

The Body in Jung's Work: Basic Elements to Lay the Foundation for a Theory of Technique

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Abstract

This article reviews Jung's key ideas regarding the body to lay the foundation for a Jungian clinical approach to bodily experience. It pays special attention to some of Jung's ideas on the word-association test and psychosis, on the body-mind relation, and on the body as both shadow and self. Based on contemporary research on implicit relational processes, the author proposes ways to integrate the somatic dimension into clinical work. The author suggests that analytical psychology's historical emphasis on the psychological side of the individual's psychosomatic totality needs for completeness to be balanced with theoretical and practical knowledge regarding the patient's bodily side.

Keywords

Body, Jung, analytic technique, implicit relational processes.

In this article, I will examine C. G. Jung's central ideas regarding the body. My aim is to grant the body a larger place in Jungian clinical practice. I will link these ideas with some of Wilhelm Reich's concepts, Reich being the father of psychotherapeutic body work, and with some current concepts regarding the nonverbal, implicit dimension in psy-

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chotherapy generally. In this way, I hope to articulate some of the necessary foundation for a specifically Jungian theory of integrative technique as regards the body and somatic experience. I will emphasize various possibilities of working clinically with the body from the point of view of unconscious nonverbal interactions between patient and therapist.

Different researchers have noted the lack of attention given to the body and to bodily experience that has historically prevailed in analytical psychology (Chodorow, 1995; Heuer, 2005; McNeely, 1987). In spite of a number of references to the body throughout Jung's works, there is an absence of guidelines for the practical approach to including the body in Jungian psychotherapy in a systematic way. As Heuer (2005) puts it, "Jungian psychology seems marked by a theoretical ambivalence towards the body, whilst mostly ignoring it clinically" (p. 106), so that, in effect, "the post-Jungians have only rarely engaged with the body in their theoretical and clinical work" (p. 107).

Based on the findings of infant research and attachment theory, Beebe and Lachmann (2002), Orbach (2004), and Sassenfeld (2007) consider what they call the "relational body" to be a nonverbal vehicle of communication and interaction. This relational body has recently become an important focus of interest for a number of depth-psychological psychotherapists. This interest parallels the advances in the neurosciences that have guided many psychotherapists towards neurobiological and psychobiological aspects of clinical practice (Schore, 2003a, 2003b; Wilkinson, 2004). The exploration of the place of the body in Jungian clinical practice is becoming a genuine need if our field is to keep abreast of these developments.

To be sure, specifically Jungian contributions regarding the body have seemed to increase in the last two decades—in particular, clinical accounts of work with patients with psychosomatic disturbances (i.e., Redfearn, 2000; Sidoli, 1993; Wiener, 1994) and attention to so-called somatic countertransference and enactments (i.e., Cambray, 2001; Redfearn, 2000; Samuels, 1985a; Stone, 2006; Wyman-McGinty, 1998)—but despite these helpful starts, contributions that approach the topic from the perspective of theory of technique are scarce. The publications of McNeely (1987), Chodorow (1995), Wyman-McGinty (1998), Greene (2001), and Heuer (2005) have included elements that could be applied to the construction of a Jungian theory of technique regarding the body. However, we do not have at our disposal anything systematic. Jungian clinicians have limited themselves to presenting their own ways of including the body and somatic experience in psychotherapeutic work and some practical recommendations. For example, somatic countertransference is usually discussed simply as unconscious communication within the therapeutic field.

One can agree with Heuer (2005) that in analytical psychology the body is at times viewed as a vehicle for the expression of the vicissitudes of the soul, “but rarely is it regarded as the primary agent in effecting psychological change. This avoids the question, ‘Can soul be changed by body?’ In clinical practice there seems to be a clear bias for psyche and against physis” (p. 107).

Jung and the Body (I): Word-Association Test and Psychosis

An early interest of Jung’s was the development of the word-association test, an instrument that allowed him to carry out a set of psychophysical investigations whose results are published in the second volume of the *Collected Works, Experimental Researches*. Jung’s early studies in this area included such unconscious bodily phenomena as electrical skin conduction and breathing patterns, and enabled him to uncover the existence of an intimate connection between subjects’ emotional reactions and various physiological processes. He was able to show that the activation of a complex has clear and measurable physiological correspondences, a fact that opened up the way for his later understanding of body and mind as unitary (Greene, 2001; Heuer, 2005; McNeely, 1987). The word-association test was his main way to prove empirically the existence of unconscious complexes. Jung verified that the complexes identified through word association express themselves simultaneously in somatic ways.

