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**‘Between Bodies’  
An Implicit Relational Model**

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**Doctor in Psychotherapy by Professional Studies**

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# 1. ABSTRACT

The main aim of this study was to generate a theory of what happens between the body of the therapist and the body of the client in a psychotherapeutic setting. This was achieved through documenting and analysing first-hand therapists' experiences of their own embodied being in the psychotherapeutic process. A descriptive phenomenological design was adopted using a grounded theory methodology. Participants were experienced psychological therapists, nine of whom were female and three of whom were male. Through use of semi-structured interviews the research captured therapists' direct experience of their embodied interaction with clients.

It was discovered that at any given juncture the body of the therapist registers a considerable amount of intersubjective somatic information. The Core Category of Between Bodies emerged from this analysis and this is divided into five sub-categories. These include (i) Body to Body (ii) Connection (iii) Somatic Experiencing of Other (iv) Embodied Process and (v) Intersubjective Space. Findings describe a theoretically salient Implicit Relational Model of what happens between bodies in the psychotherapeutic encounter.

Movement to and between each of the sub-categories is mediated by the embodied processes of the first sub-category *Body to Body*. These embodied relational processes are co-created and act as a mediator between client and therapist for generating one or more of the sub-categories *Connection*, *Somatic Experiencing of Other*, *Embodied Process* and *Intersubjective Space*.

This research study highlights the importance of exploring and attending to implicit processes. The findings are discussed in relation to current research on neuroscience and infant studies. Such theory will add to knowledge and understanding of the implicit intersubjective field of the therapeutic relationship. It will also help to inform specific recommendations for supervisors, trainers, therapists and researchers.

## 2. INTRODUCTION

The aim of this study was to develop a theory of what happens between the body of the therapist and that of the client in the psychotherapeutic encounter. The study captures therapists' experiences of their own embodied being in the psychotherapeutic process. This research highlights the importance of exploring and attending to implicit bodily processes in the intersubjective dyad. It is anticipated that this research will contribute to clinical theory and understanding of the embodied intersubjective field.

### 2.1 My relationship to the subject

I was first drawn to focus on the body during my MA Counselling Psychology studies over 15 years ago. Having experienced various approaches to working with the body I came to consider attention to body central, as body and mind cannot be separated. I noticed in my day to day work as a therapist that much of what clients were bringing to therapy was connected to body and/or body experiences. I observed how clients live through their feelings, emotions, bodily experiences and senses as much as through their cognitive faculties of thinking and imagining. One particular memory that stays with me occurred during a Gestalt therapy workshop with Gaie Houston in Ireland in 2001. Gaie brought my attention to my shoulders and to my surprise I became aware for the first time how tightly I held them and hunched them up. Reference was made to the German word '*haltung*' which carries the dual meaning of posture and attitude. This resonated with me as I contemplated the internal attitude I embodied in my tense shoulders. This was an attitude of self protection and defence. It was as if I was bracing myself for things to come. Once I became aware of this I began to release my shoulders which allowed me to breathe easier and in turn helped me to feel more confident and relaxed as I faced the world.

As my exploration and investigation into this area developed I noticed an expansion in my own interest and outlook. This was taking me along a trajectory from the body of the client to that of the therapist. I remember being

touched deeply by my own therapist when I saw a tear in his eye in response to what I was saying. This simple empathic gesture in his body met me where words never could. What began to unfold was a deepening fascination with what happens between the body of the therapist and that of the client. I was interested in the idea that our bodies hold all our life experiences of attachment, separation and trauma and I became increasingly committed to understanding how these experiences show up in the therapeutic relationship.

## **2.2 LITERATURE REVIEW**

### **2.2 History of Body**

The History of the body in psychological therapy can be tracked alongside the mind-over-body split of Western culture. Traditionally, body has been perceived as the ‘poor cousin’ of the mind and this dualism has been the foundation for modern scientific thought and psychology. The literature highlights Descartes’ belief in a complete split between mind and body and his conviction in the ultimate truth of reason and analytic thinking (Descartes, 1649; 1680). Descartes’ assertion that mind *“is entirely and absolutely distinct from my body and can exist without it”* (Descartes, 1649, p.18) appears to epitomize this schism. Brown (1990) however suggests that Descartes did indeed consider body and mind to be interdependent and related. It is argued (Brown 1990) that Descartes, whilst viewing the body like a machine, supported the notion that mental, affective and perceptive states had an underlying somatic base. Brown (1990) contends that the philosophy of Descartes appears to have been misunderstood perhaps owing to its complexities. This ‘Cartesian split’ however had radical significance for the subsequent development and establishment of later scientific paradigms and it was in this climate that psychological thinking was developed.

A review of the literature indicates that attention to body in psychological therapy has its origins in psychoanalysis. Initially body was at the heart of psychoanalysis for Freud who theorized that ego is essentially a body ego (Freud, 1923). Freud’s student, Ferenczi expanded on Freud’s theory and this



was later developed by Reich. However, whilst Freud, Ferenczi and Reich may be viewed as the grandfathers of bodily integration in psychological therapies the development of a body emphasis can be traced back pre-Freud to Janet (Janet, 1894). In the late nineteenth century Janet was exploring psyche's use of body in his studies into hysteria. Boadella (1997) contends that much of Freud's work grew out of Janet's body-oriented work and highlights that in 1894 Freud was in the process of confirming Janet's findings. Janet's work focused on the link between emotional tension and blockages in the flow of bodily fluids. A key tenet of Janet's model includes massage, taking into account channels of contact and the embryological stages of development (Janet, 1925). Attention was also given to movement and kinaesthetic sense, trauma and body image. It appears from this that Janet's model encompasses much of what current day bodily based therapies address. This leads me to believe that what is proposed as 'new' approaches to working with the body today may not in fact be as new as they claim to be and can in fact be traced back to the late 19<sup>th</sup> century.

The whole foundation of psychoanalytic thinking is founded on drive theory which is intrinsically a body based theory. Drives are fundamentally body based impulses and the whole psychic structure can be seen to develop out of these impulses. Freud stated that "*the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body*" (Freud, 1923, p.364). In Freud's early analytic accounts we encounter him actively engaging with the bodies of his clients (Freud and Breuer, 1895). Freud used a kind of 'pressure technique' which involved laying his hands on the patient's forehead and commanding responses to various questions and he used massage to release blocked libido. In a personal communication to Fleiss Freud describes how he had invented a therapy of his own where he worked with the patient's body (Freud to Fleiss March 1895 in Freud, E.L. 1961).

Freud moved away from his more organic, instinctual, drive-based model of understanding and his approach evolved into a 'talking cure' based more on a passive attentiveness rather than direct intervention. He stopped using any physical contact with clients in therapy and free association became his

primary method. Body was relegated to second place to be overtaken by the psyche in his later analytical work. In traditional analysis the therapist is seated behind the patient, thus depriving the analyst of any visual contact with the client. This lack of eye contact may seem to epitomise Freud's 'rejection' of the body if we consider the gaze between mother and infant to be mirrored in the therapist-client interaction (Schore, 1993). Trevarthen (2001) however takes issue with the emphasis on gaze and demonstrates studies with babies (Trevarthen & Aitken, 1994) who are blind from birth indicating that infants match the rhythm and expression of the adult. Trevarthen and Aitken (2001) suggest that "*infants have a coherent psychoneural organisation that specifies the timing and form of body movements*" (Trevarthen and Aitken, 2001, p.6). It is necessary therefore that attention is given to the range of body based exchanges that occur through the other senses. Schore (2003b) describes the innate bodily co-ordination that takes place between infant and caregiver whereby they co-ordinate themselves bodily in the direction of the other. Trevarthen (1993) outlines experimental data for 'proto-conversations' that take place between the child and caregiver from as early as 6 weeks. The child makes a 'statement of feeling' towards the caregiver which is in turn matched and synchronised through the mother's response.

Whilst Freud turned away from a bodily emphasis this bodily focus was expounded by his student Ferenczi in the 1920's and 1930's. Ferenczi (1988) adopted a more interactive approach with his clients enlisting the analyst in re-enacting clients' memories and fantasies. Clients were encouraged to act out the parent-child relationship with their therapist with an emphasis on countertransference. Ferenczi supported and encouraged patients into altered states where they relived traumatic experiences. He considered the therapeutic relationship to be critical in body oriented work and was deeply concerned with embodiment issues. Ferenczi (1932/1988) was aware that client and therapist communicated on multiple levels simultaneously and introduced the notion of a dialogue of unconsciousness's. He was keenly aware of non-verbal communication as a means of understanding what clients are trying to communicate about themselves and their feelings about their relationship with the therapist. Although developed over a century ago

Ferenczi's ideas have laid the foundation for many of these concepts stressed in contemporary clinical practice.

Wilhelm Reich (1945) built on Ferenczi's model paying particular attention to breathing, posture, body armour, physical energy and physical expression in mental health. Reich considered breathing to be at the centre of emotional blocking and he worked directly with the body to free up blocked energy. This central attention to the breath is common to many modern approaches to working with body (Boadella, 1987; Lowen, 1976; Perls, 1947/1969). Reich believed that essentially we fear the free movement of libido – hence the rejection of body. This damns up sexual energy, blocks the life force and causes misery to human beings. Like Freud, Reich considered sexual energy to be the driving force behind psychic life, the blocking of which led to neurosis and dis-ease. However, whilst Freud postulated that bodily repression arose from an innate struggle to tolerate spontaneity and pleasure, Reich differed in his view. Reich (1945) considered armouring to be the physical component of repression and occurs when an impulse is physically stopped. He contended that repression was borne out of familial relationships and/or traumatic experiences. These experiences block the natural flow of life-energy in the body, giving rise to physical and mental disease.

Reich developed vegetotherapy which aimed to dissolve neurotic conflicts by releasing energy blocks in the body. Reich considered a two-way interaction between psychic functioning and somatic functioning and he perceived change in either influencing the other. This is different from purely verbal therapies – which don't address physical changes directly and differs from purely somatic therapies which don't attend to psychological issues.

Reich (1945) borrowed the term '*character*' from Freud and applied it to all the habitual mental and physical patterns from which human beings defend against. Character is a reflection of the person as a whole. It is through muscular body armouring that the character or bodily attitude is maintained by locking the repressed energy into the tissues of the body. Reich's early work focused on a slow process of unpacking these defensive structures. It was a

slow, patient and gentle approach, following the client's process and analysing bodily impulses as they appeared. Reich didn't work hands on in the early years. This way of working by Reich was closely aligned with psychoanalysis and is the foundation for today's Analytic Body Psychotherapy and Embodied-Relational Therapy (Totton, 2003).

As Reich developed his work into the 1930s it gradually became more direct, systematic and aggressive. He described life-energy or bio-energy which he called 'orgone' energy. This resonates with Freud's description of "*an energy which is spread over the memory traces of ideas somewhat as an electrical charge is spread over the surface of the body*" (Freud, 1894, p.75). In the 1940s and 1950s Reich continued to develop his own views which culminated in his theory of Orgonomy. Reich used more physical intervention becoming more invasive with an emphasis on surrendering sexually. This intervention is known as Vegetotherapy and focuses on deep rhythmic breathing in addition to palpating areas of muscular tension in the body. It could be argued however that this therapy doesn't take into account the underlying anxiety and conflicts that may arise as they serve to protect the client. The protective function of these sensory-motor defences must be understood and integrated before real change is effected. Reich's later work seems to open up these defences too quickly leaving the client more vulnerable or resistant. This precaution is reflected in modern day trauma work where care is taken not to re-traumatise clients as traumatic memories can be stored as somatic sensation or visual imagery (Ogden, Minton & Pain 2006; Van der Kolk, 1994).

Reich's insistence on the body's place in psychoanalysis and introducing what was repressed made him unpopular with his colleagues. He moved further and further away from the psychoanalytic mainstream and was expelled from the International Psychoanalytic Association as an apparently known anti-fascist. Reich considered how "*Slowly but surely psychoanalysis was cleansed of all Freudian achievements. In particular sexuality became a psychological phenomenon divorced from the body; sexuality became something shadowy*" (Reich, 1973, p.124-125).

Reich was the first to introduce and describe the notion of somatic resonance whereby the therapist feels something of what the client is feeling within their own body. This idea of somatic resonance is becoming popular again (Lewis, Amini & Lannon, 2000; Stauffer, 2009) and seen as a form of somatic transference. This is central to the current study when exploring what happens between bodies. Reich's focus on body-mind holism remains a key component in psychological therapies today and a view that was also upheld by Jung. Whilst Jung and Reich differed in their approach – both sought to treat the whole person stressing that we need to consider the personality as a whole.

Jung believed in the ultimate unity of all existence and viewed mind and body to be different facets of one reality as viewed through different lenses. He maintained that the psyche and soma were inherently connected and claimed that *“psyche and matter exist in one and the same world, and each partakes of the other”* (Jung, 1951, p.261). Jung was keenly aware of the dangers of dualistic thinking and stated *“We cannot rid ourselves of the doubt that perhaps this whole separation of mind and body may finally prove to be merely a device of reason for the purpose of conscious discrimination – an intellectually necessary separation of one and the same fact into two aspects, to which we then illegitimately attribute an independent existence”* (Jung, 1972, p.619). Jung (1976) described the psyche as living body which he equates with animated matter. He considered emotions to be deeply rooted in the body. Current day neuroscientific research confirms this thesis by demonstrating the physiological basis of emotions suggesting that body and mind are interconnected. (Damasio, 2000; Pert, 1986).

In *The Psychology of the Transference* Jung (1946) described how therapists were like *“the old alchemists [who] were often doctors... they could collect information of a psychological nature, not only from their patients but also from themselves, i.e. from the observation of their own unconscious contents”* (Jung 1946, p.201). He considered the client-therapist relationship to be founded on mutual unconsciousness whereby client and therapist engage in

mutual unconscious dynamics such as projection and entanglements (Jung, 1966). This notion is relevant to the current study as we explore the implicit dynamics that are at play in the client-therapist interaction.

Jung viewed dreams and symbols to originate in the body and described how *“the symbols of the self arise in the depths of the body, and they express its materiality every bit as much as the structure of the perceiving consciousness. The symbol is thus a living body, corpus et anima”* (Jung, 1969, p.326). Jung demonstrated a preference to work with the symbols rather than working directly on the body, believing they had a materiality of their own, and a profound ability to shift the energy of the body.

Jung (1960) considered the seed of healing to be contained within the body. He theorised that the healing is held within the symptom and thus through working with the body and exploring the symptom the body can guide us. This allows the shadow to be processed and integrated into consciousness. Jung maintained that the body tells us what we need to know if we acknowledge, own and understand it. This approach to working with the body has lived on very much in the work of theorists and practitioners such as Arnold Mindell (1982) and Marion Woodman (1985). Woodman (1985) places the body centre stage alongside the psyche and considers imagination to be the key to connecting both. Woodman (1985) takes a non-dualistic approach to her work describing the body as a container – holding presence for the psyche. Mirroring, which involves reflecting back another’s feelings and perspective non-judgementally and with empathy and attunement, is a central component of Woodman’s work. Woodman considers that when the body of the child is not heard or seen by parents this can result in the ‘soul’ of the child going ‘underground’. Mirroring in the therapeutic setting is an attempt to reconnect with what the child has lost. The importance of mirroring clients is supported by neuroscientific research and the work of Schore (2003a) demonstrates how cells can change at a neurological level and damage to early attachment relationships can be healed through mirroring.

Originally a physicist and a Jungian analyst, Mindell (1982) developed Process Oriented Psychotherapy which he considered to be a 'daughter' of Jungian analysis. This approach, though developed separately, strongly parallels Gestalt therapy and considers awareness to be crucial for change. In this approach focus is on the body and being aware of the body's signals. It views the potential of body symptoms to lead to transmutation and change. Body symptoms are considered to contain essential information and are seen as an attempt to relay messages from the body into consciousness (Mindell, 2004). Process work involves working directly with these symptoms and illnesses. The therapist picks up on how the symptom manifests and follows this by focusing particular attention on gestures and bodily movements. This process can in turn lead to unexpected cathartic shifts and release. 'Dreambody' refers to the patterns that get expressed in our body and in our dream images (Mindell 1982). Influenced by Jung, Mindell contends that just like the dream holds the insight into healing and change so too does body. By focusing on the body and giving it our attention we can gain great insight. The concept of dreambody however does not suggest a dualistic separation of mind and body, rather it implies a deeper level of integration of mind and body through channels of experience that are not normally acknowledged as being meaningful in western culture (Mindell, 1982).

Both Jung and Reich viewed the body as shadow and Jung's concept of shadow is akin to Reich's 'secondary layer' of biopsychic structure. This secondary layer is where repressed energy and negative emotions reside. These could be considered to correspond roughly with Freud's 'unconscious'. Jung worked on shadow through dreams and symbols. Reich however believed in completely dissolving this secondary layer of the shadow (body armouring). More recent thinking however considers some body armouring necessary and attention is more on integrating it rather than trying to dissolve it (Conger, 1988).

In the years since Reich more progress has been made on integrating bodily aspects in psychological therapies. Reich had a major influence on humanistic

psychology and his ideas gained ascendancy in the 1960's and 1970's. Reich's students, Alexander Lowen (1958) and Fritz Perls (1951) incorporated this bodily focus in the development of their approaches to psychotherapy, Bioenergetics and Gestalt therapy.

Body has been considered an integral part of Gestalt therapy and Gestalt therapy is considered to be essentially an embodied therapy. Gestalt therapy develops Reich's notion of contact, excitement and organismic regulation. Gestalt therapy however is more a process therapy than one of discharge. Perls' work differs from Reich in that the focus is on the here-and-now aspects of bodily being rather than how our bodies carry the history of our trauma. This focus on here and now bypasses much of how and why repression happened. Increasing awareness is central to Gestalt therapy with the focus on body awareness and impulses. There has been some criticism of a Gestalt approach suggesting that it considered 'body work' to be complementary to the 'real work' of therapy. However Laura Perls (1988) considered attention to the body to be intrinsic to the therapeutic process and stated that "*It's not use of the body.. the point is to be a body*" (Perls, 1988, p.18)

This attention to the body in Gestalt therapy can be viewed as more holistic in comparison to the more mechanical approach of Reich founded upon 'desire' theory. Perls, Hefferline & Goodman (1951) were critical of these mechanical methods and considered them to encourage the sense of split between self and body. For Reich, resistance was perceived as a physical manifestation of tension and something to be 'broken down'. For Perls et al (1951) however resistance was considered to be an expression of the self which was to be made aware and active and expressed. In Gestalt therapy any withholding or expression is considered an attempt by the individual to get his needs met. Whilst Reich was concerned with cathartic break-through, Perls (1969) was interested in the client's realisation of a sense of self.

Lowen (1958) developed Bioenergetic Analysis describing orgone energy as bioenergy. He moved away from an emphasis on sexuality and whilst recognising its importance he didn't view it as the central issue. Lowen



worked with clients whilst standing unlike Reich who worked with clients lying down. Bioenergetic Analysis involves the client moving their body in order to release painful tensions. This work differs from Reich, which worked very much from the unconscious, whereas Lowen emphasises the role of conscious will. From Lowen's work came the development of Somatic Emotional Therapy (Keleman, 1985) which focuses on the relationship between our anatomy and our psyche. Pierrakos (1987) a close student of Lowen went on to develop Core Energetics which is heavily influenced by Lowen's work.

Biodynamic therapy, developed by Gerda Boyeson (1980) is a combination of Reichian thinking with physiotherapy. It places central attention on soma and less on psyche – unlike Reich and Lowen. Central to biodynamic therapy is the role of peristalsis. Embodied Relational Therapy (Totton, 2003) is a more recent synthesis of Reichian analysis with process approaches. This way of working places a strong emphasis on the therapeutic relationship. Like Reichian analysis it pays attention to breath. It also pays attention to contact, blocks to contact and uses character analysis to facilitate client-therapist communication.

With the development of these therapies, attention to body gained much momentum within the psychological therapies. This development contributed much and brought body out from the shadows of mind based theory. However inherent within this movement lay an implicit dualism as body suddenly had sovereignty over the mind in some quarters. This body-mind dualism mirrored the 'Cartesian' mind-body split with body now given precedence over and above the mind, thus furthering the body-mind split. Wilbur (2000) refers to this as the "*European Split [which is] a peculiar lesion in the modern and post-modern consciousness*" (Wilbur, 2000, p.53). Bringing body out 'into the light' however has contributed much to the field of psychological therapies. Thus whilst it is incumbent upon us not to get tangled in the dualistic web it is also important not to dismiss body completely. It is necessary to proceed with caution, and whilst giving body its rightful place we must be careful not to over idealise the body.

## 2.3 Current Thinking on Body

Current thinking views the body as a relational subjectivity and takes a developmental and constructivist view of body (Carroll, 2006; Damasio, 1994; Panskepp, 1998; 2006). The body is considered to be an outcome of the relational intersubjective field of the caregiver and the infant. Orbach & Carroll (2006) state that “*Whenever you see a body, you see a body that has been internalised in the context of a relationship with another body*” (Orbach & Carroll, 2006, p.69). Aron (1998) considers “*body life and body ego*” to be “*constructed through intersubjective and interactive dialogues*” (Aron, 1998, p.28). The lived body perspective of Merleau Ponty (1945/1962) considers everything to be interconnected and through intersubjective relating we come to know what it is like to be in a relationship with another body. Merleau-Ponty talks of the phenomenal body or the lived body. From a lived body perspective human beings’ very existence is known through the body. Our own body (*le corps propre*) is at the centre of our experience, the pivot of our world and the medium for our ‘being-in-the-World’. We engage with the world through our bodies and we come to understand and make sense of our world through our body. Body is considered our ground and everything else is field. Our experience of our body tells us what contact with the world is like and it is through our body that experience becomes possible. Whilst the body boundary may be defined by the skin, it is not limited to the skin boundary alone. There is always implicit communication going on which makes the system a more permeable one and allows body to be viewed as both separate and not separate.

Infant development studies support this notion that self is co-created through the individual’s interaction with their environment. Unlike early psychoanalytic theories which believed in a unitary and isolated mind these theories view the individual from a relational and co-constructive perspective. Studies show that infants are not behaving within a social vacuum but are engaging in mutual imitating behaviour, responding and reciprocating to the caregiver (Meltzoff & Moore, 1979; Trevarthen, 1979; Wolff, 1987). We thereby see the foundations of intersubjectivity. The contemporary literature demonstrates the

interconnection between early environment and a developing sense of self (McCluskey, 2005; Fonagy, Gergely, Jurist & Target, 2004; Gerhardt, 2004; Stern, 1985). Some theorists consider the infant's concept of self to be inseparable from his/her interaction with others (Gergely & Watson, 1999; Fogel, 1995). Trevarthen (1979, p.323) identified 'primary intersubjectivity' in the new born infant and Trevarthen & Aitken (2001) describe the infant-caregiver relationship as an intersubjective one. I consider this view to be in opposition to former psychoanalytic thinking which viewed infant development in discrete stages (Reese and Overton, 1970). Development is not based on a linear model of development but instead there is an emphasis on continual change and restructuring (Beebe, Lachmann & Jaffee 1997).

Recent developments in research have moved us further ahead from Freud and Jung's theories of development. McTaggart (2011), Wilkinson (2010), and Lewis, Amini & Lannon (2000) draw on new scientific research demonstrating that human beings have an innate drive to connect with others and a deep desire for connection. Unlike classical theory, these theories emphasise how minds do not exist as individual, isolated entities but rather they exist within interpersonal and intersubjective relationships. McTaggart (2011) suggests that "*Our most basic urge always is to connect. Human beings... are born desperate to play as a team*" (McTaggart, 2011, p.66). Totton (2005) emphasises that the main source of this contact is bodily and it is a basic requirement of living. Wilkinson (2010) purports that being aware of and responsive to another is fundamental to the therapeutic interaction and occurs for the most part at a physical level. Lewis, Amini & Lannon (2000) suggest that in truth psychotherapy is physiology. They state that "*When a person starts therapy he isn't beginning a pale conversation; he is stepping into a somatic state of relatedness*" (Lewis et al, 2000, p.168). Fonagy & Target (2007) consider eye contact to be an important evolutionary mechanism which initiates the process of linking or connecting. Through mutual eye contact subjectivities are *interlocked* which then allows a "*joining of attention to focus on a reality*" shared between but going beyond each mind (Fonagy and Target, 2007, p.921). They emphasize that this dual process lies at the heart of therapeutic practice. Cozolino (2006) outlines the importance of the part of

the brain known as the insula cortex in developing our sense of self and our sense of other and the developing social brain. The Insula Cortex has been identified as that part of our brain that *“links hearts and minds”* (Cozolino 2006, p.208). Cozolino (2006) states that *“this sort of physical and emotional resonance serves as a foundation not only to connect our own bodies and minds, but to link us to the bodies and minds of those around us”* (Cozolino, 2006, p.208).

Research and clinical work with infants have identified key interactional concepts such as attunement and affect regulation (Beebe and Lachmann, 1988, 2002; Schore 2003, 2004; Stern, 1985) which can also be applied to the therapeutic setting.

### **2.3.1 Attunement**

Ogden, Minton and Pain (2006) describe how the primary caregiver creates secure attachment through *“reciprocal, attuned somatic and verbal communication with her infant”* (p.43). Such attuned interactions encompass rhythm, co-ordination of sound and movement, facial expressions, gaze and touch. Schore (2003a, p.48) describes them as *“right-brain-to-right-brain emotion-transacting mechanism”*. The intersubjective nature of this process is highlighted by Stern (1985) and Beebe and Lachmann (1998) and is modelled in the client-therapist relationship. Stern’s (1985) notion of affect attunement is common within both the infant-caregiver relationship and in the client-therapist relationship. Similar, though not identical, to Stern’s account of affect attunement is Merleau-Ponty’s (1962) description of the intersubjective relating body. Merleau-Ponty (1962) states that *“In perceiving the other, my body and his are coupled, resulting in a sort of action that pairs them”* (p.119).

### **2.3.2 Affect Regulation**

Ogden et al (1996) outline how the regulatory system in the child is developed through face to face and body to body interactions. This is further developed through attuned motor and sensory interactions which precede verbal communication. This process contributes to the development of the orbital prefrontal cortex – the part of the brain responsible for self-regulation

(Schore,1994; 2003a; 2003b). Hence one's sense of self is formed through sensations and movements of the body and not through language. This has very important implications for therapy as it suggests that body is innately intersubjective and points to the crucial role body has to play in self-regulation. Just as the parent is attuned to the infant's needs by assisting them in regulating their internal emotional state the attuned therapist can help the client to learn healthy ways of self-regulation. The therapist's body can act as a regulator for the client's physiology through non-verbal somatic cues such as pace, tone, volume, eye contact and postural shifts. Beebe & Lachmann (2002), Schore (2003b, 2005, 2008) and Carroll (2005) describe how therapy can provide a similar relational context within which individuals can explore and develop new ways of self-regulating. Schore (2003b) describes the role of the therapist as a "*psychobiological regulator and coparticipant in the 'dyadic regulation of emotion'*" (p.102). Carroll (2005) defines psychotherapy as an interactive regulatory process providing an opportunity for self-regulation.

