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The Use of Imagery in Body Oriented Psychotherapy
by Margaret Landale

"Where do these wise and creative things come from? The answer is the apparent chaos of the depth self. The music of essence plays over this chaos, pulling patterns up from the depth." Nietzsche.

Introduction

This chapter is about imagery, in particular those forms of imagery, which arise spontaneously, and directly from the depth of the unconscious.

I will be focussing specifically on the inter-relatedness between the body and imagery, or the interface between physical- emotional and imaginative processes and will be highlighting some of the clinical applications of the use of imagery in body oriented psychotherapy.

Imagery has been of great influence and consequence in my clinical work. I consider it as one of the most vital tools for the release of unconscious hidden patterns and experiences. So often I have been stunned by the sudden emergence of a symbolic image, which when caught and acknowledged in time has led to the spontaneous unfolding of a deeper understanding.

We all know about the symbolic power of imagery, in fact most of us will have had experiences as to how certain symbols engage our imagination intensely. Some dream images, scenes or pieces of art will leave a lasting impression more clearly than many other events or experiences. There seems to be a radiance or charge to certain images, which at times can even become palpable to others. I remember for example a client who, as she became increasingly aware of how much rage she felt inside, saw herself as a volcano. As she let images of the volcano's eruption spew forth from her unconscious I could literally feel the room and myself heating up. Whether this was the power of her or my own imagination is beside the point, what matters is the realisation that imagination is a powerful force deep within which can make us both well or unwell.

Imagery becomes particularly potent when it is being embodied, in other words when it is being experienced physically and emotionally.

Imagery is seen here as a mediating force between conscious thought process and unconscious psychological and biological dynamics and patterns. I call this innate imagery in order to distinguish it from the large spectrum of imagery and visualisation techniques, which have a more general application and have been written about widely in humanistic and transpersonal settings.

I will define innate imaging as a form of free association with distinct physical properties. Traditionally body psychotherapists have viewed the body as the container of unconscious material and conflict and have aimed at surfacing or carthartically releasing these patterns. I believe that

innate imaging provides a less challenging and thus less resisted approach, as it works more indirectly with the body.

In this context I will illustrate some of the imaging techniques which help to create a communicative link between mind, feelings and body and which can give the body a voice to express it's hidden insights and medicine.

I will be looking for example at how to involve the body more actively within the psychotherapeutic process and how to overcome some of the typical mind-body dissociations experienced by most people. Often these dissociations may have resulted in psychosomatic symptoms and I will therefore also be focussing on how to work more directly with physical sensations and symptoms.

Another question I will be addressing in this chapter is how imagery can provide access to early memory and be used as a tool to facilitate regression, thus making sense of early manifested relational responses and patterns. I have been deeply influenced here by the work of Winnicot and Stern, both of whom have brought greater insight into early developmental states and the impact of the environment on the growing self. I will draw particularly on Winnicot's concept of true and false self.

In this context I will also consider how imagery can help us to understand the dynamics of the psychotherapeutic relationship and how it allows the therapist to engage with a client on an inter-affective and/or pre-verbal level, bringing deeply rooted relational patterns to the surface.

Imagery as ongoing mental activity

Imagery has been developed and applied in a number of forms throughout the history of psychotherapy. It is commonly identified with guided forms of visualisation and hypnosis techniques. All of these techniques involve the body initially and make use of relaxation to facilitate visual images. In fact hypnosis was an inspiration to medical professionals in the late 19th Century and had a significant influence on the development of psychoanalysis. Both Breuer and Freud initially experimented with hypnotic techniques and Freud's concept of free association was conceived from these experiments. Freud saw images as arising out of primary process thinking or as a way of surfacing or releasing unconscious early memory, which then could be interpreted by the analyst.

Jung was fascinated by the symbolic content of the unconscious and the psyche's creative forms and expression. His concept of active imagination acknowledged the key role that imagery plays in promoting the unfolding of meaning in relation to personal experience. Based on his own experience he was keen on promoting an inward reflection in his patients and believed that the study of their own active imaginative processes would help integrate unresolved or unconscious material. Describing active imagination he writes: "One concentrates one's attention on some impressive but unintelligible dream image, or on a spontaneous visual impression, and observes the changes taking place in it. Meanwhile of course all criticism must be suspended and the happenings observed and noted with absolute objectivity." (1).

