Embodied therapeutic presence:

A proposed extension and clarification of the CAT model of reciprocal roles, relational space and integration when working with developmental trauma

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Abstract:
Working relationally with developmental trauma may present profound challenges to therapists and be burdening or exhausting. The potential of therapist embodiment as a relational resource is explored. It appears to integrate readily into the CAT model and may offer clarification and development of CAT theory of reciprocal roles and integration. This approach is based upon the author's clinical work alongside extensive experience in introducing it to CAT therapists in training workshops.

Keywords:
embodied therapeutic presence, therapist embodiment, developmental trauma, self-to-self, reciprocal roles, collusive reciprocation, therapist burdening and exhaustion, therapeutic space, relational space, relational field, projective identification, embodied counter-transference.

Tim Sheard has a background in medicine and qualified as a CAT psychotherapist in the late 1990s. He has also undertaken training in body psychotherapy (biodynamic), family constellations work and transpersonal counselling.

THIS paper seeks to address the profound relational challenges that are frequently encountered when working with the adult life consequences of developmental trauma. In the past these difficulties were often regarded as 'untreatable' (Ryle 1997b pp ix & xi) and still attract diagnostic labels such as 'borderline' and 'personality disorder'. Less pathologising descriptive terms have not, as yet, come into mainstream use (Ryle and Kerr 2020 pp225-230) although the recently proposed 'Power, Threat Meaning Framework' offers a non-diagnostic approach (Johnstone & Boyle 2018). For the purposes of this paper the

term 'developmental trauma' will be used to speak to a wide range of adult life difficulties characterised by partial or full dissociative processes. CAT understands these to be largely unrevised ways of managing relational trauma originating in childhood.

Working with developmental trauma confronts therapists with major challenges. Clients frequently bring stories of childhood abuse and neglect that can be profoundly distressing or indeed horrific. The empathising therapist may suffer 'vicarious trauma' (Rothschild 2006). This may be compounded when abuse and neglect still feature prominently in clients' daily lives: be it as victim or perpetrator. In addition, clients may explicitly act out during the therapy and disrupt or terminate it. This paper focuses on a third aspect of the challenge of this work, on more implicit enactments, which can be more difficult to describe or define, although familiar to all who have worked relationally in this field.

Therapists may feel overwhelmed, deskilled or stuck in a split relational field of great intensity or apparent absence of emotion. They may find that they are unable to think, experience distressing phenomena on a bodily level and/or their customary relational capacities may seem compromised or even disabled. It as if therapeutic or relational space has either been lost or was stillborn: 'doing to' predominates as the core relational stance (Benjamin 2004) and collaboration may seem a distant dream.

Leiman describes this in his paper on projective identification:

> 'with severely ill patients we frequently get the impression of being deluged by their unmanageable experiences. We feel being controlled and 'forced to take in' bits of the joint sequence.'
>
> (Leiman 1994 p107)

Field, a Jungian analyst, vividly describes finding himself quite literally losing the capacity to speak or form words at all during a charged moment with a client. (Field 1996)

The author has facilitated workshops with a few hundred CAT therapists and trainees which have been focused on how therapist embodiment may serve to free up stuck or overwhelming process when working with developmental trauma. Participants had the opportunity to explore the details of their subjective experience when feeling stuck or overwhelmed with particular clients. On a literal level these problematic experiences included physical pain in muscles, abdomen or heart, difficulty in breathing, a choking feeling, numbness, an inability to think,

nausea and concern they might vomit, feeling sleepy, being heavily weighed down, crushed and exhaustion. On a more explicitly relational level participants reported dread at the prospect of a session with a particular client, great anxiety or fear within the session and feeling 'beaten up'. The client might be felt to be invading, occupying, or even violating the therapist's personal space. The overwhelmed therapists' reciprocations varied – some felt as if they were reeling away backwards to try and have space or some simply wanted to 'run away'. It is of note that much of this difficulty was experienced on a bodily level and often involved a sense of invasion of boundaries, indeed of the very interior of the therapists' bodies. Whatever the manifestation, be it invasion or absence, the common factor running through all of the experiences was a subjective sense of an absence of relational therapeutic space within which the therapist and client might begin to engage. As if the potential therapeutic space was either filled up/invaded/over-charged or somehow out of reach, unable to be touched on.

Such difficulties are clearly 'countertransference' reciprocations (Ryle 1997a), and if unrevised they can be understood to be collusive reciprocations. Within the frame of neuroscience these are descriptions of dysregulated states induced in a therapist who is working outside of her own 'window of tolerance' (Rothschild 2006).