## **2.4 Two Person Psychology**

The studies cited above have led writers to elaborate on the notion of a two-person psychology. In a one-person psychology development is seen to be driven by internal forces which are impacted by the environment. In comparison to traditional psychoanalysis where the focus is on the intrapsychic, a two-person psychology recognises that the intrapsychic is context-dependent and develops within a relational context. A two-person psychology considers development to evolve from mutually reciprocal relationships and is a co-constructed experience. Wachtel (2008) contends that a two-person epistemology enables the therapist to observe what is pervasive in the client's make up and manifests in a wide range of relationships and contexts. The suggestion is that client and therapist are both inextricably linked whereby both constitute an intersubjective field or "*reciprocally interacting subjectivities*" (Stolorow & Atwood, 1992, p.1). Two person theorists suggest that "*everything we observe about the patient is drenched in our participation in the events we are observing*" (Wachtel, 2008

p.36). Aron (1996) describes how in a two-person psychology the relationship between client and therapist is “*continually being established and re-established through ongoing mutual influence in which both patient and analyst systematically affect and are affected by each other*” (p.77). This relational standpoint differs greatly from the classical psychoanalytic approach of Freud and others which viewed the client as an object to be fixed and therapy was aimed at ‘curing’ the mind of the individual client.

Relational theories however are by and large located in subjective writings rather than in relevant research. Many relational theories tend to be grounded in clinical observation. They understand what is going on based on interpretive modes of understanding rather than established from the findings of systematic empirical research. We look therefore to infant research in order to explore the interconnection between the contemporary paradigm of a two person psychology and the traditional view of one person psychology.

Infant research indicates that whilst the infant-caregiver relationship is an intersubjective one (Beebe and Lachmann, 2002; Trevarthen & Aitken, 2001; Trevarthen, 1979) infants are aware of their separateness and having a sense of self-agency (Stern, 1985). Infants develop implicit self-knowledge through exploration with self and through interactions with others. Stern (1985) identified how infants are conscious of union and separateness and capable of experiencing their body as a differentiated entity. In a study with four-month old conjoint twins, Stern (1985) reports that when the twins sucked each other’s fingers they were able to differentiate their own hands from that of their sibling. The twins responded differently when sucking on their own thumb and when sucking on the thumb of the other.

A two-person paradigm contends that just as the caregiver shapes the child’s experience the infant also shapes the caregiver’s experience, although not necessarily in the same way or to the same degree. However, whilst each member of the parent-infant dyad is altered in their transaction they are not obscured by the transaction. Similarly, whilst the therapeutic relationship is considered a mutual influencing system this does not exclude the intrapsychic

dynamics at play. Beebe et al (1993) present a view of the therapeutic relationship as a system whereby each party is affected by his/her own behaviour (self-regulation) and by the behaviour of the other (interactive regulation) on a continual moment-by-moment basis (Beebe, 1993; Beebe and Lachmann, 1988, 1994). Theorists and analysts (Wallerstein, 1986; Weiss & Sampson, 1986) have acknowledged the role of the intersubjective system without depreciating the role of intrapsychic processes. Ferrari's (2004) model of relating distinguishes between the horizontal dyadic relating between bodies and the vertical relationship of each to their own body. This model can be seen to incorporate both one and two person psychologies as the horizontal relating between bodies facilitates our vertical relationship to self.

An interactional relational theory of bodies needs to take into account individual characteristics and dyadic processes. Whilst we need a two person psychology to discuss what happens between bodies, we cannot eschew all intrasubjective factors. We need to encompass both one and two person psychologies as we are working within and between bodies. Wachtel (2008, p.11) makes reference to "*one and three quarter person theories*" whereby he claims therapists partially integrate relational theory yet they continue to practice in ways that are more in keeping with a one-person psychology. He advocates for moving beyond one person and two person distinctions in an attempt to "*recast the essence of the relational viewpoint as a fully contextual psychology*" (Wachtel, 2008, p.53).

## **2.5 The Third**

Through the mutual interaction of their lived bodies therapist and client enter into an intersubjective state sometimes referred to in psychoanalytic writing as *thirdness* (Benjamin, 2004, 2002). Through the co-ordination of two embodied subjects something emerges which is neither attributable to the client nor the therapist exclusively. A 'third' system or space arises and what comes forth is a function of both together. It is what Gerson (2004, p.64) describes as a '*co-created reality*'. The symbolic space of thirdness begins in

the earliest non-verbal interactions between infant and caregiver (Benjamin, 2004, 2002). Affect resonance or rhythmicity in our interactions help to create this third as we are hard-wired to match and mirror and be in synch with each other (Benjamin, 2004; Knoblauch, 2000). Studies by Beebe and Lachmann (1994) which look at mother-child face to face play demonstrate that this shared-third appears as a cooperative endeavour with mother and infant establishing a co-created rhythm or a complementary two-ness. In this non-verbal interaction, both follow a pattern which is simultaneously created. This creation of thirdness is an intersubjective process whereby each recognises and is recognised by the other. I view the third as a reciprocal interactive process which is not fixed but describes the mutually created, yet temporary space that emerges from the interaction of two subjectivities.

## **2.6 Neuroscience**

Neuroscience helps to shine a light in deconstructing the mind over body paradigm. Recent studies in neuroscience point towards a functionally integrated body-mind and confirm that the traditional view of mind-body split no longer serves. Neuroscientists such as Damasio (2000), Edelman (1992), Panksepp (2006), and Pert (1999) stress the relationship between brain physiology, bodily function and mind. Damasio (1994) considering the connection between mental states and corporeity asserts that body has to be there for mind to develop. He states that “*mind is probably not conceivable without some sort of embodiment*” (Damasio, 1994, p.234) and he considers consciousness to be the mapping of the map of our bodily state. Damasio (2004) defines ‘*Spinozo’s insight*’ to be “*That mind and body are parallel and mutually correlated processes, mimicking each other at every crossroad, as two faces of the same thing*” (Damasio, 2004, p.17). Whilst current day psychological therapies may espouse the views of Damasio, in practice in the therapy room primacy is still given to verbal, conscious, mental understanding or left brain strategies. This manifests itself in therapeutic techniques aimed at mind telling body how to be, how to override symptoms and how to behave. Compared to the narrative level of therapeutic action, the implicit, non-verbal systems have received little attention.



## 2.7 Right Hemisphere Receptivity and Implicit Processing

The field of science is currently experiencing a paradigm shift from explicit to implicit processing. Whilst working at an explicit, conscious level is important the significance of the implicit level is gaining ascendancy and becoming more and more evident (BCPSG, 2007; Chused, 2007; Schore, 2005; Stern et al, 1998, 2003; Tronick, 1998; Wilkinson, 2010). We are witnessing a movement from rational, analytic, conscious, verbal, left-brain processes to more right brain, non-verbal, implicit, unconscious ones. In the therapy setting implicit communication is occurring through unconscious transmissions between right brain hemispheres (Schore, 2005; Schore & Schore, 2008; Wilkinson, 2010). Lewis Amini & Lannon (2000) contend that many clients leave therapy feeling stronger, calmer and safer without knowing why or what in particular happened to result in this. They argue that these changes have taken place within the shared implicit relationship. Nahum (2005, p.697) contends that *“Most of the affectively meaningful life experiences that are relevant in psychotherapy are represented in the domain of nonconscious implicit knowledge”*. Implicit knowing is a bodily knowing and it is palpable in our body.

Studies in neuroscience demonstrate the role of the right hemisphere in implicit information processing (Happaney Zelazo & Studd, 2004; Schore, 2005; Wilkinson, 2010). Implicit processing begins at birth and continues throughout the life span guiding all of our moment to moment interactions (Schore, 2002, 1994; Stern et al, 1998). Developmental studies (Sander, 1985) show us that much is stored, not in verbal, imagistic or symbolic form but implicitly. These implicit, right brain to right brain transactions such as body posture, movement, facial expressions, tone of voice, patterns of speech and eye contact are common to both the infant-caregiver relationship and the therapist-client dyad (Schore, 1994, 1997, 2002). Schore (1994, 2003) maintains that these right brain to right brain processes are central to psychotherapy and the foundation for therapeutic change. Stern et al (1998) and Tronick (1998) consider right brain increases in implicit relational knowledge to lie at the core of change in the psychoanalytic process. Schore

(2005) maintains that the capacity to receive implicit communications is “*optimized when the clinician is in a state of right brain receptivity*” (p.842). When therapists are in a state of ‘right-brain receptivity’ subliminal stimuli that is taken in is bypassed by the conscious mind and processed in the unconscious. The therapist receives these messages and processes them in the unconscious mind. As this material is preverbal or prementalised the client is unaware of it and it is as if the therapist ‘holds’ this raw material until the client is able to own it. Schore (2005) suggests that there is a bodily interchange, not just an emotional one, in the intersubjective field where the right brain is dominant (Schore, 1994; 2003a; 2003b). This implicit communication within the therapeutic dyad is bi-directional. Both therapist and client are influenced by these right-brain to right-brain intersubjective exchanges (Meares, 2005). This therapist-client engagement is referred to by Stern et al (1998, p.917) as ‘*moments of meeting*’.

Chused (2007) maintains that the implicit communications that take place back and forth between therapist and client “*may have more mutative power than an explicit communication*” (Chused, 2007, p.875). He suggests that making them explicit may weaken their power to change a client’s inner world. Stern (2003) corroborates this view with his conviction that “*Implicit knowledge is extraordinarily rich and complicated*” (p.22). For the Boston Change Process Study Group (2007) long lasting change is seen to occur in the implicit relational realm where the “*heart of analytic work occurs*” (p.855). Stern (2004) states that “*we now see therapy, even psychoanalysis, as greatly based on action in the implicit domain, even when we are just speaking and listening*” (Stern, 2004, p.146). Whilst this shift may be attributed to recent thinking we can in fact see parallels with early psychoanalytic notions of unconscious and preconscious processing (Freud 1901; Janet 1907). These structures and processes which operate outside of our awareness, yet nevertheless influence conscious experience form the corner-stone on which the structure of psychoanalysis rests (Freud 1923).

## 2.8 Mirror Neurons

Mirror neurons help to explain how one individual's internal condition registers in the experience of another person. Mirror neurons may underpin our ability to sense and implicitly understand the sensations of others through creating a shared intersubjective space (Ginot, 2007). Mirror neurons are activated in active relational interactions and gestures, tones, postures and facial expressions and activate sensory responses and emotions. Gallese, Eagle & Migone (2007) state that "*we recognise another individual's emotional state by internally generating somatosensory representations that simulate how the individual would feel*" (Gallese, Eagle & Migone, 2007, p.143). The discovery of Mirror Neurons (Gallese, 2007; Gallese, Eagle & Migone, 2007) has given us a neuroscientific explanation for much of what is happening in the processes of resonance and somatic identification. In discussing the psychomotoric understanding of human development Bentzen, Jarlnaes, & Levine (2004) illustrate how children learn through direct absorption of information from the body-self of the parent. Bentzen et al (2004) describe "*Somatic Identification*" (p.148) as the nonverbal transmission of body sensation or affective states between people. Lewis, Amini & Lannon (2000) utilize the concept of "*Limbic Resonance*" (p.81) to describe the neural underpinnings of this process. Limbic resonance is considered the "*door to communal connection*" (p.81). It is limbic resonance that tells a mother how to respond to her baby, when to hold him and when to let him be. The mother can intuit what her baby needs by attuning to his inner states. Through this process of resonance or mirroring the infant's neural activity resonates with that of the caregiver.

## 2.9 Body as Starting Point

Tracing right back to the early days of Psychoanalysis the body was considered to be the founding entity upon which identity is based. We see how Freud (1923) considered the body to be the starting point and necessary for the development of the mind. Damasio (2003; 1999) presents a comprehensive theory of how sensory stimuli can cause somatic changes in the body giving rise to emotions. These emotional responses emerge into

consciousness and are represented mentally as feelings. Feelings are considered to be the mental representation of emotional processes. Through self-reflective analysis, conscious experience of feelings can in turn impact on emotions (Miller, 2008). Damasio states that “Emotions *play out in the theatre of the body. Feelings play out in the theatre of the mind*” (Damasio, 2003, p.28).

The “*Concrete Original Object*” is the term Ferrari (2004, p.29) designates to the body. He considers the body to be a living object from which mental phenomena are generated and describes the transition from the concreteness of the body to abstract mental phenomena. Mental phenomena are given birth to in the body as “*the mind begins to function with its first recording of a sensory perception*” (Ferrari, 2004, p.43). This unmentalised or raw material is akin to what Bollas (1987) refers to as the ‘unthought known’, Donnel Stern’s (1997) ‘unformulated experiences’ and Bucci’s (2005) ‘subsymbolic processing’. There is much neurobiological evidence for these implicit processes as neuroscience demonstrates how the brain stores experiences and memories in the right side of our brain from week seven in utero (Cozolino, 2006). These memories are formed in the period before language develops (Brady, 2009) and thereby get registered in the brain without words. These formative experiences which have never been articulated nor integrated and for which the individual as of yet has no word or meaning, are registered in the body. Donnel Stern (1997, p.643) describes these unformulated experiences as “*the uninterpreted form of those raw materials of conscious, reflective experience that may eventually be assigned verbal interpretations and thereby brought into articulate form.*”

Bucci (2008) describes *subsymbolic processing* (p.55) as the gut feeling of intuition or wisdom held in our body. He outlines the way in which information comes to us in subsymbolic, analogic form as in Reik’s (1948) notion of ‘listening with a third ear’ or Stern’s (1985) concept of ‘affective attunement’ (p.140). Gendlin (1979) applies Heidegger’s concept of the German word *Befindlichkeit* (meaning mood or feeling) to that which is felt or sensed and not yet thought. Gendlin’s ‘Felt Sense’ indicates that it is through our body

sense that we access this implicit realm. We 'feel' the implicit rather than think it. The implicit refers to knowledge that is directly enacted rather than known or verbalised consciously. It is not language based and isn't often transformed into semantic form.

Gendlin refers to the process of accessing the unthought known as *focusing*. As these unformulated experiences refuse to be spelled out going to the felt-sense level can help to access or get in contact with them. Subtle shifts in expression, posture and therapist's own somatic or kinaesthetic experience can indicate a change in the emotional state of the other. As therapists attend to their own body and the intersubjective relating they may become aware of what is evoked in them. By tuning in to the nonverbal language of emotion and the body – for which the client has as yet no words - the therapist connects with the client's 'unthought known'. Bollas states that “*some analysands ...precipitate complex body tensions within us which we endure but to which we may give little attention... we somatically register our sense of a person: we 'carry' their effect on our psyche-soma and this constitutes a form of somatic knowledge which again is not thought*” (Bollas, 1987, p.282). Lyons-Ruth (1996) describes how the implicit relational knowing of client and therapist “*intersect to create an intersubjective field that includes reasonably accurate sensing of each person's way of being with others sensings we call the 'real relationship'*” (p.282).

Bollas' concept of unthought known corresponds to Freud's concept of 'Primary Repressed Unconscious'. However the context within which these preverbal and precognitive mental states develops differs. In Bollas' interactive developmental process we witness a shift from a drive-defense motivation to a relational motivation. This corresponds to the research that demonstrates relational factors as being key to the development of thought and mentalisation. (Beebe & Lachman, 2008, 1994; Fonaghy, Gergely, & Jurist, 2002; Schore, 2005; Stern et al, 1998).

## 2.10 Projective Identification

Unarticulated experiences can be communicated by clients and received by therapists at a visceral level in such a way that the therapist can feel it at a physical level. The experience may be too painful or intolerable for the client and thus it remains unconscious, yet with a lot of charge. Within the psychoanalytic tradition this is referred to as Projective Identification. Klein (1946) first described projective identification as the means by which the infant rids itself of intolerable sensations by projecting them into an object, usually the mother's body. Maternal reverie refers to the mother's capacity to contain what the child experiences as uncontainable (Bion, 1967). These intolerable and intense sensations become modulated and thinkable via maternal reverie. This in turn allows the sensation to lose some of its explosiveness and transform into thinkable 'alpha elements' (Bion, 1967). Schore (2005) discusses how clients use projective identification in order to bring into the therapeutic relationship affective experience that has not been processed and hence is remembered physiologically and is communicated on a somatic level. As clinicians, it is necessary to be able to tolerate and contain these projected affects. This process signals the importance of therapists listening to their own body as the projected material is picked up somatically.

## 2.11 Mentalization

Mentalization (Fonagy, Gergely, & Jurist, 2002) or "*reflective function*" (p.8) is defined as the capacity to think about mental states in oneself and in others or the capacity to relate to one's own and other people's thoughts and feelings (Fonagy, 1991; Fonagy and Target, 1995). Through mentalization the child has the capacity to 'read' other people's minds. "*We see the self as originally an extension of the experience of the other*" (Fonagy et al, 2002, p.8). Mentalization arises through the regulation of affect as intensive sensations become regulated and 'thinkable' or mentalized. This is referred to as a 'theory of mind' by developmentalists. There is a correlation between ability to modulate and tolerate intensive arousal and one's ability to mentalize. Fonagy et al (2002) draw on developmental studies to demonstrate the central role of the caregiver in the development of the child's mentalization

and reflective function. Studies show that parents with a high reflective capacity are three or four times more likely to have secure children, (in turn facilitating the development of mentalization) than parents whose reflective function ratings were low (Fonagy, 1991). Murray (1992; 1996) demonstrates how a deficiency in affect attunement in mothers who are unresponsive and depressed is linked to reduced cognitive development in children. When the caregiver is unable to provide appropriate reverie or responsiveness this leads to the infant becoming distressed and withdrawn (Tronick et al, 1996; Murray & Trevarthen, 1985).

The development of the capacity for mentalization and reflective function in the child is mirrored in the therapeutic encounter (Fonagy, 1991; Bateman & Fonagy, 2004). Through the use of the process of reflective functioning the therapist regulates affect. The therapist adopts a mentalizing stance allowing the client to recognise and internalise their own affective states (Fonagy & Bateman, 2006). Zanocco (2006) considers that the therapist functions as the client's auxiliary ego as the body of the therapist helps the client to think and thoughts to become articulated. Simply identifying or naming the feeling can be containing for the client. It is vital that the therapist is able to differentiate the client's feelings from their own responses to the client's feelings when adopting a mentalizing stance (Bateman & Fonagy, 2004).

## **2.12 Somatic Countertransference**

Stone (2006) describes the therapist's body as a 'tuning fork' whereby the client's psychic material is picked up somatically by the therapist. On examination of the literature to investigate embodied phenomena we find there is a scarcity of empirical research exploring therapists' embodied experience and much of the literature is based on observation studies. Field (1989) was one of the first to explore the therapists' bodily reaction and he gives an account from his own clinical experience. Shaw (2003) outlines how therapists view their own bodies in their therapeutic work by exploring the physical reactions they experienced with clients. He reports a range of

symptoms which therapists experience in their bodies including nausea, smell, hot and cold, pregnancy feelings and visual disturbances.

Viewed through a traditional psychoanalytic lens, these intersubjective phenomena are referred to as Somatic Countertransference. Carroll (2006) considers countertransference to be the therapist's "*sophisticated relational response to the client*" (p.67). This response includes sensations, images, feelings and fantasies which are connected to the process of the client and the intersubjective relationship. Aron (1996) describes how a client who has been traumatized as a child may enter a hypnoid state and may in turn put the therapist into a hypnoid state. This response may occur in order to avoid repetition of the earlier trauma or to communicate the nature of the tragedy that has taken place. Hart (2008) describes a body based countertransferential response she had to a young boy who had been sexually abused whereby she experienced a sharp pain in her abdomen and envisioned images of daggers.

Samuels (1985) emphasised that therapists bodily responses are significant in the therapeutic encounter. In a research study of 30 therapists, Samuels (1985a) found that in 46% of the cases the reported countertransference could be described as *embodied*. The literature describes a myriad of symptoms of somatic countertransference including nausea, headaches, tearfulness, unexpected shifting of body, genital pain, muscle tension, aches in joints, boredom, stomach disturbance and numbness (Spiegelman, 1996; Hazell, 1994; Samuels, 1985; Field 1988; McLaughlin, 1975). Stone (2006) concludes that the symptoms most frequently experienced by therapists include sleepiness, erotic and sexual feelings. Stone's conclusion differs slightly from Booth, Trimble & Egan (2010) who studied the frequency of body-centred countertransference amongst 84 psychologists across a variety of therapeutic orientations. They found that muscle tension and sleepiness were the most common forms of somatic countertransference. Interestingly sexual feelings were amongst the least reported symptoms in this study. This variance may be attributable to the participant sample and the client group with which they worked.



### **2.12.1 Client Presentations and Somatic Countertransference**

Warnecke (2009) spells out the frequency with which somatic symptoms are experienced by individuals with a borderline process and in turn picked up by their therapists. Schwartz-Salant (1989) gives a graphic description of a therapist's experience of intense bodily sensations in a session with a mildly borderline woman. Stone (2006) supports these conclusions and notes that body-centred reactions are more frequent with clients exhibiting borderline, psychotic or severe narcissistic elements and in cases where there has been early severe childhood trauma. He explains that clients who presented with borderline personality or psychosis tended to project their embodied affect onto the therapist. In his study Samuels (1985) reported that clients presenting with problems relating to the body (e.g sexual aggression, eating disorders) tended to evoke greater somatic countertransference in the therapist. Van Der kolk (1996) illustrates that a Borderline Personality presentation corresponds with those of Post Traumatic Stress Disorder.

In a qualitative study carried out by Geller & Greenberg (2002) therapists who sought to be *fully present* in the therapy room reported feeling a somatic resonance with their clients and described how this gave them information on the client and also guidance on how to proceed. Spiegelman (1996) attests to the frequency with which the somatic symptoms he experiences relate to symptoms his client is currently having or had in the recent past. He further testifies to the underlying symbolic parallel between the symptom and the psychological content of the material being discussed.

### **2.13 Client-Therapist Interaction Studies**

There has been an increasing recognition of the pivotal role of the therapist client interaction in psychotherapeutic practice. Carkhuff and Berenson (1977) tracked the reciprocal client-therapist exchange highlighting the centrality of therapists' skills to facilitate exploration and to respond to affect. A qualitative study by Knox (2008) demonstrated that clients perceive moments of relational depth with their therapists to be highly significant moments in therapy and to have an enduring positive effect. Clients described feelings of

aliveness, realness, and openness and experienced their therapists as being holding, accepting, and 'really real'.

On reviewing the literature on client-therapist interaction the majority of accounts tend to be individual writers descriptions from their own experience and/or observation studies. Observational studies have demonstrated that non-verbal behaviours such as smiling, nodding, eye contact and posture assist in developing rapport and client disclosure (D'Augelli, 1974; Fretz, Corn & Tuemmler, 1979; Hasse & Tepper, 1972; Trout & Rosenfeld, 1980). Lachmann & Beebe (1996) identified the salient role of nonverbal, mutually regulated interactions such as vocal rhythm, pitch, and the level of arousal in treatment. McCluskey (2005) explored the role of empathic attunement in effective care giving. Based on recent research and empirical studies she introduces the concept of 'goal-corrected empathic attunement' demonstrating how caregivers can be trained to become empathically attuned. McCluskey (2005) identified nine patterns of relating between client and therapist based on verbal, non-verbal and emotive messages in their interactions.

Studies by Anstadt, Merten, Ullrich & Krause (1997), Birdwhistell (1962) and Scheflen (1963, 1968) used film, tape and video technology to demonstrate the central role of nonverbal interactions between clients and therapists. Mohacsy (1995) investigated the place of non-verbal communication, suggesting that it could provide very valuable insight into the client's internal world. This non-verbal communication may be related to information that the client consciously withholds or client's unconscious processes. A study carried out by Hatfield, Cacioppo & Rapson (1993) demonstrates the whole body synchrony and mimicry that occurs automatically and involuntarily when two people interact. Facial expression, rate of speech, pauses for breath and posture all become entrained for the purpose of connecting with each other.

Condon (1985) carried out a study whereby videos were watched frame by frame in an attempt to understand what happens between people's bodies. His findings suggest that our every movement is synchronised with our speech patterns. Movements of our hands, arms, shoulders, head and even

the blinking of our eyes keep in rhythm to the beat of our speech. Interestingly, a listener to a conversation begins to synchronise his body and co-ordinate his movements to the patterns of the speaker in a very short space of time. Like a choreographed dance, both bodies move together in perfect co-ordination. Shaw (2004) explored therapist's somatic experiences in the therapeutic relationship. Following 3 discussion groups, 14 in-depth interviews and 2 professional scrutiny groups he developed a grounded theory of psychotherapist embodiment. Findings suggest that the body is experienced by the therapist as a receiver, a source of empathy and as a source of management.

Reports in the literature of the therapist's body in the clinical setting are largely descriptive. Clinicians drawing on case examples have explored the impact of the therapist's body on the client in the context of gender (Baker-Pitts, 2007; Orbach, 2006), eating-disorders (Lowell, 2005; Pacifici, 2008) and the pregnant therapist (Bienen, 1990). What appears to be missing in the psychotherapy research are empirical studies exploring the implicit intersubjective interaction. Mearns and Cooper (2005) stress that much of the empirical studies have looked at relatively "*surface level therapeutic variables*" (p.15). They assert that it is now time to focus on more in-depth processes of connection and intimacy within the relationship. They note that we know little if nothing of these processes. Such processes of connection and intimacy are largely non-verbal, implicit processes which are chiefly accessed through the body.

## **2.14 Rationale for Current Study**

From infant development studies we have learned that our bodies are an outcome of the intersubjective field of the caregiver and the infant. As human beings we have the ability to sense and implicitly understand the sensations of others through creating this shared intersubjective space. If our bodily being is central to our relationship to the world then we need to take this embodiment into the therapy room and view the process of psychotherapy as an embodied intersubjective phenomenon. It is proposed that we can become

alert to how client and therapist affect and are affected by each other. These processes are taking place largely within the implicit relational realm where long lasting change is seen to occur. It is through our body sense that we access this implicit realm and thus in order to explore this dimension we need to look at what happens within and between bodies.

Neuroscientific research indicates that mind and body are functionally integrated and the body is considered a living object from which mental phenomena are generated. Mental phenomena are given birth to in the body and it is within our body that a deeper wisdom and knowing is held. Mentalization arises through the bodily process of affect regulation as intensive sensations become regulated and 'thinkable' or mentalized. This development of the capacity for mentalization and reflective function in the child is mirrored in the therapeutic encounter. Sensations experienced as overwhelming and unmentalizable may be lodged in the body. These intrusive sensations, whilst originating in the body of the client, may make their presence felt in the body of the therapist. The therapist's body is like a 'tuning fork' whereby the client's psychic material is picked up somatically by the therapist. By tuning in to the nonverbal language of the body the therapist connects with the client's psyche. It is necessary therefore that we explore how therapists are attending to this non-verbal language and the meaning they make of it.

Reports in the literature of the therapist's body in the clinical setting are largely descriptive. Clinicians drawing on case examples have explored the impact of the therapist's body on the client and the importance of therapist's non-verbal behaviour. Much of the current literature investigating embodied phenomena is based on case studies. What appears to be missing in the psychotherapy research are empirical studies exploring implicit intersubjective interactions.

Given the history of the body in psychotherapy therapists seem to have less experience attending to kinaesthetic information received from their own body. Current neuroscientific findings need to be incorporated into the way in which

therapists think about their work. The evidence suggests that therapists need to be engaging at an experience-near subjective level whereby the moment-to-moment, implicit processes are being attended to. It is incumbent upon us to explore how therapists are experiencing these bodily interchanges and attending to nonverbal implicit functions and tracking the affective cues of the client. Without this awareness interactions that are happening through movement, posture, gesture and other bodily means may go unrecognized. Right brain interoceptive bodily-based affective responses to the client's shifting states may be neglected and not attended to. This results in the loss of many of the nonverbal, visual and prosodic transactions between client and therapist. Schore (2008) contends that much therapist training has neglected to teach therapists how to attend to this implicit, non-verbal dimension. In order to gain a greater understanding of the mechanisms that lie at the heart of the change process it is necessary to research the nonverbal activities and implicit processes underlying the psychotherapeutic process.