From the clinical point of view, this ascertainment is of great utility because, to the attentive and trained observer, it makes possible the recognition of the presence of a complex based on “postural characteristics of the body as well as chronic emotional reactions, somatic symptoms, chronic or recurring illnesses and other physiological manifestations of tension” (McNeely, 1987, p. 17). In other words, given that the complexes manifest themselves not only in interferences to the psychic processes of the patient but equally in body language, the patient’s body becomes a main indicator of complex activity in the psychotherapeutic context. The psychoanalyst Reich (1942, 1945 [1933]) discovered a similar phenomenon which he described in his concept of “muscular armor”: unconscious repressed emotional and psychological processes are literally anchored defensively in the individual’s muscular structure.¹ We will return to these ideas further on in relationship with the shadow.

As is well known, an important interest of Jung’s in his first years of professional experience was the psychology of schizophrenia, then called *dementia praecox*. Chodorow (1995) states that Jung always gave attention to the repetitive and stereotyped gestures of schizophrenic patients at the Burghölzli psychiatric clinic, “frequently [relying] on the

body experience as a communicative bridge to reach patients who were completely withdrawn" (p. 392). More than fifty years later, owing to Winnicott's work (Little, 1990) and that of other psychoanalytic therapists, there emerged among classically trained psychoanalysts heated discussions over the possibility of using physical contact and somatic countertransference (e.g., the bodily experience of receiving someone's projective identification) as tools for working through issues with borderline and psychotic patients. This discussion has not yet come to resolution. What is clear is that over time, given the already mentioned influence of infant research and attachment theory, the range of patients for which the body and nonverbal communication are considered relevant has widened progressively and now includes psychotherapy with almost any individual client, regardless of specific psychopathology.

Implicit Processes and Psychotherapeutic Change

Chodorow (1995) thinks that Jung "had an instinctive grasp of movement as the primal means of expression and communication" (p. 392). In the last decades, what Jung may have instinctively grasped has received empirical support from research on early interactions between infant and primary caregiver and, equally, clinical support from studies on nonverbal implicit interactions in the therapeutic dyad (Beebe & Lachmann, 2002; Schore, 2003a, 2003b). The concept of implicit processes is currently used to designate a modality of psychological processing of experience (including psychic functions such as memory, perception, attention, learning, etc.) that is nonverbal, nonsymbolic, and in principle nonconscious. It is used to identify a level of interpersonal interactions (Sassenfeld, 2007) as well as of unconscious psychic representations that have not been defensively made unconscious but are intrinsically nonconscious (BCPSG, 2002, 2005, 2007; Lyons-Ruth, 1999).

Implicit representations are sometimes referred to by the somewhat vague term "implicit knowing," which is a type of comprehension that can be updated progressively through new experiences but which also contains the history of the individual's past experiences. Explicit processes, as distinct from implicit processes, are verbal or verbalizable, symbolic, and conscious or relatively easily accessible by conscious attention. Recent clinical discussions have centered, among other things, on clarifying in what measure and by what means implicit representations can be made conscious in psychotherapy (Mancia, 2006; Sassenfeld, 2007).

Many psychotherapists nowadays are of the opinion that therapeutic change is determined in great measure by implicit processes that are nonverbal and also not even conscious. Contributions from the

Boston Change Process Study Group (BCPSG, 2002, 2005, 2007; Lyons-Ruth, 1999; Stern et al., 1998), a research group specifically dedicated to furthering our understanding of implicit mechanisms of change, and other researchers (Bayles, 2007; Beebe, 2004; Beebe et al., 2005; Beebe & Lachmann, 2002; Fosshage, 2005a; Knoblauch, 1996; Schore, 2003a, 2003b) have gradually been developing a relational theory of psychotherapeutic change that emphasizes a potential therapeutic action moving toward transformation in implicit interactive processes. Without denying the relevance of better-known change mechanisms (such as making the unconscious conscious through mutative verbal interpretations), the work of these researchers has shown that in-session micro-changes can be related to small but significant modifications of the nonverbal interaction patterns of patient and therapist.

These modifications seem to allow for a widening and differentiation of the patient's implicit relational knowing. As the patient's relational possibilities become more complex, they open up alternatives to the patient's psychopathological or dysfunctional patterns of interaction with others, which are at the core of the patient's pathology.² Fosshage (2005b) points out that, from this point of view, "the explicit revelation of implicit themes and the co-creation of new implicit procedural learning powerfully combine to create analytic change" (p. 880).

