches theoretically what experienced therapists report regarding their perception of the client: the sense of a tapestry, with recurring themes weaving in and out of a person's *psyche* and life, with multiple occurrences and resonances all the time.

This tapestry manifests within the therapeutic space and becomes accessible in the countertransference if - as the therapist - I can allow myself to be constructed as an object by the client's unconscious. But the multi-dimensional nature of parallel process implies that the answer to that moment-to-moment question in the back of the therapist's mind: "what object am I being constructed as?" is necessarily multiple and complex.

As we saw, most of the time I am being constructed as at least *two* objects simultaneously. By attending to parallel process, I recognise that these two objects have multiple resonances internally and externally, in the past and in the present, inside and outside the consulting room.

Which of the multiple resonances is currently relevant, accessible to the client's awareness *and* charged and significant in their unconscious ?

Body psychotherapy can contribute significantly to this question, from its experience with subtle and energetic perception, its habit of reading otherwise subliminal and non-verbal messages in a way which grasps the biological and physical *as* the emotional, psychological and relational. If body psychotherapists can take countertransference on board and apply their energetic, holistic perspective to their own 'internal process' when at work, they can help the 'countertransference revolution' take another quantum leap.

Charge

As body psychotherapists, we think of 'internal process' in body/mind terms, along a spectrum comprising body-emotion-image-mind-spirit (for a detailed list of body/mind processes along this spectrum, see Soth 2004). One term in use in the body psychotherapy tradition (Boadella 1987, Kepner 1987, Eiden 2002) which nicely captures the energetic and process quality of the interaction (rather than the verbal and content aspects) is 'charge'.

There is some confusion in the literature as to whether this refers to ...

- the vegetative 'charge' of energetic aliveness in the client's physical body (which *can be* influenced through consciously directing the breathing, physical exercises and stress positions, and is observable and even measurable from the outside), or ...
- the relational 'charge' arising from the subjective, spontaneous and inherent meaningfulness of the contact, internally or externally or both.

There can be 'charge' in a therapeutic moment when, for example, the client realises that he has spent most of his life in a contracted, paralysed position which is fuelled by an underlying fear, recognisable now in the contact with the therapist. Although there may be little sense of aliveness in his body, as he is becoming aware of his actual paralysis, there is a lot of 'charge' in the embodied, meaningful recognition and in the relational contact; although the body is not 'alive and well' at this point, there is a sense of embodiment as the client's reflection is connected to the actual condition of his body rather than to a compensatory self-image of how his body *should* be.

If we liberate the notion of charge from its predominant use in the first sense, and begin to include *both*, charge can be a suitable embodied-relational term to describe the body/mind phenomenology of transference / countertransference. It can become a crucial ingredient in the therapist's awareness and attention. Reflection on countertransference often boils down to a contemplation of charged moments in the relationship.

Three kinds of contact (see Fig. 4)

We can think about charge in terms of three kinds of contact which reflect how transference and countertransference are mutually linked via parallel process. The 'quality of relating' implicit in these kinds of contact also constitutes three kinds of 'working alliance'. I mean not only the working alliance as a bond between the 'adult, healthy ego' of the client and therapist (Clarkson 1995): this rather static notion becomes questionable when we see the ego itself reflecting internalised object relations. I am complementing this with a more fluid, dynamic notion of an alliance with the client's (partially unconscious) 'spontaneous process'. This will become clearer as we proceed.

There are moments when the therapist's sense of the working alliance is:

- 1) unambiguous: the therapist has no concerns about the working alliance, as it is currently taken for granted. The transference is not constellated, active or in the foreground - the client is unambiguously using the therapist in role, or relating to the therapist as a person.
- 2) ambiguous: the therapist has a sense of the working alliance as ambivalent. The transference reality has entered the room, is constellated and active, but kept in check by, balanced by, or existing side by side with the ego-ego working alliance. This kind of contact is a confusing mix, full of double messages, which eventually affect the therapist via projective identification. This, in turn, often leads to apparent mis-attunement and miscommunication.
- 3) intensely conflicted: the therapist has a sense of the working alliance being severely threatened or broken down. Usually this means the transference reality has taken over, not only in the client but in the whole relational system: always a largely unpalatable and painful experience, which constitutes both the worst and - if it can be survived and eventually contained - the best therapy has to offer. In this moment client and therapist participate in a spontaneous re-enactment of the client's wound, for once not mediated and diluted by the client's ego. Paradoxically, re-enactment and relational transformation of the wound are two sides of the same coin (Soth 1998, 2003, 2004).