## **2.15 Aims and Objectives of the Current Study**

### **2.15.1 Aims**

The main aim of this study is to generate a theory of what happens between the body of the therapist and the body of the client in a psychotherapeutic setting. This is achieved through documenting and analysing first-hand therapists' experiences of their own embodied experiences in the psychotherapeutic process. It is hoped that through developing a rich understanding of what happens between bodies, this will add to our knowledge of the embodied intersubjective field in the therapeutic dyad. It will also contribute to our understanding of implicit interactions and enhance our clinical skills within the therapy setting. Furthermore it is anticipated that results will help to inform specific recommendations for supervisors, trainers, therapists and researchers.

### **2.15.2 Objectives**

1. To explore how therapists attend to their own body in the psychotherapeutic process.
2. To understand what happens between the therapist's body and client's body in the therapeutic encounter and what are the implicit mechanisms at play.
3. To build a theoretical framework of what happens between bodies in therapy.
4. To inform specific recommendations for supervisors, trainers, therapists and researchers.

### **2.16 Research Questions**

The research was concerned with capturing therapist's direct experience of their embodied interaction with clients in order to develop a theoretically salient model of what happens between bodies in the psychotherapeutic encounter. The following questions were posed to therapists in an attempt to explore their observations of the therapeutic process.

1. How do therapists pay attention to their own body when working with clients?
2. What do therapists do at a bodily level with clients?
3. What happens between the body of the therapist and the body of the client?
4. From a therapist's perspective how are clients impacted by the therapist's body?
5. How are therapists impacted by the client's body?

## **3. METHODOLOGICAL CONSIDERATIONS AND RESEARCH DESIGN**

### **3.1 Rationale for Research Methodology**

Qualitative methodology provides the researcher with a framework to understand experience as closely as possible to how the participants feel or live it. As this particular research question was directly concerned with therapists' experiences as they are lived or undergone within a psychotherapeutic context, a qualitative methodology was chosen. The purpose of this study was to explore what happens between the body of the therapist and that of the client in psychotherapy. A Grounded Theory (Charmaz, 1990, 2006; Glaser & Strauss, 1967; Glaser, 1978) methodology was used to collect and analyse the data.

#### **3.1.1 Which grounded theory**

Since its introduction by Glaser & Strauss, in 1967, grounded theory has continued to develop, with various diverging perspectives emerging over time (Charmaz, 1996, 2003, 2006; Glaser, 1992; Henwood & Pidgeon, 2003; Strauss & Corbin, 1994, 1998). There are many philosophical tensions embedded in these differing emerging approaches. A classical approach to grounded theory is based on the epistemological position of positivism which seeks to make predictions about an objective reality. The approach in the current study more closely reflects a constructivist paradigm which attends to the social construction of knowledge. I adopted a kind of double hermeneutic in the current study as the process entailed interpreting meaning through the eyes of the participants in addition to allowing the active participation of the researcher in the construction of meaning.

A classical approach to Grounded Theory advocates constant comparison of observed or verbalised descriptions and incidents in order to identify the abstract higher-level concepts or processes underlying these incidents (Glaser & Strauss, 1967; Glaser, 1978). There is an underlying assumption inherent in this classical methodology that a universal truth exists out there waiting to be discovered. Factual truth about reality is sought and theory is

then discovered from these facts. The social processes that impact on the generation of data and the social construction of knowledge are not of interest in this approach (Hall & Callery, 2001). Classical Grounded Theory which is part of the positivist tradition adheres to systematic and rigorous methodology and procedures aimed at arriving at theoretical understanding. Glaser (1992) states that “*Grounded theory uses a systematic applied set of methods to generate an inductive theory about a substantive area*” (p.16). The data that is generated is considered to be a reproduction of participant’s realities. This is in contrast to a constructivist approach which offers ‘*plausible accounts*’ rather than ‘*verified knowledge*’ (Charmaz, 2006, p.132). A classical approach identifies underlying processes or behaviours and seeks one underlying core category which represents that particular behaviour (Christiansen, 2007). The core-category is grounded in the data and emerges directly from the participants rather than interaction with the researcher. This approach seeks to separate the observer from the observed and doesn’t attend to the interaction of researcher and participant.

Strauss and Corbin (1994) developed Glaser’s approach in order to accommodate a relativist epistemology. Strauss and Corbin (1994) describe a theory as “*interpretations made from given perspectives as adopted or researched by researchers*” (p.278). Thus because it is an interpretation, theories are not established forever. The generated theory cannot be readily transferable to a context outside of the research one. Because they are interpretations of contemporary society they are limited in time. Theories are constantly being outdated and they are fluid. Theories are interpretations made from the participants’ account of things. Strauss and Corbin (1994) advise that the matching of theory to data must be rigorously carried out and theories must always be traceable to the data that gave rise to them.

In the past two decades Grounded Theory has become widely adopted by researchers in a variety of fields. It has been refined, evolved and developed by its founders and other theorists. Charmaz (2006) is one such theorist who has developed an innovative and creative approach to Grounded Theory. Her approach differs from that of Glaser and Strauss which she claims seeks to



discover theory as emerging from the data and neglects the relationship between the researcher and the participant. Charmaz (2006) proposes that *“Unlike their position I assume that neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives and research practices”* (p.10). Such a constructivist view considers knowledge to be constructed by our interaction with a specific social context (Crotty, 2003). This means that our world is constantly being constructed through our interactions with others. A constructivist view acknowledges multiple realities in an ever changing world along with diverse perspectives, views and complex systems. The contemporary constructivist outlook of Charmaz (2006) and Payne (2007) recognises the role of the researcher’s hermeneutic in the grounding of theory. This signifies a movement away from a more positivist outlook.

In the current study I adopted a constructivist/interpretivist research paradigm as propounded by Charmaz (2006). A post positivistic philosophy presupposes that there are no universal truths or generalizable laws (Bergin, 2008) and instead multiple truths exist which are constructed by individuals (Mills, Bonner & Francis, 2006). The accuracy of our knowledge about the world can only be relative as it is distorted by the lenses of our own perception. The researcher is constantly interacting with the data and theory is considered an interpretation. In alignment with Charmaz’s view this study offers an *interpretative* picture of the field of study, and not an exact copy of it. Underpinning the current analysis is the tenet that meaning is constructed thus attention is given to the impact that the researcher-participant interaction had on the construction of data. Consistent with a constructivist approach data is seen to emerge from the experiences of participant and researcher and their interaction. This approach extends beyond how one might view their own situation as meaning and action is constructed by researcher and participant. The researcher facilitates the discovery of knowledge rather than being the creator of it (Charmaz, 2006).

Traditional grounded theorists reject reflexivity and consider it to be a distraction from the data (Glaser, 2001; 1978). Glaser (2001) considers reflexivity to be unnecessary describing it as “*paralyzing, self-destructive and stifling of productivity*” (p.47). Much attention to reflexivity and its contribution within the grounded theory literature has emerged in recent years (Charmaz, 2006; Hall & Callery, 2001). Mallory (2001) considers reflection on the researcher-participant relationship inherent within a grounded theory methodology. Finlay (2002, p.534) states that “*reflexive analysis is necessary to examine the impact of the researcher and participants on each other and on the research*”. Hall & Callery (2001) propose that attention to reflexivity enhances the rigor of a grounded theory study. In their words “*the knower is subjectively linked to what can be known*” (Hall & Callery, 2001, p.261). The current study adopted a reflexive approach to address the impact of investigator-participant interaction on the process. This study allowed for this reflexive process as the biases, beliefs and assumptions of the researcher were made explicit and captured in memos and auditing procedures. Reflexivity also enhanced the research as analytic decisions and emerging theoretical ideas were documented.

### **3.1.2 Why Grounded Theory**

Grounded theory is a perspective based methodology which was in character with the current study as the focus was on the experiences of therapists and how they make sense of these. Grounded Theory is interested in the subjective experience and phenomenological world of the participants. It involves procedures that result in rich, descriptive, contextually situated data, based on participants’ spoken words. Choosing a Grounded Theory approach enabled me to access and interpret meaning ‘as if’ through the eyes of the participants. A Grounded Theory methodology furnished me with a framework to understand these experiences as closely as possible to how the participants live them.

The emphasis on theory development is what renders Grounded Theory methodology different from other methods of qualitative research. The aim of grounded theory is to generate working hypotheses which in turn lead to the

development of theory. This study was interested in the development of a theory which is informed by the data. Given the inductive nature of its methodology grounded theory was chosen over other approaches. A grounded theory methodology allowed the researcher to develop a theory of embodied intersubjectivity as this study was interested in conceptualizing what happens between the body of the therapist and that of the client. It is anticipated that this theory which is grounded in the data will help to inform practice.

Furthermore, a grounded theory approach was chosen because of the nature of the subject under investigation. Strauss & Corbin (1990) propose grounded theory as a suitable methodology when the phenomenon under analysis is difficult to identify quantitatively. Given the largely implicit and 'elusive' nature of the embodied intersubjective relationship a grounded theory approach was befitting to this study.

Initially I had considered the possibility of using an IPA methodology, however it was decided that a grounded theory methodology was the most appropriate one to answer this particular research question. Grounded theory helped me to identify and explain the processes which account for what happens when two bodies meet in the therapy room. However, an IPA methodology may be a suitable methodology to use in future research. IPA is concerned with the 'What's it like' question and this may be a very interesting way to explore in greater depth the sub-categories which emerged from this grounded theory study. A grounded theory methodology was also chosen as much has been written about this methodology and it is a more established and better known qualitative method (Willig, 2008).

### **3.2 Participants**

Nine female and three male psychological therapists participated in the study. Participants ranged in age from 33 to 71 years and work in urban and rural settings. Therapists were selected from across a range of modalities and were all accredited psychological therapists. The researcher contacted participants who fulfilled the criteria, outlining the purpose of the research and inviting

them to take part in the study. All those invited to take part in this research accepted the invitation to participate.

The following criteria were used for selection:

1. Therapists who had been practising as a psychological therapist for over five years. This ensured that they had sufficient experience working as a psychological therapist.
2. Work in Southern Ireland and available for interview.

### 3.2.1 Participant Characteristics

<b>Therapist</b>	<b>Gender</b>	<b>Years in Practice</b>	<b>Work Setting</b>	<b>Modality</b>
<b>1</b>	Female	13	Service for survivors of abuse	Existential Integrative
<b>2</b>	Female	12	Counselling Centre/ Private Practice	Humanistic Integrative
<b>3</b>	Male	21	Private Practice (Trauma Counsellor)	Humanistic, Somatic Experiencing
<b>4</b>	Female	6	Service for survivors of abuse	Gestalt
<b>5</b>	Female	10	Private Practice	Humanistic, Integrative
<b>6</b>	Male	9	Private Practice	Person-centred
<b>7</b>	Female	15	Service for survivors of abuse/ Private Practice	Humanistic, Integrative
<b>8</b>	Female	11	Service for survivors of abuse	Psychoanalytic, Psychodynamic
<b>9</b>	Female	15	Private Practice	Humanistic, Integrative, CBT.
<b>10</b>	Female	12	Service for survivors of abuse	Psychodynamic, Relational
<b>11</b>	Female	18	Private Practice (Trauma Counsellor)	Psychodynamic
<b>12</b>	Male	10	Private Practice	Humanistic Integrative

### **3.3 Research Design and Related Considerations**

Following data collection I was presented with a large body of unstructured data. A grounded theory methodology provided me with a systematic approach to analyse this. However, whilst the literature describes this process in a linear fashion the reality is very different. Although I followed the steps of 1.Data Collection, 2. Coding the Data, 3.Theoretical Sampling and Sorting and 4.Writing the Draft; this was a 'messy' process and not as neat and tidy as is sometimes proposed in the text books about research. Getting stuck in to the 'messiness' of this research project involved surrendering to the concurrent process of data collection, coding, conceptualizing and theorizing. In Grounded Theory the process of data collection and analysis is interwoven as theory is developed during the course of the research through interplay with the data. The iterative and recursive nature of this process meant that each stage informed the next and all stages were revisited as the research progressed. This process, whilst not straightforward, certainly brought the research alive and made it exciting. At times I felt that I was engaging in an artistic process whereby I had to surrender to the uncertainty and the not knowing whilst awaiting what emerged.

### **3.4 Interrogation of the Literature**

In the early stages of conceptualising this study I carried out an initial exploratory interrogation of the literature. I drew on historical developments and the therapeutic literature in order to develop a coherent rationale for my study. Through this I became more familiar with the extant literature in this area, identified some of the gaps as I saw them in the existing literature and gained an overall understanding of how this area had been researched. Doing this initial review was also necessary in order to satisfy an Ethics Committee and Prior Approval Panel.

As the research got underway and codes, categories and topics grounded in the data began to emerge I engaged in a further interrogation of the literature. This allowed me to reflect on my early interviews. As data analysis proceeded I continued to explore the literature by incorporating more of the specific

literature and developing a more comprehensive review. Moving between the data and the literature was a very important step in this later phase. I was constantly comparing the literature to the emerging theory. This involved understanding how the literature was a 'fit' to the data and whether it agreed or disagreed with the findings.

### **3.5 Data Collection**

Data were collected through use of Semi-structured interviews and Memo Writing. Using a semi-structured interview schedule (see Appendix C) allowed for an open-ended and detailed exploration of the research topic. I began by putting general, open-ended questions first followed by more in-depth ones. By having a prepared set of questions, I was able to focus more on what the participants were saying rather than having to worry about what to ask next. Interviews were audio taped which allowed for detailed data and enabled me to give my attention to the participant.

The research interviews were carried out in the participants' place of work, a rented counselling room and/or the researcher's office. Materials used included a tape recorder, tape and an interview schedule. Participants were given a full briefing of the purpose of the study and assured of confidentiality and anonymity. Participants signed a consent form (Appendix B) agreeing to take part in the study. Interviews lasted an average of 75 minutes. Following interview, the raw data recorded in the interviews was transcribed by the researcher and each data set was labelled. Names were deleted from the data and each participant was assigned a code number. It took approximately 8 hours to transcribe one hour of tape.

A hard copy of the transcript was sent to the participant for checking in order to verify its accuracy and clarify anything outstanding. The researcher aimed to send the transcript to participants within one month of their taking part in the study. Interviews were coded once they were transcribed, thus giving further direction on the kind of data to collect next. Each line of the transcript was given a numerical reference. Wide margins were used providing space

for comments, line-by-line coding and focused coding. Appendix F and G provide examples of coded transcripts.

All therapists described using body-oriented interventions to a more or lesser degree. This included a general responsiveness to the client's body, awareness of the therapist's own embodied process and interventions designed to highlight the client's awareness of sensory elements, impulses, breathing, feelings and defences in addition to body work skills (e.g. focusing on bodily sensations, movement and tracking the breath in the body). All participants regarded attention to body a significant aspect of their work and to varying degrees, thus they are representative of a homogenous sample.

On the basis of the emerging responses to the initial three interviews, the original interview schedule was adjusted slightly. Having asked the question '*Are you aware of being attuned to your clients at a bodily level?*' I noted that this language was unfamiliar to some participants and they were unsure of what I was asking. I decided to expand the question to ask '*Are you aware of what happens between your body and that of your client?*' This question yielded a much richer response. This change underlined for me the need to use language which is understood by participants and not to use jargon or complicated terms. I also realised during the process of interviewing that when a participant finds it difficult to articulate something, it was important for me to stay with this and not to rush in to rescue them.

As I interviewed each participant I was alert to my own body responses. I was particularly aware at times when my body got tense or tight or my breathing changed. I was also cognisant of moments when my body felt excited by what participants were describing. I noticed that my energy levels were heightened following some interviews and dipped after others. This somatic information assisted me in understanding and deepening into the research process. I was also aware of a parallel process in the interviews with what can occur in therapist-client sessions. This information was recorded in a research journal which captured any observations and processes that emerged. I wrote

detailed memos throughout the research process which documented my emerging theoretical ideas, hunches, insights, feelings and questions.

During the course of the interview two therapists wavered and continually brought the focus back to the client's body and not what happens between bodies. In the words of one participant '*Yeah. Yes. I keep forgetting why you're here*'. (2). It was important that I brought them back to the research question. This tended to happen mainly with participants who described themselves as 'doing' body work and I experienced them as being more focused on bodywork as technique. This possibly reflects what happens in therapy as it can be the client's body that tends to be the main focus of the work.

In one interview I was aware of feeling slightly uncomfortable and I noticed myself wanting the interview to be over. It was the shortest interview carried out. I felt this therapist had a prescribed way of doing things – and even though they attended to body when working with clients – it seemed quite formulaic and prescriptive to me. Whilst I didn't discuss this with the interviewee at the time, I questioned myself after the interview about what was going on between us. I realised that it felt more like a lecture than an experiential exploration or knowing. The responses were very closed and didn't allow much scope for exploration. As I deepened into this inquiry I realised that what I was experiencing in the interview was a sense of this participant having it all wrapped up and analysed with no room for further movement. When I reflected on what was missing, it seemed to me that this therapist was cut off from their own body. This brings up questions for me around whether or not I should have named this with the interviewee. If I were wearing my clinician's hat I would name this, but as a researcher I didn't consider it to be appropriate.

This brings to the fore the kind of dilemmas that can emerge for the 'insider – practitioner as researcher'. Issues around the kind of contract we had are highlighted and lead me to question what I do with the clinician part of myself when researching. In this case the clinician was silenced as naming my



response in the interview didn't seem appropriate. In addition to the clinician/researcher distinction, it may also reflect the power differential between me the 'student' and participant as 'experienced therapist'. What I took away from this was the importance of staying open to exploring it in the interview. Whilst this didn't happen in the aforementioned interview it certainly helped me to address my own responses and reactions in subsequent interviews with participants. I learned that the more transparent I was in the interview the better.

This predicament also underlines some ethical issues. I am very conscious in writing up this piece that I retain my courage to write about this in a truthful, yet respectful manner. When I question my feelings around this interview and towards the participant I am aware that part of me doesn't want to offend this person. Furthermore I notice my reluctance even to bring this into the discussion here as the adaptive part of me wants to say '*I've stuck close to Charmaz's methodology*'. However in remaining loyal to my reflexive leanings it is in the best interests of the research to make these biases and assumptions transparent.

A further interesting feature of this is that on re-reading the transcript at a later stage I could see much more in the responses than I had previously seen and indeed much of the data from this interview supported the main findings. This heightens my awareness of the co-created dynamic in the interview and that whatever was created in the exchange was embodied in the dialogue between us.

### **3.6 Coding the Data**

Coding is the transitional step between data collection and development of theory. Data was coded in a systematic manner through use of line by line and focused coding. I began coding from the word go and coded between interviews. This was of enormous value for focusing in later interviews and ensured better coverage of the area of research. It also brought more nuances and subtleties into my mind enabling more sensitive exploration in subsequent interviews.

### 3.6.1 Line by line coding

Through line by line coding I was able to make analytic sense of the data and re-adjust subsequent interviews. Line by line coding involved reading through the transcript line by line and identifying meaningful units of text and labelling each one: attention was given to actions, events, implicit meanings and processes that were perceived as occurring in it. The following is an example of line by line coding.

Line Code	P = Participant I = Interviewer	Interview Data	Line Code
1.34 1.35 1.36	P	.. even in a recent session where the client was kind of in such pain, and I could feel pain in my own stomach	<b>CLIENT IN PAIN THERAPIST FEELS CLIENT'S PAIN</b>
1.37	I	you could actually physically feel it?	
1.38 1.39 1.40	P	literally. And yet there was also something about not trying to get rid of the pain in any way, but just literally stay.	<b>NOT GETTING RID OF THE PAIN IT'S ABOUT STAYING</b>
1.41	I	Hmm	
1.42 1.43 1.44 1.45	P	but I can't say that was about the client or it was about.. it was something about the dialogue and something about the nature of what was going on. So I think that I listen to it. I don't say.. 'oh this is about the client'.	<b>TELLING ABOUT THE DIALOGUE TELLING WHAT IS GOING ON LISTENING TO THE SENSATION NOT MAKING IT ABOUT THE CLIENT</b>

See Appendix F for further examples of line by line coding. The following questions posed by Charmaz (2006, p.51) were of enormous benefit to see actions and identify processes in the data.

- *What process(es) is at issue here? How can I define it?*
- *How does this process develop?*
- *How does the research participant(s) act while involved in this process?*
- *What does the research participant(s) profess to think and feel while involved in this process? What might his or her observed behaviour indicate?*
- *When, why and how does the process change?*
- *What are the consequences of the process?*

Codes were kept active and I stayed close to the data, using participants' exact words (*in vivo* codes) at times. Coding proved challenging and I had difficulty at first finding succinct codes as some seemed a bit 'longwinded'. Finding the balance between remaining too concrete and being too abstract was problematic at times. It was helpful to consider that the goal was to

encapsulate the smallest quantum of meaning in each code. Some of the codes tended to overlap, however this resolved itself once I had completed the first level coding. Having interviewed the first three participants and coded the data I set about tweaking my questions. These first interviews presented me with some 'golden nuggets' and I was interested in exploring these in subsequent interviews.

An example of one such 'nugget' occurred when one participant stated '*It's not just body, its body and soul too*'. When she stated this I realised that when we focus on the body – we are not just talking about the corporeal body. We are in fact talking about everything that body incorporates – body, heart and soul. This insight really opened up the whole area of the research for me and named something that was lurking beneath the surface that I couldn't quite grasp until that point. This insight led me to look more broadly at body in subsequent interviews.

As I studied the transcripts of each interview and performed line by line coding this led to further research questions. Interview questions were now more directed since they were grounded in concepts arising out of the data. One example of this shift occurred in relation to the in-vivo code of 'embodying the relationship' which emerged from one of the first interviews. As this theme was introduced in the early stages I decided to include more prompts to identify how it was significant when exploring what happens between bodies.

### **3.6.2 Focused Coding**

Focused coding involved taking the line by line codes of interest and significance and applying them to a larger amount of data. I found the use of wall charts indispensable at this state as I cut and pasted each line by line code onto a chart labelled with the focused code. The following is an example of focused coding.

<b>Focused Code</b>	<b>Participants contributing to this (Code No. corresponds to participant)</b>	<b>Participant</b>	<b>Key cross references</b>	<b>Indicative Quotes (With reference to sentence number)</b>	<b>Notes</b>
<b>USE OF BODY</b>	1, 2, 3, 4, 5, 6, 8,	1	<b>Connection</b> <b>First Meeting</b> <b>Implicit Relating</b>	'I use my body to do that' (1.428) 'Impossible not to communicate with body' (1.138) 'what happens when they're new. I attend to all my stimuli' (1.246) 'We're probably using body an awful lot more' (1.726) 'My tone of voice is used to calm' (1.899)	Bodies are communicating with each other all of the time (body to body)  The implicit use of body/ RH to RH relating
<b>USE OF BODY</b>	1, 2, 3, 4, 5, 6, 8,	2	<b>Mirroring</b> <b>Somatic Experiencing of other Tracking with the body</b>	'I might mirror back to the client' (2.1516) I use my own body to evaluate the boundary' (2.227) 'I'm tracking their breath' (2.541) 'I actually tell myself to ground' (2.975)	Much of this appears to happening at an unconscious level (Vs Intentional)

See Appendix G for further examples of focused coding. This phase was characterised by continually revisiting the data as codes emerged and engaging in a cyclical process. New data was compared with the previously collected data and comparisons were made across participants. As I collected more data codes gradually became categories. Whilst codes were raised to the level of category others were subsumed within one or other category. In raising codes to the level of categories it was important to keep preconceptions at bay and resist the urge to adopt a core category too soon. I also needed to maintain vigilance that I wasn't just finding what I already knew.

The core category of 'Between Bodies' emerged strongly at this point. The five sub-categories of this core-category also began to emerge and coding continued until no new data emerged and where incidents coded merely provided further indication of existing properties. Use of diagrams to display each sub-category, its dimensions and relevant quotes was a very useful tool. The following diagram is an example of one such diagram for the sub-category Connection (see Appendix H for more examples).

## SUB CATEGORY – CONNECTION

Properties of subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
Connection to Client	Meeting of two psyches. At the boundary where bodies meet Physical body is channel of connection Different ways body makes connection	3, 4, 6, 8	<i>'You're out there at the boundary, meeting it. And connecting. The boundary connects to her' (3)</i> <i>'And I couldn't make any contact with her. So my only way to reach her was to use my body' (4)</i> <i>'so there would be real eye to eye connection' (6)</i> <i>'just touch was worth a million words' (8)</i>
Beyond Words	Beyond words Connection known in and through the body	1, 5, 6, 12	<i>'the body allows something beyond words' (1)</i> <i>'Words fall short really for it' (6)</i> <i>'more than words can ever do' (5)</i> <i>That's an example of the communication that happens without words' (12)</i>

What emerged was a kind of inductive-deductive interplay whereby the theory arose inductively. This emergent theory was then confirmed through deductive testing through subsequent theoretical sampling of data. Sorting of memos was performed in order to establish how the categories fitted into the preliminary theoretical framework. Theoretical sampling and sorting of memos took place simultaneously.

### 3.7 Memo-Writing

Memo-writing formed a crucial part of this study and supported me in making sense of the emerging data. (See appendix D for examples). Through use of memos I was able to keep an on-going dialogue with myself about my observations, questions, ideas and assumptions that occurred whilst coding. This assisted me greatly in getting to grips with the data and its meaning. Charmaz (2006) describes memo-writing as *"the pivotal intermediate step between data collection and writing drafts of papers"* (p.72). I wrote memos throughout the process capturing ideas I had about a concept or property of a concept. Memos became more theoretical and abstract as I collected more data. They were invaluable in helping me to make sense of the way in which concepts related to each other and to keep track of the emerging theory. This process also assisted me in exploring the relationship between the sub-categories. Documenting the analytic process fully supported the subsequent

development of theory. As memos were sorted I created a preliminary theoretical framework capturing what happens between bodies. Glaser (1998) describes how “*Sorting a rich volume of memos into an integrated theory is the culmination of months of conceptual build up*” (p.187). Writing some memos brought about a turning point for me in the whole research. Memos were in the form of words and diagrams. I constantly drew diagrams to represent concepts and categories. I found this to be of enormous benefit in aiding me to generate my grounded theory.

The process of this research was interesting for me as I began to ‘embody’ the research. Initially embodiment was more of a mental construct that I was exploring. However over time as I was continually reflecting, integrating and processing the findings I began to get a felt sense of the research in my own body. The time it took me to devise, carry out, analyse and write up this project was very important as it allowed me to integrate the results at a bodily level which in turn supported me in the research.

### **3.8 Theoretical Sampling**

As I began to develop a theoretical framework I proceeded to refine my categories. As tentative theories emerged and in order to develop this emerging theory it was necessary to collect more data. Theoretical sampling refers to the process of explicitly recruiting further participants based on the conceptual categories that are emerging from the data. As the sub-categories emerged in this study I wanted to get more information on their properties and develop greater analytical depth. Strategic and systematic data collection helped me to build up and refine sub-categories. Through theoretical sampling I was able to gather more data from new participants exploring ideas and questions which required further inquiry. Questions I asked built on the previous findings and emerging sub-categories. As I interviewed more participants this allowed me to collate more data which focused on expanding and building on the sub-categories. Constructing an idea based on the data and then exploring this through further inquiry helped to make the sub-categories sharper and more robust. It also allowed me to elaborate the relationship between sub-categories.

Sampling also involved returning to and revisiting the existing data (Fassinger 2005). As theory was developed I began to go back through all my transcripts and codes. New data was constantly compared to emerging ideas which initiated further directions for inquiry. Each new piece of data was compared to existing data in order to make analytic sense of the data. This process helped me to define the boundaries and delineate the links between categories. It also allowed me to raise categories to a more abstract level yet maintain their groundedness in the data.

