Contents

Preface x
Acknowledgements xii

Part I Narratives of Health 1

1 Introduction 3
   The body and the word 3
   Postmodern themes in psychoanalytic thinking 5
   The ‘joining up’ of physical and psychological experience 9
   Different approaches in health research 10
   Outline of the book 11

2 Psychoanalysis and Health 14
   The myth of perfect health 14
   Psychoanalysis and embodiment 16
   Bringing meaning to experience 19
   Winnicott and ‘indwelling’ 20
   Sylvia’s dream 22
   The centrality of narrative 23
   Surfaces and inner spaces 25

3 Thinking about Health 29
   Psychosomatic illness and psychosomatic health 29
   The enigma of health: contributions from phenomenology 33
   Postmodernism, social constructionism and health 36
   Humanistic psychotherapy approaches 39
   Eastern philosophical approaches 40
   Somatic awareness 42

4 Science, Medicine and the Psyche-soma 46
   Science and dualism 46
   The biomedical model of health 49
   The biopsychosocial model 52
   Cognitive behavioural psychotherapy 53
   Cause and effect 56
   Developments in the neurosciences 57
   The rise and rise of holism 58
CONTENTS

5 Psychoanalysis and the Psyche-soma 60
   Metanarratives 60
   Sigmund Freud 61
   Carl Jung 64
   Wilhelm Reich and body psychotherapy 67
   Melanie Klein 69
   Object relations theory 71

Part II Infant Observation Studies 75

6 Psychoanalytic Infant Observation 77
   Psychoanalytic infant observation as a research method 78
   Winnicott and observation 79
   Heredity and environment 80
   Psychoanalysis and developmental psychology 81
   Infant health and handling 83
   Holding and handling 85
   ‘Good enough’ mothering 87
   Primary maternal preoccupation 88

7 Touch and Well-being in Infancy 90
   The selection of observation extracts 90
   Early feeding experiences (Jack, Emma, Freddy) 91
   Lunch time (Jack and Emma) 98
   Falling apart and not falling apart 102
   A psychosomatic crisis (Emma) 104
   Touch deprivation: research findings from other sources 105
   Kangaroo care and baby massage 106

8 Movement, Enjoyment and Health 110
   The joy of movement 110
   Movement, touch and proprioception (Jack) 113
   Early infant play (Jack and Emma) 115
   Movement and psychosomatic recovery (Emma) 120
   Learning to walk (Jack) 125
   ‘Style’ and ‘quality’ of psychosomatic indwelling 128

Part III Adult Case Studies 129

9 The Body and the Word 131
   ‘Indwelling’ in adult life 131
   A confusion of tongues 132
CONTENTS

Listening with the body 133
The case study as research method 135
Touching and not touching in psychotherapy 137

10 Touch and Health in Adult Life 141
Symbolic equivalents of touch 142
Touch deprivation in adult life 143
‘Gentle bumps’: a case study of Richard 147
‘Body-brushing’: a case study of Linda 154

11 Physical Exercise and Emotional Well-being 160
‘Use’ and ‘abuse’ of exercise 160
Research findings from exercise psychology 163
Exercise and self-expression 164
Experiences of muscle and skin 165
Some meanings of running: a case study of Betty 166
Swimming: a case study of Sheila 172
The cultural context of physical exercise 177

12 Body Storylines 180
The ‘storying’ of experience 180
‘Showings’ and ‘tellings’ 183
Winnicott and body storylines 185
Essentially physical activities 186
Unconscious somatic communication 188
Working with body storylines 190
Concluding thoughts 193

Bibliography 195
Index 202
Part I

Narratives of Health
CHAPTER 1

Introduction

This book is written for the very large number of people who take a serious interest, whether personal or professional, in the interplay of psychological and physical aspects of health. It brings a psychoanalytic perspective to bear on our many and varied experiences and uses of physicality. Chapter 1 introduces the key themes that will be explored in the pages that follow.

