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To be or not to be: divergence and communality in Jungian analytic and humanistic approaches

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This presentation explores instances of divergence and communality in Jungian analytic and humanistic therapies in two distinct areas, namely their approaches to the body and relationality. Informed by body psychotherapy, *the experience of embodied being* is discussed. Conversely, it is argued that analysis tends to apprehend the body in terms of meanings. While this can be insightful and emancipatory, it fails to encompass the dimension of *being*. The talk's second part discusses communalities in tacit pre-clinical views, which impact on another experience-near concern: the subtle relational 'feel', or *relational sensibilities*, in the consulting room. According to the author's textual research of clinical writing, such sensibilities are implicitly communicated, yet not usually reflected upon. Here, the author's research into *implicit pre-clinical bias* is touched upon, and alternatives, such as a *sanatological* bias of *deep positivity*, are briefly discussed.

Keywords: Embodied being; relational sensibilities; implicit pre-clinical bias; sanatology; deep positivity

Introduction

This presentation addresses two different aspects which may, at first glance, seem to contradict each other. The first of these themes is to do with the reception of the body by analysis. The bodily dimension features in Jung, and many Jungians have addressed it. In addition, approaches such as body movement and cranial osteopathy are increasingly recognized. However, analysis itself tends to employ the body chiefly as a carrier of meaning. Conversely, my approach emphasizes the experience of *being*, for speaking of 'the' body suggests an object in the mind, while *body as being* evokes its experience. I shall thus discuss *embodied being*, and frame it as a developmental capacity. I am trained in two modalities: body therapy and Jungian analysis. This exposes a therapist not only to different theories, but also to different clinical values. In body therapy, the experience of embodied being is recognized and fostered. In contrast, mainstream analysis does not seem to register being-based experience in its own right, except negatively as part of dissociative or borderline pathology. My aim is to introduce what might be called *being-based values* to the analytic clinic. While it can be useful to think about the body symbolically, or emancipatorily, to theorize it socio-politically, the people who come to see us might need help in strengthening their very capacity to be.

In a converse gesture, the second part of my talk queries the customary juxtaposition of humanistic therapies and Jungian analysis. Here I argue that, while both approaches

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have been useful to very many people, there are unhelpful commonalities which need addressing. I shall discuss my doctoral research into pre-clinical bias, which suggests that there is a crucial difference between an approach's theory and its translation into the consulting room. Textual analysis of the language used in clinical case histories indicates a worrying gap between benign theoretical ideas and their less benign clinical translations, which are implicit in the therapist's communications. To be clear, this is not about the way individual therapists work; rather, it is a systemic phenomenon, involving subtle attitudes and views learned during training. I have coined the term 'relational sensibilities' in order to frame this. My research indicates an underlying tendency towards what I call 'adverse relational sensibilities' in the consulting room.

In addition, my findings suggest that such implicit attitudes tend to be more similar across approaches, whether humanistic or analytic, than one might expect. In other words, a humanistic orientation does not guarantee benign relational sensibilities in the consulting room, nor does an analytic orientation by necessity mean the opposite. Rather, relational sensibilities might hinge on a therapist's capacity to individuate with regard to their training. Individuation is Jung's term for the capacity to step away from received values and develop more authentic views. My thesis offers a model called 'sanatology', which can be applied across the approaches, and which is discussed in the second part of the article. First, however, I shall return to the theme of embodied being.

Embodied being and analysis

Is it possible to define the experience of embodied being? This seems akin to catching a butterfly. As a quality of experience, being needs to be evoked rather than defined. For this purpose, I would like to invite you to imagine the state we enter just before falling asleep. We become more and more relaxed, perhaps more aware of our body, aware of some of its tensions too, aware of thoughts and feelings left over from the day, before letting go and drifting off into sleep. We are relaxing yet aware, and this is an example of a being-based state. We are linking with our being. Something similar happens in meditation, where awareness and being come together not as awareness *of*, but awareness *in*, being.

As a vital dimension of human experience, the capacity for embodied being tends to be overlooked in the analytic clinic, for clinical accounts make no mention of it. Humanistic approaches, such as neo-Reichian body therapy, however, pay close attention to both body impulses and spontaneous, involuntary movement. These usually guide the theme of a session, which then arises out of the patient's being experience. Conversely, the aims informing the analytic clinical hour at present centre on making meaning and relating. Experience on a being level is not usually valued in itself, and clinical accounts tend to reduce them to their meaning. As others have noted (e.g. Plaut, 1993), clinical accounts tell us *what it said*, rather than *how it is said*, in tone of voice and body expression, nor do they tell us how a comment might impact on the patient's embodied being. Analysis is then oriented towards narrative and meaning, based in transference/countertransference experience. I think it important to positively include the dimension of being. This enables us to perceive our patients' states of being and their embodied experience. Making meaning is then complemented by linking with one's being and deeply experiencing 'what is'.