In Grounded Theory methodology the researcher carries out theoretical sampling until no new properties of a category emerge or until categories are “*saturated*” (Charmaz, 2006, p.96). Charmaz (2006) considers that the common use of the term saturation refers to when the researcher continues to find the same patterns. However a more “*sophisticated*” view considers that “*categories are saturated when gathering fresh data no longer sparks new theoretical insights nor reveals new properties*” (Charmaz 2006, p.113). Given time constraints and the nature of the current study I continued to sample until nothing new was happening in the data. This corresponds to having achieved what Dey (1999, p.257) refers to as “*theoretical sufficiency*” and best describes how I conducted this stage of the research.

At this point in the process I experienced an embodied sense of being ‘steeped’ in the data. It was time now to go back to my research questions again and ask what I set out to find out and what answers I was getting. Doing this functioned as a sort of a container to hold what was important. It was crucial to let this entire process filter through like the dancer creating something new as all the pieces came together. I found this stage of the research invigorating and enlivening. Up to this point I was closely held by the analysis and now it was time to let go and to take a leap of faith. This level required a dive from being very in touch with the data to moving into a more creative, intuitive mode. At this point I felt ready to fly and soar on ‘flights of fancy’. It entailed testing for the bigger hunch. I had a sense of being in a laboratory of creativity where I was fuelling up a wealth of creative ideas and

stoking up the fires of the imagination. The jump to this level however was also anxiety provoking as it entailed residing in the 'intuitive zone'. It was very helpful at this stage to map out and diagram conceptual ideas that were grounded in the data. This facilitated me to see the process that appeared to be emerging between sub-categories and how they changed and moved. At first this process seemed hazy and not clearly defined. Learning to trust this as part of the research journey and to accept its inherent ambiguity helped me to abide with the lack of clarity and to trust my hunches and gut feelings. As I conducted theoretical sampling I noticed my memo writing became sharper and more analytic. I also felt more energy and confidence as I began to develop more conceptual ideas and refine my theory.

### **3.9 Reflexivity**

Whilst a classical approach to Grounded Theory seeks to limit researcher bias on the data and maintain an objective stance, the post-positivistic approach that I adopted assumes the existence of multiple truths which are mutually constructed by interviewer and interviewee. In this inductive research process it was essential to consider my potential influence on participants and the data. Throughout the study I paid close attention to my own preconceptions and acknowledged my own beliefs and knowledge. I was particularly aware of my previous experience and learning, my professional knowledge and interest in the area and how this might impact on the study. This meant being open with participants about my background and adopting a reflexive approach to data collection and analysis.

Adopting an inductive-deductive interplay throughout the study and remaining true to the constant comparison method helped to eliminate bias. I engaged in a bracketing exercise throughout the study in order to minimize the influence of my biases on the research. This involved self-reflection and reflexivity to identify, explore and 'bracket off' any presuppositions and connections about the phenomena being researched. This helped me to maintain the focus of the study on the subjective experiences of the participants. I constantly kept a journal which incorporated notes of images, thoughts, feelings, reactions to



the interviews and transcribing the interviews in addition to writing memos. Through the use of memos I recorded and explored any potential impact I had on the data. Memo writing helped my awareness of impact of my prior knowledge and my potential effect on the data. I also employed an independent auditor to check emergent codes to ensure analysis was not overly influenced by my perspective.

### **3.10 Issues of Evaluation and Credibility**

The systematic qualitative approach of Grounded Theory was used to analyse the data. This systematic procedure enabled me to handle the rich qualitative data that emerged from the study. Codes and themes were developed from, or grounded in the data thus helping to eliminate bias. The coding procedures of constant comparison and theoretical sampling helped to ensure validity. Respondent validity was sought by forwarding each participant a copy of their interview transcript. They checked this for any errors, misunderstandings and addressed anything that needed further clarification.

Smith (1996) recommends the use of an independent auditor to check the validity of a research report and to reduce bias. An auditor was employed to check the reliability of the codes and categories. The codes identified were checked by this auditor who is a female psychotherapist with 10 years experience in practice. This person also read the final report to check that it was credible based on the data collected. In the words of Smith (1996) “*An independent audit is not attempting to suppress alternative readings or necessarily to reach a consensus; it is attempting to validate one particular reading*” (p.193).

### **3.11 Ethical Considerations**

Ethical issues are constantly present and Orlandi (2007, p.60) emphasises the need to “*keep on our reflexive toes*” as we consider and understand ethical issues in practice and research. In this study I took a ‘relational *and ecological*’ view to ethics as outlined by Flinders (1992). A relational view emphasises egalitarianism. Issues of caring and respect are more important

than any agreements made. Participants were informed that they could retract anything they said by asking the researcher not to include it. An ecological view emphasises researcher sensitivity to language and culture. I was cognisant and sensitive to the language used by participants and the backgrounds from which participants came. I aimed to communicate the findings in a responsible manner.

The initial literature review, methodology, letters of consent and ethical considerations were discussed in detail in the research proposal submitted to the Metanoia Research Ethics Committee (MREC) and Middlesex Prior Approval Panel. Ethical approval was granted in February 2008 (See Appendix E).

### **3.11.1 Key Ethical Considerations**

In accordance with the BPS Code of Human Research Ethics (2010) particular regard was given to the rights of participants for self-determination and privacy. I was aware from the outset that research into 'body' may be a sensitive topic for participants and thus I considered in advance any potential for harm or psychological distress or discomfort in this study. Every precaution was taken to ensure the dignity and respect of the participants. Prior to interview a complete outline of what this study entailed was given to each participant in order to furnish them with an understanding of what was involved (Appendix A). Participants signed a consent form agreeing to participation and indicating their willingness to take part in the study (Appendix B). They were given the freedom to retract such consent at any point along the way. Respondents were informed that their participation was voluntary and confidential and that the interview would be audio-taped with their permission. Interviewees were assured that audio tapes and any personal identifying information would be stored confidentially. No personal information such as names, addresses or contact details of participants were reported. Any data emerging from the interviews would be used in the research report in a manner which would not allow identification of the participants. All agreements were made explicit from the outset and kept in writing

Precautions were taken to minimise any harm that might occur during and subsequent to interviews. I informed participants that I could offer them the names of individuals or services that would be available should they become upset whilst discussing this topic. All participants stated that they had support available should they become distressed and feel the need to discuss this further. Participants were informed that they could stop or completely discontinue the interview at any time. It was also stated that they were free to refuse to answer any question asked during the interview. No participant refused to proceed with the interviews at any time during the research. A copy of interview transcripts was sent to each participant allowing them the opportunity to verify and extend interpretations and correct any misunderstandings. This also acted as a debriefing (Sieber, 1998) and was an appropriate time to consolidate the educational and therapeutic value of the research to the participants.

Human Research ethics are concerned with weighing the potential benefits for the individual or society against the possibility of causing harm to the participant (BPS, 2010). Feedback from participants indicated that they benefited from having taken part. Benefit arose from gaining insight into their own bodily process, contributing to research in this area and enabling them to better understand their experience.

Throughout the course of the research process I had support and on-going supervision and consultation. As a registered counselling psychologist and psychotherapist I had previous experience of carrying out research on a sensitive topic (MA thesis). My background ensured that I was theoretically sensitive to the data and skilled in communication. My training as a counselling psychologist helped me to get nuances and to understand the vocabulary of participants. The use of an open-ended interview schedule assisted me in avoiding imposing my prejudices or preconceived biases onto the data. This was also helped by looking for categories emerging directly from the data rather than from previous publications.

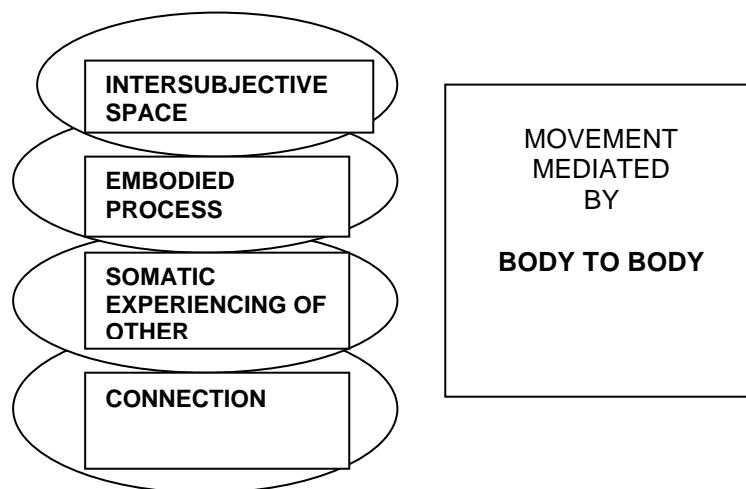
## 4. FINDINGS

### 4.1 Overview of Findings

The current study explored therapists' experiences of their embodied being in the dyadic relationship. On investigation, it was discovered that at any given juncture the body of the therapist registers a considerable amount of intersubjective somatic information. The Core Category of Between Bodies emerged from this analysis and is divided into five sub-categories. These include (i) Body to Body (ii) Connection (iii) Somatic Experiencing of Other (iv) Embodied Process and (v) Intersubjective Space. **Table 1** illustrates the interconnection between these sub-categories.

**Table 1**

#### Between Bodies An Implicit Relational Model



When the body of the therapist meets the body of the client in therapy, this results in the emergence of the following sub-categories: *Connection*, *Somatic Experiencing of Other*, *Embodied Process* and *Intersubjective Space*. Movement to and between each of the sub-categories is mediated by the processes of the sub-category *Body to Body*. Movement between sub-categories is represented by a spiral. The qualities of each sub-category are presented in **Table 2**.

**Table 2**

<b>BETWEEN BODIES</b>				
<b>1. BODY TO BODY</b>	<b>2. CONNECTION</b>	<b>3. SOMATIC EXPERIENCING OF OTHER</b>	<b>4. EMBODIED PROCESS</b>	<b>5. INTERSUBJECTIVE SPACE</b>
(1a) Detector	(2a) Connection to Client	(3a) Experiencing Clients at a Somatic Level	(4a) Integration of Physical and Mental Processes	(5a) Embody the Relationship
(1b) Mirror	(2b) Beyond Words	(3b) Experiencing what client experiences	(4b) Window into Client's Experience	(5b) Shared Knowing
(1c) Regulator	(2c) Energy	(3c) Overwhelm	(4c) Naming Resonates	(5c) The Third
(1d) Attuner	(2d) Interconnection	(3d) Interfere with session	(4d) Somatic Experiences and Feelings	
(1e) Listening and Tracking with the body	(2e) Connection to Self	(3e) After the session		
(1f) Giving Information	(2f) Disconnection	(3f) Client Presentations		
(1g) Pre-sensing				

The following section outlines in detail the qualities of each of these sub-categories. Relevant quotes from research participants will be used and a number is used to reference each participant (e.g **(1)** denotes the quote came from participant Number 1).

## **4.2 Body to Body**

As participants reflected on what happens between their own body and that of the client, they described various ways in which their body is in relationship to the client's body. These include being a detector or a gauge, a mirror, an attuner and regulator. Therapists also demonstrated ways in which this body to body communication enabled them to listen and track the client and pre-sense what is to come. This bodily response also gives the therapist information about the client. These embodied relational processes are co-created and act as a mediator between client and therapist for generating one or more of sub-categories 2-5.

#### 4.2.1 Detector

Therapists described their body as a kind of detector or gauge for what was happening with clients. One participant described how her body has become *'the strongest indicator for me of what might be happening'* (7) and another stated that *'the greatest thermometer or compass that we have are our body sensations'* (12). Attending to these sensations and detecting changes and movement in their body provides therapists with valuable information.

*(11) I use it as a barometer. I know that if I'm getting a physical sensation something's happening. If I get a pain in my lower back I'm beginning to know this is about something being too much or you know something around support.*

*(8) I'm quite conscious of the way I sit always.. and will immediately notice if I change position, if I cross my legs or fold my arms. I would be interested to check to see what's going on.*

These sensations alert the therapist to something that may be happening. For example, one participant likened these bodily cues to a motorist honking their horn in order to bring us back to awareness.

*(9) My body gives me an indication.. it's a bit like you're away in traffic or something like that and somebody gives you a beep you catch yourself .. So that awareness is my cue you know that body awareness.*

Therapists reported that these bodily sensations in the therapist frequently precede any awareness in clients. They gave examples of how their bodies detected what was unconscious for the client.

*(6) She could see I was raging.. absolutely raging. And she wasn't in touch with it at all in herself.*

Participants agreed that not alone does the body impart knowledge to us of the client, it also relays information about our own process in relation to the client. This is information that may not otherwise be available. One therapist described a situation in which his body knew he wasn't looking forward to seeing someone before his conscious mind was aware of this.

*(6) And I thought I was looking forward to seeing him, but my body still hadn't left the chair and it was only at that point I began to ask 'why is my body still here?' 'why am I still here?'.. my body knew it more than I knew it. So sometimes the body knows before we know ourselves.*

Some participants highlighted that whilst physical sensations in our bodies can act as important transmitters of information, it is important to be discerning as to their origin and meaning. Therapists stressed that whilst they use their physical responses as a detector or a gauge, they will first of all check in to see if it's not something they are bringing to the encounter.

*(12) And that's the skill. . when is it just my personal reaction and when is it actually useful information that's coming to me from my client. And really being able to access that internal supervisor ... and go 'hang on a second what's happening?'*

Notwithstanding adopting a discerning stance the reliability of body as detector was largely agreed upon. Therapists have a strong sense that the sensations they feel in their body are very accurate as a gauge for what is happening.

*(3) I do get some echoes in my own body of things that are happening which often are accurate*

*(8) I've grown to trust what it means.. so I would be surprised if what I think might be going on wouldn't be going on... when I consult the client with it. It can happen.. and that's fine.. but by and large something is accurate in it.*

### **Parallel Process in Interview**

In one of the early interviews whilst discussing an 'embodied approach' I sensed a defensiveness on the part of the participant. I experienced this as a tension in my own body and was curious about it. At one point the therapist described that she was '*resistant to reducing it to just body.. It's body and soul*'. As she stated this I felt the tension loosen in my body and suddenly I felt freer. My bodily response to what the participant had just said alerted me that something had shifted. I acknowledged this and I could feel her open up more. She seemed to drop her resistance to the use of the word 'embodied' and was able to embrace the role of body whilst also seeing that it is much more too. I had a strong sense that this opened up the rest of the interview and took us to a deeper place of enquiry.

#### **4.2.2 Mirror**

A common theme emerging from the data was that when two bodies come together they begin to mirror each other. Therapists described the mirroring that happens between their body and the client's body. Therapists reported how they mirrored clients on a physical level both consciously and unconsciously. Sometimes without a conscious effort the therapist re-creates the actions and emotions of the client. Therapists described how mirroring happened automatically.

*(7) quite a lot of what I'm working with is mirroring.. so as I'm working with the client and noticing.. I just notice when you take a breath that seems to help or support.. or I notice your foot is tapping.. it may be that I begin to mirror that automatically.*

At times participants find themselves in a similar body state or position without consciously intending this.

*(4) And I would be very much aware of sitting in the same way that she sits. I wouldn't be aware when I actually take on the pose that I'm doing*



*this... but when I check in with myself I find that I'm mirroring the way that she's sitting.*

At other times, mirroring is performed in a more active manner. Therapists explained that by attending to the client and merely observing them, they begin to consciously mimic the client's facial, vocal and/or postural expressions.

*(11) I would be noticing a body sensation or whatever it would be and I would try to consciously be breathing with her as well*

At other times, therapists will match the client's behaviour.

*(6) when I arrive in the client is sitting on the floor.. and so I'm aware that probably means that I must sit on the floor.. because I don't like sitting on my chair then when they're sitting on the floor*

By matching and mirroring the client's body, therapists appear to recreate the body sensations associated with the client's emotional state. They described how they literally feel what the other feels. Through this they can come to feel into the emotional world of the client. One participant described this as follows:

*(1) And so what your trying to do is almost do a little bit of mirroring.. and what is it like for them. I think it's a way of trying to get a sense of their experience.... I think it's very useful to even try for a moment to put my body into that kind of what's it like. So I find that a very useful thing to do ... because it gets me into what does this feel like.*

Participants described how mirroring can lead to a shift taking place. It would seem that when the therapist mirrors the non-verbal cues of the client this resonates with the client – and brings about a change in the client. The following therapist described how mirroring led to change.

*(5) And it wasn't until I was mirroring her that she changed something. Before that she wasn't understanding.. she wasn't actually changing.*

The simple act of matching the client's postural or facial cues acts in the service of facilitating the client to feel understood and gain a greater understanding of him/herself. This can pave the way for deep connection and healing. One therapist referred to this stating how mirroring the client was a way of being in service to the client.

*(7) when someone is holding for another they are working in the service of the other. So it's not about role playing. It's literally about mirroring what it is that you have seen.*

Whilst participants described both an active and automatic mirroring that occurs, their accounts show that much mirroring is happening at an implicit level. Mirroring appears to be predominantly an automatic and unconscious process and seems to have occurred before it becomes a conscious idea for the therapist. One therapist articulated the implicit nature of this process when he said

*(6) The body would know it wants to move before the mind has caught up with it.. the body might be ahead of the mind..... The two bodies would be dancing without either of us being conscious of it. I'd move over and they'd move over and that just goes on so easily.. even breath-wise. If I take in a deep breath... they might take in a deep breath.*

The analogy to dance was also noted by the following participant. She explained that mirroring the therapist enables clients to drop into their body. She went on to say

*(2) It feels like a dance. And they have built up the trust in their own body where we can do that dance together.*

It appears that when two bodies interact in the therapy room they move together in a co-ordinated way without any pre-devised orchestration or direction. An implicit physical and emotional synchronisation takes place whereby the therapist and client move together.

#### **4.2.3 Regulator**

Many non-verbal aspects of the therapeutic relationship appear to help to promote the process of affect regulation. Therapists described how interactions occurring through facial expression, gestures and tone of voice serve this regulatory process. Much of this regulation is occurring at levels below awareness and it seems to be largely an intuitive and unconscious response on the part of the therapist. Therapists described how eye contact, tone of voice, breathing and body language all lend themselves to the interactive regulation between bodies. Participants were aware of how their very being can have a regulatory impact on the client. In the following examples they describe how their calming presence and tone of voice can act as powerful regulatory processes.

*(4) mostly it's just about my being calm.. when they come in they're quite distressed anyway.. and that they felt they were calming down themselves when they were in that space.. I have a calming presence. And my tone of voice often drops much lower.. And I'm aware that that does have an effect on people when they come in.*

*(8) the calmness or the solidity or that sense of steadiness. I think my voice is quite an important part of that actually. It's calming... it's soothing.. It allows them to ease off.. or people would say to me I feel less fearful.. I feel calmer.*

The therapist's instinctive response such as tone of voice, facial expression or gesture are largely occurring beneath awareness and have an important role to play in the downward modulation of affect. Whilst much of these interactions are occurring at an unconscious level there is evidence again for

implicit processes interacting with explicit planning. One therapist described how she intentionally slows down her speech in order to regulate clients.

*(5) I'd definitely use my tone.. my voice.. slowing my voice down.. and I wouldn't speak that quickly.. but I'd slow it right down.*

Another therapist illustrated the use of breathing and grounding techniques

*(12) So I consciously bring her down and it does work. I would notice if a person is getting agitated or distressed that my breathing drops. And I often even sit myself back physically in the seat and put my two feet on the ground. And sometimes that does have a knock on effect with the client that they catch... I don't know if they're aware of it.. but that their breathing will start to smooth..*

One therapist was aware of using her body in a calm and still way to deliberately regulate the client.

*(7) I appear very calm and still. And.. I'd understand that to be quite a deliberate thing really. In a kind of an attempt or in an effort to .. try and use my body to regulate.*

Therapists however stressed that this regulation is a mutual experience

*(1) But the client is regulating me too. So we organise each other very much I think in the therapy. So I think we're regulating each other a lot of the time. So there is a lot of mutual regulation going on.*

#### **4.2.4 Attuner**

When the body of the therapist and body of the client come together respondents experienced them attuning at a physical level. The following extract describes how they are attuning physically to the physical being of the client.

*(3) And I'll also adjust the distance to see what is most comfortable for them. And so that way we're attuning with the bodies*

Therapists described this physical attunement as a body to body attunement and not driven by consciously planned behaviour. They reported it to be very much a felt experience and not a cognitive one. The following participant summarised this as follows:

*(7) I think for me.. my experience of it is a felt experience.. its not anything to do with my head. And the moments of attunement, alignment, of oneness.. of being.. it's not the head.. it is being.....*

When therapists are attuned they are aware of and responsive to the client and this was considered by some to be the foundation of the therapeutic process. One therapist described how physical attunement was fundamental for directing the work.

*(4) I'm in tune with her in that sense. I'm in tune with her in a physical way. So it's like getting a felt sense of where they're at. And that's really important for directing the work.*

Therapists were keenly aware of the attunement which happens between their body and that of the client. Physical attunement happens through attunement to bodily states, attunement to emotional states as well as through voice. One participant described her ability to attune as a strength.

*(8) One of my strengths as therapist .. is my ability to attune. I'm quite sensitive to signals and would always seek to try and match something of myself.. with voice or maybe with body.*

Attuning can often be out of conscious awareness and happen intuitively. Sometimes therapists are aware of being attuned and sometimes not. This can depend very much on the client and the presenting issues as the following participant illustrates.

*(1) How much in awareness is it? Am I aware of my attunement to the client's body? Probably an awful lot more than I realise. Maybe if I'm working with somebody who has a history of being violent. Maybe I'm more consciously attuned at those times. But there's, a lot of the time I think there is attunement without necessarily saying 'oh I'm attuned now'.*

Here we see participants struggle with having a sense of something being known to them but not yet conceptualised. They described a palpable knowing, a bodily knowing or wisdom as if they are listening with an extra pair of ears or an extra set of eyes. Much of the attuning that happens between therapist and client occurs in the implicit realm of interaction. Whilst not consciously attended to it is known to both therapist and client at an unconscious level. Attuning behaviours such as silences, gestures, facial expressions, shifts in posture all serve to bring about changes in the moment by fine-tuning the immediate relationship between therapist and client. These micro-interactive processes occur in the domain of the implicit. However, whilst therapists described having a bodily knowing of these processes findings suggest that they can also raise this to a conscious level. Therapists made the link between their affective or sensory experience and their capacity to think about this demonstrating both right hemisphere and left hemisphere processing.

#### **4.2.5 Listening and Tracking with the body**

Responses clearly indicate that when two bodies come together communication begins to happen at an implicit and subliminal level. Therapists described the central role their bodies have to play in this implicit relating. Implicit knowing is a bodily knowing and it is palpable in our body. By paying attention to what unfolds in their body, therapists describe how '*with this kind of work I'm sort of listening with the whole body* (3). The following quote illustrates how this way of working, beyond the explicit content level, enriches the therapy.

**(10)** *I'm listening to something else as well. With my body, I'm listening to tensions, I'm listening to a whole other, and it's not just the content. I suppose I'd never have completely got stuck in it but I'm more confident in staying with a level below content.. and it's more alive.. I'm picking up more.*

The following excerpts illustrate ways in which therapists are listening with their whole body and using their physical sensations to track the client

**(1)** *And I'm also noticing too how my breath is.. and so I'm noticing if my breath starts to become shallow. That gives me a clue to how the client might be feeling. And so if there's a contraction in my gut, lets hear what that symptom really wants to say'.*

**(2)** *I'm also tracking if there's a body part that's holding tension.. So he was talking about his challenge and struggle in his confusion around sexual identity.. And I'm tracking. I'm tracking this particular tension in my chest. And it feels like a pressure.. it feels like a pressure on my chest from an out in.. The psychological piece shows up through my own body and I take it on.*

Being able to sense in their body what the client is feeling helps therapists to understand what is happening for the client and/or to be more empathic.

**(2)** *Now if I'm noticing that there's tension here in my body that doesn't feel like mine, so to speak, then that would be a way in to maybe being particular about the client's experience.*

**(7)** *So my jaw..my mouth.. so sometimes I'm sitting and I notice that my jaw is gone tighter and tighter.. and again it's like checking in.. has something happened that I've been activated somehow? Or then thinking just notice what's actually happening for the client.*

Therapists described how listening to their own physical response gives them information about what is needed in that moment.

*(4) I would be aware at times when she is becoming ungrounded of my own toes going into the ground. Of doing that [pointing toes downward]. My needing to ground.*

*(5) I notice sometimes that when the client is very activated sometimes there is a tendency to [move forward].. and I often actually tell myself to ground.*

*(10) Because what I found was I was pulling back rather than challenging.. so I was very aware of that on a physical level.*

#### **4.2.6 Giving Information**

Therapists described how their physical response to the client's body gave them information about the client.

*(3) I would be very much paying attention to those feelings. And they are often a gateway into what it might be like for the client*

*(11) my head was spinning.. And so I was really just trying to ground myself and very physically contacting my own body. And again I suppose I was using it as information and I was trying to pay attention to it as information, in terms of what is going on with this woman here?*

Reports suggested that these physical sensations may give information about how the client appears in the world outside. Participants illustrated this as follows.

*(1) It made me also realise that my reaction could be to .. defend and shut down. And it also told me what it must be like to meet a person like this out in their other world*



*(6) Well I'd say she comes across a lot of repulsion. I'd say a lot of projection... everything about my reaction to it would say that, yeah.*

This information can also help therapists in their response

*(8) And that made me aware that instinctively what I wanted to do was to get annoyed with him. To express that annoyance in some way. I'm registering something physically in that.. that gives me information or directs me in my response*

The first session can be a particularly vibrant time physically. From our analysis it is evident that the bodies of the therapist and client are continually responding to each other and this appears to be even more pronounced in the first session. The freshness and newness of the first session appears to bring with it an openness and responsiveness, on the part of the therapist, to all the non-verbal and physical cues that clients convey. Therapists aren't just meeting clients at a verbal level they are entering a somatic state of relatedness with the client.

*(6) And what happens when they're new. I really try to attend to all my stimuli, my nerves, when I meet a client first because that newness. It's a new.. it's really the first impact.. 'So I think that's a really important time to attend to the signals a person's body sends out.*

Being impacted by the client's body at a physical level can be hugely important in the work as it may give much more accurate information than what the client is actually saying. The following participant demonstrates the centrality of this.

*(1) And yet at the same time you have to let yourself be hit, be impacted, to see how they are. Because they'll tell you one thing. You know the client that tells you 'Well I'm fine and everything's perfect' and you know that actually.. well hang on.. something.. doesn't fit.*

Registering these physical sensations and using it as information for the therapy can help therapists to change something. As one participant reported.

*(7) If I start to notice that I'm getting very heavy headed or I'm getting busy or I start to feel something bordering on a headache, then it might be time to just shift something.. maybe that it's energetically what's happening in the room and all I need to do is shift it.. and clear it for myself.. which may allow something to clear for the client.*

#### **4.2.7 Pre-sensing**

Therapists described how they somatically register in their body something in the client's process which is about to emerge in the session. They recounted feeling a sense of anticipation or premonition whereby they feel a tension in their body which they intuit as something that is about to happen with the client. These bodily sensations help therapists to sense in advance that something is going to happen in the session. This is illustrated in the following excerpts.

*(4) and that is one of those cases when it happens ..I'd be feeling it already.. I would yeah.. and it's good for me as well because it pulls me up.. it's a trigger for me. And to anticipate her getting to that point.*

*(5) also being aware that I'm trembling.. I can feel her.. Because it was mounting up and mounting up and I knew that 'oh God she's just going to lose it here'.. And I could feel that.. I was feeling it in my own body*

*(8) I knew something was about to come into the room. I was very conscious of my own tension in my own body as I sat there waiting to hear what was coming.*

Through this body to body relating in the client-therapist interaction a coordination of two embodied beings occurs. The client and therapist enter into a dyadic bodily connection. Through attuning, regulating, mirroring listening and tracking the connection ripens between therapist and client.