The body and the word

In the beginning, the word is just one aspect of bodily experience. To the newborn infant, it is all cadence, rhythm, volume and tone. Words soothe, tease, excite or shock; sustain or cut across the infant’s own sense of its being. At this stage, the meaning of words resides in their physical impact alone. Later, words are understood to have a representational value also. If I say to a friend, ‘Look! The cat has come in’, the words themselves have a meaning. But the physicality of the words remains crucial to a more complete understanding. It is the manner of my delivery, and that alone, which will reveal whether the cat is an accursed nuisance or a loved and welcomed family member. Some playwrights – Harold Pinter springs to mind – are exquisitely aware of the physical impact of words. They create characters who use words as piercing darts, as weapons of war, who call into question our understanding of words as a civilised and refined form of communication.

The ‘word’, as I use the term here, includes not only speech and text, but also the whole quasi-verbal activity of thinking. The age of dualism, usually acknowledged as beginning with the work of philosopher René Descartes (1596-1650), has seen the body located in a separate arena from the word. In Cartesian philosophy,
thinking is attributed to the ‘mind’, which is seen as distinct from the body. Within holistic perspectives, this separation is disputed. Thinking and speaking are seen as aspects of our overall functioning, which is rooted in our ever-present embodiment. The body is regarded as essentially communicative and replete with memory and meaning. Our fingers remember the number of the bicycle padlock. Our bodies remember how to ride the bicycle, even after ten years, twenty years, out of the saddle.

The psychoanalyst and paediatrician D.W. Winnicott (1896–1971), who will be referred to on many occasions as the book proceeds, conceptualised the psyche-soma as a unity. In his work, ‘mind’ or mental functioning is described as being no more than a ‘special case of the functioning of the psyche-soma’ (Winnicott, 1949a). Like Winnicott, I believe that the nature of our being is essentially psychosomatic, in the original meaning of the word, given in the Concise Oxford English Dictionary (9th edn, 1995) as ‘of mind and body together’.

As most readers will be aware, psychoanalysis has been involved with psychosomatics from the very start. It was Freud who developed and made famous the ‘talking cure’ to help patients with a variety of physical symptoms which had not responded to conventional medical treatments. The array of symptoms in question was extraordinary – nervous tics, paralysed limbs, an inability to drink water, sexual dysfunction, outbursts of speaking in a foreign language accompanied by an inability to speak in one’s native language. For the most part, the term ‘psychosomatic’ has continued to be used, as Freud used it, in relation to situations involving pathology. We are accustomed to seeing the phrases ‘psychosomatic illness’, ‘psychosomatic symptom’ and ‘psychosomatic disorder’ but not the phrase ‘psychosomatic health’.

In this book, I characterise health in all its aspects as ‘psychosomatic’, as involving a complex and ongoing interplay of physiological and psychological factors. I build on the psychoanalytic understanding that, as a part of our ongoing human meaning-making activity, we consciously and unconsciously imbue our physical experiences with psychological significance. I suggest that the meanings that we ascribe to our experiences of physicality are woven into a narrative, which I have called a ‘body storyline’ (Turp, 1999a). It follows that physical changes are mirrored in psychological changes and vice versa. For example, it
may be the experience of a new sense of physical energy that indicates that emotional recovery is under way.

A client who came to me for psychotherapy had been depressed for more than a year, following a very harrowing sequence of events. One day, she found herself wanting to go for a walk. Rather excitedly, she dug out her boots from the cupboard under the stairs. She said to them ‘Hello there. I’m sorry I left you in that musty cupboard for such a long time.’ Then she put them on and went for a long hike. She told me that while she was walking, she began to feel much better. In fact, she felt really healthy. I asked her what it meant to feel healthy. She thought for a long time and then said that for the first time in ages she was able to imagine some kind of a future.

Postmodern themes in psychoanalytic thinking

The style and content of this book reflect the growing influence of a postmodern perspective. The overlaps and interstices between psychoanalysis and postmodernism have seen Freud’s work profoundly reshaped in the body of writing contributed by French psychoanalyst Jaques Lacan and his colleagues. More subtle and diffuse effects of postmodernism have found expression in a shift away from ‘totalising’ theories of supposedly universal application. Description and observation have come to the fore, and the local and provisional nature of ‘truths’ is more widely accepted. As a part of this development, psychoanalytic infant observation has become an important tool for understanding the nature of our experience. In psychoanalytic infant observation, description takes precedence over theory and the coexistence of multiple ‘versions’ or interpretations of the same observation is an accepted part of the discussion.

