ROUTLEDGE Taylor & Francis Group

The fear of the body in psychotherapy

JOHN ANDREW MILLER

ABSTRACT This paper identifies the fear of attending to and engaging with the patient's body and the therapist's body, regardless of therapeutic orientation, as a topic rarely explored in books and articles but pervasively experienced because of the cultural norms brought to the consulting room. It explores how we might name the constituent parts of this fear and describes how they inter-link. A case study then exemplifies learning about and transforming such fear in both patient and therapist. Finally, the paper offers suggestions of how therapists might increase their awareness and turn this fear into a tool which extends their range of skills.

KEYWORDS Body, bioenergetics, Bioenergetic Analysis, fear, somatic countertransference

INTRODUCTION

A psychoanalytic colleague reacted in horror when her patient got off the couch and walked around the room, swinging his arms, talking loudly. When I heard her story, I thought I would not have had the same reaction: as a body-oriented psychotherapist, I expect my clients to move around, inhabit their body and embody their experience in the consulting room, in my presence. Yet I too have been frightened in sessions: once a client became increasingly

Psychodynamic Counselling
ISSN 1353-3339 print/ISSN 1470-1057 online © 2000 Taylor & Francis Ltd
http://www.tandf.co.uk/journals

hysterical and rageful, flailing away at pillows, unable to stop or in any way interact with me, crying, and yelling louder and louder. Although we had worked together for several years, and had talked at length of her fear of using her body in our therapy, now, when the body movement was finally happening, I was afraid, lost, overwhelmed.

Then I noticed signs of fear of the body even among body-analytic colleagues. In America, many body therapists now shy away from active cathartic body expression in their sessions. In Britain, we have often heard that body-oriented psychotherapy was too un-British to succeed in this country. Yet, on the Continent, Bioenergetic societies have waiting lists for training places and patient loads. Perhaps the fear that my colleague and I had each experienced was reflected institutionally, internationally and culturally.

I think the fear over the body is a neglected field, mostly handled in supervision if at all: rarely talked about, rarely written about. Although writing from the perspective of a body-oriented psychotherapist, I think fear of the body permeates any psychotherapy, regardless of the therapist's orientation. Such a fear is psychodynamic, that is, part of the interplay between therapist and patient.

In this article, I aim to discuss what might be some of the fears of the body in psychotherapy, both the therapist's and the patient's fears, reflecting, I think, our cultural ambivalence towards bodies and body expression. I shall then share a particular patient of mine with whom I had to begin without any body involvement, perhaps out of his fear, perhaps out of mine. Recognizing how this reluctance affected both of us enabled me to turn it into a helpful contribution to accessing his blocked emotions by utilizing a mixture of bodily interventions and verbal interpretations. I shall end with some specific practical recommendations for fellow counsellors and therapists.

THE BODY, MOVEMENT, AND PSYCHOTHERAPY

Every school of psychotherapy pays attention to and makes use of the body, but usually limits involvement to a verbal and thus symbolic, even intellectual discussion of the body. The work of Joyce McDougall, especially *Theatres of the Body* (1989), is already familiar in Britain. Perhaps less well known are the books of the New York Jungian, Nathan Schwartz-Salant, especially his book *The Borderline Personality: Vision and Healing* (1989), which is full of discussion on clinical body material.

Actual physical expression through the body, that is, incorporating an experiential component, is rare but not unknown in psychoanalysis. For example, Patrick Casement (1985) writes about allowing and exploring why his patient wriggled excessively on the analytic couch. Donald Winnicott reports holding the head of a woman patient in his hands and rocking her (1969). And Nina Coltart's patient, in a fit of rage, swept everything off the mantelpiece (1993). These examples are of patient-initiated movement. In books and articles, we rarely hear of the therapist matching the client's movement or even suggesting movement. Only through personal communications have other psychodynamic practitioners shared with me how they use their body and their client's body in sessions.

Humanistic psychotherapies also give the body prominence, verbally and sometimes physically. Transactional Analysis, the creation of Eric Berne, enjoins the therapist to 'think sphincter', that is, heed the patient's references to those body parts like the anus and the mouth with a circular, closing-and-opening muscle (1974). Both psychodrama and Gestalt Therapy make active use of the client's physical being: Gestalt with its emphasis on repeating the client's spontaneous gestures and giving a voice, a message to them; psychodrama in exploring the physical enactment of the patient's story and trying out alternative responses (Kepner 1993; Polster and Polster 1973).