The explicit revelation of implicit relational themes is related, at least in part, to making conscious the prominent body-to-body interaction patterns within the therapeutic dialogue. The co-creation of new implicit learning is related to the emergence of more flexible, inclusive, and satisfactory novel forms of nonverbal communication between patient and psychotherapist. Nonverbal communication includes, of course, not only more easily discernible interactive patterns and enactments, but also subtler patterns of visual contact, gestural dialogue, and bodily posture.

With all this information being reported from many quarters, the relative neglect of the bodily dimension of patient-therapist interaction by Jungian therapists cannot be justified today. Jacoby (1999) and Knox (2003) have made pioneering efforts to carry on this integration within analytical psychology, but even they have not specifically focused on the body and on nonverbal communication as the basis of analytical technique.

Jung and the Body (II):

Body-Mind Relation and the Archetype Concept

As many have noted, Jung's approach to the body-mind problem was more philosophical and abstract than clinical (Greene, 2001). However,

this is not to say that Jung was unaware of the central importance of the body. In his seminars on Nietzsche's *Zarathustra* he pointed out:

So one can say it is always a wise thing when you discover a new metaphysical truth, or find an answer to a metaphysical problem, to try it out for a month or so, whether it upsets your stomach or not; if it does, you can always be sure it is wrong. [A] good metaphysical idea does not spoil one's stomach. . . . Of course, it sounds funny, but I start from the conviction that man has also a living body and if something is true for one side, it must be true for the other. For what is the body? The body is merely the visibility of the soul, the psyche; and the soul is the psychological experience of the body. So it is really one and the same thing. (Jung, 1988 [1934–1939], p. 99)

Jung's basic conception of the body-mind problem suggests a fundamental interconnection or interdependence of both (Chodorow, 1995; Greene, 2001; Heuer, 2005; McNeely, 1987). In fact, for Heuer (2005) various Jungian concepts (i. e., synchronicity) only make sense if they are understood from a perspective that includes the body. Jung himself suggested that attending to the reciprocal relationship between body and mind provides an alternative to having to regard either body *or* mind as the primary source of psychological experience. Rather than seeing these two poles of the psychophysical as parallel and separate processes, Jung (1988 [1934–1939]) declares:

But the body is, of course, also a concretization, or a function, of that unknown thing which produces the psyche as well as the body; the difference we make between the psyche and the body is artificial. It is done for the sake of a better understanding. In reality, there is nothing but a living body. That is the fact; and psyche is as much a living body as body is living psyche: it is just the same. (p. 114)

This formulation is very close to Reich's (1942, 1945 [1933]) idea of a "functional identity" between psychic and somatic processes and provides a perspective that justifies direct therapeutic work with the body as part of Jungian analysis. The functional identity notion lays a conceptual foundation for body psychotherapy. Differing from Reich, however, Jung did not clarify the implications of this part of his thinking for the practical work of psychotherapy. Jung's dialectical vision focused on the body and mind as just one of the important pairs of opposites whose interactive play

governs all psychic life. The polarity of body and mind is not only the occasion for much individual suffering but is also a great cultural problem of the Western world. Jung could be ambivalent about how to address it. McNeely (1987) states that Jung was interested in finding a way to transcend the body-mind dualism and to integrate the opposites, but Redfearn (1998), on the other hand, points out that in his writings on alchemy Jung emphasized repeatedly the need of an existing separation between body and mind. He did so, however, so that both could be reunited on a superior level of synthesis. Jung (1928) wrote that if we are able to reconcile ourselves with the mysterious and paradoxical truth that spirit is the life of the body seen from within and the body the external manifestation of the life of the spirit, then we can "understand why the striving to transcend the present level of consciousness through acceptance of the unconscious must give the body its due" (in Chodorow, 1995, p. 401).

Sidoli (1993) has emphasized that Jung's bipolar theory of archetypes, according to which every archetype is composed of a psychic pole (from which archetypal fantasies and images stem) and a pole related to pure instinct (from which instinctive behaviors derive) is central to analytical psychology. The archetype, that is, refers to phenomena that invariably include a bodily facet, if we conceive of the instincts as intrinsically somatic processes. McNeely (1987) has argued that the notion of the archetype represents a bridge in the body-mind dichotomy by including in its definition both psychological and somatic aspects. This is similar to Freud's attempt to conceive of processes that are located on the borderline between body and mind. Saiz and Amezaga (2006) think that "the common denominator that unifies [psyche and matter] is the archetypal pattern of organization" (p. 53). The question then becomes: If analytical psychology is truly dedicated to working clinically with the archetypal dimension of human experience, why does it leave the bodily pole of the archetype out of its conception of what is being analyzed?