Winnicott spoke in favour of observation before these shifts in thinking took hold. His phenomenological approach and his desire to keep the consideration of physicality at the centre of proceedings offer a secure base for thinking about psychosomatic health. Winnicott accorded an unusual degree of attention in both his practice and his writing to the physical ‘handling’ aspects of the mother’s care of the infant, and to the ongoing adult issue of the ‘indwelling of the psyche in the soma’ (Winni-
cott, 1970). Other writers have also noted his distinctive emphasis on the physicality of the self:

(But) in post World War Two developments, psychoanalysis has become primarily a theory of mind and mental contents. Winnicott’s work stands out from this tendency in the deeply physical sense that he conveys to us about his work and his understanding of mental processes. (Orbach, 1995: 3)

Winnicott was also unusual in his explicit concern with health as well as with illness. In The Spontaneous Gesture, which draws together many of Winnicott’s letters to other analysts, Rodman writes of Winnicott that:

His theory of health is not defined as the absence of pathology. He is interested in more than that. He wants to define a healthy life in positive terms. (Rodman, 1987: xix)

Alongside Winnicott’s work, I draw on a narrative perspective, which represents one line of development of the postmodern ethos. My sources include the work of American psychoanalyst Roy Schafer and of Australian family therapists David White and Michael Epson. The basic narrative assumption in play is that events and experiences are available to us only as ‘versions’ and that we have no direct access to the true and the real. In an area of discourse which has spawned many dense and difficult texts, Schafer expresses this idea with admirable clarity:

It is especially important to emphasize that narrative is not an alternative to truth or reality; rather it is the mode in which, inevitably, truth and reality are presented. We have only versions of the true and the real. (1992: xiv)

This point of view has profound implications for psychotherapy practice. It speaks of the impossibility of neutrality, implying that all behaviour, including the psychotherapy dialogue, is organised and constrained both by the immediate context in which it is performed and by the wider social and political context inhabited by psychotherapist and client. Recognising the inevitable influence of consciously or unconsciously held beliefs or assumptions leads to an approach characterised by curiosity, by a greater respect for
the client's way of seeing, by the exploration of alternative possi-
bilities and hypotheses. The idea of arriving at a final truth, to the
exclusion of other versions of events, falls by the wayside. Reflec-
ting on his own psychoanalytic practice, Schafer states:

Psychoanalysis is conducted as a dialogue. In this dialogue, actions
and happenings (for example, traumatic events) are continuously being
told by the analysand and sooner or later retold interpretively by both
analyst and analysand. Closure is always provisional to allow for further
retellings. (1992: xv)

As will emerge, it has served my purpose to create an interface
between Winnicott’s work and narrative theory. Would Winnicott
have wanted this interface to be created? It is, of course, impossible
to know, but it is clear that Winnicott was not afraid to voice his
opposition to orthodox thinking. His independence of thought is
revealed in his refusal to align himself with either Melanie Klein’s
followers or Anna Freud’s followers during the 1940s, and in his
sometimes sharply critical letters to members of the Kleinian group
of the British Psychoanalytic Society during the 1950s.

It seems to me too that Winnicott’s work has a great deal in
common with the concerns of postmodernism. Winnicott found
himself intuitively opposed to ‘totalising’ tendencies. He favoured
observation and description over attempts to construct a grand
overarching theory. He had no desire to see everything ‘sewn up’.
When Joan Rivière wrote, in the preface to Klein’s text Developments
in Psychoanalysis (1952), that Klein had produced:

an integrated theory which, though still in outline, nevertheless takes
account of all the psychical manifestations, normal and abnormal, from
birth to death, and leaves no unbridgeable gulfs and no phenomena
outstanding without intelligible relation to the rest.

Winnicott vehemently expressed his opposition. He sent a letter to
Melanie Klein stating that:

You are the only one who can destroy this language called the Kleinian
doctrine and Kleinianism and all that with a constructive aim. If you do
not destroy it then this artificially integrated phenomenon must be
attacked destructively. (Rodman, 1987: xxii)
In relation to practice, Winnicott emphasised the importance of the facilitating environment, of the play, or interplay, between client and psychotherapist, of the transitional space between two people, the site of unconscious to unconscious communication and the crucible for the co-construction and reconstruction of experience. In his clinical work as well as in his public communications, Winnicott was concerned that theory – both in the narrow sense of personal beliefs and assumptions, and in the broader sense of psychoanalytic theories – should come into the service of practice, and not the other way round. He understood that theory had the potential to become a straitjacket and to stifle the creativity of therapist and client alike.