## 4.3 Connection

The findings in this section describe the connection that occurs when two bodies meet in the therapy space. There is a dynamic interplay between client and therapist which is mediated through 'body to body' relating. Therapists described how this connection is happening right from the beginning when the two bodies meet.

*(6) Yeah I think the connection is there at the very first session yeah... in the hello and the eye contact.. ... So I think the beginnings are there very early.*

*(7) it's about connection with another being in the purest sense of the word.*

### 4.3.1 Connection to Client

Therapists revealed feeling a deep personal connection to some clients which was felt in their body and was palpable at a somatic level. When therapists talked of connection with the client there is a paradox in this as they talked about connection through the body – yet they are alluding to a 'psychic' connection. This connection arises from the ongoing process of relationship and is not achieved through words, but through other modalities such as eye contact, posture, silences and gestures. Whilst the connection is experienced somatically the quality of it is a psychic one. This 'meeting of two psyches' happened at the boundary of where their bodies meet. One therapist captured this meeting in the following way.

*(3) You're out there at the boundary, meeting it. And connecting. The boundary connects to her. So I'm connecting to her and able to sense and know some of what she's feeling.*

Reports indicate that at times the only way to make contact is through the body whereby the physical body is the channel through which connection is made. In the words of one participant

*(4) And I couldn't make any contact with her. So my only way to reach her was to use my body.*

Therapists described various ways in which this connection is made. This included breathing, eye contact and body proximity. Few therapists used physical touch and when they did it was sparingly. However when used it was deemed very powerful and one participant described how *'just touch was worth a million words'* **(8)**

One therapist described feeling very connected to clients through eye contact and described the following

*(6) In particular I might ask the client.. 'I want you to look at me'.. and I would look at them.. and they would.. so there would be real eye to eye connection.*

#### **4.3.2 Beyond Words**

As we deepened our enquiry into what happens between therapists' and clients' bodies it became difficult at times to find words to describe it. There was a general consensus amongst participants that when two bodies meet something happens between them which cannot always be described in words. It is difficult to articulate this kind of intersubjective communication in words as at this level of interaction there is not yet any verbal exchange. This common view shared by participants was encapsulated as being *beyond words* **(7)**. One participant described how *'the body allows something beyond words and I don't always feel the need to reduce it to words'* **(1)**. There was agreement that this field between bodies has an intangible nature and doesn't lend itself easily to words. This connection or implicit relating is known in and through the body – and whilst palpable in the body it may never achieve a linguistic equivalent. As one participant stated

**(6)** *Words fall short really for it. I don't know what words to use there.. but something goes on there in the unspoken and in the unknown of it.. that is bigger than all the talk.*

According to one participant this non-verbal connection far exceeded what words could ever do.

**(5)** *It's extraordinary. It's more than words can ever do. But that's a whole bringing of yourself to connection. Sometimes it's a bringing of myself at times that no words are adequate for what a person is in, only to make a connection.*

The difficulty experienced by interviewees finding words is mirrored in the therapy session. Therapists describe how client and therapist frequently communicate without words. The back and forth movement between them both occurs in the implicit realm of interaction without verbal exchange. Whilst these interactional processes are known and may register with both client and therapist, they are not articulated. The following extract gives an account of a moment of meeting between therapist and client where no words were necessary.

**(12)** *And we sat there side by side... and just without saying anything I looked at her and she looked at me... and then there was this moment where she was kinda ready .. to experiment with bringing the chairs more face to face again.. So that was quite a beautiful moment. And that's an example of the communication that happens without words.*

In describing an important breakthrough a client had, one participant described how words weren't needed to communicate this shift. Yet at a deep somatic level both therapist and client were aware of the profundity of what had just happened.

**(12)** *And it was that wonderful feeling that I was getting in my own body as well. And we both knew that.. and there were no words.. but there*

*was this powerful recognition that went on between us.. something big had happened.. and it is a turning point.*

In her struggle to find a language to describe what happens between bodies one therapist portrayed it as 'a flow'.

*(7) Because I'm trying to put a language on something that actually doesn't have a language. We've tried to put words on it. And for me all I can describe is a flow.*

### **4.3.3 Energy**

Whilst therapists struggled to find words to describe this connection they repeatedly used the word *energy* when talking about this interaction. One participant described how she is constantly tuning into '*this flow of energy that is moving constantly between the individuals.*' (7). A second participant explained that '*The only way I can describe it is as an energetic feeling or an energy. So it's like an energy in the room.*' (9). When describing her work with a client, one therapist explained the heightened energy she felt between their bodies.

*(10) So I began to feel like a heightened energy. It was like my energy was.. trying to line up with her it was probably body to body again. There was an aliveness in myself not quite tingling but something like that.*

Therapists described this as an energetic communication that happens between therapist and client. One therapist stated that while '*A lot of the work is verbal, yet there can be an energetic connection*' (9). The following excerpt illustrates how implicit relating happens through this energetic connection.

*(12) I would be interested in the idea that there is an energetic connection that we have between each other.. and that so much information passes between us on an energetic level.. Because I do*

*believe there's some sort of an unseen, energetic communication that goes on between us.*

Therapists also indicated that stepping into the client's world and feeling their energy at a somatic level can have an impact on them physically. One therapist described how he struggles to stay awake in sessions with a client. In the following excerpt he links this experience to the client's depressive energy.

*(6) there's one particular client.. and consistently I'm tired in the session. I'm yawning and I have to stop yawning. So I suppose it's picking up her energy really. Something depressive in her energy. And she brings that with her.*

Connection comes about through rich implicit processes and can happen even before the rational, cognitive, conscious mind knows to make connection. Therapists explained that although they may not be consciously aware of it, their body is already making the appropriate movements to stay in connection. Therapists had a felt sense of the energy field between their body and the client's. Responses suggest a process by which energy is constantly moving and shifting between the body of the client and the therapist as therapists tune into the energy within and around their bodies. One participant described this energetic connection as being at a metaphysical level

*(5) My sense is that the connection isn't so much at the physical level... There's a real energetic connection... that it's on a metaphysical level as opposed to the physical. It is that metaphysical level which is very hard to talk about. .*

#### **4.3.4 Interconnection**

Participants were aware of the unremitting influence that client and therapist had on each other. Their responses attested to the reciprocal nature of the encounter and the mutual influence which they exerted on each other. They described this as a joining in the space between. Within this space there is an

interweaving where therapist and client are physically impacting on each other. One therapist described the way in which she is moved by and in turn moves through this connection.

*(2) And also in witnessing the mover I'm also being moved internally.. and that movement then supports my interaction. And so there's this sort of interweave in the space between that I think is part and parcel of all psychotherapy.*

Therapy doesn't happen through the activity of the individual therapist and/or client but in the interconnection between them. What matters is not the isolated entity but the connection or bond between therapist and client. This connection cannot come about by either of them acting alone. There is a shared implicit connection which emerges from the relational overtures each provides the other. This interconnection is described as 'the eight'.

*(7) So in the room I am all the time tuning into what's happening with a client and responding out of that because we are in relationship. I often describe it as 'the eight'*

Through this interconnected relationship, participants described that what they felt in their body can often convey to them something of the client's world. This was referred to as a kind of shared somatic state whereby therapists connected with a deeper sense of what it is like to be in the client's shoes. One therapist referred to a client who lived quite a chaotic lifestyle. In the following example she describes picking up in her body a sense of the 'craziness' of the client's world.

*(5) I don't mean she was crazy because she wasn't at all.. but there was that sense of craziness she brought into the room with her.. I mean it was palpable in my body.*

Therapists were very aware of the implicit nature of this reciprocal dyadic relating. The following quote illustrates this insight.



*(1) It's a bit like how do you describe what happens between two people. How do you describe what happens when somebody comes in, in immense pain and you touch them in some way and they go out feeling something has shifted but they don't know what has shifted and you don't know what has shifted.*

#### **4.3.5 Connection to Self**

Respondents agreed that in order to maintain meaningful connection with others they have to first establish contact with themselves. As therapists become attuned to themselves and mindful of their own body process they described feeling more connected to the client. It appears that an attuned internal state precipitates a greater interpersonal connection whereby information is transmitted somatically. When they are in contact with their own being, they are then able to be in touch with and connected to clients. One participant described it as being akin to the dancer who needs to be in touch with herself before connecting with the other.

*(11) I'm doing tango dancing which is getting very tuned into your own body and be aware of the contact with yourself .. and then the contact with the other person.*

Responses suggest that if they don't stay in contact with their own bodies therapists may miss vital cues and messages which are being communicated in the connection. Participants expounded the importance of staying in contact with their own body and just listening to what it is saying.

*(6) So if I just look right now.. just at my body. it probably wants to tell me something now that I'm going to be conscious of now that I wouldn't be conscious of if I don't connect into my body.*

Connection to self was maintained by therapists through continual awareness and mindfulness of their own body. From this place of being connected to themselves they embodied a therapeutic presence which allowed them to stay

connected to clients. Several participants indicated the importance of keeping this connection with self through grounding and mindfulness of body. In the words of one participant:

*(7) Its all about the grounding. It's about mindfulness and awareness.. sometimes it's literally in the grounding piece of feeling myself in this space. Feeling the space that I occupy in the chair. Feeling my feet. Noticing my breath. So that's .. happening for me.. on an ongoing basis.*

Sometimes in the connection between the two bodies, the therapist may move too far over to the client's side. Paying attention to their own body is the means by which therapists can bring themselves back

*(4) I think just that awareness of myself in there.. not just my whole awareness on the other.. and I think at times just being aware to sit back.. that when I'm getting too involved.. it's usually a cue for me that there's something going on that I'm moving too far in. and to just sit back and breathe and let it flow.*

Keeping awareness on one's own body, breathing and grounding were considered fundamental to remaining in connection with oneself and the client. When 'going off' with the client it is important to deepen one's connection with the self and to connect with one's own body in order to come back. Therapists described how they maintain contact with their own body when they feel themselves becoming ungrounded.

*(2) And I often tell myself to ground.. and I know it serves myself and the client better if I stay grounded in my pelvic floor and my belly and use the support of the chair in order to maintain the consistent, anchored, safe object for the client.*

*(4) And I really had to ground myself ..cos there was no point in the two of us going off..*

*(5) Just breathe, feet on the floor.. and really really had to bring myself back and hold myself.*

*(9) I find breath work, just to take a breath and the art of taking a breath without the client realising exactly what you're doing so just generally I would breathe in through my nose and I would push myself back into the chair or else just push my feet into the ground, just so I'm more connected.*

In addition to therapists maintaining contact with self, they stressed that it is also necessary to encourage clients to stay connected to their physical being. Therapists described how they focus on allowing the client to make contact with self in order to make contact with and connect with the therapist.

*(4) we start with a breathing exercise. So I consciously bring her down and it does work. It works so that she can be in contact with herself. And then we can be in contact with each other.*

### **Interview Process**

During the interview process, I was aware of staying connected to my body and being mindful of my internal process as I remained in contact with each interviewee. Participants too were aware of keeping first attention on their body as they maintained a connection with me during the interviews. One participant shared the following:

*(7) Even as you and I are sitting here I could tell you, pretty quickly I could track what's happening in my body, so I can notice there's a kind of slight nervousness, and that's around the chest, heart centre and all that. my throat.. a kind of hesitance..*

In one interview the participant was discussing how clients can tend to dissociate. She described how clients eye's tend to 'glaze over' and as she spoke I sensed in my own body that I was losing contact with her. I fed this

back to the participant and she concurred with this stating that she herself started to feel 'hazy' and 'space out' (5). Later in this same interview the participant described how she frequently used breathing to regulate clients and sometimes she would simply remind clients to breathe. At this point I became extremely conscious of my own breathing and my need to breathe deeply. Throughout the course of the interviews I was aware that at times my own breathing was constrained. I became increasingly alert to this over the course of the interviews and frequently the therapist's words were a reminder to me to breathe.

I was aware of my heightened anxiety levels in one of the earlier interviews and frequently had to take deep breaths in order to feel less anxious. Later on as the interview progressed the participant described her experience in the interview as follows.

*(2) In this interaction I've been tracking when I go speedy. I've been tracking when my intention is to give you as much information as I can. And I've noticed that. So I'm also seduced into the speedy nervous system.*

It seemed as if her experience was registering in my body as anxiety. When she identified her 'speedy' process my somatic experience made sense to me.

#### **4.3.6 Disconnection**

Results indicate that while connection happens at the boundary where two people meet, disconnection also happens at this edge. Just like connection, a physical sense of disconnection can also be experienced at a 'psychic' level. A sense of disconnection can provide the therapist with valuable information about what may be happening in the relationship between them. One therapist described how picking up a sense of disconnection at a bodily level may indicate that the client isn't present to the therapy or to the therapist. Therapists described a somatic sense of distance, absence, and deadness in

the relationship which they attributed to a disconnection on the part of the client. One therapist described this as follows:

*(1) maybe I'd call it disconnection.. that can happen. Where I have a sense maybe that the client isn't in the room, or in connection with me.*

Feeling disconnected can provide the therapist with important information about the client's own disconnection from their feelings. The following is an example of how a therapist might approach this in a session by raising the client's awareness to their lack of connection

*(6) well they might be telling me something that's sad or exciting or something, whatever it is.. and for me I'm not connected to that at all... so I'm disassociated from a feeling around this and I think well are you connected to.. I might say 'I hear what you're saying and I get at some level.. at an intellectual level I get the importance of what you're talking about.. but I don't feel connected to the emotion' and then almost always that I can think of they would say in that situation 'yeah, I'm not connected to it myself.' they might have disconnected from it because it was just too hard.*

## **4.4 Somatic Experiencing of Other**

Somatic Experiencing of Other relates to the way in which one body can sense the experiences of the other when two bodies come together. Reports suggest that therapists are registering a vast amount of bodily phenomena whilst engaging with clients. Much of this somatic information which is attributed to the client is mediated through the therapist's body. Participants described how experiencing these physical sensations in their body can assist them in gaining a greater understanding of the client.

### **4.4.1 Experiencing Clients at a Somatic Level**

Findings suggest that therapists are sensitised to somatic experiences and 'perceive' more about the client through their bodily responses. Participants

described how they experience the other acutely and at a deep bodily level. This was very evident in the following illustrations.

**(1)** I've often felt nauseated with clients. I've felt very sleepy with clients. I notice more tension in myself... distraction... numbness... force.

**(4)** *it is very sickening... so horrific that it's palpable in my body... it's physical. I can feel it. I can feel it in my tissues.*

Therapists frequently used metaphors to express their somatic experience of the client. One participant gives an evocative description of how she experienced the client in her body.

**(1)** *When you actually have a sense of somebody coming into the room and you feel they're a damaged soul. The sap is dried up... and that's attention to their body and it is my body's response to their body. maybe having the sense of kind of wanting to water the plant.. to kind of get some life back in it.*

This ability to access clients' phenomena in their own body was considered by therapists to be a useful tool to have in their therapeutic repertoire. At times the therapist's body seems to be the only channel through which certain material can be relayed or communicated to the therapist. Without the therapist's somatic response to the client this information may not be so evident.

**(6)** *she doesn't walk in a depressive way or talk in a depressive way. And she cries and she gets angry and ..unless I was feeling it inside myself.. it's literally I'm trying to keep my mouth closed and wanting to yawn.*

Participants concurred that frequently these bodily experiences relayed a greater amount of information than what was shared through verbal communication alone. Therapists reported that this somatic information can at times appear to be at variance with what they are experiencing at other levels. One therapist described how the somatic experience in her body seemed contradictory to the words that she was hearing from the client.

*(9) when I was staying with my body and it was like there was a contradictory thing going on that if I was listening to what was being said as being logical and factual that, yes, he wasn't abusive but my own body was leading.. and literally the hair stood up on the back of my neck*

#### **4.4.2 Experiencing what client experiences**

Therapists frequently experience directly the physical sensation which the client feels. These sensations accurately reflect what the client is experiencing and may be corroborated by the client.

*(1) I could feel a coldness and reflected that. And.. the person said "no, no, I don't feel that". But actually came back to it later and said coldness is an apt description.*

*(4) I'd be aware of .. say for instance with one person feeling quite sick in my tummy.. . And it might come up then with her that she actually feels sick.*

One common situation that occurred for participants was the experience of feeling heavy headed when working with clients whose primary access route was through their thinking. In the following extract the therapist gives an explicit description of this when working with clients who operated from a very cognitive, cerebral place.

*(2) And when for example clients [are] in their heads sometimes I notice.. sometimes it's quite energetic.. sometimes it's headachey.. and*

*it's sort of a rush of energy right up here [points to her head] and it's like this is spiralling and it can be thick and heady.. And I notice my own struggle to come down.*

The following extract demonstrates the way in which these sensations frequently correlate with what the client is experiencing.

*(5) I have said "I don't know about you but my head is spinning right now".. what's going on with you? And then she'd laugh and say "yeah me too".*

This sensing what the other senses can be quite sudden and dramatic as in the following instance

*(3) All of a sudden she said 'Oh I'm being possessed by my evil Grandfather'. And she went into this fierce state. And when she did that this wave of cold sensation just washed over me.. kind of like you'd see in the horror movies.. stuff like that. Everything turns to goosebumps. And there was just this huge wave came off her and went right through me.*

However therapists didn't automatically assume that there was a causal connection between their bodily feelings and the client's body. Therapists described a process of checking out whether these somatic sensations arose as a result of something that is going on for them or something which originates with the client. It appears that the more adept they become at attuning to their own bodies the easier it is to make this distinction. One therapist described how he did this by monitoring his body over a number of sessions. Putting the information back into the therapeutic arena was another way of verifying if their experience had significance for the client. Therapists did this in the main by disclosing their bodily experience to the client and naming the experience. However, there didn't appear to be a consensus amongst participants of how to use these bodily responses. Some therapists tended to share this material in a collaborative way, others held it lightly in



their awareness and others stated that it depended on the client and their relationship.

#### **4.4.3 Overwhelm**

Some therapists considered that they were picking up the client's unconscious material at a somatic level. At times this felt like they were being physically attacked or bombarded. These somatic experiences were described as being very real and tangible and at times overwhelming for therapists. One therapist described how the somatic experiencing with one particular client was so overwhelming that she felt she couldn't cope. She explained that she *felt absolutely bombarded at a physical level (4)*. Another participant told of the impact of feeling a client's energy and described how it was *coming straight in and at my body.. and I would be down on the floor (7)*. Feeling a sense of force or attack from a client's body was a common experience for participants. The following excerpt depicts this somatic experience vividly whereby the therapist felt almost as if her body was being pinned against the wall.

*(1) I remember once working with somebody and the sense of force coming from attack. Coming from them. Literally physical. I would find myself pinned against the wall because the other person's presence was very strong. I felt the room, even the physical space couldn't hold it almost.*

Therapists described how they can lose touch with their own body because of the impact of the client's bodily being on them. In the words of two participants.

*(2) sometimes I struggle when I'm aware of being caught up in the client's speed. And I often notice when I get seduced into the speed.. And I'm also trying to sort of anchor myself. And this is often a challenge because it's about staying in relationship.*

*(9) we were like two magnets that were just repelling off each other and I found that extremely difficult because the only way I can describe it, it*

*was like a car crash in my own body that I would be feeling a connection and almost as quick as anything it was like being ripped out of that again. It was almost like violent internally connecting in, being pulled out and if I can just use that imagery like two magnets that you can connect and then the forces can be turned to just repel off each other and that was very hard for me.*

Participants expressed how difficult it can be to contain these overwhelming somatic experiences. For one therapist it felt like something quite *intolerable and unbearable* was happening inside of her and she described how the *fear of actually fainting came very strongly. I thought I wouldn't be able to sustain it* (8). Another participant offered the following description of what she does when she feels bombarded.

*(10) I just have to hold myself together, and keep breathing and wait, and hold myself back as well.*

One female participant described how destabilizing somatic sensations can be requiring her to ground herself in her seat.

*(5) I become ungrounded.. it's like I nearly feel myself lifting off the chair. And I really have to grip the floor with my feet.. and I would push into the ground... I'm pushing in because it wouldn't at all be enough to just sit like this.*

#### **4.4.4 Interfere with the Session**

At times this somatic experiencing of the other can interfere with the therapy session or with the therapist's ability to remain present. As participants reflected on this theme they questioned how available and present they could be to clients, particularly when the somatic experience was overpowering. One participant described how this overwhelm can take over the space and likened it to being annihilated.

*(7) the energy that that takes up, in my experience, fills the whole space. And in its doing will begin to annihilate anyone else that's in that space*

In another case this somatic experience of the other led to the therapist deciding not to take on a client.

*(6) One client I didn't take her on because I felt revolted by her body.. and she came for one session.. and I just got the willies... an absolute repulsion.*

#### **4.4.5 After the Session**

Therapists agreed that occasionally somatic experiencing continues even after the session is over. Some participants gave examples of ways in which they dealt with this. One therapist stated that **(4)** *'I do need to go and get support after each session'* in reference to a client with whom she has a very strong somatic reaction. The following excerpts illustrate means by which one therapist attends to these sensations after the session.

*(6) I'd want to wash myself after they leave.. or I'd want to walk or shake my head or shake my hands.*

Therapists were aware of the physical effect which the work can have on their bodies and mentioned using breathing techniques, exercise, burning essential oils, stretching and having regular massage as ways to clear their body of the somatic residue.

#### **4.4.6 Client Presentations**

Some therapists tended to make a link between a physical reaction they had and a client's diagnostic presentation. This suggests that somatic experiencing can be intensified with particular clients or client presentations. One participant described how he frequently feels anger in his own body when working with clients with a schizoid presentation. He stated *'I often can feel the anger in my own body.. that they're experiencing. ..that they're not*

*quite ready to face up to ' (12). In the following extracts, therapists described somatic experiences with clients with borderline and schizoid presentations.*

*(7) Thinking of a client I worked with who had quite a borderline process. And I used to regularly experience quite a degree of terror.*

*(8) Again one client I worked with.. and she had quite a schizoid process.. I was registering myself... part of the spacey feeling but quite a depletion of energy as well.*

*(10) I was seeing a young man who was diagnosed as schizophrenic. I remember one day I had this very acute feeling of my nipple had been bitten.*

This sub-category of Somatic Experience of Other is interlinked with the following two sub-categories. However at this level the therapist is just paying attention to sensory data in the body. They are registering the sensation and understand it to mean something about the client. It is in a sense a more *primitive* stage than that of 'Embodied Process' or 'Intersubjective Space' and may in some cases be the pre-cursor to the following sub-categories. Whilst the material is still relatively undigested therapists recognise that these sensations emerge through being in the presence of another body – that of the client. Although the sensations register with the therapist they are not yet taking it to the level of making meaning about the relationship.

## **4.5 Embodied Process**

From our findings we witness an interplay between sensations, feelings and thinking as part of an embodied process. Physical sensations become apparent first as the therapist somatically experiences the client. Once the therapist is in touch with this experience, it frequently leads to the registering of an emotion. One participant described how emotions were anchored in bodily sensations.

*(1) when I am emotional in sessions with clients I think that's very much a part of body. I think I might have separated emotion from body, but when I feel moved.. deeply touched.. I think that kind of depth of emotion is real bodywork as well.. body.*

#### **4.5.1 Integration of Physical and Mental Processes**

There appears then to be a progression from somatic experiencing through to emotions, feelings and thoughts leading to an integration of physical and mental processes. One therapist describes this progression as follows.

*(9) I'll listen to what's going on in my body.. there might be a tightening in my chest or a little bit of breathing or I noticed that I haven't swallowed for a while and I will say 'OK what's happening there' and often I find myself saying it before you know it happens that quickly that I've kind of almost figured it out.. and I'll name an emotion.*

Therapists described how clients frequently experience intense arousal but are unable to understand it or put words on it. This arousal is felt in the body of the therapist. Through self-reflection the analyst comes to identify the accompanying emotion. One participant describes this process as follow:

*(9) First it would come to my awareness and it would be a case of uh huh, I sense this, let me just hold that for a minute and then see what unfolds from there. So it's like a registering of it.*

In this process we witness how interpretations or thoughts have a physical component. Therapists experienced these thoughts in their body, firstly as a sensation. Having experienced the sensation therapists may then interpret or give meaning to these sensations. Feelings thus appear to be the product of sensations and participants describe the process of how this evolves.

*(7) If I notice that something is happening.. say in my left shoulder.. I may not speak about that in that moment... I might check in was there*

*a feeling that goes with that. maybe the emotions will come.. it's just to allow it to be there.*

**(9)** *If I go with body sensations it was almost like a tingling, a tingling coming from the front of the throat down resonating on the chest level so it was almost chest to chest, y'know that heartfelt kind of emotion. .... and naming the feeling that was going on, and naming that as grief.*

Many participants lacked a clear distinction between sensations, emotions and feelings and used these words interchangeably. Not only did they describe bodily sensations which resonated with client experiences, they also talked of emotions and feelings. This blurring of boundaries may echo the complexities involved in differentiating sensations from feelings and emotions.

#### **4.5.2 Window into Client's World**

The therapist's somatic reaction to the client's material provides a window into the client's subjective experience as the therapist transforms them into meaningful feelings. These feelings inform the client about the meaning of his or her emotional experience and can also enrich the interpersonal encounter. Through picking up the client's feelings in their own body, therapists could empathise at a bodily level with their clients. This had the impact of deepening their understanding of the client. Several participants indicated that through these somatic experiences they can gain a greater insight into the client's world. One participant portrayed an experience in which she felt she might die.

**(10)** *it felt like in my heart area I was being sucked into a whirlpool.. sucked in.. and I just had to let it happen and I might die in it.*

Yet she clarified that this overwhelming sensation helped her to understand what the client may be feeling when she said

**(10)** *It gave me a sense of the extreme terror that he would be feeling because I really thought 'I could die now this second' .*

Participants suggested that communication is happening at a pre-verbal level and therapists are somatically experiencing what the client is unable to verbalise. At times these feelings and sensations may be experienced intensely by the client. Frequently however clients will not be aware of these feelings in themselves. The following excerpt illustrates this dynamic.

**(12)** *what I notice with clients is that if they're coming with a feeling that they haven't quite acknowledged.. that it's a bit unconscious to them... I'd often feel it before they'd feel it. I sometimes find if a client is coming and they're feeling anxious I can suddenly find myself feeling anxious.*

Therapists had a sense that they were holding the client's unresolved material somatically. Participants tended to be of the opinion that this arose in cases where clients were unable to tolerate the feeling. The following examples convey ways in which feelings of anger, fear and terror may be projected onto the therapist before the client is ready to feel it themselves.

**(5)** *one client... I would guess that what I was feeling at the time was what she was feeling.. but she wouldn't have been ready to look at her anger at all.*

**(8)** *A female client I've been working with .. I have certainly registered quite a lot of fear in my own.. in myself when I'm working with her. And there was a particular time when she was going through a court case.. And I noticed my own fear intensified a great deal during that time. And yet she was presenting quite matter of factly really.*

**(11)** *And I used to regularly experience quite a degree of terror in the room. And understood I suppose after a while that it was a very unacknowledged terror in herself.'*

The following is an illustration of how the client gradually came to tolerate the feeling.

*(4) In one particular case .. it was like I was carrying the client's anger that she couldn't access herself and I was very conscious of it in my own body. ... And I would have fed it back to her. I would just say I'm aware of being angry... and I'm wondering does that resonate with you? And with this particular person it did .. she was aware of it when I said about mine, she was aware of it in herself. Now she wasn't comfortable to go with it at that stage.. It did take another session or two. But once it was named she did work on it from there on.*

#### **4.5.3 Naming Resonates**

Therapists reported that when they experience and name the sensation or emotion it often resonated with the client. Naming is arrived at through a process of feeling the sensation in their body, registering this and then naming it. Therapists described how they may articulate this to the client to check out if the client has a similar experience.