Implicit Processes in Clinical Practice

Jung is not to blame for the fact that the field of analytical psychology has still to face up to this question. He was clear that the unconscious is biologically localized in the body. At times, he was quite neuroanatomical in his way of articulating this. The collective unconscious, despite "its being everywhere . . . is located in the body; the sympathetic nervous system of the body is the organ by which you have the possibility of such awareness; therefore you can say the collective unconscious is in the lower centres of the brain and the spinal cord and the sympathetic system" (Jung, 1988 [1934–1939], p. 175). Moreover, Jung (1931) delineated a

correspondence between the psychic system (made up of consciousness, the personal unconscious, and the collective unconscious) and the body: "This whole psychic organism corresponds exactly to the body, which always varies individually but which, besides this fact and in all essential features, is always *the general human body*" (p. 175, italics in original).

Over twenty years ago, Andrew Samuels (1985b) was able to point out that it is possible to establish a link between the archetypes and the right hemisphere of the brain. This association is significant because the archetypes are specifically involved in *giving form* to personal subjective experience. Human activities, moreover, have been shown to involve pre-symbolic, unconscious, embodied knowing and action—the formal aspect of which is knowing how to do things, the most important being the things we know how to do with others (Beebe & Lachmann, 2002; Knox, 2003; Schore, 2003a, 2003b; Wilkinson, 2004). Implicit knowing, then, can be understood as tacit knowledge that manifests itself nonverbally and somatically in human interactions through bodily patterns of behavior. For instance, in the therapeutic relationship the implicit relational knowing of both patient and therapist will give form to their interactions, even if the fact of the form is known only at the implicit level.

Implicit knowing is revealed by *how* a patient does certain things. A patient who, when asking a question, tends to breathe in inflating her chest and speaks more loudly than a moment earlier, can be manifesting nonverbally her implicit relational knowing that it is always necessary for her to prepare to fight for space and attention when faced with the expression of her own needs. She may be countering a fear of the other's potential avoidant or indifferent reaction by adopting a firm, confronting attitude. A male patient, A, with serious problems in establishing deep emotional contact and intimacy in his relationships, at the beginning of every session sat down, grabbed his chair with both hands, and pushed it a few inches away from me. This nonverbal pattern of behavior, aimed implicitly at affect regulation through distance regulation, was a somatic expression of an implicit early relational history of interactions with an intrusive mother.

Another male patient, M, in our first four sessions did not once establish visual contact with me. As in the previous example, this nonverbal pattern of interaction allowed him not to enter into what seemed to him like threatening emotional contact. M had an early interactive history with a seriously depressed mother who had often engulfed him with her depression. He had learned to avoid contact with her emotionally overwhelmed and overwhelming state and generalized that experience into an implicit knowing that being open and receptive to someone else was dangerous.

These examples show how the therapist is allowed to pick up on the patient's implicit relational knowing, which is an important clinical strategy, but they omit the reciprocal nature of these implicit nonverbal interactions. A's implicit "relational move" (Lyons-Ruth, 1999) tended to have the following impact on me: I felt somewhat taken distance from and, with it, slightly emotionally abandoned. This feeling was not missing in my own relational history, which had been with an emotionally flat mother who had difficulties in maintaining alive human contact. Hence, I tended to withdraw too and, as a consequence, sessions with A were often very rational and affectively deadened. With A, even though I did not move my own chair, I tended to sit on the most distanced side of it and, in addition, my body became stiff and my jaw tended to be tenser than usual. Implicit processes are in principle nonconscious, so I do not exactly know how many times this nonverbal interactive pattern went on before I became conscious of it. Once I did become conscious of its occurrence, I was able to gradually understand its meanings explicitly and, consequently, to begin to transform the dyadic pattern of interaction that A and I had co-created.