Many of these different approaches are utilized and synthesized in Bioenergetic Analysis, a psychoanalytically oriented dynamic psychotherapy which looks at how the patient embodies – that is, has structured into the body – his or her past experience. Developed by Wilhelm Reich's student, Alexander Lowen, Bioenergetic Analysis posits that all trauma is rooted in the musculature of the body. By putting the patient into a stress position and then coming back to normal – that is, by tightening and then releasing the musculature – the underlying trauma can come back into consciousness and be dealt with psychoanalytically. This does not just happen in therapy: any one who has been massaged will recall how, as the masseur or masseuse works on the muscles, day dreams come into awareness, fantasies which might be rich in psychological material.

'The body never lies.' By attending to body shape, breathing, and muscular tightness, the Bioenergetic therapist can quickly make a diagnosis of the client's core problem in terms of developmental arrest, often perceiving correctly the age at which growth was compromised (Lowen 1975). Bioenergetic theory believes the client,

originally in childhood, constricted muscles and reduced breathing to cope with some situation she or he could not master. Not surprisingly, some inkling of this original problem is encountered when freeing up the body, that is, using exercises to loosen the long-constricted musculature (Lowen and Lowen 1977). In so doing, the client often comes in touch with his or her fear of bodily self-perception, fear of bodily expression of emotion or even fear of sometimes quite simple movement. Bioenergetic approaches appear to work particularly well with clients facing pre-verbal issues or experiencing a shock state (Kirsch 1997).

Activating the body, the therapist utilizes Bioenergetic exercises such as standing with knees slightly bent, called 'grounding' and working to strengthen the legs and loosen muscular tension. At other times, the therapist might suggest expressive work such as kicking and hitting, or touching, palpating, or massaging to release tight knots of tension. These physical interventions aim to mobilize the blocked energy in the body and enhance bodily feeling.

Three recent developments have influenced Bioenergetic practice in England. David Boadella, in his approach called Biosynthesis (1987), has modified Lowen's original ideas of provoking feelings through Bioenergetics exercises and replaced them with the therapist attending to ways of evoking feelings through accentuating body awareness and patient-led enactment (personal communication). Object relations theories, particularly the work of Mahler and Masterson, Kohut and Kernberg, and Winnicott, have helped to provide a theoretical underpinning to why Bioenergetics is effective. Bioenergetics provides a model of diagnosing bodily the time when the infant–caretaker relationship went awry. More recently, advances in psychobiology and attachment theory have also validated the need perceived by Bioenergetic therapists for body mobilization and involvement (Schore 2000).

This type of therapy also provides the patient with a model of an embodied person, a self-object in the therapist who is active and alive, who sees the body as Lowen sees it, a source of pleasure and not only a source of suffering.

Much of the theoretical underpinning of body-oriented psychotherapy comes from analytic practice and writing. Like most Bioenergetic analysts I know, my work has been greatly informed by traditional verbal analysis, in my case by my Freudian first analysis and my Jungian training analysis, and by reading widely in psychodynamic books and articles.

I have tried here to sum up a few points that would unify a wide spectrum of neo-Reichian body psychotherapies, including derivatives of Lowen's pioneering work. Regardless of orientation, these practitioners believe change takes place only when the client is able to release and reorganize bodily. Therefore, the patient needs to re-enact the situation in the presence of the therapist, utilizing the body, allowing it to be alive and present in the re-enactment, and not just kept symbolic and only verbal. The aim, I think, of all body psychotherapies is that of integrating psyche and soma.

AMBIVALENCE ABOUT BODIES

This integration is difficult to achieve in our culture, as it is, at best, ambivalent to the body. Cultural training has taught us as children to be quiet, sit still, and not fidget. We are told not to be too active, boisterous, or talk too loudly because the neighbours will hear you or think you are crazy or you might upset them; above all, don't touch yourself or another person, don't stare. By the age of 10, we know the handsome man gets the beautiful woman and we perceive the ugly one as the villain, the overweight one needing a diet. By adolescence, if not before, we have developed a love/hate relationship with the body, our own and others: supermodels sell glossy magazines telling us how to be more attractive. We hear stories about or experience illness; we are told to do a thousand things from flossing our teeth to practising safe sex because our body will betray us – develop anti-bodies – be unable to fight off some invading germ or virus, stop some terrible cancer. Certainly by adulthood, we see the body as a battlefield of conflicting forces, and a minefield of things that could go wrong. Conversely, if not perversely, bodies are seen as beautiful, the source of happiness, the means for being real. Sex and sexual attractiveness reign supreme, if not in everyday life, at least in media image creation and in our fantasies.