*(2) So in my verbalisation of my being able to identify what happens in my body and using that to check out the client's... and I'm using my own experience in my offering to the client. And noticing if that resonates or not.*

*(9) I'll have an experience of maybe what could be happening for a client and if it's appropriate I'll take the risk and put it out there. I'll check in with them... Sometimes it can be accurate, sometimes it doesn't seem to fit... and sometimes they'll come back at it and say you know what now I'm feeling it.*

Participants considered that this simple act of identifying and naming the sensations was in itself containing for clients. One participant described it as the client being able to 'own her anxiety' **(12)** which came about through him first experiencing anxiety in his own body and then feeding this back to the



client. In the following excerpt the client immediately resonated with the grief which the therapist was experiencing in her body.

*(8) but I used to regularly feel overwhelmed with grief. And it immediately registered with him as something that had a lot to do with him around authority figures when he was a child.. because he was very hurt actually.. physically, emotionally and even sexually.*

The ability to name the emotion before the client is aware of it was described as *getting there before the client arrives* which can signify to the client that the therapist is in tune with them.

*(4) Its being in tune with the client on an emotional level and sometimes being there before they arrive. So it's like getting a felt sense of where they're at... I think it gives me a better sense of standing in the space beside them when I'm that in tune with them.*

*(9) So I suppose all the time it is about the client and what it's like to be in their world their shoes.*

Responses indicated also that clients are frequently astonished that the therapist can accurately name the emotion.

*(9) I'll name an emotion and sometimes it's just met with complete unbelievable kind of 'how would you know that'?*

One therapist describes how the client was unable to feel the feeling in its fullest form and thus it needed to be 'digested' by the therapist before the client could acknowledge it.

*(8) When he started to talk I started to feel that something quite intolerable and unbearable was happening inside of me. And that kind of physical sensation.. And the telling of it I think was his first step towards realising how unbearable it had been for him with his mother as a young child. I understood afterwards that in a way.. the necessity I*

*suppose the idea of container is very key to it. That somebody was willing emotionally or empathically to register his experience.. and he could get some kind of return of it.. in a digested form. And I think the communication of that by me to him was a very important part of it.*

## **4.6 The Intersubjective Space**

Whilst discussing what happens between bodies in the therapeutic encounter respondents focused on the intersubjective space that emerges between the therapist and the client. This was described as a kind of physical representation of what was emerging in the interchange. Therapists described this shared world as the '*in-between*' (1). It was perceived as an embodiment of the interaction and belonged to neither the therapist nor the client. In the words of one participant:

*(7) for me its something that I'm embodying... as is the client. and somehow I can't really fully interpret that as being one or other. It is the between.*

### **4.6.1 Embody the Relationship**

As therapists deepened their enquiry into what is happening between the two bodies in the room they were open to the possibility of what their experience communicated about the relationship. In the words of one participant '*but I can't say that was about the client... it was something about the dialogue and something about the nature of what was going on*' (1). Interestingly many therapists shared this view and described how they might consider these sensations as information about the process between therapist and client rather than the client per se.

*(6) I no longer make the leap that it tells me about the client. it might.. it gives me something that I might speculate about what's going on between us. rather than it actually telling me about a client. If I feel.. I can feel a coldness sometimes. It might give me a sense of a hypothesis or a speculation.. is our process getting cold here. Its like*

*another tentative exploration rather than a definitive .. oh the client has dissociated now.*

These sensations contain data about what is happening relationally. Hence therapists expand this enquiry to understand what is happening between therapist and client. This is illustrated in the following examples.

*(1) but I think if I suddenly feel something.. or if I feel an incredible tiredness where I'm absolutely feeling a repetitive sleepiness with a particular client and suddenly at the next session its gone it makes me question about what is my body communicating to me about what's happening in the in-between*

*(7) So sometimes I'm sitting and I notice that my jaw is gone tighter and tighter .. and again its like checking in.. has something happened between us that I've been activated somehow..*

Therapists illustrated ways in which physical sensations in the therapist's body can give information about the process. One therapist felt like she was under attack from a client.

*(1) And I remember actually the experience of feeling as if my face had caved in... And I did feel like I was under attack.*

One therapist described how sensations in particular 'spots' (locations) in her body give her an indication of what may be going on.

*(11) So I was beginning to recognise these spots myself thinking this must be something to do with support, so I'm wondering what's happening here in the room then.*

Holding and expanding one's curiosity into what these physical sensations may convey about the intersubjective space allows their particular significance to unfold. This lends itself to understanding what is being communicated in an

embodied manner. One therapist gives an example of this process and describes how a physical sensation may indicate an unspoken communication between therapist and client.

*(1) If I noticed a persistent sleepiness I might wonder is there something that we're not able to talk about.*

In another instance a therapist reported how her body began to take on or embody what needed to be said.

*(10) so I just started to notice in myself a feeling of very cut off, detached, unfluid. If my body could speak it would be saying 'this had to stop, I'm not opening up to this, I'm not going to empathise with this because it needs something else'.*

In the following illustrations the therapists' somatic responses to the clients' way of being indicate what therapists register on a physical level and various ways in which they are 'moved' to respond.

*(2) An express train. And sometimes there is a feeling in my body that I'm struggling to run after him.*

*(8) it sometimes feels a bit lonely..It's interesting.. sometimes it feels like I could get up and move and it wouldn't make any difference.*

This attention to somatic material can impart information about what may be happening between the therapist and the client. Participants offered the following perspectives with regard to how they use their bodies to understand what is happening in the intersubjective space.

*(7) If my sense in myself is that I'm beginning to kinda space, that my energy is going up and out .. so something is happening in the space between us..*

*(8) I've certainly been conscious at times of not being quite present in the room... or cut off.. I .. would kind of assume it was information about something that was happening in the room.*

#### **4.6.2 Shared Knowing**

Participants' responses suggest a kind of somatic resonance or attunement that takes place in the intersubjective space. Client and therapist appear to be able to sense and implicitly understand the sensations of the other. Therapists described having an inner felt sense of the client and considered this to be reciprocated at times through the intersubjective nature of the relationship. The following extract demonstrates this resonance to the being of the client occurring in the shared space between therapist and client.

*(5) And I just truly, truly could feel her pain.. But it's .. in the space between you.*

Through attuning to clients, participants sensed that they were *within* each other's felt experience. Participants described mutuality between therapist and client where each is aware of sensing what the other senses even though it is not talked about. One participant described it as being like a *'light bulb moment'* for clients when they recognise *'yeah you get me'* **(9)**. Another therapist described how in these relational moments clients can *'feel held.. and really really supported... a client can sense 'oh my God she really got it'* **(5)**. This resonant state of shared implicit knowing is communicated through and between bodies.

One therapist described feeling deeply touched by a client which resulted in tears welling up in her eyes. Through her tears the participant had a sense of feeling *'felt'* by the client. The therapist described how the client affirmed this later.

*(1) And I remember that client coming back and saying that she'd never felt anyone had understood her until she saw tears in my eyes.*

One therapist described how this implicit communication between therapist and client was occurring through right brain to right brain processes.

*(10) My body was actually feeling sorry for her body and it was saying 'no more'. So it's right brain talking to right brain.*

Right brain to right brain relating takes place at the implicit level and was considered to take place at a bodily level. Through listening to their bodies therapists described how they remain open and receptive to their clients' inner state. One therapist described this as a 'deep knowing' **(1)** another described it as 'a deep listening.. And it's within us.. it's in our very being **(7)**. One participant explained that 'It's intuitive.. which is of the body..' **(2)**. Therapists were in agreement that working at this level required a reliance on a *felt sense* **(5)**, a *gut feeling* **(3)** and/or *instinct* **(12)**. One participant described how 'there is a deep knowing.. in all of us.. And I think the place it comes from is the gut... it's from the body **(8)**. This knowing is not a conscious, verbalisable knowing but an implicit, intuitive one. It arises out of the intersubjective meeting of two bodies.

*(12) I was trying to stay tuned into my body.. and I just felt.. I just had a feeling that this is right.. follow this.. follow this.. just this voice inside of me.. and this feeling of this is right.*

Whilst working at this level, the micro processes outlined in the subcategory 'body to body' are vital. These processes act as mediating factors in the build up from sensing in the body to the creation of thirdness.

#### **4.6.3 The Third**

This shared, co-created experience emerged as a kind of a 'third entity' in the room. This 'thirdness' was seen to arise largely out of the non-verbal interaction and exchanges that happen between therapist and client. Underlying the thirdness is the attuning, mirroring and regulating of the 'body to body' experience. It was described as a '*matching rhythm*' **(11)** or an '*alignment*' **(5)** and was considered a mutual experience. This experience was

described as a shared interactive process and therapists differentiated it from times when they would be observing what is happening in their body or naming to the client what is happening.

One therapist described this third presence as *'the zone. And the zone is about us meeting in that [interaction]'* (7). In this 'zone' relating happens at an implicit level and it appears that a synchronisation can occur at a physical and psychological level. In this meeting place therapists described a deeper sense of interconnection and a strong feeling of interpersonal attunement with the client. One participant described working in the zone as *'The altered state of the artist'* (2). Whilst therapists are attuned to the client in this space, they are also keenly attuned to their own body. The following extract demonstrates the way in which the therapist continues to attend to the somatic experience in her own body, whilst being fully present to the client.

*(2) how do we allow the art to happen? When we go into the zone. It is about letting go and being really present moment by moment. .. And so there's this sort of interweave in the space between.. But in working somatically then would be inclusive of working with my body. And I'm also noticing what comes up in my body and that becomes appropriate.*

Moving in to this 'third' place thus implies an awareness of oneself yet a certain letting go of the self whilst sustaining connectedness to the other. One therapist vividly described the qualities inherent in this 'third' place *where the words begin to slow, and disappear... and silence comes in.. when we can actually dare to be still* (12). Therapists were in accordance that working in this 'third' space was taking therapy to another level.

*(9) It's that kind of space where you know two people are in a relationship and it's taking that to the next level.*

Describing this attuned intersubjective process was a challenge for some participants and they were inclined to use words like 'Spiritual' or 'Divine' to describe this 'third' entity. One therapist proposed that when we are talking

about this intersubjective relating *the general word I would put on that it's like in a spiritual kind of attunement.* (2) Another participant described this relating as follows: *'For me it is the Divine.. it is Spirit.. it is the Divine Mother... It is God'* (7). One male participant offered the following perspective.

*(6) Sometimes people might say that God exists in the person.. and for me I think it's not really in the person but in the space between two people. I feel that alchemy.. magical.. spiritual.. undefinable space in between two people.. in the relationship..*

#### **4.6.4 Parallel Process in Interview**

In one interview I was aware of feeling uncomfortable and felt constricted in my body. I felt as if there was little room for movement and I had a physical sense of being blocked or constrained in my body. Whilst I didn't refer to this in the interview or connect it to what was happening at the time, my body wanted to say *'Let me in'*. Later, on listening back to the interview I experienced the interview to be more like a lecture than an exploratory dialogue or conversation. I had a sense that the participant's responses were all neatly 'wrapped up' and polished, allowing little room for further exploration. I had experienced this relational dynamic as a constriction in my body and this unspoken communication, *I speak and You Listen*, had registered at a somatic level.

In summary from our findings we begin to see an emergent theory of what happens between bodies and how these processes are generated. The next section will discuss how the emergent theory fits into the broader picture.



# 5. DISCUSSION

## 5.1 Between Bodies

This study explored, documented and conceptualised therapists' experiences of what happens between bodies in the psychotherapeutic encounter. Based on the findings a coherent theoretical framework for an Implicit Relational Model of what happens between bodies was built. The following discussion will contextualise the findings within recent developments in neuroscientific research, developmental theory and the psychological therapies. The findings show that when two bodies meet much happens at the implicit level of relating and implicit bodily exchanges take place. A bidirectional, somatic communication occurs within the therapeutic dyad. This study points to the role of right hemisphere relating which is facilitated by micro-body to body processes. These processes underlie the co-created container of the embodied intersubjective field of client and therapist. This field between the two bodies creates the fertile ground within which Connection and Somatic Experiencing of Other can be attended to, the Embodied Process emerges and the Intersubjective Space is cultivated. Table 3 below demonstrates the process by which body to body processes facilitate right hemisphere relating thus giving rise to therapeutic change.

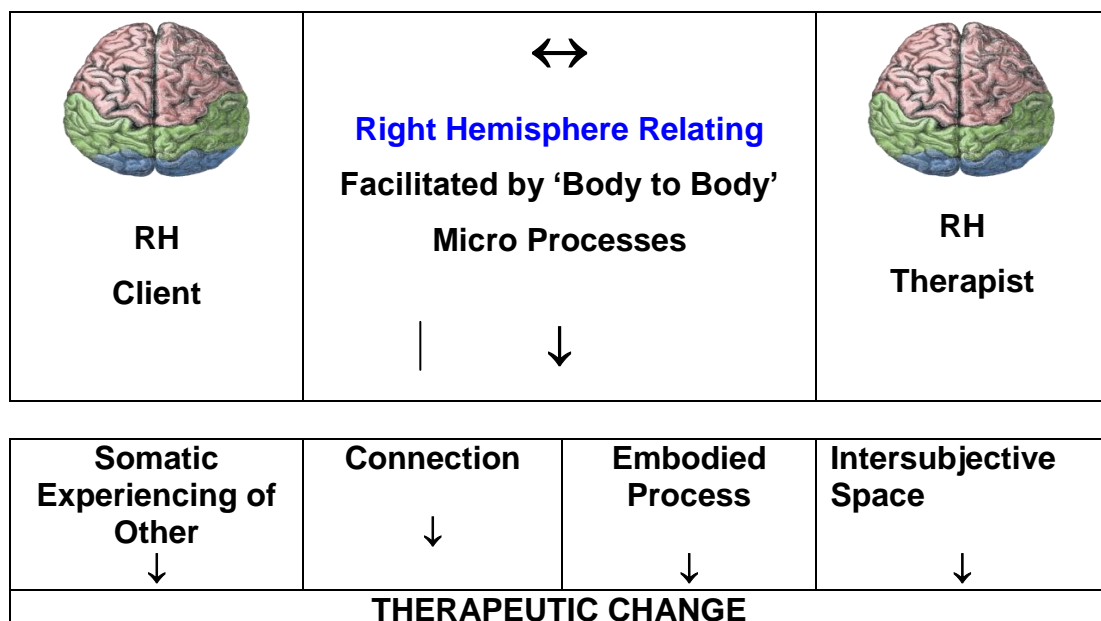


Table 3

## **5.2 Body to Body**

This study highlights how therapist and client are continually relating to the body of the other in a co-ordinated way. Client and therapist interact through the embodied microprocesses of attuning, regulating, mirroring listening and tracking. These transactions take place through non-verbal behaviours such as gestures, facial expressions and prosody. Schore (2007a) contends that in order for therapeutic change to occur these implicit, affective and non-verbal processes are extremely important. These dyadic relational moves take place within a state of right hemisphere to right hemisphere relating and require the therapist to be in a state of right hemisphere receptivity (Schore, 2005). In this study we identified how these embodied relational processes act as a mediator for generating connection between therapist and client and eliciting somatic experiences of the other. They also facilitate the emergence of embodied processes and the creation of the intersubjective space.

Therapists viewed their body as detector or a gauge which gives them information about the client. This corresponds to Stone's (2006) analogy of the therapist's body as a tuning fork which resonates with the client's psychic material. The body of the therapist is likened to radar picking up somatic responses to the client's material. Therapists reported how their body mirrors the client's body at both a conscious and unconscious level. Implicit mirroring through posture, facial expression, vocal expression or emotional state frequently brings about change and assists clients in developing deeper understanding. The uncovering of this process of mirroring which establishes pathways for the implicit exchange of information is consistent with reports in the literature (Schore, 2003a; Woodman, 1985). Harris (1998) contends that by mirroring the client, therapists can grasp their affective state.

The current findings identify two kinds of mirroring – automatic mirroring and active mirroring. Evidence from the Neuroscientific research (Gallese, 2001; Rizzolatti, 2006) suggests that the mirror neuron system is involved in both the automatic and active mirroring behaviours reported in this study. When discussing the neural processes underlying mirroring, Gallese (2007) states

that “we seldom engage in explicit interpretative acts” (p.659) instead our response to others is more “immediate, automatic and almost reflex-like” (Gallese, 2007, p.659). Carr et al (2003) shed further light on this automatic process demonstrating that through the mechanism of action representation the amygdala in the right hemisphere is activated. Resonance which results from imitation does not involve the left hemisphere which is the seat of explicit representation. This right hemisphere to right hemisphere relating is implicit, automatic and below conscious awareness (Gallese, 2001). More complex or advanced forms of interacting such as imitation, intentional communication and mirroring, matching gestures and expressions rely on more elaborate organisation of the mirror neuron mechanism (Gallese, 2001; Rizzolatti, 2006).

Therapists described how non-verbal, implicit processes such as facial expression, eye contact, breathing, gestures, body posture and tone of voice support the process of interactive affect regulation. These right hemisphere to right hemisphere transactions all play a crucial part in the process of regulation. Schore (2007b) attests to the vital psychobiological function of affect regulation in the clinical dyad. Findings also correspond with Ogden, Minton & Pain’s (2006) description of how the therapist uses non-verbal somatic cues in order to regulate the client and to enable the client to regulate their own affective states. Aron’s (1996) contention that clients may use the analyst as a regulator, when they themselves are unable to rely on self-regulation was alluded to by therapists in this study. Participants considered that the therapist’s very being can act as a regulatory factor. The analogy one client makes to the therapist’s body being ‘like a rock’ illustrates this.

**(8)** *Her experience of my body was part of the feedback she gave me. She said I feel sometimes you’re like a rock sitting and I can wander around you.. and come back... and I really understood to be about .. her experience of my body in the room.*

Therapists stressed that this regulation is a mutual experience and client and therapist are mutually regulating each other. The client regulates and is

regulated by the relationship with the therapist through bodily relational processes such as rhythm of exchange, pacing of speech, eye contact, tone of voice and postural shifts. This process is consistent with the view put forward by Aron (1996) who explains how therapist and client are involved in mutually regulating each other. Aron (1996) describes how this is occurring at both a conscious and unconscious level which correlates with our findings.

Participants described how they attune to the physical being of their clients and being attuned was considered fundamental to the work of therapy. These findings concur with Siegel (2007) who considers attunement to be the central process of psychotherapy. It is through these right hemisphere to right hemisphere transactions (Schoore 2003a) that therapists attune to the inner state of their client. Participants described attunement as a bodily knowing rather than a cognitive one. Therapists weren't always aware of being attuned and much attuning occurred in the implicit realm of relating. Through attuned relating therapists became attuned to the client's affective states. In turn therapists were able to assist clients in developing greater awareness, understanding and attunement to self.

Therapists described how they are not just listening on a verbal conscious level, they are also listening at an implicit and subliminal level with their bodies. Therapists described how picking up somatic cues in their body and tracking these was at the heart of their practice. In particular attention is given to subtle changes and nuances in body tension, breathing, posture and facial expression. Listening at this level provides therapists with information about how to be with the client and/or how to proceed. This notion of listening with the body parallels Gendlin's (1992) concept of felt sense. This mode of listening has a visceral quality and is a bodily knowing. As therapists listen, their bodies register a myriad of messages from the intersubjective field. By attending to physical sensations and bodily responses therapists glean much information about their client. This may be how the client presents in the world outside of therapy and frequently this information may be contradictory to what the client is actually saying. Therapists reported the presence of somatic sensations to be particularly strong in the first session. This was considered to

be a crucial time for relaying information about clients in a somatic way. These reports correspond with Pacifici's (2008, p.108) contention that the therapist must "*sensitize all the senses to perceptual channels to receive the other, in particular the channels of the other's complex bodily dimension*". It is through the *lived body* (Merleau-Ponty, 1945/1962) that the therapist is understanding and making sense of the other. The therapist's body is at the centre of their experience and the body is 'environmental information' (Gendlin, 1992).

Participants explained how a feeling of anticipation or premonition frequently experienced as a tension in their body can alert them to something that is about to happen in the session. When we explore the neuroscientific evidence we can find support for these findings. The ability of the brain to predict, anticipate and prepare ahead of time appears to be a global function of the human brain (Pally, 2007). Mirror neurons in the pre-motor area are activated when one observes non-verbal behaviour such as facial expression, posture or position of head – just as they would be if the individual were performing these behaviours. Studies show that individuals can know what another feels because the brain predicts that the other feels as we would were we to engage in these same non-verbal behaviours. Pally (2007) stresses that these predictions operate continually and are entirely automatic and unconscious.

### **5.3 Connection**

Findings suggest that when two people are interacting, connection is taking place at a somatic level. This connection is made through eye contact, breathing, body proximity, posture, silences and gestures. At times these physical processes are the only means by which connection can occur. These findings are in accordance with the literature (Hatfield, Cacioppo & Rapson, 1993; McTaggart, 2011; Totton, 2005; Wilkinson, 2010) which demonstrates how as embodied beings our lives are centred around relationship with other bodies. This study indicates that therapists experience this felt connection with their clients. This connection, known through the body, was frequently considered to be occurring at a level beyond words. Connection was reported

to take place in the implicit realm of relating and was non-verbal. These findings are consistent with Lyons-Ruth's (2000) basic tenet that the primary medium of an affectively charged interchange between two people is enacted at an implicit level and language may never be incorporated into the encounter. This implicit or unspoken dimension referred to as '*implicit relational knowing*' (Lyons-Ruth, 1996, p.282) is directly enacted rather than known consciously. "*Implicit knowings governing intimate interactions are not language based and are not routinely translated into semantic form*" (Lyons-Ruth, 1998, p.285).

Finding it difficult to put words on this experience of connection, therapists likened it to 'a flow of energy' or an 'energetic connection'. This is similar to Schore's (1997) description of '*synchronised energy exchanges*' (Schore, 1997, p.595) where engagement is heightened due to the nature of the relationship between therapist and client. Bass (2005, p.165) insists that we are always doing 'body-centred energy work' as the energy field of the client and therapist constantly intermingle with each other. '*Energetic Perception*' (Carroll, 2009, p.99) is the term Carroll uses to describe the ability to hold at a bodily level information which resonates in a felt sense from client to therapist. The concept of energy is a universal one and it refers to the subtle life force which resonates within and around our bodies and is considered to "*underlie all form*" (Stone, 1978, p.15). Reports suggest that therapists are tuning in to the client's energy and there is always an interweaving of the energy field of client and therapist.

Findings indicate that therapists need to be able to remain connected to their own body whilst listening to the presence of the client's body. Therapists in this study described having a healthy template of relatedness within oneself in addition to being attuned to the impact of the client on them. Results indicate that maintaining an attuned internal state through connection to self, allows for a greater connection between therapist and client. It was evident from findings that important somatic messages and cues may be missed when therapists are not in contact with their own bodies. This connection to self was reported to be maintained through mindfulness of one's own body, grounding and

awareness of breathing. These processes assist therapists in remaining present and not getting caught up in the client's process. This ability to maintain contact with self whilst also resonating with the other is underscored by Carroll (2009). Carroll (2009) highlights the importance of therapists paying attention to their own body in order to not get pulled into the demands of client's unregulated affect. Findings expand on Aron's (1996) assertion that by paying attention to their own body therapists may access the inner world of their client. This research goes one step beyond this by suggesting that attention to one's body facilitates a discovery of what is happening in the relationship between therapist and client.

Siegel (2007) stresses the importance of sensing our client's pain but not becoming that pain. In order to do this we need to have the modulating capacity to remain present and empathic to our clients without becoming traumatised vicariously. Siegel attributes this ability to a theoretical set of "*supervisory mirror neurons*" which allows therapists to remain open whilst not getting lost in the other (Siegel, 2007, p.294). By remaining attuned internally and maintaining mindfulness of self, therapists can discern between remaining empathic and resonating with the client without being flooded and overidentifying with the client's experience.

In this study it was identified that connection occurred not only between people but also within the individuals in the relationship. Whilst the therapeutic encounter incorporates mutual and reciprocal interchange between bodies, it also incorporated the idea of a relatedness within bodies. This is consistent with Ferrari's (2004) concept of the horizontal and vertical relating bodies. Participants stressed the importance of assisting clients in staying connected to their physical being. This was considered vital in facilitating connection. The need to take the context into account when exploring contact between and within individuals is evident from our findings. This model therefore supports the need to move beyond either a one-person and two-person distinction to embrace a contextual psychology (Wachtel, 2008).

## 5.4 Somatic Experiencing of Other

This study revealed that therapists register a considerable amount of somatic material in their own body, which they attribute largely to clients. Therapists described powerful physical reactions which they have to their clients and in response to their clients' communication. Paying attention to their own bodily responses in their interaction with clients can assist therapists in their work. Through attending to these responses they come to gain a deeper understanding of their clients and gather more information about them. The importance of therapist's attention to their own body is congruent with the writing of theorists such as Aron (1998) who considers our bodies to be the "*primary arena for the psychophysiological processing of affect*" (Aron, 1998, p.28). Therapists in this study described using this somatic data to finely tune their reactions and determine the next step to take with clients. This is consistent with Pacifici's (2008) description of how the body of the therapist is touched by that of the client which in turn can bring about physiological change. Pacifici (2008) stresses that awareness of these changes is crucial in how therapists proceed with clients.

This study highlights the process whereby the therapist is actively communicating through the body and using the information that arises from this process to gain a deeper understanding of the other. Much of the literature has described this phenomenon as "*Body Empathy*" (Shaw, 2003, p.139) or "*Sensory Empathy*" (Zanocco, De Marchi & Pozzi, 2006, p.146). Zanocco et al (2006) highlight how sensory empathy happens through bodily sensations rather than thoughts and consider it to be the therapist's response to the client's material. Empathy arises when our subjectivity merges with that of another. Shaw (2003) contends that body empathy is a heightened body awareness which assists therapists in deepening their connection with clients. Sensory empathy or body empathy arises from the therapist's capacity to 'identify' at a somatic level what the client is feeling. The concept of Identification can be traced back to Freud (1921) who considered identification to be "*the earliest expression of an emotional tie with another person*" (Freud, 1921, p.105).



Studies in neuroscience equip us with a greater understanding of the neural underpinnings of these processes and consider them to be the product of right-brain activity (Schutz, 2005). Rizzolatti (2006) contends that it is the emotional mirror neuron system that is responsible for understanding the emotions of another. Whilst speculative as of yet, Gallese's work on mirror neurons highlights an individual's ability to understand the inner world of another through means of '*embodied simulation*' (Gallese, 2007b, p.659). Through the mechanism of embodied simulation the therapist's body functions as an organ of perception and observing another's action involves an implicit, unconscious process of imitation. Through use of their own physical sensations the therapist is provided with information about the client.

In this study accounts indicate a kind of somatic identification whereby body sensations or states are described as being transmitted between therapist and client. The transmitted sensation may closely resemble the unconscious affect that the client is unable to experience for themselves. This mechanism arises within the realm of the implicit. Whilst therapist and client may experience a similar physical sensation, clients do not always experience these sensations at a conscious level. Sometimes clients do not feel these sensations and at other times they may feel them intensely, as does the therapist. Whilst somatic sensations may alert therapists to information about the client or to their response to the client, therapists will check that it's not something to do with them and are discerning as to their origin and meaning. This is consistent with Shaw's (2003, p.83) warning that when picking up sensations in their body therapists may have a tendency to assume that they are picking up the client's body memory. Shaw cautions that therapists are making inferences that may sound plausible but are not substantive. The findings here would support Shaw's contention, and therapists in this study described how they don't take for granted that the sensations which they feel are assigned to their client.