We can apply this to our case vignette:

At first, the therapist has no doubts about the working alliance: the client has no hesitation or scepticism and talks freely, assuming and using the therapist's support. Then, when they focus on the emotional difficulty with the manager, the wound does not just get talked about, it is also constellated in the room. The client no longer feels or behaves as if the therapist is on his side: he feels pressurised by the therapist's questions just as he feels pressurised by the manager.

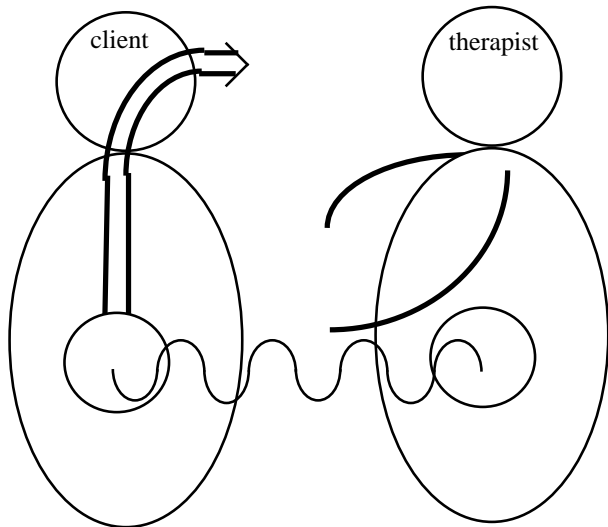
It is conceivable that the therapist communicated some urgency or impatience when asking his questions. Is the client's experience based on accurate perception, or is it transference? What's more important now than figuring this out, is the surrender to the recognition that, indeed, two relational realities are co-existing. To judge by the client's spontaneous feeling reality at this point, he might as well be sitting with the manager (who, we surmise, is a recent repetition of the same dynamic with his father). Superficially, some ego-ego alliance with the therapist remains: the client still tries to respond cooperatively to the therapist's questions (with hindsight we may recognise this, too, as enacting a compliant, appeasing transference to the father).

It is when the client attacks the therapist that there is an unmistakable impression of the working alliance being lost and re-enactment taking over. The emotional impact of this is what the therapist is left with and brings to supervision. The therapist's countertransference illustrates the confusing interweaving of his and the client's reality, mixed up with attempts at processing the relationship through therapeutic knowledge.

Fig. 4 THE THREE KINDS OF CONTACT IN THE THERAPEUTIC RELATIONSHIP

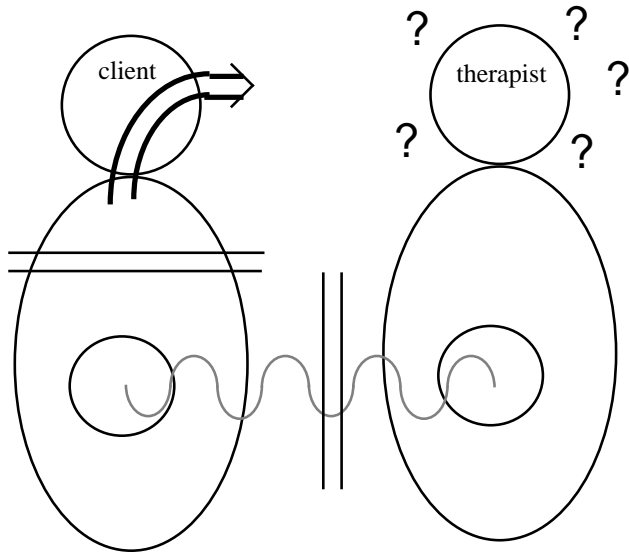
In terms of the therapist's internal process, it is useful to distinguish the following three kinds of contact, noticeable in the countertransference as the current degree of 'working alliance':

1) unambiguous Therapist experiences:



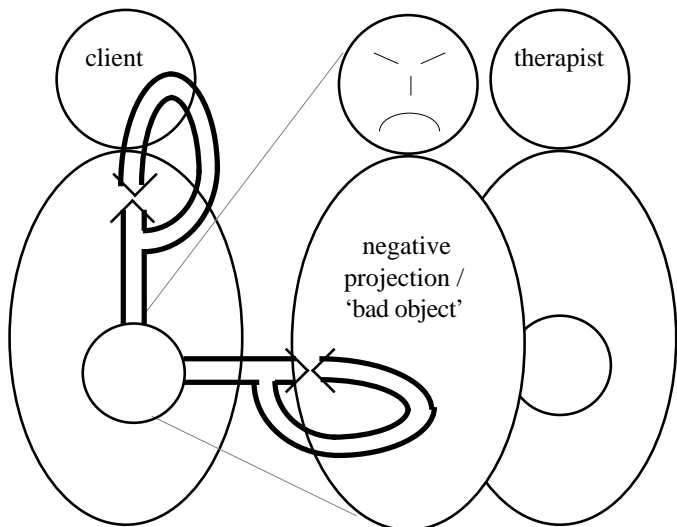
RESONANCE
(spontaneous and explicit empathic flow;
no doubts about working alliance)

2) ambiguous



DISSONANCE as well as RESONANCE
(doubts about working alliance)

3) re-enactment



INTENSE CONFLICT / PRESSURE
(charged & conflicted moment -
working alliance intensely threatened)

Transition from 3) to 1) happens spontaneously:
the conflict will re-organise itself
if contained 'sufficiently'

Countertransference as parallel process: the client's conflict becomes the therapist's conflict

In relation to the client's character conflict, the therapist is in an impossible position: having conceptualised the internalised aspects of character as the conflicted ego in conflict with a spontaneous conflict, whose 'side' does the therapist take: the side of the ego or the side of the spontaneous conflict?

The ego's overall aim, in relation to the spontaneous experience of the wound, is to keep it at bay and to maintain, if not improve, the *status quo*. The pressure from inside, whether we conceptualise this as the re-emergence of the wound which is hoping for resolution, or in Jungian terms along the ego-self axis as the impulse towards individuation, is opposed to the *status quo*.

The answer of traditional body psychotherapy was largely unequivocal: Reich took sides with the 'body' against the 'ego' (Reich 1983, chapter V). Psychoanalysis, through insisting on verbalisation and symbolisation, precisely because it appreciates the dangers of re-enactment, can be seen to be implicitly siding not exactly with the ego, but with the ego's capacities.

It is only when we fully appreciate the therapist's dilemma *as parallel process*, and see the therapist's allegiance to the two sides necessarily being as split and opposed as they are chronically in the client, that we can make full use of 'embodied countertransference'. In simple terms: the client's conflict becomes the therapist's conflict. It is only then that we get access to the paradox that *both* 'nothing has to happen' (and certainly nothing should be forced to happen) and that 'something desperately needs to happen'.

This dilemma acquires 'charge' for the therapist during the kind of contact I above labelled 'ambiguous'. Its initial manifestation in the countertransference is often as questions in the therapist's mind: what is going on? what should I do next?

These questions usually distract from the ambiguity and conflictedness of the contact. The therapist may have impulses to re-establish a clearer sense of their therapeutic position, precisely because they are in the process of losing it. These are understandable impulses, but rather than taking refuge in the trappings of the role and how we can shore it up, ideally we find some internal space for the questions: *How* am I losing my position? What is the body/mind and relational detail of this process? *What* re-enactment are we being drawn into?

Surrendering to re-enactment

If we accept that the wounding relationship not only enters the client's perception, nor only their experience in the consulting room, but indeed enters and affects the therapist's subjectivity as a pervasive, and largely subliminal body/mind process, we are embracing the fundamental premise of the 'countertransference revolution' in holistic, embodied terms. This is equivalent to surrendering to re-enactment as emergent process. The therapeutic inevitability of re-enactment can be formulated like this:

It is impossible for a therapist to follow a strategy of overcoming a dysfunctional pattern without enacting in the transference the person in relation to whom the pattern originated.

I see re-enactment and how to deal with it as the central issue of all relational psychotherapy (Soth 2004).

Subjectively, from within it, it always feels 'wrong' in some way: the therapist, inevitably, is aware that this is the *opposite* of what - implicitly - the client is paying for.

Attempts to structure the therapeutic space in such a fashion as to minimise the dangers of re-enactment inevitably rely on ...