Jung firmly believed in an alliance between patient and analyst and introduced the notion of self-reflective processes into the analytic framework. He influenced the humanistic and transpersonal traditions, which all rely heavily on the self-reflecting capacities in their clients and have continued to develop the use of imagery as a form of self-exploration and discovery.

Roberto Assagioli was inspired by Jung's work and in developing his Psychosynthesis approach, has probably done most to highlight the practical applications of imagery in psychotherapy. Importantly Assagioli emphasises that imagery is not only to do with the visual; it is much wider than this and includes all our sensory perceptions. "Imaging is a function which in itself is to some extent synthetic, since imagination can operate at several levels concurrently: those of sensation, feeling, thinking, and intuition. It includes all the various types of imagination, such as visualisation - the evocation of visual images - auditory imagination, tactile, kinesthetic imagination and so on." (2). It is important to remember that many people do not have visual images, but a very active imagination triggered by and experienced through other senses.

In this context I would define imagery as an ongoing mental activity which underlies or evokes conscious thinking processes. It is distinct from thinking because it always includes a sensory component. Thinking and imaging overlap however and tend to be interwoven. Images are experienced consciously or unconsciously on a physical level. In other words, the body is actively and continuously involved in any imaging process. For example we can think about an oak tree and it's relevant data but as soon as we imagine the oak tree, some sensory functions will be evoked. An image of a particular oak might come to mind, a memory of walking past it, or touching it, resting under its shade, hearing the leaves rustling above etc. These mental associations might not even be registered by the conscious mind but will evoke some form of physical response such as relaxation. This has been traditionally applied and adapted by various healing traditions and notably with terminally ill patients. Jean Houston, who is a leading voice in the world of Humanistic Psychology has throughout her work emphasised the potent inter-relatedness between body and mind. She writes: "Numerous studies have confirmed the fact that vividly experienced imagery, imagery that is both seen and felt, can substantially affect brain waves, blood flow, heart rate, skin temperature, gastric secretion, and immune response - in fact the total physiology" (3).

Imaging processes in Body psychotherapy

All forms of Body psychotherapy that have been developed since Reich, are based on the key assumption that from birth experience is being embodied, resulting in a complex structure of physical, emotional, mental and relational patterns, defenses and dynamics.

Recent neuro-scientific research supports this assumption. Notably Antonio Damasio's (4) investigation of the interplay between body-mind-emotions highlights the important role the body plays in psychotherapy.

The aim of Body psychotherapy is to surface and release embodied experience and memories. This can occur through symptoms, sensations or involuntary motoric or cathartic processes. However,

what has at times been lost or not sufficiently acknowledged is that these spontaneous body processes are inevitably linked with imaging processes and/or flashbacks. They are inextricably inter-linked.

In the past great emphasis was put on the physical discharge of blocks and tensions with the aim of motivating spontaneous cathartic processes. The idea was to sufficiently shake up the embodied psychological structures, to aim at a form of physical breakdown so that a new structure could emerge with the help of vegetative process. The criticism that was laid at the door of the more radical body approaches was that whilst something was certainly triggered through physical catharsis it could be difficult, if not impossible, for a client to understand this experience. As a result the client could be left feeling disturbed or overwhelmed.

Images can bridge the gap between overwhelming physical-emotional sensations and conscious recognition. They offer symbolic meaning and thus containment to an otherwise overwhelming experience. Given the above definition of imaging as mental processes with sensory qualities, it follows that we can expect a strong imaging aspect in all body induced awareness processes. In fact it is through imagery or metaphor that we can consciously recognise or describe physical or vegetative process.

As Stern's work has shown (5), the newborn baby immediately begins to organise her initial world of sensations into recognisable structures. Imaging is the earliest form of mental activity. Vision as a sense is fully developed from the beginning and babies quickly respond affectively to shades and forms. Furthermore tests with young babies showed that they were able to recognise the form of a nipple which they had sucked blindfolded. This confirms that sensory perception is interwoven with mental and imaginative activities.

The baby experiences himself and his environment through the senses and thus first develops his sense of embodied self (body self). Experience is being internalised and is quickly formed into mental representations. In this way memory as well as interpersonal patterns and beliefs and most importantly unconscious fantasies are developed and stored. Body experience and imaging processes are thus interactive right from the start and unresolved experiences remain alive and penetrate a person's existence in many ways. They can surface in the psychotherapeutic environment either within the psychotherapeutic relationship (transference/counter transference), or through symptoms or through innate imagery.