The study suggests that frequently somatic sensations can be very strong and overpower the therapist. This experience of overwhelm could be debilitating for therapists and was experienced at times quite violent, like an attack or

being annihilated. Therapists experienced these somatic sensations as excruciating or unbearable. Faced with these experiences, therapists recounted how they can lose contact with themselves, the client and with the relationship. Such experiences have been referred to as enactments in the literature (Hart 2008, Stern 2008, Ginot 2007, Zanocco et al 2006). In an enactment, through gesture, or posture or tone of voice the therapist and client interact in an implicit, intersubjective shared act. Enactments are considered primitive elements of experience that are not yet conscious and not yet nameable (Zanocco et al. 2006). Gallese (2001) considers that enactments come about as a consequence of imitative mechanisms being activated when observing the actions of others. Ginot (2007) maintains that enactments contribute to *“an intersubjective mode of empathy based not only on an emotional echo of the patient’s explicitly expressed feelings, but on an unconscious experience that directly connects with the patient’s dissociated emotions, defenses and attachment patterns”* (Ginot, 2007, p.327).

Participants in this study reported that whilst they considered these somatic experiences to often be overwhelming, they helped to facilitate a deeper understanding of the client and gain a deeper insight into the client’s process. Therapists appeared to empathise at a somatic level with their clients and through the medium of this resonance they came to understand and facilitate change in the client. This implicit process provided both therapist and client with a significant and direct means to connect with what needed to be brought into awareness and integrated into the developing sense of self. Ginot (2007) emphasises the transformational power within these implicit affective interactions and stresses that we can no longer focus exclusively on explicit content and interpretation. According to Ginot (2007) it is only through participating in an enactment that the therapist can be aware of, understand and integrate the client’s early implicit relational patterns. Stern (2008) considers that enactments can be of enormous value as they can help to *“understand the unconscious impact of the patient on him, and then to use his knowledge of this impact, and of his own disequilibrium, to grasp parts of the patient’s experience that the patient has no way to put into words”* (Stern, 2008, p.402). Much support for the transformative power of enactment is

currently gaining prominence in the neurobiological and attachment literature (Hart, 2008; Stern, 2008; Zanocco et al, 2006; Gallese, 2001).

In this current study, participants reported somatic experiencing to be more intense with particular presentations – namely Schizoid and borderline personality and psychosis. Sensations appear to show up more strongly in the body of the therapist with these clients and these findings are borne out in the literature (Warnecke, 2009; Stone, 2006; Schwartz-Salant, 1989; Samuels, 1985). Although participants in this study did not refer to their experiences in terms of somatic countertransference, their descriptions were akin to reports in the literature on this construct (Stone, 1996; Samuels, 1985). At this level therapists were attending to sensations in their body and whilst attributing it to the client, they were not yet interpreting it to make meaning about the intersubjective relationship between therapist and client.

## **5.5 Embodied Process**

This investigation highlights an embodied process whereby physical and mental processes are integrated. From our findings feelings appear to be the product of sensations and participants describe the process of how this evolves. Therapists recounted a progression whereby physical sensations register in their body which then leads on to the identification of emotions, feelings and thoughts. Therapists describe this interplay between sensations, feelings and thinking whereby the somatic experience manifests as the starting point. This leads to the therapist representing in words the sensation or emotional reactivity they are having to clients. This process is consistent with findings by Damasio (2003, 1994) who considers the whole body to be involved in emotional reactions as it adapts to its environment. Feelings are the mental representations of emotions (Damasio, 2003, 1999) and in the interviews therapists referred to feelings which were clearly anchored in bodily sensations. These findings can be traced back to Reich who considered that *'the emotions, more and more came to mean manifestation of a tangible bio-energy, of the organismic orgone energy'* (Reich, 1945:1972, p.xi). As the

body adapts to its environment mind is created and in turn as the mind organises somatic information it impacts on the body.

From the findings we witness a blurring between sensations, emotions and feelings and distinguishing somatic experiences from feelings was a difficult thing to do. The complex interaction between these states can be understood when viewed through the lens of Damasio's work. Furthermore there is a lack of clear distinction in the terminology used relating to sensations, emotions and feelings in the literature. Damasio (1994) uses the word 'feeling' to describe body responses which accompany a cognitive aspect of emotion. In neuroscience the terms emotion and affect are used interchangeably (Pally, 1998). At times the term 'affect' is used to denote the mental representation of the emotion (Pally, 1998).

In the current study I could have explored this indistinctness by digging deeper into the bodily aspect of this. I could have asked therapists what bodily sensations went with a particular feeling or if any feeling was linked with a body sensation. Therapists appear to be most often trained in detecting feelings rather than sensations (Wilkinson, 2010). The model of working here allows for therapists to become more sensitised to implicit levels of relating by attending to bodily sensations and experience near processes whilst also attending to feelings.

Therapists described how experiencing a somatic response to the client can provide a window into the client's world. This was described as a 'shared somatic state' – a feeling of what it's like to be in the world of the client through experiencing sensations in their own body. From a relational perspective human beings are viewed as being interconnected, hence these intersubjective processes can be considered to accurately communicate the client's inner world. These findings converge with descriptions from the literature (Wilkinson, 2012, Hart, 2008, Aron, 1996).

Participants outlined the process of naming the sensation once they have become aware of it registering in their body. Naming a sensation will often

resonate with the client and can bring it to the client's awareness or help them to make sense of it. Pally (2007) stresses the value of conscious self-reflection on the implicit processing that occurs below consciousness as a medium for effecting change in therapy. This way of working is also consistent with Schore's (2003b) suggestion that simply naming the emotion or sensation can contribute to the client's capacity for affect-regulation, particularly when the client's capacity for self-regulation is poor. Schore (2003b) asserts that when interactive regulation is offered by a consistent, reflective and boundaried therapist this can greatly assist the client in their ability to self-regulate. This has important clinical implications as it highlights the need for therapists to attune to their physical responses and be aware of how they can use these to facilitate therapeutic change.

Therapists described a process by which they somatically experience what the client is unable to verbalise. Frequently however clients will not be aware of these feelings in themselves. Therapists were also aware of holding the client's unresolved material somatically when clients were unable to tolerate the feeling. Within the literature the body of the therapist has been posited as a point of registration for the client's experience which is not yet articulated or verbalised (Donnel Stern, 1997; Harris, 1998; Bollas, 1987). Dissociated states or non-mentalized material first becomes available for expression through the body of the therapist. Wallin (2007) states that "*Often the reverberations of the patient's own disavowed emotions, or the defences against them, will register first in the body of the therapist*" (Wallin, 2007, p.131). It is therefore of much interest that in this study participants experienced being deeply impacted at a bodily level by somatic information. The therapist's body appears to act as a conduit by which information about the client which may not otherwise be known is communicated. What cannot be experienced within the client's body is 'transmitted' between the two bodies and experienced by the therapist. This takes place within the co-created container of the intersubjective field of therapist and client. The client may be unable to bear aspects of their experience up to a point and hence the therapist 'carries' this or 'holds' it somatically until the client is able and ready to own it. Participants described a process analogous to Projective

Identification (Klein, 1946) whereby the therapist is like an '*auxiliary hard-drive*' (Bass, 2008, p.162) which offers the client a greater space for processing. The therapist takes on that which does not fit for the client where it is then re-organised and taken back by the client.

This study emphasises the importance of therapists listening to their own body as the projected material is picked up somatically. These unformulated experiences (Donnel Stern, 1997) that have never been articulated register in the body of the therapist. Through the process of subsymbolic processing (Bucci, 2008) the therapist accesses this implicit information through 'listening with a third ear' (Reik, 1948) or through being affectively attuned (Stern, 1985). This process of tuning in to their own somatic experience allows the therapist to access the client's 'unthought known' (Bollas, 1987). This somatic experience is a means by which rich information may be imparted. Indeed at times information revealed at a verbal level was considered contradictory to what was conveyed through the body. Therapists experienced inconsistencies between what was expressed verbally through the spoken word and what was communicated at the implicit realm of interaction through means of the body. Conflicting messages are conveyed and intercepted by the therapist on a physical level. The role of the therapist is to help the client to gain access to and communicate these experiences that have never been thought yet are known at an unconscious level. Whilst the unconscious can be brought to consciousness and can be verbalised the BCPSG (2007) outline that it is with great difficulty that it is brought to consciousness and suggest that it "*will never constitute a perfect or perhaps even good fit with its linguistic and narrated version*" (p.845).

## **5.6 The Intersubjective Space**

Participants considered that what emerges in the intersubjective space between the therapist and client represents an embodiment of the relationship. Rather than being about the therapist or the client, sensations experienced by the therapist can give information about what is happening between them. This information about what is happening relationally can give

vital clues as to how to respond. These findings are in accord with Mindell's (2004) contention that attention to symptoms in our body and the space between bodies can in fact be the medicine for healing. He states that we are not separate beings but in fact "*an unknown shared field of intensity*" (Mindell, 2004, p.125). I was particularly struck by my own experience of this deep knowing in the body in one interview. The discomfort and constriction I felt in my body was communicating what was happening in the intersubjective space between us. These sensations provided me with clues to the meaning of the participant's communications, and facilitated a deeper recognition of what was happening in the relationship.

Samuels (1985) considers the body of the therapist to be a sort of '*mid-point*' between therapist and client rather than belonging to the therapist. In this study the body of the therapist was viewed as a kind of bridge between therapist and client and healing was seen to take place in the space created by the interaction of two bodies. This interaction was seen to precipitate change in the therapeutic relationship as "*one mammal can restructure the limbic brain of another*" (Lewis, Amini & Lannon, 2000, p.177). These findings concur with Siegel's (2007) assertion that when two individuals engage they become changed by the connection as they "*begin to resonate with each other's states*" (Siegel, 2007, p.290). Interpersonal neurobiology shows us how client and therapist are continually interacting with and affecting each other thus affirming the transformative power of the intersubjective space (Wilkinson, 2010; Schore, 2007b; Stern, 1985; Trevarthen and Aitkin, 1994). The current study underscores this and helps us to understand the role of the body in these intersubjective processes and opens up new way to integrate these insights into clinical practice.

It appears from the present findings that therapy is not a unidirectional relationship in which the therapist simply observes the client's body. Our results suggest that both therapist and client are involved in an intersubjective bodily process whereby both are seen, met and felt by the other. Through this mutual, interactive process each recognises and is recognised by the other. Results illuminate a deep knowing or deep listening which is communicated

through and between bodies. This theory is analogous to Siegel's (2007, p.172) description of '*Internal State of the Other*'. Through this process both therapist and client have an awareness of each other and each senses the embodiment of their mind inside the other. This can be understood when we consider the intersubjective relationship between bodies. Our 'lived bodies' are essentially relational and through relating we gain an 'inner felt sense' of the other (Gendlin, 1981). In this exchange aspects of our lived experience that are not shared at a verbal level are sensed on a somatic level. This inner felt sense has been described by some writers as 'embodied empathy' (Finlay, 2005; Cooper, 2001). Boris (1994, p.173) states that "*The analyst is the medium in which the patient happens. It is the patient occurring within and upon him that provides him the data.*"

Within this intersubjective space both therapist and client are in synchrony and resonate at a somatic level. There is an implicit understanding and a mutual deep felt sense of the other. At these times, participants appear to experience *moments of meeting* (Stern et al, 1998). A *moment of meeting* is defined as a moment of "*authentic person-to-person connection with the therapist that altered the relationship with him or her and thereby the patient's sense of himself*" (Stern et al, 1998, p.94). In these moments there is recognition of the other's subjective reality (Lyons Ruth, 1996) and each party comprehends what is happening between them. Within these moments "*a new dyadic possibility crystallises when the two partners achieve the dual goals of complementary fitted actions and joint intersubjective recognition in a new form*" (Stern et al, 1998, p.1). Participants' reports indicate that such relating requires a level of self-reflective awareness whereby both therapist and client recognise that something new and important has taken place. Findings suggest that this level of intersubjective recognition and relating is not common to all therapy sessions and may be confined to fewer cases. Therapists described it happening over time with a client or in some very particular cases. This supports Stern et al's (1998) contention that moments such as these are rare and not characteristic of the day to day business of therapy. When they do occur they can bring about major changes in the therapeutic relationship.



Findings suggest that a 'third presence' is created from the interaction of two separate subjectivities in the room. The mutual interaction of lived bodies is mediated through body to body processes and therapist and client enter into an intersubjective state from which emerges this third 'presence'. These accounts correspond with other writers' reference to this intersubjective space as the 'third' (Benjamin, 2002; 2004; Gerson 2004; Ogden 1994). This third entity was seen to arise from the union of the client and therapist together and emerged through a co-created resonance. This implicit bodily resonance may be explained by an activation of the mirror neuron system as the brain is essentially a relational organ (Catmur et al, 2007). The 'third' is mutually constructed and is not a product of client or therapist exclusively. It is like 'a 'new presence' arising out of the space which emerges from the transaction of the two embodied beings who participate in the interaction. Participants consider that this space of thirdness emerges when the therapist opens up and surrenders to the co-created, interactive process. Working at this level required therapists to let go of the self and remain in contact with the client.

In this study, therapists were inclined to give substance or corporeal status to this third presence and referred to it as 'God' or 'Divine. I consider this third not as a fixed entity, but a dynamic series of processes. These processes are borne out of the lived phenomenal encounter of therapist and client. As this presence is neither permanent nor fixed, it is necessary to view it as a temporary construct which is contingent upon the interaction of the two subjectivities of client and therapist.

## **5.7 Implicit Relating**

Many concepts emerging from this study are congruent with those identified in previous research on implicit relating. Therapists are continually tuning into subtle somatic cues and responding to these cues. Frequently the information is out of the therapist's awareness until they are alerted to it by their body through affective prompts and responses. These findings correspond to Lyons-Ruth's (2000) contention that relational communications occurring at an

implicit level are frequently too rapid for verbal rendition and conscious reflection. Nahum (2005) describes how rich implicit processes can bring about change without requiring explicit reflection on what has transpired. This is the domain of 'implicit relational knowing'. This knowing emerges gradually from "*the co-creative relational overtures each provides the other*" (Nahum, 2005, p.698). Stern (1995) contends that therapy concerns knowing how to be with someone and it occurs through "*interactional intersubjective processes*" (p.905). Our current study indicates that these intersubjective interactional processes occur within the shared implicit relationship and are generally an intuitive and unconscious response on the part of the therapist.

Findings from this study, however, suggest that whilst these responses generally occur below awareness, at times they are intentional on the part of the therapist. This has important implications for the future direction of therapy. Whilst therapists are paying attention to the implicit messages transmitted through the body they also demonstrate an ability to raise this to a conscious level and to think about this. The therapist uses this somatic information to help the client to mentalise their experience and thus make sense of hitherto unprocessed and unreflected upon affective experiences. The capacity to work in this way is underpinned by right hemisphere and left hemisphere processing. This has important implications for psychological therapy as we move forward. It proposes that therapists can learn to use their body intentionally in order to assist in the emergence of new experience from implicit to explicit. The body has an important role to play in midwiving the emerging experience.

## **5.8 Practical Implications**

This study provides a potentially useful perspective from which to view what happens between bodies in the therapeutic dyad. This model serves as a rich focal point for therapists to shine a spotlight on what happens between bodies in therapy. Whilst much relating takes place at a somatic level rather than a verbal one, many therapists lack the knowledge, skill and experience to engage with this realm. Stern et al (1998, p.94) refer to the implicit as '*the*

*something more*' and argue that modalities which believe in the supremacy of interpretation – miss out on this something more. The model proposed here complements existing models by drawing attention to the unconscious implicit bodily exchanges between therapist and client. It also furnishes us with a framework by which therapists can ground their practice and move towards a greater inclusion of an embodied approach to psychological therapy. The theory developed in this research provides a framework with which implicit somatic relating within the therapeutic setting might be observed.

Knoblauch (2008) insists that attention to embodied experience is central to the therapeutic process. Shaw (2003) contends that psychotherapy is inherently an embodied process. However findings demonstrate that therapists can only relate to self as an embodied system when they are attuned to themselves, to the client and to the relationship between them. Hence it is crucial that therapists remain experience near and become sensitised to the somatic undercurrents of relating in the therapeutic setting.

This research has significant implications for how we train therapists to attend to the communication between people that lies beyond language. A common experience for participants after the interviews was the realisation that they were attending to their own body much more than they had realised. This model has the potential to assist therapists to tune into the micro-processes of relating and make interventions based on material at implicit levels. This can be done by applying the current framework to their client work and shining a light on the implicit bodily exchanges that are taking place. It can alert therapists to the idea that what they pick up somatically can represent something in the client or in the dialogue between therapist and client. This can have an impact on how they respond to their clients. Application of this framework could also assist therapists in determining if the somatic experience belongs to them, the client or both and equip them to handle it sensitively and appropriately.

Whilst we have seen a shift within psychotherapy towards a greater focus on implicit relating the empirical evidence exploring therapist's experience of this

is scanty. The bulk of the data from research on the therapeutic process attends to client's verbal and cognitive processes. When we view therapy as a right-brain to right-brain interaction we see how research focusing only on left hemisphere processes leaves a gap. There is a need for more research to understand the factors that operate at an implicit level, beyond language and cognition. The model presented here provides us with an orientation for continued research into what is happening between bodies in the psychotherapeutic relationship. It provides us with a lens with which to view change and the way we think about our clients and the intersubjective relationship.

This research explored how the body of the therapist registers information in response to the body-self of the client. This model of working could pave the way for new therapeutic tools to be developed which consider the centrality of the therapist's body. These tools could enrich our therapeutic practice and inform treatment models. They can also serve as a resource for supervisors and trainers.

The current model has important implications for therapists. By applying this theoretical framework to their work it can assist them to train their eye to see differently and to perceive what is happening between two bodies rather than within each individual body. This framework could be applied by focusing on each particular subcategory or honing in on the one which is most relevant in to particular case. McTaggart (2011) encapsulates the power of this learning when he says *“By learning to see the space between things – we may learn to recognise the connections that were always there but remain invisible to the Western eye: the connections that tie us all together. We will begin to recognise what is most invisible of all: the impact of ourselves on others”* (McTaggart, 2011:142).

## 5.9 Limitations of the Research

My own interest in this area and my professional background may have had an impact on the interaction with participants and the meaning attributed to actions and behaviours. However, reflexivity was built into the study as a whole and I continually reflected on my own beliefs and assumptions and how this may have had a bearing on the research.

This study examined therapist's experiences and their perspective on what was happening. However Clients may view it very differently. Research exploring clients experience of what happens between bodies may yield different results and could add a rich understanding of the embodied intersubjective relationship.

I was Interested in what happens between two bodies in the therapy room irrespective of therapist's modality. A future study which pays attention to particular modalities may generate interesting results.

In this study I was relying on participant recall and thus may need to question the validity of this. A semi-structured interview was used to assist recall. In order to enhance the validity a study which captures the micro-processes of the interaction between therapist and client could be carried out. This could be achieved by video recording client sessions and analysing the video recording similar to methodologies used in mother-infant studies. This could be further substantiated by asking therapist and client to comment on the session.

Charmaz (2006, p.96) describes theoretical saturation of a category to mean that *"through constant comparing .. the conceptualisation of each comparison yields properties of the category until no new properties emerge"* . However given the constraints of time and resources this study was unable to reach 'theoretical saturation' or the point at which no new codes or categories or relationships emerged. These limitations resulted in achieving *"theoretical sufficiency"* (Dey 1999, p.257) rather than *"saturation"*.

A study using an IPA methodology to explore what it is like for therapists to live a particular situation could yield very interesting and rich results. Exploring what it is like to experience the 'Embodied Process' or 'Intersubjective Space' could give us a deeper understanding of what it is like to encounter and work with these particular processes in therapy.

This study did not differentiate between client presentations and the level of somatic relating between bodies. A valuable study would be to focus on clients with borderline presentation or psychotic clients as they are more likely to project their embodied feelings onto the therapist (Stone, 2006). Grant & Crawley (2002) contend that more and more clients with borderline and schizoid presentations are presenting for counselling thus it would be interesting to explore further what happens between bodies in the intersubjective relationship for clients with different presentations.

## 6. CONCLUSION

In the traditional Cartesian split mind and body were deemed to be separate entities. The domain of language and non-verbal experiences were believed to be separate. However a contemporary view considers that we cannot feel, think, imagine or have sensations without the participation of our bodies. As embodied beings our lives are centred around relationships with other embodied beings.

This study highlights the way in which the body of the therapist is at the centre of their experience. Findings demonstrate the process by which body to body processes facilitate right hemisphere relating. These processes mediate the emergence of Connection, Somatic Experiencing of Other, Embodied Process and Intersubjective Space - thus giving rise to therapeutic change. These embodied intersubjective mechanisms serve to assist therapists in understanding and gaining deeper insight into the client's process and/or the relationship between client and therapist.

Within the limitations of its sample, the study adds to an understanding of what happens between bodies in therapy and the implications this has for future ways of working. This study extends current theory on the embodied intersubjective relationship and opens up new ways to integrate these insights into clinical practice. It stimulates the generation of new questions and a fresh approach to embodied therapeutic interaction. It assists our understanding of the link between our bodies and the implicit realm of relating and gives us an insight into the detail of finely co-ordinated attuned interactions. Attention to what happens between bodies takes us into the specificity and micro-processes of the dyadic relationship. It is hoped that this study will facilitate greater understanding of what happens between bodies and implementation of an embodied implicit relational model.

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# APPENDIX A

## Invitation to Participate in a Research Project

Dear Therapist,

I am a Registered Counselling Psychologist and currently in the fifth year of a Doctorate at Metanoia Institute, London. I am carrying out investigative research into the therapist's experience of their own body in psychotherapy.

I would like to meet with you for one interview, which is likely to last about one hour. The aim of the interview is to talk through your experiences of use of body in psychotherapy. I will be supervised at all times by Professor Vanja Orlans (Metanoia Institute). The results of this study will be written up as a doctoral thesis.

If you wish to take part in this study I am enclosing an information sheet with further information. If you would like to find out further information, I would be delighted to hear from you. You can contact me at [gsheedy@ireland.com](mailto:gsheedy@ireland.com) Tel: 087 6872204

I look forward to hearing from you

Yours Sincerely

Geraldine Sheedy  
MA Counselling Psychology, MIACP, Reg. Psychol PsSI



## **INFORMATION SHEET**

**Study Title:** An Exploration of an 'Embodied Relational Approach' to Working with Trauma  
**Researcher:** Geraldine Sheedy MA Counselling Psychology, MIACP, Reg. Psychol.

### **Participation**

If you decide to take part you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

### **What happens if I take part?**

If you agree to take part, the researcher (Geraldine Sheedy) will contact you to arrange a convenient time/venue for an interview. The interview will take place at your Centre or a pre-arranged venue. The researcher will ask you a series of questions relating to your use of body in psychotherapy.

### **What are the possible disadvantages and risks of taking part?**

There are no potential hazards in taking part. Participation is completely voluntary and if you feel like stopping the interview at any stage you can do so.

### **What are the possible benefits of taking part?**

The study will give you the opportunity to explore the way in which you work with clients. Benefits may arise from gaining insight into your own bodily process, contributing to research in this area and enable you to better understand your experience.

### **What happens to the information I give?**

The interview will be audio taped so that it can be transcribed at a later date. It will be transcribed by the researcher. Following completion of the doctoral studies the tapes will be destroyed. Whatever you say will be treated as anonymous and confidential. Confidentiality is very important and all transcripts of interviews will be made anonymous and only distinguishable by number.

Following transcription of your interview I will forward the transcript to you. At this point you can check for any errors and/or ask to delete any information which you do not wish to have included in the research.

I will be supervised at all times by Vanja Orlans (Metanoia Institute).

### **What happens to the results of the study?**

The results of this study will be written up as a doctoral thesis. No participant will be identified in this thesis. Following completion of the study I will forward the findings to you if you wish to receive same.

### **How can I find out more about the research?**

If you have any further questions about the research, then please get in touch with me. You can contact me at [gsheedy@ireland.com](mailto:gsheedy@ireland.com) tel: 087 6872204. If you wish to take part I would be delighted to meet with you at a time and place that is convenient for you.

**APPENDIX B**  
**CONSENT FORM**

**Study Title:** An Exploration of an 'Embodied Relational Approach' to Working with Trauma  
**Researcher:** Geraldine Sheedy MA Counselling Psychology, MIACP, Reg. Psychologist.

**Please  
initial box**

<b>1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions</b>	
<b>2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason</b>	
<b>3. I understand that the interview will be recorded on audiotape</b>	
<b>4. I understand that what I say will be confidential. Names won't be used in any writing</b>	
<b>5. I agree to take part in the above study</b>	

**Date:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

## APPENDIX C

### INTERVIEW SCHEDULE

1. Are you paying attention to you own body when working with clients?  
If yes, how are you paying attention to your body when working with clients?
2. Are you aware of what happens for you at a physiological level in the therapy session? How are you aware of this?
3. What are you doing at a bodily level with clients? (particularly at a somatic, non-verbal level).
4. Are you aware of using your tone of voice, eye contact, breathing or body language in the room to impact on the client?'
5. Do sensations in your body give you information about the client?  
In what way?
6. Are you aware of being attuned to your clients? If so how do you attune at a bodily level?

#### ***Later changed to***

Are you aware of what is happening between your body and the body of your client? Expand

7. Are clients impacted by your body?  
If yes, in what way?
8. Are you impacted by the client's body?  
If yes, in what way?
9. Is there anything else you wish to add?

## APPENDIX D

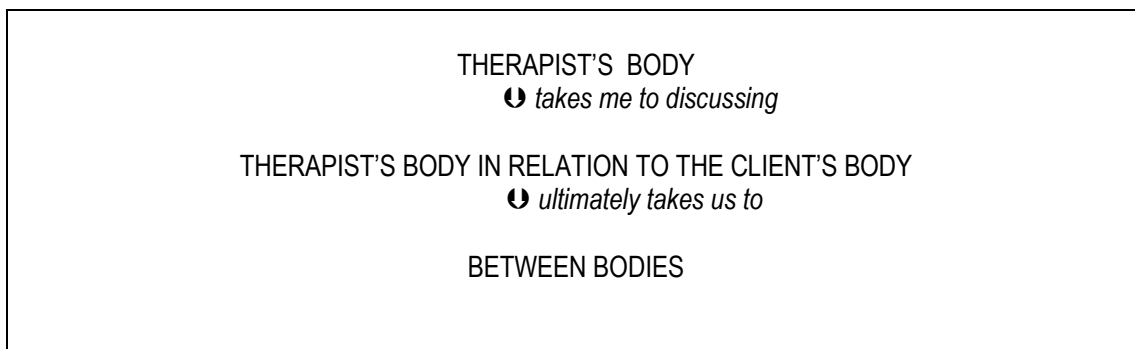
### Example of Memo-Writing

#### **Memo 24: Movement from therapist's body to between bodies**

As I reflect on the exploration I see a pattern emerging whereby I began by asking therapists about their own body but very quickly they moved into what happens between them and the client – can't talk about their own body in isolation. This movement in the interview from 'I' to 'We' is reflected in the therapy sessions. Also reflected in the movement to a **two person psychology**.

The body is a gateway into the 'between'. A gateway or door into 'the zone'. Body can be seen as an avenue into the transitional space. Therapists can use their body as a gateway to 'the between'.

*Diagram to help me gain a greater sense of this movement..*



#### **Memo 44: PreMentalised material shows up in the therapist's body**

Clients sometimes not aware of a sensation/ but therapist feels it palpably. Pre-mentalised material is 'taken in' by the therapist. Therapist 'holds' this for the client. This is like Bollas's *Unthought Known* OR Bucci's *Subsymbolic Processing*.