- a) creating a bias towards the ego and the ego-ego working alliance as the predominant area of engagement;
- b) positioning the therapist outside the danger zone of unconscious relating, and setting up a more objectifying therapeutic frame.

This is not to say that such ego-focused, objectifying work cannot be appropriate and helpful for the client. It just cannot be called holistic relational depth psychotherapy with the unconscious. Character disorders, addictions, disturbances of the self reach right down, across all the body/mind levels to the self-organising dynamics at the root of modern Western pathology. If we want the work to be powerful enough to affect these spontaneous, pre-conscious levels of being, we have to embrace re-enactment as part of the process.

Re-enactment becomes possible through the therapist - whatever their particular theory or technique - allowing themselves to be constructed as an object by the client's unconscious. Surrendering to this is difficult. In the process, re-enactment precipitates the de-construction of that object. Surrendering to this is *more* difficult. It involves meeting the full force of the client's pain and aggression as spontaneous process, without hiding behind the therapeutic role. This is inconceivable without the therapist risking their own subjectivity and being de-constructed not only as a professional, but also as a person.

If we do open ourselves and the therapeutic space to these risks, we are aware that no therapeutic concept or tool, no theory or technique in and of itself ensures that the inevitable re-enactment will not be damaging to the client. There is, in fact, not much of a guarantee beforehand that it can be worked through. All therapeutic skills, thoughts, principles and competencies can feed into re-enactment. There is no Archimedean fixed point by which we can lever ourselves onto solid ground: re-enactment is one of the essential features of a participative universe.

Having acknowledged the inevitable dangers, how can we prepare ourselves and facilitate the process so as to ethically and professionally maximise the possibilities for re-enactment to become transformative rather than further damaging?

Body/mind transformation in the relationship

As I have tried to establish, 'embodied countertransference' is necessarily a complex phenomenon, both relationally and in body/mind terms. However, it is essential for making sense of re-enactment and remaining response-able when caught in the middle of it. Here is the basic principle I have formulated for myself as to what inclines the re-enactment experience to become transformative:

When all the fragments of the conflict inherent in the re-enactment can be held in sufficient awareness across the levels of body-emotion-image-mind in the relationship in the 'here and now', the conflict will tend to re-organise itself.

This is formulated deliberately from the perspective of the client-therapist relationship *as a system*. Transformation cannot be brought about by the therapist unilaterally and intentionally: it is the whole system which re-organises itself.

It is a feature of the chronic character pattern, described as the five parallel relationships, that the client's awareness of it is necessarily partial and fragmented. Both the wound and its repression need to be kept unconscious. The whole body/mind pattern, therefore, functions to habitually keep the possibility at bay that the wound may be re-experienced acutely, in the here and now. This is ensured both through splits in the ego and the ego's opposition to spontaneous processes. Within the pattern, the ego's reflective grasp (on the level of image and thought) both of the wound and the mechanisms of its avoidance, including the ego's own functioning, is never more than fragmentary. The ego is kept chronically unaware of the complete experience and is, therefore, by definition, incapable of presenting a full account of it in the *here and now, as it happens relationally*.

This manifests phenomenologically as the client's body/mind experience being split and fragmented. The client can, for example, report intense physical sensations, without any emotional connection. Equally, they may be capable of talking about painful memories without being aware of the corresponding feelings or physical symptoms, even if these are quite strongly manifest in the here and now. Or, they may be capable of discharging strong and maybe primal feelings, as long as these have no relational context or 'other' to receive or meet them. Therapists from across the approaches will recognise the significance of these fragments coming together as a coherent and owned experience of body, emotion, image and mind in a sense of wholeness, or an embodied sense of self.

But not only the client's awareness is fragmented: as the client's conflict has become the therapist's conflict, there is a tendency for the therapist to be drawn into similar denials and avoidances. The client's implicit fear of experiencing the wound is communicated to the therapist, who can readily identify with the impulse to avoid the actual experience of it, right here and now.

Holding all the fragments of the conflict implies, for a start, that the therapist is not seduced out of these dilemmas into a shortcut of siding with either spontaneous or reflective processes, even when under pressure. It is essential for the therapist to rest in not-knowing, in ambiguity and conflict.

This especially applies to the inherent complexity of the countertransference experience: any fragment of the client's body/mind process, any object, can appear in the countertransference. The main problem is that an object does not necessarily get projected in its entirety, as a physical, emotional, imaginal *and* mental process at the same time.