Above all, we have developed some mind–body split. The head prevails; knowing the right answer is what counts, as is reinforced by television quiz shows and the school examination system. We judge it important to be in control of – not in touch with – feelings: again, most television shows and movies value the clear-thinking James Bond and overtly or subtly downplay the emotional, perhaps romantic, and lovelorn supporting character. This triumph of mind over body – these conflicts over the body beastly versus the body

beautiful – are known in every consulting room, and indeed may be the underlying reason why people seek therapy.

So ingrained in us therapists are these issues that they remain when we practise, subconsciously if not unconsciously. We might say that we therapists embody these cultural norms, as we usually sit very still, talk quietly, and, if using the couch, are heard but not seen. We consider ourselves – and others deem us – professionals who have opted for a quiet, reflective, contemplative life in the head, not for a lot of physical exertion or athletic prowess.

DIFFERENT TYPES OF FEAR

Ambivalence towards bodies often becomes fear, and we take different types of fear into the consulting room. Many of these fears overlap, but in writing I have to separate them out, so I will indicate the links I perceive. I can group these fears into losing control, not knowing, and losing face.

Loss of control in both emotional content and management is certainly feared. In truth, we probably fear the patient or ourselves becoming too sexual, or too angry, or too violent, or too noisy. During a recent noisy session, I found myself concerned about colleagues when one of my own patients started shouting loudly. Somehow I felt I was responsible and thus likely to incur my adjacent colleague's displeasure, even though I often hear her client's noise in my room.

Rarely do we fear the patient will lose sphincter control in the session. The only example I can readily recall is from Nina Coltart's *How to Survive as a Psychotherapist* (1993) when she talks of a patient vomiting in a session. But frequently, a patient reports a fear of losing sphincter control, and perhaps having to find the loo in the middle of a session, or possibly even using the toilet before each session, which indicates an underlying fear.

We fear a loss of control of the practical elements: fear of when or how to stop, including stopping on time. I include here the perhaps very real fear that, if some feared area is explored and the underlying or resultant fear not contained, if it gets too heavy, if too much comes up, the patient might not come back.

In many cases, this fear of loss of control might be linked to shame, a fear of loss of face, a wound to self-image. This fantasy often involves a real or fantasized observing outside person – we fear another colleague might judge how we practise. But we can as often

be our own worst judge: we could fear that the bodily expression is acting out, not going deeper, thus engendering the fear of being professionally incompetent.

With just the verbal material, we struggle often enough to make sense of what our patient is saying. The therapist fears not being able to make sense of the body movement, especially if, for therapist and/or client, there are no words for it. A related fear for both patient and therapist is not knowing what will emerge from the body work, which again may touch on not understanding and may also engender a fear of being misunderstood. We may not live up to our self-image if we do not know what structures to suggest, what sensation to highlight, how to interpret when engaging actively with the body in psychotherapy.

If we do not know, will we survive? Can we tolerate (I link this with a fear for survival that might also be a fear of) powerlessness? This fear is obvious, say, in the face of terminal illness, human deterioration, or impotence. It is less obvious but very much present in the face of potential damage to therapist or patient. Fear of survival may be engendered by our furious hostility. We need to remember that hostility is meant to frighten us, to render us powerless, and we are programmed to react instinctually to hostility with fear, with a fight/flight response. Additionally, I would put here the fear of contagion, that the patient's fear will be so great as to disempower us.

It is thus not surprising that therapists shy away from direct contact with the body, either their own or their patient's. It seems much safer to keep the psychotherapy on a purely verbal level. Moreover, Bion reminds us that, in every consulting-room situation, there are two frightened people, and I believe the fear interacts to ensure the contact remains verbal. I certainly felt powerful forces were at work to keep the therapy verbal with the client I am about to discuss.

THE CLIENT WHO WOULD NOT MOVE

James started working with me after a second suicide attempt had led to hospitalization. A four-year psychoanalysis after his first attempt had been moderately successful but had not prevented, after termination, another nearly successful suicide attempt. Now James felt burdened and confused; he labelled himself manic-depressive. He sought Bioenergetic Analysis as he felt his previous analysis had missed something vital, something very deep, perhaps in his body.