It is a core feature of CAT's multiple self states model that it seeks to name, map and make therapeutic use of the problematic self states and relationship challenges characteristic of developmental trauma (Ryle & Kerr 2020). The problematic states and sequences can be jointly described, this process being mediated by diagrams. In many cases this is sufficient to open and hold a therapeutic space and relationship, provide containment and the therapy can progress. However, in some instances this may be achieved at considerable cost to the therapist in suffering somatic burdening and exhaustion, or the process may become stuck and overwhelming for client and therapist alike. Some workshop participants had dismissed these problematic bodily phenomena as a distraction from the real work of the therapy, others as a necessary price of the work simply to be endured, while others sought to include them as important relational phenomena. However, CAT therapists found that *recognition* of an identifying or reciprocating embodied countertransference (Ryle 97a) does not always open the door to revision. It was as if they felt stuck and unable to find a means of moving into a constructive relational position (an 'exit' for the therapist).

It is of note that CAT does not offer a way of engaging directly with

these predominantly bodily relational phenomena, but instead seeks to reflect on them as relational data. It is as if CAT assumes a dualistic paradigm in which the mind and body are separate domains. This is in contrast to neuroscience and associated newer trauma therapies where considerable emphasis is placed on stabilisation of the neuro-physiologically dysregulated client as an essential first step, (Ogden & Fisher 2015), and sometimes, indeed, on stabilising the therapist (Rothschild 2006, Geller & Porges 2014). Such stabilisation is largely mediated by embodied processes/techniques and the integration of these into CAT is being actively explored (Walker in press, Bristow in press). But on a relational level it is as if CAT does not equip therapists to engage directly with this 'subterranean' body-to-body level of communication and relationship in which the normally assumed boundaries of the self, body and other can seem to have unnervingly dissolved.

The question arises of how we may equip ourselves as therapists to engage with, modulate and make therapeutic use of these challenging processes when at the times when they seem beyond the direct therapeutic reach of the CAT model? It is proposed that actively engaging with our own relational embodiment as therapists may be a significant resource.

A brief overview of embodiment

Most psychological therapies, CAT being no exception, appear to be anchored in a dualistic paradigm in which the subject of interest is a disembodied mind or simply behaviour: what we call 'our bodies' are marginalised as largely irrelevant and objectified as a 'thing' and denied any subjectivity. This dualistic splitting has deep roots in western culture (Shea 2001) and can be seen to be an unacknowledged relationship of power, control and exclusion. This is now increasingly being challenged from a number of different quarters:

1. Research in infant development supports the understanding that the foundations of our relational sense of self, other and the world are formed within preverbal, co-embodied relational experience (Trevarthen 2017).

2. Inter-personal neurobiology has widened the focus beyond a single brain, or even two brains into a more complex landscape of embodied nervous systems interacting in relationship (Siegel 2010). This forms the basis of much of the rationale underpinning the newer trauma therapies (Badenoch 2018, Ogden & Fisher 2015, Schwartz *et al* 2017, Taylor 2014).

3. The body psychotherapy tradition has been in existence, but marginalised, for over a hundred years (Heller 2012, Totton 2003). Many of its approaches are being integrated into trauma therapies, (Taylor 2014, Heller & La Pierre 2012, Ogden & Fisher 2015)

4. Enactivist cognitive science assumes a non-dualistic foundation in which cognition, sense of self and relating are inextricably and dynamically interwoven with what we would call bodily structure (Varela, Thompson & Rosch 2016, Galbusera & Fuchs 2013, Kyselo 2014).

5. A 'corporeal turn' is occurring in the wider social psychological and political sciences and indeed philosophy, (Sheets Johnson 2009, Lakoff & Johnson 1999)

However perhaps the strongest argument for the relevance of direct engagement with our embodiment in work with developmental trauma is that much of the problematic communication and associated burdening and exhaustion appears to be mediated by what might be called a body-to-body level of reciprocal roles. In trauma 'The Body Keeps the Score' (van der Kolk 2015).

Experience in CAT relational embodiment workshops

The author has facilitated workshops with CAT therapists and trainees in the UK, Finland and Ireland. The majority of workshops were for one or two days but two residential courses spanning a year were held in Finland and England. In introductory workshops participants were asked to select a client with whom they felt stuck or in some way overwhelmed and then guided through an exercise in which they explored in detail their thoughts, feelings and embodied responses in three situations: imagining being about to see the client, in session and following a session. They were asked to depict their experience in crayon drawings and share with other participants.

They were then introduced to simple exercises in attuning to three different dimensions of embodiment. These are:

(a) Vertical alignment: participants were guided through grounding, but also finding a position of ease of alignment of the head and torso in gravity, perhaps with a sense of a natural upward lift. This accompanied by a whole body scan for muscular tension/holding

and gentle release; the whole resulting in varying degrees of discovery of a relaxed but alert poise.

(b) Visceral attunement: using breath, interoception and felt sense to attune to the abdominal viscera and relational heart (in the central chest) and

(c) an energetic dimension in which participants were guided in exploring their subjective experience of their 'energetic field', of engaging with 'energy' in a form similar to qi gong that involved charging the 'hara' and playing with holding an energy ball in their hands. . .

For detailed descriptions of the exercises and the experience of participants see Sheard (2017) and Sheard (in press) and online audio introductions (Sheard in Press).