All of the above applies also to those analysts who have drawn on and developed Winnicott’s work – Jan Abram, Michael Balint, Christopher Bollas, Patrick Casement, Ronald Fairbairn, Masud Khan, Marion Milner, Adam Phillips, Charles Rycroft, Thomas Ogden, Val Richards, Neville Symington and many others. In recent years, a fruitful dialogue has developed between the Kleinian and the British Independent strands within psychoanalysis. In the sphere of psychoanalytic infant observation, for example, Winnicott’s understandings are thoughtfully integrated with those of the post-Kleinians. I have found that this conjunction offers a particularly rich blend of ways of seeing.

The practice of psychoanalysis has always taken the form of narrative and dialogue, of a certain kind of conversation between two individuals. Adam Phillips has described psychoanalysis as ‘a story and a way of telling stories that makes some people feel better’ (1993: xvii). For a long time, however, there was no readily available philosophical context within which to locate this central narrative and conversational aspect of the psychotherapy process. Postmodernism has provided that context and in so doing has faced psychoanalysis with a challenge. In some quarters, psychoanalytic orthodoxy continues to hold sway. This orthodoxy reveals itself in an unquestioning approach to basic assumptions. Psychoanalytic concepts continue to be discussed as if they were solid ‘facts’, certain and unchanging realities which hold good in all cultures and all circumstances. In other quarters, though, there is an openness to and engagement with postmodern ideas, particularly the ideas of social constructionism and cultural relativism.
Messer and Warren (1995) set out the central issue raised by contemporary developments in the following manner:

The question is raised as to whether good psychotherapy entails the discernment and working through of the correct and accurate underlying focus or conflict - which derives from a modernist, logical positivist perspective - or whether it is more like story construction or meaning making - an idea more wedded to a postmodern outlook. (1995: viii)

The ‘joining up’ of physical and psychological experience

The book falls into three parts, and my hope is that they do join up and form some kind of coherent whole. The first part is concerned with broad historical and contemporary issues which inform our understanding of the bodymind question. The second draws on psychoanalytic infant observations and considers how a sense of psychosomatic unity evolves and is supported, and at the same time how it can be damaged or depleted. The third section looks at the question of the recovery and enhancement of psychosomatic health, drawing on examples from psychodynamic counselling and psychoanalytic psychotherapy practice. A theme that links together the three parts of the book is the process described by Winnicott in terms of the joining up of the physical and psychological aspects of experience, first played out by the mother with her baby:

The beginning of that part of the baby's development which I am calling personalization, or which can be described as an indwelling of the psyche in the soma, is to be found in the mother's ability to join up her emotional involvement, which is originally physical and physiological. (Winnicott, 1970: 264)

In ordinary ‘good enough’ circumstances, the mother-to-be first engages in this joining up within herself, moving from seeing herself as simply ‘pregnant’ to feeling herself to be in relationship to an unborn child, with personal characteristics of his or her own. Stroking the infant in the womb through the skin of the abdomen, attributing intentions to the unborn infant (‘I see you’re in no mood to let me have a sleep!’) and asking questions (‘How are you
doing in there? Is it getting a bit squashed, eh?') are some of the external markers of this shift. After the birth, this ability to ‘join up’ is communicated to the infant through maternal care which involves a seamless experience of being held in mind and physically handled. Winnicott suggests that maternal handling meets with and supports an inborn tendency within the infant towards integration. Adam Phillips offers the following summary:

This natural ‘tendency to integrate’ is made possible by the mother’s care in which the infant is ‘kept warm, handled and bathed and rocked and named’. (1988: 78)

The question of how the mental and physical facets of experience are joined up is the ‘connective tissue’ (to use a body metaphor) which links together the three parts of the book. So it is that in Part I, I consider this joining up at the most general and abstract level, as it finds expression in changing historical and philosophical perspectives on the question of ‘mind’ and ‘body’. In Part II, I illustrate and discuss the role of maternal handling in the individual infant’s joining up of mental and physical facets of his experience and of himself. And in Part III, I consider adult narratives that reveal a need to address difficulties in feeling joined up, in feeling all of a piece within a skin. Here, the focus is on the psychotherapist’s role in assisting a process of joining up, through the creation of a context which supports the establishment or restoration of ‘a psyche-soma that lives and works in harmony with itself’ (Winnicott, 1967: 29).