Particular charged fragments of it can appear in the therapist's experience, without any obvious link or reference to other fragments. For example, it is perfectly possible for the therapist to experience a stiff neck which has, as yet, no explicit relational context, long before other body/mind fragments coalesce with it into a more graspable fantasy.

This is further complicated by the fact that, as a rule, *both* object poles of the wounding relationship are communicated *and* projected simultaneously, and are both being projectively identified with by the therapist. As the two objects are usually anchored and conveyed in different communicative body/mind channels, they are also taken in by the therapist and manifest in the countertransference as fragments in different aspects of the therapist's body/mind. As a consequence, 'embodied countertransference' can never be simply a congruent body/mind experience. By empathising and identifying with split and opposed objects, which are manifest in the client as a conflicted ego in conflict with a spontaneous conflict, the therapist ends up internalising the client's body/mind split and its implicit object relational dynamics.

Gathering/holding the fragments

The body-emotion-image-mind fragments of the conflict and the relational fragments are, of course, only two sides of the same coin, but they do tend to get apprehended separately by the therapist. The relational fragments are apprehended more readily through a perspective which sees the re-enactment in terms of the originally wounding relationship and the steps of character formation. But as the steps of character formation reflect the internalisation process, the same point could equally be formulated as the conflicted ego in conflict with a spontaneous conflict. This formulation tends to alert us more to the body/mind matrix which constitutes the experience of the re-enactment. It, therefore, is more helpful in focussing the therapist on the multitude and subtlety of charged spontaneous processes and how they are being managed, in client *and* therapist.

We understand the re-enactment in terms of a currently constellated wound. We understand that wound as layered and enacted in ways which parallel the steps of character formation in the original wounding. We understand that the enactment of that wounding between client and therapist manifests as a fragmentary body/mind matrix throughout the relational system. We also understand the paradox that whilst the client's character position affords some protection against the re-experience of the wound, it also actually perpetuates it.

In this perspective two - equally valid - universes coincide: one in which the wound is being protected and denied and one where the wound is constantly being repeated and re-enacted. The first is constituted by the all-too-real presence of a fragmented and conflicted body/mind. The second holds the potential for the wounding to be experienced acutely, but also for the elusive transformative possibility that in some unpredictable fashion the wound may finally be embraced in the context of a larger wholeness which does no longer need to deny it.

The therapist's overall presence and gesture is an embrace *both* of the potential wholeness *and* the currently fragmented dis-integration, without any habitual bias one way of the other. The ineluctable sense of potential wholeness manifests as an impulse to 'gather' the fragments, and hold them in awareness without splitting or projection. This implicitly invites the client into a universe where the wound is present, but not protected against. The therapist, having projectively identified with the various objects and thus having experienced the client's body/mind split, is inclined to increasingly hold the fragments in awareness in their own body/mind.

At this point of increasing charge, the therapist needs to understand that transformation implies a spontaneous process which cannot be forced or imposed. The 'gathering' of the fragments, therefore, is not a process which the therapist can do on behalf of the client. Unlike traditional body psychotherapy, we are not trying to unify the client's expression into catharsis, but we see the conflict between primary impulse and resistance as parallel process to the original wounding. Any impulse on the part of the therapist to short-circuit the existing fragmentation towards his own fantasised version of transformation would need to be reflected upon as another enactment, presumably of the client's unbearable desperation, pain and defensiveness.

I am formulating the therapist's contribution to the transformative possibility inherent in the re-enactment as paradoxical: the therapist *is* co-responsible, but it is not the therapist unilaterally who is 'holding' the conflict. However, it is essential that - within the client-therapist system - the conflict is held in sufficient awareness for transformation to occur. This requires of the therapist *both* active involvement *and* the capacity to passively wait: it requires an active 'gathering' of the fragments *and* an allowing of the spontaneously emergent process; it requires drawing attention *both* to these spontaneous processes (which the client may be unaware of) *and* how they are spontaneously being resisted, by both client *and* therapist. It requires being available *both* to being constructed as an object *and* to engaging authentically, without necessarily knowing which is which. It requires *both* helpless surrender to the re-enactment *and* the authority to modulate its intensity through directive or interpretive interventions. Ultimately, it is not the therapist who contains the client, but the experience of spontaneous, co-created transformation. Such transformation is unlikely in any consistent fashion unless the therapist can work both relationally and holistically, with the multiple resonances of parallel process as body/mind phenomena in the here and now, being *in* the relationship whilst having an awareness *of* it. Most of this is impossible without some notion of 'embodied countertransference' along the lines I have been suggesting.