The different dimensions were introduced sequentially, layered, and the impact on their imagined experience with the same client explored. No indication was given as to what any relational effect of these exercises might be. To varying degrees the exercises can be understood to be a relational shift from body as object to identification with body as a relational subject.

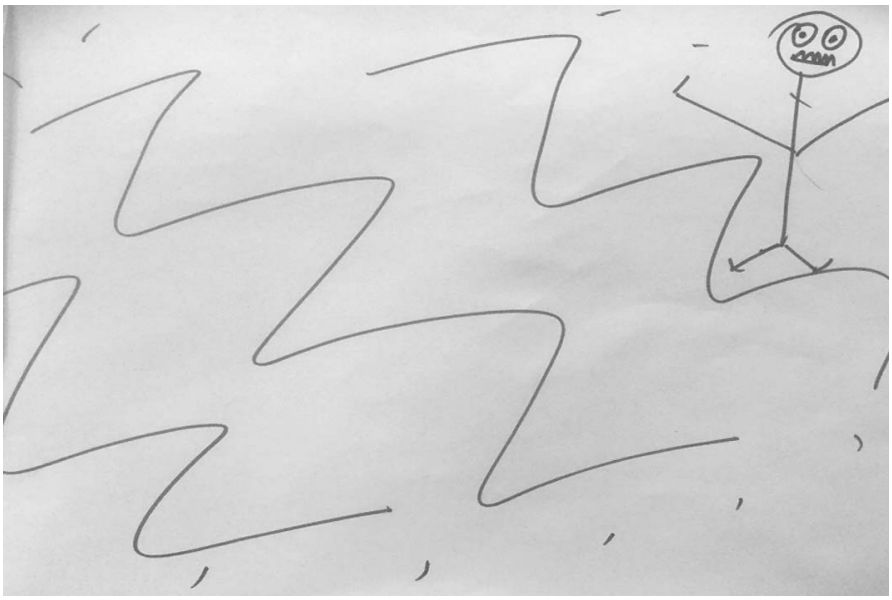
Participants were often surprised at discovering the magnitude and nature of their raw embodied responses when they gave them attention prior to the introduction of embodied attunement, as if they became aware of how much they were carrying and/or their boundaries 'transgressed'. Some participants found the subsequent embodied attunement exercises not particularly helpful but the majority experienced significant subjective changes. The emergent pattern was:

Vertical alignment was associated with greater definition and sense of separateness from the client both in terms of the boundaries of the body and of personal space, along with modulation of anxiety, panic or overwhelm. However, there could also be a sense of a loss of contact with the client.

Visceral attunement to the abdomen and relational heart was layered on top of vertical alignment and often afforded a sense of feeling connection within bounded separateness. Participants gave moving accounts of being able for the first time to feel and see the client as a fellow human being, an experience previously obliterated by the level of emotional intensity and state shifting.

The *energetic level* left some untouched, but many reported a

Drawing No 1: A depiction of a charged and overwhelming relational field. (With kind permission). For a larger library of drawings by participants see website associated with Sheard in Press)



variety of enhanced relational capacities or 'affordances': A strengthening and clarification of boundaries, a sense of greater resource (spirit) to engage, a greater sense of containment of both themselves and the client and an opening of a transpersonal level (Wellings & McCormick 2000).

There is perhaps no great surprise in the first two levels. The English language has many expressions that support this: 'standing her ground', having 'backbone', 'gut feeling', 'gutted', 'heart-felt'. We literally 'articulate' ourselves in space (geometrical or relational 'space') through our musculoskeletal system and experience many emotions and feelings in our bellies and hearts, not in our heads. Many poems and songs attest to this. The energetic level is suggested in the expression 'the eyes are the windows of the soul' and it is becoming much less 'fringe' (Mollon 2018, Feinstein 2021), and a detailed description can be found in Brennan (Brennan 1990). Schwartz-Salant describes integrating an energetic level into Jungian therapy (Schwartz-Salant 1998).

Participants in workshops frequently reported a dilemma in their work: as relational therapists it was as if they could *either* remain empathic and 'open' to contact but burdened/overwhelmed *or* they could put up a barrier and feel safe but cut off and no longer relational. It as if embodiment offers an 'exit' from this in affording boundaries and

separateness *alongside* affording visceral empathic and feeling connection. As if supporting a 'safe enough' and regulated position for the therapist when engaging with the intense and split relational fields of developmental trauma. This is also likely to offer a clearer and safer relational presence for the client to engage with.