**Different approaches in health research**

Many readers will be familiar with the well-established links between health, illness and social indices such as housing and income level. Research into health inequalities between different social and ethnic groups is of great importance and is indispensable to large-scale planning. I have not tried to summarise the research into the psychosocial aspects of health in this book, partly because my expertise is limited and partly because good summaries are available elsewhere (see, for example, Bakal, 1999; Sheridan and Radmacher, 1992).
I will say, however, that a full understanding of inequalities in health depends not only on identifying the key external factors, but also on understanding how individuals interpret their experience of an environment. Why does one person remain healthy in a disadvantaged situation while another falls ill? How does a low income translate into poor health at the level of the individual? It is in considering these questions from the point of view of the experiencing subject engaged in bringing meaning to his or her experiences that psychoanalytic thinking can make a valuable contribution. The point is not to arrive at general laws of connection between circumstances and individual health, but rather to understand what it is like for an individual child or adult to sustain, to lose, or to recover a state of health.

The psychoanalytic methodologies of the infant observation study and the clinical case study are those which I have used in my original research. They are described at the beginning of Parts II and III of the book respectively. At certain points, I have also introduced findings from quantitative research. In discussing the role of touch experiences in infancy, for example, I draw on several larger-scale studies to provide ‘triangulation’ (Denzin, 1970) of the qualitative evidence that I have gathered myself.

Within the general framework of factors that contribute to or detract from health, I have taken a particular interest in a more specific question. How are experiences of touch and movement implicated in the establishment, maintenance and recovery of health? Winnicott draws particular attention to these matters in his account of maternal handling, and I have extended his thinking to bring it into relation to ‘self-handling’ in adult life. The concept of self-handling, as I use it here, refers to all the experiences of movement and touch that we consciously or unconsciously seek out and that form a part of our continuously evolving body storylines.

Outline of the book

In Chapter 2, I describe in more detail Winnicott’s concept of ‘the indwelling of the psyche in the soma’. I sketch out some key characteristics of a psychoanalytic approach to health and these are compared and contrasted in Chapter 3 with other holistic perspectives. Chapter 4 reviews key features of the biomedical model of
health and looks at the relationship between science, philosophy and our understanding of health. Chapter 5 concludes Part I of the book, with a broad (although inevitably incomplete) overview of some specific psychoanalytic perspectives on ‘mind and body’ and/or ‘embodied mind’.

Parts II and III of the book establish its character as a book of single cases, of individual narratives which I refer to as ‘body storylines’ (Turp, 1999a). The examples illustrate some of the ways in which an individual comes to inhabit, experience and express his or her physicality. In both of these sections of the book, narratives of touch and movement experiences are at the centre of the discussion.

The infant observation section offers what is, as far as I am aware, the most sustained descriptive account available of ‘handling’ in infancy. The discussion focuses particularly on physical aspects of maternal care, on the infant’s self-initiated movements and on the responses encountered by the infant as he begins to become mobile. In my view, it is infant observation which makes the most compelling case for the essential unity of the psyche-soma. I have been fortunate in having permission from the families concerned to use observation extracts in their original form in the book, and only names and other identifying details have been changed.

The narratives in Part III come from clinical work, undertaken by myself or by psychotherapists and counsellors whom I supervise. In these cases, details have been changed, interspersed and recompiled so that no one person will find his or her story revealed to the public eye. This part of the book considers individual endeavours to sustain and/or recover a sense of well-being, particularly where poor handling in infancy or later trauma has damaged the psychosomatic integrity that underpins the experience of overall health.

I use the terms ‘psychotherapist’ and ‘psychoanalyst’ in the book as seems appropriate. What I have to say applies equally to psychodynamic counsellors, whose work is also represented here. Where a practitioner is working from a non-psychoanalytic perspective, for example family therapy, cognitive behavioural psychotherapy or a bodywork approach, I make this clear in the text. I use the word ‘client’ to refer to the person who is seeking help or self-understanding. For the sake of simplicity, the person mothering an
infant is referred to throughout as ‘the mother’. This person is most often the biological mother but may also be the father, a same-sex partner or a close family friend or relative. Infants are generally referred to as ‘he’, except where I am writing about a specific girl infant or where the gender of the infant makes a significant difference to the dynamic being described.