Implicit Processes, Archetypal Determinations, and Therapeutic Change

In psychoanalysis, given the growing recognition of the importance of implicit mechanisms of change (BCPSG, 2002, 2005, 2007; Sassenfeld, 2007; Schore, 2003a, 2003b; Stern et al., 1998), the discussion on how to access the implicit domain and on how to modify implicit representations has become essential. Although some tend to think that the implicit knowing that a relationship has to be structured a certain way has to become explicit to be transformed, others consider that the implicit dimension changes in its own level (Sassenfeld, 2007). Even though it is obvious that both possibilities for change might be effective, many researchers seem to feel that implicit knowing is more usually modified in the same dimension to which it belongs, a belief which is linked to the notion that implicit knowing does not seem to be accessible to explicit consciousness in its totality. The way implicit knowing changes is when nonverbal patterns of interaction change (Lyons-Ruth, 1999; Sassenfeld, 2007, 2008). Wyman-McGinty (1998) stresses that therapeutic work with the body allows access to the patient's affective and somatic memory, making possible the transformation of implicit knowing without requiring conscious insight.

The previously described implicit interaction pattern I co-constructed with A eventually became verbalized and therefore explicated.

This made possible the conscious exploration of its past and present relational meanings. Something similar happened with M's avoidance of eye contact. C's case, however, is an example of a transformation of an implicit interaction pattern on a more implicit level. C was a young woman with a severe psychiatric disorder. After nearly two years of a therapeutic process that had allowed C to construct a relatively firm identity, separate psychologically from her parents, and finish her college studies, something changed. C came to her sessions as regularly as before but, before starting to talk, she moved her chair, which had until then always been in a slight angle from my chair. Her chair, and hence she, now faced me directly. I noticed what had happened, but did not touch the subject directly with her.

This change repeated itself in every session of the third and last year of our therapeutic journey. Her nonverbal behavior had changed and I did not feel the need to verbalize what I observed. I merely responded in a relatively spontaneous and certainly not self-conscious way to what this change seemed to imply for her. She had begun asking for my opinions on different topics and, if until then I had been rather scant in expressing my personal opinions, I now began introducing them freely into our dialogue when it seemed appropriate and tolerable for her. Our frequency of direct eye contact also increased. We had managed to transform an old scene into a new scene (Knoblauch, 1996): her early implicit relational knowing about not *facing* another who tended to burst and become violent—her mother and often also her father—had been updated to include the possibility of direct intersubjective dialogue with an alter-ego who could be respectfully intimate and even disagree with her without being disagreeable. I should add that this was only possible when C's initially feeble sense of confidence in her own perception of reality had become stable enough to tolerate the divergent perception of a significant other without breaking down.

It can be hypothesized that the modification of right-hemisphere implicit systems, made possible by a deep psychotherapeutic process grounded in an emotionally significant and truly reciprocal therapeutic relationship (Schore, 2003a, 2003b), has the potential to transform or amplify the archetypal determination of subjective experience. Archetypes, associated with the functioning of the right hemisphere, have in common with implicit knowing the determination of forms of experience and interaction. In this sense, without going so far as to equate all implicit knowing with the existence of unconscious archetypal determinants, we can say that both archetypes and implicit knowing have the capacity to shape interactive behavior and both have been associated with structures in the brain's right hemisphere (Samuels, 1985b; Schore,

2003a, 2003b). It is not unreasonable to postulate that transforming forms of implicit interaction can impact archetypal processes that determine experience as well. If form changes, those processes that have the function of giving form have to change too, even if this is not directly and immediately observable.

Such an hypothesis helps us to understand that many psychopathologies may be linked to archetypal fixations or chronic and inflexible archetypal determinations, just as they may be also linked to inflexible, repetitive, implicit patterns of nonverbal interaction. Implicit change mechanisms include the expansion and differentiation of implicit relational knowing, and specifically the amplification of nonverbal interaction patterns into new interactive forms. We would tentatively propose that, from this point of view, it is possible to assert that these change mechanisms contribute to the flexibilization and amplification of unconscious archetypal determination patterns as well as to the working through of what have traditionally been understood as restrictive object relations learned in the patient's past developmental history.

In C's case, allowing for the necessary simplification in examining new clinical hypotheses, one possibility for understanding how change occurred with her is as follows: C's mother complex was deeply grounded in the negative aspect of the mother archetype. This archetypal aspect contributed importantly to the determination of her conscious experience of containment and thus of self-containment in a highly inflexible and dysfunctional manner. Following the change in her implicit relational knowing that had so drastically inhibited her relationship with me—a relational knowing whose origins could be traced clearly to her early experience of trying to relate to her mother—C began to be able to regulate her negative affects with much more effectiveness than before. She also became more able to self-contain her own perception of reality.