Imaging continues to serve as a major mental activity throughout our lives and we can assume serves continuously as a bridge between our physical and mental experiences and activities.

Body communication

We have already explored the sensory qualities of imaging and viewed imagery as a form of communication in which physically held experience or memory can be revealed. We now need to look at how to help the body release this hidden information, or in other words how to prepare the ground for imaging processes within the therapeutic reality.

We may well perceive the body to be central to the psychotherapeutic process but it is worth remembering that clients often have an extremely uneasy and alienated relationship to their body. This means that we have to find subtle ways to include the body and foster ways in which the client can integrate sensual perception alongside their growing psychological self-awareness.

Creating a space for the body in the psychotherapeutic environment starts with an ongoing observation of the client's body language - how they hold themselves, the way they speak, the texture of their skin, the clothes they wear and the mannerisms they use.

Most people have complicated relationships with their own bodies. Embarrassment, shame and fear of the body, and its involuntary processes, are common. For many clients the concept that their body represents a part of who they are would be incomprehensible. If clients have a sense of self-image through their body it may well be glorified (narcissistic) or expressed though negative identification e.g. "Nobody loves me because my nose is too big". Attempting to communicate to a client through their body image is a charged affair and can easily be misinterpreted.

So how can we use this unconscious language and communication which is being broadcast by our client and which we believe can hold such useful material in the search for identity and meaning?

The principle here is to remember that the body's reality is immediate and simple. The language a therapist uses when engaging with the body's communication thus has to aim at getting the client into their body rather than thinking about it. Engaging the body in the psychotherapeutic process starts simply with 'what is' statements such as: "You look sad" or "You seem restless". This emphasises the non-verbal levels of communication and reflects our interest in the body's language.

A client who is stuck with a seemingly intractable problem can sometimes relate to it differently and more deeply when her attention is drawn to its physical components such as short breath, tight chest or involuntary movements. As therapists we can be aware of these physical signs of distress and respond and acknowledge them accordingly. We can also comment on changes of posture or gestures which seem related to the lines of thought in which the client is engaged. All these interventions will be registered by the client and will validate the body as a valuable part of the psychotherapeutic process.

The building of rapport in this area is both sensitive and extremely valuable. Most people will feel self-conscious or embarrassed when their physical expression is commented on. Such close observation can feel like an intrusion. But since these observations or 'what is' statements are based on shared reality and fact, it also provides ground for the exploration of transferriential dynamics and allows the therapist to develop forms of communication which are tuned into the client's internal experience. So, for example, if a client is rubbing her knees as she recounts an argument she had with her mother, the therapist's comment: "I see you are rubbing your knees." might be taken as lack of attention to what the client was saying or making her feel self-conscious. Whatever the reaction to the therapist's intervention, it provides ground for exploration and can only be useful. 'What is' statements or observations are advisable when working with clients who have a sensitive relationship to their body or who find it hard to accept the psychological dimension of their body. It can also be seen as an active way of working with resistance.

When working with a client who has more tolerance for his psycho-somatic reality, we might choose to encourage the insight into his own bodily perception of a situation by saying things like: “Just notice how you feel in your body as you recount the argument with your mother; or: close your eyes for a moment and let yourself feel your legs and hands; or: Perhaps your legs and hands would like to say something to your mother that you haven’t dared say with words”.

Alternatively we might open our own awareness to the movement and contemplate it in the context of the material presented. Thus the rubbing might seem a way of holding her knees still, perhaps keeping them from kicking? Or as a way of comforting herself at a time of distress? We might then use these intuitive impressions to formulate an interpretation or wonder with the client what such rubbing might represent.

The body remembers

Often clients will bring a traumatic event to therapy and will be unable to access their emotional responses to the event. When one of my clients broke up with her partner because he had started a relationship with one of her friends, she found it impossible to feel anything; her only response was numbness. Though she kept recollecting the moment he had told her, she was unable to feel any affect as she spoke. This is of course a common feature when dealing with traumatic material. In order to help her engage with the physical memory of the experience, I began to ask specific questions regarding the details of the exchange such as where they’d met, which words he’d used, what his face looked like as he broke the news. She told me how he had looked guilty and had held her hand, saying how sorry he was. I encouraged her to tell me how he had held her hand, was it firm or gentle, her hand in his or his hand on hers. I engaged with the image of his holding her hand because I had noticed that she had been wringing her hands for most of the session and it seemed to me that some of her unfelt emotion was being held back in her hands. She said with a breaking voice: “He is holding my hand only to push me away!” and then she cried for a long time. This opened the door to an emotional process, which over time helped her to integrate the experience. By focussing on the descriptive details of a situation, we can engage the senses and, with that the body's stored memory. This helps in the reliving of a situation and consequently encourages an affective expression and release.