The book moves from some general and quite complex scene-setting to individual examples, taking the form of illustrative material written in non-technical language. Some readers may prefer to turn to this illustrative material first, and I have set the book out with this possibility in mind. Readers with a strong interest in infant development will probably feel inclined to begin with Part II, while those who are most interested in clinical work with adults may wish to move directly to Part III. The reader can return to the historical, theoretical and philosophical issues addressed in Part I at any stage.
Index

A
acupuncture 41
adult case studies 147–59, 166–76
Alexander, F. 18, 51, 57
attachment theory 143
Ayurvedic medicine 41

B
Bakal, D. 54
biomedical model of health 49–51
Bion, W.R. 19
biopsychosocial model of health 52–3
Blackmer Dexter, J.
on movement and touch 66–7
on proprioception 26, 114–15
body, dual meaning of 25
body, objectification of 27
indwelling, problems caused by 27
psychosomatic disturbances increased by 27
society, emphasis on 27
body storylines ‘alexithymia’ 181
as conceptual framework 180–1
body clues, in clinical situation 181
countertransference in clinical situations 189–90 see also adult case studies, Chapters 10 and 11
narratives of physicality 4, 140, 180–94
physical appearance, response to 180
psychosomatic indwelling and essentially physical activities 186–8
psychosomatic splitting, as part of 181–2
showings as psychosomatic symptoms 183–4
showings as reflection of experience 184
showings, definitions of 183
somatic communication (unconscious) 188–90
tellings, as key to behaviour change 184
tellings, as reflection of experience 184–5
tellings, definitions of 183
valuing of self (Alvarez) 182
Winnicott on psyche-soma 185–6
working with (in psychoanalytic psychotherapy) 190–3
bodywork psychotherapy 40, 67–9
Boss, M. 33
British Psychoanalytic Society 7
Broom, B. 18
Burr, V. 36

C
Cartesian philosophy 3, 33
case study research methods 135–7
infant development, role of 83–5
‘kangaroo care’ of premature babies 106–7
touch deprivation 105–6
Winnicott on 5, 10, 83–5
see also infant observations
health
and postmodernism 36–9
and social constructionism 36–9
phenomological approaches 35
health, biomedical model 49–51
clinical experience 50–1
Western medicine, limitations of 50
health, biopsychosocial model 52–3
break with behaviourism 53
challenge to biomedical paradigm 52–3
health, environmental influences as factor 18
health, perfect (myth of) 14–16, 35
false understanding of 16
Phillips on Freud 15
self-denial 15
self-punishment 15
health research, different approaches 10–11
Heaton, J. 33, 34
on health as dynamic 35
Heidegger, M. 33
heredity and environment evolutionary psychology theories 80
Klein’s theories 80–1
political views on 80
Winnicott on 80
holism, in psychoanalytic approaches 58–9
holistic approach to health practices 41
holistic perspectives of
mind/body 4, 19
humanistic psychotherapy approaches 39–40
bodywork psychotherapies 40
Maslow, A., peak experiences 40
WHO perspective on health 40
humanistic psychotherapy/existential psychoanalysts, different perspectives 14–15

I
illness
causation, confusions in 31
causation, theories 31
porphyria as example of 31
see also physical illness and psychosomatic illness
indwelling (psychosomatic health)
and essentially physical activities 186–8
case study 32
characteristics of 32
‘good enough’ concept of 33
positive elements, summary of 33
indwelling in adult life,
psychoanalytic approaches 131–2
case study research methods 135–7
psyche–soma split, recurrent risk in adult life 132
therapy, somatic aspects of different approaches 132–3
transference and countertransference, somatic aspects 133–5
indwelling, disturbances of case studies in adults 147–59, 166–79
INDEX