These changes, which can be attributed to a modification of her previously inflexible archetypal determination of the negative aspect of the mother archetype, helped her manage a later pregnancy without serious difficulties. She had not only become able to contain relevant and conflictive aspects of her own experience but also to let in the experience of another human being.

The possibility of change is linked to any initial transformation of what Beebe (2004) calls the "action dialogue" and, in consequence, a clinical approach needs to be constructed to the relational interactive and communicative bodies that create the dialogue that is being acted out. Such an approach has to take into account what is happening in each participant's body. In the past, analytical psychologists "have overvalued, even idealized, the mind and what might be called 'thinking', and neglect-

ed both the body and, in particular, the contribution of body language to the understanding of patients" (Wiener, 1994, p. 331). I would add that they have neglected its central contributions to the action dialogue that emerges between these and the psychotherapist. What I have tried to present theoretically and exemplify clinically opens up possibilities for analytical psychologists to include the body and nonverbal interaction in their daily work with patients. Such a development can still be linked to the ideas we are already used to from classical analytical psychology.

Jung and the Body (III): The Body as Shadow

Jung thought that the more the psyche leaves the body aside, the more the body is apt to fall on evil days and adopt undesired paths. He believed that individuals' unconsciousness of their own bodies leads them to "suffer from a certain unreality of life [and not] know when they are hungry, and . . . neglect the simple functions of the body" (1988 [1934–1939], p. 48). In 1935, he also declared:

We do not like to look at the shadow side of ourselves; therefore there are many people in our civilized society who have lost their shadow altogether, they have got rid of it. They are only two-dimensional; they have lost the third dimension, and with it they have usually lost the body. The body is a most doubtful friend because it produces things we do not like: there are too many things about the body which cannot be mentioned. The body is very often the personification of this shadow of the ego. (in Greene, 2001, p. 568)

Subsequently, various therapists have used the notion of the body as shadow as a theoretical frame of reference to ground clinical work with the body (Conger, 2005; Heuer, 2005). But what does the expression *the body as shadow* mean?

Remember that Jung (1962) defines the shadow as the sum of all personal and collective psychic dispositions that are not lived due to an incompatibility with the consciously chosen form of life and that constitute a relatively autonomous partial personality with antagonistic tendencies in the unconscious. To some extent, the shadow is linked to the personal unconscious, which contains lost memories, painful repressed ideas and experiences, subliminal perceptions, contents as yet too immature to access consciousness, and, of course, the complexes (Jung, 1943 [1916]). Consequently, *work with the body in analysis is equivalent to work with the shadow*. To put the matter in symbolic terms, touching the body

is equivalent to touching the shadow. As Redfearn (1998) points out, in psychotherapy “the recovery of lost parts of the self always implies reestablishing a lost link between the ego and a part or function of the body” (p. 33).

Working clinically with the concept of the body as shadow implies paying attention to bodily phenomena in the treatment situation. These include both the patient’s and therapist’s bodily experience in response to implicit ways of “knowing” what is going on. Attention to somatic complaints and symptoms, somatic sensations, bodily movements and gestures, and subtle impulses or tendencies is one of the most fundamental ways to enter in contact with potential shadow contents in another person. This assumes that what the body expresses is often a direct manifestation of the shadow. To make this conscious, basic clinical interventions can include asking the patient to pay attention to his body and verbalize bodily phenomena when it seems appropriate, repeating consciously spontaneous movements or gestures and registering the inner experience that accompanies them, and relating specific somatic phenomena to the present contents of the therapeutic dialogue (for a description of some specific techniques with which to do this, see Conger, 1994).

Somatic phenomena can be treated in analytical work just like any other contents of the unconscious that require the therapist’s help to access the patient’s consciousness (i.e., a dream or an accident). This form of working with the body nevertheless can be, but is not necessarily linked to, implicit interactive processes that, as we have seen, are of great relevance in a relational body conception. In a relational body framework, explicit attention to implicit somatic phenomena is also an important focus of therapeutic work. But additionally the clinician has to be able to understand the reciprocal, interactive nature of the processes in question and, with it, his own implicit participation in the co-creation of nonverbal interaction patterns. The clinical examples we examined previously show relevant aspects of how this approach can be translated into practice. In any event, the concept of the body as shadow is a significant theoretical element that allows for the construction of a specifically Jungian conception of the possibility and importance of therapeutic work with the body.