The ways of welcoming the body into the psychotherapeutic space are manifold. Yet it is the simple acknowledgement of the client’s physical reality which forms the interactive ground for experiential process. One approach with which most body psychotherapists are familiar is introducing the horizontal position as a way of engaging the client with their inner reality.

In my own practice I will encourage clients, when it seems appropriate, to lie on the couch - especially when working with imagery. Lying down puts into operation some important mechanisms. The client physically relaxes and their body experiences a general feeling of being held. As in early infancy their head and whole body is being supported, which activates and supports regressive processes and inner reflection. The client does not have to keep eye contact or face me, which means I am being experienced as less intrusive. Energy, which is bound up in maintaining the superficial layer of relationship with the therapist can get released into free

associations or inner awareness processes. Most of all by encouraging the client to lie down, whether on the couch or a mattress, I am signaling again that there is a space in the process for the body. The following vignette illustrates this and also highlights the importance of following the client's process even when offering a directive.

Sally came into therapy because she felt unable to cope with her stressful workload and was frightened she would lose her job. She was a middle aged, petite woman who had an anxious and upset appearance. She had problems sleeping because she kept worrying about things that had happened during the day.

Sally spent the first few sessions sitting on the edge of her chair. She was agitated, visibly tense and overtly critical of herself. She felt that nothing in her life was going right for her and was particularly worried about her workload which she felt increasingly unable to manage.

I put it to her that despite thinking hard about her problems she always seemed to return to the same dilemma. I suggested that she might need to stop thinking so much and allow herself to rest and look within for an understanding of why and how she had ended up in this position. I then I asked her if she would consider lying down, as a way of physically shifting her position.

As often happens, Sally found the idea of lying down awkward and embarrassing. I therefore asked her to simply imagine herself lying down and to then describe what she saw. She immediately said “It would make me feel like I am an ill child”. I noticed how spontaneously she had slumped into her chair, her attention drawn inwards. I asked her to tell me a bit more about the ill child. “She is all alone in a dark room, she’s got the measles, like when I was five. My Mum is busy and the others are at school or out playing." " I hated being sick" she added "and everybody says that I got better amazingly quickly.”

I encouraged Sally to become aware of how she felt in her body. She was silent for a moment and than said: “I feel heavy and tired. If I lie down I fear I would never get up.” Before I could respond she quickly opened her eyes and, sitting upright on the edge of the chair, commented: “I just can’t afford to get tired. I have so much on, I need to keep my wits about me.”

This vignette makes several important points. By asking Sally to lie down I introduced the reality of her physical body and how it might be involved in her search for answers to her problems. I had the impression that Sally needed to slow down and that her inability to rest was exacerbating her problems. I chose to respond to her embarrassment only in so far as not insisting on her physical lying down and therefore met her in the middle, inviting her to image the situation. Sally could, it quickly transpired, clearly imagine herself lying down, otherwise she would not have shown such a strong response. It consequently allowed her body to release a small fragment of memory, which provided an important clue to her current situation. Even though Sally snapped out of the imagery quickly this memory and indeed her statement that she could not afford to get tired, became an important narrative in helping her to understand her habitual anxiety and her inability to find rest.

Finally it’s worth emphasising that it is important to respond intuitively and immediately to those moments of inward energy or reflection. Such moments are often found in the brief instances where habitual or comfort states are being challenged or indeed when the body is being acknowledged.

Imagery, body sensations and symptoms

In order to work with body sensations or symptoms, a client will typically have to be taken by surprise or feel relaxed and trusting enough to drop her mental thinking defenses and engage directly with the present experience as process. Spontaneous body-led process can be evoked by encouraging the client to identify with a sensation or sometimes just by generally looking within. It is important to get the timing right when introducing imagery and to intuit the client's readiness for it. The instructions I give are simple and I believe it is unhelpful suddenly to develop a 'misty sotto voce'. Being oneself and using ones normal voice helps to make imagery a natural part of the interaction. The sort of instruction I might give would be as follows. ‘Close your eyes and notice how you feel in your body/chest/legs right now. You talk about your back aching so let your attention go there, see whether there is an image coming to you from your back. Notice what comes up and try not to censor anything.’