Certainly James did not look a man at home with his body. Of short height, he appeared very compressed, almost squashed or burdened, with a thick, short neck, heavy legs, and a puffed-up chest. He was admittedly overweight, due, he said, to his anti-depressant medication but, as it turned out, also due to his fondness for good food and quality wines. He moved in a very rigid, halting, almost robotic way. In bioenergetic terms, he showed a masochistic body structure in his compressed presentation, orality in his collapsed yet bloated chest and stomach, and rigidity in his segmented movement.

These aspects of his body structure were confirmed by the concerns he verbalized. At our first meeting and after, James could not recognize how much he talked about anal topics or talked in anal terms, saying he hated any mention of elimination functions. Although he denied any fears of homosexuality, his constant references to it, especially anal sex, made me wonder about some passive-feminine problems and passive-aggressive behaviour. His recurrent fussing over food and medication reflected developmental problems at the earlier, oral level. Not fitting into an obvious character type, his fear of developing cancer made sense in terms of the family history, as did the frequent mention of alcoholism.

His attachment history was dire. He was the youngest child of a very ill mother who had survived breast cancer when James was 4. From that time, James remembers her as being obsessed with cleanliness, tidiness, and a fear of germs and viruses. She was unable to play with her three children and often left them alone, ostensibly asleep, as she went out to work the night shift. James's father was much older and also often too ill to work, having a liver condition brought about by alcoholism, which put paid to his promising military career. Their combined states of ill-health and the resultant financial hardship meant several moves around the country as James was growing up, plus pressure on James to leave school and earn money as soon as possible. He worked his way up in a law firm, getting A-levels at night school and eventual professional recognition as an international corporate lawyer. He moved from law firm to law firm and from girlfriend to girlfriend, marrying a woman professional with a workaholic script with a large income and potential inheritance from her controlling and alcoholic mother. James and his wife now lived with their two small boys in a large house in an expensive part of town.

This outward success masked an inner fragility. When I asked James, he thought the suicidal feelings came when he faced an intractable

problem in the legal cases he was arguing. Each time he encountered professional difficulties, he also encountered perfectionist demands from his wife who insisted he do better, especially harping on about James's problems in collecting fees. He stated, more with disbelief than with anger, that the wife, the judges, and even his own clients 'did not play by the rules', especially when he was in crisis.

James started coming to therapy twice weekly, ostensibly for body-oriented psychotherapy. I soon discovered, however, that if his spirit was willing, the body was not. Getting James out of his chair and moving in the session proved very difficult. Bioenergetic standing exercises, designed to get more feelings into the legs, or stretching exercises over a breathing stool or large balloon, so as to soften his very tight, inflated chest, failed to elicit any emotion from him. If I asked him to explore by exaggerating a hand or foot gesture he was making – here using Gestalt Therapy body awareness – I got no response except a polite 'that was interesting' before James returned to what he had been talking about or some seemingly unrelated new topic. When queried, James said that, with the talking, he knew where he was; it was just like his previous therapy. He was clearly 'playing by the rules' as he knew them. Perhaps he was also displaying masochistic withholding, spite, and contempt for me.

With resistance to the bioenergetic work, I proceeded more verbally, which I often do with patients who are attracted to body therapy but unable to make use of it. I pondered whether the inability to engage James's body was a defence – part of his obvious rigidity and his need to control everything that came out of him and everything I might give him. I then wondered what was being avoided by keeping everything verbal? And who was avoiding what? I knew increasingly how he feared losing control of what was happening in court or control of what his administrative staff were doing. It was a short step to asking myself whether his resistance to body movement was due to his fear of losing control of what came out of or went into his body. I also asked myself if I was opting for talking because I feared another breakdown if I engaged his body in our sessions, and perhaps he feared that as well.

James showed classic signs of fear, such as dry mouth and sweaty hands, a tripping over his words and, above all, changing the topic instead of exploring difficult areas. Some of these symptoms could be due, I knew, to his psychiatric care and medication. I once asked him directly, but he insisted he felt no fears, only a mild amusement whenever I brought in something about his body.