Jung and the Body (IV): The Body as Self

Chodorow (1995) writes that for Jung the symbols of the self emerge from the depths of the body. Jung (1988 [1934–1939]) also states that there would be no “meaning if there were no consciousness, and since there is no consciousness without body, there can be no meaning without the body” (p. 94). So, the therapeutic approach to the body con-

stitutes a fundamental pathway of access to shadow contents as well making possible the emergence of significant symbols that can contribute to the patient's individuation process. In his commentaries on Nietzsche's *Zarathustra*, Jung (1988 [1934–1939]) goes even further: "It is a fact that we have bodies which have been created by the self, so we must assume that the self really means us to live in the body, to live that experiment, live our lives. [The] body is . . . one of the experiments in the visibility of the self" (pp. 120–123).

Furthermore, in "The Psychology of the Transference," Jung (1946) wrote that "the body is necessary if the unconscious is not to have destructive effects on ego consciousness, for it is the body that gives bounds to the personality" (p. 291). In light of these ideas, it seems surprising that analytical psychology has not as yet developed with greater systematicity methods to carry out what body psychotherapists call *grounding* an individual (Lowen, 1975), that is, methods to embody the individual in his own somatic reality, which is equivalent to what Jung calls "living in the body." Conger (1994), who trained as a bioenergetic body psychotherapist, describes relatively simple grounding techniques of direct work with the patient's body. Their application requires, however, that the therapist be grounded him- or herself. This means that the clinician has to be deeply familiarized with her or his own historical and immediate somatic reality and, from the point of view we have been developing in this paper, with her nonverbal interactive tendencies encoded in her or his implicit relational knowing.

One of the main methods of analytical psychology to access symbols of the self through an imaginary dialogue with personified figures of the unconscious is active imagination. Besides a traditional understanding of this method as a technique similar to working with other sorts of imagery, historically Jung suggested the possibility of using it quite differently. In "The Transcendent Function," he specifies that there are individuals "that do not see or hear internally, but their *hands* have the capacity to express the contents of the unconscious. . . . Relatively exceptional are those whose motor gifts make possible an expression of the unconscious through *movement* and dance" (Jung, 1957 [1916]), p. 100, italics in original). Even if he considered individuals like these as exceptional patients, what Jung says concretely is that in his office patients danced, sang, acted, played music, painted, and modelled (McNeely, 1987; Wyman-McGinty, 1998).

From the point of view of body psychotherapy, there were also "cases in which Jung made basic body-centered interventions such as rocking a client and singing to her" (Conger, 2005, p. xiv). Also, as stated by McNeely (1987), even if he did not develop his ideas about movement

as a form of active imagination, his pioneering experiments with the encouraging of healing bodily enactments opened to the post-Jungians a door to a beginning of integration of body work and dance in clinical practice. And, in fact, apart from the specific contributions of various post-Jungian dance therapists, there is a tradition of post-Jungian dance therapy (Chodorow, 1995). However, as we have mentioned, in the mainstream of analytical psychology one can detect an important lack of basic theoretical foundation for the use of body-centered interventions. One reason may be the fear of unethical bodily enactments. In this regard, it should be pointed out that, contrary to legend, Jung did not endorse and in fact specifically sanctioned against sexual enactments with clients (see Meier interview in the 1985 film *Matter of Heart*). The struggle to develop clinical principles regarding a Jungian theory of technique in relation to the somatic dimension can be observed clearly in Greene's (2001) work.

In the present reality of professional clinical practice, however, even the mention of therapeutic work with the patient's body always raises cautions about potential boundary transgressions, with direct touch of the patient's body evidently being one of the most controversial themes. This topic has emerged recently in depth psychology partly because relevant research has shown that not only between infants and early caregivers but also between adults physical contact contributes appreciably to the modulation of physiological stress responses (Fosshage, 2000; Sassenfeld, 2007; Schore, 2003a, 2003b). Notwithstanding the contradictory opinions in this unresolved area and of course its legal implications, many of Jung's thoughts regarding somatic reality and many of the findings of contemporary investigations of the implicit dimension of human interactions offer a significant alternative to physical touch between patient and therapist in working clinically with the body: the focus on nonverbal interaction patterns and their importance as immediate expressions of, and thus as potential vehicles for, the exploration and transformation of the patient's, the therapist's, and even the dyad's implicit relational history.