Analysts are increasingly aware of the bodily dimension. It has been addressed in books and numerous papers, and international conferences nowadays always include

body movement sessions. However, somatic experience tends to be reduced to its archetypal or symbolic aspects, emphasizing knowing and minimizing embodied experience. The idea of somatization, for instance, implies that embodied expression is valued less than its verbal equivalent. Current biochemical research shows that neurotransmitters found in the brain also occur elsewhere in the body, particularly in the gut. This suggests a thinking capacity in embodied being which is missed by the notion of somatizing. In my view, body movement work is extremely helpful in facilitating a connection with one's body, and can stimulate wonderful glimpses of embodied being. However, the deep somatic experience that is fostered in body therapy is often necessary to promote embodied being in a more sustained way.

Developmental theory

Among analytic approaches, Winnicott's developmental theory stands out in conceiving being as a capacity acquired in infancy. His model describes the intricate ways in which we might learn to experience ourselves as embodied. Here the dimension of being features in its own right, rather than as an aspect of the developing mind. Winnicott describes three stages of development, which are termed 'integration', 'personalization' and 'object-relating' (Winnicott, 1945/2014, 1962).

Integration – Winnicott's first stage – means the baby's developing experience of continuity from one minute to the next and of hanging together bodily, which Winnicott relates to the mother's attuned responses to her baby. Integration represents a great achievement on a being level. It promotes the capacity to experience oneself embodied, without undue anxiety in a continuous, non-fragmented way.

Winnicott's next stage – personification – denotes the baby's experience of itself as a separate unit, with the skin as limiting membrane, and relates to the mother's handling of her growing baby. The ability of experiencing oneself as separate and held together by one's skin on a being level is another considerable achievement. The focus here is not on the symbolic act, but on the state of unity *in* one's being, which fosters the capacity to sink back into oneself with pleasure rather than fear.

Winnicott's last stage is object-relating, which is closely interwoven with the mother's object-presenting. Object-relating is to do with the infant's creation of reality, and leads to a capacity for a shared reality. Because object-relating involves the two stages already mentioned, we may conclude that, for Winnicott, relating and reality are being based. Winnicott's developmental theory thus puts being on the map; however, this does not automatically render it something that is valued and pursued in the clinical practice of analysis.

I have sketched Winnicott's developmental theory to make the experience of embodied being come alive by evoking its various aspects with words. When embodied being becomes a personally experienced quality to the therapist, he or she is then likely to perceive its relative absence in current analytic clinical accounts. In turn, this is likely to lead to changes and adjustments in clinical values, which, as mentioned earlier, is one of the aims of this article.

Introducing sanatology

To summarize, I have explored embodied being as an example of an important dimension, which can be conceptualized and valued by one therapeutic approach,

yet missed by another. Conversely, this section discusses what amounts to an unhelpful commonality traceable across approaches. Before enlarging on this aspect, I need to introduce *sanatology*, a clinical discourse organized around the notion of health and healing, and which can be used by any approach (for a definition, see Heuer, 2015). Sanatology conceptualizes a parameter of *relational sensibilities*, informed by an approach's pre-clinical bias, which contains ontological and socio-political views, as well as a *weltanschauung*. Relational sensibilities are to do with the subtle, underlying relational 'feel' of verbal and non-verbal communications by the therapist. In principle, these may vary from adversely to lovingly related.

Importantly, such sensibilities are not guaranteed by an approach's theoretical outlook, nor by its clinical theories, however emancipatory or helpful, for the actual, yet subtle, relational 'feel' in the consulting room often differs considerably. Sensibilities register in the tone and language that therapists use, and in their non-verbal communications. My research indicates that they are determined by a therapeutic approach's implicit attitudinal bias, which is discovered by analysing the language and narrative employed in clinical accounts. As therapists, we are induced into specific sensibilities during training as part of the underlying views and values of our approach, with which trainees are required to identify. Such views, though, are pre-clinical in nature, for they contain philosophical-ontological and socio-political views, as well as a *weltanschauung*. Importantly, they are largely learned without words, yet become bound up with what is regarded as professional competence. As a result, practitioners with alternative views, and those wishing to innovate, can easily be charged with professional incompetence, when the issues at hand are actually related to pre-clinical bias. To remedy this, two minimum conditions are required of a sanatological approach: first, exploration of pre-clinical bias and open declaration of otherwise tacit views and values; and secondly, clarification of implicit relational sensibilities.