Following an eight-day course spread over a year a participant reported:

> I feel steadier, less thrown about, less anxious, more centred in the midst of this difficult work that we do. I feel more resilient, less drained by the work, and have less physical pain in my body and I know that my clients sense this and that it is very containing for me and for them. It gives us both confidence and increases trust in the therapeutic relationship. This is not about knowledge or skill, it's a sense of trusting in myself, trusting in my body, in my whole embodied self, that I can be 'enough'. (With kind permission)

Discussion

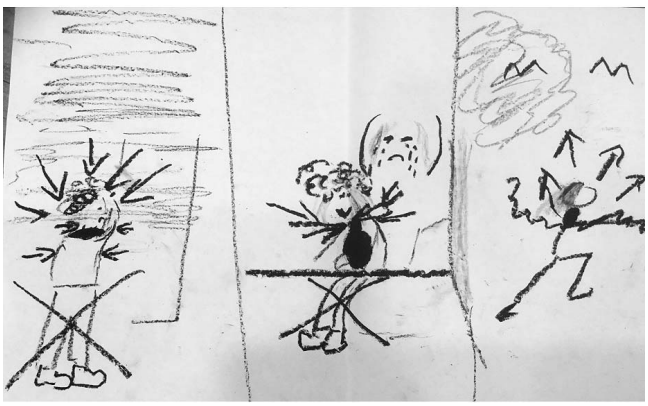
Experience in workshops and the author's practice offer support for the understanding that attunement to, and greater subjective identification with, our bodies can afford a strengthening of relational capacities and mediate a more direct and conscious engagement with bodily communication of split-off reciprocal roles. This is consistent with enactivism theory of 'affordances' (Varela, Thompson & Rosch 2016, Galbusera & Fuchs 2013). It can also be seen to be consistent with the neuroscience derived model of vicarious trauma and the use of embodied techniques to facilitate restoration of a regulated state in the therapist in which higher centres can come back 'online' (Rothschild 2006).

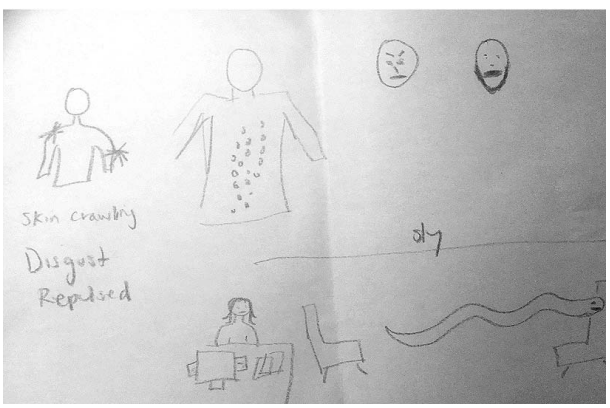
It is as if this approach supports the development of a therapeutic relational stance that might be termed 'embodied therapeutic presence' and could be a significant relational resource in work with developmental trauma. For a clear description of therapeutic presence and client safety related to polyvagal theory see Geller & Porges (2014). Possible implications of this approach for CAT theories of embodied countertransference, projective identification, reciprocal roles, containment, therapeutic space and integration will be briefly explored.

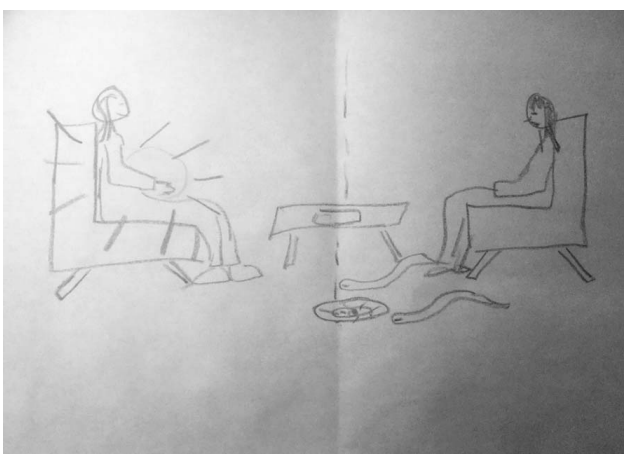
Embodied countertransference and collusive reciprocation

The CAT multiple self-states model (MSSM) makes it clear that therapists

Drawings 2 & 3: The tryptich represents a therapist's raw and overwhelming experience at three timepoints: before, during and after a session. Drawing 2represents her experience following the vertical poise and visceral attunement exercise. The circle in the centre of the chest and lines emanating from it were drawn in red (By kind permission)







Drawings 4 & 5: The fragmented therapeutic space of the first drawing became ordered and contained following attunement to the energetic level, the therapist is to the left holding her energy ball

are likely to be under intense pressure, be it explicit or subtle, to reciprocate problematic reciprocal roles collusively. It is essential to resist this as otherwise collusive reciprocation will be a simple repetition of a long-suffered repertoire of problematic self-states and procedures. Potential therapeutic space would be lost, and the therapy become a maintaining factor. Collusive reciprocation may be more straightforward to avoid if the invitation or pressure is simply to rescue or reject, but bodily level communications of traumatised reciprocal roles present a different kind of challenge. How can the voice of trauma and exclusion be heard, felt and included if it is impacted and concretised in repetitive embodied enactments?