Introducing imagery requires confidence and good timing. It also requires that the psychotherapeutic relationship is safely established and that the therapist is experienced as containing and holding. Transferential dynamics often have to be explored and understood before the client will allow his conscious defenses to drop and before they will surrender to a spontaneous physical emotional process, innate imagery or free association.

Body led imagery or innate imagery often happens in the form of free association. The spontaneous flow of image and association indicates that the defenses are momentarily relaxed. It is important to distinguish between what we might call conscious imagery and innate imagery. Conscious imagery has an order to it, it is easily accessible in its meaning and often clichéd. The client tends to observe it and talk about it rather than becoming fully submerged in it. It might also be described as a kind of voluntary daydreaming.

Innate imaging means that defense organisations have momentarily been surrendered to a spontaneous flow of emerging associations, which tend to come across as somewhat chaotic and unstructured. Like dreams they appear to operate under a secret code, which cannot immediately be deciphered.

Winnicot's reflects on this when he writes: “I am trying to refer to the essentials that make relaxation possible. In terms of free association this means that the patient on the couch, or the child among toys on the floor, must be allowed to communicate a succession of ideas, thoughts, impulses, sensations that are not linked except in some way that is neurological or physiological and perhaps beyond detection.”(6)

As Body-oriented psychotherapists we can apply this directly to sensation or symptoms. Sensations or symptoms already carry a certain emotional charge as they are linked with the unconscious through biological process (i.e. embodied memory, somatic markers). Thus the physical symptom can function either as a symbol for, and catalyst of, spontaneous body process or give rise to free association and imagery.

Sensation, imagery and free association interlink to form a dynamic triangle. It is essential, however, for both therapist and client to give up control momentarily and surrender to the unfolding process which can be felt as chaotic. Again I would like to quote Winnicot:..."free association that reveals a coherent theme is already affected by anxiety, and the cohesion of ideas is a defense organisation....Organised nonsense is already a defense, just as organised chaos is denial of chaos". (6)

Symbols and images are containers of process and allow a seemingly chaotic sharing of unstructured process. Sustaining rapport through this apparent chaos of free associative mental or physical emotional process builds instinctive trust and tends to have a transformative quality. If the therapist remains in the role of observer or commentator and tries to control the situation then the involuntary and organic process is restricted or non-existent.

One client, Nick's spontaneous free association, when actively identifying with his headache, went as follows: "My head aches… pain and ache… my body is light… my head is heavy… a heavy blackness, heavy and black as the night… no features… just heavy blackness… my body is so light it loses air… the blackness sucks out the air… I'm being squashed… can't see… no features… can't get away".

Nick fell silent at this point, a heavy silence which became palpable in the room. My instinct was to let the silence happen, both because he seemed deeply engaged in the experience of heaviness and also because this behavior differed dramatically from his usually verbally active and rational manner. I used my countertransferrential experience of heaviness to stay engaged and it was from within this shared state that I ventured: "heavy and silent". With a voice deeper than his usual, he responded: "silent as the grave, I'm buried...they've buried me alive..", deep heavy inbreath, shaky, rattling outbreath, signals of distress. "They have buried you alive," I repeat, slightly emphasising 'they'. "People in black, all are wearing black, staring down at me as the coffin goes down... I have to stay with him... he is taking me with him!..." short, panting breathing, distress.

Being careful not to interrupt what had become a deep involuntary process, I chose to assure Nick indirectly of my presence by echoing his last comments: "have to stay with him, he is taking me with him..." And with greater distress in his voice, almost shouting, with a childlike quality: "But he is gone, he's just left me, I'm here all alone and the darkness is so heavy, so alone..." and he sobs heavily and uncontrollably.

Nick's father had died in an accident and the news had arrived at night, ripping him and his mother out of their sleep. His mother had been unable to cope with this sudden loss and had started to drink heavily and regularly brought different men home at night. He remembered lying awake at night, listening to the noisy sexual activity that went on in his mother's bedroom. This was the first time he had been able to release the grief and despair he had felt in the years after his father's death. He began to understand that a part of him had been buried with his father and that the active and happy little boy he had been had also died at that time. Over the coming months he grieved for this loss and began to understand how this experience had affected his life and relationships.