touch deprivation, linked to 105–6, 145–6
see also infant observation studies
infancy, touch and well-being in 90–109
infant health
‘good enough’ mothering 87–8
handling, role in development 83–5
‘holding’, Winnicott definition of 85
‘unthinkable anxieties’ 86
see also infant observation studies
infant–mother relationships 83–9
‘good enough’ mothering 87–8
primary maternal preoccupation 88–9, 99
infant observation, psychoanalytic methodologies 11
clinical case study 11
infant observation studies
anxiety, infant coping mechanisms 103
baby massage 107–9
depressed mother 100–1
early feeding experiences and child’s well-being 91–102
family vs professional care 108–9
kangaroo care of premature babies 106–7
observer’s role 97, 118
physical symptoms as communication device 104–5
play, early infant experiences 115–20, 122–4
Stern on mother–infant interaction 99
touch deprivation 105–6
Internet, role in information exchange 38
J
Jung, C. 26, 64–7
K
kinesthetic sense 26
Klein, M. 7, 18, 69–71, 80–1
knowledge
Foucault on information–power relationship 38
in doctor–patient relationship 38
information, importance in decision-making 39
Internet, role in information exchange 38
Kuhn, T. 52
M
Maslow, A. 40
massage, benefits of 144–5
for babies 107–9
for depressed mothers 144
for the elderly 144
post operatively 144–5
May, R. 14–15
McDougall, J. 16, 18, 71
meditation 41
Merleau-Ponty, M. 33
Messer and Warren 9
metanarratives 60–1
mind–body relationship, philosophical issues 47–8
holistic perspectives 4, 19
modernism, criticism of 48
mobility see walking and movement
mortality, denial of 35
movement
early experiences of 110–12
maternal response to 111
physical self-expression
through of healthy infant 110–11
see also walking
movement and psychosomatic recovery 121–5
in depressed mothers 122–4
mobility as aid to recovery 121–6
mobility, healthy development of 121
mobility used in negative way 120–1
movement and touch in growing child 120
see also walking
movement and touch, physiological processes 113–14
‘double touch’ experiences 116–17
play, infant observation 115–20, 122–4
proprioception 113–14

N
narratives
dreams 22–3
experience, re-narrated
nature of 37
implications for psychotherapy 6
interpretation 23
metanarratives 60–1
of physicality see body storylines
postmodernist ethos 6
psychoanalysis as 8
reinterpretation 23–4
‘storying’ 24
theory 23

neurosciences, developments in 57–8
and psychoanalysis 57–8
dualistic framework, shift away from 57

O
object relations theory 70, 71–4
Ogden, T. 133–4
Ogden, W. 73
Orbach, S. 189

P
perfect health, myth of 14–16, 35
phenomenological approaches 33–5
dualism, views on 34
health, definition of within 35
in psychotherapy context 34
totalising theories, antipathy towards 34
Winnicott, agreement with 34
Phillips, A. 8, 10
physical activity as psychological help 140
physical exercise
and relationship to own physicality 165–6
and self-expression 164–5
as offset to frustration 164
beneficial use for emotional well-being 161, 162, 172, 178 see also adult case studies
different expressions of 161 ‘essentially physical’ activities 161
exercise psychology, research findings from 163–4
motivations for 162, 163–4
negative use (exercise abuse) 161, 162, 178
physical benefits of 160, 163
psychological recovery
process, as part of 161,
163–4, 166 see also adult
case studies
running, case study (Betty)
166–71
social and cultural context
162, 177–9
swimming and quality of
psychosomatic indwelling
172–3
swimming, case study (Sheila)
172–6
within holistic framework 179
physical illness, importance of
psychological factors in 17
psychoanalysis/science/
medicine, clashes between 17
symptoms as expression of
psychological conflict 17
physicality
experiences of, as narrative
(body storyline) 4, 140,
180–94
Jungian view 26
proprioception, examples of
26, 113–14
self, sense of as embodied 26
positional sense 26
postmodernism and health 36–9
experience, re-narrated
nature of 37
Foucault on
information–power
relationship 38
future-oriented thinking 39
information, importance in
decision-making 39
intellectual framework 36
Internet, role in information
exchange 38
knowledge in doctor–patient
relationship 38
theories incompatible with 36
postmodernism, narrative
perspective 6, 23, 38
postmodernism vs orthodoxy 8
proprioception 26, 113–14
Blackmer Dexter J. on 114–15
consequences of damage to
26–7
psyche-soma and psychoanalysis
Field, N. 73–4
Freud 61–4
Jung 64–7
Klein 69–71
McDougall 71
metanarratives 60–1
object relations theory 70, 71–4
Ogden, W. 73
Reich and body
psychotherapy 67–9
theories and
counterarguments 61–74
Winnicott 72
psychoanalytic approaches,
holism in 58–9
psychoanalytic infant
observation
as research method 78–9
developmental psychology
81–3
environment, influence of
80–1
handling, importance to
health 83–5
heredity, influence of 80–1
training programmes, use in
77–8
video footage, microanalysis
83
Winnicott’s work in 79–80
psychoanalytic orthodoxy 8
psychoanalytic theory
case studies, importance of 18
dualistic paradigm 18
Klein on 7, 18
psychoanalytic thinking,
postmodern perspective 5
Freud, 5
Lacan, J. 5
psychological disturbance as
factor of physical symptoms 17
Freud on 17
psychosomatic health
(indwelling), characteristics of
32
case study 32
‘good enough’ concept of 33
positive elements, summary of
33
see also somatic awareness
psychosomatic illness
Freud on 4, 16, 17
‘malingering’, perception as 30
pathology bias 17
psychoanalysts’ views 16–17
self-blame 30
symptoms, reality of 30
terminological stigma of 29–30
psychosomatic pathology,
perspectives on 30
psychosomatic
aggravation by mental stress
30–1
and aspects of health 4
definitions of 30
Freud’s work 4
meaning (original) of 4
mind–body link 31–2
psychoanalysis, relationship
with 4
use in relation to pathology 4,
17
psychotherapy outcome studies,
results of 25