It has long been recognised that countertransference is often experienced through, or mediated by, our bodies (Sedgwick 1994, Sletvold 2014, Soth 2005). This is perhaps to be expected in developmental trauma as the original traumatic events, usually a form of acting out by adults on children, were often bodily mediated (abuse, sexual violation, abandonment). Unless substantially revised it is likely that these states will, at least in part, be communicated to the therapist through the medium in which they were experienced: i.e. body-to-body communication/acting out. This bodily level is at least partially recognised in CAT theory of transference and countertransference (Ryle 1997a) and in Ryle and Leiman's contrasting understandings of projective identification (Ryle 1994, Leiman 1994). However, it is proposed that an embodied approach to CAT clarifies some of these processes.

Embodiment, CAT and therapeutic space

It is as if embodiment offers a paradoxical, part literal, part metaphorical, perspective on boundaries, separateness and relational space. An attempt to resolve this paradox would most likely slip back into dualism. On a literal level it is as if our musculoskeletal system affords us separation but also contact at the edges/boundaries (see Frank and La Barre 2010 for a gestalt based model of 'four fundamental movements', also Dower 2015 describing using Frank's approach within CAT). It is as if this sense of 'definition' gives a clear distinction between the space inside us, our personal space around us, and different boundaries and spaces in and around people and the world. It is as if our abdominal visceral level affords the possibility of empathic resonance with others within our interior space, affording a different form of contact or communion from the musculo-skeletal. The 'relational heart' and the energetic level appear to hover between the literal and metaphorical and are discussed below.

On a more metaphorical level it is as if embodiment may be mediating a greater capacity in therapists to engage with, and to be conscious of, their self-to-self reciprocal roles. CAT therapists widely report that engaging with embodiment makes reciprocal roles much more tangible, felt and real in the present moment (see Sheard *et al* 2000 for an early form of using elicited, partly embodied, countertransference to inform mapping during assessment sessions). Embodiment mediating increased awareness of reciprocal roles is particularly the case for self-to-self reciprocal roles that otherwise can seem vague or elusive. Embodied attunement can open up a landscape of positive embodied self-to-self reciprocal roles. 'Space within' may therefore not just be literal but also metaphorical/relational. As if the capacity to be in positive and enabling self-to-self reciprocal roles is an opening of 'relational space within', while conversely negative self-to-self reciprocal roles restrict, tighten and close it down.

It was striking that the exercises sometimes provoked a feeling of guilt, as if giving attention to oneself through embodied attunement was somehow 'taking something away from the client'. Most stark was the injunction: 'you should be there 100% for the client'. It is suggested that the converse might be the case: 100% attention on the client could well be oppressive and involve a loss of relational therapeutic space. Experience from the author's practice and workshops suggests that the capacity to be in relation with oneself self-to-self *at the same time* as with the client serves to open relational space: that it can support a therapeutic and containing 'space between'. As if the capacity to be present to oneself as a therapist as well as to the client can change the quality of therapeutic presence and open potential relational space for the client to engage in.

CAT has two principle overlapping approaches to opening therapeutic space:

(i) The collaborative stance which includes the sharing of understandings in a prose reformulation and in particular joint mapping which can defuse intensity and constellate a 'third' position for client and therapist to jointly engage with. All of which supports:

(ii) The development in the client of a reflective 'observing eye/I'. Empathic naming and feeling connection also part of the CAT model but the degree of emphasis placed on them varies in the CAT literature (McCormick 1995).

However, these do not appear to involve therapist self-to-self engagement as an explicit part of seeking to open a therapeutic space within which the client and therapist can work jointly, such that the therapeutic process can feel more safe and contained for both parties. Potter's description of 'shimmering' perhaps speaks to the therapist deliberately occupying a certain kind of relational position that opens up a wider scope of possibility through a quality of presence, one that is not over direct or too intently focused on the client but instead responsive to the subtleties of therapeutic space and process (Potter 2018).

Leiman has explored similarities between the joint creation of signs and Winnicott's notion of transitional space, (Leiman 1992) which in turn overlaps with Thomas Ogden's inter-subjective concept of the 'analytic third' (Benjamin 2004) and Bion's understanding of 'containment' (Snell 2021, Kuchuk 2021). The author's experience 'in the room' suggests that embodied self-to-self engagement supports a sense of therapeutic presence in relation to not only the client but also to a therapeutic 'space between'. This can give a sense of relief for therapists from imagining that they have to somehow do all the holding or containing of the client, that they can instead give more of their energy and attention to the emergent therapeutic process. Schwartz-Salant gives detailed descriptions of working on relational processes in a 'space between' on an energetic/imaginal level (Schwartz-Salant 1998).