With my supervisor, I discussed the tremendous amount of rage James stifled. More significantly, I broached my fear of that anger, especially if physical exercises released anger too rapidly to be analysed and contained. I see now how I was expressing the fear that his angry feelings were too overwhelming. One countertransferential sign of this fear of anger was getting very tired in James's sessions. Another was my tendency to side with James's children when he tried to control them with threatening punishments. Upon reflection, I realized I was identifying with their natural vigorous responses to the events that befell them, and I too was rebelling against James's highly stylized, programmed, and often anti-alive responses to any natural and possibly exuberant behaviour in our therapy.

After several years, the therapy remains primarily verbal, but we have evolved some ways of using his body in our psychotherapy. We often start the sessions with some warm-up exercises. Verbal free association follows as James shares whatever comes to mind, which increasingly relates to the physical work we have just done. At first, I made links between the body work and the associations, like the good-enough Winnicottian caregiver modelling how to make connections between body and mind. Increasingly, James seems more ready to make links himself between what is happening in his body and in his mind. For example, in a recent session, when lying on the mattress, James noticed how he tightened his anus when gently lifting his pelvis. Trying to lift with a relaxed anus reminded him of a time at school when he feared reaching the toilet on time. He then said quite spontaneously, 'I still don't know when to hold and when to let go; I guess I only know how to tighten.'

Another childhood incident came back into his consciousness when I undertook to hold the back of his head while he lay on the mattress. I became aware of my hands going very cold and very stiff, which does not usually happen when doing this work. I started to feel great anxiety; I became very worried about my hands getting paralysed. James seemed to stop his breathing, and then said he was getting cold and stiff. I asked him what it reminded him of. After his habitual statement of 'nothing', he remembered his older brother trying to strangle him when some wrestling went awry. At home without parents, only his sister's intervention stopped James's suffocation.

Gradually, I am helping him to trust that his insights, his feelings, above all his body feelings will help him reconnect with a troubled past he, at times, wishes to block out. Both the patient and I

believe this mixed body and memory approach is showing rewards. James is now noticeably calmer. He has become much closer to his children, spending more time with them, giving them hugs, enjoying rough-and-tumble play with them. Both at home and at work, James reports he is more firm and consistent, and definitely less punishing of himself and others. More professional legal work has come his way, and he is looking for larger offices, perhaps to share with a colleague in a branch of the law which complements his speciality. His psychiatrist is very happy with the noticeable changes in James.

Much remains to be done in James's psychotherapy, of course, especially exploring his anal concerns and fears. Underneath this masochistic level is an oral level, with its fear of collapse and probably a very schizoid fear of falling apart, and these are yet to be faced.

As can be seen, I have learned much from working with this man. I am much less frightened of some sort of explosion or evacuation of messy, rageful feelings. I no longer dread his hours with me and I no longer get dozy in his sessions. I have had to overcome my fears of being unable to contain, while not so constricting myself that I disempowered myself of my body psychotherapy skills. The obvious changes and feedback from the client, his family and colleagues, and his psychiatrist have shored up my confidence at low points in the therapeutic work with this man.

RECOMMENDATIONS

How can therapists recognize and work with the fear of the body in the consulting room?

First of all, get to know your own body by experiencing how you move and how your mind moves when doing the Alexander Technique, Pilates, yoga, massage, movement, or a sport like swimming or walking. Remember, Freud was an avid walker, and Jung an avid hiker and sailor. Some psychodynamic practitioners join body-oriented psychotherapy groups as a way of deepening their self-knowledge and knowledge of their patients. As you know more about your own body, you will better recognize fear when you start to feel it and have more tools, such as grounding yourself or loosening your breathing, to contain and analyse the fear.

Second, get to know the links between the mind and body, by both self-observation and reading. Monitoring your own mental

responses during body movement or massage will start building a wealth of experientially based insights to draw upon. Reading about the interplay between psychoanalytic thinking and Bioenergetic thinking will provide a theoretical base. Several good books exploring the connection include Stephen M. Johnson's *Characterological Transformation: The Hard Work Miracle* (1985) and *Character Styles* (1994) and Stanley Keleman's *Emotional Anatomy* (1985) and *Bonding* (1986). Other books which demonstrate rather than explicate psychodynamics of the body include Ken Dychtwald's *Bodymind* (1986) and Jack Lee Rosenberg *et al.*'s *Body, Self and Soul* (1986).