R
Reiki 41
Riviere, J. 7

Rodman, F. 6
Rogers, C. 14–15
Rycroft, C. 17

S
Schafer, R. 6, 7
self, sense of as embodied 19,
26
self-expression and exercise
164–5
self-handling 11, 165, 166
self-harm, as result of touch
deprivation 145–6
therapist’s role 146–7
self-narrative, social/cultural
context within 20
social constructionism 23
and health, 36–9
Lacanian theory 37
metanarratives 37
social indices, health/illness
links between 10–11
somatic awareness,
impoverishment of in clients
42
in cognitive behavioural
therapy 54
increasing awareness, benefits
and problems 43
patient–carer relationship,
role in healing 44
processes to achieve 43–4
psychosocial approaches 44
psychosomatic health 44–5
Soth, M. 134
Stern, D. 82, 99

T
therapist–client relationship,
unconscious mirroring 171–2
see also transference and
countertransference
INDEX

touch
and somatic awareness 141–2
and well-being 141
attachment theory 143
gaze as touch 142–3
symbolic equivalents of 138, 142–3
see also movement and touch
touch deprivation
ageing process, as part of 143–4
case studies and therapy outcomes 147–159
elderly, depression in 145
harmful touch experiences 145
in adult life 143–159
in infancy, developmental and physical effects 113
linked to disturbances of indwelling 145–6
linked to self-harm 145–6
massage, benefits of 107–9, 144–5
therapist’s role 146–7
touch, increase of in health improvement 144–5
‘hands-on’ therapy, growth of 144, 145
touch in psychotherapy, arguments 137–8
bodywork therapists 137, 139
distancing, use of 139–40
formal physical contact 138, 139
informal physical contact 138
limitations/risks 139
transference–countertransference matrix 139
transference and countertransference
countertransference in clinical situations 189–90,
see also adult case studies, Chapters 10 and 11
somatic aspects 133–5

W
walking, development of 125–8
infant’s own experience of 125, 126–8
others’ negative attitudes 127
others’ positive attitudes 125–6
pseudo-independence 127
White, D. 6
Winnicott, D.W.
development of work by others 8
false self 21
handling, in mother–infant relationship 5, 10, 83–5
‘holding’ in mother–infant relationship 85–6
indwelling, of psyche in soma 5, 20–22
infant observation 79–80
integrated theory, opposition to 7
object relations theory 71
phenomenological approach 5, 34
postmodernism, commonality with concerns of 7
psyche-soma 4, 185–6
psyche-soma, holistic perspective 72
self, physicality of 6
true self 21
words, physical impact of 3
see also touch, symbolic equivalents of

Y
yoga 41