Projective identification and containment of split-off body-to-body communication

Therapist embodiment may mediate direct and conscious engagement with split-off body level communications. The original traumatic event(s) were an acting out in which any potential relational space-between was obliterated. In coming to therapy, it is as if the voice of this experience is seeking to be heard and included, to perhaps at last have its human(e) homecoming. But it is as if the experience is still in exile, embedded in body-to-body re-enactments (implicit memory) without words or images. It is likely to be communicated in this form. This takes us into the strange and peculiar relational landscape of projective identification (Grotstein 1985, Hinshelwood 1991, Ryle 1994, Leiman 1994) in which it could be said that the split-off experience is looking for some-body to have, to hold, to see, to feel and to include it. If the therapist is at home in her body, then resonance of this experience may well still be felt internally but (a) it is likely to be recognised and (b) be contained more in the

embodied therapeutic 'space between' rather than experienced as stuck inside the therapist's body. Conversely for therapists who work from a position of dismissing their embodiment as largely irrelevant it is as if the split-off experience may become embedded in their disowned and consequently vacant, unoccupied internal relational spaces. If the therapist is not 'at home' in her body, then her body may become like an unoccupied house – vulnerable to squatting. It may be 'broken into' by the homeless, split-off, traumatic experience and squatted, a collusive reciprocation. If the therapist is at home in her body, then she is more present to meet and greet the experience that otherwise might be felt as 'intrusive' or dismissed as uninteresting.

It is as if the phenomenon of projective identification is very telling: if it is not met and engaged with on a consciously embodied level then it is likely to remain out of dialogue, concretised, impacted in the somatic and experienced as invasive and/or dismissed as irrelevant. But if engaged with on an embodied level it is as if relational space can open up around it and integration begin through its being held, symbolised, felt, meaning bridges built, brought into narrative and then to take its place as a memory belonging in the past rather than repeatedly relived and re-enacted when triggered.

An illustration: The strangeness and intensity of embodied relational processes were forcibly drawn to my attention in the late 1990s as a more embodied approach to my CAT work was beginning to take shape Arriving home from a day of CAT I went upstairs, as usual, to get changed. I realised I was feeling unsettled and this increased as I gave it embodied attention. I felt I had to do something or whatever this experience was would linger with me for the evening. I would be stuck with it. Following this decision to include rather than ignore it, the unsettledness rapidly began to take embodied shape as an increasingly strong urge to scream. This wasn't really feasible out loud so I screamed, very powerfully, into a pillow. As I did so I had the odd sensation of 'this isn't mine' and immediately one of the clients I had seen that afternoon came to me. Then it was over. It was if something had moved through me, as if my temporarily 'lending' my body to the experience had included it, made it conscious and freed me of it. It was as if I was no longer unknowingly 'carrying' something for the client, but that a felt experience, 'a voice' had been included and could begin to have a place in the therapy. In time the client and I were able to recognise a 'silent scream' hidden and stifled under layers of professional coping and alcohol abuse. To be clear: I am relating this as I experienced it over twenty years ago, I would hope

now to be more alive in the room to such embodied processes, (as described below), such that the process might be experienced as safer and more contained for both the client and myself.

Possible implications for reciprocal role theory

Ryle's Multiple Self States Model (Ryle 1997b pp 26-42) was groundbreaking in linking a theoretical model of developmental abuse and neglect with the mapping in relatively simple diagrams of the relational challenges experienced in daily life and within the therapeutic relationship. Polarised, intense, reciprocal roles and dissociative state shifts lacking any integrating or helpfully meaningful narrative could be mapped out. This includes self-to-self as well as self-to-other, and other-to-self reciprocations. However, the only self-to-self that appears to reflect, or even mediate, the opening of relational space is the observing eye/I which affords an integrating 'gestalt' or overview. Otherwise, CAT mapping and discourse about reciprocal roles tends to be two dimensional: either concentrating on one reciprocal role dyad at a time, movement between self states or a dialogical sequence. It is suggested that to be in embodied self-to-self relationship modifies the experience for the therapist of self-to-other and other-to-self reciprocal roles and indeed of the quality of therapeutic space. This suggests a different form of mapping in which more than one pair, indeed possibly multiple pairs of reciprocal roles are active at any one moment in three, or more, dimensional embodied relational space. As if embodied therapeutic presence opens up an embodied landscape of multiple reciprocal roles, forming what might be termed a 'relational field' (Snell 2021, Schwartz-Salant 1998). This might sound like trying to play three dimensional chess but our embodiment immediately affords us three, or more, dimensional relational experience. As if the therapeutic space has both a literal place in the room: both between and around therapist and client but it is also felt or sensed on a relational, more metaphorical, level of alive process. At the same time we can experience supportive reciprocal roles from our supervisors and trainers in the space behind us, 'taking our back', (or conversely, critical self-to-self voices 'on our back'), we can have the 'shoulder to shoulder' support of colleagues *beside* us, we have the ground and earth *beneath* our feet, our own (wounded) child self may be held in the background, we are still *within* nature, the biosphere, even when in a building (Rust 2020), and so on. Engagement with all of these relational spaces or orientations can be mediated through embodied presence. This three dimensional embodied mapping may of

course be extended to work with the client's embodied reciprocal roles, in particular rendering negative self-to-self reciprocal roles more tangible and supporting the finding of positive embodied reciprocal roles as exits.