Third, look at and get to know your patient's body. Your eyes are among your most valuable tools, just as your hearing is. What seems new or changed when your patient first walks into the room? What does the face tell you about his/her emotional state? The posture? Look and listen to body changes: at what point does this person constrict breathing or let out a meaningful sigh?

Fourth, somatic countertransference, another valuable tool, means using your now more-refined body sensations and knowledge as valuable communication from your client's body manifestations and unconscious messages. What is your own sudden in-take of breath telling you about what the patient just said? Could a slight sense of arousal in you, given the asexual nature of the client's material, indicate a deeper layer which needs exploration? Somatic countertransference brings together the previous recommendations. Experiment with it, learn to trust it, and find ways of basing your interventions and interpretations on it.

CONCLUSION

'There is nothing to fear but fear itself.' Franklin Delano Roosevelt's stirring words are also a psychotherapeutic truth: if we feel the fear too much, we are paralysed. If we feel we are not skilled enough to undertake the task, to attend to what we would rather not or do not know how to attend to, then we are also defending and blocking. Certainly, ignoring our ambivalence and our fears about bodies will not help the psychotherapy we provide. But, if we can bracket the fear in us or contain and analyse the fear in the patient, we can make some progress. Trusting body sensations and body observations will turn the dreaded, the often-denied fear of the body into a helpful contribution to working with our patients.

ACKNOWLEDGEMENTS

An early version of this article was presented in 1996 to a scientific meeting at the Association for Group and Individual Psychotherapy.

I wish to acknowledge the comments and the support of Diana Goodman and Keith Silvester in turning the AGIP talk into this article.

John Andrew Miller, therapist, supervisor, and academic consultant, 22 Fitzjohn's Avenue, London NW3 5NB

REFERENCES

Berne, Eric (1974) *What Do You Say After You Say Hello?*, London: Deutsch.

Boadella, David (1987) *Lifestreams: An Introduction to Biosynthesis*, London: Routledge & Kegan Paul

Borysenko, Joan (1998) *Minding the Body, Mending the Mind*, Toronto: Bantam.

Casement, Patrick (1985) *On Learning from the Patient*, London: Tavistock.

Coltart, Nina (1993) *How to Survive as a Psychotherapist*, London: Sheldon Press.

Dychtwald, Ken (1986) *Bodymind*, New York: St Martin's Press.

Johnson, Stephen M. (1985) *Characterological Transformation: The Hard Work Miracle*, New York and London: Norton.

Johnson, Stephen M. (1994) *Character Styles*, New York and London: Norton.

Keleman, Stanley (1985) *Emotional Anatomy*, Berkeley, CA: Center Press.

Keleman, Stanley (1986) *Bonding*, Berkeley, CA: Center Press.

Kepner, James I. (1993) *Body Process: Working with the Body in Psychotherapy*, San Francisco: Jossey-Bass.

Kirsch, Sander (1997) 'I can't believe it ever happened to me: recognising and working with unresolved shock states', *Energy & Character* 28(2): 67–80, 29(1): 76–89.

Lowen, Alexander (1975) *Bioenergetics*, New York: Coward McCann & Geoghean; London: Penguin.

Lowen, Alexander and Lowen, Leslie (1977) *The Way to Vibrant Health: A Manual of Bioenergetic Exercises*, New York: Harper & Row.

McDougall, Joyce (1989) *Theatres of the Body*, London: Free Association Books.

Polster, Erving and Polster, Miriam (1973) *Gestalt Therapy Integrated*, New York: Random House.

Rosenberg, Jack Lee, Rand, Marjorie L. and Asay, Diane (1985) *Body, Self and Soul*, Atlanta: Humanics.

Schore, Allan N. (2000) 'Attachment and the regulation of the right brain', *Attachment and Human Development* 2(1): 23–41.

Schwartz-Salant, Nathan (1982) *Narcissism and Character Transformation*, Toronto: Inner City Books.

Schwartz-Salant, Nathan (1989) *The Borderline Personality: Vision and Healing*, Wilmette, IL: Chiron.

Totton, Nick (1998) *The Water in the Glass: Body and Mind in Psychoanalysis*, London: Rebus Press.

Totton, Nick and Edmondson, Em (1988) *Reichian Growth Work*, Bridport: Prism.

Winnicott, Donald W. (1969) 'The mother–infant experience of mutuality', in C. Winnicott *et al.* (eds) *Psycho-Analytic Explorations*, London: Karnac, pp. 251–60.