This example illustrates how surrendering into a sensation can trigger strong affective memory, how the body releases its stored and unresolved experience and allows an identification with old pain which can bring meaning to unconscious reactive patterns.

It was crucial for me to follow Nick's emerging process closely, echoing his words and allowing my own instinctive perception of what was unfolding before me, but most of all trusting his body and imagination to navigate us through the material.

These types of sensations and images are always personal and unique and it is important to stay open to the underlying story. As it unravels it will release it's individual and innate meaning and can then be integrated in the context of past or present experience.

Sensations can trigger deep process because clients are unsuspecting about the experience stored in their bodies. When Nick started to talk about his headache he had no inkling that there would be such a revelation around the corner. Of course when we work with more severe psychosomatic states we cannot expect such spontaneous process to occur. In such cases symptoms are often part of a deeply held anxiety and an internal disorder, the exploration of which will be fiercely resisted for fear of being overwhelmed. Yet there will still be vivid images, stories or metaphors surrounding the psychosomatic symptoms and their careful exploration through free association, detailed body awareness and other creative techniques can prove meaningful.

Helpful imagery techniques that I use in this context are drawing, working with objects and dialoging with the symptom (i.e. objectifying it). I would include these techniques as part of imaging work because they trigger a person's imagination. Working with objects I have found to be particularly helpful, because client's often experience it as playful and creative. I have a collection of small toys and oddments which I sometimes introduce in sessions. I ask clients to choose one of these objects to represent the situation or person with whom they have been grappling. My intention in using this technique is that I will both be engaging the client's playful and inquisitive nature as well as bypassing their more entrenched defenses. And when clients go along with the suggestion, they often find it easy to make meaningful associations from their chosen object and gain considerable insights into the history or nature of their issue.

Drawing is another powerful technique which accesses the images of a clients inner world. A female client who was suffering from Bulimia, when asked to draw an image of herself in front of the fridge in the middle of the night (the typical scene of her bingeing), drew a mouse with a hole in its belly which was stuffed up with old teddybear straw. Asked what came to mind about teddybear straw, she remembered her old teddybear, which she had operated on as a four-year-old, cutting open its belly in order "to take out what made his belly hurt". In tears the client then remembered how her mother had thrown the teddy into the bin. Yet the teddy had helped her go to sleep and she remembered lying awake at night, feeling frightened without it. The image of her teddy and explorations around tummy aches provided the first fragments of meaningful explanation to what drove her to binge in the middle of the night.

Core images in a client's life story

Another way of thinking about imagery in psychotherapy is as a creative and facilitated process for the re-discovery of self.

I would like to draw here again on Winnicot and explore his concept of the true and false self. Winnicot, as we know, was particularly interested in observing the unfolding development of infants and young children. He came to believe that we enter life with an in-born sense of self, following an individual and natural blueprint.

He argued that when the environment is friendly and receptive enough to our unfolding, we can develop naturally from within, gradually waking up to the world around us and integrating outer influences into a congruent self experience. We can 'go on being' ourselves. Or as Josephine Klein put it: "The true self appears as soon as there is any mental organisation of the individual at all, and it means little more than the summery of sensory-motor aliveness". She then continues: "The true self is firmly associated with all things bodily, including the homunculus core of the self, where all perceptions, all movements, all reactions are mapped. The fortunate infant develops self-structures whose core is homunculus based. The me-to-whom-things-happen and the I-who-do-things are homunculus based. Winnicot calls this fortunate state 'indwelling': I dwell in my body and my body is very much 'me' - I have the sense that my body and mind are integrated and not isolated each from the other."(7).

As experience is processed on an organic-physical and primitive emotional level, these early influences become personal memory, which is stored on a somatic and largely unconscious level. Winnicot calls these self-organising processes and they continue throughout childhood, giving rise to our mental processes and conscious forms of identity from within the embodied experiences of our early years. Thus they shape the complex structures of our ego and personality.

When, however, this natural process of self-development and integration is disrupted, the in-born sense of self will be arrested or surpressed, which in turn gives rise to the development of a false self, a self which is being constructed as a response to environmental pressures and expectations. It is a structure based on survival and thus charged with existential anxiety. This anxiety becomes embodied and forms unconscious structures or defenses.