Describing ourselves as embedded, or perhaps more accurately, constituted, in an embodied relational field of active reciprocal roles perhaps points more clearly to CAT being a systemic model. This is already implicit in CAT's inclusivity and the notion of the multi-voiced self and is explicit in contextual reformulation (Ryle & Kerr 2020, p269-278) In a systemic model integration would be understood as an 'emergent process' arising spontaneously within a complex system (Capra & Luisi 2014); in the context of CAT the container of this emergent process might be understood to be the therapeutic relational space.

Integration

Embodiment may cast a fresh light on aspects of CAT understandings of integration.

It offers a direct way of including and bringing into 'dialogue' split-off bodily enactments that may otherwise remain marginalised and impede if not derail the therapeutic process. They can be felt in a resonant way within the therapist's body space but can be more readily consciously engaged with and contained within the embodied relational 'space between'. A dialogical CAT therapist poetically described these embodied spaces as 'the birth-place of signs' (personal communication during a residential course).

The therapist's relational 'space within' (enhanced through embodied self-to-self reciprocal roles) supports the opening of potential relational 'space between' that can contain the therapeutic process. If the client is able to engage in this 'joint' space then the possibility arises of relational space opening up within the client (client self-to-self) as the therapy progresses, i.e. internalisation. (This may be supported by work with the client's relational embodiment, but this is not seen as essential to this embodied relational space understanding of internalisation).

Embodied therapeutic presence supports different dimensions of containment and integration complementary to the CAT observing eye/I. Our relational hearts can explicitly be included, and experience suggests they afford an integrative function, as indeed is suggested in many cultural narratives of the heart in literature, song and spiritual discourses. It is as if it affords a translation of emotion into human feeling, as if it mediates

feeling another, being felt and love. It may be the primary locus of narcissistic wounding to the sense of self. As if it takes the literalness and physicality of emotion, translates it to a conscious level and opens the possibility of a felt meeting that touches and changes both parties at the level of 'I and thou'. It is suggested that the 'feeling heart' is relationally and qualitatively different from an observing eye/I and can profoundly complement it.

In relation to integration the energetic level appears to afford an enhancement of a sense of containment, what might be termed mindful presence (Siegel 2010) and for some an opening of a transpersonal level that can support symbol formation and serve integration. Kalsched describes a Jungian approach to developmental trauma (Kalsched 2013) and Schwartz-Salant, also Jungian, describes working with the 'subtle body' within an energetic relational field (Schwartz-Salant 1998).

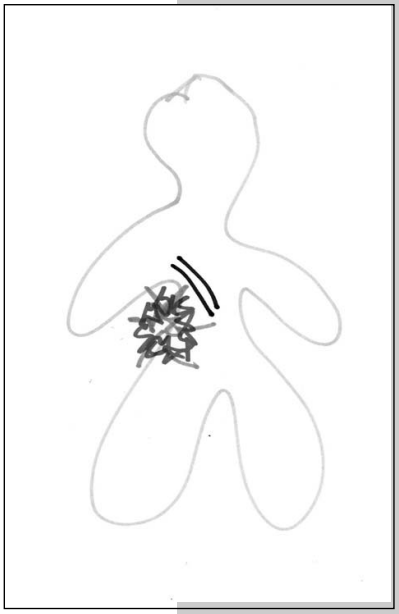
It might seem odd that attuning to and augmenting our subjective identification with what we call our bodies leads us not into a mechanistic world of anatomy and physiology but rather opens up different dimensions of subjective relational experience. But such an expectation belongs fair and square in our dualistic cultural heritage, in which body and mind, the material and the spiritual, ourselves and nature are split apart. It is as if moving beyond this old cultural paradigm affords new relational possibilities. □

ACKNOWLEDGEMENTS

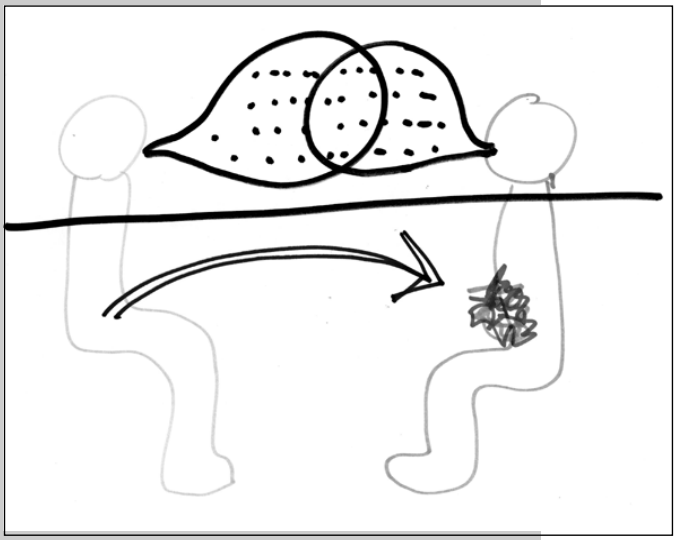
The author wishes to thank all of his clients and workshop participants with whom he has learned and developed this work. This paper is written with the understanding that 'we teach what we need to learn'.

APPENDIX

Here (overleaf) are a series of drawings seeking to depict some of these processes.