Can access this material by focusing on the body. Thus therapists need to connect in with their own body in order to access it. Importance of CONNECTION to self.

#### **Memo 63: Implicit Processes and Right Hemisphere**

When participants talk about what happens between bodies the processes they describe are implicit processes (e.g. tone of voice/ eye contact/ posture). In order for implicit processing to take place therapists need to be in a '*state of right brain receptivity*' (Schoore 2005, p.842). Thus right hemisphere to right hemisphere communication is the dominant force when relating between bodies.

The implicit processes of the sub-category body to body (e.g. attuning, regulating, detecting, listening with body) all involve this right hemisphere to right hemisphere processing. Thus the therapist is in a '**right hemisphere receptive**' state. This then enhances further implicit processing. Body to Body processes mediate movement between other sub-categories.

## APPENDIX E

### Letter of Ethical Approval



13 North Common Road  
Ealing, London W5 2QB  
Telephone: 020 8579 2505  
Facsimile: 020 8832 3070  
[www.metanoia.ac.uk](http://www.metanoia.ac.uk)

Geraldine Sheedy  
'Shambala'  
Milltown  
Killarney  
Co. Kerry

28<sup>th</sup> February 2008

Dear Geraldine,

RE: An Exploration of an 'Embodied Relational Approach' to Working with Trauma

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please discuss these with your research supervisor in the first instance, and inform me as Chair of the Research Ethics Committee.

Yours sincerely,

A handwritten signature in blue ink that reads 'Patricia Moran'.

Dr Patricia Moran  
Research Co-ordinator  
Chair of Metanoia Research Ethics Committee

## APPENDIX F

### Example of Line by Line Coding (Interview No. 1)

1.34 1.35 1.36	P	Naturally enough there can be occasions where I might feel maybe.. even in a recent session where the client was kind of in such pain, and I could feel pain in my own stomach	<b>CLIENT IN PAIN THERAPIST FEELS CLIENT'S PAIN</b>
1.37	I	you could actually physically feel it?	
1.38 1.39 1.40	P	literally. And yet there was also something about not trying to get rid of the pain in any way, but just literally stay. Do you understand?	<b>NOT GETTING RID OF THE PAIN IT'S ABOUT STAYING</b>
1.41	I	Hmm	
1.42 1.43 1.44 1.45	P	but I can't say that was about the client or it was about.. it was something about the dialogue and something about the nature of what was going on. So I think that I listen to it. I don't say.. 'oh this is about the client'.	<b>TELLING ABOUT THE DIALOGUE TELLING WHAT IS GOING ON LISTENING TO THE SENSATION NOT MAKING IT ABOUT THE CLIENT</b>
1.46	I	yeah	
1.47 1.48 1.49 1.50 1.51 1.52 1.53	P	and I know there are theories that will tell you a specific experience you are having in your body might be about a trauma a client has had. And I respect that. But I can't say that I would ever be that definitive as to what its telling me. So its part of a communication about what's going on in the same way... y'know I really think you're doing a very tough area because so much of what we actually know we can't articulate.	<b>SOME THEORIES MAKING LINK  NOT DEFINITIVE  COMMUNICATING WHAT'S GOING ON  IT'S A TOUGH AREA  DIFFICULT TO ARTICULATE MUCH OF WHAT WE KNOW</b>
1.54	I	yes	
1.55	P	so what you're trying to access in some ways is my	<b>ACCESSING COGNITIVE INTERPRETATION</b>

1.56		cognitive interpretation of what happens	
1.57	I	absolutely	
1.58 1.59 1.60	P	and I think if you'd probably been in my last session with me and taped that you'd probably have a lot more to work on than what I'm trying to articulate now.	<b>IF TAPED LAST SESSION MORE TO WORK ON</b>
1.61	I	yeah	
1.62 1.63 1.64 1.65 1.66 1.67	P	but I think if I suddenly feel something.. or if I feel an incredible tiredness where I'm absolutely feeling a repetitive sleepiness with a particular client and suddenly at the next session its gone it makes me question about what is my body communicating to me about what's happening in the in-between	<b>FEELING SOMETHING SUDDENLY FEELING TIRED OR SLEEPY MAKES ME QUESTION SENSATION ONLY PRESENT WITH CLIENT BODY COMMUNICATING WHAT'S HAPPENING IN THE 'IN-BETWEEN'</b>
1.68	I	hmm.. yeah	
1.69	P	more than about the client.	<b>NOT ABOUT THE CLIENT</b>
1.70	I	Right.. the relationship.	
1.71 1.72 1.73	P	Correct yeah. the dialogue.. the in-between maybe.. the third, whatever theory you want to talk about. But for me its something that I'm embodying the dialogue.. as is the client.	<b>'THE THIRD' 'THE IN-BETWEEN'  THERAPIST &amp; CLIENT EMBODY THE DIALOGUE</b>
1.74	I	yeah.	
1.75 1.76	P	and somehow I can't really fully interpret that as being one or other.	<b>DON'T INTERPRET SENSATION AS BEING ONE OF THE OTHER (THERAPIST OR CLIENT)</b>
1.77	I	aha. It's the between.	
1.78 1.79 1.80 1.81	P	It is the between. And I suppose I've begun to trust more of that communication about the between, the communication ... than actually 'oh well she was y'know something.. or he was'	<b>COMMUNICATION ABOUT THE BETWEEN  NOT ALWAYS ABOUT THE CLIENT</b>

## APPENDIX G

### Example of Focused Coding

#### FOCUSED CODE: USE OF BODY

Focused Code	Participants contributing to this Code <small>No. corresponds to participant</small>	Participant	Key cross references	Indicative Quotes <small>(With reference to sentence number)</small>	Notes
<b>USE OF BODY</b>	1, 2, 3, 4, 5, 6, 8,	1	<b>Connection</b>  <b>First Meeting</b>  <b>Implicit Relating</b>	‘I use my body to do that’ (1.428) ‘Impossible not to communicate with body’ (1.138) ‘what happens when they’re new. I attend to all my stimuli’ (1.246) ‘We’re probably using body an awful lot more’ (1.726) ‘My tone of voice is used to calm’ (1.899)	Bodies are communicating with each other all of the time (body to body)  The implicit use of body/ RH to RH relating
<b>USE OF BODY</b>	1, 2, 3, 4, 5, 6, 8,	2	<b>Mirroring</b>  <b>Somatic Experiencing of other</b> <b>Tracking with the body</b>	‘I might mirror back to the client’ (2.1516) I use my own body to evaluate the boundary’ (2.227) ‘I’m tracking their breath’ (2.541) ‘I actually tell myself to ground’ (2.975)	Much of this appears to happening at an unconscious level (Vs Intentional)
<b>USE OF BODY</b>	1, 2, 3, 4, 5, 6, 8,	3	<b>Listening with the body</b>	‘I’ll adjust the distance’ (3.71) ‘the way you sit and position yourself makes a difference’ (3.85) ‘I’m listening with the whole body’ (3.87)	Communication is happening between bodies (body to body)



<b>Focused Code</b>	<b>Participants contributing to this Code</b> No. corresponds to participant	<b>Participant</b>	<b>Key cross references</b>	<b>Indicative Quotes</b> (With reference to sentence number)	<b>Notes</b>
<b>USE OF BODY</b>	<b>1, 2, 3, 4, 5, 6, 8,</b>	<b>4</b>	<b>Mirroring</b>  <b>Attuning with the body</b>   <b>Between Bodies</b>  <b>Intentionality</b>	‘I’m mirroring’ (4.23) ‘I have a calming presence’ (4.253) ‘I’m in tune with her in a physical way’ (4.26) ‘very much in tune with my own body’ (4.18) ‘keep myself grounded’ (4.19) ‘When she is becoming ungrounded I would be aware of my own toes going into the ground’ (4.737) ‘I often even sit myself back physically in the seat and put my two feet on the ground’ (4.263)	Much attuning is happening at an implicit level – happening body to body  NB to be grounded and attuned to self in order to be attuned to other.
<b>USE OF BODY</b>	<b>1, 2, 3, 4, 5, 6, 8,</b>	<b>5</b>	<b>Mirroring</b>  <b>Intentionality</b>	‘It wasn’t until I was mirroring her that she changed something’ (5.83) ‘it would be a big part . to use my body’ (5.393) ‘I’d make a conscious.. I would breathe loudly’ (5.358)	Impact of one body on another  Conscious use of body/ using body
<b>USE OF BODY</b>	<b>1, 2, 3, 4, 5, 6, 8,</b>	<b>6</b>	<b>Mirroring</b>   <b>Connection</b>  <b>Between Bodies</b>	‘I’d mirror sometimes’ (6.494) ‘I knew from my tone that I was getting angry’ (6.633) ‘How far I sit forward in the chair’ (6.515) ‘I’m not taking my eyes off them very much’ (6.267) ‘The way my body dances with another body’ (6.900)	Body knows before we do  The dance between bodies is an interesting analogy

<b>Focused Code</b>	<b>Participants contributing to this Code</b> No. corresponds to participant	<b>Participant</b>	<b>Key cross references</b>	<b>Indicative Quotes</b> (With reference to sentence number)	<b>Notes</b>
<b>USE OF BODY</b>	<b>1, 2, 3, 4, 5, 6, 8,</b>	<b>7</b>	<b>Connection</b>	‘Something goes on at the physical level’ ‘I moved my left foot.. just to make contact’ (7.578)	
<b>USE OF BODY</b>	<b>1, 2, 3, 4, 5, 6, 8,</b>	<b>8</b>	<b>Giving Information</b>  <b>Somatic Experiencing of Other</b>	‘I consult my body for the most part’ (8.42) ‘Aware that my body is a source of information for me’ 8.46) ‘name my own physical sensations’ (8.77) ‘I’m registering something physically in that’ (8.449) ‘my voice is an important part of that – the calmness, the steadiness’ (8.334)	

## APPENDIX H

### FINDINGS

#### 1. SUB CATEGORY – BODY TO BODY

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
Detector	Detector or gauge/ Alert therapist Precede awareness Be discerning/ check Reliable	3, 6, 7, 8, 9, 11, 12,	<i>'a thermometer' (12)</i> <i>'a barometer' (11)</i> <i>'my cue' (9)</i> <i>'strongest indicator' (7)</i> <i>'body knows before we know' (6)</i> <i>'will immediately notice' (8)</i> <i>'echoes in my own body' (3)</i>
Mirror	Conscious and Unconscious Mirror emotional state Brings about change Like a dance	1, 2, 4,5, 6, 7, 11	<i>'get a sense of their experience/put my body into that' (1)</i> <i>'we can do that dance together' (2)</i> <i>'mirror automatically' (7)</i> <i>'two bodies dancing' (6)</i> <i>'consciously be breathing with her' (11)</i> <i>'sitting in the same way that she sits' (4)</i> <i>'And it wasn't until I was mirroring her that she changed something' (5)</i>
Regulator	non-verbal aspects  Mutual regulation	1,4, 5, 7, 8, 10, 12	<i>'tone of voice' ( 4, 8, 5)</i> <i>'breathing and grounding' (12)</i> <i>'use my body to regulate' (7)</i>

<b>Properties of this subcategory</b>	<b>Dimensions of the properties</b>	<b>Participants contributing to the properties (No. corresponds to participant)</b>	<b>Indicative Quotes (No. corresponds to participant)</b>
			<i>'Client regulating me too' (1)</i>
Attuner	Physically /Bodily attuning Attunement to emotional states Through voice In or out of awareness Fine-tuning the relationship	1, 3, 4, 7, 8,	<i>'Attuning with the bodies' (3)</i> <i>'it's not the head' (7)</i> <i>'with voice or with body' (8)</i> <i>'more consciously attuned at time' (1)</i> <i>'I'm in tune with her in a physical way' (4)</i>
Listening and tracking with the body	Beyond the explicit content level, Enriches therapy. Listening with their whole body Using their physical sensations Understand what is happening for the client More empathic What is needed in that moment.	1, 2, 3, 4, 5, 7, 10	<i>'listening with the whole body'</i> <i>'With my body, I'm listening to tensions'</i> <i>Staying with a level below content.. it's more alive.. I'm picking up more. (10)</i> <i>That gives me a clue to how the client might be feeling. (1)</i> <i>The psychological piece shows up through my own body (2)</i> <i>I'm tracking this particular tension in my chest. (7)</i> <i>'I would be aware at times of my own toes going into the ground' (4)</i> <i>'I notice sometimes ... there is a tendency to [move forward]' (5).</i>
Giving Information	Gives information about the client. How clients appear outside. Can help in response. First session is a vibrant time	1, 3, 6, 7, 8 11	<i>'a gateway into what it might be like for the client' (3)</i> <i>'it also told me what it must be like to meet a person like this out in their other world' (1)</i> <i>'that gives me information or directs me in my response' (8)</i>

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
			<p><i>'when I meet a client first because that newness. It's a new.. it's really the first impact' (6)</i></p> <p><i>'I was using it as information' (11)</i></p> <p><i>If I start to notice that I'm getting very heavy headed or I'm getting busy or I start to feel something' (7)</i></p>
Pre-Sensing	Register in body – anticipation/ premonition.	4, 5, 8	<p><i>'I'd be feeling it already. it's a trigger for me' (4)</i></p> <p><i>'it was mounting up, and I knew that' (5)</i></p> <p><i>'I knew something was about to come into the room' (8)</i></p>

## 2. SUB CATEGORY – CONNECTION

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
<b>Connection to Client</b>	Meeting of two psyches. At the boundary where bodies meet Physical body is channel of connection Different ways body makes connection	3, 4, 6, 8	<i>'You're out there at the boundary, meeting it. And connecting. The boundary connects to her' (3)</i> <i>'And I couldn't make any contact with her. So my only way to reach her was to use my body' (4)</i> <i>'so there would be real eye to eye connection' (6)</i> <i>'just touch was worth a million words' (8)</i>
<b>Beyond Words</b>	Beyond words Connection known in and through the body	1, 5, 6, 12	<i>'the body allows something beyond words' (1)</i> <i>'Words fall short really for it' (6)</i> <i>'more than words can ever do' (5)</i> <i>That's an example of the communication that happens without words' (12)</i>
<b>Energy</b>	Word 'energy' describes connection. Body makes the appropriate moves to stay in connection – before mind knows	5, 7, 9, 10	<i>'this flow of energy that is moving constantly between the individuals.'</i> (7). <i>'it's like an energy in the room' (9)</i> <i>'a heightened energy... probably body to body again' (10)</i> <i>'there can be an energetic connection' (9)</i>

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
			<i>'and the body deciding not to lose the client. so me sitting forward' (5)</i>
<b>Interconnection</b>  <b>CROSS REF WITH THE 'IN BETWEEN'</b>	Reciprocal and Mutual Process Shared implicit connection Described as 'the eight'.	1, 2, 7,	<i>'And so there's this sort of interweave in the space between' (2)</i> <i>I am all the time tuning into what's happening with a client and responding out of that because we are in relationship. I often describe it as 'the eight'" (7)</i> <i>'How do you describe what happens when somebody comes in, in immense pain and you touch them in some way and they go out feeling something has shifted but they don't know what has shifted and you don't know what has shifted (1)</i>
<b>Connection to Self</b>	Crucial to establish contact with self Attuned internal state precipitates greater interpersonal connection Like a dance. Connection maintained through Continual awareness and mindfulness of body. Staying with one's own body	2, 4, 5, 6, 7, 9, 11	<i>'getting very tuned into your own body and be aware of the contact with yourself .. and then the contact with the other person' (11)</i> <i>'it probably wants to tell me something that I wouldn't be conscious of if I don't connect into my body' (6)</i> <i>'It's about mindfulness and awareness..</i>

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
	Encourage clients to stay connected to their physical being. Parallel process in Interview		<p><i>Grounding.. Feeling my feet. Noticing my breath. (7)</i></p> <p><i>'just being aware to sit back.. that when I'm getting too involved... sit back and breathe (4)</i></p> <p><i>'tell myself to ground.. and use the support of the chair' (2)</i></p> <p><i>'And I really had to ground myself ..cos there was no point in the two of us going off'. (4)</i></p> <p><i>'Just breathe, feet on the floor... grip my toes so that I can feel the floor' (5)</i></p> <p><i>'I would breathe in through my nose and ... just push my feet into the ground, just so I'm more connected'. (9)</i></p> <p><i>'she can be in contact with herself. And then we can be in contact with each other' (4)</i></p>
Disconnection	Physical sense of disconnection Provides important information	1, 6, 8, 11, 12	<p><i>'maybe I'd call it disconnection... Where I have a sense maybe that the client isn't in the room, or in connection with me (1)</i></p> <p><i>'I don't feel connected to the emotion' and then... they would say "I'm not connected to it myself"' (6)</i></p>



### 3. SUB CATEGORY – Somatic Experiencing of Other

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
<b>Experiencing Clients at a Somatic Level</b>	<p>Sensitised to somatic experiences</p> <p>Perceive through bodily responses</p> <p>Experience client at a deep bodily level</p> <p>Use of metaphor to express somatic experience</p> <p>Therapist's body is the only tool to access information about the client</p> <p>Somatic information can be at variance with what they are experiencing at other levels.</p>	1, 4, 6, 9	<p><i>'I've often felt nauseated with clients. I've felt very sleepy with clients. I notice more tension in myself.. distraction.. numbness.. force' (1)</i></p> <p><i>'it is very sickening.. so horrific that it's palpable in my body.. it's physical. I can feel it in my tissues.'</i> (4)</p> <p><i>'having the sense of wanting to water the plant.'</i> (1).</p> <p><i>'unless I was feeling it inside myself..'</i>(6)</p> <p><i>'when I was staying with my body and it was like there was a contradictory thing going on' (9).</i></p>
<b>Experiencing what client experiences</b>	<p>How one body senses the experiences of the other</p> <p>Sudden and dramatic</p> <p>Sensations reflect accurately what the client is experiencing</p> <p>Corroborated by the client</p> <p>Don't automatically assume causal connection</p> <p>Different ways of testing this -monitoring body/</p>	1, 2, 3, 4, 8, 10, 11	<p><i>'And when for example clients leave their bodies and they're in their heads... And I notice my own struggle to come down' (2)</i></p> <p><i>'this wave of cold sensation just washed over me' (3)</i></p> <p><i>'I'd be aware of .. say for instance with one person feeling quite sick in my</i></p>

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
	Put information back out/ Share collaboratively/ Hold in awareness		<i>tummy.. . And it might come up then with her that she actually feels sick' (4)</i>
<b>Overwhelm</b>	Picking up the client's unconscious material at a somatic level Being physically attacked or bombarded Feeling a sense of attack Can loose touch with own body Difficult to contain overwhelming somatic experiences Means to deal with overwhelm Can also enrich the interpersonal encounter Empathise at a bodily level with client Gain insight into clients world	1, 2, 4, 7, 8,9, 10	<i>'absolutely bombarded at a physical level' (4)</i> <i>'and I would be down on the floor' (7)</i> <i>'the sense of force coming from attack. Coming from them. Literally physical. I would find myself pinned against the wall' (1)</i> <i>'I often notice when I get seduced into the speed' (2)</i> <i>'like two magnets repelling off each other .. like a car crash in my own body .. almost like violent internally connecting in, being pulled out (9)</i> <i>'intolerable and unbearable' (8)</i> <i>'I just have to hold myself together, and keep breathing and wait, and hold myself back as well' (10)</i> <i>'It gave me a sense of the extreme terror that he would be feeling' (10)</i>
<b>Interfere with the Session</b>	Can interfere with the therapy session or with the therapist's ability to remain present May decide not to work with client	1, 2, 6, 7, 10	<i>'the energy that that takes up, in my experience, fills the whole space. And in its doing will begin to annihilate</i>

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
			<p><i>anyone else that's in that space' (7)</i>  <i>'One client I didn't take her.. and I just got the willies... an absolute repulsion' (6)</i></p>
<b>After the Session</b>	Continues even after the session is over Different ways to deal with this	3, 4, 5, 8, 9, 12	<p><i>'I do need to go and get support after each session' (4)</i>  <i>'I'd want to wash myself after they leave.. or I'd want to walk or shake my head or shake my hands' (5)</i></p>
<b>Client Presentations</b>	Link between physical reaction and client's diagnostic presentation.	7, 8, 10, 12	<p><i>I often can feel the anger in my own body.. that they're experiencing. ..that they're not quite ready to face up to (12).</i>  <i>'a client I worked with ..who had quite a borderline process. And I used to regularly experience quite a degree of terror' (7)</i>  <i>'one client I worked with.. and she had quite a schizoid process.. I was registering myself... part of the spacey feeling but quite a depletion of energy as well' (8)</i>  <i>'I was seeing a young man who was diagnosed as schizophrenic. I remember one day I had this very acute feeling of my nipple had been bitten (10)</i></p>

#### 4. SUB CATEGORY – EMBODIED PROCESS

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
<b>Integration of Physical and Mental Processes</b>	<p>Interplay between sensations, feelings and thoughts</p> <p>Emotions anchored in bodily sensations</p> <p>Progression from somatic experiencing through to emotions leading to mental processes</p> <p>Clients experience intense arousal but unable to put words on it – felt in body of therapist</p> <p>Through self-reflection therapist identifies accompanying emotion</p> <p>Thoughts have a physical component</p> <p>Feelings appear to be the product of sensations</p> <p>Lack of clear distinction between sensations and feelings</p> <p>Blurring of boundaries</p> <p>May echo complexities in differentiating sensations from feelings.</p>	<p>1, 7, 9,</p>	<p><i>'when I am emotional in sessions with clients I think that's very much a part of body... that kind of depth of emotion is real bodywork as well.. body.'</i>(1)</p> <p><i>'I'll listen to what's going on in my body.. might be a tightening in my chest or a little bit of breathing... and I'll name an emotion.'</i> (9)</p> <p><i>'First it would come to my awareness and it would be a case of uh huh.. I sense this.. let me just hold that for a minute and then see what unfolds from there. So it's like a registering of it.'</i> (9)</p> <p><i>'I might check in was there a feeling that goes with that.. maybe the emotions will come..'</i> (7)</p> <p><i>'If I go with body sensations it was almost like a tingling.... And naming the feeling that was going on.. and naming that as grief.'</i> (9)</p>

<p><b>Window into Clients World</b></p>	<p>Therapist's somatic reaction provides window into client's subjective experience  Empathise at a bodily level with clients  Deepen understanding of client  Gain a greater insight into the client's world  Happening at a pre-verbal level - no words. Somatically experiencing what client is unable to verbalise.  Clients aware of these feelings  Somatically holding the client's unresolved material  Client gradually comes to tolerate the feeling</p>	<p>4, 5, 8, 10, 11, 12</p>	<p><i>'it felt like in my heart area I was being sucked into a whirlpool. Sucked in.. and I just had to let it happen and I might die in it.. it gave me a sense of the extreme terror that he would be feeling'</i> (10)  <i>'it's a bit unconscious to them... I'd often feel it before they'd feel it.. (12)</i>  <i>'I was feeling at the time was what she was feeling.. but she wouldn't have been ready to look at her anger at all'</i> (5)  <i>'I noticed my own fear intensified a great deal during that time. And yet she was presenting quite matter of factly really.(8)</i>  <i>'And I used to regularly experience quite a degree of terror in the room. And understood I suppose after a while that it was a very unacknowledged terror in herself' (11)</i>  <i>'I was carrying the client's anger.. I was very conscious of it in my body.. and I would have fed it back to her.'</i> (4)</p>
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<p><b>Naming Resonates</b></p>	<p>Resonates with client.  Naming arrived at through a process of feeling the sensation in the body, registering this and then naming it.  Containing for client.  Getting there before the client arrives  Client astonished therapist 'gets it'  Therapist 'digests' the feeling before the client is able to acknowledge it</p>	<p>2, 4 8, 9.</p>	<p><i>'so in my verbalisation of my being able to identify what happens in my body and using that to check out with the client's.. and noticing if that registers or not' (2)</i>  <i>'I'll take the risk and put it out there' And it immediately registered with him (8)</i>  <i>'It's being in tune with the client on an emotional level and sometimes being there before they arrive' (4)</i>  <i>'all the time it is about the client and what it's like to be in their world their shoes.'</i> (9)  <i>'I'll name an emotion and sometimes it's just met with complete unbelievable kind of 'how would you know that?'</i> (9)  <i>'the telling of it I think was his first step towards realising how unbearable it had been for him as a young child.. .. the idea of container is key... he could get it in a digested form.'</i> (8)</p>
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## 5. SUB CATEGORY – INTERSUBJECTIVE SPACE

Properties of this subcategory	Dimensions of the properties	Participants contributing to the properties (No. corresponds to participant)	Indicative Quotes (No. corresponds to participant)
<b>Embody the Relationship</b>	Space that emerges between therapist and client Belongs to neither therapist nor client Experience communicates about the relationship Not about the therapist or client individually Sensations can give information about the process Sensations in particular 'spots' (locations) in the body Data about what is happening relationally Holding and expanding one's curiosity Allows significance to unfold. Physical sensation may indicate unspoken communication between therapist and client May indicate what needs to be said 'Moved' to respond in various ways Imparts information about relationship	1, 2, 6, 7, 8, 10, 11	<i>'it was something about the dialogue and something about the nature of what was going on' (1)</i> <i>'I no longer make the leap that it tells me about the client.. it gives me something that I might speculate about what's going on between us' (6)</i> <i>'the experience of feeling as if my face had caved in... And I did feel like I was under attack' (1)</i> <i>'I was beginning to recognise these spots myself .. this must be something to do with support' (11)</i> <i>'it makes me question about what is my body communicating to me about what's happening in the in-between' (1)</i> <i>'checking in.. has something happened between us that I've been activated somehow' (7)</i> <i>'If my body could speak it would be saying 'this had to stop' (10)</i>

<p><b>Shared Knowing</b></p>	<p>Somatic resonance or attunement that takes place in the intersubjective space          Implicit understanding          Inner-felt sense          Mutuality          Sensing what the other senses          Gut feeling/ intuition</p> <p>Parallel Process in Interview</p>	<p>1, 2, 3, 5, 7, 8, 9, 10, 12,</p>	<p><i>yeah you get me' (9)</i>  <i>'client can sense 'oh my God she really got it' (5)</i>  <i>'And I remember that client coming back and saying that she'd never felt anyone had understood her until she saw tears in my eyes' (1)</i>  <i>'My body was actually feeling sorry for her body and it was saying 'no more'. So it's right brain talking to right brain' (10)</i>  <i>"a deep listening.. And it's within us.. it's in our very being' (7)</i>  <i>'It's intuitive.. which is of the body..' (2)</i>  <i>the place it comes from is the gut... it's from the body (8)</i>  <i>'stay tuned into my body. I just had a feeling that this is right.. follow this' (12)</i></p>
<p><b>The Third</b></p>	<p>'third entity' in the room.          Arise out of the non-verbal interaction          The Zone          Synchronisation/ Resonance          Being part of something bigger          Difficulty finding words to describe          Awareness of oneself yet letting go</p>	<p>2, 3, 5, 6, 7, 9, 11, 12</p>	<p><i>matching rhythm' (11)</i>  <i>'alignment' (5)</i>  <i>'the zone. And the zone is about us meeting in that [interaction]' (2)</i>  <i>'like in a spiritual kind of attunement' (3)</i>  <i>'Divine Mother... It is God' (7).</i>  <i>I kinda feel that alchemy.. magical.. spiritual.. undefinable space in between two people.. in the relationship.. (6)</i>  <i>'when we can actually dare to be still' (12)</i>  <i>'It's that kind of space where you know two people are in a relationship and it's taking that to the next level' (9)</i></p>