The concept of the body as self and of the body as "symbolic locus" opens up the possibility of developing techniques related to active imagination in working with the body. Such attempts have already been proposed and explored in post-Jungian dance therapy and in a Jungian approach to a body-centered methodology called "authentic movement" (Chodorow, 1995; Wyman-McGinty, 1998). These approaches have even emphasized relational concepts, such as the witness notion in authentic movement. However, it seems that an emphasis on nonverbal communication patterns in general and especially on the specific implicit interaction patterns that emerge and are co-constructed between patient and

therapist has been largely lacking, as has a more systematic link to recent research and conceptualization in areas such as those we have discussed in this paper.

Given Jung's (1935, 1951) repeated insistence on conceiving the psychotherapeutic relationship in dialectical, reciprocal terms, this might be surprising. At the same time, Jung's mutual-influence model of the therapeutic dyad is an additional conceptual element that can be read as pointing in the direction we have outlined in the present article. In this author's opinion, the development of active imagination techniques focused on implicit interaction will have to wait until we know more about how to handle and use intentionally and consciously the processes of the implicit dimension. As we said previously, until now it has not been quite clear how much of implicit knowing can actually be helped to access explicit processing, or even how desirable or necessary making explicit reciprocal implicit relational moves is for therapeutic change to occur in this dimension. We know that implicit processes are highly relevant and that implicit change mechanisms have a great therapeutic potential, but to my knowledge clinical work with them has not yet gone beyond initial attempts at presenting clinical material in light of these new concepts, as we have also done here. Nevertheless, it is not hard to intuit that this field of research will give way to significant and profound ways of working with unconscious relational processes and, for analytical psychology, with their symbolic potential.

Final Thoughts

Heuer (2005) points out that one of the goals of Jungian psychotherapy is touching the soul, but he notices that this formulation, though cast in a bodily metaphor, largely leaves the body out. In light of various of Jung's thoughts regarding the relationship between body and mind, the situation mentioned by Heuer seems in some measure surprising, though understandable. In an article on "Psychological Typology," Jung (1936) states that, in contrast to Freud, his own point of departure is

the sovereignty of the psyche. Given that body and psyche at some place form a unity despite being so different in their manifest natures, we cannot help but attribute to each one of them its own substantiality. Until we count with some form of knowing that unity, there is no alternative but studying them separately and, for now, treating them as if they were independent, at least regarding their structure. (p. 139)

So it seems that Jung actually chose consciously to dedicate his efforts to investigating the psyche in relative neglect of the bodily dimension. He knew that “in some form and at some place there is a unity difficult to discover of psyche and body that would require investigating psychically and physically” (Jung, 1936, p. 134). In this context, it should be remembered that apart from his attempts at understanding the psychological meaning of his psychotic patients’ delusions, Jung was a pioneer in hypothesizing that a neurobiological disorder whose details ought to be studied could underlie schizophrenia. Since, of course, no single researcher can pretend to study and apprehend human reality in its totality, today we are faced with the need to complete and amplify Jung’s understanding of the psychic dimension with contemporary knowledge about the somatic dimension.

If we consider the recent advances in fields like infant research and the study of implicit interaction in therapeutic processes, it seems clear that the body has already begun to occupy a significant place in psychotherapists’ work, and it is time for a theory of technique that lays the foundations of that dimension. As we have seen in this article, the conceptual elements for the construction of a theory of technique regarding the body from the perspective of analytical psychology are not lacking. We have tried in this article to show the most significant aspects of these in Jung’s own ideas about the human body. Additionally, we have tried to show that what Jung pioneered allows for the construction of an analytical theory with robust links to contemporary findings and concepts, especially as regards implicit relational processes. This line of thought should make possible the articulation of clinical strategies to work with the somatic interactive dimension of the therapeutic relationship.

The definition of psychotherapy as formulated by McNeely (1987) still speaks to what we have been trying to show in this contribution: “It is about bringing life back to deadened psyches through the body, and to deadened parts of the body through the psyche” (p. 10). To develop clinical guidelines for how this can happen within analytic work would be one way to move closer to the goal stated by Jung (1988 [1934–1939]): that body and psyche may live together.

Notes

1. Despite being Reich’s contemporary Jung does not seem to have taken notice of his work. Heuer (2005) regrets the lack of knowledge of Reich’s important contributions among analytical psychologists, who “mostly continue to dismiss Reich.” Some exceptions to this rule are McNeely (1987) and Wyman-McGinty (1998).

2. It is interesting to remember that Jung (1935) conceived of neurosis more as psychosocial phenomenon than as illness in a strict sense. He proposed visualizing the neurotic individual as a relational system which has become dysfunctional.

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