I would argue that the true self-quality remains dormant throughout a person's life and can be activated or aroused at any point in time. As the true self was originally a body self, the body preserves these latent or innate qualities. An experience of well-being which is primal to the experience of being well or of being one-self, can be evoked or induced through sensuous or body felt experience. Thus even when working with deeply distressed individuals, simple relaxation techniques can provide some balance and perspective.

However, if the true self has been deeply lost, and we are dealing with overpowering false self-dynamics, the relational wounding needs to be addressed first. The stronger the true self had to be surpressed, the more this will lead to mental and emotional confusion and a disembodied sense of self which is driven by internalised misconceptions, fantasies and fears. Clients with borderline personalities or psychotic disorders for example are typically alienated from their own bodies. Furthermore some people will be fearful even of closing their eyes and going within, or simply will not know what 'going within' means. Others might present a flood of images which are not really being experienced. All those I would argue are signs that the relationship with the other has been deeply disrupted and it is particularly important here to work primarily with the relational or

psychodynamic approaches which act as a catalyst for the surfacing of early experience and relational patterns.

False self dynamics can produce core images with which the person is strangely dis-identified. We hear clients for example talking about physical or emotional abuse yet feel unable to relate to it because the client themselves don't seem to be hearing their own story, it is as if they are deeply disconnected from their own experience.

In the following case study I want to illustrate how clients can present such a disconnected core image. It is as if the true self offers an essential clue to their required healing but that at the same time the false self completely denies its validity. What the therapist has to do in such a case is hold the true self-image for the client and work within a transferential framework in order to relax the client's deeply held anxiety. It is my experience that it is only then and when they are ready, that the client will be able to reclaim what for so long has been lost.

Vanessa is a pretty, vivacious woman in her mid 30s. She came into therapy because she was suffering from anxiety attacks, which would come on without warning when she was on her own or in public places. The symptoms during these attacks would include dizziness, severe breath restriction and heart palpitations.

It emerged during the history taking, that Vanessa's mother had suffered from post natal depression after her birth. Vanessa was the second of three children and her mother had told her that it was because of her love for Vanessa's then three year old brother that she had been able to go on living. Vanessa held the view that she was lucky because she "had been far too little to even notice her mum's despair". She described her childhood as otherwise being normal and happy.

During the first year of therapy Vanessa talked about her life, and the occurring anxiety attacks, in an almost entertaining, anecdotal fashion. Though during the attacks she experienced extreme terror, she was not able to connect with this in therapy. She would say that "it is no use wallowing in it, I've come to sort it out".

My interventions at this time were predominantly reflective, trying to help Vanessa become aware of how she was operating in her life and around the anxiety attacks. I pointed out to her how she didn't seem to take herself seriously, as if she could not believe she was suffering such distressing episodes. She agreed that she was finding it hard to believe this was happening to her and promptly began reading psychological self-help books and reporting on the various practical steps she was taking to sort herself out. I tried to interpret this flight into action as both a familiar pattern of becoming efficient when dealing with overwhelming emotions as well as her need to appease me after what she might have perceived as my telling her to get on with it. None of these seemed to engage her and I experienced an ever-increasing hopelessness and despondency. I wondered whether I was experiencing some of Vanessa's disowned feelings in the counter-transference.

The image of the baby who had been left to cope on her own because her mother was too depressed to engage with her, kept occupying my mind. But I had learned already that Vanessa had rigorously detached herself from this early vulnerable part of herself and whenever I had made an attempt to form a connection in this respect I'd been met with incomprehension, cynicism or polite denial. So

all I could do was to remain calm and present, whilst holding on to the image of the unwanted baby for her.

This is a common feature when dealing with core images, which arise spontaneously from denied or disowned parts of a client's experience. It's as if, as soon as the image has sneaked out, it has to be vehemently denied and as therapists we are being left to hold and nurture the most vulnerable parts of clients whilst these are being denied or attacked by the client. As Vanessa put it: "You have this thing about me as a baby that's nothing to do with my problem. I want you to help me to get rid of my panic attacks!" Yet my silent engagement with her core image, the lonely baby, gave our relationship a background and helped me to stay empathetic and reflective. Unconsciously she will have perceived my attention and I believe that this contributed to what emerged next.