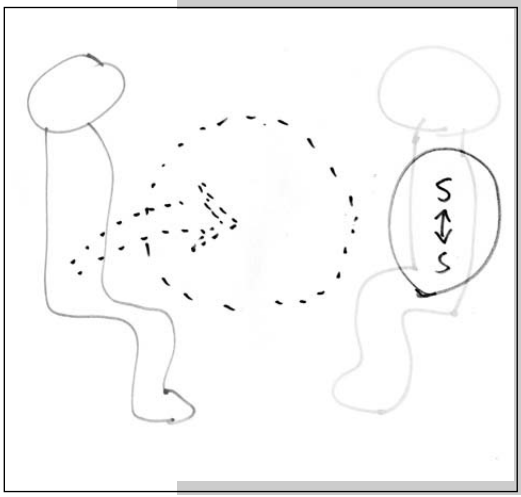


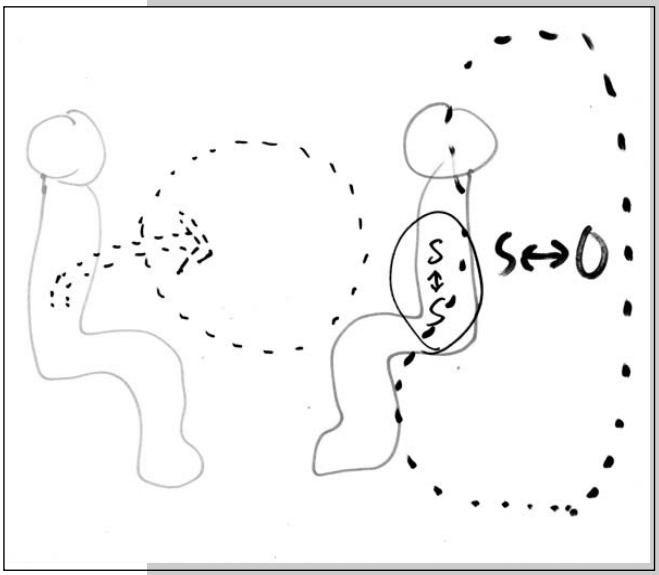
Client's traumatic experience split off in body (implicit memory) out of relationship, dialogue and narrative



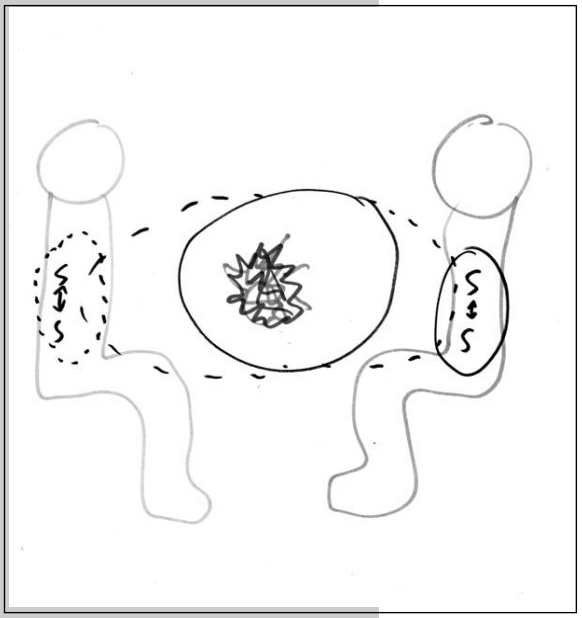
Therapist conducting therapy on a disembodied level and split-off experience seeks inclusion in therapist's body: projective identification as invasive as therapist not in conscious embodied dialogue

Therapist embodied self-to-self, space between and beginning of containment



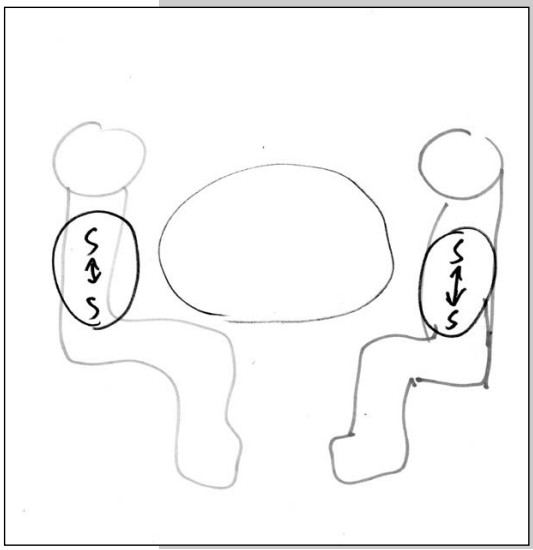


Therapist self-to-self 'backed up' e.g., by supervisor/ trainer/partner/family



Split-off experience contained in the space between/therapeutic space and coming into dialogue. Self-to-self beginning to form in client: internal relational space, beginnings of internalisation

Internalised: client's self-to-self relationship sufficiently established and the space between is relatively empty and can end



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