Both minimum conditions are contained in the concept of 'clinical paradigm'. This is developed though the critical philosophy of science of the previous century (Foucault, 1970; Habermas, 1968; Kuhn, 1962; and Polanyi, 1975). These authors concur in arguing that there are vital factors which precede and constitute scientific undertakings, irrespective of empirical or hermeneutic methodologies. For psychotherapy, this dimension contains a pre-clinical bias, and it is important to note that no clinical approach is without one. When a clinical paradigm is researched, bias is uncovered, enabling therapeutic approaches to take an informed view on their implicit sensibilities, and address any gaps to their theoretical outlook.

Sometimes, clinical controversy leads to a direct spelling out of otherwise tacitly held views. In a recent exchange in the *Journal of Analytical Psychology*, Colman (2013a, 2013b) discusses the need for a more related analytic approach, while Meredith-Owen (2013) defends 'traditional' Jungian analysis. In this context, Meredith-Owen accuses Colman of naiveté, and proceeds to spell out his own bias, based on the biblical notion of original sin. In other words, patients are implicitly viewed as profoundly flawed and subtly to blame, while the author fails to recognize this as a biblically informed ontological view. Rather, he makes an implicit and normative reality-claim for this outlook. On this basis, different ontologies are framed as unrealistically positive. A similar charge has been levelled at the clinical innovation proposed by the Boston Change Process Study Group (2010).

While most therapists are unlikely to find such stark views useful, my research indicates that the notion of original sin seeps into clinical practice in very subtle ways. Whenever we consider the people coming to see us in relation to their struggles, we indirectly invoke this tradition. One only has to think of supervision or collegial clinical discussions to become aware of how difficult it is to avoid this. However, this is a more subtle and complex matter than pathologizing. Rather, it is a generic issue, due to a gap between theoretically held emancipatory, benign views, and tacit, systemic pre-clinical attitudes. Importantly, the latter significantly influence the relational 'feel' in the consulting room. My preliminary research indicates, contrary to expectation, that humanistic and analytic approaches might share in this clinical difficulty. *Sanatology* attends to this in two ways. First, it provides critical tools, such as clinical paradigm, through which pre-clinical views and relational sensibilities can be apprehended. Secondly, it argues a rethought view of the world, which is termed 'deep positivity'. This outlook can be reasoned through quantum information logic, and is coherent with quantum empiricism. Deep positivity covers ontology, epistemology, socio-politics and spirituality. It induces relational sensibilities, which are informed by love and its transformations. Deep positivity can be employed across therapeutic approaches.

Generally speaking, I take it as read that both humanistic and analytic psychotherapy are essentially relevant, and that contemporary culture is inconceivable without them. While its ideas were challenging to society at psychoanalysis's inception, they have been largely assimilated since. This changed in the 1980s and early 1990s, when socio-political issues were beginning to be established as clinically relevant. In the Jungian world, this shift was largely achieved by Samuels (1993).

Sanatology belongs with this tradition on two counts, and for reasons of space I will conclude my article with these considerations. First, deep positivity addresses the lack of publicity, both in the press and society at large, of information, which strongly suggests a world-view where the dynamics of love might be much more prevalent than we are currently led to believe. Thus, positive stories are not regarded as newsworthy, and research like Steven Pinker's (2011) on the significant decrease of violence over time is marginalized. Deep positivity is able to assert a more hopeful outlook that concurs with Pinker. In my experience, such views foster calm and confidence, which are empowering, for overwhelmed and terrified citizens are likely to be either more passive or more extreme.

In addition, the notion of relational sensibilities frames the difference of relational exchanges that revolve around power, as distinct from those informed by love. This enables understanding racism, sexism or fundamentalism as acts of relational transgression, in directly or indirectly asserting power over another. Conversely, in Levinas (and Kearney) (1986), whose philosophy has recently emerged in psychotherapy, the *otherness of the other* is sacred. Situating the holy in otherness adds a spiritual layer to relational sensibilities. Sensibilities that emphasize the principle of love, as distinct from that of power, and include love of otherness, are then politically relevant. In the psychotherapeutic clinic they inform a re-envisaged pre-clinical dimension. This enables deepened awareness of subtle relational processes, catching them up, where necessary, with the emancipatory theoretical ideas of our approaches. To end on a traditional Jungian note, in the language of the grail myth, the transformative question 'What ails you?' gently recedes, and re-emerges as 'What heals you?'.

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No potential conflict of interest was reported by the author.

Notes on contributor

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