About eighteen months into the therapy something began to shift. Vanessa gradually began to lose hope that she would overcome the panic attacks. This made her feel despondent and angry with me for not helping her. She had re-created me in the transference as her unavailable mother. These were important transferential dynamics as they allowed me to interpret her feeling let down by me in the light of her emotionally unavailable mother. I believe that as she experienced me withstanding her attacks without loosing my caring attitude, her defenses began to relax, which led to the following experience.

At one point Vanessa said: "I just don't know what else I can do to get on top of it". I asked her to close her eyes and to let herself stay with the image of trying to get on top of it. She saw herself trying to climb up a sand hill. It was made of very fine, slippery, grey sand and as she struggled to find some footing she became aware that she just kept on sinking deeper and deeper. She said repeatedly: "I can't get up, the harder I try the more I get sucked in!" Her body at this stage showed increasing signs of distress. Her breathing became erratic, her fingers seemed to try and grasp on to something, her feet moved in the attempt to find some ground. All these were signs of an unfolding spontaneous organic process and I felt sure I needed to encourage and support this. I then noticed that her body was beginning to display symptoms of her panic attacks. I encouraged her to stay with these sensations and to let her body guide her.

[It is important not to panic when we witness such a strong vegetative response. The body memory was breaking through and my calmness and trust in these functions was a vital therapeutic response, reassuring Vanessa, who was by now in a deeply regressed place, to trust her process. It felt crucial to stay engaged so that she could experience my presence in this raw state of being. I also felt certain that this was an opportunity to momentarily replace the ingrained memory of the absent mother].

Vanessa gave way to her body's impulses and began to move with her panic. Her legs and arms moved rapidly and in an uncoordinated way and I could see her stomach contract in terror. I noticed too that Vanessa's energy seemed to be forcefully directed upwards and there seemed to be an accumulation of tension around her head. In response I encouraged her to stand and to push down into her feet, to give her a sense of her own ground. She moved her feet and spontaneously began to stamp. Yet the stamping seemed to make her collapse around her middle, her belly contracted into what looked like silent, violent sobbing and her arms began to flail helplessly up and outward as if she was trying to grab hold of something. Responding to her hands and arms I held out a

cushion, allowing her to grasp it or push it away. She just touched the surface of the cushion and her breathing and movements nearly stopped entirely - she had an inward looking expression. When I asked her "what is happening" she responded: "It's as if I am lying down, just lying, there are bars around me, blue and white, blue bars and all this white behind the bars. The white hurts my eyes. The white is huge and cold, like snow, like a vast mountain of snow. I am cold. The white hurts my eyes, I just want to go to sleep, there are colours when I sleep. I am so tired."

Again I encouraged her to stay with what she experienced, that it was alright to give in to the tiredness and helped her to lie down. Her hands remained on the cushion gently stroking it and she said "so soft, soft, the sand was soft… soft like skin…softness on my hands… lots of little dots, white dots on pink, making me sleepy...". She seemed calmer, and when, after a period of silence I checked what was happening, she said: " I feel warmer, my skin warms me."

This imagery provided Vanessa with the first real connection of her early experiences in life. It opened the door to understanding the cold climate which she had endured during the first months of her life. She remembered that her baby blanket had been pink with white dots and it gave her the impression that she had been comforting herself by the feel and the patterns of her blanket. The process also helped her understand her panic attacks as an existential anxiety which had its roots in her infancy. The body had released its deeply held memory and thus helped her to relate to the lonely baby and the achiever child within.

Vanessa's core image, and how it connected to her sense of true self, was both the container and the trigger for her healing process. The work didn't stop here of course but the anxiety attacks did start to recede from this point.

Conclusion

My aim in this chapter has been to illustrate how both our body and our imagination are powerful catalysts for change.

When the unspeakable is expressed through an image, when a symptom releases it's metaphor; when the pain which has lingered in the darkness of a person's unfulfilled live can finally be

imagined, re-experienced and understood, then s/he can begin to make sense of who they are, not only in relation to their own lifestory but also in relationship to others.

The exploration and experience of imagery is always potentially integrative or unifying.

This has been understood and applied by many practitioners from diverse approaches such as cognitive-behavioural therapy, hypnosis, transpersonal psychology and of course analytical, psychodynamic and holistic psychotherapy.

The role the body is playing in imaging processes and in psychotherapy has been underestimated or ignored for too long.

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