In our vignette, we have understood the client's experience in terms of 'embodied transference': the therapist's questions are experienced as pressurizing, and the wounding father is constellated in the room, refracted through the manager. The therapist's attention to the client's fear constitutes a re-enactment of both these relationships. The therapist correctly perceives the client's evasiveness, which - in terms of character formation - we understand as the client's survival mechanism, developed early on as a protection against further wounding. In the countertransference, however, the therapist feels lost and helpless when his attempts to challenge the evasiveness do not succeed. This we can now interpret as the beginnings of a projective identification process by which the therapist - although also being perceived as the pressurizing, humiliating father - participates in the boy's feeling reality. As I suggested earlier, both poles of the wounding relationship tend to appear in the therapist's body/mind experience.

By taking refuge in a textbook manoeuvre which is part and parcel of his habitual countertransference (the injunction to focus on the essentials!), the therapist defends himself against his helplessness. In trying to hold on to a waning sense of therapeutic position, he loses connection with the re-enactment implicit in his questioning. As we see, this only serves to deepen the re-enactment, in a way which becomes unmanageable for the therapist. This is a general feature of re-enactment: once constellated, there is no way out of it, only a way in. Every attempt by the therapist to minimise it, even if temporarily successful, actually exacerbates it. In this case, the very object experience which the therapist was trying to get out of, i.e. feeling as lost and helpless as the child, gets re-enacted in an unmediated fashion by the client then lashing out. The client is - finally - enacting the dreaded bullying father, the therapist gets to experience the unsurvivability of this attack as the boy. This is a reversal of the enactment just a minute earlier by which the therapist was being the father, insisting on an interrogation which the client experienced as humiliating. All of this escalated under the guise of an apparent ego-ego working alliance, with the therapist apparently concerned about the client's feelings, and the client apparently co-operating with the therapist-expert.

The therapist would have needed a sense of 'embodied countertransference' during the build-up in order to make full use of the information contained in his lostness and helplessness. This does not mean that the continued questioning did not lead to a potentially productive expression - at this point transformation was just a whisker away. But it meant that the therapist was then not available to meet and facilitate that spontaneous expression further. This might have resulted eventually in the feeling and the relational context, the past and the present coming together. As it was, not all of the fragments of the re-enactment could be held, and the transformative potential inherent in it went unrealised, at least for now.

Conclusion

I have tried to show that by integrating the body/mind sensitivities of the body psychotherapy tradition and the relational sensibilities of modern psychoanalysis we can arrive at an embodied notion of countertransference. Making use of the full body/mind complexity of 'embodied countertransference' relies on the recognition that the therapist's experience is necessarily conflicted, torn between polarities, and that the therapist's conflict - both as a person and as a professional - frequently reflects the client's inner world as a parallel process. The therapist's subjective body/mind process therefore contains information about the 'other'. If the therapist can surrender to this, the spontaneous, self-organising processes occurring within the therapist's body/mind constitute the construction and de-construction of the therapist as an object by the client's unconscious. The therapist is forever drawn into uncontained and uncontainable re-enactments which require re-organisation and transformation of both people involved in order to stand a chance of eventually being contained. 'Containment' and 'working alliance' are paradoxical notions: they need to break down in order for them to exist. The therapist's surrender to the constellated re-enactment is facilitated by a differentiated and attuned awareness to the multiple parallel processes resonating throughout the therapeutic relationship and the body/mind of both people involved. The therapist needs to be aware both of the overall relational pattern and of the specific and subtle spontaneous body/mind detail of 'emergent process'.

I have considered countertransference as *embodied* in contrast to the historically developed notion of countertransference - a meta-psychological context which has a good portion of disembodiment structured into it. But the systemic, parallel process view I have proposed here goes beyond the issue of embodiment. My hunch would be that in a couple of decades we will have moved beyond the 19th century embodiment / disembodiment juncture into an integral-systemic-parallel process view of what I would call the 'fractal self'.

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